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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.

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メジカルビュー社の医学英語書籍

医学・医療系学生のための
総合医学英語テキスト Step 1

◆編集　日本医学英語教育学会

日本医学英語教育学会による「医学英語教育ガイドライン」のminimum requirementsレベルに対応する医学英語教科書であり，専門知識に乏しい1～2年生を対象に，貧血，頭痛，骨折，腹痛といった一般的症状をトピックとして構成している。各トピック毎に，①問診の会話 (listening)，②語彙 (vocabulary)，③読解 (reading)，④演習 (writing)の構成とし，また練習問題を配して，ガイドラインの4項目 (vocabulary, reading, writing, communication) をカバーしている。

＊音声ダウンロード・サービス付き。

■ 定価（本体 **2,800** 円＋税）・B5判・168頁　ISBN978-4-7583-0448-1

医学・医療系学生のための
総合医学英語テキスト Step 2

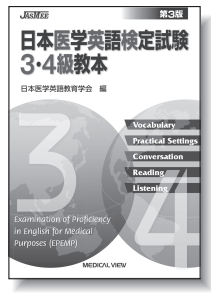
◆編集　日本医学英語教育学会

日本医学英語教育学会による「医学英語教育ガイドライン」のminimum requirementsレベルに対応する医学英語教科書。Step 2では専門教育を受ける3年生以上を対象として，急性心筋梗塞，炎症性腸疾患，糖尿病など代表的な疾患の定義や治療法で構成している。各トピック毎に，①疾患の定義・分類・治療法 (reading)，②語彙 (vocabulary)，③症例報告 (listening)，④演習 (writing)で構成。また練習問題を配して，ガイドラインの4項目 (vocabulary, reading, writing, communication) をカバーしている。

＊音声ダウンロード・サービス付き。

■ 定価（本体 **3,000** 円＋税）・B5判・192頁　ISBN978-4-7583-0449-8

日本医学英語検定試験 3・4 級教本 第3版



◆編集　日本医学英語教育学会

日本医学英語教育学会が主催する医学・医療に特化した英語検定である「日本医学英語検定試験（医英検）」の受験者向け教本の第3版。3級・4級試験で出題される「語彙問題」，「プラクティカル問題（写真や図表の読み取り）」，「読解問題（長文読解，会話読解）」，「リスニング問題」の出題傾向や対策についての解説に加え，後半にはこれまでの医英検で実際に出題された問題とその解答・解説が豊富に収載されている。巻末には必須ワード・略語リストも掲載されており，受験準備に最適。

＊音声ダウンロード・サービス付き。

■ 定価（本体 **3,600** 円＋税）・B5判・284頁　ISBN978-4-7583-0442-9

講義録 医学英語 I　語彙の充実と読解力の向上

◆編集　日本医学英語教育学会　　担当編集委員　清水 雅子

■ 定価（本体 **2,500** 円＋税）・B5判・168頁　ISBN978-4-7583-0407-8

講義録 医学英語 II　科学英語への扉

◆編集　日本医学英語教育学会　　担当編集委員　Nell L. Kennedy・菱田 治子

■ 定価（本体 **2,500** 円＋税）・B5判・164頁　ISBN978-4-7583-0408-5

講義録 医学英語 III　専門英語の理解と実践

◆編集　日本医学英語教育学会　　担当編集委員　J. Patrick Barron

■ 定価（本体 **2,500** 円＋税）・B5判・272頁　ISBN978-4-7583-0409-2

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第23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。第23回学術集会は下記により開催します。今回は，東京オリンピックの開催期間を考慮し，例年より1カ月程早い時期に，四国の高知で開催します。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23回日本医学英語教育学会学術集会

日　時：2020年6月27日（土）～28日（日）

会　長：高田　淳（高知大学医学部）

会　場：高知県民文化ホール（〒780-0870　高知県高知市本町4-3-30）

演題募集：2019年12月20日（金）～2020年2月21日（金）

（国際的交流活動，医療現場と医学英語，USMLE対策，医学英語達成度評価，医学英語教育における新たな取り組み，JASMEEの今とこれから，その他）

＊筆頭演者は本学会の会員に限ります。非会員の方は演題提出前に入会してください。
＊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

問い合わせ先：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：楠山）
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First Announcement

The 23rd Academic Meeting of the Japan Society for Medical English Education

The Japan Society for Medical English Education (JASMEE) held its first meeting as a study group in 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 23rd JASMEE academic meeting is presented below. In consideration of the Tokyo 2020 Olympics, the meeting will be held at the end of June, one month earlier than usual, in Kochi, Shikoku. We look forward to welcoming JASMEE members and non-members alike to this meeting, where they will be able to share their experience and expertise with others in the field to the greater benefit of medical English education in Japan and beyond.

Dates: Saturday June 27 and Sunday June 28, 2020

Venue: Kochi Prefectural Culture Hall
4-3-30, Hon-machi, Kochi-shi, Kochi 780-0870

President: Jun Takata
(Kochi Medical School)

Call for papers: Proposals for papers on the following subjects (or similar) should be submitted by February 21, 2020.

- International Exchange Programs
- Medical English in Clinical Settings
- USMLE Preparation
- Evaluation of Proficiency in Medical English
- New Developments in Medical English Teaching
- JASMEE–Now and in the Future

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. Kusuyama)
TEL 03–5228–2274 FAX 03–5228–9000
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Journal of Medical English Education

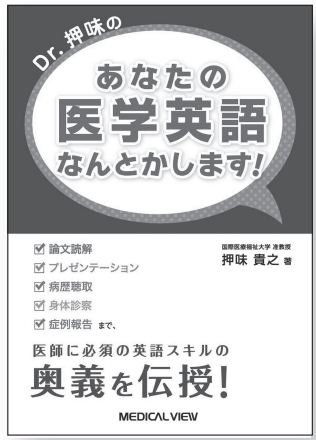
The official journal of the Japan Society for Medical English Education

jasmee@medicalview.co.jp

医学英語習得の近道である「基本ステップ」と「基本表現」を身につけよう！

Dr. 押味の あなたの 医学英語 なんとかします!

著者
押味 貴之
国際医療福祉大学 准教授



医師や医学生にとって本当に必要なのは「論文を読めるようになる」「国際学会で質疑応答ができるようになる」「外国人患者さんが満足できる医療面接ができるようになる」「海外の医師にもわかってもらえる症例報告ができる」という医学コミュニケーションができるようになることである。本書では医学英語教育分野の第一人者である押味貴之医師が，医師にとって必要最低限の医学英語スキルである「論文読解」「プレゼンテーション」「医療面接」「症例報告」という 4 つのスキルに関する奥義を余すことなく伝授する。
「医学英語をなんとかしたいけど，どこから手をつけたらいいのかわからない」というあなたにこそ，ぜひ手に取ってほしい 1 冊である。

定価（本体 3,000 円＋税）
A5 判・232 頁・2 色刷
ISBN978-4-7583-0960-8

目次

受付や案内・予約・電話対応など，窓口での対応は病院の “ 顔 ”。スムースな対応で窓口業務のスペシャリストになろう！

病院スタッフのための シチュエーション英会話

Situational Communication Skills for Hospital Staff

著者 服部 しのぶ 藤田保健衛生大学医療科学部 准教授　英文校閲 Chris Donaldson

グローバル化や医療ツーリズムの進展に伴い，日本語が不自由な在住外国人や外国人旅行者が日本の医療機関を利用する機会が増えている。受付や案内，会計，薬局等の病院職員がそうした状況に適切に対応できるように，外国人患者が日本の病院を訪れた際に考えられる種々の場面での英会話をロールプレイ形式で紹介。また，宗教や食文化など，異文化理解に役立つ知識をコラム形式で解説。音声ダウンロードサービス付き。

定価（本体 1,800 円＋税）
A5 判・128 頁・2 色刷
音声ダウンロードサービス付
ISBN978-4-7583-0964-6

目次

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スマートフォンで書籍の内容紹介や目次がご覧いただけます。

From the editor

Let me start by thanking the President of JASMEE's 22nd Annual Academic Meeting, Dr Hiroaki Igarashi of Kawakita General Hospital, and everyone else involved in the organization of this year's conference, which was held during the first weekend of August at Nakano Sun-Plaza in Tokyo. I was not able to attend myself because of family wedding duties in the UK, but having read all of the abstracts submitted by the presenters, I knew in advance that it would be a great success. We can now look forward to next year's conference, which will be held in Kochi over the weekend of 27th and 28th June (not July – please note) under the presidency of Professor Jun Takata of Kochi Medical School.

Along with three original articles, this issue of the Society's journal contains expanded versions of nine of the presentations given at this year's conference, for which I thank their authors. Nine is not as many as we had hoped to include, but I know that many of us (myself included) find it hard to apply ourselves diligently to work amidst the heat and other distractions of summer! We are, therefore, planning to include another conference proceedings section in the February issue and would like to encourage presenters who have not yet contributed to apply themselves during the cool autumn and early winter days that lie ahead. We will be able to process all contributions that reach us by the end of the year. Please submit them in the usual way to the JMEE secretariat (jasmee@medicalview.co.jp), not forgetting to attach a completed submission form (a blank form can be found on p. 125 of this issue). As always, we are flexible regarding the format of articles submitted for inclusion in the conference proceedings, but please note that submissions in Japanese should be accompanied by an abstract in English.

For many of us, the summer was overshadowed by the death in the middle of August of Professor Patrick Barron, who was instrumental not only in the founding of JASMEE in 1998 but also in its management and development over the years. The Society owes him an enormous debt of gratitude, as noted in the two obituaries you will find at the end of this issue, one contributed by JASMEE founder Professor Kenichi Uemura, and the other co-authored by my predecessor as editor-in-chief, Professor Reuben Gerling, and by one of Patrick's colleagues at Tokyo Medical University, Professor Takako Kojima. My own connection with Patrick predated JASMEE: he had just moved to TMU from St. Marianna School of Medicine, so it must have been 1991 or '92 when we first met. The occasion was a seminar on medical writing at which both of us had been asked to speak, and I remember first being impressed by the fact that he delivered his talk in Japanese, and then by the great bonhomie he manifested afterwards as we downed copious amounts of whisky at a hotel bar in Shinjuku. This was the start of a long and friendly association, and I am sure I am just one of the many who will continue to raise the occasional glass in his memory.

T.D. Minton
Editor-in-Chief
Journal of Medical English Education

高山赤十字病院が培った「外国人患者対応ノウハウ」をこの１冊に完全凝縮！

高山赤十字病院・編

医療現場ですぐに役立つ
外国人患者対応マニュアル

監修 棚橋　忍　高山赤十字病院 院長

編集 竹中 勝信　高山赤十字病院 副院長　英文校閲 Jeffrey Huffman

岐阜県高山市は人口約９万人の小規模都市だが，2016 年には約 46 万人の観光客が訪れた。その高山市の中核病院として機能している高山赤十字病院が培った「外国人患者対応のノウハウ」を余すことなく詰め込んだのが本書である。
本書は大きく「受付・看護」「診察」「薬剤」の３項目にわかれ，各項目ごとに「奔出する英会話フレーズ」と「英文資料（問診票，同意書，薬袋など）」が掲載されている。英文資料はすべてダウンロードが可能で，病院ですぐに使うことができる。
これからますます増加していく外国人患者にすばやく対応し，適切な医療を提供するために，ぜひ本書にあるノウハウを使って病院の国際化を進めていただきたい。

定価（本体 3,500 円＋税）
B5 判・156 頁・２色刷
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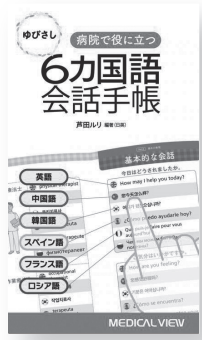
目次

この小さな１冊が６カ国語対応のコミュニケーションツールになる！

病院で役に立つ
ゆびさし6カ国語会話手帳

編著（日英） 芦田 ルリ　東京慈恵会医科大学国際交流センター 教授



東京慈恵会医科大学において外国人患者対応にあたっている看護師が，現場で必ず役立つ（言いたくても出てこなかった）フレーズを厳選し，６カ国語（英語，中国語，韓国語，スペイン語，フランス語，ロシア語）に翻訳して１冊にまとめたのが本書である。
病院で外国人患者さんに対応するとき，ぜひ本書をポケットに忍ばせてほしい。

定価（本体 2,500 円＋税）
B6 変形判・232 頁
オールカラー，イラスト 50 点
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スマートフォンで書籍の内容紹介や目次がご覧いただけます。

Can we improve TOEFL ITP® scores by teaching test-taking strategies and assigning an online test preparation course?

Cosmin Mihail Florescu,[1] Yusuke Hayasaka（早坂裕介）,[1] Takayuki Oshimi（押味貴之）,[2] Mutsumi Inokawa（井之川睦美）,[1] Barnabas Jon Martin,[1] Tamerlan Babayev,[2] Haruko Akatsu（赤津晴子）,[2] and Shigefumi Takasuka（高須賀茂文）[1]

[1] Center for Liberal Arts, School of Medicine, International University of Health and Welfare, Narita, Chiba

[2] Office of Medical Education, School of Medicine, International University of Health and Welfare, Narita, Chiba

Background/Objectives The English language program at the IUHW School of Medicine is using CLIL methodology to engage students in active learning. The TOEFL ITP® test is the main tool used for placement and measuring areas of improvement. This paper aims to establish how much of an impact test preparation in and out the classroom has on TOEFL scores.

Methods Whereas no TOEFL coaching took place during the mandatory courses (English I and II), test-taking strategies were explicitly taught to students (n=54) with lower TOEFL scores attending the elective courses (English Communication A1 and A2). Additionally, all students (n=140) were required to complete an online TOEFL preparation course. A correlation analysis was carried out involving 21 factors including test scores, online course scores and attendance.

Results The analysis revealed a moderate positive correlation between attendance of TOEFL preparatory lessons and TOEFL score improvement for one class, although the improvement was observed for a different section of the test than the one targeted during preparatory lessons(prep-lessons). While moderate positive correlations were identified between the online preparation course score and the pre- and post-program test scores on the Reading Section, there was so significant correlation between the online course score and TOEFL score improvement.

Conclusion The results indicate that providing prep-lessons or an online course for students with lower TOEFL test scores will not necessarily yield improved performance on the test. These findings suggest that a different approach is needed for students with lower English proficiency.

J Med Eng Educ(2019) 18(3): 55-64

Keywords test preparation, language testing, TOEFL ITP, test-taking strategies, CLIL

1. Introduction

Language testing and test preparation are typically perceived as "necessary evils," both in teaching and learning English as a Foreign Language (EFL). Language instructors generally agree on the value of using proficiency tests to assess their students' ability to use the target language; on the other hand, as educators, they express mixed feelings about the value and efficacy of formally preparing students to take such tests.[1]

The Test of English as a Foreign Language Institutional Testing Program (TOEFL ITP®) has been adopted by a significant proportion of medical schools in Japan[2] and has also been employed for placement and for measuring areas of improvement in the newly opened School of Medicine at the International University of Health and Welfare (IUHW).

The IUHW School of Medicine is the first medical school in Japan to teach all medical subjects in English in the 1st and 2nd years, making it imperative for teachers to ensure that students improve their English language proficiency and stay motivated throughout their English language program. With these ends in mind, there is little focus on formally preparing

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A summary of this paper has been presented orally at the 21st JASMEE Academic Meeting on July 28, 2018 in Tokyo.

students for the TOEFL ITP® test, as the program is using Content and Language Integrated Learning (CLIL) methodology to promote active learning matching the approach recommended for all English education programs at Japanese universities.[3]

The IUHW English curriculum for 1st year students (n=140) consists of two mandatory courses (English I and II) which focus on ensuring that students feel motivated to actively participate in various class activities designed first and foremost to improve their confidence in speaking in front of others and to boost their ability to attend to, as well as decode authentic materials (mostly using *TED talks*).

English I, which consists of 60 one-hour lessons over a two-month period, is divided in four sub-courses titled "Japan," "Career," "News" and "Healthcare." Within these four sub-courses, students are assigned a variety of communicative tasks designed to prepare them to understand and discuss with non-Japanese speakers:

(a) topics related to Japanese culture, religion or art ("Japan"),
(b) seven habits[4] to become effective medical school students ("Career"),
(c) English language media coverage of globally relevant issues ("News"), and
(d) the Japanese healthcare system and how it compares with its Western counterparts ("Healthcare").

English II, which consists of 180 one-hour lessons over a six-month period, is also divided in four sub-courses titled "Culture and Humanity," "Medicine and Science," "Global Issues" and "Patient Encounter." In the first three of these sub-courses, students engage in more communicative tasks focused on understanding and discussing the content of *TED talks* selected to match the sub-course titles. The last sub-course, "Patient Encounter," provides students with activities simulating the experience of a doctor taking a patient's history, performing physical exams, considering possible diagnoses, etc.

The IUHW English curriculum also includes an elective course (English Communication; henceforth, EC) primarily aimed at students (n=108) who scored below CEFR B2 in the pre-program TOEFL test. These 108 students were assigned to one of four EC classes (27 students per class) based on their TOEFL listening scores, with EC-A1 and EC-A2 comprising students in the bottom half, whereas EC-B1 and EC-B2 include students with higher scores (although still below the CEFR B2 threshold). The concept behind EC, which consists of 180 one-hour lessons delivered daily for each class (EC-A1 through EC-B2) during the 7th period (16:20 to 17:20), is to offer students a relaxed environment to communicate in English with the main goal of increasing time spent using the target language; this flexible format is made possible by the fact that attendance is entirely up to the students and the EC grade is not reflected in their GPA scores. The eight English faculty members teaching EC can thus concentrate on any skill that students require, from basic conversation to listening exercises, covering a wide range of materials, from content taught in other courses to topics drawn from American culture (sitcoms, political issues, etc.). From the students' point of view, EC is being taught by a different teacher each week day (for example, I was teaching EC-A2 on Wednesdays and EC-A1 on Fridays); this allows the teacher to plan his/her course semi-independently of other faculty members. Overall coordination of the EC course focused mainly on avoiding content overlap.

It was within this context that some students from EC-A1 and EC-A2 classes requested that strategies for taking the TOEFL test should be taught during EC lessons. It should be noted that, unlike English I or English II, there was no assigned teacher for each class, so that students were interacting with a different teacher every day. Students were duly notified about the test preparation classes using the Moodle e-learning system (which the students use every day for nearly all learning tasks, from registering for attendance to downloading lecture notes). The above conditions provided an opportunity to evaluate whether test preparation in the classroom makes a difference in language proficiency scores, which is one of the research questions this study aims to answer.

RQ1. *Can test preparation through the teaching of test-taking skills in a formal class improve TOEFL scores?*

Additionally, this paper will also try to establish how effective an online TOEFL course (which students were required to complete in their spare time) was in improving their performance on the test. Readers interested in knowing more details regarding the online course are directed to the official website of the company providing the course.[5]

RQ2. *Can test preparation through self-study using an official TOEFL preparatory course improve TOEFL scores?*

There is conflicting evidence on the efficacy of coaching students for EFL tests. While some researchers have been able to point to improved performance on standardized language tests following a test preparation course,[6-8] others discovered that courses which focused on improving academic skills were as effective as the test preparation courses in improving test scores.[9,10] There are also studies which found no significant score gains for students undertaking test preparation.[11,12]

The relative scarcity of conclusive findings regarding the

effectiveness of test preparation was summarized by one author as follows: "empirical evidence currently available about the effectiveness of second language (L2) test preparation on score improvement is limited."[13] Additionally, there is also little research aimed at establishing the impact of out-of-class preparation by the students themselves with the notable exception of Liu's study[14] whose findings are somewhat weakened by the fact that the test scores were self-reported and the materials used for study were not standardized. This study aims to contribute to the research literature in the area of test preparation by analyzing what correlations can be established between test preparation (in and out of class) and score gains on the TOEFL ITP®.

2. Methods

TOEFL test-taking strategies were introduced during EC-A1 and EC-A2 made up of students (n=54) who scored in the bottom half on the Listening Section of the pre-program TOEFL ITP® test. A total of 11 lessons were delivered for each class by the lead author of this study once a week between September and December 2017. The specific strategies were based on the "Skills for Listening Comprehension" in Longman's Preparation Course for the TOEFL® Test;[15] these skills are summarized in **Table 1**.

The typical lesson started with a brief explanation of two-three skills using actual test questions for illustration, followed by 20-30 minutes of practice using material from the textbook, and ended with a short Q&A session during which the teacher covered particularly challenging vocabulary or grammar points. Attendance of EC lessons had stabilized by September 2017, thus ensuring that those who attended the test preparation segment within EC did so consistently (**Fig 1** below). The six EC=A1 students (in darkgray) and the 12 EC-A2 students (in lightgray) who attended less than 50% of test prep-lessons were those who had gradually stopped coming to EC classes altogether (i.e., their attendance of the remaining EC lessons also fell well below 50%). There were no significant differences in attendance rates on different days (i.e., students who attended test prep-lessons would also, on average, attend lessons provided by other teachers on a different day).

In addition to the above-mentioned courses, all students were required to complete an online TOEFL preparation course using a customized module of the National Geographic Learning's web-based learning management system (MyELT), which allowed students to practice TOEFL-type questions for the Reading and Listening Sections in a self-study format. The course consisted of 141 activities, took up to 40 hours to complete and was available for a six-month period from July 2017 to January 2018 (this online preparation course will henceforth be referred to as "MyELT

Table 1. 22 Skills for the TOEFL ITP Listening Section

Part A	1. Focus on the second line
	2. Choose answers with synonyms
	3. Avoid similar sounds
	4. Draw conclusions about Who, What, Where
	5. Listen for Who and What in passives
	6. Listen for Who and What with multiple nouns
	7. Listen for negative expressions
	8. Listen for double negative expressions
	9. Listen for almost negative expressions
	10. Listen for negatives with comparatives
	11. Listen for expressions of agreement
	12. Listen for expressions of uncertainty/suggestion
	13. Listen for strong expressions of surprise
	14. Listen for wishes (contrary meaning)
	15. Listen for untrue conditions
	16. Listen for two- or three-part verbs
	17. Listen for idioms
Parts B and C	18. Anticipate the topics
	19. Anticipate the questions
	20. Determine the topic
	21. Draw conclusions about Who, When, Where and What
	22. Listen for answers in order

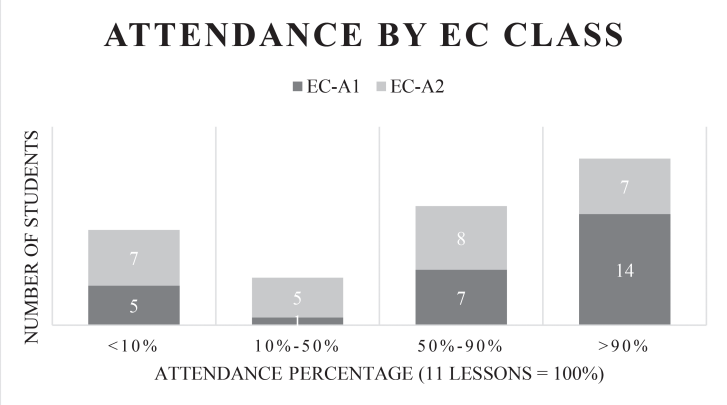

Fig 1. Attendance of test prep-lessons by class

course"). While all students were required to complete 100% of these activities, it was left up to individual students whether they would make use of a course feature which allows learners to review their own answers after submission and, if they so desire, to attempt again assignments they answered incorrectly. In practice, this meant that high final scores on the MyELT course could be attributed to either (a) students' actual high English-language proficiency or (b) their diligence in redoing questions they were not able to answer correctly on their first attempt due to lower proficiency. This specific online course was chosen based on convenience and authenticity; the Japanese company that handles preparation and scoring of the TOEFL ITP® tests at IUHW, CIEE Japan, also provides officially approved test materials under a license from Educational Testing Services, the company producing the TOEFL tests. The company recommends the MyELT course as the optimum tool to become familiar with and to prepare for the TOEFL ITP® test. To help instructors build a better learner profile, students were also asked to rate their own English proficiency using the Self-Assessment Grid included in the Common European Framework of Reference (CEFR).

A Pearson correlation analysis was carried out involving 21 factors which are defined in **Table 2** below.

Table 2. Definitions/Abbreviations for the 21 factors used in the correlation analysis

Category	Measured Item (abbreviation)	Measured Item (description)
TOEFL ITP® Test Scores	TOEFL Apr2017	Total score on the official TOEFL ITP® test administered in April 2017
	TOEFLS1 Apr2017	Listening (Section I) score on the official TOEFL ITP® test administered in April 2017
	TOEFLS2 Apr2017	Structure and written expression (Section 2) score on the official TOEFL ITP® test administered in April 2017
	TOEFLS3 Apr2017	Reading (Section 3) score on the official TOEFL ITP® test administered in April 2017
	TOEFL Jan2018	Total score on the official TOEFL ITP® test administered in January 2018
	TOEFLS1 Jan2018	Listening (Section I) score on the official TOEFL ITP® test administered in January 2018
	TOEFLS2 Jan2018	Structure and written expression (Section 2) score on the official TOEFL ITP® test administered in January 2018
	TOEFLS3 Jan2018	Reading (Section 3) score on the official TOEFL ITP® test administered in January 2018
	TOEFL Imprv	Points gain between Total scores administered in April 2017 and January 2018
	TOEFLS1 Imprv	Points gain between Listening (Section I) scores in April 2017 and January 2018
	TOEFLS2 Imprv	Points gain between Structure and written expression (Section 2) scores in April 2017 and January 2018
	TOEFLS3 Imprv	Points gain between Reading (Section 3) scores in April 2017 and January 2018
Attendance	ECTOEFL Attend	Attendance of English Communication A1 and A2 classes during which test-taking strategies were taught
	EC Attendance	Attendance of English Communication classes (180-hour elective course, including the test preparation component)
	English I Attendance	Attendance of English I classes (60-hour mandatory course)
	English II Attendance	Attendance of English II classes (180-hour mandatory course)
Self-ratings on a 5-point scale: A1=1, A2=2, B1=3, B2=4 and C1=5 (based on the CEFR can-do statements list)	Self-Rate Listen	Student's self-rating of his/her listening skills
	Self-Rate Read	Student's self-rating of his/her reading skills
	Self-Rate SpknIntrct	Student's self-rating of his/her spoken interaction skills
	Self-Rate SpknPrdct	Student's self-rating of his/her spoken production skills
	Self-Rate Write	Student's self-rating of his/her writing skills
MyELT course score	MyELT Score	Student's final score upon completing the online TOEFL preparation score (MyELT)

3. Results

The mean, standard deviation (SD) and score distribution measures for the TOEFL ITP® test scores in April 2017 (pre-program) and January 2018 (post-program) are shown in **Table 3**. A two-tailed paired t-test revealed significant differences ($p < 0.001$) between pre-program and post-program performance, both on each section and for the total score.

The Pearson correlation analysis revealed several significant correlations (statistically significant correlations using the two-tailed p-value are shown in **bold**). When discussing test preparation in the classroom (i.e., EC lessons focused on TOEFL taking skills), the correlation analysis will be confined to the 54 students in EC-A1 and EC-A2; this will be indicated in the left-upper corner of each table showing correlation and significance values. This is to distinguish cases when the analysis involves factors that apply to all 140 students. Weak positive correlations were identified between attendance of prep-lessons and gains in Total score and Section 2 score, but there was no significant correlation between attendance of prep-lessons and gains in Section 1 score (**Table 4** below). By breaking down the analysis to the two EC classes, we can see that EC-A2 students who attended more prep-lessons had a better chance of improving their scores, although this did not occur in the expected section of the TOEFL test.

