October
2025

Vol. 24
No.3

Journal of

Medical English Education

Japan Society for
Medical English Education

From the editor

As we move into October following an exceptionally hot summer, I am pleased to present the latest issue of our journal. A substantial portion of this edition is devoted to the proceedings from our July conference in Osaka, which brought together a diverse range of insightful and inspiring presentations. Several of these presentations are featured here in written form, allowing readers to engage with the ideas and discussions that shaped the event. We are also pleased to include two original research articles that I am confident will both capture your interest and encourage thoughtful discussion among our readers.

To better balance submissions throughout the year, the editorial committee will be introducing a new Conference Proceedings Articles section in the February issue as well. February has often been quieter, and this addition will provide more opportunities to highlight excellent work being submitted to the journal. We would like to remind authors to review our author guidelines carefully and follow them closely when preparing their submissions.

The editorial committee is also working to strengthen our peer-review process. One ongoing challenge has been the limited pool of available reviewers. To help expand our team, we circulated a survey earlier this year to JASMEE members, to welcome new reviewers. We are very grateful to those who responded. Their expertise will enable us to provide more thorough reviews across various areas of medical English education.

The continued success of this journal is made possible by the collective effort of its community: the authors who share their research, the reviewers who generously contribute their time and expertise, and the readers who engage thoughtfully with each issue. We are truly grateful for your contributions and hope this issue proves both enjoyable and valuable in supporting your professional endeavors.

Takako Kojima
Editor-in-Chief
Journal of Medical English Education

Training medical students in clinical examination and presentation skills in English prior to elective clinical rotations abroad: Learning Medicine in English project

Tomohiro Arai,[1] Kiyoshi Sano,[2] and Kazuo Takahashi [3]

[1] Department of International Education, Fujita Health University School of Medicine
[2] Noguchi Medical International Relations, Fujita Health University School of Medicine
[3] Department of Biomedical Molecular Sciences, Fujita Health University School of Medicine

Abstract

Background: The reclassification of the coronavirus disease 2019 (COVID-19) as a category V infectious disease in Japan has precipitated a resurgence of international clinical training opportunities. However, a systematic curriculum on pre-travel medical English education has been the subject of only a paucity of research.

Objectives: This paper assessed the efficacy of Learning Medicine in English (LME), a clinical medical English education program for fifth-year medical students in Japan prior to overseas clinical training.

Methods: From October 2023 to March 2024, a total of six sessions, each lasting eight hours, were conducted monthly. The participants were predominantly fifth-year medical students from Japan who intended to pursue their clinical training in a foreign country. The training sites included Italy ($n = 5$), Taiwan ($n = 3$), South Korea ($n = 2$), Spain ($n = 1$), the United States ($n = 1$), the United Arab Emirates ($n = 1$), and Singapore ($n = 1$). Surveys were administered immediately upon completion of the program and following the conclusion of their clinical training, with responses collected for analysis.

Results: All six sessions were attended by 84% of the participants, and many expressed satisfactions with the program. While the frequency of sessions and group size were well received, some participants suggested starting the learning process earlier and introducing presentation skills at an earlier stage.

Conclusion: The survey results indicated that key factors for effective preclinical education include (1) early implementation, (2) organizing appropriate faculty members, and (3) collaboration with teaching assistants. The necessity for curriculum revision and inter-institutional collaboration was underscored for the purpose of sustainable development.

J Med Eng Educ (2025) 24 (3): 24-31

Keywords undergraduate medical education, medical English education, clinical English communication, overseas clinical training, English for Specific Purposes (ESP), medical students

1. Introduction

1.1 Background

As of May 2023, COVID-19 was reclassified as a Category V infectious disease in Japan, lifting restrictions on medical students' clinical training-related travel. Consequently, clinical training opportunities for medical students have resurged both domestically and internationally.

Proficiency in English, the global lingua franca, is vital for medical students engaging in clinical training abroad. However, despite recognition of the need for pre-departure clinical English education in Japan,[1] structured curricula remain scarce. Although reports on international clinical training have increased, persistent deficiencies in basic medical English vocabulary, conversation, and presentation skills remain. Medical students preparing for overseas training are expected to deliver case presentations in English, yet preparatory training is insufficient.

A major challenge in Japan's medical education is limited exposure to English-based communication. Students must be able to deliver case presentations in English before training in non-Japanese-speaking countries. Moreover, with Japan's globalization, opportunities to provide care for patients whose native language is not Japanese are increasing, especially in major cities. In such settings, basic medical English is increasingly necessary. Young healthcare

● **Corresponding author:**

Tomohiro Arai
Department of International Education, Fujita Health University School of Medicine
1-98 Dengakubo, kutsukake-cho, Toyoake-shi, Aichi, 470-1192 Japan
TEL/FAX: 0562-93-9075
E-mail: tomohiroarai1590@gmail.com

professionals aiming to work globally should begin developing these skills early in their education through a structured approach.

1.2 Previous research

While there are some reports in previous studies of students from non-English-speaking countries going abroad for practical training, it is rare to find reports of organized and systematic education as a university program.

In the 1990s, Japanese medical schools began to report the introduction of elective clinical training at overseas medical institutions. For instance, in 2004, a questionnaire survey was conducted by Sakuyama et al., which revealed a lack of language proficiency in communication among medical students and the necessity for prior learning.[1] In the 2010s, amid an escalating influx of foreign patients, precipitated by global integration and the preparations for the Tokyo Olympics, reports emerged concerning the enhancement of English language proficiency. In their report on education in Southeast Asian universities, Matsuda et al. mentioned the need to strengthen English language training for Japanese medical students.[2] Noda also reported on the English study session and orientation before the overseas clinical training, with questionnaires and interviews conducted immediately after the pre-training activities and after the overseas clinical training.[3] In the nursing English education program, Ochiai et al. reported on their practice with first-year nursing college students.[4] However, in the years following the implementation of Quarantine measures in response to the outbreak of the COVID-19, there was a shortage of reports.

On the other hand, overseas literature on English education in pre-graduate medical school education, especially on ESP such as Medical English, began to show reports from countries where English is not the native language around 2010. To cite one example, Milosavljević et al. from Serbia defined the objective of ESP education as the successful education and professional training of medical students, emphasizing the necessity of conducting a comprehensive needs analysis.[5] In addition, because English for medical purposes (EMP) is designed based on the active use of English after graduation, it encourages education that prepares medical students for realistic situations that they will encounter as future medical professionals.[5] Dilafruz also noted the rapid shift in English teaching in Uzbekistan's medical schools from general English to medical English, noting the gap between English faculty and those who teach specific subjects in English.[6] These findings may be useful for pre-graduate education at medical schools in Japan.

1.3 Objectives

In light of these circumstances, this study reports on our medical English education program, Learning Medicine in English (LME), implemented in the spring of 2024 for fifth-year medical students in Japan prior to their participation in overseas clinical training following the lifting of travel restrictions due to the COVID-19. The primary objective of the LME program is to provide preparatory training tailored to real-world scenarios that students are likely to encounter during international clinical rotations. The program's primary educational content encompasses the acquisition of knowledge and practical skills in medical English. Specifically, the program aims to enhance students' proficiency in English for clinical contexts, including its application in interviews, physical examinations, and case presentations to supervising physicians.

2. Methods

2.1 Participants

A total of 13 participants, primarily fifth-year medical students from Fujita Health University School of Medicine, were scheduled to commence a period of clinical study at medical institutions outside Japan, with the initial commencement date set for the spring of 2024. The participants pursued their studies primarily in non-English-speaking countries. Specifically, five medical students studied in Italy, three in Taiwan, two in the Republic of Korea, and one each in Spain, the United Arab Emirates, and Singapore. Notably, one participant who studied in Italy spent half of her study period in the USA.

2.2 Procedures

The duration of LME was from October 2023 to March 2024. Participants attended classes approximately every four weeks for approximately eight hours at a time (**Table 1**).

The lecturers were all highly educated and most of them had accumulated extensive clinical experience in the United States or Europe. Notably, five of the six lecturers were board-certified physicians, and three of the six were board-certified family medicine doctors. In the fourth and fifth sessions, six international students whose native language is not Japanese participated as Teaching Assistants (TAs). The primary role of the TAs was to act as the mock patient in the role-play scenario.

2.3 Questionnaires

In this study, online surveys were conducted at two time points: prior to the start and after the completion of overseas clinical training.

The first survey was administered immediately following the final session of the LME program, held on March 16, 2024. The primary objective of this survey was to collect foundational data for the qualitative improvement of the course. The questionnaire items included evaluations of the course content, assessments of individual instructors, and open-ended responses for participants' feedback and suggestions for improvement. A combination of multiple-

Table 1. LME study content in 2023-2024

Sessions	Date	Contents
1	21 October 2023	Medical vocabulary, Patient encounters Structure of clinical skills (USMLE-based)
2	18 November	Medical vocabulary, History taking, Physical exam, Roleplays Risk management: the Swiss cheese model
3	16 December	Medical vocabulary, History taking, Physical exam (Musculoskeletal) Clinical reasoning, Writing medcal records, Case presentation, Roleplays
4	10 January 2024	Medical vocabulary, History taking, Physical exam Writing medical records, Differential diagnosis, Requesting lab tests
5	24 February	Medical vocabulary, History taking, Physical exam Presenting cases
6	16 March	History taking, Physical exam, Writing medical records Evaluation of case presentation

Description: Roleplays (OSCE simulations) were actively incorporated into every class session. Typically, a brief demonstration was given first, followed by pair-based roleplay exercises. For writing medical records, students first worked individually, then shared their results in small groups.

choice questions, Likert-scale items, and free-text response sections was employed. All 13 participants completed the survey.

The second survey was conducted between April and June 2024, after participants completed their clinical training abroad and returned to Japan. The main aims were to analyze the content of the overseas clinical experiences and to assess the practical relevance of the LME program. It should be noted that some participants were unable to travel due to political instability in their intended host countries. Valid responses were obtained from 10 participants.

3. Results

3.1 Before training abroad（*n* = 13）

A total of 84.6% of the participants attended all classes. However, a proportion of participants did not attend all classes; some missed one to two classes due to illness or conference presentations.

3.1.1 Course hours and frequency

Regarding the frequency of the course, 84.6% of participants indicated that a total of six sessions was appropriate, while 15.4% indicated that too few sessions were offered. The most common reason given was that the monthly meetings would not interfere with daily clinical training or studying for exams. On the other hand, others complained about not having enough time to practice.

Furthermore, the majority of participants, 69.2%, expressed satisfaction with the scheduled course time, which was from 9:00 a.m. to 5:00 p.m. on Saturdays. However, there were also comments that the length of each meeting was excessive and requests to hold the meetings on weekdays (**Figure 1**).

3.1.2 Overall evaluation

With respect to the necessity for LME, 76.9% of the

participants expressed a strong conviction regarding the importance of LME. None of the participants provided a response that indicated "not much" or "not at all". In the fourth and fifth sessions, six international students (predominantly from non-English-speaking countries in Europe and Asia) participated in role-plays as simulated patients in the OSCE. Regarding this practice, 92.3% of the participants expressed that it was necessary (**Figure 2**).

3.1.3 Feedback from students

The LME program received high levels of satisfaction from participants, particularly regarding the quality of instruction, the small-group format that facilitated questions, and the opportunities for hands-on practice. However, several areas for improvement were identified, including strategies to enhance knowledge retention, the expansion of practical training, and considerations for broadening participant eligibility and refining selection criteria.

Many participants expressed overall satisfaction with the program. Comments such as "*I was able to learn both medical knowledge and clinical reasoning*" suggest that the program contributed not only to the development of English language skills but also to the enhancement of clinical thinking. The program was generally regarded as well-structured to facilitate progressive learning. Additionally, the clear presentation of essential skills for international medical practice, the hands-on physical examination sessions, and the clarity of some instructors' pronunciation were positively received. Regular review sessions and OSCE preparation were also noted as beneficial for reinforcing learning.

At the same time, participants highlighted the need for enhanced learning support. Specifically, suggestions were made to clarify the scope of self-study and distribute vocabulary lists and lecture materials in advance to facilitate preparation. Concerns were also raised about the difficulty of reviewing content due to the program's once-monthly schedule, prompting requests for increased session

Were the course hours (Saturday 9-5pm) appropriate? (Multiple choice)
13 responses
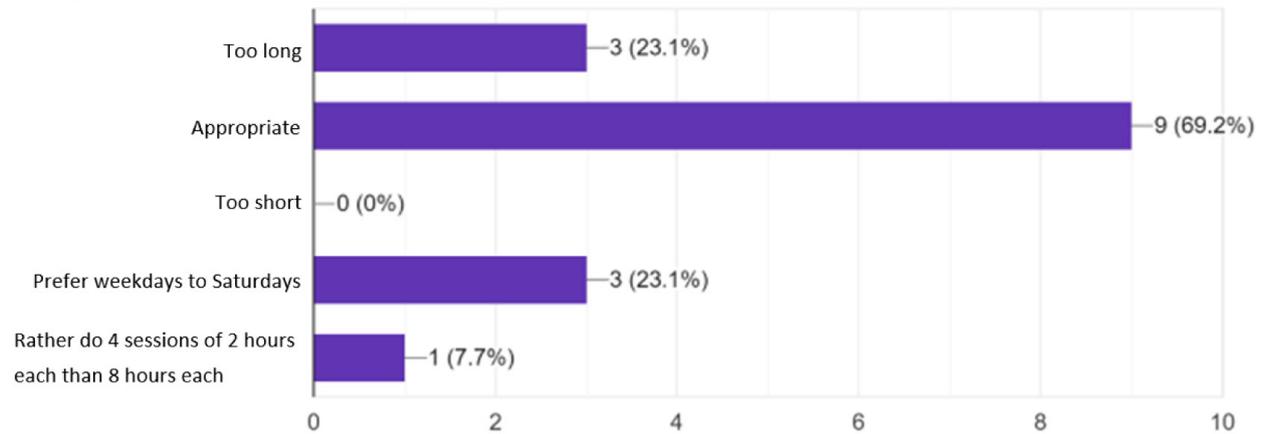
Results of a questionnaire administered at the end of all six Learning Medicine in English (LME) classes (March 2024). Responses to the fact that the classes were held once a month on Saturdays from 9-5 pm.

Figure 1. Course hours

How necessary do you feel this course is?
13 responses
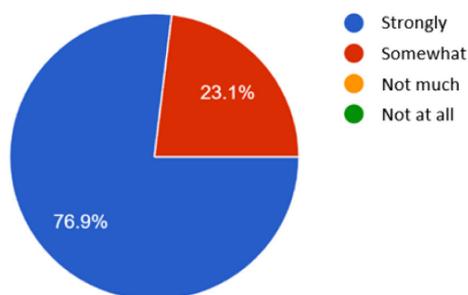
How much do you feel the need for practice sessions with international students?
13 responses
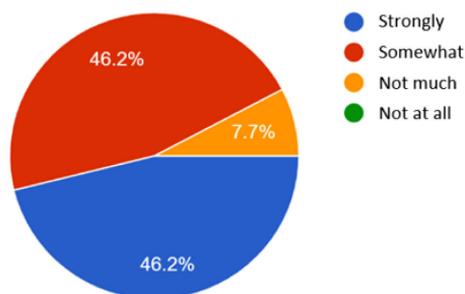
Results of a questionnaire administered at the end of all six LME classes (March 2024). 4th and 5th classes were conducted with the cooperation of a foreign graduate student studying at Fujita Medical University, who spent about half a day as a simulated patient (SP) in the role-play.

Figure 2. Before Training Abroad

frequency. Furthermore, recommendations were made to present the structure of case presentations earlier and to expand small-group practical exercises to create a more effective learning environment. Lastly, calls were made to introduce earlier learning opportunities and implement

a minimum English listening proficiency requirement to improve comprehension during lectures.

3.2 After training abroad（*n* = 10）
3.2.1 Clinical skills activities during overseas training

More than 80% of respondents reported having opportunities to apply clinical skills in hospital or other clinical environments (**Figure 3**). However, fewer than 50% had opportunities to engage in history taking or case presentations. Furthermore, less than 20% of respondents reported using clinical skills in university courses or simulation centers.

In clinical environments, more than half of the respondents participated primarily in observational (shadowing) training. However, physical examination was the only skill for which more than half of the respondents reported hands-on participation. The next most frequently practiced hands-on activities were medical communication and history taking. Conversely, case presentation and interpretation of medical records were the least commonly practiced, with only 20% of respondents engaging in them.

Physical examination was rated as the most useful clinical skill, with 80% of respondents providing positive evaluations. The next most highly rated skills were interpretation of medical records, medical discussion, and history taking, in that order. Although case presentation was rated as the least well-performed skill, 50% of respondents still recognized its usefulness. Additionally, half of the respondents reported having no opportunities to practice history taking or case presentations.