Table 5 below shows very strong significant correlations between attendance of prep-lessons (11 lessons) and attendance of EC lessons in general (totaling 180 lessons throughout the year); by contrast, these correlations become weaker or insignificant when we consider attendance in the mandatory courses (English I and English II). These findings indicate that the improvement effect is perhaps better ascribed to a more diligent attitude and more contact hours with the target language.

We have so far considered what can be done for lower proficiency students from the teachers' perspective, so it is important to add the students' point of the view to the above analysis by looking at some aspects (beliefs, attitude, self-image) constituting the learner profile of the 54 students who were taught test-taking strategies.

There was no significant correlation between attendance of TOEFL prep-lessons and pre-program TOEFL scores

Table 3. Descriptive statistics for the pre- and post-program test scores

	Mean	SD	Sample Variance	Kurtosis	Skewness
2017 Total Score	519.09	51.57	2659.28	0.23	0.70
2017 Section 1 Listening	50.70	6.56	43.01	-0.05	0.44
2017 Section 2 Grammar	51.74	6.04	36.47	0.17	0.53
2017 Section 3 Reading	53.28	4.68	21.90	1.14	0.39
2018 Total Score	551.47	49.26	2426.69	-0.26	0.31
2018 Section 1 Listening	54.88	5.99	35.86	-0.42	0.52
2018 Section 2 Grammar	54.00	5.57	30.99	-0.10	-0.05
2018 Section 3 Reading	56.55	5.08	25.79	-0.34	0.19

* n=139 test-takers out of 140 1st year students

(one student was not able to take the test due to being sick on the test day)

Table 4. Correlations between attendance of TOEFL preparatory classes and improvement in TOEFL ITP® scores

Only EC-A1		TOEFL Imprv	TOEFLS1 Imprv	TOEFLS2 Imprv	TOEFLS3 Imprv
ECTOEFL Attend	Pearson Correlation	0.121	-0.059	0.183	0.044
	Sig. (2-tailed)	0.556	0.775	0.372	0.830
Only EC-A2		**TOEFL Imprv**	**TOEFLS1 Imprv**	**TOEFLS2 Imprv**	**TOEFLS3 Imprv**
ECTOEFL Attend	Pearson Correlation	**0.464**	0.157	**0.601**	-0.004
	Sig. (2-tailed)	0.015	0.434	0.001	0.985
Combined EC-A1 and EC-A2		**TOEFL Imprv**	**TOEFLS1 Imprv**	**TOEFLS2 Imprv**	**TOEFLS3 Imprv**
ECTOEFL Attend	Pearson Correlation	**0.276**	0.105	**0.347**	-0.018
	Sig. (2-tailed)	0.046	0.456	0.011	0.900

***Bolded correlations** are significant at the 0.05 level (2-tailed).

(**Table 6** below); in other words, among the 54 students with below-average English proficiency, it was not necessarily the students with the lower proficiency who chose to participate regularly in the elective classes designed to help them improve.

The above finding is also supported by the fact that, in terms of students' self-perceived image of their English-using selves, correlations between attendance of prep-lessons and self-ratings of English language proficiency level were not significant when the analysis was confined to the two classes (EC-A1 and EC-A2) for which prep-lessons were offered (**Table 7**).

Moving on to the online TOEFL preparation course (MyELT), no significant correlations could be identified between MyELT scores and test score gains, either when considering all students, or when looking at the lower proficiency group of students (**Table 8** below).

It is necessary at this point to test the validity of the MyELT course in terms of whether it accurately mirrors performance on the actual tests; to do so, we looked at correlations between MyELT course scores and pre-program as well as post-program test scores. When all students were included in the analysis, moderate positive correlations could be identified between MyELT scores and TOEFL scores. With the notable exception of Section 3 scores, these correlations disappeared when the analysis is limited to students in the bottom half of proficiency levels (**Table 9**).

Similarly, when all students were included in the analysis, moderate positive correlations could be identified between MyELT scores and scores for each separate section as well as Total score on the post-program TOEFL test. When the analysis was limited to students in the bottom half of proficiency levels, these correlations became weaker (Total and Section 1 scores) or insignificant (Section 2 score), again with the notable exception of the correlation between MyELT scores and Section 3 scores which remained moderate (**Table 10**

Table 5. Correlations between attendance of TOEFL preparatory classes and attendance in elective or mandatory courses

Only EC-A1		EC Attendance	English II Attendance	English IAttendance
ECTOEFL Attend	Pearson Correlation	**0.938**	0.307	0.184
	Sig. (2-tailed)	0.000	0.119	0.359
Only EC-A2		EC Attendance	English II Attendance	English I Attendance
ECTOEFL Attend	Pearson Correlation	**0.910**	**0.508**	0.326
	Sig. (2-tailed)	0.000	0.007	0.104
Combined EC-A1 and EC-A2		EC Attendance	English II Attendance	English I Attendance
ECTOEFL Attend	Pearson Correlation	**0.896**	**0.462**	**0.290**
	Sig. (2-tailed)	0.000	0.000	0.035

* **Bolded correlations** are significant at the 0.05 level (2-tailed).

Table 6. Correlations between attendance of TOEFL preparatory classes and pre-program TOEFL ITP® scores

Only EC-A1		TOEFL Apr2017	TOEFLS1 Apr2017	TOEFLS2 Apr2017	TOEFLS3 Apr2017
ECTOEFL Attend	Pearson Correlation	-0.178	0.037	-0.267	-0.040
	Sig. (2-tailed)	0.383	0.856	0.188	0.845
Only EC-A2		TOEFL Apr2017	TOEFLS1 Apr2017	TOEFLS2 Apr2017	TOEFLS3 Apr2017
ECTOEFL Attend	Pearson Correlation	0.280	-0.041	0.150	0.348
	Sig. (2-tailed)	0.157	0.841	0.456	0.075
Combined EC-A1 and EC-A2		TOEFL Apr2017	TOEFLS1 Apr2017	TOEFLS2 Apr2017	TOEFLS3 Apr2017
ECTOEFL Attend	Pearson Correlation	-0.052	-0.137	-0.097	0.139
	Sig. (2-tailed)	0.712	0.329	0.488	0.320

* **Bolded correlations** are significant at the 0.05 level (2-tailed).

Table 7. Correlations between attendance of TOEFL preparatory classes and self-ratings of English proficiency level

Only EC-A1		SelfRate Listen	SelfRate Read	SelfRate SpknIntrct	SelfRate SpknPrdct	SelfRate Write
ECTOEFL Attend	Pearson Correlation	0.052	0.177	0.278	-0.022	0.096
	Sig. (2-tailed)	0.796	0.377	0.160	0.913	0.634
Only EC-A2		SelfRate Listen	SelfRate Read	SelfRate SpknIntrct	SelfRate SpknPrdct	SelfRate Write
ECTOEFL Attend	Pearson Correlation	0.161	-0.227	-0.191	-0.101	0.002
	Sig. (2-tailed)	0.432	0.264	0.351	0.623	0.993
Combined EC-A1 and EC-A2		SelfRate Listen	SelfRate Read	SelfRate SpknIntrct	SelfRate SpknPrdct	SelfRate Write
ECTOEFL Attend	Pearson Correlation	0.090	-0.046	0.065	-0.073	0.062
	Sig. (2-tailed)	0.522	0.741	0.643	0.601	0.662

* **Bolded correlations** are significant at the 0.05 level (2-tailed).

Table 8. Correlations between MyELT score and TOEFL ITP® score improvements

All students		TOEFL Imprv	TOEFLS1 Imprv	TOEFLS2 Imprv	TOEFLS3 Imprv
MyELT Score	Pearson Correlation	0.012	0.020	-0.079	0.099
	Sig. (2-tailed)	0.887	0.816	0.357	0.247
Combined EC-A1 and EC-A2		TOEFL Imprv	TOEFLS1 Imprv	TOEFLS2 Imprv	TOEFLS3 Imprv
MyELT Score	Pearson Correlation	0.240	0.209	0.159	0.041
	Sig. (2-tailed)	0.084	0.134	0.257	0.772

* **Bolded correlations** are significant at the 0.05 level (2-tailed).

Table 9. Correlations between MyELT score and pre-program TOEFL ITP® scores

All students		TOEFL Apr2017	TOEFLS1 Apr2017	TOEFLS2 Apr2017	TOEFLS3 Apr2017
MyELT Score	Pearson Correlation	**0.625**	**0.55**	**0.555**	**0.579**
	Sig. (2-tailed)	0.000	0.000	0.000	0.000
Only EC-A1 and EC-A2		TOEFL Apr2017	TOEFLS1 Apr2017	TOEFLS2 Apr2017	TOEFLS3 Apr2017
MyELT Score	Pearson Correlation	0.250	0.020	0.066	**0.442**
	Sig. (2-tailed)	0.071	0.886	0.641	0.001

* **Bolded correlations** are significant at the 0.05 level (2-tailed).

Table 10. Correlations between MyELT score and post-program TOEFL ITP® scores

All students		TOEFL Jan2018	TOEFLS1 Jan2018	TOEFLS2 Jan2018	TOEFLS3 Jan2018
MyELT Score	Pearson Correlation	**0.66**	**0.616**	**0.538**	**0.603**
	Sig. (2-tailed)	0.000	0.000	0.000	0.000
Only EC-A1 and EC-A2		TOEFL Jan2018	TOEFLS1 Jan2018	TOEFLS2 Jan2018	TOEFLS3 Jan2018
MyELT Score	Pearson Correlation	**0.389**	**0.303**	0.220	**0.413**
	Sig. (2-tailed)	0.004	0.026	0.109	0.002

* **Bolded correlations** are significant at the 0.05 level (2-tailed).

below).

Table 11 below reveals weak but significant positive correlations between MyELT scores and attendance of EC lessons in general as well as attendance of prep-lessons for the students in the bottom half; by contrast, the correlations between MyELT scores and attendance in the mandatory courses (English I and English II) are insignificant. These findings suggest (again) a more diligent attitude of learners achieving higher scores in the online preparation course, regardless of their proficiency level.

In terms of students' self-perceived image of their English-using selves, when all students were included in the analysis, weak positive correlations were identified between MyELT scores and self-ratings of English proficiency level. These correlations were not significant when the analysis was confined to the two bottom classes (EC-A1 and EC-A2) (**Table 12** below).

4. Discussion

The authors had hypothesized that, since prep-lessons were specifically provided for students with lower English proficiency and since these students had the most to gain by repeatedly practicing in the MyELT course those test-taking strategies which were taught in class, the analysis would reveal the following trends (table numbers are given in parentheses for the reader's benefit to contrast each hypothesis with actual findings):

1. the higher the attendance rate of prep-lessons, the higher the score gain on the test (prep-lessons' effectiveness) (**Table 4**);
2. the lower the initial test score, the higher the attendance rate of prep-lessons (learner needs) (**Table 6**);
3. the lower the self-rating, the higher the attendance rate (learner needs) (**Table 7**);
4. the higher the score on the MyELT course, the higher the score gain on the test (online course effectiveness) (**Table 8**);
5. the higher the score on the MyELT course, the higher the post-program test scores (online preparation course validity) (**Table 10**);
6. the lower the self-rating, the higher the score on the MyELT course (learner needs) (**Table 12**).

It should be emphasized that items 2, 3 and 6 are premised on students feeling positively motivated to improve their test results and self-image as English language learners by taking advantage of every opportunity to study English provided by the school. Looking at the results listed above and contrasting these with our assumptions, the following can be said in answer to the two research questions.

RQ1. *Can test preparation through the teaching of test-taking skills in a formal class improve TOEFL scores?*

Table 11. Correlations between MyELT score and attendance of elective or mandatory courses

All students		EC Attendance	English II Attendance	English I Attendance	ECTOEFL Attend
MyELT Score	Pearson Correlation	**0.236**	**0.206**	0.066	NA
	Sig. (2-tailed)	0.014	0.015	0.473	NA
Only EC-A1 and EC-A2		EC Attendance	English II Attendance	English I Attendance	ECTOEFL Attend
MyELT Score	Pearson Correlation	**0.349**	0.126	0.047	**0.368**
	Sig. (2-tailed)	0.010	0.363	0.736	0.006

* **Bolded correlations** are significant at the 0.05 level (2-tailed).

Table 12. Correlations between MyELT score and self-ratings of English proficiency level

All students		SelfRate Listen	SelfRate Read	SelfRate SpknIntrct	SelfRate SpknPrdct	SelfRate Write
MyELT Score	Pearson Correlation	**0.322**	**0.24**	**0.228**	**0.242**	**0.301**
	Sig. (2-tailed)	0.000	0.005	0.007	0.004	0.000
Only EC-A1 and EC-A2		SelfRate Listen	SelfRate Read	SelfRate SpknIntrct	SelfRate SpknPrdct	SelfRate Write
MyELT Score	Pearson Correlation	0.222	0.127	0.087	0.084	0.145
	Sig. (2-tailed)	0.110	0.365	0.536	0.552	0.301

* **Bolded correlations** are significant at the 0.05 level (2-tailed).

The prep-lessons were effective in ensuring only modest score gains on the TOEFL test and in a different section of the test than the one for which specific test-taking strategies were taught (**Table 4** above). Attending these lessons seems to have offered a slightly better chance of improving one's score for the lower-intermediate class (EC-A2), but not for the lowest proficiency class (EC-A1). Intriguingly, this moderate improvement appeared in the Structure and Written Expression Section of the test and not, as expected, in the Listening Section. This finding indicates that other factors may be responsible for improved performance on the test.

One such factor is likely to be the significant increase in "comprehensible input"[16] for the select group of students who proved to be more diligent in attending prep-lessons as these students were also more likely to attend more elective English Communication classes beyond the period during which TOEFL prep-lessons were delivered (**Table 5**). Another possible factor which could explain this finding is the more pronounced reliance on visual input (i.e., conversation scripts) by Japanese university students struggling to remember the native speakers' utterances[17] in order to better answer test questions. As mentioned above, the teacher delivering prep-lessons spent the last part of each class going over challenging grammar/vocabulary points while showing the conversation scripts.

While not directly connected with the first research question, two points which may be of interest to English curriculum planners can be made regarding the way lower proficiency learners view prep-lessons.

1. A student's initial test score is not a reliable predictor of his/her motivation to attend prep-lessons designed to help him/her improve test scores (**Table 6** above).
2. Similarly, a student who self-rates himself/herself as having a lower English proficiency is not guaranteed to see prep-lessons as a good opportunity to remedy such a weakness (**Table 7** above).

RQ2. *Can test preparation through self-study using an official TOEFL preparatory course improve TOEFL scores?*

The online preparatory course (MyELT) was not effective in bringing about a significant score gain (**Table 8** above). On the other hand, the online course appears to be a useful tool for predicting student performance on the actual tests, especially for its Reading Section (**Tables 9** and **10** above, which show that Reading scores on both pre- and post-program tests correlated consistently with the MyELT course even for lower proficiency students). Additionally, those who achiever higher scores on the online preparation course are more likely to attend elective test preparation classes (**Table 11** above).

These results should not be interpreted as denying the educational value of this online preparation course, but should rather be a reminder of the risks inherent in blending learner autonomy with teacher-imposed requirements. While some self-directed students may have benefitted from being assigned this online course, making course completion mandatory for all students meant that a significant percentage of learners did so only pro forma as other needs (e.g., studying for basic medicine subjects) were prioritized over making full use of this tool.

A point of interest for English curriculum planners is our finding that students who self-rate as having poor English language skills (and thus with plenty of room for improvement) are not guaranteed to make full use of online learning tools such as the MyELT course (**Table 12** above). Online learning platforms (e.g., flashcard apps, open courses, etc.) have been touted as providing the perfect, individual-customized environments in which students can proceed at their own pace until a certain skill or a specific segment of knowledge has been mastered. In spite of these claims, our study revealed that a significant number of lower proficiency students failed to practice sufficiently to achieve a close-to-perfect score in an environment which provides such an opportunity. This finding confirms Ryan's observation that "the strong relationship shown between the ideal L2 self and effort is hardly affected by current perceptions of L2 competence."[18]

5. Conclusions and Limitations

English-language programs at the tertiary level are often expected to include a component designed to help students who perform poorly on standardized language tests such as the TOEFL ITP® test. Such a component can be delivered either in the context of a formal class teaching test-taking strategies and skills, or as an online course which students can complete at their own pace through self-study.

Our research showed that higher attendance of prep-lessons is not necessarily correlated with lower initial test scores or lower self-perceived proficiency. Moreover, even among those students who diligently attended this course, being taught test-taking strategies and skills seems to achieve only a mild enhancing effect on their TOEFL test scores and not necessarily in the expected skill domains. Additionally, the findings of this study suggest that the final score of an online preparation course which offers ample opportunities to practice test-taking strategies and to become familiar with the test format generally mirrors performance on the test itself (pre- and post- program) and does not play a significant role in bringing about score gains.

It is important to stress three limitations of this study:

1. prep-lessons were provided in the format of an elective course and classes were offered in a less-than-ideal time-slot, 16:20 to 17:20, often after attending five or six lectures of a medical subject (this continues to be the case even now);
2. the language instructor who delivered these lessons (the lead author of this study) had only one-year experience teaching English to university students;
3. completion of the online course was mandatory, making the students' final scores on MyELT unreliable as some rushed through this assignment with little regard for the accuracy of their answers (this claim is backed by evidence from the completion rate of an "optional online TOEFL course" (focused on speaking skills) which was provided in parallel with the mandatory course; no student went beyond 1% completion).

In the following year, the authors made significant changes in the way the elective course was delivered, essentially making it open-to-all, with no assigned class, and organizing it around fixed genres/topics such as English for Academic Purposes, Hobbies, English for General Purposes, US politics etc.; a follow-up study may shed more light on the effectiveness of attempts to improve TOEFL ITP® test scores in the EFL context in Japanese medical schools.

While this study points to a cautionary approach to "teaching for test-taking purposes," the fact that IUHW Medical School students achieved an average score gain of 32 points between April 2017 and January 2018 shows that an intensive CLIL-based English language program can achieve the type of improvement both educators and learners desire.

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Global learning experiences of Japanese nursing students through international exchange

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As globalization progresses in Japan, there is a growing need to raise Japanese healthcare professionals who can serve as globally competent members of their healthcare teams. As an attempt to address this need, this paper describes participation in an international exchange program by two nursing students at a Japanese health sciences university. The students spent two weeks at a school of health at the university's partner institution in Calgary, Canada. During the visit, the students attended lectures and laboratory sessions in healthcare specialty subjects, received English language lessons, took part in a wide range of on- and off-campus extracurricular activities, did sightseeing, and experienced multicultural life in Canada. Upon their return to Japan, the students were required to submit a written report describing their observations, experiences and impressions from the visit. In the reports, students described the experiences as transformational and having a huge impact on their professional and personal lives. In particular, the students reflected that they found attending the specialty classes and laboratory sessions to be an extremely good incentive for learning and active participation in the classes by the Canadian students as positive. On taking the English language classes, students wrote of having become more aware of their weaknesses in learning English and of how to improve their ways of learning the language. Students also appreciated the different ways of thinking and values of people from other countries and seemed greatly impressed by how people from different ethnic backgrounds co-existed in the same place and communicated well with each other, a quality most important for healthcare professionals in a multiethnic society. Although these are observations made by only two students, their depth and relevance to the practice of healthcare profession in a globalized world underscore the importance of including global learning experiences in Japanese nursing education.

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1. Introduction

Increasing globalization of healthcare is making it necessary for schools of health around the world to provide international exchange opportunities for their students. Recognizing this need, in 2015, Kagawa Prefectural University of Health Sciences (KPUHS)[1] in Takamatsu, Japan and Southern Alberta Institute of Technology (SAIT)[2] in Calgary, Canada, established an exchange program that entailed an annual reciprocal exchange of students and faculty between the two institutions. KPUHS offers programs in nursing, medical laboratory technology, midwifery and public health under its faculty of health sciences. At SAIT, a wide range of health-related programs are offered by its School of Health and Public Safety (SHPS).[3]

Although SAIT's SHPS does not offer a program specifically in nursing, the educational contents of several of its programs such as Diagnostic Medical Sonography, Emergency Medical Technology, Respiratory Therapy, and Rehabilitation Therapy are relevant to nursing practice and can provide meaningful learning opportunities to nursing students at KPUHS. Likewise, students enrolled in healthcare programs at SAIT can gain much from learning about nursing and other program at KPUHS. Accordingly, participation in the exchange program between KPUHS and SAIT is open to students enrolled in all healthcare disciplines at both institutions.

The KPUHS-SAIT exchange program agreement is overseen at KPUHS by the International Exchange Committee and

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at SAIT by the Educational Relationships, Study Abroad Services, and implemented in collaboration with the respective healthcare programs at each school whose students are selected to take part in the exchange in a given year.

Since establishing the agreement, both sides have carried out an exchange of students and faculty for four consecutive school years. During this period, a total of 11 KPUHS and 10 SAIT students have participated in the exchange with the student numbers ranging from 2-4 in a given year with one accompanying faculty member per visit. The study majors of the participating students have included nursing and medical laboratory technology in case of the KPUHS students and medical laboratory technology, respiratory technology, emergency medical technology and nuclear medicine technology in case of the SAIT students. While the fundamental aspects of the program have remained the same, several features such as the timing of the visit and details of curricular and extracurricular activities have varied from year to year. This paper looks at participation by KPUHS students in the outbound part of the exchange in the first year of the program.

2. KPUHS-SAIT outbound exchange

In September 2015, two KPUHS nursing students (both women and first-year) and a faculty member (woman) visited SAIT for two weeks as a part of the outbound exchange. September was chosen for the visit since KPUHS students are on summer vacation whereas at SAIT the fall semester is in session, thus allowing the visiting students to take part in the curricular part of the exchange at the host institution.

2.1. Curricular activities

During the two-week period of the visit to SAIT, KPUHS students attended lectures and laboratory sessions in a variety of subjects in health sciences specialties. A list of the typical classes and labs that the students attended is given in **Table 1** together with their duration and number. With the exception of English language classes (11), all were regularly scheduled sessions in the SAIT curriculum, thus making it possible for the KPUHS students to attend these classes together with the SAIT students.

Table 1. Classes and laboratory practices attended by KPUHS students at SAIT

Subject (Duration) x Number of sessions
1. Paramedic Lab (2 h) x 1
2. Ultrasound Lab (Obstetrics) (2 h) x 1
3. Ultrasound Lab (Vascular) (2 h) x 1
4. Ultrasound Lab (Abdomen) (2 h) x 1
5. Rehabilitation Lab (Anatomy of movement) (2 h) x 1
6. Rehabilitation Lab (Fundamentals of Client Care) (45 min) x 1
7. Rehabilitation Lab (Mental Health) (3 h) x 1
8. Respiratory Therapy Lab (Simulation) (1 h) x 2
9. Respiratory Therapy Lab (Cardiopulmonary) (1 h) x 1
10. Respiratory Therapy Lab (Cardiopulmonary-Patient assessment) (2 h) x 1
11. English Language Classes (3 h) x 4

Figure 1. KPUHS students performing fetal scans on a model womb in the Ultrasound Lab

Most classes for specialty subjects (1-10, **Table 1**) were two hours long. They involved an initial lecture/theory component followed by observations and/or practice. In the classes, the KPUHS students did the same activities and tasks as the SAIT students, such as performing fetal scans on a model womb in the Ultrasound Lab (**Figure 1**) and drawing arterial blood from a bionic arm in the Respiratory Therapy Lab (**Figure 2**).

With respect to the English language classes (11, **Table 1**), the KPUHS students attended four sessions of three hours each spread over the two-week period of the visit. These classes were taught by an instructor from SAIT's English Language Foundations (ELF) program. By the time the exchange visit began, the regular ELF classes had already been in progress for more than two weeks, and it was felt that it would be difficult for KPUHS students to join midway through the lessons when a significant amount of instruction had already taken place. Hence the English classes were not a part of the regularly scheduled ELF classes at SAIT, but instead were customized for KPUHS students.

The content of the English language classes ranged from conversation topics on culture to activities such as pronunciation practice and learning how to order food at a restaurant and then actually doing that at a campus eatery as a part of the class. Students were also given homework tasks that, for example, required them to prepare a five-minute speech about a person who had influenced their lives in a positive way and read a monthly feature story from the Canadian Broadcasting Corporation (CBC) program, "Learning English with CBC Calgary," for discussion in the class.

2.2. Extra-curricular activities

In addition to attending the classes and labs, the KPUHS students took part in a wide range of on- and off-campus extra-curricular activities.

Among the highlights of the on-campus activities were a visit to the Aboriginal Resource Center to attend a presentation on Blackfoot Culture, a guided tour of the SAIT's official ice-hockey team arena with an introduction to the game of ice hockey, and participation in a Bowling Party Mixer at SAIT Campus Center together with other international students attending SAIT. Besides these on-campus extracurricular activities organized by the SAIT side as a part of the exchange program, the students also explored the campus life on their own by dining at multiple on-campus eateries, browsing and shopping at the campus bookstore, and joining a drop-in conversation club meeting of international students at SAIT.

Off-campus extracurricular activities organized by the SAIT side included visits to the operating base of Shock Trauma Air Rescue Service (**Figure 3**) commonly known by its acronym, STARS, WinSport Olympic Park and Canada Sports Hall of Fame, Calgary Curling Club to have a lesson in curling, and Calgary Saddledome to watch a game of ice hockey.

2.3. Sightseeing and experiencing multicultural Canadian life

Sightseeing visits organized by the SAIT side included a visit to Calgary Tower and trips to Lake Louise and the town of Banff, Royal Tyrell Museum in Drumheller, and Heritage Park in Calgary. Additionally, in their free time, the students visited Calgary Zoo, attempted skating at the University of Calgary skating rink, and experienced multicultural life in Canada by visiting a Canadian family home, exploring local shops, and trying Canadian and various ethnic foods.

2.4. Accommodation

On the recommendation of the SAIT side, the KPUHS stu-

Figure 2. KPUHS students drawing arterial blood in the Respiratory Therapy Lab

Figure 3. At the Shock Trauma Air Rescue Service (STARS) operating base

dents and faculty member were housed at a hotel in downtown Calgary during the two-week period of the exchange visit. The hotel had easy access to the SAIT campus by local train and was used frequently by the host institution to accommodate short-term international exchange students. The arrangement made it easier for the hosts to organize and conduct cultural activities and sightseeing tours for the visitors. At the time of the KPUHS visit, two groups of students and instructors, one each from Australia and Singapore, were also visiting SAIT as a part of their respective exchange programs and were staying at the same hotel. While the study areas of the Australian and Singaporean groups were different from those of KPUHS students, the shared parts of the program such as the sightseeing trips were organized together for all three groups. The set-up also provided an excellent opportunity for the KPUHS contingent to interact with their counterparts from Australia and Singapore, thus adding an additional dimension to their exchange visit to SAIT.

2.5. Cost

The cost of the trip was roughly 300,000 JPY per student including the passport fee, travel insurance, airfare, and accommodation, meals, local transportation and personal expenses. The cost was borne fully by the students. The accompanying faculty member's travel expenses were covered by KPUHS in accordance with the guidelines for payment to public employees when traveling on business.

3. Student perspectives

At KPUHS, students taking part in the exchange program are required to submit a report after returning back from their trip to SAIT. While in more recent years the International Exchange Committee at KPUHS has developed a specific format for writing these reports, in 2015 which was the first year of the KPUHS-SAIT exchange program, there was no defined pattern to prepare the study abroad reports and students were instructed to write freely about what they observed, did and experienced during the visit along with their impressions. The following sections include excerpts from the students' submitted reports corresponding to three categories: General impressions; Studying English; and Cross-cultural understanding. The excerpts are English translations followed by the original text in Japanese corresponding to the respective sections. Although the students submit their reports in both English and Japanese, as native speakers of Japanese, they are able to express themselves far better in their native language. In particular, the Japanese versions of the students' reports are clearer, more natural and realistic and, quite understandably, grammatically correct as compared to the English versions. Therefore, students' perspectives presented here are taken from their reports written in Japanese.