3.2.2 Usefulness of LME

Participants acknowledged the value of prior learning in medical English, yet they reported constraints stemming from language barriers and the nature of the training context
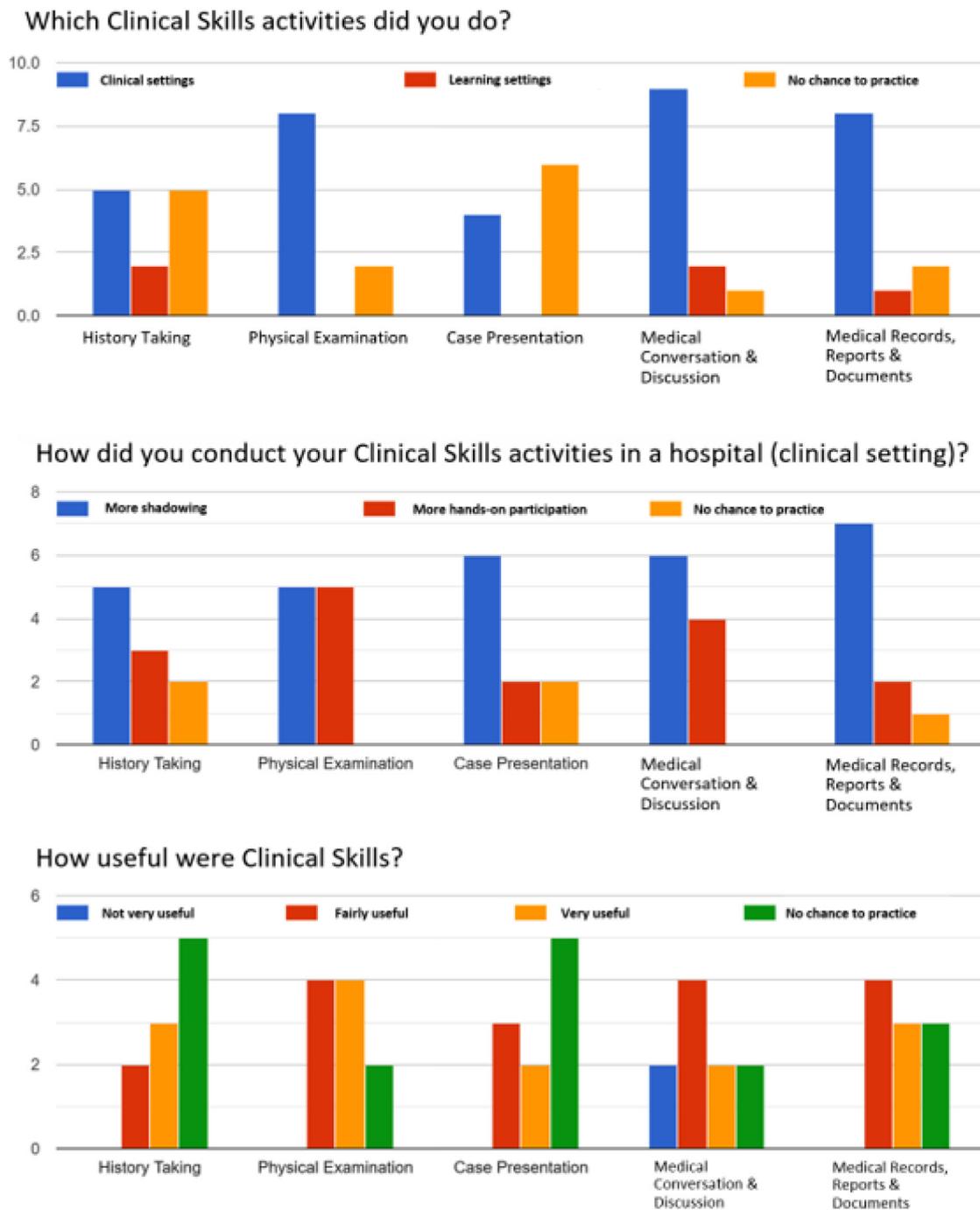
Which Clinical Skills activities did you do?

How did you conduct your Clinical Skills activities in a hospital (clinical setting)?

How useful were Clinical Skills?

Results of a questionnaire administered to LME participants after their return from clinical training abroad (April-June 2024). Participants were asked about the Clinical Skills they experienced at their training sites, in terms of what they learned and their practicality in the field.

Figure 3. Clinical Skills Activities

(**Figure 4**).

Many participants provided positive feedback on the LME. For example, comments such as "*Studying medical English vocabulary in advance was beneficial*" and "*I was able to recall appropriate phrases during actual patient encounters*" indicated the usefulness of medical English vocabulary acquisition in clinical settings. Additionally, some participants noted that they were better able to comprehend explanations from supervising physicians, and pre-training

in history taking, physical examinations, and patient explanations was evaluated as beneficial. A major advantage reported was the ability to recall appropriate phrases when interacting with patients, which facilitated smoother participation in clinical activities.

Conversely, certain issues were identified. For instance, several participants remarked that they encountered limited opportunities to utilize medical English in actual patient care, as communication in the clinical setting was predominantly

Did what you learnt on the LME training course help you in your CME abroad? (*n* = 10)
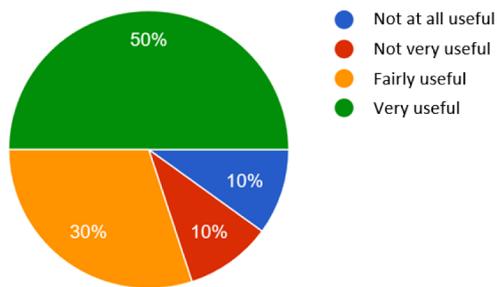
- Not at all useful
- Not very useful
- Fairly useful
- Very useful

Results of a questionnaire administered to LME participants after their return from clinical practice abroad (April-June 2024). Most participants rated their learning at LME highly, but negative ratings were included from some who practiced in non-English-speaking countries.

Figure 4. Usefulness of LME

conducted in the local language. Moreover, given that the primary activity of the training program was observation of surgical procedures, the participants indicated a paucity of opportunities to engage in the practical application of clinical skills.

3.2.3 Further suggestions

Respondents provided several recommendations for improving the training program. Key suggestions included enhancing medical terminology instruction, increasing opportunities for discussion, and adjusting the frequency and duration of training sessions to facilitate continuous learning. Additionally, the implementation of ability-based class divisions was proposed.

Many participants emphasized the importance of practical learning, advocating for earlier and more frequent practice in history taking and physical examination, as well as instruction in case presentation and medical record documentation. Furthermore, small-group discussions and the incorporation of problem-based learning (PBL) in English were identified as effective strategies for enhancing clinical skills. Specifically, engaging in case analysis, differential diagnosis, and discussions in English was seen as a means to create a more immersive and practical learning environment.

Moreover, some respondents highlighted the benefits of initiating training at an earlier stage to facilitate familiarity with medical English. While a subset of participants expressed satisfaction with the current curriculum, a majority believed that a more interactive and structured approach would better prepare trainees for international medical training.

4. Discussion

4.1 Positive factors

The survey results suggest that the LME program had a positive impact on learners' academic and clinical skill development. Several factors likely contributed to these outcomes.

First, the expertise of the instructors played a crucial role. The LME program set a clear objective for students to conduct patient interviews, physical examinations, and case presentations in English from the early stages of their training. Most instructors had international study experience and were able to provide instruction based on ESP. In particular, the program was structured according to outcome-based education principles, which likely facilitated a more effective assessment of learners' specific needs. Comments such as "*Having prior knowledge from LME made it easier to read medical records written in English during outpatient rotations*" and "*The medical dialogues practiced in LME and class were highly useful*" support this assertion.

Second, the integration of medical education theories into the syllabus enhanced learning efficiency. Specifically, Knowles' adult learning theory was applied to clarify learning objectives and promote a self-directed learning environment. Additionally, instructional strategies such as Gagné's Nine Events of Instruction, Keller's ARCS Model for motivation, appropriate task-rest balance based on the Ultradian Rhythm, and Schön's concepts of Reflection in/on Action were incorporated. Survey responses such as "*Having clearly defined tasks for each session was reassuring*" and "*The review time at the beginning of each class helped reinforce learning*" indicate that these approaches contributed to improved learning outcomes.

Third, the homogeneity of learners was a key factor. The LME program consisted of a small, selective class based on TOEFL scores, with all participants preparing for clinical training abroad. As a result, students demonstrated high levels of motivation and relatively uniform readiness. This environment likely facilitated the formation of a "Community of Practice" (CoP), as proposed by Lave and Wenger. In practice, students actively utilized online platforms such as Teams and Slack to engage in continuous learning, share knowledge, and support each other.

Taken together, these findings suggest that the effectiveness of the LME program can be attributed to the interplay of instructor expertise, a syllabus grounded in educational theory, and the characteristics of the learners. These factors collectively contributed to the program's positive impact on learning outcomes.

4.2 Negative factors

The results of this survey indicated that while the program received predominantly positive evaluations, several challenges were also identified.

To begin with, the LME syllabus exhibited exploratory nature. Participants expressed specific requests for improvements regarding its structure. For instance, one participant commented, "*I would have appreciated earlier instruction in fundamental presentation techniques.*" In the initial phase of the program, instructors lacked a comprehensive understanding of learners' knowledge and skill levels, which may have led to instructional challenges. Actually, most instructors were external faculty members.

In addition, most participants completed their study abroad programs in non-English-speaking countries. Consequently, they reported that the country's native language was primarily used when interacting with patients, while English was used when communicating with medical staff and writing medical notes. In addition, there are reports indicating that "*local medical students served as interpreters*" and that "*participants primarily observed surgeries with limited opportunities to practice clinical skills*" further suggest the limitations of clinical skills education conducted in English.

Moreover, as the program progressed, disparities in participants' proficiency levels became increasingly evident. For instance, some participants noted that "*the speed of English communication was too fast to comprehend,*" suggesting that differences in English proficiency may have existed from the outset. Additionally, as learning advanced, these gaps widened, making it increasingly challenging to establish an appropriate level of difficulty for all learners.

Given these findings, more effective learning outcomes may be achieved through pre-assessment of participants' knowledge levels, curriculum development that considers the linguistic environments of study abroad destinations, and instructional strategies that accommodate variations in participants' proficiency levels.

4.3 Further perspective

The implementation of clinical medical English education prior to overseas clinical training is essential for other educational institutions as well. Several key factors must be considered in this regard.

Firstly, the early introduction of clinical medical English education is of paramount importance. Previous findings included comments such as, "*It is better to start early and become accustomed to it.*" Specifically, incorporating instruction on fundamental medical vocabulary and history taking in the early years of medical school, followed by training in case presentation—including physical examination and differential diagnosis—before the commencement of clinical training, would be highly beneficial. Considering potential curriculum revisions, the early integration of medical English education tailored to clinical settings is expected to enhance learning outcomes.

Next, the establishment of a well-structured faculty team is crucial. Faculty members who demonstrate a strong alignment with students' learning needs are essential, particularly those with clinical experience abroad. Furthermore, faculty members with a comprehensive understanding of the culture, history, and healthcare systems of the host countries would significantly enhance the quality of education. However, securing personnel who meet all these criteria is challenging, and forming an appropriate faculty team within a short period is not an easy task. Therefore, in institutions that support medical students pursuing study abroad programs, the presence of a responsible leader with strong leadership skills is imperative.

The cooperation of teaching assistants (TAs) should also be considered. In the LME program, international graduate students participated as standardized patients in role-playing exercises, receiving high evaluations from learners. Additionally, administrative staff at the university's internationalization promotion center facilitated communication with these students and contributed to practical assistance, such as preparing the necessary equipment. To reduce the burden on faculty members, establishing a collaborative framework that incorporates teaching assistants is essential.

In conclusion, strengthening clinical medical English education is essential for enhancing students' practical skills. This requires early implementation, qualified faculty, and effective TAs, enabling institutions to better prepare students for global medical settings. These approaches can be integrated into existing medical English programs.

4.4 Limitations

This study has several limitations that should be considered.

First of all, selection bias may have influenced the findings. Saito et al. investigated the intention to participate in overseas training programs among students at a Japanese university specializing in healthcare and welfare. Their study reported that 47.5% of students expressed interest in or willingness to participate in such programs.[7] However, this study did not include medical students who opted out of clinical training abroad due to financial constraints or concerns about communication in English.

Secondly, sample bias must be acknowledged. The number of respondents was relatively small, with $n = 13$ immediately after the completion of the LME program and $n = 10$ for post-overseas clinical training reports. As a result, the findings may be applicable only to a specific population or context, limiting their external validity. Therefore, caution should be exercised when generalizing these results to different populations.

Furthermore, potential expectancy biases and confounding factors must be considered. Without a control group or standardized syllabus, causality is difficult to establish. Temporal factors (history effect) may have

compromised internal validity. Although clinical English proficiency improved after the intervention, this may reflect natural learning progression. Moreover, baseline differences in proficiency and motivation were uncontrolled and could have influenced the results.

Lastly, while the program benefited from expert faculty and a small-group format, its resource-intensive nature limits applicability to other settings. To ensure sustainability and balance cost with quality, it may be necessary to restrict sessions, select participants carefully, and reduce instructors. Although the optimal model varies with learners' goals and institutional context, these factors could be informative.

5. Conclusion

This paper reports on the newly implemented pre-departure clinical English training program at Fujita Health University School of Medicine, introduced in 2023 following the effective lifting of COVID-19-related travel restrictions in Japan. Based on the survey results from participating students, three key factors for effective pre-departure clinical English education were identified: (1) early implementation, (2) organizing appropriate faculty members, and (3) collaboration with teaching assistants. However, given the resource constraints faced by individual institutions, achieving these objectives require not only a revision of existing curricula but also strengthened collaboration with other universities and relevant organizations. Moving forward, it is essential to develop a more practical and sustainable educational model to further advance clinical English training for medical students.

Declaration of conflicting interests

The authors disclose current (KS) and former (TA) affiliations with the Noguchi Medical Research Institute.

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Exploring the relationship between English-language haiku and empathy

Ian Willey[1] and Hiromi Suzuki[2]

[1] Higher Education Center, Kagawa University
[2] Department of Hygiene, Faculty of Medicine, Kagawa University

Abstract

Reflecting upon poetry has been found to increase the empathy of both students in healthcare-related majors and healthcare professionals; poetry has thus become a staple in Medical Humanities education. However, traditional and modern English poetry pose challenges for people whose first language is not English. For English as a foreign language（EFL）learners in Japan, a more suitable alternative may be English haiku, a short-form genre typically written in plain language and with which Japanese learners are familiar. This exploratory study examined the effect of English-language haiku on the empathy of medical students（N = 91）enrolled in a Medical English course at a Japanese university. Each week the instructor presented students with one English-language haiku; students discussed these haiku in groups and had the option to write about them using the Forum function on Moodle. Emphasis was placed on identifying the emotions of each haiku's author. As an empathy measurement, the Multidimensional Empathy Scale was given to students in the first and last class of the fifteen-week semester. Using a Google Form, students also evaluated the haiku tasks in terms of their potential for developing learner empathy. Although students tended to believe that reflecting upon English haiku was beneficial for developing empathy, significant increases in students' empathy levels were not identified. Preliminary findings suggest that English-language haiku may promote empathy-building in Japanese students, though further research is needed to clarify its value to EFL learners.

J Med Eng Educ (2025) 24 (3): 32-40

Keywords　empathy, haiku, medical English, medical humanities, poetry, questionnaire

1. Background

1.1 Understanding empathy

The notion of empathy has received considerable attention in numerous fields, including psychology, neuroscience, nursing, and applied linguistics. Empathy first entered the English language in 1910 as a translation of the German term *Einfühlung*, used to express a feeling of "projecting oneself into" a work of art to better appreciate the artwork.[1] The term has since come to mean the general ability to understand or experience the emotional experiences of others,[2] although definitions of this term vary across the research literature.[3] Empathy is generally divided into two types or strands: affective (or emotional) empathy and cognitive (or clinical) empathy.[4] Affective empathy typically involves feeling the same emotion as another person; this occurs, for example, when a teacher sees a student who looks sad and feels sad herself. With cognitive empathy, a person understands what someone else feels without feeling that same emotion. Cognitive empathy is generally described as "good" empathy, as affective empathy can cause emotional contagion and burnout,[5] though cognitive empathy can lead to emotional detachment and the manipulation of others' emotions.[4, 6]

Many different scales have been devised to measure empathy, each with respective strengths and shortcomings.[7] In general, these scales have been designed to measure both the cognitive and affective aspects of empathy, often providing a single empathy score.[8] One of the most well-known scales is the Interpersonal Reactivity Index (IRI) created by Davis.[8, 9] Davis argued that cognitive and affective scales of empathy cannot be combined to obtain a single empathy score.[8] The IRI scale consists of four sub-scales measuring distinct dimensions of empathy: the *perspective-taking* scale measures an individual's ability to spontaneously adopt the point of view of others; the *fantasy* scale measures one's propensity to vicariously

● **Corresponding author:**

Ian Willey
Professor, Ph.D., Higher Education Center, Kagawa University
1-1 Saiwai-cho, Takamatsu-shi, Kagawa, 760-8521 Japan
TEL／FAX: 087-832-1578
E-mail: willey.ian.david@kagawa-u.ac.jp

experience the circumstances of characters in books, movies, etc.; the *empathic concern* scale assesses "other-oriented" feelings of sympathy and concern for people experiencing hardships; and the *personal distress* scale measures "self-oriented" feelings of anxiety or unease induced when one sees someone else experiencing hardships. The first two dimensions measure an individual's cognitive empathic capacities, while the latter two measure emotional reactivity or affective empathy.[9]

Drawing from Davis' IRI, Suzuki and Kino developed the Multidimensional Empathy Scale (MES), a 24-item self-report questionnaire in Japanese consisting of the four dimensions of the IRI as well as a *social empathy scale*, which assesses influences on an individual in social situations, such as the extent to which one's own opinions are shaped by the people around them.[10] This scale may be appropriate for measuring empathy in a "high-context" culture such as Japan, where regard for others' opinions can profoundly influence a person's behavior.[11]

1.2 The value of empathy

As mentioned above, empathy is not without associated problems, which include empathy fatigue,[12] professional burnout,[5, 13] and bullying.[6] Empathy can lead to poor clinical outcomes, as doctors sometimes misunderstand patients' feelings.[14] Despite these caveats, empathy is generally considered to be positive. Empathy on the part of clinicians has been found to lead to patient satisfaction,[15] inspired trust in the physician,[16] improved compliance,[17] and — for conditions ranging from diabetes to the common cold — better healing outcomes.[17, 18] Moreover, empathy may increase the health and well-being of physicians.[19] Worryingly, empathy has been found to decline in medical students and residents as they gain experience with patients.[20] Medical humanities programs aim to counter this trend by promoting empathy in both students and healthcare professionals through studies of literature and narrative medicine.[21]

In the field of applied linguistics, empathy has long been recognized as an essential component of second language learning and intercultural communication. Brown identified empathy as one of the key social variables determining success in second language learning and recommended group work and role plays to promote learner empathy.[22] Gudykunst asserted that effective communicators rely not on their own cultural perspectives when attempting to understand people from other cultures; rather, they are "empathic" with their interlocutors.[23] Empathy is one of the core variables in several models of intercultural communicative competence.[24–26] A link has also been found between frequent use of multiple languages and higher levels of cognitive empathy.[27] In addition, empathy may contribute to improved pronunciation as well as grammatical sensitivity and vocabulary learning.[28, 29]

Empathy remains difficult to define, not to mention measure, and the findings described above must be viewed with caution.[6, 30] Empathy has been described as an action,[31] an attitude,[4] an ability,[27] a skill,[32] a response,[32] and an interpersonal phenomenon.[1] Despite this ambiguity, however, it is clear that empathy refers to *something* of value to medical professionals as well as language learners. It follows that empathy is relevant to English for medical purposes (EMP) instructors in Japan.

1.3 Poetry and empathy

Poetry has come to occupy a prominent position in medical humanities training, despite the relative unpopularity of poetry in the general population.[33] Cole et al. state that poetry "deals with the raw material of human experience… of illness and injury, healing and grief, love and death" (168).[34] Poetry also differs from traditional prose in its use of verse and metaphorical language, allowing for artistic ways to convey feelings about an experience as well as multiple interpretations.[35] Importantly, poetry may invoke an emotional response in the reader, thereby triggering empathy.[36] However, a clear link between reading poetry and empathy has yet to be established. One study using poetry as a narrative medicine intervention found significant gains in participants' empathic concern (affective empathy) using pre-/post-surveys, though a decrease in perspective taking (cognitive empathy) was also observed.[37]

English-language poetry can be difficult to understand, even for native English speakers, and these difficulties are exacerbated for EFL learners in Japan. Reading haiku in English, though, may alleviate these difficulties for several reasons: they are short, typically consisting of three lines of 17 syllables or fewer; they are written in plain, non-metaphorical language[38]; and having originated in Japan, they are familiar to Japanese students. The merits of haiku as a narrative medicine tool in promoting empathy have been explored in classroom-based inquiries and workshops.[39, 40] However, to our knowledge, no empirical investigations have examined a relationship between haiku and empathy. As understanding a haiku involves grasping the perspective of the haiku's author, we predicted that reflecting upon English haiku would exercise an individual's cognitive empathy, particularly in the dimension of perspective-taking; moreover, if empathy is a skill, as previous research suggests,[32] perhaps this reflection will lead to increased empathy.

1.4 Research aims

This study was exploratory in nature, as it attempted to examine a topic that has not yet been substantially researched.[41] We aimed to assess the effect of English-language haiku on the empathy levels of students enrolled in a Medical English course at one university. The study was guided by three research questions.

1. How do students feel about reflecting on English language haiku as a means of empathy development?
2. What effect does reflecting on English-language haiku have on the students' empathy development?
3. Is there a relationship between empathy and students' level of involvement with English-language haiku tasks, as measured by how often they write about haiku?

The first question attempts to gather students' subjective impressions, while the second question was meant to gather objective data. In other words, this study set out to examine whether students *thought* reflecting on English-language haiku was good for their empathy, and whether reflecting on English-language haiku *actually had* a positive effect on their empathy. The third question was formulated because the Moodle writing task on English-language haiku presented each week, as described below, was optional. Last, for each question, we hoped to ascertain whether gender affected participants' empathy or their attitudes toward English-language haiku, as previous studies have found that females tend to have higher empathy than males,[42] as well as read more literature than males.[43]

2. Methods

2.1 Participants

Participants were third-year Medical students enrolled in the required Medical English I and II courses at our institution, a national university in western Japan. Of the 111 students enrolled in these courses, 91 students (35 females and 56 males) completed the surveys and became study participants. Participants were not asked to disclose their age, but they were asked to state their gender (female, male, or other). Course grades were also used as data.

The Medical English courses are divided into two groups. In the spring semester, 42 students in one group participated; in the fall semester, 49 students in the other group participated. In this manner, all students enrolled in the Medical English courses were able to participate in the study. Each Medical English course met once per week over the 15-week semester; classes were 90 minutes long.

2.2 Intervention

We first collected English-language haiku with medical- or healthcare-related themes or content by searching through both online and printed English haiku journals. Each week of the 15-week Medical English course, the instructor (one of the authors of this paper) presented a new English-language haiku to participants using PowerPoint slides. The haiku below is an example.

coronavirus
a vase of daffodils
in the living room[44]
~Janice Doppler

Students were given 5 minutes to discuss these English haiku in groups of 3-4 students. Their discussion centered on the following three questions: 1) What is the situation? 2) How does the author feel about the situation? 3) How does the haiku make you feel? Students were told they could discuss the haiku in English or Japanese. Students were then given an optional writing assignment on Moodle where they could answer the same three questions about the haiku in English; those who completed this task received one bonus point. As the task utilized the Forum function on Moodle, students' writing was visible to all other students in the class. The following week, the instructor would share with the class some of the students' writing on the haiku discussed in the previous class before presenting the new haiku for that week. Pedagogical advice regarding the selection and presentation of English-language haiku to students is offered in **Appendix 1**.

2.3 Research instrument and analysis

As an empathy measurement, the Multi-dimensional Empathy Scale (MES) was used.[10] As described above, this Japanese-language survey consists of five separate scales that measure both cognitive and affective empathy. Participants must indicate the extent to which they agree or disagree with each item on five-point Likert scales. To reduce the amount of time required to fill in the survey, the number of items was reduced from 24 to 15, keeping three items from each of the scales and removing all negatively-worded items requiring reverse-coding, as using both positively- and negatively-worded items may increase invalid responses.[45] Items were randomized to remove ordering biases.[46] Examples of survey items are included in **Appendix 2**.

Students completed the MES survey online, using a Google Form. The same survey was administered at the beginning and end of each semester. Students who responded to only one of the two surveys were excluded from the study. In addition, students in the spring semester completed an end-of-semester survey using a Google Form that inquired about students' impressions of the English haiku tasks. Due to an unforeseen class cancellation, this survey could not be successfully administered in the fall semester; few students responded to the call for responses to the survey on Moodle, likely because they were preparing for other examinations.

In the survey, students were asked the extent to which they agreed with the following four statements (presented in both English and Japanese).

1. Reflecting on English haiku was interesting.
2. Reflecting on English haiku was a useful activity for Medical students.
3. Reflecting on English haiku made me more understanding of how patients feel.
4. Reflecting on English haiku is a good way to develop empathy.

Data analyses were performed using SPSS Version 27 (IBM, USA) and JMP Pro 16.1 for Windows (SAS Institute, USA). The statistical significance of the calculated coefficients was determined at $p < 0.05$. A statement at the beginning of each survey informed students of the purpose of the survey, assured students that their participation was voluntary and would have no bearing on their course grade, and that their identities would remain confidential. The research instrument and procedures were approved by the Institutional Review Board of our institution (#002).

3. Results and discussion

3.1 Student evaluations of haiku tasks

As described above, a survey using a bilingual Google Form was conducted at the end of the first semester to gather students' opinions about the haiku tasks. A total of 51 students responded to this survey (20 females and 30 males; one student selected "prefer not to say"). The survey asked students the extent to which they agreed with four statements, with response options on a 5-point Likert scale, ranging from "Strongly disagree" to "Strongly agree." **Figures 1 through 4** show the number and percentage of students who selected each option for each statement.

For the statement "Reflecting on English haiku was interesting," 35 students (68.7%) either strongly or somewhat agreed, indicating that the haiku tasks were relatively well-received (**Figure 1**). Only 7 out of the 51

students (13.7%) indicated any disagreement. Students were slightly less positive in their response to the next statement, "Reflecting on English haiku was a useful activity for medical students": 30 students (58.8%) either strongly or somewhat agreed, with 13 students (25.5%) neither agreeing nor disagreeing, and only 8 students (15.7%) indicating disagreement (**Figure 2**). However, for the statement, "Reflecting on English haiku made me more understanding of how patients feel," responses were more positive: 40 students (78.5%) indicated agreement, while only 4 students (7.8%) disagreed (**Figure 3**). Students thus believed that reflecting on English haiku would help to develop their cognitive empathy. Interestingly, responses were less positive for the statement, "Reflecting on English haiku is a good way to develop empathy," with 34 students (66.6%) agreeing, though only 4 students (7.8%) disagreed (**Figure 4**). Perhaps students were not comfortable with the word "empathy" (共感力 in Japanese), as it is abstract and hard to define.

We next examined whether gender differences could be observed in responses. As the majority of students identified as either female or male, these two categories were used in the analysis, and the one student who preferred not to disclose their gender was removed. Independent samples T-tests were run, and it was found that female students had higher mean scores than males for all four statements (**Table 1**). For statements one and three, on whether haiku tasks were interesting and led to a greater understanding of how
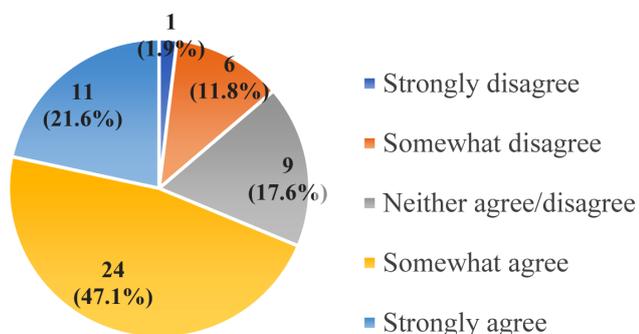

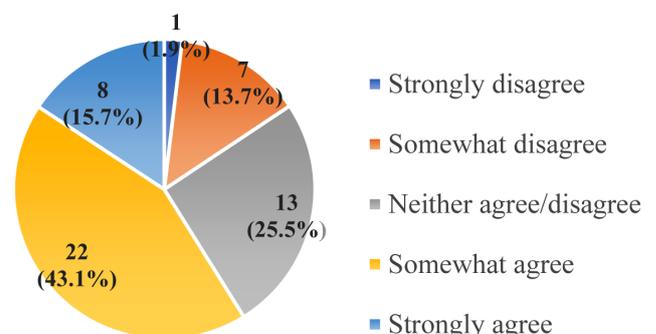**Figure 1. "Reflecting on English haiku was interesting." (*n* = 51)**

Figure 2. "Reflecting on English haiku was useful." (*n* = 51)
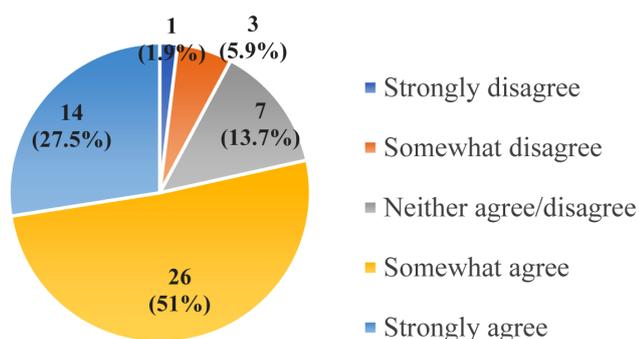

Figure 3. "Reflecting on English haiku made me more understanding of patients." (*n* = 51)
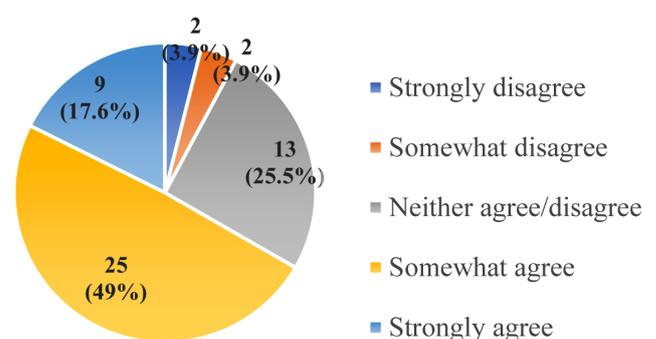

Figure 4. "Reflecting on English haiku is a good way to develop empathy." (*n* = 51)

Table 1. Gender differences in student evaluations of the haiku tasks

Question	Female (*n* = 20) Mean (SD)	Male (*n* = 30) Mean (SD)	Mean Diff.	*t*	*df*	Cohen's D	*p*
1. Interesting	4.10 (0.79)	3.57 (1.04)	0.53	2.06	47.12	0.56	0.05*
2. Useful	3.90 (0.85)	3.40 (1.00)	0.50	1.89	45.12	0.53	0.07
3. Understand patients	4.10 (0.85)	3.50 (0.94)	0.60	2.34	43.49	0.66	0.02*
4. Promote empathy	4.25 (0.79)	3.83 (0.91)	0.42	1.72	44.79	0.48	0.09

Note. Significance at *p* < 0.05. *n* = Number; SD = Standard Deviation; Mean diff. = Difference between the two means (Female and Male)

Table 2. Empathy scores at the two collection points (*n* = 91)

MES item	C1 Mean (SD)	C2 Mean (SD)	Mean diff. (C2-C1)	*t*	*df*	*p*	D
1. Overall	3.66 (0.43)	3.61 (0.47)	-0.05	-1.38	90	0.17	-0.15
2. PT	3.83 (0.55)	3.73 (0.68)	-0.10	-1.65	90	0.10	-0.17
3. F	3.54 (0.94)	3.56 (0.94)	0.02	0.41	90	0.68	0.04
4. EC	4.11 (0.61)	3.87 (0.78)	-0.24	-3.45	90	< 0.001*	-0.36
5. PD	3.51 (0.81)	3.66 (0.68)	0.15	2.20	90	0.03*	0.23
6. SE	3.32 (0.91)	3.25 (0.88)	0.07	1.09	90	0.28	0.11

Note. Significance at *p* < 0.05. *n* = Number; C1 = Collection 1; C2 = Collection 2; SD = Standard Deviation; Mean diff. = Difference between the two means (C1 and C2); D = Cohen's D; PT = perspective-taking; F = Fantasy; EC = empathic concern; PD = personal distress; SE = social empathy

patients feel, these differences were statistically significant (*p* < 0.05 and 0.02, respectively). Effect size was calculated with Cohen's D; effect sizes were mostly in the moderate range (below 0.50), except for *greater understanding*, which was relatively high (0.66). These findings support the notion that women tend to be more empathetic than men and have a greater interest in literature.[42, 43]

An open-ended item at the end of the survey asked students to write their opinions about English haiku. Only three students responded, giving the following opinions.

- Haiku in English was fun.
- I prefer learning how to write logical sentences to reading an English haiku.
- 曲の方がいいと思う。[I think music would be better.]

3.2 MES surveys

Out of 111 students enrolled in the class, 91 students (a response rate of 82%) completed both surveys. There were 35 females and 56 males, with no students identifying as "other." Differences between empathy values at the two collection points were first compared using dependent-sample T-tests. **Table 2** shows, for both collection points, combined empathy means as well as means for the five dimensions of the MES: perspective-taking (PT), fantasy (F), empathic concern (EC), personal distress (PD), and social empathy (SE). PT and F relate to cognitive empathy, while EC, PD, and SE are dimensions of affective empathy.

Before launching this study, it was predicted that reflecting on English-language haiku would involve a student's cognitive empathy skills, particularly perspective-taking, and perhaps lead to increased cognitive empathy. However, after one semester, decreases in the cognitive dimensions of perspective-taking and fantasy were observed, though these differences were not statistically significant. Significant differences were observed in the affective dimensions, with a significant decrease in empathic concern (*p* < 0.00) and a significant increase in personal distress (*p* = 0.03). These results are alarming, as increases in personal distress can lead to fatigue and burnout,[5] and a drop in empathic concern suggests a decrease in caring for patients—hardly an attribute one would hope for in a doctor. It is uncertain, however, whether these changes were linked to reflecting upon English haiku or other factors, such as end-of-the-semester pressures and fatigue, which may dampen students' empathy and make them more prone to stress.

Effect size was again calculated with Cohen's D. For all dimensions, the effect size was small (ranging from -0.36 to 0.23), indicating little difference between participants at both collection points, which would be expected, as they are the same participants.