3.1. General impressions

[Firstly, as a student of health sciences myself, observing the classes in the school of health at Southern Alberta Institute of Technology (SAIT) was an extremely good incentive. At SAIT, one can undertake professional studies in specialized areas such as diagnostic and therapeutic technology, health management, as assistant technologists and so on. In addition, since the teachers and students expressed their opinions equally during the classes, the students participated actively in the lessons and I felt that this was positive for learning.

And, from this experience of study abroad, of course, I learned about Canada but I could also know about the ways of thinking and the values of people from other countries, Japanese culture and about myself as a Japanese. Indeed, these days, since transportation has advanced and it is now an age where one can go anywhere in the world, in Japan too there are many foreigners and one can interact easily with people from other cultures. However, despite such opportunities, there are many things that cannot be experienced in Japan. For example, just by walking in the city and seeing only foreigners when looking around and being placed in a multicultural environment, at times I could verify my identity as a Japanese. On the contrary, at times, I had questions about what Japan is. I think that it is only because I actually went abroad that I had the opportunity to think in this way about Japan and myself.]

「まず，南アルバータ工科大学で保健医療学部の講義を見たことは，私も同じ医療系の学生として非常によい刺激になった。南アルバータ工科大学では，診断や治療上の技術，アシスタント技術や健康管理のプロとしての授業など専門的な授業が受けられる。加えて，講義中は先生と学生が対等に意見を出し合っていたので，学生たちは積極的に講義に参加し，学習に対して前向きなのだと感じた。

そして，この留学の経験からカナダのことはもちろんのこと，他国の人々の考え方，価値観，日本の文化，日本人としての私について知ることができた。確かに，今日では交通が発達し世界中どこへでも行ける時代になったので，日本にもたくさんの外国人がいて他の文化の人々と交流することは容易にできる。しかしそのような機会があっても，日本では体験できないことは大いにある。例えば街を歩くだけでも，周りを見渡せば外国人ばかりで，多文化の環境に自らを置くことによって，私は日本人であるのだというアイデンティティを確認することもあるし，またその逆で日本とはどういうものなのかと疑問を持つこともある。このように，日本，そこにいる自分について考える機会を持

てるのも，実際に海外に行ったからこそだと考えられる。」

3.2. Studying English

[Through this study abroad I got to know how to study English. First of all, what I learned was that I must read a lot more 'native English.' Since my English sentences, being direct translations of Japanese sentences, were unnatural, everyone had a hard time understanding the meaning of what I was saying. For example, the translation of「彼女は癌だ。」「kanojo wa gan da.」, is not "She is cancer." It is, "She has cancer" and so on. Like this, there are many instances where one can learn only from' native English.'

In my study (of English) up to high school, I only focused on understanding grammar and reading comprehension of long sentences, but (from this study abroad experience) I thought that I also had to study to actually make natural sentences using English.

Secondly, I learned to pay attention to pronunciation. Even if one can make a correct sentence, if the pronunciation is poor, the content will not be conveyed to the listener or will be understood in a completely different way. Certainly, if one knows only the English words, it may be possible to use gestures, etc., to tell others what one wants to say. However, if those words cannot be pronounced correctly, they will not be conveyed to the other side. I felt that it becomes extremely important to pronounce correctly when one is in an international setting and trying to communicate with others. Moreover, if one is able to pronounce correctly, one can also understand better what others are saying. Thus, I understood that it is important to pronounce correctly.]

「この留学を通して私は英語の勉強の仕方を知ることができました。

第一に，ネイティブの文章をもっとたくさん読まなければならないということです。私の文章は日本語をそのまま英語に訳したもので，不自然な英語であったために，私の言っていることの意味を理解するのにみんな苦労していました。「彼女は癌だ。」は“She is cancer.”ではなく，“She has cancer”となるなど，実際にネイティブの文章からしか学べないことがたくさんあります。

高校までの勉強では，文法の理解，長文の読解ということにしか目を向けていませんでしたが，実際に英語を使って自然な文章を作れるような勉強もしなければならないと思いました。」

第二に，発音に気を付けるということです。正しい文章を作れても，発音が悪いと相手に伝わらなかったり，まったく違う意味でとらえられたりします。確かに，英語の単語さえ知っていれば，ジェスチャーなどを使って，相手に自分の言いたいことを伝えることができるかもしれません。しかし，その単語も正しく発音できなければ，相手には伝わらないのです。国際的な場に出て，相手とコミュニケーションをとろうとするときに，正しく発音することは大変重要になると感じました。また自分が正しい発音ができるようになると，相手の言っていることも，もっと理解できるようになるので，これらのことから，正しい発音をすることは大事であると分かりました。」

3.3. Cross-cultural understanding

[Canada, the destination of my study abroad this time, is a multi-ethnic country. People of various races such as Africans, Asians and Caucasians coexisted in the same space. I felt that while being Canadian, they were proud of their roots. I thought that by cherishing their respective personalities (ethnicities), people from various cultures were communicating well with each other.

I thought that by knowing about the kind of culture I grew up in and the kind of person I am, and by discovering the differences and common points between myself and others, I could enjoy the cross-cultural exchange.

I think that the points I learned this time can also be said to be important for communication among the Japanese. What I learned were extreme examples, which is why I was able to notice them. Until now I had been a stubborn person. I did not know how to interact with people who had a nature different from mine and could not get along with people well. But, after returning from Canada, my way of looking at others has changed and I have a strange feeling now, as if I am in a new world.]

「今回の留学先のカナダは多民族国家です。黒人，白人，黄色人種というように，様々な人々が同じ空間に共存していました。彼らはカナダ人でありながら，自分のルーツに誇りを持っているように感じました。それぞれが自分のパーソナリティーを大切にすることで様々な文化を持つ人々が上手にコミュニケーションをとることができているのだろうと考えました。

自分はどういう文化のなかで育ち，自分はどういう人間なのかを知り，相手との違いや，共通点を見つけ出すことで，異文化交流を楽しむことができるのだと思いました。

今回学んだポイントは，日本人同士のコミュニケーションにおいても重要であると言えます。極端な例を知ったからこそ，それらのことに気づくことができました。私は今まで，頑なな人間で，自分とは違う性質を持つ人をどのようにとらえればよいのか分からず，上手に人と関わることができませんでした。しかし，カナダから帰国し，人を見る目が変わり，新たな世界にいるような不思議な感覚を持っています。」

4. Discussion

In 1998, Freda,[4] in an article on the need for international education for the 21st century nurse, wrote that as "the world becomes a smaller place through international travel and instant communication, nurses must expand their notions of the populations for whom they will care and the nursing colleagues with whom they will work." Freda reasoned that nurses need to become more knowledgeable about international health issues, international nursing research, and nursing education and practice in different countries.[4] More than two decades later, the needs perceived by Freda[4] are becoming more real than ever. Today, especially in countries like Canada, the UK, and the USA, it is no longer uncommon for nurses to care for patients with ethnic and linguistic backgrounds different from their own.[5] Although Japan is still considered an ethnically homogeneous society, the country's demographics are rapidly changing. With a record number of foreigners now living in Japan,[6] a-never-before-seen rise in inbound tourism,[7,8] and an urgent need for provision of healthcare services during the upcoming 2020 Tokyo Summer Olympics[9] and likely beyond, it can be projected that in the not too distant future, just like their counterparts in other multicultural countries, it will not be uncommon for Japanese nurses to care for non-Japanese patients. In fact, as globalization progresses in the country, a greater demand for culturally competent nursing care is already being recognized.[10] Under such a backdrop, how can Japanese colleges and universities that offer nursing programs, include global learning experiences in their nursing education? The international exchange program described in this paper reflects an attempt to address this question.

The bilateral exchange program between KPUHS and SAIT, now in its fifth year, has made a significant contribution toward providing global and cross-cultural experiences to a large number of its students including the nursing majors, through the inbound part of the program.[11] The observations on nursing students' gains from the outbound portion of the program reported in the present article point further to the importance of international exchange programs for Japanese nursing students. The impressions of nursing students who took part in the outbound exchange, as described in their written reports, vividly relate the impact the experience had on their lives and how it transformed them as individuals. In particular, the students found attending the specialty subject classes and learning about the various health sciences study programs offered at the Canadian school to be an extremely good incentive to study. They also made a note of the active participation by the Canadian students and of the expression of opinions by both the teachers and the students in the classes, and found this practice to be positive for learning. In the English language classes, the students became more aware of their weaknesses and learned how to improve their ways of learning the language.

The students also appreciated being in a foreign milieu and in their reports related how it made them question their own identity as Japanese and compare what they were observing in Canada with the culture that they were brought up back home in Japan. One student wrote that she could experience these feelings only because she actually went on this study abroad visit. Most importantly perhaps, students became aware of the differences in the ways of thinking and values of people from other countries. They also seemed greatly impressed by how people from different ethnic backgrounds and cultures co-existed in the same place and communicated well with each other, a quality that may be the most desired for healthcare practitioners in the present day and age. For one student, the experience helped her overcome communication difficulties even in the Japanese context. As the student writes in her account under section 3.3, *'Until now I had been a stubborn person. I did not know how to interact with people who had a nature different from mine and could not get along with people well. But, after returning from Canada, my way of looking at others has changed and I have a strange feeling now, as if I am in a new world.'*

Only two KPUHS nursing students participated in the outbound exchange described here. Generally, while personal and motivational factors are also involved in many students' decision to take part in a study abroad program, the cost of the trip is often the most frequent reason for not participating. For the present outbound trip, all travel expenses were the responsibility of the students. Although, following the success of this initial exchange, the Alumni Society of KPUHS has pledged to provide a subsidy of 20,000 JPY to each KPUHS student taking part in the outbound exchange, the amount comes to only about 6% of the total trip cost and is not likely to attract more students to participate in the program. Given the importance of gaining global learning experiences for nurses, it is crucial for Japanese nursing institutions to provide better financial support to facilitate greater participation by more nursing students in outbound exchange programs. It is worthwhile noting here that SAIT subsidizes a major part of the travel costs (such as the airfare or accommodation expenses) for their students who visit KPUHS as a part of the exchange program.

5. Conclusion

Even though the outbound exchange described in this paper involved only two students, its success underscores the significance of including global learning in Japanese nursing education. There is certainly a need for more international exchange programs for nursing students in Japan that can contribute to preparing them as globally competent members of their healthcare teams, and for more financial resources that can help to realize this goal.

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Piloting in-service English courses for medical professionals

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Research in English for medical purposes (EMP) tends to focus on the needs of pre-service learners (undergraduate students) rather than those of in-service learners (working professionals). This project builds upon an English needs analysis of medical doctors and nurses in western Japan, which showed that these medical professionals need basic English speaking skills more than specialized terminology and expressions. Based upon these findings, two in-service English courses, each running for 8-week terms, were organized and conducted during a 1-year period at one university in Shikoku. Approximately 20 medical professionals (including medical doctors, nurses, and paramedical staff) participated in each course. The objective of this 1-year trial was to identify successful elements in the course design and methodology in order to establish in-service courses on a permanent basis. An emergent syllabus design was used in order to test various methods, including fluency-building tasks, instruction in compensatory strategies, and techniques from improvisational theater. Feedback from participants on the courses was gained through questionnaires and focus group interviews. This project revealed the importance of tailoring in-service English courses to the needs and interests of specific groups of participants.

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Keywords emergent syllabus, English for medical purposes, focus group interview, in-service learning, questionnaire

1. Introduction

Numerous articles published in the English for medical purposes (EMP) field have described needs analyses of pre-service learners, typically undergraduate medicine majors, and curricula designed to meet these needs.[1,2] Much less has been written about the English needs of working medical professionals (in-service learners) and English programs designed for them. However, this issue has gained attention in international journals due to the increasing number of international medical graduates (IMGs) entering the workforce in such countries as the United States and Australia.[3, 4] These studies have shown that communication problems encountered by IMGs often stem from a lack of understanding of English communication norms, causing IMGs to appear aloof or rude to their English-speaking interlocutors. EMP instructors in Japan have also shown an interest in developing English courses for Japanese medical professionals, and several innovative programs have been described, focusing on formal English genres, such as the case presentation, as well as informal conversation practice.[5, 6]

Our own needs analysis of medical doctors (MDs) and nurses at hospitals in western Japan has revealed that these medical professionals experience anxiety when speaking in English, and feel they are unable to initiate or sustain conversations in English with people from other countries.[7] The majority of these MDs and nurses felt a need for further improvement in their English skills, and were interested in participating in in-service English training or "brush-up" courses for medical professionals.[8]

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2. Objective

With our needs analysis findings in mind, we set out to develop in-service English courses for medical staff at our university hospital. Our objective was to experiment with speaking-focused techniques and formats over a 1-year period, in order to learn how to organize and conduct these courses on a permanent basis.

3. Methods

In designing in-service courses, we decided that three criteria were essential. First, the course syllabuses should be "emergent" in nature, i.e., drawn from the immediate needs of attendees as a course develops.[9, 10] Our previous teaching experiences with in-service English courses indicated that learners' needs and interests vary greatly from group to group; flexibility in course design and content is thus essential. Second, each course should be limited to 10 weeks or less; any longer than that, we believed, could cause participants' motivation to waver and lead to a drop in participation, a phenomenon noted by the designers of similar projects.[6] Last, the courses would be voluntary, for both participants and instructors. No participation fee would be required.

To elicit feedback from participants, a questionnaire asking participants to evaluate each course was drafted. Due to differences between the two courses, the second questionnaire slightly differed from the first (one question asking about the time slot was added, and one question asking about the International English Language Testing System (IELTS) tasks was removed); this second questionnaire is displayed in **Appendix 1**. Also, a focus group interview, approximately 1 hour in length, was held after the end of the first course (as the second course ended in late December, we were unable to organize a focus group interview after the last class).

To recruit participants, medical staff were notified of the courses by email a few weeks before each course was set to begin, and posters advertising the courses were displayed in strategic locations throughout the medical campus. For the first course, the message sent to all staff indicated that MDs were the main target. For the second course, the target was widened to include MDs as well as nurses and paramedical staff. For each course, those hoping to attend were asked to contact one of the authors before a set deadline. The window for enrollment was closed after these deadlines, as we feared that new participants joining each course throughout the term would distract other participants.

In the next sections, the content and development of each course will be described.

4. Course 1

4.1. Overview

The first course took place over an 8-week period from May to July, 2018. The class was conducted in a classroom on Mondays, from 18:00 to 19:00. A total of 19 participants joined this course, including 15 MDs, from the departments of Pediatrics (5), Radiology (4), Urology (2), Nephrology (1), Anesthesiology (1), Pathology (1), and the Clinical Research Support Center (1). Also, although the course was advertised as a course for MDs, 2 master's students in nursing applied and were admitted, and 2 non-medical faculty (in nursing and biochemistry) also joined.

4.2. Content

The major finding of our needs analysis was that the MDs and nurses surveyed thought that they needed to improve their English speaking skills in order for them to sustain conversations and discussions with English speakers. We therefore decided to focus the course on timed 2-minute fluency building exercises, modeled after Part Two of IELTS Speaking test. In this task, participants are shown a topic, and then given 1 minute to prepare a short talk on the topic, taking notes if they wish. They then must speak for 1-2 minutes about this topic to an interviewer. This task is commonly called the "long-turn." An example task used in one class is shown in **Appendix 2**. Topics were adapted from IELTS textbooks and online preparation sites and were generally about non-medical topics. Participants practiced one such exercise, with a partner, once in every class throughout the term. In class we gave students tips on how to structure their responses, and useful language such as fillers and lead-ins (e.g., "I don't remember it clearly, but…"). We adopted a strict English-only policy for the class. Two example long-turn tasks employed in the course and an activity for describing pictures are shown in **Appendix 2**.

In addition to the weekly long-turn practice, we presented participants with a variety of speaking tasks, including ice-breakers, describing pictures, talking about news stories, and explaining Japanese items or concepts. We thought that timing these tasks was important in order to encourage participants to speak faster and to use class time efficiently. As participants were clearly busy, we did not assign homework or give quizzes on the class content. For most classes, all three authors were present, and we also participated in pair work and group discussion. One of us often teamed up with less proficient students, so that those with greater fluency would be able to work together.

4.3. Feedback and challenges

Overall, completed questionnaires (received from 7 participants) and the focus-group interview (attended by 4 MD participants, who did not complete the questionnaire) revealed that participants were mostly positive about this first course. Several participants indicated that they had

enjoyed the course and hoped to attend the next one. However, there were at least three learning points for us. First, several participants stated that they found the long-turn task to be difficult and stressful. Although getting people to speak about unfamiliar topics is one purpose of this IELTS task, ambivalence towards this task was problematic, as it could lead to participants dropping out, which did happen towards the end of the 8-week term. Perhaps our reliance on this task also made the class monotonous for some. Although we were advised not to drop the task completely, focus group interviewees suggested that we do not use it every week.

Second, we had wondered if it would be beneficial to include homework or review assignments for more eager participants, and included a question about homework on the questionnaire. Respondents were roughly split on this issue, with some against homework assignments and others welcoming them. In the focus group interview, we were told that it may be a good idea to give homework assignments that some participants could do, such as tasks that would help them prepare in advance for the next class. Initially we had been afraid that homework would scare away some very busy attendees, but we realized that the next course should incorporate some form of out-of-class work. Last, respondents indicated that they would have appreciated learning more useful expressions or techniques for communication, especially for formal situations such as in Q & A sessions. Although we had devoted some class time to expressions and techniques, we had not done so every week, as we tended to focus on ways to help attendees speak faster and more fluently in relatively informal situations.

5. Course 2

5.1. Overview

The second course ran for 8 weeks beginning in late October and ending in late December, 2018. Due to changes in two of the authors' schedules for the latter half of the year, the class meeting day was moved from Mondays to Tuesdays. We also moved the time slot to 1 hour earlier: from 18:00 to 17:00. We had heard from a few young, female doctors that they had been unable to attend the first course as it was scheduled too late in the evening, interfering with family responsibilities.

A total of 24 people signed up for the course. In order to encourage greater participation, we had notified all medical, nursing, and paramedical staff of our medical faculty about the course, and this time a large number of paramedical staff signed up: 5 pharmacists, 2 radiological technologists, 1 pathology technician, and 1 rehabilitation therapist. A total of 10 MDs joined the class, from the departments of Gastroenterology (3), Pharmacology (2), Endocrinology (1), Pediatric Surgery (1), Urology (1), Cardiology (1), and the Clinical Research Support Center (1), as well as 1 molecular physiologist, 3 graduate students from China (in the departments of Pharmacology and Orthodontic Surgery), and 1 undergraduate with previous work experience as a pharmacist. Only two of these participants had attended the first course (from the department of Urology and the Clinical Research Support Center). No nurses joined the class, despite our push to promote the class among nursing faculty and staff, nor did any of the female doctors who had recommended an earlier time slot. **Figure 1** shows the breakdown of participants according to profession in both English courses.

Although 24 people enrolled in the course, 1 participant (the rehabilitation therapist) never attended any classes, and the 3 gastroenterologists attended the first class only.

5.2. Content

Initially, we had resolved to make this class more substantial than the first course by teaching more communicative expressions. The first author consulted resources on improving professional communication skills,[11-13] and drafted a

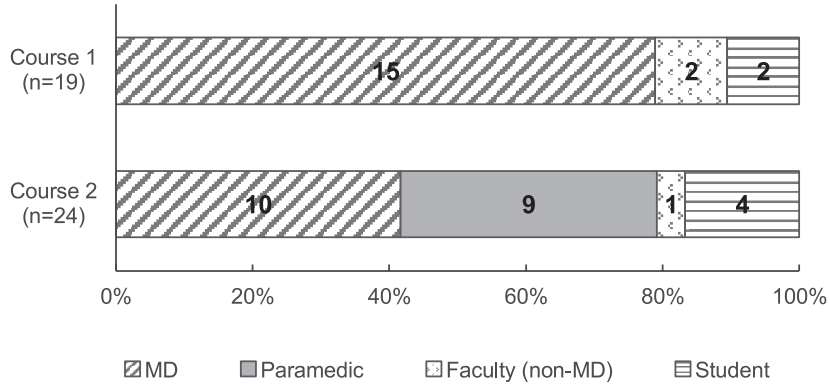

Figure 1. Professions of participants in both courses

rough syllabus including techniques and topics gathered from these sources. Also, as mentioned above, our reliance on the IELTS long-turn task in the first course may have made the course tedious to some participants; for the second course we resolved to offer a variety of communicative tasks in order to keep the class atmosphere lively. Techniques from improvisational theater, and its more recent spin-off "medical improv," were included on the syllabus, as these techniques promoted active listening and aided in the development of impromptu speaking skills.[13] One class would focus on Globish, a simplified form of English combined with active body language promoted by Jean-Paul Nerrière as a more efficient communication tool than standard native English.[14] We also planned to give participants homework every week, to review expressions and prepare for short speech activities.

However, in line with the emergent syllabus design of this course, the syllabus was adjusted after meeting participants. It immediately became clear that the overall English ability level of participants in the second course was lower than that of the first. On the first day of class, we asked participants to write down what they hoped to do in the course, in English or Japanese, and responses were various, ranging from basic English conversation (especially among the pharmacists) to more formal speaking practice required for international conferences (especially among the doctors). The course content was scaled down so that we would not have to proceed quickly through each class. The syllabus outline for the class is shown below, as it was actually executed. Activities used in the course are shown in **Appendix 3**.

Class 1: Icebreaking
Class 2: **Speech 1: Self introductions**, & Globish
Class 3: The three-sentence rule & 'Yes, and…'
Class 4: **Speech 2: Describing pictures**, & Clarification expressions
Class 5: Facilitation expressions
Class 6: **Speech 3: Opinion speech**, & Lead-in expressions
Class 7: Agreement/disagreement expressions
Class 8: Review & Wrap-up

5.3. Feedback and challenges

Completed course evaluation questionnaires were received from 7 participants, and as with the first course, attitudes towards the course content and organization were mostly positive. Respondents held a neutral attitude towards whether or not the course had improved their confidence to use English, a similar result for the first course. However, given the short duration of the course, and the overall lack of confidence held by most Japanese users of English,[15] we did not find this to be a worrying trend. What did cause concern was a few gaps that could be observed in responses from the medical and paramedical staff. Although only one respondent (an MD) tended to agree that medical content should be introduced in the course, the MDs expressed an interest in devoting more class time to formal English presentation skills, as they had written for their goals on the first day of class. The pharmacists, however, were more interested in general English conversation, with one respondent writing that she hoped to learn useful expressions for travelling abroad.

Also, the MD respondents indicated that the class starting time of 17:00 was too early, and should be moved back to 18:00. One of the gastroenterologists, who only attended the first class meeting, wrote that he had to miss many classes because his work did not finish before 17:00; after missing a few classes he hesitated to attend the class, even when he had free time. However, all participants either agreed or strongly agreed that the communicative expressions and techniques taught in class were useful, suggesting that shifting focus away from the long-turn speaking task may have been successful. Attitudes towards homework were more negative for the second course than they were for the first, perhaps because homework was actively included in the second course. Attitudes towards the speech practice in class—which depended on participants' completion—were mostly positive.

On the other hand, a painful experience after the second class reminded us how stressful public speaking in English can be for many participants. In the second class, we asked participants to give brief introduction speeches in groups. Following this, we asked participants to select one participant in each group to give their short speech before the class, a practice regularly employed by one of the authors in general English classes for medical students. One participant was selected to speak for his group, and though the instructors were unaware at the time, this experience was so stressful that he contacted one of the instructors afterwards and said that he would no longer be attending the class. Tasks that work well in the undergraduate classroom—where students cannot drop out—may not be applicable to in-service courses. Speech practice in front of the class, we resolved, would occur only on the last day of class, if at all.

6. Discussion

In reflecting upon what we learned from these two courses, three main issues stand out: the problem of attendance; the varying ability levels, goals, and availability of different groups of participants; and the difficulty of assessing course effectiveness.

6.1. Attendance difficulties

Irregular attendance of participants was an obstacle to the smooth execution of classes. Weekly attendance values for each course are shown in **Figure 2**. As can be seen, the last 2-3 weeks of each course tended to have the lowest number of attendees.

Several factors likely contributed to the irregular attendance for both courses. Medical staff are busy, and—especially in the case of MDs—often work irregular hours. The prospect of an English class at the end of a long and tiring day may also have daunted some participants. We also suspect that "English fatigue" may have had a role in the dwindling number or attendees in each course's final weeks.

Perhaps the most troubling issue was the lack of attendance of registered nurses. Our previous needs analysis had included nurses as well as MDs, and based on these findings we believed that the courses we had planned would benefit them as well.[7, 8] Miyake and Tremarco also found that Japanese nurses at one hospital felt the need to develop their social English skills, and were not satisfied with their university English education.[16] However, only 3 nurses joined our first course, and none of them had clinical responsibilities at the time; 1 nurse was a faculty member with exceptional English skills, and the other 2 nurses were graduate students. One of the nursing graduate students dropped out after the third week, telling an instructor that the class activities were too difficult. A high drop-out rate among nurses in in-service courses was a problem noted by Midorikawa.[5] The courses described by Midorikawa, however, included separate classes for doctors and nurses. Though we had initially believed that doctors and nurses studying English together could have been enjoyable and meaningful to all participants, this approach may not be realistic.

Providing incentives for staff to join these courses could help to improve attendance. One option would be to provide formal faculty development (FD) credit for attendees, as FD has become a standard criterion in the evaluation of staff at Japanese universities. We intend to explore this option in the second year of our trial.

6.2. The diversity of participants

The grouping of medical and paramedical staff in the same course may also have been problematic. Overall, the MDs in the second course possessed better English skills and more professionally-focused goals than the paramedical staff, including the pharmacists and radiological technologists. Although this topic was not raised in feedback from any participants, we suspect that the second course, especially, was too easy and slowly paced for some of the MD participants, and this may have contributed to their failing to attend the last few classes. In the first course, where most of the participants were MDs, we felt a greater sense of cohesion among participants. Courses scheduled slightly later in the evening may also be more amenable to the MDs' schedules than those of the paramedical staff. One option would thus be to establish separate courses for medical and paramedical staff, and for nurses as well. However, there are limits to the number of courses we would be able to establish.

The inclusion of non-Japanese graduate students in the second course may have been a positive development; one MD noted that the presence of foreign students in the class was "stimulating." In general, these students more willingly volunteered to speak in class; thus, encouraging non-Japanese participants could be one way to promote a lively class

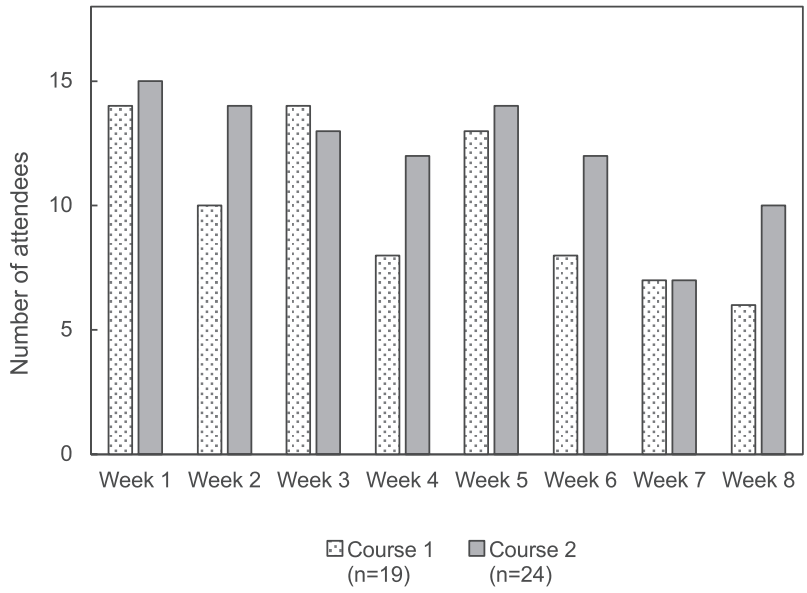

Figure 2. Weekly attendance numbers for both courses

atmosphere. However, we fear that such an atmosphere could discourage some of the less active Japanese participants.