Next, independent samples T-tests were run to identify gender differences in these results, as previous studies have suggested that women have higher levels of empathy than men.[41] **Table 3** shows the mean values, at both collection points, of all MES items for both female and male students. Only one significant difference was found: male students had significantly higher fantasy scores than female students for the second collection (*t* (70.75) = -2.19, *p* = 0.03). Overall, female participants did not have higher empathy levels than male participants, for both cognitive and affective dimensions of empathy. Contrary to prevailing views on gender and empathy, these findings suggest that the male students in this study employ empathy more often than the

Table 3. Empathy scores by gender at the two collection points

MES item	Female (n = 35)			Male (n = 56)		
	C1 (Mean, SD)	C2 (Mean, SD)	Mean diff. (C2-C1)	C1 (Mean, SD)	C2 (Mean, SD)	Mean diff. (C2-C1)
1. Overall	3.69 (0.44)	3.57 (0.39)	-0.06	3.64 (0.43)	3.64 (0.51)	0.00
2. PT	3.92 (0.56)	3.70 (0.56)	-0.22	3.77 (0.54)	3.75 (0.74)	-0.02
3. F	3.44 (0.94)	3.30 (0.94)*	-0.14	3.60 (0.95)	3.73 (0.91)*	0.13
4. EC	4.16 (0.66)	3.80 (0.66)	-0.36	4.07 (0.58)	3.91 (0.85)	-0.16
5. PD	3.47 (0.84)	3.67 (0.64)	0.20	3.54 (0.80)	3.65 (0.71)	0.11
6. SE	3.46 (0.86)	3.38 (0.64)	-0.08	3.24 (0.93)	3.17 (1.0)	-0.07

Note. Significance at $p < 0.05$. n = Number; SD = Standard Deviation; C1 = Collection 1; C2 = Collection 2; Mean diff. = Difference between the two means (C1 and C2); PT = perspective-taking; F = Fantasy; EC = empathic concern; PD = personal distress; SE = social empathy

female students when relating to characters in literature and films.

To examine differences within gender groups at both collection points, dependent sample T-tests were run. Significant differences were found for female students but not for male students. For female students, there were significant decreases in combined overall means (t (34) = 2.23, $p = 0.032$), perspective-taking (t (34) = 1.01, $p = 0.01$), and empathic concern (t (34) = 3.47, $p = 0.001$). For the sake of space, and as effect sizes were calculated for empathy scores and all constituent dimensions in **Table 2**, Cohen's D values are not displayed in **Table 3**.

We cannot explain why female and not male students experienced significant decreases in empathy. However, in light of responses to the survey evaluating the haiku tasks, an interesting pattern may appear. The female students were generally more positive towards the haiku tasks, and believed the tasks were more beneficial to the empathy development of medical students, than the male students. The notion that women tend to be more empathetic than men is pervasive in many societies, including Japan; thus, these female students may have *believed* that they are more empathetic than the male students. In actuality, their empathy levels are roughly the same. Accordingly, male students may think that empathy is of low importance to them, and their evaluation of the haiku tasks and their effect on empathy tended to be less positive. Further research is required to confirm whether this pattern holds among Japanese medical students, as well as students in different majors.

3.3 Empathy and diligence

The last item for examination was the relationship between the number of times students wrote about English-language haiku on Moodle and empathy levels, as measured by the MES. Although all students were able to take part in discussions of the English-language haiku in class, the writing task was optional, and students received one bonus point for each haiku they wrote about. The number of students who wrote about haiku each week on Moodle is shown in **Table 4**. The average number of Moodle tasks

Table 4. Number (percentage) of students who wrote about haiku on Moodle

Gender	0	1-2	3-4	5-6	7-8	9-10	11-12	13
Female (n = 35)	6 (17)	10 (29)	4 (11)	2 (6)	4 (11)	2 (6)	5 (14)	2 (6)
Male (n = 56)	12 (21)	14 (25)	3 (5)	2 (4)	4 (7)	5 (9)	10 (18)	6 (11)
Total (n = 91)	18 (20)	24 (26)	7 (8)	4 (4)	8 (9)	7 (8)	15 (16)	8 (9)

undertaken was 4.9 per student for females and 5.4 for males. As **Figure 5** shows, most students wrote either 0-2 times, or 11-13 times, with relatively fewer students grouped in the middle. It appears that students were either uninterested in writing about haiku or very much interested.

A simple linear regression revealed no correlation between the number of times students wrote about haiku and any MES dimension. Those students who wrote more frequently about English-language haiku did not have higher empathy levels or show greater gains in empathy than those who wrote less frequently or not at all.

A simple linear regression was used to test if students' course grades significantly predicted the number of haiku written about, and the overall regression was weak but statistically significant ($R^2 = 0.05$, F (1, 88) = 4.44, $p = 0.04$). As course grades increased, the number of times students wrote about haiku tended to increase as well. As expected, the more studious students tended to write about haiku, more often than those who genuinely needed bonus points to boost their course grades.

A simple linear regression found no significant correlation between course grades and any dimension of empathy; diligence (as measured by grades) and empathy were unrelated in this study.

4. Conclusions

The first research question asked how students feel about reflecting on English-language haiku as a means of empathy development. The majority of students (nearly
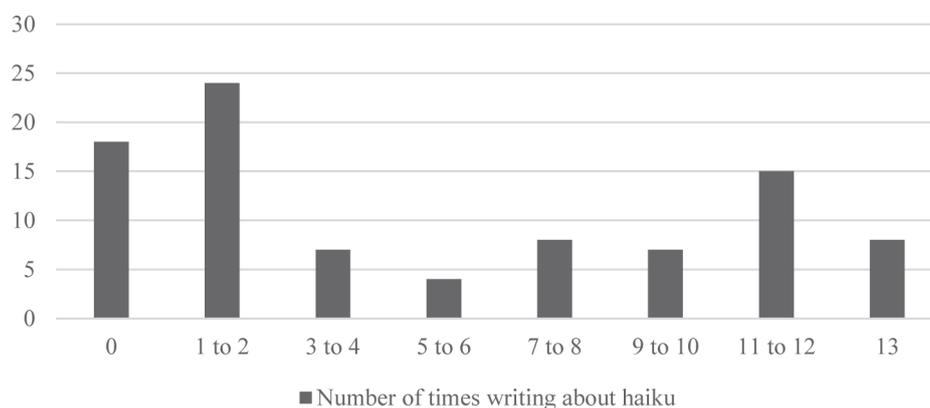
Figure 5. The number of times students wrote about English-language haiku

80%) indicated that reflecting upon English-language haiku made them more understanding of how patients feel. Students were more skeptical of the value of English-language haiku when the word "empathy" was employed, due perhaps to the ambiguous nature of this term. These findings suggest that students believe English-language haiku will help them become more understanding (i.e., empathetic) of patients, and that reading English-language haiku particularly relates to cognitive empathy.

The second research question asked whether reflecting on English-language haiku has a genuine effect on students' empathy, and here results were less positive. There were non-significant decreases rather than increases in the cognitive empathy dimensions of perspective-taking and fantasy. In terms of the affective empathy dimensions, students experienced an increase in personal distress and a decrease in empathic concern; both of these results could be perceived as negative for healthcare professionals, and further research, perhaps involving qualitative measures, will be needed to identify what caused these suboptimal changes.

The third research question asked whether there is a relationship between the frequency of writing about English haiku and empathy, and no significant relationship was found. Rather, students' diligence toward the course, as measured by course grades, predicted the frequency of writing about haiku.

Regarding gender differences, female students were found to be more positive about the English-language haiku tasks than males, though they did not have significantly higher empathy levels. Indeed, male students had a significantly higher fantasy score than female students for the second collection point. Moreover, only the female students experienced significant decreases in empathy. These results suggest that the relationship between gender and empathy is not straightforward and may be shaped by stereotyped notions about gender differences related to empathy.

This study was small in scale, collecting mainly quantitative data and involving only one cohort of third-year medical students. Further studies, involving more robust samples and a combination of quantitative and qualitative data, are required before definitive conclusions can be drawn about the relationship between English-language haiku and empathy. In particular, interviews or reflection tasks involving think-aloud protocols would help to clarify how students reacted to haiku. However, this study was intended to be exploratory in design, and our most significant finding may be that English-language haiku were generally well-received by these students. We believe that the genre of haiku holds promise in helping students in EMP classes exercise their empathic muscles, and we intend to continue exploring the relationship between English-language haiku and empathy.

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Appendix 1: Pedagogical advice

One of the authors of this paper writes and publishes haiku regularly, and it was relatively easy to find English-language haiku with medical themes in the author's collection of haiku journals and familiar websites. For those unfamiliar with English-language haiku, we recommend searching for haiku on the websites of established English-language haiku journals, such as *Frogpond* (The Journal of the Haiku Society of America), *Modern Haiku*, *The Asahi Haikuist Network*, and *The Heron's Nest*. These journals publish genuine haiku, capturing a moment of human experience, often embedded in nature, that give students something substantial to reflect upon. Many sites offer English-language haiku, often on medical themes, that are mostly clever exercises in syllable count—five, seven, five is the typical three-line syllable pattern—and lack substance for discussion. We recommend using simple haiku that students can relate to, and avoid haiku that are too

ambiguous, jokey, or philosophical.

Last, when presenting English-language haiku, we recommend that instructors first simply show students the haiku. Read the haiku aloud, and explain any vocabulary that may be unfamiliar to them. That is enough; teachers would be wise not to give their own thoughts about what the haiku are about, as this can influence students' reactions, as well as bore them. Give students time to discuss the haiku. Many students are unaccustomed to this kind of activity and have no idea what to think. Students should be told that the purpose of the activity is the act of reflection itself. There are no right or wrong answers, and all interpretations of haiku should be respected. As a haiku poet, the author tells students that *even authors themselves* are often unsure what their own haiku "means"; meaning exists only in the mind of the reader.

Appendix 2: Sample questionnaire items

Cognitive empathy categories
1. Perspective-taking
人と対立しても，相手の立場に立つ努力をする。

(Even when I disagree with someone, I try to understand that person's point of view.)

[Response options were on the five-point scale below.]

1. 全くあてはまらない (This is not at all true for me.)
2. あまりあてはまらない (This is somewhat not true for me.)
3. どちらともいえない (This is neither true or untrue for me.)
4. ややあてはまる (This is somewhat true for me.)
5. とてもよくあてはまる (This is completely true for me.)

2. Fantasy
面白い物語や小説を読んだ際には，話の中の出来事がもしも自分に起きたらと想像する。

(While reading an interesting story or novel, I feel as though the things happening in the story are happening to me.)

Affective empathy categories
3. Empathic concern
悲しんでいる人を見ると，なぐさめてあげたくなる。

(When I see someone in distress, I want to comfort them.)

4. Personal distress
他人の失敗する姿をみると，自分はそうなりたくないと思う。

(When I see someone who has failed at something, I don't want the same thing to happen to me.)

5. Social empathy
自分の感情はまわりの人の影響を受けやすい。

(My feelings are easily influenced by the people around me.)

Enhancing history-taking confidence and empathy through student-created simulated patients: a pilot study

Timothy P. Williams

Office of Medical English Education, Nihon University School of Medicine

Abstract

This pilot study explores the use of student-created simulated patients (SCSPs) as a pedagogical tool to enhance confidence, communication, and empathy in a second-year English-based history-taking course at Nihon University School of Medicine. Traditional simulated patient (SP) programs face logistical and financial limitations, particularly for large cohorts. In contrast, the SCSP approach enables students to develop and role play their own detailed patient profiles in peer-based simulations. Over six weekly sessions, 120 students participated in structured listening, role play, and targeted feedback activities. Pre- and post-course survey data showed marked improvement in self-rated confidence (from 2.49 to 3.85 on a five-point scale) and strong agreement that SCSPs improved communication (87%) and empathy (over 80%). Qualitative analysis of open-ended responses revealed that students valued the realism, autonomy, and insight gained through creating and portraying patients. Most feedback was positive (80%), with 15% neutral and only 5% negative. These findings suggest that SCSPs offer a flexible, low-cost, and scalable alternative to actor-based SPs, while fostering essential clinical competencies in a supportive, peer-driven environment. The approach aligns with constructivist principles and is particularly effective for promoting patient-centered communication and psychosocial awareness in second-language medical settings.

J Med Eng Educ (2025) 24 (3): 41-45

Keywords simulated patients, history-taking, empathy, communication skills, patient-centered care, peer role-play

1. Introduction

Simulated patients (SPs) have long been a cornerstone of medical education, offering students the opportunity to develop interviewing and clinical reasoning skills in a safe, controlled environment.[1] However, traditional SP programs face significant limitations. Hiring and training actors is costly,[2, 4] scheduling can be logistically challenging, and the one-off nature of many encounters limits continuity.[1, 4] Additionally, students often encounter a narrow range of cases that do not adequately reflect the psychosocial complexities of real-life patient care.[4] For students working in a second language, unfamiliar SPs can also increase anxiety and hinder performance.[5]

This paper reports on a pilot study conducted at Nihon University School of Medicine to explore a low-cost, high-engagement alternative: student-created simulated patients (SCSPs). As part of a required 6-week English-based History Taking course for second-year students, 120 participants designed and acted their own student-created simulated patients. The course was structured around small-group sessions (approximately 16 students each) and included guided listening tasks, structured interviews, and peer-based role plays.

The study aimed to assess the value of the SCSP approach by focusing on three areas of development:

1. Confidence in conducting patient interviews
2. Communication skills in English
3. Empathetic engagement and awareness of psychosocial factors

A combination of pre- and post-course surveys, Likert scale data, and open-ended reflections was used to evaluate the impact of the SCSP model on these learning outcomes.

● **Corresponding author:**

Timothy Williams

Assistant Professor, Nihon University School of Medicine, Office of Medical English Education

30-1 Oyaguchikamicho, Itabashi-ku, Tokyo, 173-8610 Japan

TEL: 090-1203-1970

E-mail: williams.timothy@nihon-u.ac.jp

2. Methods

The study was conducted over six weeks at Nihon University School of Medicine as part of a required, English-based History Taking course for second-year students. A

total of 120 students participated, divided into small groups of around 16. Each group attended one 90-minute session per week. The course aimed to build confidence, develop communication skills, and deepen empathy, particularly in relation to the psychosocial dimensions of patient care.

We asked students to create their own, original, highly detailed Simulated Patient (SP) profiles, which they would use during every session of the six-week course. Each student had full creative control and was encouraged to design their SP from the ground up. While they were required to identify a clear presenting complaint, onset, and symptom profile, they were also encouraged to think beyond the usual demographic and lifestyle information. Students were prompted to consider more granular aspects of their patient's background and daily life, such as family dynamics, work stress, financial pressures, mental health, and religious beliefs. This approach gave students the freedom to build a rich, plausible patient narrative, while encouraging attention to psychosocial detail.

To guide this process, students completed a structured Simulated Patient Profile form. This comprehensive template helped ensure that each SP was internally consistent, clinically credible, and usable across all six sessions. The form was built around the four-frame structure used throughout the course: (1) Presenting Complaint and History of Presenting Complaint (PC/HPC), (2) Past Medical History (PMH), (3) Social and Family History, and (4) Ideas, Concerns, and Expectations (ICE). The same four-frame structure was used for the patient note sheet completed by student-doctors during their simulated consultations. This alignment made it easier for both student-patient and student-doctor to conduct a structured 6-9-minute history-taking interaction that covered not just symptoms, but social and emotional context as well.

In addition to core biographical data (e.g. age, gender, occupation), the SP Profile form included fields for lifestyle habits (diet, alcohol and tobacco use, exercise), psychosocial stressors (family dynamics, sleep quality, sources of stress), and health-related behaviors (medication, dental health, mental health history). It also encouraged students to develop their patient's voice and worldview, what they believed was wrong, what they were afraid of, and what they hoped the doctor could do to help. This structure ensured that even students with limited clinical knowledge could build convincing, nuanced characters that reflected the complexity of real-world consultations.

Students submitted their completed SP profiles during the first week. These were reviewed for coherence and medical plausibility, and written feedback was provided. Students then made any necessary revisions and were ready to begin using their SPs from the second session onward.

Each 90-minute class session followed a consistent structure: a model consultation was presented using four-frame doctor–patient dialogues voiced by AI text-to-speech,

followed by note-taking practice using the same four-frame template and a role-play read-through of the dialogue transcripts. The listening tasks provided exposure to natural consultation language and helped students internalize both structure and tone. After the initial listening and role-play read through, students moved straight into role-play pairs, one student in the role of doctor and one acting as the SP using their own SCSP, they then swapped roles. New pairings could be made as necessary to ensure that students experience the maximum variety of SPs. Students were instructed to keep their role consistent during the interview, making sure their answers were believable and coherent, and asked to stay in character throughout the role play.

Because students used the same simulated patient profile in every session throughout the course, they developed familiarity and confidence in portraying the character they had created. Over the course of a few weeks, students tended to rely less on their profile sheet and engage in more natural, nuanced interactions, adding detail to their SCSP as needed.

Assessment was designed to reflect the dual emphasis of the course: communication skills and the creation of realistic, pedagogically useful SP characters. The evaluation criteria were as follows:

- Classwork and participation: 25%
- Doctor video (student conducting a history-taking interview): 25%
- SP video (student acting as their self-created patient): 20%
- SP profile (submitted in week 1): 20%
- Patient notes (from final consultation): 10%

For the final assignment, students submitted three items: a video of themselves acting as the patient, a video of themselves conducting the interview as the doctor, and the written patient notes taken during the final history. These submissions were evaluated by the course instructor using standardized rubrics that focused on clarity, structure, depth of information, and communicative effectiveness. The SP profile itself was graded based on coherence, creativity, medical plausibility, and psychosocial insight.

Importantly, assigning substantial weight to the SP video and profile (40% combined) motivated students to invest in the quality and internal consistency of their simulated characters. This resulted in a wide range of creative and well-developed SPs, many of which included rich backstories, varied cultural backgrounds, nuanced social challenges, and believable emotional responses. Most student-generated SPs were complex and authentic, with many demonstrating strong narrative coherence, contextual awareness, and clinical credibility.

One of the key benefits of this approach was that it allowed students to explore both sides of the consultation. By switching roles, students gained first-hand insight into what it feels like to be a patient - uncertain, vulnerable, and dependent on the doctor's listening and communication

skills. This dual perspective supported deeper empathy and shifted the focus from simply extracting medical information to understanding the patient's lived experience.

In terms of workload and feasibility, the SCSP model proved sustainable even with large student numbers. All 120 students created their own SPs, submitted profiles, and produced videos. Because each student managed their own case, there was no need for external actors or elaborate scheduling. Feedback could be targeted and specific, and the model offered a high level of engagement at minimal cost.

To assess outcomes, students completed pre- and post-course surveys. These included Likert-scale questions on self-rated confidence, communication skills, and empathy. Students also responded to open-ended reflection prompts which provided additional qualitative feedback. This combination of quantitative and qualitative data provided a broad picture of the SCSP model's impact on students' learning, confidence, and professional development.

3. Results

Quantitative data revealed significant gains in confidence. On a five-point scale, students rated their confidence in history-taking at 2.49 before the course and 3.85 after (**Figure 1**).

Communication skills also showed strong improvement: 87% of students rated the impact of SP role play on their communication skills as 4 or 5 out of 5. In terms of empathy, 83% of students agreed that creating a detailed SP helped them better understand the patient perspective. Likewise, 85% agreed it helped them understand the process of history-taking more deeply.

Qualitative responses supported these gains. Students reported feeling more engaged and prepared. Feedback themes included greater confidence, deeper empathy, and

Figure 1.   Increase in response to the survey question: "How confident are you in your ability to conduct a detailed patient history interview?"

improved fluency. Overall, feedback was 80% positive, 15% neutral, and 5% negative. The most common theme in the negative comments related primarily to the short duration of the course and the limited opportunities for practice and feedback.

A thematic analysis of open-ended reflections on their experiences with the SCSP approach revealed three key areas of impact: empathy and perspective-taking, clinical and communicative competence, and narrative construction. These themes reflect not only the technical skills gained, but also the personal and professional growth students experienced through repeated role play and self-created patient narratives.

3.1 Empathy and perspective-taking

Many students expressed a growing awareness of the emotional and human dimensions of patient care. Creating and enacting their own simulated patients encouraged them to consider how illness affects individuals' lives, and how doctors' words and manner can influence patient comfort and trust. These themes emerged clearly in students' open-ended reflections, which highlight how the SCSP experience deepened their understanding of empathy and the human aspects of clinical encounters:

"*Now I think more about what the patient is feeling, not just what symptoms they have.*"

"*During one session, the simulated patient displayed unexpected emotional distress. This taught me the importance of adapting my approach and using empathy to build trust.*"

"*I now see that truly listening and responding with empathy makes patients feel heard and respected.*"

These comments reflect an emerging shift in students' attitudes, from seeing the patient as a source of clinical data to engaging with the patient as a person.

3.2 Building clinical and communicative competence

Students reported that repeated practice and variation in case scenarios helped build fluency, confidence, and flexibility in history-taking.

"*Repeating simulated scenarios multiple times made me more confident and natural in my questioning.*"

"*Practicing with different scenarios improved my ability to adapt to unexpected patient responses.*"

"*I feel more confident in building rapport, asking open-ended questions, and managing the flow of the conversation effectively.*"

These reflections indicate that students were not only gaining familiarity with clinical English but also developing practical strategies to manage real-time interactions.

3.3 Constructing and applying medical narratives

Creating detailed patient profiles helped students understand how various elements of a patient's life story interconnect and influence their health. Some described
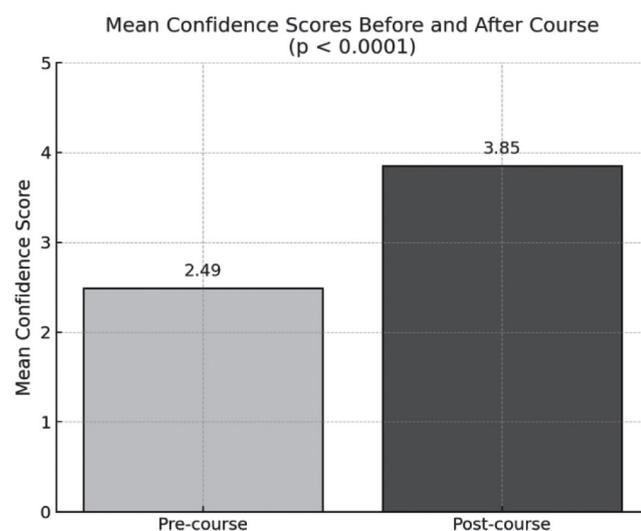
how the process of acting as their SP revealed gaps or new connections in their own thinking.

"*Developing profiles for my own fictional patients taught me how to construct a complete patient history.*"

"*There was a patient with difficulty sleeping. By asking about his lifestyle and stress, the trigger for his symptoms was discovered.*"

"*During a simulated patient exercise, I uncovered underlying stress and poor nutrition in a patient with vague symptoms of fatigue and weight loss through empathetic questioning and active listening. This experience underscored the importance of thorough, patient-centered history-taking.*"

These examples suggest that students were not only learning how to ask questions, but also how to listen for context, link symptoms to psychosocial factors, and think like clinicians.

4. Discussion

This study demonstrates that the SCSP approach can successfully replicate many of the benefits of traditional SP programs while minimizing cost and logistical barriers. Students embraced the opportunity to take creative ownership of patient characters, which appeared to drive motivation, engagement, and reflective thinking.[5] The consistent practice with a familiar peer role increased confidence and authenticity.

Switching between roles gave students valuable insight into both patient and healthcare provider perspectives, supporting the development of empathy. Students became more responsive and emotionally attuned, particularly when engaging in more complex psychosocial conversations. Many reported beginning to see patient interviews not as a checklist of questions but as human interactions built on trust and understanding.

The structured yet flexible course design also contributed to its effectiveness. Listening activities, note-taking, and repeated role play helped students internalize both content and structure. Peer accountability created a supportive but motivating learning environment.

Compared to traditional SP programs, SCSPs offer multiple practical advantages. They eliminate the cost of hiring and scheduling actors, allow for continuity across sessions, and scale easily for large cohorts. Importantly, they also empower students to personalize and contextualize their learning.

In this study, consistent role-play practice contributed to growing autonomy and fluency. Students gradually abandoned their script and profile notes, responding more spontaneously and confidently. This shift toward natural dialogue is critical for future clinical encounters.

Furthermore, the SCSP format promoted perspective-taking and independent thinking. As students crafted unique profiles, they had to make diagnostic decisions and reflect on

the interplay between medical and psychosocial issues. This aligns with broader educational goals of holistic, patient-centered care.

5. Limitations and future research

Limitations of this study include its relatively short duration (six weeks) and reliance on self-report measures. While Likert-scale responses and open comments offer useful insights, future iterations would benefit from triangulation with objective performance measures, such as structured clinical exams or faculty ratings.

This pilot study will also form the basis for an ongoing research project at Nihon University School of Medicine. The expanded study will include a broader dataset, refined survey instruments, and independent faculty evaluations. Its aim is to produce generalizable findings on the long-term impact of SCSP-based training on communication competency, confidence, and clinical empathy in multilingual and multicultural medical education environments.

Another avenue would be to compare SCSP outcomes with those from traditional SP programs or standardized case materials. Such comparative work would help delineate where and how SCSPs are most effective.

6. Conclusion

Student-created simulated patients represent a scalable, low-cost innovation with substantial pedagogical value. By involving students in the creation and performance of patient roles, this model supports communication skills, confidence, and empathy in meaningful, practical ways. Results suggest that SCSPs are a promising supplement, or even alternative to, traditional actor-based simulations, especially in resource-limited or language-learning contexts.

Given the increasing importance of patient-centered, culturally sensitive care, the SCSP approach helps students develop not only clinical interviewing skills but also the insight needed to treat the whole person. In particular, it offers a concrete and engaging way for first- and second-year medical students to begin understanding the role that social determinants of health, such as unstable housing, financial insecurity, caregiving burdens, limited access to nutritious food, social isolation, and work-related stress, play in shaping patient behaviors and health outcomes. Future work may explore adaptation across specialties, expanded case variety, and longitudinal follow-up to assess long-term retention.

As medical education continues to place greater emphasis on patient-centered care and communication, approaches that promote empathy, perspective-taking, and psychosocial awareness are increasingly valuable. The SCSP framework provides a practical and adaptable way to help students develop these skills in a structured,

low-cost setting. By involving students in the creation and performance of patient roles, the approach supports meaningful engagement with the human aspects of clinical practice.

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久留米大学における国際医学交流の現状と将来展望

Trends and prospects of international medical exchange at Kurume University School of Medicine

溝口恵美子
久留米大学医学部免疫学講座国際医学交流部門

Emiko Mizoguchi

Department of Immunology, International Affairs Division in Medicine, Kurume University School of Medicine

要約

本稿では，久留米大学医学部における国際医学交流の現状とその将来展望について紹介する。著者の24年間にわたる米国での研究・教育経験を基に，国際医学交流部門の設立，多くの大学との協定，ならびに海外研修生の本学への受け入れ増加について簡潔に述べる。短期語学研修，RMCP（研究マインド育成プログラム），HMEP（ハワイ医学教育プログラム）など多様な取り組みを取り上げる。近年はアジア諸国に加え，ヨーロッパやオーストラリアからの応募が急増しており，質の高い支援体制の維持が今後の重要課題となっている。地方都市に位置しながらも，安定した学術提携と体系的な医学教育により，久留米大学は国際的な存在感を高めつつある。今後の課題としては，受け入れ講座・部門の拡大，留学生受け入れインフラの整備，そして国際的に通用する医療人の育成が挙げられる。

Abstract

The presentation outlines the current status and future prospects of international medical exchange at Kurume University School of Medicine（KUSM）. Drawing from the author's 24-year academic and research experience in the US, the report highlights the establishment of the Division of International Medical Exchange, MOU with many universities, and the increasing number of international trainees. Programs such as short-term English study in Canada, the Research Mind Cultivation Program（RMCP）, and Hawaii Medical Education Program（HMAP）are discussed concisely. In recent years, applications from Europe, Asia, and Australia have increased sharply, and maintaining a high-quality, well-supported exchange system has become essential. KUSM, while located in a regional city, is enhancing global visibility through stable academic partnerships and structured medical education. The report concludes with future challenges, including expanding the acceptance capacity, improving infrastructure for visiting students, and nurturing globally competent medical professionals.

J Med Eng Educ (2025) 24 (3): 46-49

Keywords international exchange, overseas clinical training, medical school agreement, RMCP, Kurume University

1. はじめに

　急速にグローバル化が進む現代医療において，医学教育・研究における国際交流は，医学的視野の拡大，異文化の理解，そして多様な価値観を持つ医療人の育成という面で今や不可欠な要素となっている。本稿では，久留米大学医学部医学科における国際医学交流の取り組みを，著者自身の四半世紀にわたる米国留学経験を踏まえながら紹介し，今後の展望について考察する。

2. 著者の留学経験と国際的視野の醸成

　著者は，1990年に久留米大学医学部医学科を卒業後，大学院博士過程在学中の1992年より米国ハーバード大学医学部附属マサチューセッツ総合病院（Massachusetts General Hospital）にて留学を開始した。病理学講座および内科学講座において基礎研究と教育に従事し，2006年には

● Corresponding author:
溝口恵美子
久留米大学医学部免疫学講座国際医学交流部門
〒830-0011 福岡県久留米市旭町67
TEL: 0942-31-7551 FAX: 0942-31-7699
E-mail: emizoguchi@med.kurume-u.ac.jp

Assistant Professor として独立した研究室を持つに至った。

その間に著者が雇用・指導した研究者は 27 名にのぼり，出身国は 16 ヵ国に及ぶ。研究室は常に多国籍な研究者で運営され，多様な背景を持つ仲間との協働を通じて，文化的感受性，科学的な柔軟性，国際的なネットワーク構築力が養われた。この四半世紀にわたる経験は，後述するように，著者が帰国後に久留米大学で推進している国際医学交流の大きな原動力となっている。

3. 久留米大学における国際交流の枠組み

久留米大学では，全学的な国際化の推進を目的に，2002 年，御井学舎に「国際交流センター」が設立された。このセンターは大学全体の海外協定校の拡充，交換留学制度の整備，外国人留学生の支援，日本人学生の語学・文化研修など，多岐にわたる業務を担っており，現在では 19 ヵ国 42 校と大学間協定を結んでいる。これにより，大学内の学部・研究科を問わずに国際交流が可能な体制が整備されつつある。

一方，医学部においては，全学的な枠組みに加えて，より専門性と即応性の高い独自の国際交流体制が求められていた。また，米国ブラウン大学や韓国建陽大学との実質的な医学部間交流が開始されたことを背景に，2018 年，本学医学教育研究センター内に独自の「国際医学交流部門」が新規に創設された。この部門は，医学部に特化した国際連携，教育・研究交流の企画・実施，各講座との調整役を担い，医学科の国際交流の中核的存在として機能している。設立当初は，免疫学講座主任教授の溝口充志先生が部門長を務め，2022 年より著者がその職務を引き継いでいる。

さらに本学では，医学生による JIMSA（Japan International Medical-ESS Students' Association）のクラブ活動も盛んである。JIMSA 部メンバーは，来日留学生に対して英語によるキャンパス案内や日本文化紹介，生活面でのサポートなどを通じて，彼/彼女らにとっての同士や相棒のような存在として機能しており，実際に国際的学生間交流の輪が広がるきっかけとなっている。著者が JIMSA 部の部長を務めているため，留学生の研修期間などの情報をいち早く部員に伝えることができ，学生間の円滑なコミュニケーションの一助となっている。

このように，久留米大学医学部における国際交流の枠組みは，継続的かつ発展的に構築されている。今後の課題としては，全学と医学部との協働を更に進化させ，教育・研究・臨床全ての側面において真にグローバルな医学部を目指すための基盤整備を加速していく必要があると考えている。

4. ブラウン大学との学術協定と学生間交流

著者が 2008 年より医学部免疫学講座の研究者と共同研究を進めているブラウン大学とは，2018 年 1 月に大学間協定を締結した。以降，毎年 1 名の本学医学科 3 年生が基礎研究を行う RMCP の期間内（5 週間）にブラウン大学消化器内科学・分子生物学・免疫学の講座で生命科学的な実験に携わってきた。本年度からは，かねてからの悲願であった臨床実習生が最長 4 週間の短期留学を行う制度（毎年 4 名まで）も開始された。同大学で臨床研修が許可されている日本の大学は，京都大学，東京女子医科大学に続き久留米大学が 3 校目となり名誉なことである。

現在までに派遣された久留米大学生は 4 名，受け入れたブラウン大学生は 5 名にのぼる。対面交流のほか，コロナ禍ではオンライン講義やディスカッションによる連携も行われた。このプログラムの特徴は，英語力に加え「自由度の高い，受け入れ側・送り出し側の相互理解」に重点を置いている点であり，単なる研修にとどまらず，医学生間の信頼関係構築の契機となっている。

5. 久留米大学が海外から選ばれる理由と現状

2022 年以降，継続して海外から久留米大学医学部に留学生を受け入れており，ここ 2 年は臨床研修希望者が急増している。2024 年度には 72 名，2025 年度には 103 名の応募があり，受入数はそれぞれ 15 名（21%），13 名（12.6%）である。

国際医学交流部門を創設以来，主な受け入れ国は**図 1**に示すように，アジア（台湾・韓国など），ヨーロッパ（ドイツ，オーストリア，フランスなど），オセアニア（オーストラリア），北米である。受け入れ基準は，免疫関連書類（Immunization Form）の提出状況，協定校か否か，英語力，世界ランキングなどが含まれる。本学が研修先として選ばれている主な理由を**表 1**に示す。今後は受け入れ率をさらに向上させるため，指導体制の強化・多施設連携・奨学金の拡充が求められる。

6. 語学・研究留学プログラムの展開

本学医学科では，低学年の段階から国際マインドを養う取り組みも行われている。

第 2 学年では，カナダ・ビクトリア大学で夏休みを利用して，3 週間の語学研修を行っている。寮滞在・食費込みで参加費用は高額に及ぶが，4 名までは大学の基金を利用して

国際医学交流部門が設立されて以降,久留米大学医学科が受け入れた留学生の出身国を示している。
アジア,ヨーロッパ,北米,オセアニア,中東など世界各地から多くの学生を受け入れていること
がわかる。

図 1. 久留米大学医学科における受け入れた留学生の出身国(2018 年以降)

表 1. 久留米大学医学部で海外からの研修生が増加している理由

主な理由	説明
1. Web Application System	検索エンジン上位表示と,ワンクリックで留学応募できるシステムを構築している
2. 国際交流センターの存在	御井学舎国際交流センター(学生課)のスタッフによる迅速できめ細やかな対応
3. ガレノス久留米	徒歩圏内にある学生寮・ホテル「ガレノス久留米」の宿泊施設(朝食・夕食付)
4. 交通の利便性	新幹線,西鉄電車や空港連絡バスなどアクセスの良さ
5. 指導体制の充実	熱意ある指導医と学生との積極的な交流
6. 通年受入れ体制	通年で受け入れ可能なフレキシブル制度設計