To an extent, participation in in-service learning programs may be inherently unpredictable; the instructors will never be sure who will join, how skilled they are at English, and what they hope to gain from the course. For this reason, some flexibility is necessary in planning the content of such courses, and syllabuses should be shaped by, or emerge from, the needs of specific participants.[9] The challenge for instructors may lie in determining how much needs to be planned, and how much should be left open to adapt to participants' abilities and needs. One of our goals in launching this project was to learn how to prepare a manual to help other EMP instructors organize and plan in-service courses for medical professionals. However, we have begun to see that more than methodical planning, a flexible mindset on the part of the instructor—as well as a great variety of adaptable tools—may be critical in the success of these courses.

6.3. Assessment issues

Last, one concern we had in running this project was how to assess the efficacy of our courses, particularly in terms of our primary goal of developing participants' speaking fluency. Although a fair amount has been written about evaluating ESP or EMP curricula,[17] we are unaware of any studies that have scientifically examined the efficacy of in-service English programs in the ESP or EMP domains. With the first course, we had planned to have three participants take a long-turn task as a pre-test before the course began, and then again at the end of the course; then we would compare recordings in order to identify whether any changes had occurred in their speaking fluency. However, we were only able to locate two willing participants, and one of these participants dropped out of the course after a few weeks for family reasons. We were thus forced to abandon the pre-test/post-test comparison. In the second course, focus shifted away from the long-turn task, and we decided we were not ready to attempt a second pre-test/post-test comparison in the first year of this trial.

We believe that assessment is important, and will attempt to involve a pre-test/post-test comparison to assess gains in speaking fluency in the second year of our courses. Another intriguing avenue would be to see if these courses have an effect on participants' levels of empathy; it has been found that communication skills training courses in Japanese for Japanese MDs significantly increased participants' empathy scores.[18] If so, in-service English courses would have a much deeper value than simply the development of language skills. However, this trial has made us aware of the difficulties of combining in-service courses with research. The reality is that medical professionals are busy people with shifting responsibilities both inside and outside of the hospital. Their attendance will be irregular, and even when they can attend they may be exhausted from their work. The undergraduate EMP classroom—where the audience is a captive one—is likely a better place to assess teaching methods which may later be used in courses for working medical professionals.

7. Future directions

Based on participant feedback and attendance patterns for the two courses, we intend to shorten courses by 2-3 weeks, and to offer 3-4 courses over the course of the year, each one 4-5 weeks in length. This may help reduce the learner fatigue some participants may have experienced. In addition, shortening each course could allow for the establishment of course themes, such as icebreaking skills, basic speech practice, and conference skills. Potential participants would then be able to select courses most suitable to their English abilities and goals. Problems posed by differences between groups of participants might, in this manner, be diminished.

8. Conclusion

This 1-year trial has shown that in-service English learning courses for medical professionals require a flexible approach, in order to accommodate participants with diverse abilities and goals. Although attendance is often irregular, we have found that all of the attendees know they need English speaking skills, and are often desperate to improve them. Moreover, by participating in such in-service courses, either in the early evening or in lunchtime sessions, EMP instructors can gain valuable insights into the needs of medical professionals in Japan, which they can then apply to their own EMP courses to make medical English education more engaging and meaningful to students.

Acknowledgments

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Appendix 1

Class evaluation [English translation] **Medical Can-Do, Fall 2018**

How much do you agree with the following statements? Please give your answers below. Please feel free to write in Japanese for the free response questions.

Your name:

Number of times you attended this class:

	Agree					Disagree
1. Overall, this class met my expectations before joining.	1	2	3	4	5	6
2. Overall, the content of this class was useful to my work as a medical professional.	1	2	3	4	5	6
3. Overall, this class improved my confidence in speaking in English.	1	2	3	4	5	6
4. This class motivated me to continue studying English.	1	2	3	4	5	6
5. The warm-up and group discussions at the beginning of class were useful.	1	2	3	4	5	6
6. The communicative expressions and techniques were useful.	1	2	3	4	5	6
7. The speech practice activities were useful.	1	2	3	4	5	6
8. I wish the class had more medical content.	1	2	3	4	5	6
9. I wish the class had given me more listening practice.	1	2	3	4	5	6
10. I wish the class had given me more writing practice	1	2	3	4	5	6
11. I wish the class had given me more formal presentation practice.	1	2	3	4	5	6
12. I wish the class had given me more speaking practice.	1	2	3	4	5	6
13. I wish I had learned more useful expressions and techniques for communication.	1	2	3	4	5	6
14. I wish the class had given me more homework or tasks for self-study.	1	2	3	4	5	6
15. I wish I'd had more chance to speak to native English speakers.	1	2	3	4	5	6
16. 8 weeks was an appropriate length of time for this course.	1	2	3	4	5	6
17. I wish the class had lasted longer than 8 weeks.	1	2	3	4	5	6
18. This class was difficult for me.	1	2	3	4	5	6

FREE (3) Please write any comments you may have about the skills or topics learned in class, and how the class could be improved.

19. If you stopped coming to the class, what was your reason for stopping?
A. Work B. Other (Circle one)
If B. Other, please explain:

20. This class was from 17:00 to 18:00 on Tuesdays. Was this time/day suitable for you? If another day/time period would work better for you, please explain below.

21. Do you plan to attend the next course?	YES	MAYBE	NO

FREE (4). What do you expect from the next course? What kind of topics/skills would you like to study?

Thank you!

Appendix 2: Course 1 activities

1. Example long-turn tasks used in the course

Directions: Read the question below. You will have one minute to plan your answer, taking notes if you wish. Then you will talk for one to two minutes.

(A)

Describe a team you have been a member of.

You should say:
- what the team was;
- when and where you joined it;
- what your role in the team was;
- and how you felt about being a team member.

(B)

Describe an important decision that you made.

You should say:
- what the decision was
- how you made your decision
- what the results of the decision were
- and explain why it was important.

2. Describing a picture activity (directions)

You will be shown a picture. In your pair, one person (A) should look at the picture and take notes on what you see for one minute. The other person (B) should close his/her eyes—do not look at the picture!
The teacher will let you know when one minute has passed. Then, the picture will disappear and B should open his/her eyes. A should then explain the picture to B, giving as many details as possible. Try to explain what can be seen in the picture, and what A thinks is happening.
After two minutes, the teacher will show the picture again so that B can see how clearly A was able to describe the picture!

Example picture

Appendix 3: Course 2 activities

1. Icebreaking question list

1. Why did you choose your present career?
2. What do you enjoy most about your work?
3. What do you enjoy least about your work?
4. How has the Internet affected your work?
5. Describe a typical day for you on the job.
6. If you could change careers, what would you do?
7. What one thing would you do if you knew you could not fail?
8. Tell me about the best holiday you've ever taken.
9. What's your favorite thing to do on a rainy day?
10. If you could replay any moment of your life, what would it be?
11. Tell me about your family.
12. Tell me about one of your favorite relatives.
13. What was it like in the town where you grew up?
14. Who were your idols as a kid? Have they changed?
15. Describe a memorable teacher you had.
16. Tell me about your favorite subjects when you were in school.
17. Tell me about your least favorite subjects when you were in school.
18. Tell me about one of your childhood friends.
19. What do you think is the perfect age? Why?
20. Tell me about the meaning of your name.
21. What's the best surprise you've ever received?
22. Describe the scariest person you ever met.
23. What's your favorite restaurant? Why?
24. Tell me about a movie you've seen more than once.
25. Tell me about your first car.
26. Of all the places you've lived, tell me about the one you like best.
27. How has the Internet affected your life?
28. What's your favorite thing to do in your free time?
29. Tell me about a time when you had too much to eat or drink.
30. Tell me something most people don't know about you.
31. What would you do if you won 100,000,000 yen?
32. What is your favorite season? Why?
33. Tell me about a place you've visited that you hope to return to.
34. Tell me about a time when you took a big risk.
35. Tell me about a time when you lost something.

2. Self-introduction speech (template)

Complete the sentences below to prepare a short self-introduction speech. Bring this paper to the next class. Everyone will give their speech in groups.
Hi, everyone. I'm ... [your name]
I'm from ...
I ... [your work]
I'm interested in ...
In my free time, I like to ...
It's a pleasure to meet you! Do you have any questions?

3. Expressions for clarification (with answers)

Directions. Imagine you are in the situations below. What would you say? Think with a partner and write down your answers.

Situation

1. You didn't hear the person's name.
Sorry, but I didn't catch your name...
Excuse me, what was your name again?

2. The person is speaking too fast for you to understand.
Would you mind speaking a bit more slowly please?
I'm sorry, could you speak a bit more slowly please?

3. You didn't hear or understand what the person just said.
I'm sorry, could you please repeat that?
Could you say that again, please?
[*One more*. = NG!]

4. You want to confirm your understanding of what the person just said.
I'd just like to check my understanding here. You said... Am I correct?
So, you've told me that... Is this correct?

5. You want to check whether the person understands what YOU have just said.
Has what I've said so far been clear?
Are you with me so far?
[*Do you understand? Are you OK* = NG!]

Japanese medical students' reading of English academic papers and an evaluation of their ability to put grammatical knowledge to practical use

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The purpose of this study was to demonstrate how first-year Japanese medical students read English academic papers. It focused on their understanding of sentence structure, passage structure, and grammatical knowledge. Thirty-seven university freshmen read an academic paper abstract at their own pace and then were given a grammar test. The text consisted of the following unlabelled sections: background, methods, results, and conclusion. The results showed a very high average percentage of correct answers, 89%, indicating that most of the students could correctly answer questions about sentence structure, including subject and predicate. The results also indicated that, by section, 84% of the students accurately separated the methods from the background sections, 30% accurately separated the results from the methods, and 81% accurately separated the conclusion from the results. The students who scored full marks on the section division task also attained significantly higher marks on the grammar test than the other students. In other words, medical students who were equipped with knowledge of English grammar were able to distinguish between the various abstract sections. However, many students had difficulty in differentiating between the methods and results sections, in part, due to the characteristics of the paper's results section in the first sentence. Moreover, many students incorrectly answered the reading comprehension questions which asked about the main research results. Along with grammatical knowledge, it is also essential for medical students to be familiar with academic papers and medical knowledge to fully comprehend a medical academic paper.

Keywords reading, sentence, text organisation, grammatical knowledge

1. Introduction

These days, reading academic papers in English is necessary in order to gain the latest scholarly information. Medical doctors are no exceptions. Therefore, Japanese university medical schools provide students with an English as a foreign language (EFL) course. These courses may be a part of either a liberal arts education or medical English education. The area of study known as English for Specific Purposes (ESP) also attracts attention in medical English education. We have some research focused on reading academic papers written in English. Hijikata, Nakatani, and Shimizu investigated how Japanese EFL learners read academic papers with the interactions among English language proficiency, reading strategies, and rhetorical features of the papers using the think-aloud protocol method.[1] Kawamoto and Ishii analysed 395 English articles from leading medical journals and divided each paper into 12 moves.[2] A 'move' in the genre analysis is defined as 'a discoursal or rhetorical unit that performs a coherent communicative function in a written or spoken discourse'.[3] According to Kawamoto and Ishii's categories, for example, Move 1 was 'presenting perspective frame'; Move 2 was 'presenting related research and new approach'; and Move 3 was 'presenting new research'. In addition, they did a corpus-analysis which revealed, by move, English expressions frequently used in academic papers. Asano gave us a good example of practical research by conducting English lessons for fourth-year medical students.[4] These lessons focused on 'move' and 'hint expressions'. After the sessions, the participants answered the right order of moves better than before. As a result, the course helped the students learn

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how to effectively read academic papers.

This study aimed to demonstrate how first-year Japanese medical students read English academic papers, focusing on their understanding of sentence structure, passage structure, and their grammatical knowledge. The research question asks: 'how well can first-year Japanese medical students read an abstract written in English?'

First, the ability to read an abstract was divided into (a) recognizing sentence structures ('sentence structure'), (b) grasping text organization, what is also described as moves in previous research ('passage structure'), and (c) understanding the main results of paper ('main points'). Secondly, grammatical knowledge was considered as a key factor that would affect abstract reading. This is because medical students who have passed a Japanese university entrance examination are likely to have sufficient knowledge of English grammar, and moreover, reading skills are generally associated with grammatical knowledge.

2. Methods

2.1. Participants

Fifty freshmen medical students at a Japanese university participated in this study, and 37 students' data were analysed. The other 13 students, who were absent from at least one class in two days, did not complete the materials (see Section 2.2). The participants had taken English language classes at school for 6 and a half years at least. Their average TOEIC score was 495 (Range: 270–650); 255 for Listening and 239 for Reading. In other words, they were at A2 or B1 level on the CEFR (IIBC, n.d.).[5]

2.2. Materials and procedures

2.2.1. Abstract Reading Test

The Abstract Reading Test was based on the abstract of the paper 'Effect of aspirin on cardiovascular events and bleeding in the healthy elderly', published in *New England Journal of Medicine*.[6] The passage (**Appendix 1**) consisted of the following unmarked sections: 'background', 'methods', 'results', and 'conclusion', which were originally found in McNeil et al.'s research paper.

The students were given 20 minutes to (a) read the passage, (b) identify the four sections in the passage: background, methods, results, and conclusions, by inserting slash marks to demarcate these sections at the appropriate places, (c) write *S* for subjects and *V* for verbs in each sentence with an underline, and (d) answer the comprehension questions. The comprehension questions shown below were formulated for the present study. In the Abstract Reading Test, the material was written in Japanese, and students answered in Japanese.

Comprehension questions

1. How many individuals participated in this study?
2. What medication were the participants expected to take during this study?
3. What were the main results of this study?

2.2.2.Grammar Test

The test for whether students were able to use the two prepositions, *between* and *among*, in appropriate contexts was adopted from Hewings's reference book *Grammar in Use* (**Appendix 2**).[7] This test was administered for 10 minutes in class.

2.3. Scoring procedures

Tests were scored by using a scoring rubric made by the author or answer keys contained in the grammar workbook.

First, 12 subjects and 12 predicates were identified in the passage for the Abstract Reading Test (**Appendix 1**), with one point allotted to each; the total number of marks was 24. Second, we adopted the divisions in the original paper, and focused on the following three partitions – 'background-methods', 'methods-results', and 'results-conclusions'; thus, the maximum score was three (Passage Structure). Thirdly, comprehension questions were prepared to reflect their understanding of the main results of the research paper. Students who answered all the questions correctly received seven points – one point for Q1, one point for Q2, and 5 points for Q3. Students who answered Q3 perfectly were those who understood that the research was dealing with the treatment for a primary prevention, and the main results of the research; that is, the effects of an aspirin on both patients'

Figure 1. Research design of the present study

bleeding and cardiovascular events (main points).

The Grammar Test, on the other hand, had a maximum of 18 points with two points for each question; one point was for an accurate usage of prepositions, and the other one point was for choosing appropriate words and phrases given in a box (**Appendix 2**).

2.4. Statistical analyses

To answer the research question, a correlation analysis and a Mann-Whitney U test were performed by SPSS program for Windows (Version 12.0J & Version 15.0E).

3. Results

3.1. Descriptive statistics

Table 1 below indicates descriptive statistics by test. Regarding the Abstract Reading Test, both recognizing sentence structure and passage structure was relatively easy for the students and 21.30 and 1.95 were obtained as means, respectively. In contrast, describing the main results of the research in the Abstract Reading Test and reaching correct answers in the Grammar Test were relatively difficult; the average score revealed was less than half of total marks.

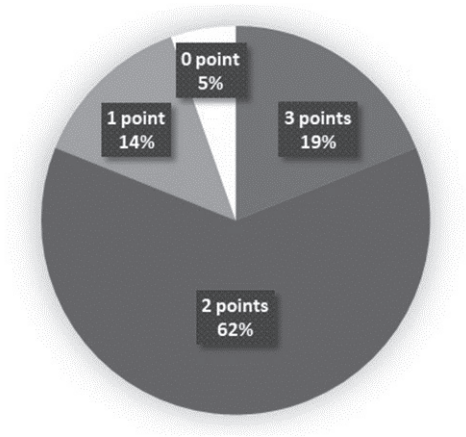

Figure 2. Percentages of students who scored 3, 2, 1, and 0

3.2. Passage structure

Studying the passage structure, 31 students (84%) accurately separated background from methods; 11 (30%) accurately separated methods from results; and 30 (81%) accurately separated results from conclusions. In sum, the division between methods and results was correctly identified only by less than one third of the students.

If we look at the results, 62% of the students obtained two points, which was the largest group; 19% scored perfect, that is, they obtained three points; 14% obtained one point; and 5% missed all divisions (**Figure 2**).

Following this, we examined whether learners who scored higher marks in the 'passage structure' had larger amount of grammatical knowledge. Before that, we made two groups – one was of the students who attained full marks, and the other was of the students who did not obtain full marks on passage structure. As shown in **Table 2**, a Mann-Whitney U test revealed that the students who scored full marks obtained significantly higher marks in the grammar test than the others (p <.05).

3.3. Sentence structure and grammatical knowledge

The relationship between sentence structure and grammatical knowledge was determined by a correlation analysis. Prior to that, raw scores of the sentence structure and grammatical knowledge were converted into a common logarithm (log) because both scores lacked normal curves. There was no significant correlation, in fact only marginally significant correlation was obtained, r =.32, p <.10.

3.4. Main points and grammatical knowledge

Next, we investigated the relationship between the abstract comprehension (main points) and grammatical knowledge by using a correlation analysis. Due to a lack of

Table 1. Means and standard deviations by test

Test		*M (SD)*	*Min*	*Max*	Full mark
Abstract Reading Test	Sentence structure	21.30 (2.99)	12	24	24
	Passage structure	1.95 (0.74)	0	3	3
	Main points	3.05 (1.67)	0	6	7
Grammar Test		8.81 (2.85)	0	17	18

Table 2. Passage structure and grammatical knowledge

Full marks		Not full marks		p value*
n	*M (SD)*	***n***	*M (SD)*	
7	5.14 (0.56)	30	4.23 (1.51)	0.031

Note. *A Mann-Whitney U test.

normal curves, a logarithmic conversion was done for raw scores of the main points and the grammatical knowledge. Results indicated that no significant correlation was found. The *p*-value did not reach the significant level ($p > .05$), and *r* was only .09.

4. Discussion

Our research question, 'how well can first-year Japanese medical students read an abstract written in English?' can be answered as follows: (a) Though students do not have much knowledge of what a research papers is, they grasp the sentence and passage structure easily. (b) Moreover, this ability is significantly or marginally significantly related to their grammatical knowledge. (c) In contrast, understanding the main result of an abstract is a difficult task and is not affected by grammatical knowledge.

These results partially matched our predictions. Before this study, we expected that Japanese students who entered a medical school of a university have the skills required to recognise a subject and verb phrase in an English sentence, and would also be able to recognise different sections of an academic paper. This assumption was verified by the study. Generally speaking, an abstract, especially in a medical research paper, has a simple and solid construction. Moreover, in some cases it contains subtitles which make it easier to read. The study indicates that understanding the passage structure of an abstract is not really a problem for novice readers. In terms of the identification of the division in sections, the participants of this study had difficulty in discriminating the end of the methods section from the start of the results section. This may be due to the information conveyed through the first sentence in the results section, e.g., *Of the 19,114 persons who were enrolled in the trial, 9525 were assigned to receive aspirin and 9589 to receive placebo*. Some researchers may include this in the results section, while others may include it in the methods section. As a result, as many as 62% of the students did not get a perfect score, that is, 62% of the students got two points out of three in the passage (**Figure 2**).

On the other hand, our expectation was that by applying grammatical knowledge, if students could correctly understand the sentence and passage structure, they would finally comprehend the main results of the research given in the abstract. This presumption was invalidated by the present study. It indicated that readers who are not accustomed to academic papers did not know which part to direct their attention to. In terms of academic papers, the research goals or author's hypothesis are written in the background or introduction section, and the main results are mentioned in the conclusion section or at the end of discussion section. This is a standard rule for academic papers. It was shown that the participants of this study did not know this general structure of academic papers though, they were able to identify differences between sections. It may demonstrate the potential of teaching this aspect to the students. An academic paper is slightly different from a general passage, which introduces a topic in the introduction, refers to a main statement and its subordinate statements in a body, and summarizes the claims in a conclusion. Faculties in charge of teaching medical English are required to teach 'moves' (see Section 1) of academic papers to the students. Asano is a good example.[4] Her students practiced reading an academic paper while focusing on 'moves' and English expressions frequently shown in moves, that are called 'hint expressions.' Moreover, English expressions which feature each move are given in Kawamoto and Ishii.[2] The results obtained in their analysis should be taken into consideration by all teachers of medical English.

This study has three limitations. First, unfortunately, 13 students were absent when the study was conducted, and eventually the data for 37 students was used for the analysis. More data is required to determine the results. Second, the grammar test tapped only a part of the grammatical knowledge. In other words, the test focused only on the proper usage of two prepositions, *between* and *among*, by the learners. We need to test them on more grammatical rules to be able to use grammatical knowledge of English language learners as a factor. Third, factors other than grammatical knowledge, such as vocabulary, familiarity with academic papers, and expertise in medicine, should be considered when we investigate the accurate comprehension of academic papers by learners.

5. Conclusion

The study reveals that medical students equipped with effective knowledge of English grammar were able to understand sentence structures and passage structures of an abstract very well. However, their ability to accumulate relevant information by reading an abstract was not very good. These results are surely conducive to an academic field of discourse processing and reading comprehension education for learners when English is a foreign language.

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Appendix 1

Abstract Reading Test

The following passage was used in the Abstract Reading Test. However, note that the section titles, and the boxes and underlines—marking out subject and predicate, respectively—were not shown in the test; they were added only for this appendix. Moreover, indents of all the sections were deleted in the test. Thus, this abstract was like a one-paragraph passage.

Background. Aspirin is a well-established therapy for the secondary prevention of cardiovascular events. However, its role in the primary prevention of cardiovascular disease is unclear, especially in older persons, who have an increased risk.
Methods. From 2010 through 2014, we enrolled community-dwelling men and women in Australia and the United States who were 70 years of age or older (or ≥ 65 years of age among blacks and Hispanics in the United States) and did not have cardiovascular disease, dementia, or disability. Participants were randomly assigned to receive 100 mg of enteric-coated aspirin or placebo. The primary end point was a composite of death, dementia, or persistent physical disability; results for this end point are reported in another article in the *Journal*. Secondary end point included major hemorrhage and cardiovascular disease (defined as fatal coronary heart disease, nonfatal myocardial infarction, fatal or nonfatal stroke, or hospitalization for heart failure).
Results. Of the 19,114 persons who were enrolled in the trial, 9525 were assigned to receive aspirin and 9589 to receive placebo. After a median of 4.7 years of follow-up, the rate of cardiovascular disease was 10.7 events per 1000 person-years in the aspirin group and 11.3 events per 1000 person-years in the placebo group (hazard ratio, 0.95; 95% confidence interval [CI], 0.83 to 1.08). The rate of major hemorrhage was 8.6 events per 1000 person-years and 6.2 events per 1000 person-years, respectively (hazard ratio, 1.38; 95% CI, 1.18 to 1.62; $p < 0.001$).
Conclusions. The use of low-dose aspirin as a primary prevention strategy in older adults resulted in a significantly higher risk of major hemorrhage and did not result in a significantly lower risk of cardiovascular disease than placebo.

Appendix 2

Grammar Test

Complete the sentences with *between* or *among* and the most likely words or phrases from the box. If you can use either, write *between / among*.

amateur	its clients	my closest friends	cooking
intake of refined sugar	the pupils	his remaining relatives	
the striking dockers	teenagers		

1. I bought four bars of chocolate and divided them between / among the pupils in the class.
2. The distinction between amateur and professional athletes is becoming less clear.
3. It has become fashionable among teenagers to dye their hair in various colours.
4. When Malik died, his daughter inherited the house and the rest of his money was split between / among his remaining relatives.
5. The advertising company is very successful, numbering most of the big banks among its clients.
6. Researchers have found a striking correlation between intake of refined sugar and arthritis.
7. Given a choice between cooking and washing up, I know which I'd prefer to do.
8. Luka and Ivan are among my closest friends, so I'll invite them to the wedding, of course.
9. Late last night the talks between the striking dockers and their employers broke down.

Medical English language summer intensive course: communication, professionalism, empathy, assessment and planning skills in first-year undergraduates

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As part of Japan's initiatives to cultivate global medical professionals, a new medical English language elective course incorporating simulated patients was offered to first-year undergraduate students at a small Japanese medical university. The course's main goals were to improve medical English communication with non-Japanese English-speaking patients and to stimulate interest in global healthcare. In this course, students were taught eight common medical cases, which were used to practice English communication with simulated patients. A small cohort of international graduate students with different lingua-cultural backgrounds were recruited with no prior experience as simulated patients at the start of the course. For each encounter, patients evaluated one primary outcome (communication) and four secondary outcomes (professionalism, empathy, assessment and planning skills) using a 1-5 scale. Although there was observed improvement in the English communication, professionalism, and empathy behavior with the foreign patients, limitations were observed for accurate assessment and planning skills. Utilizing simulated patients in the course was deemed desirable as it greatly motivated students to improve not only the primary outcome of communication but also provided awareness for professional and empathetic behavior from the formative feedback of patients. Moreover, despite the lack of development in assessment and planning skills at this level of medical education, it is postulated that exposure to such medical content at the beginning of their medical education would further their performance in higher-stakes coursework and encourage them to challenge other global healthcare pursuits in the future.

Keywords empathetic behavior, English-speaking simulated patients, medical English, patient interaction, undergraduate medical education

1. Introduction

As part of a shift toward the cultivation of global healthcare professionals, there is a growing need to improve English communication skills for both academics and professionals in healthcare. In many six-year Japanese medical undergraduate education programs, incorporating additional coursework for medical English communication is a continual challenge, especially within the later years of the curriculum, which are focused on learning the vast amount of medical content in Japanese. The majority of English coursework has therefore been implemented in the first few years of these programs, forcing educators to reconsider the focus of the course objectives with respect to the future needs of the students.

In line with the Japanese Ministry of Education, Culture, Sports, Science and Technology's Top Global University Project,[1] one small university has started implementing English coursework with medical-specific goals in the first year of the undergraduate program. Herein, I report on one elective medical English language summer intensive course for first-year undergraduate healthcare majors with two main goals: creating a foundation of medical language in English and cul-

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tivating interest in global healthcare careers. At this university, upper-level English coursework is limited, requiring motivated students to study on their own. This course was designed to provide such tools and resources that support this need for self-directed study for the latter years of the students' education and throughout their careers.

This report focuses mainly on how the incorporation of non-Japanese simulated patients in this medical English language course improved patient interaction skills, such as communication, professionalism, and empathy. Secondly, this report will also address the challenges and limitations faced when English educators try to introduce diagnostic assessment, treatment decision-making and life-style counseling to first-year undergraduate Japanese students with little to no prior medical knowledge.

2. Methods

2.1. Course background and characteristics

The course comprised five days of practice classes followed by a final oral test. Practice classes were organized by medical content into four body systems and eight different medical cases. Student doctors were required to learn about common symptoms, social and economic factors, and methods of diagnosis, treatment and counseling of two medical conditions for each body system. For each medical condition, a case was presented that contained SOAP components (subjective and objective symptoms, assessment of the history of present illness [HPI], and plans for treatment and counseling). Patient interactions were organized based on common patient assessment tools (OPQRST and PAM HUGS FOSS mnemonics) and student doctors were provided sample grammatical phrases to practice dialogues before the patient interactions.

The final test was held two weeks following conclusion of the practice classes. Student doctors had to complete a 30-minute interaction with a non-Japanese patient. The interaction included three parts: history taking followed by physical examination and counseling. After the interaction, student doctors were allowed time to write up a medical report on the patient interaction. The student doctors were provided a physical examination checklist during the examination to remove the need to remember all the steps of the examinations. The patient role-played one of the eight medical cases learned during the practice classes. Thus, student doctors had a limited number of medical conditions from which they had to differentially diagnose the patient during the final oral test.

2.2. Simulated patient recruitment

Non-Japanese simulated patients from different linguacultural backgrounds (hereinafter, patients) were recruited from the international medical and dental graduate student population of the same Japanese university where the medical English language course was conducted. Recruitment was based mainly on availability; prior simulated patient experience was not a requirement. Patients were provided a short training session before each class. Patients were given small remuneration for their participation in the course from the institutional research funds provided to the course instructor.

2.3. Patient interaction evaluation method

As part of the training session, patients received instructions on how to evaluate each student doctor using a 10-item Patient Evaluation Form that utilized a 1 (poor) to 5 (excellent) grading scale (**Table 1** for list of items by factor). Patients were asked to focus evaluation on the student doctor's ability to communicate effectively and obtain all the information they need to share for the case. How patients felt about the professionalism and empathy were also evaluated. On the other hand, the ability to perform the physical examinations accurately, diagnose effectively and provide appropriate treatment options and counseling were not evaluated strictly, if at all.

2.4. Primary and secondary outcomes

The primary outcome was successful communication in English with non-Japanese patients. The secondary outcomes were professionalism and empathy during the patient interaction. Additional secondary outcomes, which were considered less important objectives of the course, included the assessment and planning skills of differential diagnosis, treatment, and counseling.

The primary outcome (communication) was measured based on four items (two concerning basic communication [giving clear and easy to follow instructions and explaining each exam clearly without medical jargon], and two concerning target questions about the medical problem [obtaining significant details about HPI and obtaining significant details about past medical history and social history]) on the Patient Evaluation Form.

The secondary outcomes were measured based on three items for professionalism (greeting the patient properly, appearing confident and professional, and washing hands before physical exam) and one item each for empathy (obtaining information in an efficient and gentle way), assessment (giving assessment [diagnosis] based on HPI),

and planning (giving a plan for assessment [further tests, treatment options, lifestyle counseling]) on the Patient Evaluation Form. The accuracy of assessment and planning provided to the patients was evaluated using three levels: 'accurate' (student doctor could correctly make a differential diagnosis and could provide reasonable suggestions for tests, treatments, and counseling), 'partially accurate' (student doctor could generally explain the problem but not accurately diagnose the patient and/or could provide some limited suggestions for tests, treatments, or counseling), and 'inaccurate' (student doctor could not correctly diagnose the patient or incorrectly diagnosed the patient and could not provide reasonable suggestions for tests, treatments, or counseling).

3. Results

3.1. Student doctor and patient characteristics

The course was offered to all first-year undergraduate (mainly) Japanese students from two faculties and six different schools in the university. Of the 18 who enrolled, 14 (Faculty of Medicine: 11 students in Medicine, 4 Nursing, and 1 Medical Technology; Faculty of Dentistry: 2 Dentistry) were analyzed; the four remaining enrolled students were excluded from the study due to withdrawal (n=2) and a lack of written dialogue and patient evaluation data (n=2). For the purpose of simplicity, "student doctor" will be used to refer to all students hereinafter, despite the variety in their actual majors. Student doctors in the course had an average TOEFL PBT score of 547 (range, 460-640; taken in April 2018) and were all considered English as a second language learners. None of the student doctors reported having prior medical degrees or coursework and were thus considered novice learners of medical language and patient interaction at the beginning of the course.

Seven out of eleven graduate students from five different countries (i.e., Ghana, Myanmar, Laos, Egypt, and Iran) who responded to the recruitment flyer to join this undergraduate medical English language course as a simulated patient participated for at least one day (3-4 hours/day) in the course. All patients were Masters or PhD students in medical-related fields who reported having medical knowledge (one reported being a licensed medical practitioner and one a licensed dentist in their home countries), but no one claimed they had prior simulated patient experience. All patients expressed a desire to help student doctors become better at communicating in English, with some noting unsatisfactory personal experiences with Japanese medical specialists in Japan. There was an average of three (range, 2-5) patients per class during the five practice classes, who interacted with 16 student doctors. Three patients were invited back to participate in the final test.

3.2. Patient evaluation results

Table 1 shows the results of patients' evaluation of the 10 items related to each outcome. The two communication items for history taking (0.01 and -0.13) showed no significant improvement from practice to test, while communication of medical information improved slightly (+0.14). These values show patients evaluate student doctors relatively highly at practice, leaving little room for improvement at test. Basic professionalism tasks like proper greetings (+0.53) and washing hands before examination (+0.91), on the other

Table1. Patient evaluation form results

Patient evaluation form questions	Practice avg. (SD) (n=44)	Test avg. (SD) (n=16)	Change (Test - Practice)
Communication			
Gave clear and easy to follow instructions	3.70 (0.87)	3.69 (0.98)	-0.02
Explained each exam clearly without jargon	3.86 (0.81)	4.00 (1.0)	0.14
Obtained significant details of HPI	3.86 (0.76)	3.88 (0.99)	0.01
Obtained significant details of PMH & SH	3.75 (0.83)	3.63 (0.70)	-0.13
Professionalism			
Greeted patient properly	4.47 (0.69)	5.00 (0)	0.53
Seemed confident and professional	3.68 (1.04)	3.69 (1.04)	0.01
Washed hands before physical exam	4.09 (1.24)	5.00 (0.0)	0.91
Empathy			
Obtained information in efficient and gentle way	3.98 (0.92)	4.19 (0.81)	0.21
Assessment			
Gave assessment (diagnosis) based on HPI	-	3.86 (0.64)*	-
Planning			
Gave plan for assessment (further tests, treatment options, lifestyle counseling)	-	3.43*	-

HPI: history of present illness; PMH: past medical history; SH: social history

At the practice stage, assessment and planning have no numerical values because they were evaluated solely based on the written comments/feedback of patients. Assessment and planning items were included later as items to the patient evaluation form for the test.

hand, showed great improvement, with 100% success at test. Overall empathy from the perspective of the patient improved slightly (+0.21) at test. Evaluation of secondary outcomes, assessment and planning, were not based on a 1-5 scale, but rather on the written feedback by the patients and instructor (patient and instructor discussed each interaction immediately after to provide formative feedback during the practice classes and for grading at the final test). As shown in the Figure, the written feedback results identified low assessment accuracy of student doctors at practice (35%) and at test (25%), although at least 50% could partially assess the patient at practice and 75% at test. Moreover, student doctors made at least a partially accurate plan for the patient in 65% (40% were fully correct) of the practice times and 50% (12.5% fully correct) of the test times. This lower accuracy during test time for planning skills compared with assessment skills was also observed on the 1-5 evaluation form by patients at test (**Figure 1**).

4. Discussion

Offering an elective medical English language course during the first year of undergraduate programs may initiate motivation and establish a foundation for English communication that students can build on during the remaining academic program. This study reports the successful outcomes of patient interactions by first-year student doctors with no previous medical knowledge but high proficiency in general English (TOEFL mean, 547; equivalent to the minimum requirements of some universities in the United States). According to patient evaluation results, students could adequately communicate with patients and learned how to better present themselves professionally and empathetically with the help of formative feedback. The students started with almost no understanding of how to interact with a patient, and the first encounters were inundated with poor eye contact, lack of confidence, rote history taking, etc. However, once formative feedback from the patients was provided, there were stark improvements in these basic communication skills, and the most minor yet significant behaviors like introducing oneself and washing one's hands were achieved by every student by the end of the course.

To iterate the importance of patients' involvements in this course, I present one academically bright male medical student who was already very focused on the concept of the biomedical understanding of medicine. This student started out very robotically during the patient interaction, mechanically going through all the OPQRST and PAM HUGS FOSS questions thoroughly and accurately, but not providing any comfort or ease to the patient. After the first feedback, this student

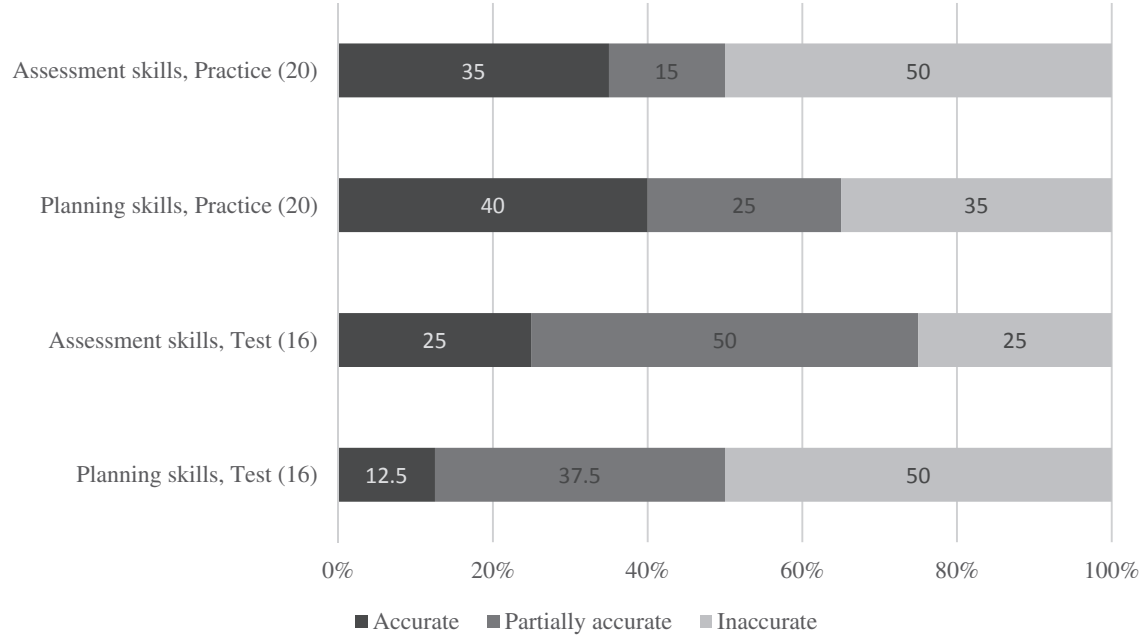

Figure1. First-year undergraduate students' assessment and planning skills

"Accurate" means the student accurately diagnosed the patient and provided a proper plan for further examinations, treatment, and/or counseling; "Partially accurate" means the student identified at least the problem area but not the actual disease and/or provided some limited plan for further testing, treatment, and/or counseling; "Inaccurate" means the student provided an incorrect diagnosis and/or plan or provided no diagnosis or plan at all. The numbers after each item refer to the number of evaluations analyzed for each skill (20 samples during the practice period and 16 samples during the test period).

admitted that he knew he lacked professionalism and empathy. Recognition by the patients of his faults seemed to have spurred him to improve. He became more conscious of these poor behaviors in subsequent patient interactions and at the final test received excellent (full) marks for his professionalism and empathy.

Students face additional challenges as well, mainly with regards to assessing the patient's case through only history taking and providing thorough and clear advice for a patient's condition that they do not understand well. In fact, the study results show a trend of less success in assessment and planning skills in the final test than during the practice classes. The reason for this drop in performance is multifactorial and most likely stems from the overload of learning eight different medical cases, the lag-time between practicing and testing, and the lack of deep understanding of the medical content due to the instruction medium being in a second language. Students themselves reported feelings of being ill-prepared and overwhelmed. Some comments include, "I can't understand the disease treatment well," "too many things to remember" and "we don't have medical knowledge, but the diseases are very difficult (sic)." These challenges are difficult to overcome during this short five-day intensive course and suggests common issues of choosing the appropriate type and amount of content and materials to achieve maximum academic success. To address these challenges, it may be preferable for future courses to cover less content and provide more practice of fewer, simpler medical cases so that students have less anxiety on the assessment and planning components of the patient interaction.

Overall, the outcomes of the course were achieved with the help of simulated patients. Interacting with patients with different lingua-cultural backgrounds can be motivational, and students show a positive reaction to their involvement. Patients have been widely utilized in medical education to encourage patient-centered medicine and to develop empathetic skills.[2] Encouraging patient-centered medicine can be achieved by shifting focus away from the biomedical understanding of the medicine and toward the biopsychosocial understanding. That is, student doctors should focus on the humanistic purpose of medicine.[2] Japanese freshman, who lack a biomedical understanding of medicine, would benefit from the removal of pressures to accurately and thoroughly differentially diagnose patients. In fact, this course encouraged students to differentially diagnose the patients but did not penalize them greatly (if at all) for providing inaccurate medical treatment options and advice. By limiting the focus on the need for accuracy in medical understanding, the instructor could instill a deeper appreciation for the humanistic purpose of medicine (e.g., to be a good listener and show honest concern for the patient's problems and pain).

This study represents a transition in medical English education toward offering more field-specific English coursework at earlier points in the curriculum.

Implementation of such coursework in the first year may satisfy policy makers and academic administrators who desire programs that nurture students' motivation and interest in global healthcare.

5. Conclusion

Medical English language coursework with simulated patients in the first year of undergraduate medical programs benefits students who have motivation and interest in global healthcare. Such coursework develops their medical English language and communication skills, establishes a precedent for patient-centered medicine, and motivates students to become globally minded healthcare professionals.

Acknowledgements

I would like to express my deepest appreciation to the simulated patients who volunteered to participate in the course and who provided motivation and support to the student doctors. I am also grateful to my institution for providing financial remuneration to the simulated patients for their participation in the course.

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How many Japanese university hospitals have websites in English?

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Keywords university hospital, website in English, foreign patients, Japan Medical Service Accreditation for International Patients

1. Introduction

As the number of foreign patients in Japan is increasing, hospital staff need to implement systems for dealing with them effectively. Website information is one way of helping foreign patients to access medical information easily. Some Japanese hospitals have English websites, but the exact number of sites is unknown. The purpose of the present study was to clarify how many Japanese university hospitals have websites in English and to analyze the content of these sites.

2. Background

Harasanshin hospital is located in the central business district of Fukuoka City, between Port Hakata and Hakata Station, and is about 6 km from Fukuoka International Airport. Consequently, we see some foreign patients every day, and our medical staff find communicating with foreign patients quite stressful because of the language barrier.[1] It seems that we are not providing ideal medical services to foreign patients who do not understand Japanese. In order to provide better medical care, we decided to apply for Japan Medical Service Accreditation for International Patients (JMIP).[2] JMIP is a certification of a hospital's ability to deal with foreign patients properly and is managed by a branch of the Ministry of Health, Labour and Welfare. In the process of applying for JMIP, we had to make an English website. I checked various hospital websites and found that there were several different types. Although I initially intended to look at all the hospital websites in Japan, there were so many that I had to narrow down my search to the sites administered by Japan's 82 university hospitals.

This led me to ask three questions. Firstly, do all university hospitals have websites in English? University hospitals provide high-level medical services, so I assumed that they all have websites in English. Secondly, what kinds of information do they offer? And lastly, what languages are available on each website? Since not all visitors speak English, I assumed that some hospitals might have websites in other foreign languages.

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This report is based upon a presentation delivered at the 22nd JASMEE Academic Meeting held at Nakano Sunplaza in Tokyo on August 3, 2019.

3. Method

The research was conducted from February 1 to February 28, 2019. I looked at 82 Japanese university hospital websites and links to English pages. I evaluated the content and noted the number of websites with foreign languages other than English.

4. Results

Of the 82 medical colleges or faculties in Japan, 50 are public and 32 are private (**Figure 1**). Each of them has one or more affiliated hospitals, and almost all of them have English websites for their students, staff, and faculty members. However, the number of university hospitals with English websites was somewhat lower: only 63% of them had websites in English, while 37% did not (**Figure 2**). More public university hospitals had English websites than private university hospitals (**Figure 3**).

From a geographic perspective, in the Kanto area, which is the most populous region in Japan, 60% of the 25 university hospitals had English websites. On the other hand, in the Shi-

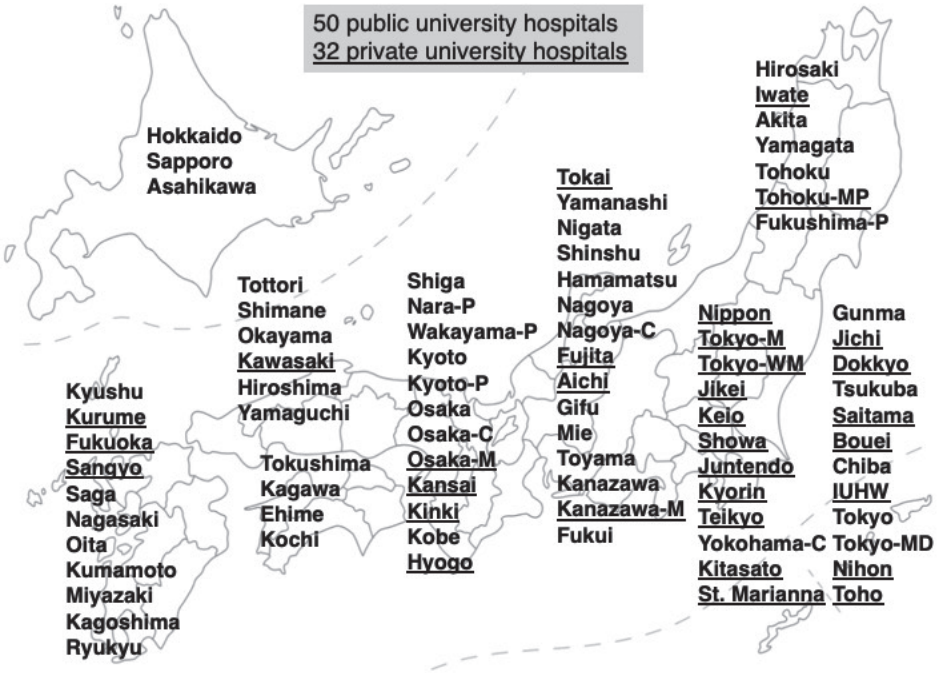

Figure 1. All university hospitals in Japan

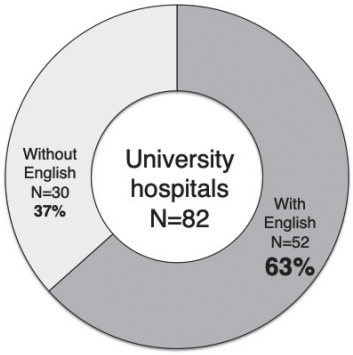

Figure 2. University hospitals with websites in English

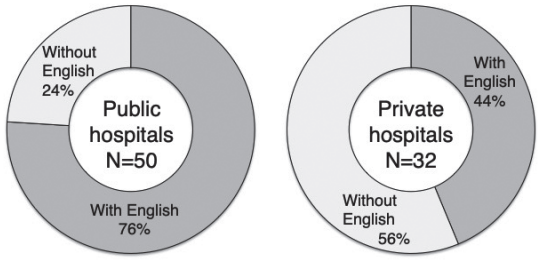

Figure 3. Public vs. private university hospitals in terms of provision of websites in English

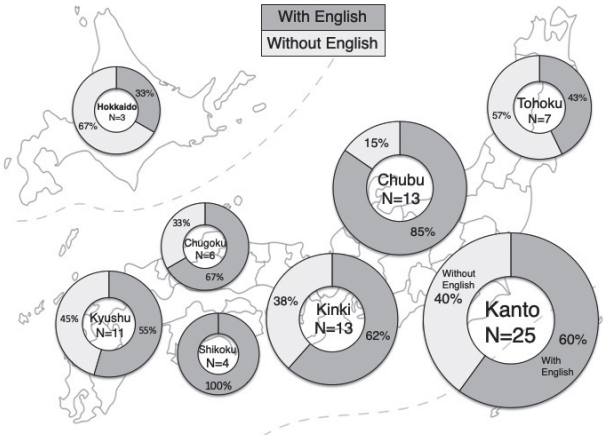

Figure 4. Regional differences between university hospitals in terms of provision of websites in English

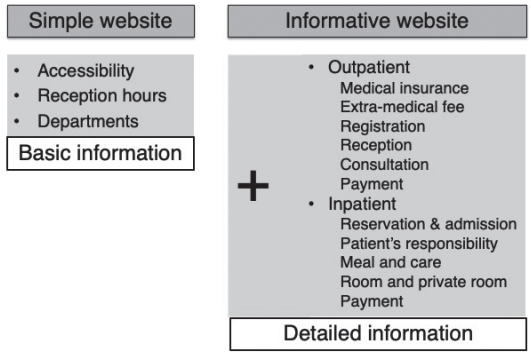

Figure 5. Contents of English websites: simple/informative

koku area, all four university hospitals had English websites (**Figure 4**), suggesting that there is no correlation between population density and the existence of English websites.

The websites were analyzed and categorized into simple ones versus informative ones. Simple websites are defined as those containing basic information such as accessibility, reception hours, and departments, while informative websites contain basic information plus flowcharts explaining how to see a doctor, how to deal with medical expenses, and the procedure of hospitalization (**Figure 5**). The results showed that 45% of the websites offered informative content, while 18% had only simple content (37% offered no content in English) (**Figure 6**).

Thirty-nine university hospitals had websites with only one foreign language, which was English, and the availability of websites in two or more foreign languages was rare (**Figure 7**), although in addition to English, some offered sites in Chinese, Korean, Russian, and Portuguese.

There were eight hospitals with Chinese websites (**Figure 8**), all of which are located in prefectures with a large number of Chinese residents. Notable was Hokkaido University Hospital, which had websites in both simplified and traditional Chinese.

Four university hospitals had Korean websites (**Figure 9**). As with the Chinese websites, the prefectures where these hospitals are located have a large number of Korean residents.

The three university hospitals providing Russian websites are located in prefectures where it can be assumed that Russians work or trade, although the number of registered resident Russians in these areas is not particularly high (**Figure 10**).

Only Mie University Hospital has a Portuguese website (**Figure 11**), presumably for the benefit of the Brazilians living there (Brazilian residents tend to be concentrated in Aichi, Shizuoka and Mie Prefectures, where they work for automobile manufacturers).

Jikei University Hospital offers webpages in 28 languages, Tokyo University Hospital offers 70, and Nagasaki University Hospital 103 (**Figure 12**). These three hospitals used Google

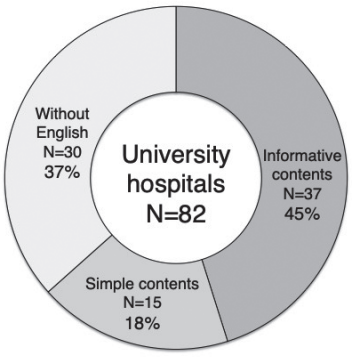

Figure 6. Ratio of informative websites, simple websites, and websites without English

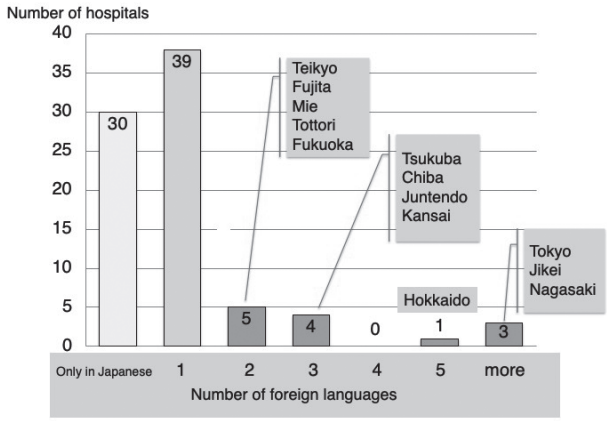

Figure 7. The number of foreign-language webpages offered by university hospitals

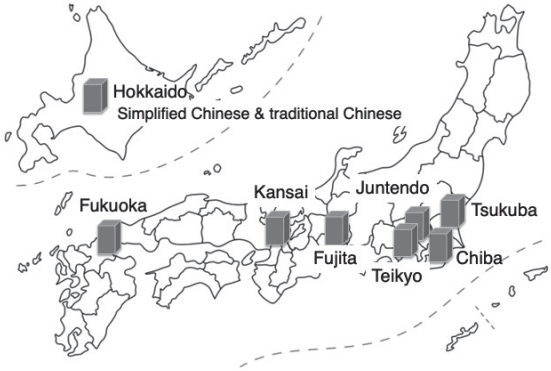

Figure 8. University hospitals with websites in Chinese

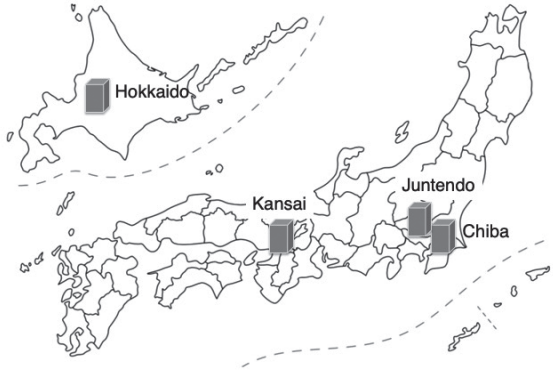

Figure 9. University hospitals with websites in Korean

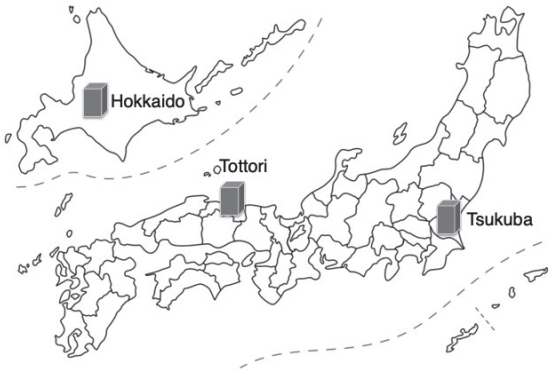

Figure 10. University hospitals with websites in Russian

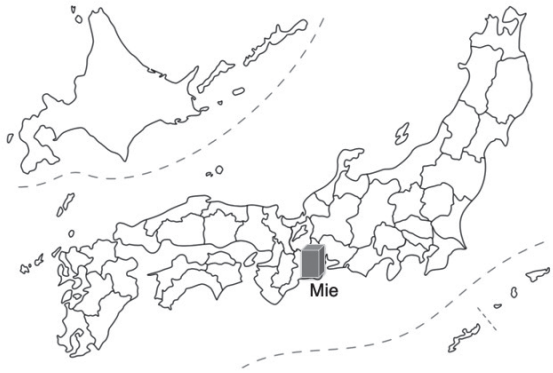

Figure 11. University hospital with a website in Portuguese

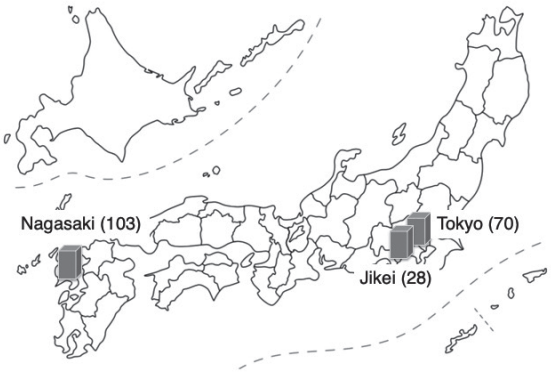

Figure 12. University hospitals with multilingual websites

Translate to produce translations. In my opinion, automated translation is convenient but can lead to misunderstandings due to translation inaccuracies.