旅費の一部を補助する制度を実施している。これまで 5 名の学生がこのプログラムに参加している。

また,第 2 学年では,RMCP という 5 週間の基礎研究に従事するプログラムを通じて,国内・海外の研究室での研修が可能である。毎年 10 名程度の学生が海外での基礎研究に従事しており,2024 年には,米国のブラウン大学,チューレン大学,ドイツのミュンヘン大学,イギリスのケンブリッジ大学,オーストラリアのモナーシュ大学などへ派遣実績がある。今後も学内の講座を通じて留学先を拡大していく予定である。

このように,段階的かつ柔軟な留学プログラムを準備することで,学生が自らの志向に応じて国際経験を積む機会を提供している。日本では今後ますます国際化が進むことが予測され,この環境の変化に適合するための医学英語力および国際力強化という面でも貴重な経験と考えている。

7. 卒業後のキャリアと今後の展望

本学は,2021 年に一般社団法人日本医学教育評価機構(JACME)による厳格な医学教育分野別評価を受審し,国際的評価基準に適合している大学と認定された。よって,本学卒業生は USMLE 受験資格を持ち,米国での臨床研修が可能である。昨年は,在学中に USMLE Step 1 に合格した学生が 1 名,また今年に入って Step 2 に合格した医師も 2 名現れ,グローバルキャリアも選択肢の一つに入ってきている。事実,医学英語の授業中に筆者が実施したアンケートでは,医学科 2 ~ 4 年生のうち実に約 6 割の学生が将来的に留学を希望し,また約 2 割の学生が USMLE の受験を考えており,確実に国際的な視野が本学学生の間に広がりつつある。

また,2024 年より,ハワイ大学医学部との提携により HMEP(Hawaii Medical Education Program)が再開され,このプログラム責任者である町淳二先生の全面的なご協力で,オンラインによる現地実習を組み合わせた米国式医学教育を体験することが可能になった。今春に,医学科 4 年の 2 名が現地での臨床研修に参加している。

今後の改善点としては,①より多くの講座・診療科による研修への協力強化,②海外からの留学生に対応できるような医学英語教育の充実,③海外研修中の学生サポート体制の充実,④大学全体で「国際的な医療人」を育成していく自覚の必要性などが挙げられる。

8. おわりに

　久留米大学は福岡県筑後地区という地方都市にありながらも，明確なビジョンと熱意ある教職員および学生のたゆまぬ努力により，国際医学交流の先進的なモデルを築きつつある。他者とのネットワークを大切にしながら，今後も継続的に世界とのつながりを深めることで，世界へと発信していく所存である。

異文化理解と医療福祉分野における国際交流

Cross-cultural understanding and international exchange in the field of medical welfare

加藤　明子
福岡国際医療福祉大学診療放射線学科

Akiko Kato
Fukuoka International University of Health and Welfare, Department of Radiological Sciences

要約

一般的な「国際交流」は外国の文化や言語を学び，自国の文化を対外的な角度から再考察することで，その文化を再確認し，視野を広げることを目的とする。福岡国際医療福祉大学では，この目的の他，海外の医療文化を学び，医療知識の幅を広げるために，海外研修を行う。同様な目的で，海外研修の送り出しだけでなく，海外の大学からも研修生を受け入れている。毎年韓国のコニャン大学から学生や教員が，日本の医療文化や伝統文化を学びに来日する。プログラム内容は病院見学から医療分野の講義，日本文化の体験など多岐にわたる。また学科独自のプログラムや異文化交流のワークショップで，学生交流を行う。外国の文化や医療制度を学ぶことで，グローバル社会において必要な「国際医療」に適応する力を養うことができるようプログラムを構成した。「国際医療」に不可欠な異文化を学ぶため，プログラムの目的を明確にし，その内容や特色，運営上の留意点について考察する。

Abstract

In general, "international exchange" aims to reaffirm and broaden one's horizons by learning foreign cultures and languages, reconsidering one's own culture from an external perspective. In addition to this purpose, Fukuoka International University of Health and Welfare conducts overseas training to learn about overseas medical culture and broaden the range of medical knowledge. For the same purpose, we not only send students abroad for training, but also accept trainees from overseas universities. Every year, students and faculty members from Konyang University in South Korea come to Japan to learn about Japan's medical care and traditional culture. The program covers a wide range of topics, from hospital tours to lectures in the medical field and experiences with Japan culture. In addition, students engage in cross-cultural exchange through the department's own programs exchange workshops. By studying foreign cultures and medical systems, students can develop the ability to adapt to "international medicine" in a global society. In order to enable students to learn about the different cultures essential for "international medicine", this paper clarifies the purpose of the program and presents its specific contents, characteristics, and operational considerations.

J Med Eng Educ (2025) 24 (3): 50-53

Keywords　cross-cultural understanding, international medical care, international communication, cross-cultural experience, international student exchange, medical English education

1．背　　景

福岡国際医療福祉大学では2年時の必修科目「海外保健福祉事情」で，姉妹校である国際医療福祉大学とともに，海外の医療や保健事情，コミュニケーションの方法などを講義で学んだ後，2週間ほど韓国やオーストラリア，シンガポールなど17か国での海外研修に参加する。[1] 研修先は大学の医療系学部で，講義を聴講するだけでなく，現地の病院や福祉施設で見学や実習を行い，現地学生との交流を通してコミュニケーション能力を養う。また，学生を海外研修に送り出すだけでなく，海外からも同様に学生を受け

● **Corresponding author:**

加藤　明子
福岡国際医療福祉大学
〒814-0001 福岡県福岡市早良区百道浜 3-6-40
TEL: 092-832-1200
E-mail: akikokato@ihwg.jp

入れている。韓国のコニャン大学から，理学療法学科，作業療法学科，メガネ工学科，放射線学科の学生や教員を，2023 年度には 40 名，[2] 2024 年度には 51 名，[3] 10 日間ほど受け入れた。このように海外研修の送り出しから受入れまで，全学で取り組む海外研修は，福岡国際医療福祉大学の特徴的なプログラムであり，その背景には，「国際性を目指した大学」「国際的視野を持った医療人材の育成」という教育理念がある。[4]

2. 目　　的

　海外研修の目的として，国際交流を通して外国の文化や言語などを学ぶことで，自国の文化を新たな視点で見直し，自己理解を深めることができる。また，異文化を理解することで視野が広がり，さまざまな分野での適応力や対応力を養うことができる。福岡国際医療福祉大学では，これらの目的に加え，海外の医療文化を学び「国際医療」の知識を広げるために海外研修を実施する。海外研修を通して異文化に対する理解を深めることで，他者と協働する力を養い，急速に変化するグローバル社会に柔軟に対応しながら「国際医療」の現場で活躍できる人材を育成することがねらいである。このような海外研修の送り出しと同じ目的を，そのままコニャン大学の受け入れプログラムにも生かしながら，「日本の医療文化」と「日本文化」の双方を体得できるプログラムを構築した。

3. 概　　要

　研修の始めにオリエンテーションを行い，大学の基本理念や歴史，プログラムの概要やホテルでの注意事項等を説明した。また，大学案内図で近隣設備を示しながら，研修期間中の生活に困らないよう配慮した。プログラム内容は病院見学から医療分野の講義，日本文化の紹介や観光案内まで多岐にわたる。学生交流を主体とした，学科独自のプログラムでは医療機器の実習をしたり，グループで文化施設などを訪れ，フィールドワークを行ったりした。また医療分野の講義や日本文化の体験を提供するだけでなく，コニャン大学の学生も，スライドを用いて韓国文化について発表したり，伝統的な遊びを披露したりなどし，本学の学生と一緒に体験する機会が得られた。最後に修了式とフェアウェルパーティーを開催し，学生間の交流だけでなく，教員の間でも研究に関して情報交換を行うことができた。

　研修プログラムは，主に 3 つの部分「日本の伝統文化体験」「医療分野の講義と病院見学」「学生交流―学科体験，フィールドワーク」から構成され，具体的な内容は**表 1** のとおりである。

　プログラムでは，日本の伝統文化をはじめとする異文化体験を重視し，コメディカル分野における医療知識を深め，日本の医療文化や慣習を体系的に学べる機会をプログラムに盛り込んだ。その他，事前の調査から「学生交流を望む」という要望がコニャン大学の事務局を通して伝えられていたので，学生交流の時間を多く確保するよう努めた。

表 1．研修プログラム

研修プログラム	活動	内容
日本の伝統文化体験	講義「日本の文化」	福岡の歴史と観光（九州国立博物館，大宰府，福岡タワーなど）
	着物体験	着物の柄や着方の説明
	茶道体験	茶道の歴史や作法，主菓子や抹茶の説明
	日本庭園散策	日本庭園の特徴や造作の意味について
医療分野の講義と病院見学	医療分野の講義	学科長による講義― PT（理学療法），OT（作業療法），ST（言語聴覚），RT（診療放射線），CO（視能訓練），NS（看護） 韓国人講師による日韓比較―公衆衛生
	病院見学	福岡山王病院の特色と概要 病院見学―リハビリテーション，放射線エリア，病室など ワークショップ―着物の端切れを用いたパスポートケース作り（見学の待ち時間を利用）
学生交流―学科体験，フィールドワーク	3D 解剖台実習（理学療法学科）	3D 解剖台を使った身体構造の理解
	国家試験クイズ（診療放射線学科）	日韓の国家試験にまつわる問題をクイズ形式で振り返り，放射線分野における日韓の比較と専門知識の増強
	視能検査機器実習（視能訓練学科）	視能検査の基本的な機器操作
	異文化交流ワークショップ	食文化・若者文化・歴史などをテーマにフィールドワークし，PowerPoint でグループ発表

表2. 研修プログラムの比較

比較項目	長期留学 （専門知識・研究テーマあり）	短期研修 （異文化体験重視）
研修期間	数か月～数年規模の長期	数日～数週間規模の短期
研修生の背景	すでに専門知識と研究テーマを有し，研究成果の達成を目指す	言語や習慣の異なる環境で，多様な価値観に触れて異文化体験を志向
受け入れ機関の対応	研修生の要望・研究計画を的確に把握し，必要な情報，設備，人的ネットワークなどのリソースを提供	文化交流やフィールドワークを通じて，異文化体験の機会を提供
主な目的・成果	研究課題への集中と最大限の研究成果を創出	グローバル社会で求められる異文化適応力の養成と，国際的な視野を持つ人材の育成

4．受け入れ体制

　海外研修を受け入れるには，一般的に大きく分けて主に2つの形態があると考えられる。[5] 長期留学にみられる，研修生が専門知識と研究テーマをすでに備えている場合と，短期留学に特徴的な異文化体験を重視する場合である。研修プログラムの比較を**表2**のようにまとめた。

　研修生は2年生がほとんどで，医療系の専門科目を十分に履修しておらず，特定の研究に対する意識をまだ持ち合わせていないことが想定された。その上研修期間も10日間と短く，時間をかけて研究課題を探求することが難しいため，日本の伝統文化や医療文化を学ぶことを目的とした異文化体験型プログラムを提供した。また将来医療従事者になることを目指しているため，日本の医療文化を知ることで，「国際医療」の意識を高めることができるよう心がけた。国際化とは，制度や慣習，言語，文化などが異なる国や地域，人々が互いの違いを認め，尊重し合う相互理解が前提となる。[6] 異文化間の相互理解を深めるためには，交流や体験を通じて多様性を認識することが求められる。こうした異文化理解は「国際医療」の現場でも欠かせない要素であり，「多様な文化背景をもつ人々の生活の支援に必要な能力を理解できる」[7] ことが求められる。

　国によって言語や宗教，文化が異なり，実際の医療現場では，患者一人一人の背景を理解し，「相手の文化を尊重する」姿勢が求められる。異文化を学ぶことによって，多様な価値観を受け入れる力を育み，それをコミュニケーションの方法に生かして工夫していくことが重要である。

5．考　　察

　異文化理解は，自国の文化と他文化を比較し，その差異を認識していく過程で，自国の文化や知識をもとに異文化を解釈する行為である。異文化間にまたがる「ずれ（shift）」を解明するには，その「ずれ」を生み出す文化的な差異を理解することが不可欠である。[8] また異文化を理解することは，自国の文化や知識に照らし合わせて，自分のことばで翻訳や解釈をし，理解する行為である。異文化交流の過程で，「ずれ（shift）」や「間違い（error）」「主体的な解釈（subjective interpretation）」は常に存在する。[9] 異文化間での相互理解が進まないと，「間違い」が多くなり，「主体的な解釈」によるコミュニケーションの「ずれ」が生じる。このような「ずれ」をなくす方法の一つとして異文化理解を充実させることが求められる。

　異文化理解を深めるためには言語的な知識はもとより，何を心がけ，どのようなトレーニングが必要なのだろうか。「異文化間トレーニング」とは，「自分の文化の境界を越えて多文化の人と円滑にコミュニケーションをするための能力を養うプログラム」で，主に以下の3つの目標が掲げられている。

1. 考え方の受容（認知レベル）：文化的な背景が異なる他者をステレオタイプで判断せず，他の文化の視点で理解できるようになる。自文化についてより深く理解できるようになり，どの文化にでも対応できる柔軟な考え方が身につく。
2. 感じ方の受容（感情レベル）：文化的な背景が異なる他者と関わることに喜びを感じ，円滑に職務を遂行していると満足できる。
3. 行動の変容（行動レベル）：文化的な背景が異なる他者とより良い人間関係を構築し，具体的な目標を設定して遂行できるようになる。[10]

　10日間ほどの短い研修期間ではあるが，相手の「考え方」や「感じ方」を受け入れ，それを「行動」に移すことができるよう目標を設定し，プログラム内容を調整した。「考え方の受容」では，学生交流をすることで相手を固定的なイメージで判断せず，相手を「知る」ことの重要性を認識してもらった。また日本の伝統文化を体験することで異文化の視点から物事を理解できるよう努めた。「感じ方の受容」では，異文化交流を前向きにとらえることができるよう，

異文化体験の内容（着付け体験，茶道体験など）や学生交流のテーマ（学科体験プログラムやフィールドワークなど）を魅力的なものにするため，先生方をはじめ事務方や業者の人々とも協議を重ねた。結果的に「行動の変容」レベルで，異なる文化背景を持つ本学の学生と良好な関係を築き，異文化コミュニケーションが促されるよう心がけた。このような異文化理解は，グローバル社会で医療職を志す者にとって必要な能力であるだけでなく，「国際医療」の現場でも重要な役割を果たすことが考えられる。

6. 課　　題

　病院見学や医療分野の講義を通じて，日本の医療文化の見聞を広めるだけでなく，異文化体験をすることで，日本文化の知識を得られるようプログラム内容を工夫したが，それ以外の面で課題も残った。コニャン大学の渡航希望日と本学の試験期間が重なったため，学生交流の時間を確保するのに，多くの調整が必要になった。今後もコニャン大学の学生が，さまざまな体験をすることで，日本の医療体制を学び，日本文化の知識を広め，「考え方の受容」「感じ方の受容」「行動の変容」を直に体得し，効果的にコミュニケーション能力を養うことができるようなプログラムにしていきたい。また，学生交流の時間を増やすとともに，異文化理解がさらに促進できるよう内容を充実させ，問題点や課題などを常に意識しながら，それらをプログラムの構成に生かしていきたい。

7. 結　　論

　「文化的経験の幅を広げる」ことで，自文化と異文化を対比させ，異質性を認識することが多様性の認識へつながる。[11] 今後も異文化コミュニケーションや異文化理解を通して，日本の文化や医療に関する知識を深めることができるよう，より充実した研修内容を構築できるよう工夫してい

く。また「国際医療」の高まりの背景には，在留外国人の増加やインバウンド医療，医療ツーリズムの影響などが考えられる。「国際医療」の役割の一つとして，文化や価値観の違いを尊重しながら，外国人患者の診療や，多文化背景を持つ人々の健康支援が求められる。外国人患者の多文化を意識し，異文化コミュニケーションを円滑に行うことが，今後の医療現場でも求められている。他国の医療文化，医療知識，医療技術について知識を深め，グローバル社会に求められる「国際医療」に貢献できるような人材を育むことができるよう，海外研修プログラムの充実を目指していきたい。

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Balancing language and content in a pre-departure training course for an international clinical elective programme

James Hobbs[1] and Ying Foo[2]

[1] Foreign Languages, School of Medicine (Hiyoshi), Keio University
[2] Medical Education Center, School of Medicine (Shinanomachi), Keio University

Abstract

Keio University's International Student Clinical Elective Programme has grown rapidly in the post-COVID years, and in the last academic year, over 50 fifth-year students had the opportunity to study at partner institutions around the world. Every year, a 7-session pre-departure course, organized and led by a native-English-speaking physician, is offered to give students valuable experience in the kind of patient interactions they will encounter during their overseas placement. As a physician, the course leader naturally finds her attention drawn to the medical aspects of students' performance, such as demonstrating correct techniques in physical examinations, choosing and ordering history-taking questions appropriately, and applying clinical reasoning to make a diagnosis. However, when an English teacher joined several sessions as a simulated patient, his attention was drawn to what he saw as a lack of structured language support, as well as apparent gaps in the students' English and communication skills. These included things such as a lack of linguistic variety when giving instructions or explanations, failure to ask for repetition of unclear answers, and an inability to redirect the conversation when a patient drifted off topic and began talking at length. In subsequent discussions, the physician listened with interest to the English teacher's suggestions for improvement and was eager to implement many of them in future courses. At the same time, the English teacher learned that there are sometimes specific clinical reasons for keeping communication simple and actively discouraging students from experimenting with more complex language. As a result of their discussions, both felt confident in their ability to improve the course and to better prepare students for their overseas placement. We believe this adds further credibility to the argument that medical English education is best implemented by physicians and language teachers working in close collaboration.