5. Discussion

The present study demonstrated that 63% of Japanese university hospitals had websites in English, a figure that was lower than I expected. The contents of the websites were either simple or informative. To provide practical medical information for foreign patients, we should make all websites informative. Since the number of foreign patients from non-English speaking countries is increasing, it is necessary to make websites with foreign languages other than English. However, English will continue to be the primary universal language, so English websites should be the first priority.

6. Conclusion

The present study demonstrated that 63% of Japanese university hospitals had websites in English, while 37% did not. Since these university hospitals function as the main medical care providers in the areas where they are located, they should have websites in English which provide useful information for foreign patients.

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Why do I want to become a doctor?: 日本・台湾医学生による英文エッセイライティングの計量テキスト分析

Why do I want to become a doctor?: Comparing responses found in Japanese and Taiwanese medical students' essays using quantitative text analysis

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Since 2015, University of Miyazaki has been collaborating with medical schools in Asian countries by exchanging essays written in English. The purpose of this project is to enhance students' cultural awareness, to deal with varieties of belief and sense of values, and to support the establishment of their own beliefs as future medical professionals. In this course, students are required to write essays of around 300 words on several topics related to medicine or health issues, upload them on to the bulletin board on Moodle, and mutually exchange them while giving feedback to each other. This article reports the results of a text analysis of students' essays using corpus data from two institutions involved, which included 39 Japanese and 34 Taiwanese participants. The analysis of data includes frequent words, co-occurrence, and co-occurrence networks using KH Coder.

1. はじめに

2015年からMoodleを利用した国際協同学習ネットワークによるアジアの医学生とのライティング交流を継続している。昨年(2018年)は台湾の医学生に参加してもらいこれを実施した。このプロジェクトの目的は，異文化への気づきを高め，多様な価値観や信念に幅広く対応し，将来の医療者として自分自身の健全な価値観や信念形成をサポートすることである。課題は全部で4つある(①なぜ医師を目指すのか［Why do I want to become a doctor?］について述べる。②家族が自動車事故により脳死となったというシナリオを読んで，臓器移植についての自分の考えを述べる。③貧困についての物語を読み，貧困と医療の関係について述べる。④映画「おくりびと」を観賞して，死生観について考えを述べる)。参加する日本人医学生は1年生と2年生なので(台湾は2年生)，専門的過ぎない身近な医療に関連するトピックについて200～300語の英文エッセイを書き，それを掲示板にアップロードして参加者相互が読んで簡単なフィードバックをアップロードするという手順を踏む。参加後の学生からの感想については横山(2018)「オンライン協同学習によるアジア医学生との交流」(JMEE Vol.17(1))で報告したが，本発表では上記①について書かれたエッセイを日本人医学生(39名)と台湾人医学生(34名)の2グループに分けてコーパスデータ化し，計量テキスト分析を試みた結果を報告する。頻出語や共起関係さらに多変量解析により得られたデータを詳細に検討することにより，日・台の医学生が抱く医師になる目的意識の違いがいくつか浮かび上がった。分析ソフトはKH Coderを使用した。なお本研究は科学研究費補助金(基盤B)「国際協同学習ネットワークによるグローバル英語ライティング教育システムの構築」の研究成果の一部である。

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2. 研究の目的と方法

上記①“なぜ医師を目指すのか［Why do I want to become a doctor?］”について書かれたエッセイを日本人医学生(39名)と台湾人医学生(34名)の2グループに分けてコーパスデータ化した。それについて，頻出語や共起関係により得られたデータをもとに，日・台の医学生が抱く医師になる目的意識の違いを探索的に分析した。参加大学は日本が宮崎大学医学部医学科1年生，台湾が国立台湾成功大学医学

部医学科2年生である。分析ツールはKH Coderを利用した。

参加者および総語数はほぼ均等であるが，その一方で異なり語数(Types)ではTaiwanが多く，使用されている語彙の多様性に特徴がある。文の数はTaiwanが少ない。一文あたりの語数が多いことがうかがえる(**表1**)。

3. 分析データ

3.1. 抽出語上位の特徴（名詞）

まず抽出語上位の特徴を探ってみたい。**表2**はJapanese group(J group)，**表3**はTaiwanese group(T group)の名詞頻出語彙上位ランキングである。

一瞥して特徴的な点はJ groupでは，家族や身内を示す語彙(father, grandfather, family, mother, grandmother, parent)，skill, communication, cancerなどの語彙が頻出していることである(**表2**)。それに対してT groupでは，個別の家族関係(father, mother他)を示す語意はさほど上位を占めずfamilyやparentで括っており，またcancerはJ groupと比較すると相対的にかなり低い出現率である(**表3**)。またJ group，T groupともにjobがともに上位にあるが，T groupではcareerがほぼ同数出現している。

日本の医学部入試では特に「コミュニケーション能力」というキーワードが幅をきかせ，ことあるごとにこれが強調される。そのこともあってある意味紋切り型のcommunication skillという連語を多用していると思われる。cancerに関しては家族の一員，特に祖父母などの高齢者がこれに罹患しその苦しみを救おうとする，あるいは救えなかった経験から医師を目指すというストーリーが多い。また，J groupで散見されるのは，下の1)～4)にみられるように，父母の意見を比較的「素直に」受け入れる彼らの姿である(下線筆者)。

1) Second, I want to become like my father. My father is a doctor who ... (J)
2) I wanted to be a doctor. It is because my father is a doctor, so ... (J)
3) The trigger was simple. My father is a doctor and my parents recommended ... (J)
4) One day, my mother fall down because of sharp pain of her back . ... (J)

そういった思いやストーリーはもちろん大事であるが，T groupでは，下の5)のように自分の経験を通してみた自分自身への眼差しに焦点が当てられている例が多い。

表1． 参加者・総語数・異なり語数・文の数

	Japan（宮崎大学）	Taiwan（成功大学）
No. of participants	39	34
Total word count	11,002	11,309
No. of types	1,341	1,560
No. of sentences	688	503

表2． 抽出語上位・名詞（Japanese group）

NOUN	FREQ.	NOUN	FREQ.	NOUN	FREQ.
doctor	253	university	15	study	9
patient	86	area	14	team	9
people	61	body	14	grandmother	8
reason	42	mother	14	health	8
school	41	pain	14	junior	8
hospital	35	experience	13	knowledge	8
medicine	30	day	12	nurse	8
disease	29	fact	12	work	8
father	29	operation	12	drama	7
job	28	other	12	example	7
life	25	skill	12	eye	7
student	24	society	12	heart	7
time	23	treatment	12	occupation	7
year	23	child	11	order	7
grandfather	21	problem	11	parent	7
thing	21	communication	10	teacher	7
lot	20	feeling	10	way	7
family	18	hand	10	…	
care	17	person	10	…	
dream	17	world	10	…	
cancer	16	home	9	biology	4
future	15	situation	9		

表3．抽出語上位・名詞（Taiwanese group）

NOUN	FREQ	NOUN	FREQ	NOUN	FREQ
doctor	196	lot	16	grade	8
people	58	way	16	occupation	8
medicine	49	biology	15	pain	8
life	47	dream	15	passion	8
school	44	teacher	15	science	8
time	41	department	14	story	8
patient	37	health		ability	7
reason	31	interest	14	fact	7
family	28	field	14	matter	7
future	27	care	13	part	7
job	24	hospital	12	question	7
parent	23	kind	12	surgery	7
thing	21	body	11	therapy	7
career	20	child	10	…	
world	19	disease	10	…	
year	19	problem	10	…	
mind	17	day	10	…	
other	17	sense	9	…	
student	17	university	9	…	
knowledge	16	work	9	cancer	4
lot	16	experience	9	grandmother	4
way	16	feeling	8		

5）Back in high school, I wasn't sure if I really like medicine or not. My parents has always hoped that I get to study medicine someday. They never pushed it, but I could always tell it from their expression. And quite frankly, during the time I was preparing for the university entrance exam, I had a really hard time finding motivation. I questioned myself why I set studying medicine as my goal. What if one day I look back and realize I actually wanted something else? It challenged me to my very core. (T)

特に I had a really hard time finding motivation. I questioned myself why I set studying medicine as my goal.という正直さ（honesty）とともに自分を振り返るという成熟した有り様を垣間みることができる。この傾向は，次の形容詞でも顕著にみて取ることができる。

3.2. 抽出語上位の特徴（形容詞）

次に形容詞の抽出語上位の特徴を探ってみたい。**表4**はJ groupの形容詞頻出語彙上位ランキングである。

T groupでは，下の6）〜8）のように，価値判断・様態を表す　語　彙（honest, meaningful, challenging, tough, crucial, exhausted, satisfied）が多様である（**表5**）。

6）As a result, I consider being a doctor a good way to enrich my life and makes it more meaningful. (T)

7）Even though being a doctor can be challenging, it is also fulfilling and rewarding. (T)

8）Then, to care for every patient suitably must be challenging and will definitely give one full sense of accomplishment! (T)

この点は名詞と同様，下の9）〜12）にみられるように，内省の正直さ（to be honestなどの表現，I really hated to be a physician. I thought that the people who dream to be doctors are just money and reputation lovers.といった修辞的対比）や自分の弱さ（vulnerability）を正直に表現する（I knew that ...）などのメタ認知を感じさせる表現が目立つ。

9）To be honest, I didn't like to be a doctor when I was young. When I was a junior high student, most of my classmates' parents hoped that their children could become doctors, and so did my parents. As a kid who didn't like to follow what my parents said, I really hated to be a physician. I thought that the people who dream to be doctors are just money and reputation lovers. However, when I worked in the hospital as a voluntary in the summer vacation I was forced to do it, I met a case which changed my view on a doctor ...(T)

10）To be honest, I really didn't consider too much on why becoming a doctor... (T)

11）Before answering this question, I have something to

表4． 抽出語上位・形容詞（Japanese group）

ADJ	FREQ.	ADJ	FREQ.	ADJ	FREQ.
medical	64	elementary	6	serious	4
many	31	mental	6	special	4
high	30	much	6	worse	4
interested	21	own	6	afraid	3
good	19	clinical	5	enough	3
such	16	due	5	healthy	3
hard	13	general	5	horrible	3
human	13	long	5	last	3
other	13	true	5	local	3
old	12	accurate	4	natural	3
first	11	cool	4	next	3
important	11	different	4	normal	3
little	10	difficult	4	rich	3
patient	10	future	4	sad	3
young	9	great	4	sharp	3
few	8	interesting	4	various	3
happy	8	necessary	4	wonderful	3
big	7	perfect	4	worried	3
more	7	physical	4	…	
sick	7	relative	4	…	
able	6	remote	4	…	
best	6	second	4	social	2

表5． 抽出語上位・形容詞（Taiwanese group）

ADJ	FREQ.	ADJ	FREQ.	ADJ	FREQ.	ADJ	FREQ.
medical	46	financial	7	interesting	4	needy	3
high	36	major	7	little	4	normal	3
good	26	only	7	meaningful	4	perfect	3
many	24	professional-	7	personal	4	physical	3
more	15	strong	7	social	4	poor	3
other	14	Chinese	6	tough	4	proper	3
senior	14	future	6	western	4	right	3
such	13	interested	6	young	4	satisfied	3
first	12	least	6	big	3	stable	3
most	12	long	6	busy	3	stronger	3
sure	11	main	6	challenging	3	suitable	3
able	9	old	6	clinical	3	warm	3
different	9	several	6	crucial	3		
human	9	easy	5	deeper	3		
important	9	honest	5	difficult	3		
much	9	last	5	exhausting	3		
new	9	whole	5	full	3		
better	8	academic	4	happy	3		
great	8	best	4	huge	3		
public	8	due	4	immune	3		
same	8	further	4	junior	3		
sick	8	hard	4	late	3		

convey first: being a doctor is not my ideal career. The reason why I applied for medical school was a long story... (T)

12) I want to get a job which is satisfying and easy. However, I knew that I was just afraid to take responsibility because I was really timid at that time... (T)

一方，J groupでは，hard, wonderfulなど価値判断の形容詞は一部の語彙に限定され，また下の13)や14)のようにcoolなどの口語もみられ医師という職業を表現する語彙の未熟さが感じられる。また下の15)や16)のように多用されているhardについては，医師の仕事がhardという表現ではなく医学部に入るためあるいは医師になるために一生懸命勉強した，というほどの意味で用いられている。

13) The second reason is that I find how cool and meaningful helping people is. When I saw a drama code blue, ... (J)

14) Until then, I didn't have my future image, but when I watched the drama, I came to think that working as a doctor is cool, worthwhile, and more than anything, for someone. (J)

15) You have to study hard even after you become a doctor. Can you do it? (J)

16) In order to do that, I have to study hard and gain experiences through many activities. (J)

J groupは1年生，T groupは2年生という1年間の違いがあるとは言え，この視点や物事を捉える深みの差は何に起因するものであろうか。

3.3. 共起ネットワークからみた特徴: J group

共起ネットワークとは，文書からその文書を特徴づける語の抽出を行い，特徴語同士の共起関係をネットワーク図にするものである。以下のデータは利用したKH Coderにより抽出したものである(**図1**)。前述の特徴語(名詞･形容詞)で探索的に分析した結果が共起ネットワークで再確認されている。study hard, communication skill, cancer, grandmotherなど，J group医学生のナラティブを中心的に構成する共起語彙群といえる。

3.4. 共起ネットワークからみた特徴: T group

同様にT groupの共起ネットワークを示したものが**図2**である。ここではlife, people, helpやhigh school, study medicineなどの予想可能な連語群はあるにはあるが，J groupほどの目立った特徴は見られない。むしろT groupのエッセイでは，個々の内容のバラエティが豊かでつい引き込まれて読み込んでしまう内容にその特徴がある。

例えば個人的な欲求や願いをかなえることと同時に限られた資源をいかに平等に配分するかという社会正義の実現を目指したい(17)とか，人生の成功は金や名声だけではなく社会に真面目に貢献することだ(18)など，多数を占めるものではないが確固とした人生哲学をもった学生の存在には驚くばかりである。参加対象となった成功大学は台湾でもトップを争う優秀な大学ではあるとは言え，2年時でこのような公共哲学的視点を培わせる教育はおそらく中学・高校からなされているのではないか。むしろそちらの方が大いに気になるところである。

17) Besides the self-satisfying results, I believe that doctor is a career with great inspiration to twist the current situations that are not that favorable. I care about social justice, mainly the problem about unequal distribution of resources. (T)

18) Therefore, I have decided to carry out my ambition to be a doctor with the hope to provide voluntary medical consultation to the needy. I strongly believe that one's success isn't measured by one's money or fame, but his or her sincere contributions to the society. (T)

4. まとめ

コーパスを活用しながら雑駁ではあるが，日本と台湾の医学生の英文エッセイの分析を試みた。筆者自身が非常に楽しかったしよき学びとなった。良きにつけ悪しきにつけ地方の国立大学医学部の学生にとっての世界はまだまだ狭いということである。J groupでは比較的定型的な表現と内容(study hard, communication skill)や限定的なself-narrative(家族の病気，幼少期から高校生までの努力，テレビドラマの影響)，さらには家族に医師がいる場合は，比較的無批判に職業としての医師を素直に受け入れる傾向があるか，または英語による表現能力の限界が感じられる。

一方，T groupでは多様な語彙・文章表現など作文能力はもとより，正直さと批判精神，メタ認知力などを含む自己省察(reflection)の深さを感じる。高校生から今の自分(医学科2年生)そして将来へのビジョン，特にただ単に自分が何をしたいかどんな医者になりたいかだけではなく，自分と社会との関わりの中でそれを捉えようとする姿勢をもった学生が少なからずいることに驚きと羨望を感じたのは正直なところである。

特に英語教育の中でかかる視点が重要であるのは，自らの価値観や信念すなわちアイデンティティをメタ認知する能力がプロフェッショナリズム教育と分かちがたく結びついているからである。Hafferty & Levinson(2008)は，プロフェッショナリズムに深く関わるProfessionalism Identity Formation (PIF)について次のように述べ，PIFが個々人の信念や価値観により形成されていく継続的発達過程への省察に焦点を当てることを強調している。

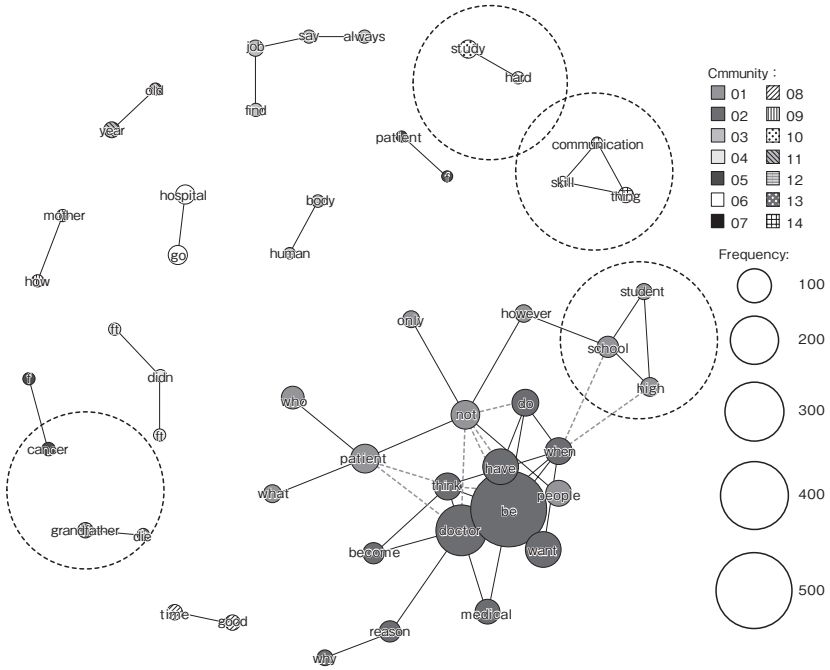

図1.　共起ネットワーク（J group）

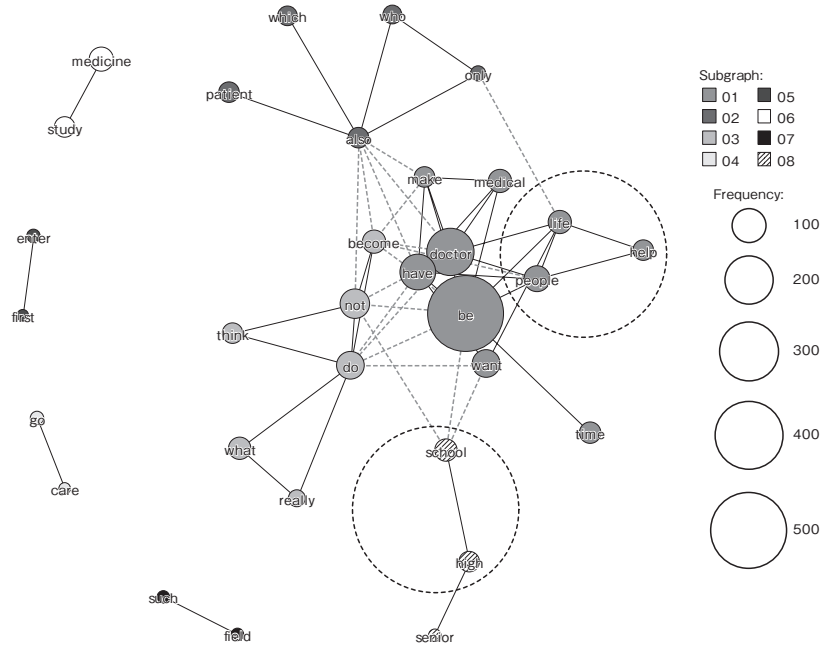

図2.　共起ネットワーク（T group）

“PIF (Professional Identity Formation) focuses ... on professionalism as a reflection of an ongoing developmental process that is shaped by the beliefs and values of the individual as well as by the environment, including both the formal planned and informal “hidden” curricula of medical education, healthcare delivery, and larger social forces”（下線，横山）[1]

個々人の信念や価値観が社会性を逸脱したものであったり，ただただ他者を助けたいという独りよがりな思いであればどうなるだろうか。Canadian Medical Education Directions for Specialists (Can MEDS)では**図3**のようにMedical Expertを定義している。[2]

よき医療者はよきcommunicator, collaborator, manager, health advocate, scholar, professionalを目指すべきであり，そのためには自分を取り巻く社会や世界を俯瞰し大きな物語の中に自分を位置づける能力が必要なのである。

例えば単なる「人を助けたい」から，「私はあなたの人生の中でどのような役割を与えられているのか」という認知のシフトはよきcollaboratorとして生まれ変わるために，そ

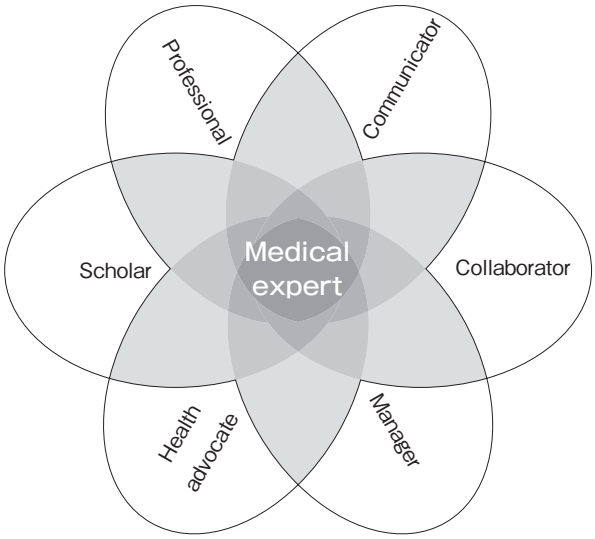

図3.　Can MED role framework (文献2)からの引用)

して社会システムと個人の関係や医療と貧困・資本主義の問題は弱者の代弁者としてのhealth advocateとして医療者が機能するために不可欠な視点であり，医学教育に人文科学的要素が欠かせないことはこれまで指摘しているとおりである(横山2018a，横山2018b)。[3,4]本稿分析データの最初の部分で触れた日本人の紋切り型に関してMichael Guest先生(宮崎大学医学部准教授)との雑談の中で，ポライトネスの観点から興味深い意見をいただいた。日本人の場合，特に初対面では対面を保つため(face-saving)どうしても紋切り型の表現やありきたりの内容を書きがちなのではないか，それは授業でも自分自身をさらけ出すことを避ける傾向にある学生の姿をみることからも想像できるというものである。日本人である筆者自身は確かにそれも一理あると理解できる。その上で，自分の失敗をすべてさらけ出す必要はないものの，自分が何者でありどこに向かおうとしているのか過去の失敗も含めたナラティブを他者に伝える手段を身につけておくことはよきcommunicatorとしての資質を培う上でも重要である。

なぜならば，彼らが医学生として求められる医師像と現在の自分とのズレを目の当たりにすることは将来一度や二度ではないだろうし，医学生として失敗することもある。そこを乗り越えていくためにも自分を俯瞰的に捉えられるナラティブ能力が必ず要求される。であるからこそPIFの一部として言語教育を位置づけることが必要である。

最後に本研究の限界としては，サンプル数がやや限定的であったことが上げられる。さらに，比較対象の問題(英語能力，総合的学力の差)はあったが，むしろそのことにより参加した日本人学生にとっては深い気づきを得られ，自らの価値観の成熟にとってよき僥倖に巡り会えたといえるかもしれない。その点についてはいずれ稿を改めて論じたい。

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Addressing the challenge of medical student "cost performance" behavior in Japan: a policy framework

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As medical universities in Japan transition to implement globally recognized standards in their medical curriculums, the medical humanities are being relegated the least amount of time in medical students' schedules. Consequently, our subjects are less regarded by students as crucial to their futures as doctors. At the same time, a growing trend toward a "cost-performance" attitude in matriculating students[1,2] has created a perfect storm. Freshmen apathy to their studies combines with misinformation from *sempai*, giving rise to increasing incidents of short-cutting (e.g. plagiarism, the use of Google translator) and creeping dishonesty in their academic performance. Unfortunately, the effect of this "cost-performance" is not one-sided as it is teachers who must pay a heavy price through ever-increasing micro-monitoring of student output, dissipating trust, stricter class policy updates, and even teacher burnout. In this paper, an academic policy framework will be outlined which the authors believe can provide a sounder foundation for ensuring fairness for all students as well as better preparing them for the steep challenges awaiting them after our pre-medical courses. Our proposed policies are created with global standards in mind and the intention of discouraging the cost-performance paradigm. The goal is to motivate our freshmen students to do their best in all their studies at our university, as opposed to the current trend of aiming to squeak by with a passing grade. In particular, we wish to elucidate the value of employing GPA minimums as a catalyst to identify problem students and guide them to lift their efforts to achieve their full potential.

Keywords medical students, cost-performance, integrity policy, probation policy, GPA

1. Introduction

Medical universities in Japan are currently in a state of flux as they transition to implement globally recognized standards in their new medical curriculums. As such, medical education is now trending away from passive, teacher-centered lectures and rote learning towards more student-centered, active experiential learning that reflects both the exponential expansion in medical knowledge and preparing doctors for their future working environments. What hasn't been keeping up with these changes are the students themselves; their attitudes, expectations and educational experiences upon entering a medical university leave them poorly equipped for the new challenges before them. Indeed, O'Dowd in 2006[3] described the behaviors of students at that time,

> *".. continually procrastinate, absent themselves from classes, prefer club activities to doing study, drink too much, regard their teachers as "boring" or that class work is "useless", and generally do too little too late,"*

and reported on the ripple-effect phenomena:

> *"How much effort each student is willing to invest in their learning processes depends primarily on their attitude; if they have a poor attitude at the outset, they see no reason to make much effort and quickly fall into bad habits. I refer to this as the "ripple effect" because just as when a stone thrown into a pond breaks the water's surface and creates ripples which run to the pond's edge, so too do student expectations and actions have repercussions which radiate far beyond the initial time frame."*

Nevertheless, it was noted that most students at that time,

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despite their casual approach to coursework, returned to their most successful strategy of high-pressured cramming just before examinations to pass classes with better than a mere passing grade. Unfortunately, although the new breed of freshmen medical students commonly display a similar apathy to their first-year studies, new factors are coming into play that mark a distinct departure from past behaviors. In particular, Japan's demographic crisis of a shrinking pool of younger citizens competing for the same number of places in Japanese universities has meant a notable decline in academic performance; as one of our professors put it, "The level of students who used to be accepted here decades ago are now able to go to more prestigious colleges, meaning that the students we are getting now would previously not have been accepted here, resulting in the current situation." In addition, a not insignificant factor is the misinformation from *sempai* (students ahead of them in school who have already completed the freshman year studies) giving rise to increasing incidents of short-cutting (e.g. plagiarism of past works, submitting the work of others as their own without even changing the name/student number) and the sharing of ill-gotten copies of past tests.

In addition, new technology-based factors are now commonly in play, such as using Google translator to produce English reports and communicating via smartphones/smartwatches during tests. And such cases are just the tip of the ice-berg of the creeping dishonesty displayed by some students each year. A more recent survey of medical students indicated their study habits are indeed atrophying and trending downwards, having a significant impact on their performance outcomes, which in turn makes the temptation toward academic dishonesty greater. Possible contributing factors may include their reliance on smart-phones for needed information, greater emphasis on test-taking techniques rather than building their knowledge base, and simple impatience due to their desire for immediate gratification.

It is when these factors combine to create a perfect storm and the situation reaches the critical point when: i) the trend becomes a collective problem not just an individual one, and ii) the poor performances are normalized, that is, integrally or holistically evaluated without any sanctions. At this point, action is necessary to prevent the inevitable collapse of the entire system to mere rubber-stamping of graduates who may in fact not be able to meet the minimum standards expected of doctors under the new globally recognized framework. But before looking at the policy action we believe is needed, this paper will briefly examine the roots of the current dysfunction, that is, the phenomena described as "cost-performance" and creeping academic dishonesty.