J Med Eng Educ (2025) 24 (3): 54-57

Keywords international clinical elective, pre-departure training, simulated patient

1. Introduction

Overseas clinical electives offer students a valuable opportunity to gain hands-on experience of a different healthcare system and interact with patients from a different cultural background. If English is the native language or a lingua franca at the host institution, an overseas clinical elective may also be a student's first chance to use the medical English learned in class for real communication. This dual focus makes a preparation course for such electives an ideal setting for an English-speaking physician and a specialist English teacher to join forces and help students develop both the linguistic competence and the clinical competence required to succeed. Indeed, reports of English teachers and medical professionals working together in such ways are fairly common in this journal.[1-3] However, these two competencies do not exist in isolation, and maintaining an appropriate balance while seeking to nurture them simultaneously can be a challenge. A physician's attention will naturally be drawn to a student's clinical reasoning skills, ability to make quick decisions and communicate effectively in real time, and skill in conducting physical examinations accurately and appropriately. Factors such as linguistic accuracy, fluency, and complexity will typically be of less concern to a physician. For an English teacher, the opposite is true: He or she is more likely to be impressed by students who display a high degree of linguistic competence, and in any case is unlikely to be able to pass accurate judgment on a student's clinical competence.

This suggests that a jointly taught course is likely to

● **Corresponding author:**

James Hobbs

MSc, Foreign Languages, School of Medicine, Keio University
4-1-1 Hiyoshi, Kohoku-ku, Yokohama-shi, Kanagawa, 223-8521 Japan
TEL: 045-755-3625 (ex. 33758)
E-mail: j.hobbs@keio.jp

create at least some degree of tension, as each teacher seeks to advance their own agenda without ignoring that of their co-teacher. It also suggests that if the two teachers are cooperative, open-minded, and eager to learn from each other, then each can acquire new perspectives that will enable them to design better courses and deliver better instruction in the future.

2. Programme description and course overview

2.1 The Overseas Clinical Elective programme

Keio University School of Medicine's Overseas Clinical Elective Programme was originally focused on the United States, and is still commonly referred to informally by teachers and students as "*Ame-ryu*" (US overseas study). However, the programme has been expanded greatly in recent years, moving past the roadblock that was COVID-19, and now offers students an extensive choice of host institutions across Europe, Asia, and Australasia. In AY2024, over 50 students applied, and in the current academic year over 60 (out of 110) 5th-year students are scheduled to participate, with their first-choice destinations spanning 15 institutions in 11 countries, as follows: USA (23 applicants), France (11), UK (6), Germany (5), Brazil (5), Australia (4), Sweden (4), Austria (3), Singapore (1), the Netherlands (1), and Spain (1).

The final range of destinations is likely to be even wider, as places are limited at any given institution and not all students will be able to go to their first-choice destination. Instead, some will be offered placements at other institutions with which the university has a Memorandum of Understanding (MOU), in countries including China, South Korea, and Thailand. Further expansion is anticipated next year and the ultimate goal is for all 5th-year students at Keio University School of Medicine to participate in an overseas clinical elective as part of their studies.

2.2 The preparation course

The preparation course is usually offered from September to early December and divided into seven sessions of 1-2 hours each, with most sessions repeated several times to keep student numbers within the range of 10-20 per session. The course follows a hands-on, interactive approach consisting of workshops, small-group feedback sessions, and practical simulations involving simulated patients (SiPs), typically overseas students from our graduate school. The seven core sessions are as follows:

1. Differential diagnosis and clinical reasoning
2. Note writing and case presentations
3. History taking (with case presentations)
4. Physical examination
5. Extra practice (for those who want/need it)
6. Post-course OSCE

7. Feedback and certificates

In recent years, the course has been taught solely by two clinicians from the Medical Education Center. However, the English teacher (and the first author of this paper), new to Keio University in 2024, was interested in learning more about the course, especially given his previous experience collaborating with a physician to teach a course with a dual focus on medical skills/knowledge and English skills.[4] His appreciation of the value of collaboration between language teachers and medical practitioners also stemmed from his involvement in a project related to dental English.[5] With the permission of the physician (and second author of this paper), the English teacher attended several sessions, both as an SiP and as an observer. He took detailed notes during the sessions, focusing in particular on areas where he felt that linguistic performance had been somewhat overlooked, and where input from a specialist English teacher could potentially improve the course and lead to better linguistic outcomes. These observations formed the basis of open and honest discussions between the authors in the weeks that followed. While some suggestions were acknowledged to be potentially very useful, there were also many instances where the physician offered valid counterarguments detailing why the English teacher's suggestions were either of limited potential value, or clearly undesirable. This resulted in the English teacher reevaluating some strongly held beliefs about teaching medical English. At the end of the process, it was felt that both teachers had learned much of value, enough to justify sharing with fellow educators through this presentation and paper. The rest of this paper presents a summary of the English teacher's suggestions and the physician's responses.

3. Observations, suggestions and responses

3.1 Initial observations: clinical vs. linguistic perspectives

In the first session attended by the English teacher, students rotated around the classroom in pairs, simulating history-taking interviews with several SiPs. From a linguistic standpoint, the students performed admirably, and the English teacher's instinct would have been simply to praise the students for a job well done, highlighting their fluency, command of relevant vocabulary, and confidence in speaking English. This was in sharp contrast to the assessment of the clinician, who felt that students had performed poorly and noted significant shortcomings in their clinical communications skills. In particular, it was observed that most students tended to lead with overly broad questions, such as, "Do you have any other symptoms?" Linguistically, this is fine, but it leaves too much dependent on patient interpretation. What was usually lacking were specific questions relevant to the case at hand—hand-picked questions stemming from clinical reasoning, such as, "Is

your headache worse in the morning?" or "Have you been suffering from constipation?"—where each subsequent question follows on from the patient's previous answer, as opposed to being taken from stock questions in a textbook checklist.

This disparity reinforces the fact that linguistic fluency and accuracy do not necessarily result in effective clinical communication, and this fact alone is perhaps reason enough to avoid leaving a preparation course such as this solely in the hands of an English teacher with no clinical background.

3.2 Pre-session training for SiPs

The English teacher also mentioned that when participating as an SiP, he struggled with what he saw as a lack of detail in his assigned case scenario. Specifically, when instructed to play the role of a patient who had suffered frequent falls, he found himself at a loss when asked "How frequent?" or "Does anything bring them on?" and was torn between either inventing an answer or simply saying, "I'm not sure".

However, while the English teacher was eager to see this as a case of missing information in the scenarios, the physician explained that such vagueness is in fact intentional, reflecting the fact that information is often incomplete or inconsistently presented in real patient interactions. Moreover, it was noted that an overly detailed script can result in unnatural interactions, as SiPs struggle to memorize information and retrieve the *correct* answer to every question. The physician also mentioned that for the more complex, and thus longer, cases, SiPs will often read entire sentences—sometimes even whole short paragraphs—verbatim from their given script. Fully trained standardized patients (SPs) might be comfortable with a detailed script, but this was considered too heavy a burden for SiPs who have undergone minimal training and receive little pay for their time. For these reasons, the SiPs are simply encouraged to offer plausible responses to common student queries, without altering core elements of the case.

3.3 Feedback and reflection

The English teacher noticed that the students received no direct feedback from the SiPs they interviewed, and suggested the idea of SiPs submitting a post-interview checklist evaluating the performance of students they interacted with. It was also suggested that the students themselves could complete a self-evaluation after each session to reflect on their own performance. Repeating one or more interview scenarios was also suggested as a tried and tested technique to consolidate learning. Regarding the final part of the sessions, in which students usually wrote and presented a summary of a case they had encountered in that session, the English teacher made two suggestions based on activities common in English classes: 1) having students rehearse in pairs or groups and give each other feedback before presenting to the whole class; 2) having students edit and re-submit their case summaries based on feedback received in class.

In response, the physician noted that SiP feedback had been incorporated in the past but had been discontinued due to time constraints. It was noted that trying to find time to reinstate feedback could be an effective way to raise awareness of problems such as poor pronunciation, insensitive questions, and lack of empathy.

Regarding rehearsing case summaries, this was deemed impractical due to time constraints. However, the suggestion of editing summaries after the sessions was welcomed, and the physician plans to offer students this option (though not insist on it) in the future.

3.4 Linguistic details and communication skills

The English teacher noted that despite the generally high level of English ability among students, many failed at the simple task of introducing themselves clearly to a patient. Self-introductions typically consisted of a student mumbling, "I'm [name]," while pointing briefly at their name tag, which is almost certain to be insufficient in an overseas setting when dealing with patients who are unfamiliar with Japanese names.

Students also tended to be relatively poor at confirming details. For example, the English teacher noticed that if he mumbled an implausibly complex name (e.g., "I'm Marmaduke Wilberforce, Jr.") when identifying himself as an SiP, students would not seek clarification but simply say, "Thank you," and move on, while avoiding any subsequent use of the patient's name. This meant that students both failed to clarify something they should have clarified and missed the opportunity to do one of the most reassuring things a doctor can do when speaking to a patient: address the patient by their name. The English teacher also noted that when he sought to confuse students with deliberately vague answers, or by giving lengthy answers unrelated to the question, there was usually no redirecting and no double checking—rather, students generally just settled for getting the gist, and then moved on. Furthermore, the English teacher commented on a general lack of empathy in students' communication, and felt that there was a need for basic reminders about eye contact and the value of a smile.

In response, the physician noted that these are all common problems. In particular, students typically have a list of questions in their heads and go through them without really listening to what their patient says, with the result that they are unable to make an accurate diagnosis due to a lack of information. While it may not be easy to fix all these issues at once, and some might only be mastered through sufficient practice, reminding students to confirm and subsequently *use* the patient's name was acknowledged as an excellent suggestion. It was also suggested that issues regarding checking details and showing empathy are areas where the

reintroduction of SiP feedback can be expected to stimulate improvement, or at least increase awareness. It was also noted that students can be prompted to show empathy by adding comments in the SiP scenarios, such as, "You are very worried about dying. Ask the doctor if they think you will die."

Overall, it was felt that these are areas where the English teacher and the physician can work together to find ways to facilitate improvement.

3.5 English for physical examinations

One of the areas where the English teacher noticed a particular disparity between what students learn in English classes and how they perform when dealing with SiPs, was that of physical examinations. When it comes to explaining actions, textbooks typically encourage students to use a variety of expressions such as "I'd just like to…," "I'm just going to…," and "Now, I'll…." However, when interacting with SiPs, students typically relied on one simple phrase: either "Now, I will… Now, I will…" or "Next, I'm gonna… Next, I'm gonna…." This makes communication monotonous and suggests a possible role for the English teacher through a pre-session mini-lesson highlighting alternative expressions and the value of linguistic variety.

The same was true with giving instructions. Given the opportunity to deploy a range of expressions, such as, "Could you …, please?" and "Can you … for me?", students instead typically just say "Do this… now do this…" while inviting the patient to copy an action.

However, while this at first seemed like a prime example of a problem in need of a solution, the physician noted that this short, simple way of communicating was in fact deliberate. The physician pointed out that giving lengthy instructions to patients is never a good idea, and that even following a perfect verbal instruction, many patients still do the wrong thing. Therefore, rather than actively striving to employ more complex and varied forms of expression, students are advised to aim to keep communication as simple as possible. Time is a precious resource in the clinical setting, and the main focus should be on limiting the possibility of the patient doing the wrong thing and reducing the need for repetition of questions or instructions. Variety of expression, and subtleties such as the addition of "…for me" at the end of requests are perhaps things best left to emerge naturally over time, rather than things to actively teach.

4. Conclusion

Language teachers and physicians approach the challenges of teaching English for clinical communication from different perspectives. However, these differing perspectives can complement each other if the teachers communicate honestly and openly. Keio University's Overseas Elective Programme preparation course is likely to become even more important as the programme expands in the years to come. The teachers involved will continue to work together to find ways to make the programme meet the needs of participating students in terms of both English and clinical communication skills. It is too early to say specifically what changes will be implemented, but we look forward to reporting on them at a future JASMEE conference.

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Creating a database for a nursing loanword glossary for nursing students

Motoko Sando

School of Health and Nursing Science, Wakayama Medical University

Abstract

Katakana is a Japanese script largely used for representing loanwords. When there is no equivalent paraphrase in Japanese, a *katakana* version of the loanword is used. With the extensive development of healthcare technology, the nursing field employs a broad range of *katakana* words. Although *katakana* is useful for Japanese people, it may sometimes lead to misunderstandings or confusion especially when communicating with people from overseas. The aim of this study was to collect the basic data required for creating a nursing loanword glossary. As an example, this article focuses on the term *sutorengusu*（ストレングス, "strength"）used in mental health nursing and explored its multiple meanings such as "resisting force," "muscle strength," "strength of a solution," and "finding an individual's strength or abilities." In the nursing field, *sutorengusu* is mainly used in the fourth sense. This sense originated from *the strengths perspective*, which was developed by the School of Social Welfare at the University of Kansas in the 1980s. The study confirmed that *sutorengusu* can be categorized as Type II, which is written directly in their original form, and Type V, which is the abbreviated or shortened form. *Sutorengusu* is also strongly connected with the term *enpawamento*（エンパワメント, "empowerment"）, which can be classified as Type II; it denotes that care providers respect patients' powers and help them develop their skills and abilities.

J Med Eng Educ (2025) 24 (3): 58-61

Keywords English for medical purposes, *katakana*, loanwords, nursing terms

1. Introduction

Katakana is one of the Japanese syllabic writing systems, and it is chiefly used for representing loanwords, adopted from other languages. The number of *katakana* words and terms has dramatically increased on the wave of rapid globalization in the nursing field. Most of these *katakana* words are based on loanwords from English and maintain the same meanings as the original English words; however, some are used differently from the original senses, others are abbreviations, and still others are Japanese creations. When we talk with people from outside Japan, using *katakana* may cause misunderstanding or confusion; first language interference may pose a stumbling block to communicating in English. For improving English proficiency skills, Japanese

speakers need to realize how to express themselves in accurate English, for which dictionaries can be a helpful resource. Several *katakana* loanword dictionaries for nursing and healthcare workers have been published in Japan, but most of them refer to only the Japanese meanings, and simply list *katakana* spellings. Therefore, there is a need for a bilingual nursing glossary of *katakana* loanwords, devoting space to the original meanings and correct English usage.

Thus, the purpose of this study was to collect the basic data required for making a nursing loanword glossary. This article focuses on the *katakana* loanword *sutorengusu* （ストレングス, "strength"）and related terms to demonstrate the process of compiling the basic data necessary for the proposed nursing loanword glossary.

2. Methods

All *katakana* words and phrases were extracted from the National Nurse Examinations over the past six years.[1-6] Except for everyday language or proper nouns, nursing *katakana* can be broadly categorized into the following loanword types: Type I, words and phrases borrowed from languages other than English, such as *gipusu* (ギプス, "plaster cast"); Type II, words and phrases written directly in their original English forms, such as *infoomudo konsento*

● **Corresponding author:**

Motoko Sando

Associate Professor, Ph.D., School of Health and Nursing Science, Wakayama Medical University

580 Mikazura, Wakayama-shi, Wakayama, 641-0011 Japan

TEL: 073-446-6700

E-mail: msando@wakayama-med.ac.jp

(インフォームド・コンセント, "informed consent"); Type Ⅲ, words and phrases newly coined in Japan from existing English words, such as *guriifu kea* (グリーフケア, "bereavement counseling"); Type Ⅳ, words and phrases used differently from original senses such as *purepareeshon* (プレパレーション, "therapeutic child care"); and Type V, words and phrases abbreviated or shortened such as *riwaaku* (リワーク, "return to work").

2.1 Steps for labeling

Firstly, definitions of *sutorengusu* were examined in the following Japanese dictionaries: *Nursing Dictionary*[7] (*ND*), *Nursing Science Dictionary*[8] (*NSD*), *Encyclopedia of Nursing Science*[9] (*ENS*), *Nursing and Medical Dictionary*[10] (*NMD*), *Smart Dictionary*[11] (*SD*), *Dictionary of Nursing Vocabulary*[12] (*DNV*), *and Katakana Nursing Dictionary*[13] (*KND*). Additional references were consulted as necessary.

Secondly, definitions of original English word for *strength* (from which *sutorengusu* was derived) were examined in English-language dictionaries: *Merriam Webster's Medical Dictionary*[14] (*Webster*), *Dorland's Illustrated Medical Dictionary*[15] (*Dorland*), *Stedman's Medical Dictionary for the Health Profession's & Nursing*[16] (*Stedman HPN*), *Taber's Cyclopedic Medical Dictionary*[17] (*Taber*), *Baillière's Dictionary for Nurses and Health Care Workers*[18] (*Baillière*), *Mosby's Dictionary of Medicine, Nursing and Health Profession*[19] (*Mosby*), *and A Dictionary of Nursing*[20] (*DN*). Additional references were consulted as necessary.

Thirdly, the definitions were compared, differences were clarified, and a working definition of *sutorengusu* was determined for the glossary. Next, *sutorengusu* was categorized and the findings were compiled into a table. The table includes the headword, Japanese meaning, English meaning, *katakana* type, parts of speech/word form, definition, usage, and examination number.