2. Cost-performance

The term "cost-performance" was first brought to the authors' attention in 2016[1] when a student used it to explain why they hadn't made more effort in class to achieve a better grade; in short, a cost-performance mindset compelled them to attempt to satisfy the minimum requirements of assessment work to pass each class with the least effort. This student comment was made before the introduction in 2016 of the university's grade point average (GPA) system and requirements, an unfamiliar system that has yet to make its way into the students' combined consciousness.

In a series of studies undertaken at Hamamatsu University School of Medicine (HUSM) since 2003, a general declining trend has been visible both in time spent on general and medical subjects study habits. An interesting finding of these HUSM studies[3-5] was that current medical students may have a lower level of intrinsic motivation driving them and their study habits when compared to medical students in years past. Indeed, when 2017 HUSM freshmen were surveyed and asked to comment about this trend, the term "kosupa" (コスパ[6]), meaning cost-performance, was frequently cited. Sadly, rather than striving to get the most out of their education, or most bang for their buck, their definition of "kosupa" is more along the lines of getting a passing grade with the least effort regardless of the negative long-term consequences of this behavior.

Driving this attitude in our millennial freshmen are the increasing demands and pressures of university life as well as the increasing study burdens of the evolving curriculum that is much more jam-packed than that of the past. Thus some students are compensating to make their lives easier by making only the minimum effort necessary to pass their courses rather than expending more effort and time to achieve better grades and a higher GPA. Unfortunately, this cost-performance attitude is also resulting in an increase in students' engaging in academic dishonesty: cheating on tests, missing deadlines, and engaging in practices that could be described as unethical. The authors believe that a tipping-point is approaching as the growing trend toward a "cost-performance" attitude has created a perfect storm. Freshmen apathy to required change combines with misinformation from *sempai* giving rise to increasing incidents of short-cutting (e.g. plagiarism, sharing copies of past tests, using Google translator to produce reports) and creeping dishonesty in their academic performance.

3. Academic dishonesty

It can be said that the goal of all students entering a university should be to apply themselves to the best of their abilities to acquire the knowledge and skills to graduate from their chosen field of study and go on to become more productive members of society as well as making a better life for themselves. It goes without saying that students should be respectful of their professors, teachers and fellow students, approach their studies with honesty and diligence, and abide by the ethical codes and standards of the university and their future profession.

However, it is a sad fact that academic dishonesty has been trending upwards for several decades in universities all around the world, Japan not being an exception. Academic dishonesty includes behaviors such as cheating, collusion, copying, improper use of technology, lying, purloining others work, and plagiarism. Much has been written about the compounding problems of the missteps in higher education in Japan since the bursting of the Bubble Economy in 1989-92.[6-9] Much of the analysis concludes that the university system that served Japan well in the past is now broken and no longer functions properly, although all the players dutifully ignore this new reality and still go through the motions year after year.

Nakai[10] identified the fundamental problem that academic skills are now required to be turned into actual skills and abilities and that global standards are now expected rather than what was normal in the past. Nakai also sympathized with students as he charges that no one has made these far stricter changes in expectations explicit, leaving college freshmen to strugcgle with false assumptions derived from a bygone era. The knowledge, abilities and ways of thinking required in this new era need to be on par with the global standard now expected of university graduates throughout the world. It is our responsibility as university educators to step up and provide guidelines to raise the standard of academic integrity at our institutions.

4. Academic policy framework

To provide a more concrete foundation for our students as well as address what the authors see as deteriorating academic integrity, we propose developing an academic policy framework that would advocate professionalism, fairness and responsibility for all students across the spectrum. Such a proposed framework would need to be formulated with global standards in mind and be aimed at discouraging the creeping cost-performance paradigm. The overall goal is to motivate our freshmen students to do their best from the outset in all their pre-medical studies, and by doing so develop better study habits that will support their future medical studies and careers.

Our proposed framework would include two major elements: an integrity policy as the foundation for the academic excellence and professionalism that our universities aim to instill, and a probation policy that serves to identify and support those students struggling to meet minimum requirements or who are at risk of failure. In particular, we wish to elucidate the value of employing GPA minimums as a catalyst to lift the efforts our students are making. Such a policy combination would clearly outline our expectations of students entering our programs as well as procedures for when problems occur. Apart from the "cost-performance" problem, it may also address the broad spectrum of behavioral problems increasingly arising in our classes.

5. Academic Integrity Policy

Our current student handbook only mentions cheating in the context of formal exams. As we introduce more classes based on active learning and grading in the context of students' ongoing performance throughout the course of a semester, there is a need for explicit guidelines expressing our expectations regarding integrity. One of our current problems is that such values are not stipulated nor regularly brought to the attention of our students.

A clear, overtly promoted academic integrity policy is paramount if teachers and administrators are to address the current breakdowns occurring on college campuses. As a starting point, we looked to The International Center for Academic Integrity (ICAI)[11] which defines academic integrity as a commitment to six fundamental values: honesty, trust, fairness, respect, responsibility, and courage. In addition, we determined that a worthwhile integrity policy should enable a professor to report any behavior that they believe undermines these values, even if the behavior is not specifically listed in the university guidelines. In short, at the discretion of the teacher/professor any activity undertaken with the purpose of creating or obtaining an unfair academic advantage over other students, or inhibiting another's academic progress, violates the integrity policy.

Therefore, the proposed goals of our integrity policy (**Appendix 2**) are:

1. to have clear ethical expectations for students,
2. consistency of standards and practices across all programs,
3. to cultivate an environment of honesty and integrity,

4. to outline a process for dealing with violations of this policy; a violation would be defined as any attempt to get a grade by means other than honest effort.

Here it is important to express that academic integrity will only improve if faculty are willing to do their part. Faculty should provide clear syllabuses that explain expectations and include guidelines for students to understand how to meet those expectations. Faculty should also be aware of their own institution's policy regarding academic integrity and be willing to take part in the improvement of policies that are no longer adequate or need updating.

After developing the framework for an academic integrity policy, the next step is to create the criteria for an academic probation policy, which requires the university to determine what will trigger such an intervention and at what point in the students' progress through the curriculum. To this end, we advocate employing GPA minimums to identify students at risk.

6. GPA

Although GPA is a common measuring stick used by universities around the world, it is fairly new, and poorly understood, in Japan. The calculation of a GPA is relatively simple, producing an easily recognizable number based on a student's achievement in their study courses and averaged per semester, per year, or for the overall program. A simple GPA scale covers a range between 1.0 and 4.0, with 4.0 being the top score possible. A student's GPA will rise or fall depending on their overall achievement in their courses (i.e. how well they did in their tests and exams). This number can be used to determine whether or not a student has met the standards set by a department, program or university.

In some countries there is a more detailed breakdown of grades and corresponding GPA points awarded, but many Japanese universities use the following common categories and corresponding GPA shown in **Figure 1**.

Generally, university entrance exam scores hold the greatest meaning in determining entrance to higher education for high school students in Japan. Thus, the introduction of a GPA system is somewhat foreign to both Japanese students and administrators alike. Familiarizing students with the meaning of the GPA and its importance, especially for students who are considering studying abroad after graduation, is a step in the direction of globalizing our institutions.

Grade in Japanese	English translation	Corresponding percentage	GPA
shū（秀）	Excellent	(90-100%)	4.00
yū（優）	Very good	(80-89%)	3.00
ryo（良）	Good	(70-79%)	2.00
ka（可）	Satisfactory	(60-69%)	1.00
fuka（不可）	Unacceptable, failed	(0-59%)	0.00

Figure 1

7. Academic Probation Policy

Once GPA criteria are established that would stipulate what students will need to achieve and what standards are expected of them, both in terms of classwork and exam outcomes, the next step is to provide a framework to identify students that need support before they slip through the academic cracks. We propose an academic probation policy to motivate students to do more than just the minimum in our classes. Most undergraduate programs in the United States require at least a 2.0 GPA from students (**Appendix 1**). Students who fall below that number are placed on "academic probation". This generally means that they can continue on in their studies, but if they do not raise their overall GPA to a 2.0 or higher in the following semester, there will be consequences, such as regular meetings with an academic advisor and possibly letters home to parents for younger students. In the USA the consequences can be quite harsh, often suspension for one year or expulsion. However, in this proposal we prefer to examine options that would generally be considered fair in Japanese university culture. Academic probation is a support system rather than a punishment.

In the USA, the average GPA of students entering medical schools in 2018 ranged from 3.42-3.9＜http://www.mcattestscores.com/usmedicalschoolsmcatscoresGPA.html＞.

This range of GPAs represents the academic achievement in undergraduate courses taken in the first 4 years before entering medical school as graduate students. When considering academic standards from this point of view, the 1st- and 2nd-year courses (liberal arts and basic sciences) taught at HUSM and other medical schools in Japan would be considered comparable to undergraduate courses in the USA.

Since our students have already been accepted into medi-

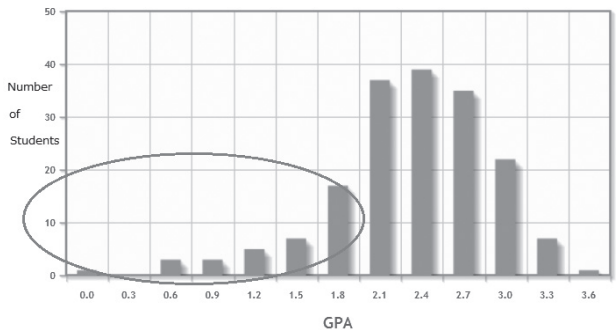

Figure 2. Below shows an example of student GPA scores with probation scores circled in red.

cal school on the basis of successfully passing the entrance examinations rather than a GPA, there is no understanding of or incentive to aim for a high GPA after entering. Therefore, an increasing number of students have a tendency to put in merely the minimum of effort required to pass our courses without regard to the effect on their GPA.

We propose the creation of an academic probation policy to help those students who did not fail our classes, but need encouragement to work harder and achieve more. We do not envisage this probation policy to be a punishment but rather a support system. In addition, students who do fail and any students caught cheating should automatically be put on academic probation. This policy would consist of the following elements:

1. standard minimum GPA of 2.0; under 2.0 would place a student on probation.
2. outline the process for failure to meet minimums
3. guidelines for getting students back on track
4. record keeping to apprise future medical subject teachers of students who may need extra support.

The long-term benefits of a policy like this would include an all-around shift in the *kosupa* mindset that many students have. An academic culture of doing one's best rather than the minimum requirement would be a great improvement and help the school achieve its mission statement of producing excellent clinicians and researchers.[12]

Since the 2016 implementation of GPA at our institution, 17 students have had to repeat a year. Among the students who repeated either their first or second year due to a failed class or classes, 16 out of 17 had a GPA below 2.0 in either the first, second, or both semesters of their first year suggesting that students who fail a class are often not doing very well in other classes either. We are currently looking more deeply into the predictability of academic decline based on first year GPA scores.

8. Conclusion

Student behaviors, choices and performance are rooted in numerous personal expectations and environmental factors. It is therefore very important that all students be made aware at the earliest possible opportunity that their behaviors towards their studies do have consequences, both favorable and unfavorable for their GPA in particular, that extend far beyond their first year on campus. Our advocacy of a new policy framework aims to provide more focused guidelines that promote academic achievement and professionalism as well as a more efficient support system that identifies students who need support early and doesn't let any students slip through the cracks. For just as Japan's medical universities are adapting to a new global environment, so too must our medical students adapt to the changes being implemented as only they themselves can redefine their role in their learning process and change cost-performance to mean something positive rather than negative.

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Appendix 1

Examples of academic probation guidelines from universities in the USA

University of Michigan

In general, academic probation occurs when a student's grade point average for a term is less than a 2.0. If you go on probation, you are required, in your next registration, to complete all courses on time and to have an average for that term which is better than 2.0. Being on probation means that you should be consulting an academic advisor and/or an Academic Standards Board member.

UCLA

An undergraduate student will be placed on probation if their term or overall grade-point average (GPA) falls between 1.5 and 1.99. They will be subject to dismissal if their grade-point average in any one term is less than 1.5 OR if they do not earn at least a C (2.0) average in any one term when on probation OR if they do not end probation by the end of the next term.

University of Washington

An undergraduate student whose GPA falls below 2.00 in his or her first quarter at the University receives an academic warning. If a cumulative GPA of at least 2.00 for courses earned in residence at the University is not achieved by the end of the next quarter, he or she is placed on academic probation.

Pennsylvania State University

When a student's cumulative grade point average (CGPA) falls below 2.00, the student is placed on academic warning (Senate Policy 54-20). When a student on academic warning earns a semester grade point average (GPA) of less than 2.00, the student is then placed on academic suspension (Senate Policy 54-40).

University of California San Francisco

A student shall be placed on probation if, at the close of any quarter, his/her grade-point average is less than 2.0 (a C average) computed on the total of all final letter grades received in core courses taken.

University	*Academic warning trigger*	*Academic probation trigger*
University of Michigan		GPA < 2.0
UCLA		GPA = 1.5 – 1.99
University of Washington	GPA < 2.0	
Pennsylvania State University	CGPA < 2.0	
UCSF		GPA < 2.0

https://www.seasoasa.ucla.edu/faqs-undergraduate-students/
https://www.washington.edu/students/gencat/front/acadstand.html
https://dus.psu.edu/academic-warning-and-suspension
https://parents.umich.edu/page/grades-academic-standing
https://pharm.ucsf.edu/current/policies/probation

Appendix 2

Academic Integrity Policy

This proposed policy would apply to all students, undergraduate and graduate, of Hamamatsu University School of Medicine.

1. Academic Integrity Policy

Hamamatsu University School of Medicine (HUSM) is committed to the excellence of the learning experiences and outcomes for all its students and aims to provide a learning environment that fosters and instils in all students the qualities of independent scholarly learning, critical judgment, academic integrity and ethical sensitivity.

To facilitate the achievement of academic integrity, HUSM staff must continually strive to cultivate, with their students, a climate of mutual respect for original work and a clear understanding of standards for academic integrity.

Therefore, all HUSM stakeholders share responsibility for maintaining the academic standing of the University.

2. Academic Integrity Policy Requirements

Undergraduate and graduate students must:

1. undertake without reservation the responsibility to maintain both the highest standards of academic integrity in their work and ensure they appropriately acknowledge the ideas, interpretations, words or creative works of others in all their studies.
2. promise to uphold the values of honesty, trust, fairness, respect, responsibility, and courage expected of a member of HUSM.
3. acknowledge without reservation that the following behaviors (and other behaviors deemed by HUSM as not appropriate behaviors) are not acceptable at HUSM: cheating, collusion, copying, lying, improper use of technology, passing off the work of others as my own, and plagiarism.

3. Academic Integrity Policy Violations

Violations by engaging in academic misconduct includes conduct on the part of a student or students that:

(i) hinders or disrupts the pursuit of academic excellence and includes cheating, collusion and plagiarism;

(ii) seeks to gain for himself or herself, or for any other person, any academic advantage or advancement through the improper use of HUSM facilities, information or the intellectual property of others; or

(iii) constitutes research misconduct.

Any member of staff who observes or receives a complaint related to any academic misconduct must:

(i) immediately refer the complaint to a relevant integrity officer; and

(ii) in consultation with the integrity officer, conduct a preliminary investigation in a timely manner;

(iii) Upon finalization of the preliminary investigation into any academic misconduct, a report must be provided to the integrity officer who will then bring that report to the attention of the relevant HUSM committees and the Head of School for further action in accordance with HUSM guidelines.

Creating awareness in medical students of the benefits of active learning in a local hospital

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This presentation was an account of an 'Active Learning' and CLIL-based practical activity involving medical English students from Kagoshima University in a local hospital. The hospital visits were designed to expose the students to medical encounters and discourse with real medical practitioners and patients in a working medical environment. The presentation focused on the experiences of medical English students and staff during the planning and implementation of a Parent and Child Asthma Seminar at Seikyo Hospital, Kagoshima. It included the events that led up to this activity and how they relate to what we do in the classroom.

Creating and maintaining motivation is one of the key components of a successful language programme. With the aim of motivating the students, we decided to engage in an 'Active Learning' activity through the preparation and execution of an asthma seminar for parents and children at a local hospital. Despite the belief of some, 'Active Learning' is far from a new concept: it has been the guiding principle of many educators for quite some time now. Of the many definitions available, the one by Bonwell[1] is a good place to start this paper: *"In active learning, students participate in the process and students participate when they are doing something besides passively listening."*

If we accept that Active Learning is about involving the students directly in their studies in and out of the classroom, and having them take responsibility for their own learning, we can readily see that participation in this seminar was a good way of helping the students take on this responsibility.

This activity came about through the addressing of two fundamental questions:

Is there a problem with Patient-Doctor communication?

If there is, how do we go about reducing the problem?

In answer to the first question, the words of Levinson et al.[2] made it abundantly clear that there is indeed a problem: *"We are faced with a breakdown in communication between patients and doctors, increasing patient dissatisfaction, rising numbers of complaints and claims for malpractice, and abandonment of conventional medicine for alternatives that are often unproved."*

There have been many anecdotal and empirical references to this problem over the past two or three decades; this is but one of them.

In answer to the second question, a 4-point plan was devised.

1. Make lessons interesting and meaningful.
2. Help students become aware of their role in Patient-Doctor discourse
3. Create awareness in students of what I like to call the 'Vertical Nature' of language
4. Create opportunities for students to be involved in Patient-Doctor discourses

Point 1 needs no description here, but it was included in the presentation in a sort of 'tongue in cheek' way because the omission of such a blindingly obvious fact often brings out an irritating pedant in a presentation audience.

Point 2 is a complex issue, and as time was very limited, only two aspects were referred to: *'Sensitivity Awareness'* and *'The importance of Treating Patients as Individuals.'*

Point 3 focused on drawing the attention of our students to what I like to call the 'Vertical Nature' of language. This is in reference to the disparity in education between doctors and patients and the problems that can occur when doctors use words like abdomen instead of 'stomach/tummy', etc. The students are encouraged to think about the different ways each individual uses language to describe things. It begins with comparing simple words like *bow wow/dog/canine* and progresses to medical words.

For quite some time now, I have talked of the problems that the disparity in education can bring in Patient-Doctor discourse and advocated this kind of approach as a way of dealing with it that is beneficial to both parties. Naturally, I think this approach is a good one, but perhaps the best validation for it can be found on the NHS website. On March 18 this year, it was reported that the NHS had decided to change the vocabulary on its websites to make it more 'user-friendly'.

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This report is based upon a presentation delivered at the 22nd JASMEE Academic Meeting held at Nakano Sunplaza in Tokyo on August 4, 2019.

Some examples cited included changing the word ***'nausea'*** to ***'feeling sick'***, and ***'haemorrhage'*** to ***'very heavy bleed.'*** To further support this view, this symbolic quote from the NHS's Sara Wilcox[3] was used to drive home the point: ***"If someone with poor literacy understands blood in your poo, it might just save their life."***

Point 4 focused on creating opportunities for students to get involved in, or witness Patient-Doctor discourse. One way in which this can be achieved is simply creating activities that challenge our students. For example, to explain to children what some of the body's systems do, one enterprising student came up with a model of paper cups and strings to illustrate the nervous system. Of course, the best way to raise awareness in students is to get them involved in real-life Patient-Doctor discourse. We did this by participating in a Parent-Child Asthma Seminar at a local Kagoshima Hospital. Our students were involved from beginning to end, and we took part in all of the planning meetings. This gave the students the opportunity to see first-hand, how nurses, nutritionists, and doctors discuss and implement the best ways to communicate their messages to both the children and their parents. Photographs and descriptions of the seminar used in the presentation illustrated the way in which medical jargon and complicated language is kept to a bare minimum.

The presentation concluded with the following question: *Who benefits from these kinds of activities?* The short answer is that everyone gains: The children and parents better understand the issues surrounding living with asthma and adjust their behaviour accordingly; the students see the benefits of understanding the different approaches needed when talking to patients who do not share the same educational background (in short, talking to patients in a way that their patients understand); senior practitioners and educators gain invaluable insights that help them with their mentoring duties; and educators gain valuable insights to help with the creation of effective syllabi/materials/classes.

I would like to extend these visits to other medical institutions, so if anyone reading this article can help in anyway with suggestions and introductions, I would greatly appreciate it.

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医療通訳ロールプレイ訓練におけるフィードバックの方法と実践

Feedback methods and practice in medical interpreting role-playing sessions

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An elective introductory course on English medical interpreting has been offered at the Ohtawara Campus since 2015. The course focuses on improving medical interpreting skills in doctor-patient encounters through role-play training. A recent goal has been to develop more systematic and effective ways of giving feedback to the students, to which end the following methods have been adopted: 1. discussing students' strong and weak points in groups after watching their video-recorded performances; 2. summarizing and recording the results of the discussions on paper, and having each group report the contents to the other groups; 3. conducting role-playing sessions with international students; 4. using assessment sheets for peer evaluation of each student's performance; and 5. providing a role-playing session just before the final examination so that students can get feedback from the lecturer. The final examination for this course includes a role-playing test at the end of a semester. These feedback methods seem to be effective in motivating students to start preparing for the final examination early in the semester and giving them enough time and opportunities to practice. In addition, they also help students to reflect on their performance and enhance their awareness regarding such issues as speech volume, eye contact, English pronunciations and accents, attitudes, and the accuracy of interpretation. In my presentation at the 22nd JASMEE Academic Meeting, I used video images to report the procedures followed in the 2018 and 2019 academic years, together with such information as the contents and timing of feedback.

1. はじめに

2019年8月4日に行った口頭発表の内容を要約して報告する。国際医療福祉大学(大田原キャンパス)では，2015年4月から選択科目として英語医療通訳入門を開講しており，今年で5年目となる。この授業では，学期末に学生による医療通訳のロールプレイ試験を行っており，開講以来ロールプレイの練習には特に力を入れてきた。学生が自分のパフォーマンスを振り返り，どこをどのように改善すればよいのかを理解したうえで，さらに練習を重ねて医療通訳のスキル向上に至ることを目指し，普段の授業のなかでこれを可能にする仕組みを作るべく，さまざまな種類のフィードバックを適切なタイミングで提供するということを目標にしている。本稿では，2019年度(前期)の様子について紹介する。

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本稿は，第22回日本医学英語教育学会学術集会（2019年8月4日，中野サンプラザ）にて口頭発表した内容を元に文章化したものである。

2. フィードバックの方法とタイミング

2019年の前期に行ったフィードバックのスケジュールは**図1**の通りである。

今年度(前期)の英語医療通訳入門は4月に始まり，7月中旬に行われたロールプレイ試験をもって終了した。受講者は1年生計22名で，看護，作業療法，放射線・情報科，視機能療法，医療福祉・マネジメント，薬学の学生であった。授業は90分×15回であり，前期をHop・Step・Jumpの時期と考えている。学生が自分のパフォーマンスに対する気づきを得て(Hop)，さらに良い通訳をするために練習を重ねた結果(Step)，自信をもって本番のロールプレイ試験に挑むことができるような(Jump)フィードバックを十分に提供することを目指し，以下5種類の方法で行った。

2.1. Hop時期：4〜5月

①ビデオ録画＆ディスカッション

授業が始まって間もない時期に，学生3人1組でロールプレイに挑戦する。教員はその様子をスマホで録画し学生に配布。グループでビデオを見ながら，自分たちのパフォーマンスについて良いところ，改善すべきところを話し合う。

②要約＆発表

①の内容をグループごとに口頭発表したこともあったが，今年度は，ポストイットにまとめ，改善すべき点をキーワードでカテゴリー化した(**図2**)。特にアイコンタクトについて改善が必要だと感じた学生が多くみられた。メモにまとめることで，学生は自分の弱点を整理するとともに，他の学生のコメントを通して新たな気づきが得られるのではないかと思われる。

2.2. Step時期：5〜7月

③留学生とのロールプレイ訓練

この授業では，日本人の学生のみならず留学生を迎えてロールプレイの訓練を行っている(**図3**)。今年度(前期)は，本学の留学生(大学院生と日本語別科生計6名)に外国人患者役として参加していただき，留学生の出身地は中国，台湾，ベトナムであった。各学期，最低3回は留学生とロールプレイを行う機会を作っており，5〜7月に各1回ずつ行った(5/20，6/17，7/1実施)。そうすることで，ロールプレイ試験(7/13・7/15に学生11名ずつ2グループに分けて実施)に向けて，学生が十分なフィードバックを得ながら，一歩ずつ着実に練習を積むことを目指している。

ちなみに，この授業を開講した2015年4月以来，有難いことに外国人の参加は途切れることなく続いている。最近はアジア系の留学生が多いが，過去にはアメリカ，フィリピン，ネパール，ウガンダ，ガーナなどさまざまな国々から来た学生や社会人に参加していただいた。外国人とロールプレイを行うことは，学生の学習意欲向上に大きく貢献しており，この授業において彼らの存在は欠かせない。これまで，そして現在も力を貸して下さっているすべての方々にこの場を借りて御礼申し上げる。

④アセスメントシートの活用＆ピアアセスメント

学生同士または留学生からアドバイスをもらう際に，アセスメントシートを活用している(**図4**)。医療通訳パフォ

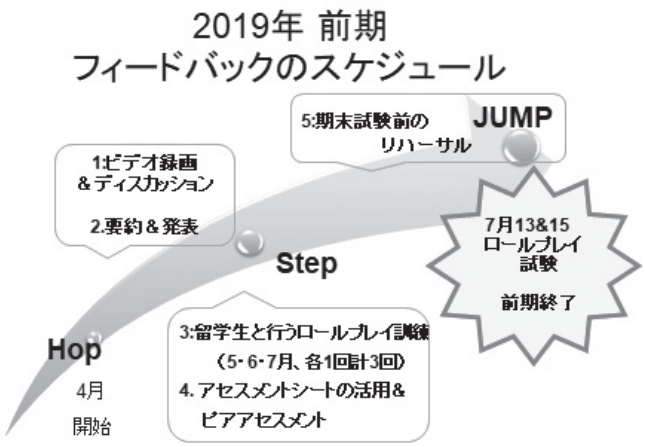

図1. フィードバックの全体スケジュール

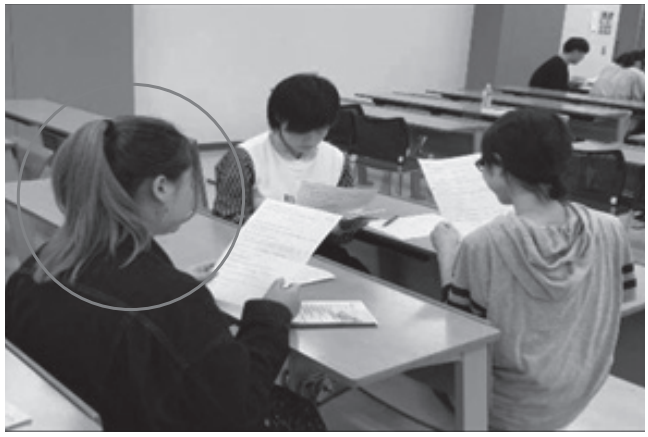

図3. 留学生とロールプレイ訓練をしている様子（〇印：留学生，1回目：2019年5/20実施）

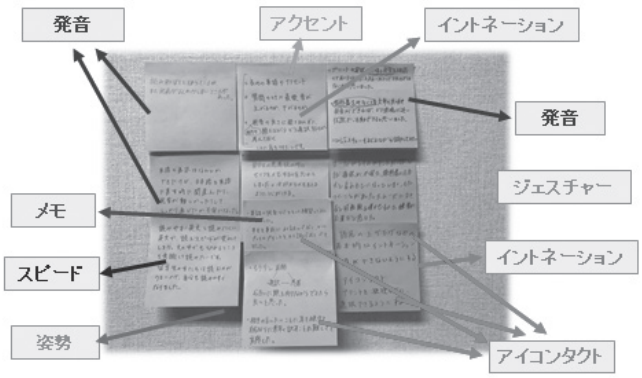

図2. 医療通訳パフォーマンスに関する学生たちの声

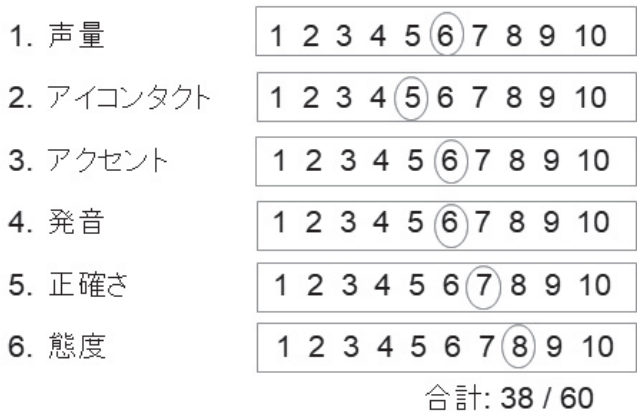

図4. アセスメントシートの内容＆使い方のイメージ

ーマンスについて，声量，アイコンタクト，(英語の)アクセント・発音，(通訳の)正確さ，態度の6つを評価項目とし，各項目10点満点・計60点満点とする。学生たちは互いのパフォーマンスを評価し合い，改善点を明確化した上で練習を重ねる。学生は評価する立場を経験することで，評価者の視点を考慮に入れながら自分のパフォーマンスを客観的に振り返ることができるのではないかと考える。とりわけ留学生からのアドバイスは，日本人の学生たちにとって刺激や励みとなっているように思われる(**図5**)。

⑤期末試験の直前リハーサル

最後のフィードバックは，期末試験の直前に行うリハーサルである。学期末ロールプレイ試験(本番)のイメージは**図6**の通りである。

今回は，ロールプレイ試験(7/13・7/15)の直前(7/8～7/12，学生の希望日時)にリハーサルを行った。本番を想定した直前リハーサルを行うことで，学生は落ち着いて試験に臨むことができ，これまで積み上げてきた練習の成果を発揮しやすくなる。医療福祉のプロを目指す本学の学生たちには，単位や高成績をとること以上に，外国人患者にきちんと向き合える志の高い人間になって欲しい。そしてこの授業が終わった後にも医療通訳に対する興味・関心，学習意欲が何らかの形で生き続けることを願いながら，今後も英語医療通訳入門のさらなる発展を目指し，よりよい学びの機会を提供していきたいと思う。

図5.　ピアアセスメントを行っている様子（〇印：留学生）

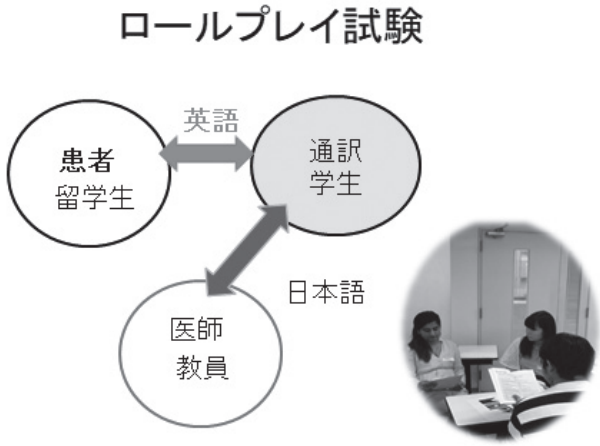

図6.　学期末に行うロールプレイ試験のイメージ

Revising JASMEE guidelines in accordance with standards in medical education research may improve the quality of English for Medical Purposes studies

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Over thirty years ago, the linguist John Maher defined English for Medical Purposes (EMP) goals:

> In general terms, EMP (a) is designed to meet the specific English language needs of the medical learner (e.g. nurse, GP, dentist, etc.); (b) focuses on themes and topics specific to the medical field; and (c) focuses on a restricted range of skills which may be required by the medical learner (e.g. for writing a medical paper, preparing a talk for a medical meeting, etc.) (p.112).[1]

"Medical" appears three times, yet in the next paragraph he considers EMP "…an entity within the field of English language teaching." Therefore, EMP appears to serve two masters: English as a Foreign/Second Language (EFL/ESL), and medicine. A recent opinion article echoes this viewpoint: While promoting "medical English as a lingua franca" (MELF) research to enhance EFL, the authors also assert "a fuller understanding of MELF may assist in the delivery of safe and effective patient care" (p.1).[2]

While dual field membership or interdisciplinarity is not inherently problematic, applied research for medicine has rules. "Best Practice" rules regard designing and conducting tests ethically, managing data to protect test subject privacy, and being transparent about funding to minimize Conflict of Interest. In reducing potential for harm, Best Practice protocols not only protect against liability but also ensure trustworthy results.

Although EMP may seem insulated from these issues – health risks from a new pedagogy are minimal compared to a new drug regime – Best Practice competency has potential EMP practitioner benefits. EMP practices are more likely to be accepted by the medical community if tested according to protocols in the field. Another benefit for proofreaders and translators is the ability to identify Best Practice infractions in proposals and reports. In short, interactions with medical professionals and students become more professionalized when Best Practices are included in EMP knowledge.

There are arguments for increased specialized knowledge in English for Special Purposes training.[3,4] However, more can be done than simply encouraging specificity in individual EMP practitioners. Integrating EMP with the *medical education* field can raise its profile in the medical community and improve research and practice quality. This is because medical education research has rigorous requirements for publication. Study design requirements mirror medical research and, more importantly, are clearly detailed in author instructions on journal websites. For example, to ensure study validity *Advances in Health Sciences Education*'s "Standards for an Acceptable Manuscript" include the following advice:

- self-assessed measures of confidence or competence improvement cannot be used as outcomes as people are not capable of accurate self-assessment
- single course or program studies with weak evidence of effectiveness such as student ratings unlikely add to generalizable knowledge without empirical testing of theoretical predictions
- proving some education is better than no education – a placebo-controlled trial – has very limited value
- studies demonstrating some intervention or invention "works" without identifying underlying variables contributing to success or failure is basically market research

The Journal of Medical English Education can adopt guidelines reflecting these standards to raise presented and published research quality. For example,

- require all studies involving students are approved by

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university ethical review committees

- require Conflict of Interest and Disclosure slides in presentations
- differentiate between *reports* describing programs and *research* investigating an issue, and increase presentation time for research
- encourage research supporting generalizability of results through study replication and collaborative research between institutions
- standardize an empirical measurement scale of performance or behavior to help validate studies of learning styles and critical thinking skills, to support generalizability of results for our target population

Generalizability is of concern here beyond external validity.[5] It can be argued JASMEE has indirectly mandated generalizability by issuing *Medical English education guidelines corresponding to the Global Standards for Medical Education*. The Preamble states "…we advise that medical school teachers aim to use medical English in their regular lectures, and that students study medicine while constantly thinking about how to express the contents in English." for reading and communication competency.[6] If JASMEE actively encouraged empirical and replicable investigation yielding generalizable data, underlying factors associating this advice with these competencies could be better understood. Pedagogy could improve, and with it the status of EMP practitioners within medical departments. In conclusion, following Best Practices may also encourage medical faculty participation in EMP research, and revising JASMEE guidelines in accordance with standards in medical education research may improve the quality of EMP studies. These will result in EMP practitioners being considered fully-fledged colleagues.

Disclosure: None to report.

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2. Tweedie MG and Johnson RC. 2019. Research directions in medical English as a lingua franca (MELF). *Lang Linguist Compass* **13**: 1–12.
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医学教育研究の推奨基準を参照したJASMEEガイドラインの改訂はEnglish for Medical Purposes研究の質を改善させる

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30年前に，言語学者のJohn Maher氏はEnglish for Medical Purposes（以下「EMP」）をこのように定義した。

一般的に，EMPは (a) 医療学習者（例：看護師，総合診療医，歯科医など）の特定の英語のニーズを満たすようにデザインされ，(b) 医療分野に固有のテーマとトピックに焦点を当て，(c) 医療学習者が必要とする限られた範囲のスキルに焦点を当てる（例えば，医学論文の執筆や医学会議の口演）（p.112）。[1]

ここに「医療～」は3回でるが，次の段落では，EMPは「…英語教育の分野に存在する」と書かれている。したがって，EMPは第二外国語または外国語教育（ESL/EFL）と，医学との2つの専門分野に属するようである。最近の論文もこの観点を反映している。著者らはEFLを発展させるために「共通言語としての医学英語」（Medical English as a Lingua Franca「MELF」）の研究を推進しており，「MELFをより完全に理解することは，安全で効果的な患者ケアを提供するのに役立つ」ことを主張している（p.1）。[2]

複数の分野に跨ることに本質的な問題はないが，医学における応用研究というものにはルールがある。「ベストプラクティス」と呼ばれるルールには，倫理的なデザインと調査の実行，被験者のプライバシーを保護するためのデータの管理，および利益相反を最小限に抑えるためのファンドの透明性に関するものがある。危害の可能性を減らすためのベストプラクティスのプロトコルであるが，法的責任から身を守るだけでなく，信頼できる結果も保証してくれる。

EMPにはこのような問題はないようにみえるが（新薬の試験と比べると，新しい教育方法からの健康リスクはない），ベストプラクティスの特性というのはEMP専門家にとって有益な可能性がある。もしEMPの教育方法がベストプラクティスのプロトコルに従って検証されれば，医学のコミュニティで受け入れられる可能性が高くなるかもしれない。また，校正者と翻訳者の一つの利点は，研究計画とレポートの中でベストプラクティスの違反をみつけることができるところにある。すなわち，EMPの知識の中にベストプラクティス（的なもの）が含まれることで，医療専門家や学生とのコミュニケーションがよりスムーズになる。

特定の目的のための英語 (English for Specific Purposes) のトレーニングにおいて，専門家が特定分野における知識を増やすべき，といった議論がある。[3,4] ただし，個々のEMPの専門家に特定の知識をもつよう促すだけでは足りないだろう。そこでEMPを医学教育分野と統合させ，医療のコミュニティでの知名度を上げ，研究と実践の質を向上させられることを考えたい。医学教育研究に厳しい出版基準というものがある。研究デザインは医学研究と似ているうえ，さらに重要なこととして，実証研究の方法についての必須要件がジャーナルのウェブサイトで明確に詳述されている。例えば，研究の妥当性を確保するために，*Advances in Health Sciences Education*の「Standards for an Acceptable Manuscript」には次の推奨事項がある。

- 人は正確な自己評価ができないため，「自信」または「能力の向上」の自己評価尺度は結果として適切ではない
- エビデンスの弱い学生の評点などを用いた単一のコースまたはプログラム研究では，理論的予測の実証調査を行わずして，一般化可能な知識を導き出せない
- 教育しないことに比べて何らかの教育をすることがより優れていることを証明する，「プラセボ対照試験」は価値が非常に限られている
- 成功または失敗を引き起こす根本的な要因を特定することなく，介入または発明が「効果的」であることを示す研究は，基本的に（学術的意義が低い）「市場調査」にすぎない

もし*Journal of Medical English Education*がこれまでに示したものをガイドラインに適用したら研究の質を向上させることができるかもしれない。以下に例を示す。

- 学生を用いた研究が大学倫理審査委員会によって承認

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本稿は，第22回日本医学英語教育学会学術集会（2019年8月4日，東京・中野サンプラザ）にて口頭発表した内容を元に文章化したものである（レボウイッツ）。

されることを要求する
- プレゼンテーションでは利益相反開示スライドを要求する
- 問題を調査する研究とプログラムを説明するレポートとを区別し，学術集会では研究のプレゼンテーション時間を増やす
- 再検証と多施設共同研究により結果の一般化を保証する研究を奨励する
- パフォーマンスや態度の測定スケールを標準化して，学習スタイルや批判的思考についての研究の妥当性を検証し，対象集団における研究結果の一般化を支持する

ここでの一般化可能性は外的妥当性だけを考えたものではない。[5]「医学教育のグローバルスタンダードに対応するための医学英語教育ガイドライン」を発行することにより，JASMEEは間接的に一般化可能性を告示したと主張できる。その前文には，「『英語で教科書・論文を読み，理解できる』『患者に英語で面接し診察できる』『学会等において英語で発表討論できる』(…)のために教員は普段から医学英語を講義で使うように心がけることが望まれ，学生は英語ではどう表現するのかを考えながら学習することが望まれる。」と記載されている。[6] もし，JASMEEが一般化可能な，実証的かつ再現可能な調査結果を積極的に推奨しているならば，このガイドラインの記載に関して根底にある事象をよりよく理解できるようになるだろう。英語教育は改善でき，それは医学部のEMP専門家の地位改善にも繋がる。すなわち，ベストプラクティスに順じてEMP研究を向上させていくことはEMP研究への医学系の教員の参加を促進させ，医学教育研究の推奨基準を参照してJASMEEのガイドラインを改訂していくことはEMP研究の改善につながる。そして，その結果，EMP専門家が真の同僚とみなされるようになるのではないか。

Disclosure: None to report.

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What I've taught and what I've learned

Christopher Holmes
The University of Tokyo Faculty of Medicine, retired

1. Preamble (or pre-ramble)

I taught Medical English full time to students at the University of Tokyo Faculty of Medicine for twenty years and I've given talks at almost every JASMEE conference and, inspired and set on the right track by Reuben Gerling years ago, I always emphasize basics (which are not so simple).

As I look back on the past twenty years, I wouldn't change anything in my four-prong program: offering listening, speaking, reading, and writing experiences in every class, always related to medicine, in English only, without any translations.

And yet I always looked forward to JASMEE conferences to hear about what other teachers are doing. I realize that in my teaching career I've been extremely privileged, and it's thanks in large measure to you. I want to thank JASMEE's leadership and its rank and file for tolerating my dogmatic, extreme, and unpopular views.

Though *I* haven't changed, I thought it was now time to take a different tack in my talk. Today I'm addressing my younger colleagues, hoping that I can help the younger generation to prepare for challenges they may face in their teaching careers in Japan.

This country, Japan, has changed a lot in the past thirty years, but I remember well that from the late 1970s (when I immigrated) until 1989, I thought Japan would never change. Then – bam! – the economic bubble burst and many major things changed overnight. So, Young People, keep this in mind: Japan and the Japanese seem slow to change, but eventually they *do*, and "chance favors the prepared mind" (Louis Pasteur). Expect the unexpected. That's one thing.

What else? Did you know before you came what it's like to work in Japan? Well, it's not at all bad: you're not treated like immigrants to the Divided States of America, for example. But here you have to get used to things like the meaninglessness and irrelevance of written "contracts" and nonsense emails and other printed documents, as well as the almost total lack of school janitorial services, workplace supervision, and curriculum guidelines (although guidelines may change).

Hiring and firing procedures in Japan are absurdly lax, but you've all been hired already and you don't have to worry too much about being fired – at least until you reach retirement age. So relax and go with the flow. You're a teacher and you'll be treated with more respect than you might think you deserve.

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2. Reminiscences and myth-busting

For twenty years I was first a full-time Japanese-to-English translator, then for the next twenty years a full-time English teacher, and after the switch I immediately realized that I enjoyed being in the classroom more, and I believed in what I was doing, because I knew my students' needs better than they did.

But *on the other hand...* The systems suck. English teaching in Japan is a failure, as Professor Uemura declared years ago. We cannot fix it. Although its failure hasn't stopped Japan from being a wonderful place, we're all teaching **remedial English**, whether you realize it or not.

I'll put aside the question of etiology (how it got this way). Instead, I want to talk first about how the English teaching establishment in Japan is haunted by myths.

First the often repeated refrain that "Japanese students can read English" is a myth. Most cannot read real English: (1) They don't fully and correctly understand what they read, and (2) they cannot read aloud intelligibly, or in other words, help their listeners understand what they have on the printed page or the screen in front of them, visible, legible and grammatically correct – and if students' pronunciation and intonation (prosody) are too poor to enable other people to understand them, how can they be expected to speak off-the-cuff, ad lib, expressing their own spontaneous thoughts intelligibly?

The belief that "Japanese students know English grammar" is also a myth. They've been taught easy-to-test fragments of grammar, but know almost nothing about the *agreement of subject and verb, about the correct use of prepositions, and about the sequence of verb tenses and moods.* And think about it: those elements compose the grammatical structure that holds the parts together. I have in my archives thousands of

pages written in English by students in my classroom that prove what I'm saying.

And note that I haven't said a word about the use of the *definite and indefinite articles* – or about singulars and plurals. (Of course *that's* not taught in English speaking countries, either, is it? So why should it be taught in Japan?)

3. The big *WHY*

Why has English teaching in Japan failed? Briefly, it's because of (1) Teaching to the Test, (2) katakana phonetics, and (3) the myopia of metrics.

Teaching to the Test undermines all the outcomes from the very beginning. The Japanese English examination system does not work, because it does not teach. It provides an excuse, on supposedly egalitarian grounds, to exclude a desired percentage of young people from higher education.

Japan is a wonderland with immense reserves of talent in many areas. Many of my med students are accomplished musicians. *(That's time consuming! On top of studying medicine!)* Outside the university, Japan's craftspeople, painters, and potters are phenomenally gifted. So why are Japanese musicians world-class while its best English speakers in any academic field are not? Very simple: Japanese musicians are taught by accomplished musicians, not by the Ministry of Examinations. English is taught principally by underqualified non-speakers and by amateurs; and even when the teachers are competent in the real English language, they are forced by the system to Teach to the Test. They prepare their students to get good scores on stupid exams.

Japanese students deserve better. Unfortunately Teaching to the Test *is* the Japanese system, from the cradle to the grave. From the age of about 12, Japanese students don't learn to learn in school, they only prepare for tests. They don't learn how to ask questions, in other words, how to think. They don't study to enrich their souls or to absorb culture, but only to secure a steady salary.

The purpose of higher education in Japan is to get a secure job – in a world where jobs are increasingly scarce. Doctors don't have to worry about that anyway. They'll become MDs whether they can navigate the world in English or not. But they're products of the same system.

The Japanese expend inordinate amounts of time and treasure pretending to learn English, suspecting or knowing the whole while that it leads to nothing. *Don't pretend to teach them.*

Why can't people in this country bring their English knowledge and skills up to a world-class level? One reason is that *Japan lacks a critical mass of English speakers competent enough to judge the* ***quality*** *of English, written or spoken.* In this world so in love with metrics, TOEFL scores just don't cut it. But some things just can't be measured, even when the differences are very real.

And the methods conventionally used to pretend to teach don't help: some teachers (most?) don't ever correct their students' mistakes, spoken or written. They merely provide scores. Those teachers are not the solution, they are a big part of the problem.

Is the answer to overlook what's "too difficult" for the masses and "dumb-down" the English language? No, no, a hundred times NO! It can't be done. *No language evolves on command.* The whole idea is stupid, stupider than our ill-named species, *Homo "sapiens."*

Dumbing down and tech-ing up is not the answer. And when it comes to the teaching of English, the Japanese education system is as dumb as it can be already. It would be difficult to make it dumber, more wasteful, less productive than it already is. But politicians do periodically attempt to make it worse by legislating and launching "Let's-do-more-of-the-same" strategies and programs. *If what we do doesn't work, let's do MORE of it!* (Why not? That's what the US war machine does.)

But if they're beginning to teach katakana English to infants in daycare centers already, what are they going to propose next? English-in-the-womb? (Perhaps the stem cell scientists in Kyoto are working on it already...) The only result of this katakanafication of English has been the bastardization of the Japanese language. Have you noticed? *Everything new in Japan gets a katakana name* – and a meaningless one at that!

Should Artificial Intelligence be brought in to fill the gap? Yeah, sure! The next thing you know, they'll program computers to write all our books for us. Artificial Intelligence is all the rage now – and that's fine. Machines can do lots of things for us. But the real problem is our Natural Stupidity.

4. Relationships

Young People, remember that in Japan, everything is relationships: on the massive wooden board on which the Japanese board game of Go is played, where you see squares, the solemn players see intersections of lines. It's *relationships.* So cultivate yours. The French philosopher Albert Jacquard once said that the most important events in his life were *"rencontres"* (relationships arising from meetings with key people).

Without knowing whether it would pay off, I began teaching at Todai with the possibility ever present in my mind that one day, these students might be my doctors. And actually, that has happened at least five times already. And *that's* a good enough reason to teach students medical English.

バロン先生を偲ぶ

植村研一
日本医学英語教育学会名誉理事長
浜松医科大学名誉教授

J Patrick Barron, 1947-2019

私は浜松医科大学脳神経外科教授の定年退職が差し迫った1998年7月11日に日本医学英語教育学会を創設しましたが，バロン先生はその最初から参加され，医学英語教育改革はもとより，学会の運営にも，大変精力的にご支援していただきました。そのバロン先生が2019年8月17日に逝去されたことは，学会にとって大変な悲しみであります。8月22日のお通夜に参列して，先生の経歴の紹介と奥様の松森晶子様のご挨拶をお聞きし，先生の並々ならぬ学会へのご支援の背景を知り，先生への感謝の気持ちと哀悼の意を一層強く感じました。それを纏めて紹介しながら，会員一同と共に先生を偲びたいと思います。

James Patrick Barron先生は1948年に英国のScotlandでお生まれになり，ロンドン大学でPh.D.の学位を取得され，1969年に来日され，1970年に東京医科大学の外科の早田義博先生と知り合ったのを契機に，日本の医学研究の成果を世界に公表するには，医学者に英語教育を徹底しなければならない，との思いで東京医科大学はもとより，日本各地で医学生や医学研究者の医学英語の教育改革に取り組んでこられました。1991年には東京医科大学国際医学情報センターの教授に就任されました。2013年3月末で定年退職され，名誉教授に就任されました。

医学英語教育学会が創設された時(1998年7月11日)には日本での医学英語教育に28年もご尽力されていたわけで，直ちに理事に就任され，2004年には副理事長に就任され，2017年までご活躍され，その後は名誉会員として最後まで学会をご支援いただきました。そればかりではなく，多くのnativeの英語教員を学会に紹介・入会へと導いていただきました。

2004年12月の理事会で医学英語検定制度制定準備委員会が設置された時には委員長に就任されて，検定制度の確立とその後の運営にもご支援・ご尽力をいただきました。今日の学会の発展は，バロン先生のご尽力に負うところが大きく，今後は天国から学会の更なる発展を見守っていただきたいとお願いしながら，先生のご冥福を皆様と共にお祈り申し上げます。

In memoriam J Patrick Barron, 1947-2019

Reuben Gerling
Visiting Professor, Nihon University School of Medicine
Takako Kojima
Associate Professor, Department of International Medical Communications, Tokyo Medical University

Professor J Patrick Barron, died after a long battle with liver cancer on the 17th of August, 2019.

Patrick was a pioneer in the establishment of the profession of medical editing in Japan and in promoting professional standards for the writing of medical papers in English. Throughout his long and distinguished career, he established and promoted facilities for teaching and improving medical writing.

Patrick gave unstintingly and freely of his time, energy, expertise, and experience to assist and advise those who wanted to improve their own writing skills, and educators who wanted to know how to establish English for Medical Purposes programmes at their schools. Throughout his career Patrick was called upon to join various committees and associations as a contributing member or advisor and, although busy managing his own department, he always agreed to help those who called upon him.

Patrick was also well respected in the international community of medical writers and editors and belonged to a number of associations and editorial boards in various countries. JASMEE was proud to count Patrick as one of its founding members and benefitted from his contributions as the Vice President of the Society.

Patrick Barron was born in Glasgow, Scotland on the 15th of January 1947. He left home at age 15 and, with the help of his sister, emigrated to the United States. He studied Chinese and Japanese at the University of Pennsylvania, graduating in 1969, and in the 1970s came to Japan to study Japanese at International Christian University. In 1981 he gained an MPhil in Japanese from the School of Oriental and African Studies, University of London.

Patrick joined the faculty of St. Marianna School of Medicine in 1982, where he began to formulate his ideas about teaching English to medical students. Instead of the general English language programmes that were common in medical schools at the time, Patrick advocated teaching medical writing, and he worked hard to devise methods that would enable students to read and write medical papers. This is what he called 'medical communication'. He formed close links with Professor Hayata of Tokyo Medical University, who shared Patrick's views on the role of English language instruction at medical schools, and in 1991 he moved to Tokyo Medical University to open the Department of International Medical Communication.

At Tokyo Medical University, Patrick developed a system for editing papers written by the medical staff at the university. Thanks to his hard work, the number of papers accepted for publication increased substantially, and the system he instituted was copied by many other medical schools in Japan. Patrick also started an advanced curriculum for upper classes that included working with videos of genuine doctor-patient interviews. These videos were shown to students on a special electronic teaching system which involved a specialist medic answering students' queries.

Patrick gave freely of his time to members of faculties at other medical schools who sought his advice, and he often spoke at various venues around the country about his methods of improving the teaching of English for Medical Purposes. His help was solicited by various societies and journals, and he was a member of the editorial boards of many medical publications, including the Japanese journals *Haigan* (*Lung Cancer*) and *The Journal of the Japanese Society for Respiratory Tract Endoscopy*, and the international journals *Chest, Allergology International*, and *The Journal of Cardiac Surgery*.

Patrick was also active as an executive member of numerous societies, some of which he had helped found. In addition to being the Vice President of JASMEE, he was also the Vice President of the World Bronchology Association and Secretary General of the World Photodynamic Association.

Upon his retirement from Tokyo Medical University, Patrick became an adjunct professor at Seoul University Bundang Hospital, a position he held to the end of his life.

Patrick was also the author and co-author of numerous books, and the initiator of JASMEE's Examination of Proficiency in English for Medical Purposes (EPEMP).

With his many publications, efforts to improve medical writing in Japan, international activities, and the unstinting help he extended to all who requested it, Patrick Barron will be remembered by the world of medical writers as a pioneer in the specialty of English for Medical Purposes and as a driving force behind its advancement.

Within my own work, Patrick was very encouraging when we started a programme of medical writing seminars and came to speak at our first meeting. When we decided to have a large-scale symposium Patrick supported us in many ways. He was, of course, one of the speakers and arranged for us to receive financial support that enabled us to invite two dignitaries from abroad. Both of these outstanding speakers were among the great many friends and associates that he had around the world.

RIP

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日本医学英語教育学会・編
編　著　伊達　勲　岡山大学大学院脳神経外科教授
英文監修　Timothy Minton　慶應義塾大学医学部教授

医師が英会話の必要性を強く感じる「外来診療」「国際学会」という2つの場面の流れに沿って，細かくシチュエーションを区切って英会話フレーズをまとめた，音声ダウンロードサービス付きの英会話書籍。日本語ではごく簡単な表現も，英語で伝えるとなると出てこない表現は多い。それらは「決まり文句」ともいえる表現なので，知っていれば驚くほどスムースな意思疎通ができるようになる。本書は，それぞれに特有の表現を日英併記で掲載。知りたい英会話フレーズをすぐに見つけることができる。

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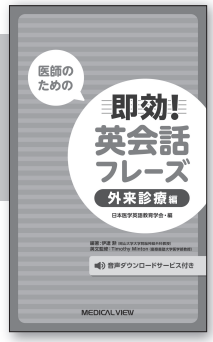

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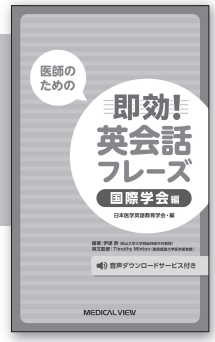

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著者
伊達 勲
岡山大学大学院脳神経外科教授

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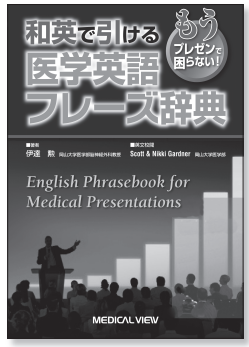

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