2.2 Usage example of *sutorengusu*

The word *sutorengusu* appeared in question number 66 in the morning part of the 112th Exam (**Figure 1**) and in question number 64 in the morning part of the 113th Exam (**Figure 2**). Based on the standard rule of the national examination, *sutorengusu* was classified as a mental health nursing term and was recently included as a gerontological nursing term.[21]

66　患者の権利や力を尊重し、自己制御している感覚を持たせ、患者が社会生活に必要な技能や能力を獲得する支援を意味するのはどれか。

1. リカバリ
2. ストレングス
3. レジリエンス
4. エンパワメント

English translation: Which of the following refers to respecting the patients' rights and powers, helping them to feel a sense of self-control and develop their skills and abilities necessary for participation in society?
1. *rikabari* ("recovery")
2. *sutorengusu* ("strength")
3. *rejiriensu* ("resilience")
4. *enpawamento* ("empowerment")

Figure 1. Excerpt from the morning part of the 112th National Nurse Examination

64　患者とその家族や医療者が患者にとって望ましい治療を探り、お互いが納得する治療を選択できるようにしていくのはどれか。

1. 心理教育
2. 共同意思決定
3. ストレングス
4. アドヒアランス

English translation: Which of the following allows patients, their families, and care providers to explore the treatment that is most desirable for the patient and choose a treatment that is satisfactory for all?
1. psycho-educational intervention
2. co-decision-making
3. *sutorengusu* ("strength")
4. *adohiaransu* ("adherence")

Figure 2. Excerpt from the morning part of the 113th National Nurse Examination

3. Results and discussion

3.1 Japanese definitions of *sutorengusu*

Within the Japanese dictionaries, the term *sutorengusu* was listed only in *KND*, where it was defined as "a basic concept of supporting people with psychiatric disabilities; focusing on their *sutorengusu* (strengths/advantages)."[13] To seek further clarification, a website called JANSpedia, an online glossary launched by the Japan Academy of Nursing Science, was consulted.[22] JANSpedia explained that the English term *strengths* or *strengths perspective* appeared in the late 1980s in the United States and it was used among social workers.[22] It was further noted that this *strengths perspective* focuses on individuals' abilities, respects them and promotes *enpawamento* (エンパワメント, "empowerment"),[22] which was identified as a keyword concept. *Sutorengusu* also appears to be associated with the terms *rikabari* (リカバリ, "recovery") and *rejiriensu* (レジリエンス, "resilience"); however, due to space limitations these will not be discussed in detail in the current study.

3.2 English definitions of *strength*

Dorland defines *strength* as "intensity or power"[15], while *Mosby* defines it as "the ability of a muscle or a person to produce or resist a physical force."[19] In *Taber*, four definitions are provided: "the maximum force that can be generated by a muscle or muscle group," "the concentration of a solution or substance," "the intensity of light, color, or sound," and "the ability to resist deformation, fracture, or abrasion."[17] None of these definitions correspond to the Japanese definitions of *sutorengusu*.

However, *DN*, which is nursing-focused, lists the term *strength-based approach*, which is defined as "an approach to personal care that focuses on an individual's strengths and abilities, including their family and community networks,

as opposed to their deficits."[20] It is further described as "promoting wellbeing and empowerment through a holistic, collaborative, and client-led approach."[20] This definition most closely resembles the earlier Japanese definitions.[22] Once again, the word *empowerment* occurs in connection with the concept of *strength*.

3.3 Relevant words

3.3.1 *Enpawamento*, *empowerment*

In order to better define *sutorengusu*, it is important to explore the concept of *enpawamento*, as these two terms appear to be strongly associated. Question number 66 in the morning part of the 112th National Nurse Examination (**Figure 1**), provides a good working definition. Here, *enpawamento* is defined as the respect the patients' rights and powers shown by care providers, along with the support provided to help patients develop their skills and abilities in society.

As noted in *ND*, *empowerment* means "to give power to someone," through the prefix *em-* indicating the act of "giving something."[7] The term *empowerment* was originally used in the legal field,[7] and was later used in the anti-war movements in Europe and the United States.[9] It began to be used in the nursing field around the 1980s,[9] where it was introduced in a health promotion program.[8]

3.3.2 *The strengths perspective*

The strengths perspective was originally developed in the 1980s by the School of Social Welfare at the University of Kansas.[23] It is an approach to social work that values the strengths and resources of people, communities, and their environments rather than their problems and pathologies.[23] *The strengths perspective* places emphasis on individuals' resilience, resistance, courage, thriving, and ingenuity towards helping them achieve their goals and aspirations.[23]

Table 1. Basic Data on ストレングス and エンパワメント

Headword	Japanese Meaning	English Meaning	Type	Parts of Speech / Word Form	Definitions & Usage	Exam No.
ストレングス	1. 強度・抵抗力	1. strength, resisting force	1. II	1. noun	1. the ability to resist deformation e.g.）They should focus on enhancing the *strength* of the product.	N112 No.66am
	2. 腕力	2. muscle strength	2. V	2. noun	2. the ability of muscle e.g.）You need to regain your muscle *strength*.	
	3. 溶液濃度	3. strength of a solution	3. V	3. noun	3. the concentration of a solution e.g.）It depends on the *strength* of a solution.	
	4. 強み／長所	4. individual's strengths and abilities	4. V	4. noun	4. individual's strong points; abilities, capacities, skills, strengths and talents e.g.）It's important to know your own *strengths* and weaknesses.	N113 No.64am
エンパワメント	－	empowerment	II	noun	Originally a legal term, "giving power to someone" Began to be used in anti-war movement in Europe and the United States since the 1960s. In the nursing field, it was used around 1980s. Care providers respect the patients' rights and powers and help them develop their skills and abilities in society. e.g.）*Empowerment* can be demonstrated as an important promoter of health.	N112 No.66am

A book titled *The Strengths Model* was published on this topic and became internationally recognized; a Japanese translation was later released,[24-26] and the strengths model has since been adopted in mental health and other fields.

3.4 Labeling *sutorengusu*

As demonstrated above, *sutorengusu* carries several meanings. In the nursing field, it is mainly used in the sense of "identifying an individual's strengths or abilities," which leads to *enpawamento*. *Sutorengusu* can be categorized as a Type II *katakana* term, in which words are transcribed into *katakana* directly in their original forms, and, being a shortened form of the term *strengths perspective*, it can also be classified as a Type V *katakana* term, in which words are abbreviated or shortened. In all cases, the term is used as a noun. These findings are presented in **Table 1**.

4. Conclusion

This study focused on the term *sutorengusu*, as an example of *katakana* word that would be listed within a nursing loanword glossary. Several meanings of the word "strength" can be found within dictionaries including resisting force[17, 19], muscle strength[17, 19], strength of a solution[19] and an individual's strengths or abilities.[20] However, the term as it is used within the nursing science field in Japan, is drawn from the concept of a *strength-based approach* which was developed in the 1980s at the University of Kansas.[23] Furthermore, *sutorengusu* is strongly connected with *enpawamento* (**Figure 1**).[7-9, 20, 22]

Although *katakana* terms are convenient for native Japanese speakers, they can be ambiguous when applied to polysemous loanwords, making it difficult to determine the intended meaning. Moreover, *katakana* can hinder effective communication in English with people from overseas. From the perspective of English for medical purposes education, further investigation of other *katakana* nursing terms is planned, with the goal of using these data to develop a glossary of nursing loanwords.

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保健医療学部生の短期海外研修における国際的志向性・WTCと英語発話行動

International posture, willingness to communicate, and communicative behavior in short-term overseas training among health science students

野口 浩子[1]，加藤 明子[2]，登道 孝浩[1]

[1] 国際医療福祉大学総合教育センター，[2] 福岡国際医療福祉大学診療放射線学科

Koko Noguchi,[1] Akiko Kato,[2] and Takahiro Noborimichi[1]

[1] International University of Health and Welfare, Center for Liberal Arts
[2] Fukuoka International University of Health and Welfare, Department of Radiological Sciences

要約

本研究は，保健医療学部生を対象に，短期海外研修が国際的志向性，第二言語での Willingness to Communicate（WTC），および英語運用能力に与える影響を検証した。研修前後のアンケートに回答した 103 名を分析対象とした。重回帰分析および繰り返し測定共分散分析の結果，研修前の WTC は，国際的志向性のうち，主として異文化接近回避傾向によって説明され，スピーキング力も準有意な影響を示した。研修後，異文化接近回避傾向は有意に向上したが，国際的志向性の他の要素の国際的職業・活動への関心や海外情報・出来事への関心の変化は限定的であった。研修中の自発的な英語発話行動は，英語力や WTC ではなく，研修前の海外情報・出来事への関心によって予測された。これらの結果は，短期海外研修が学生の異文化接近傾向を高める教育的効果を持つ一方で，実際のコミュニケーション行動には国際社会への好奇心が重要な役割を果たすことを示し，英語教育の実践において，言語技能の訓練に加え，国際的関心を育む学習環境を組み込むことの有効性が確認された。

Abstract

This study examined the impact of short-term overseas training programs on international posture, willingness to communicate（WTC）in a second language, and self-perceived English proficiency among undergraduate students in health sciences. Data from 103 students who completed both pre- and post-training surveys were analyzed. Multiple regression and repeated measures ANCOVA revealed that:（1）pre-training WTC was primarily explained by the intergroup approach-avoidance tendency（AAT），with speaking ability showing a marginal effect;（2）AAT significantly improved after the training, whereas interest in international vocation activities（IVA）and interest in foreign affairs（IFA）showed limited changes; and（3）self-initiated communication in English during the training was predicted not by English proficiency or WTC, but by pre-training IFA. These findings suggest that short-term overseas training can enhance students' openness to intercultural interactions, while actual communicative behavior is driven more by curiosity and interest in global affairs than by willingness to communicate or language skills alone. For educational practice, integrating content that fosters international awareness alongside language training may effectively promote students' engagement in intercultural communication.

J Med Eng Educ (2025) 24 (3): 62-67

Keywords English proficiency, health science students, intercultural communication, international posture, short-term overseas training, willingness to communicate

● **Corresponding author:**

野口 浩子
国際医療福祉大学総合教育センター 准教授
〒 286-8686 千葉県成田市公津の杜 4-3
TEL: 0476-20-7701
E-mail: kyutaka@ihwg.jp

1. 序　論

　グローバル化が進展する現代社会において，医療専門職にも国際的視野や異文化理解力が求められている。特に日本の医療現場では，訪日外国人患者の増加や外国籍医療従事者との協働機会の拡大に伴い，英語を中心とする外国語運用能力とともに，多様な文化的背景を理解する姿勢が不可欠となっている。全国の医療機関における外国人患者数

は年々増加しており，都市部だけでなく地方都市の医療機関でも対応の必要性が高まっている。

こうした背景の中，医療系大学教育における国際化教育は，語学スキルだけでなく異文化適応能力を涵養することを目的として発展してきた。その方法の一つが海外研修であり，実地体験を通して学生の言語運用能力や国際的志向性を高めることが期待されている。特に短期海外研修は，大学の教育課程に組み込みやすいという特徴を有しており，多くの学生に参加機会を提供できる点で教育的有用性が高い。

国際的志向性とは，八島によって提唱された概念であり，①異文化接近―回避傾向（異文化をもった人と関わりを持とうとする傾向），②国際的職業・活動への関心，③海外での出来事や国際問題への関心，の 3 要素から概念的，操作的に定義される。[1]「Willingness to Communicate in L2」は，「第二言語で自発的にコミュニケーションを図る意思」（以下，WTC）とされ，英語を使う積極性と学習意欲，英語力などとの関連から重要な要因とされている。国際的志向性が高いほど，学習意欲が高まり，英語の習熟度や WTC も高くなることが示されている。[2] また，スタディアブロードなど異文化接触の結果，英語を使う不安が減り，WTC，国際的志向性が上昇することも明らかにされている。[3] しかしながら，先行研究の多くは通常の英語の授業における変化に焦点を当てているものが多く，[4,5] 海外研修の場合もボランティア研修などが対象となっており，[6] 医療現場を含む短期研修が国際的志向性や WTC に与える影響については知見が不足している。

本研究は保健医療学部生を対象に，短期海外研修が国際的志向性，WTC，英語運用能力に与える影響を検証する。また，研修中の実際のコミュニケーション行動に関与する要因を明らかにし，教育実践への示唆を導くことを目的とする。

2. 方　　法

2.1　調査対象と調査方法

本研究の調査対象とする研修は，2 つの大学に設置された全国 6 キャンパスの保健医療学部の 2 ～ 3 年生を対象としている。専攻は看護学科，理学療法学科，作業療法学科，臨床検査学科，放射線・情報科学科が中心であり，参加形態はキャンパスごとに必修あるいは任意と異なる。10 ～ 14 日間の短期プログラムで，参加する学生は事前に「海外保健福祉事情」という授業で海外の医療や保健事情，文化的背景，コミュニケーション方法などを学び，研修先の医療制度等についてグループで調べる。その後，夏季と冬季のいずれかで，2 週間程度の海外研修に参加する。研修先は，韓国，台湾，東南アジア，オーストラリア，ヨーロッパな

ど 14 か国 23 の地域にわたり，研修内容は，現地病院・介護施設での見学，大学との合同授業，地域コミュニティ活動などで構成される。

2024 年度 2 月から 3 月にかけて 332 名の学生が冬季海外研修に参加した。渡航前，渡航後に①日本以外の国や地域の人々と積極的に関わりたいとする「国際的志向性」，②英語を用いてコミュニケーションを取ろうとする WTC（Willingness to Communicate），③英語運用能力に対する自己評価，④医療に関する理解向上（自己評価）の 4 点について，研修前と研修後で変化が見られるかについて，Google フォームによる質問紙調査を実施した。渡航の前後とも回答が得られたのは 103 名（回収率 31.0%）であった。

2.2　倫理的配慮

Google フォームでのアンケートの最初に，研究目的，研究方法，個人情報の取り扱い，個人の匿名性を確保することなどについての説明文書を参照してもらい，回答に同意した場合のみ，アンケートに回答してもらうようにした。また，研究結果について学会で研究発表を行い，学術誌に論文を投稿することも記載した。なお，本研究は，国際医療福祉大学千葉地区倫理審査委員会の審査を受け，承諾を得た後に実施した（承認番号 24-CC-025，承認年月日 2025 年 1 月 28 日）。

2.3　調査項目

質問項目は，渡航前は主に，研修先，国際的志向性，WTC，英語力（自己評価）について 5 つの群から構成され，渡航後はこれに，現地での英語によるコミュニケーション行動，研修先から医療について学習したこと，の 2 群が追加された。

国際的志向性については，先行研究を参考に，①異文化接近―回避傾向（異文化をもった人と関わりを持とうとする傾向）（AAT: intergroup approach-avoidance tendency）に関して 9 問（うち 2 問は医療現場での設問），②国際的職業・活動への関心（IVA: interest in international vocation activities）に関して 6 問，③海外での出来事や国際問題への関心（IFA: interest in foreign affairs）に関して 4 問をそれぞれ設定し，回答は 6 件法（全くそう思わない/あまりそう思わない /どちらとも言えない/少しそう思う/かなりそう思う/とてもそう思う）とした。[2,4] 各要素の質問項目は以下のとおりである。＊は逆転項目を示す。

① 異文化接近―回避傾向（AAT）

1. 日本に来ている留学生など外国人と友達になりたい。
2. 外国の人と話すのを避けられれば避けたい。＊

3. 学校で留学生がいれば気軽に声をかけようと思う。

4. 外国人の学生と寮やアパートなどでルームメートになってもよいと思う。

5. 地域の外国人と交流するような活動に参加してみたい。

6. 将来，仕事先の医療現場で困っている外国人がいても，自分の担当でなければ声をかけないと思う。*

7. もし，隣に外国人が引っ越してきたら困ったなと思う。*

8. 日本で，レストランや駅で困っている外国人がいれば進んで助けると思う。

9. 将来，医療現場で仕事をしている時に，困っている外国人がいれば進んで助けると思う。

② 国際的職業・活動への関心（IVA）

1. 故郷の街からあまり出たくない。*

2. 国際的な仕事に興味がある。

3. 外国で仕事をしてみたい。

4. 国連など国際機関で働いてみたい。

5. 海外出張の多い仕事は避けたい。*

6. 日本の外の出来事は，私たちの日常生活にはあまり関係ないと思う。*

③ 海外での出来事や国際問題への関心（IFA）

1. 外国に関するニュースを見たり，読んだりしようと思う。

2. 外国の情勢や出来事について家族や友人と話してみたい。

3. 国際的な問題に強い関心を持っている。

4. 海外のニュースにはあまり興味がない。*

WTC に関しては，渡航前に「外国で道がわからないとき，誰かに英語で質問して助けを求めると思いますか？」「日本での学生生活について英語で説明したいと思いますか？」の 2 問を設定し，回答は 6 件法とした。

英語力（自己評価）については，リスニング力について 6 段階（1. 話されていることをほとんど理解できない/2. 基本的な単語やフレーズは理解できる/3. お店やレストラン，駅やバス停などで言われていることが理解できる/4. 一般的な会話を理解することができる/5. 町の案内などで，ガイドさんの話す内容がほぼ理解できる/6. 研修先の複雑な説明が理解できる）からの選択式とした。スピーキング力についても同様に 6 段階とし（1. 英語を話すことがほとんどできない/2. 英語で自己紹介ができる/3. 買い物や交通機関を利用するために質問できる/4. ある程度自分の意見を表現できる/5. 会話をある程度続けることができる/6. 複雑な内容も説明しながら，流ちょうに会話ができる）からの選択式とした。

渡航後の質問には，現地での英語によるコミュニケーション行動として「困ったとき，誰かに英語で質問して助けを求めることがありましたか」「日本での学生生活などについて英語で説明することがありましたか」の 2 問を設定し，（1. 全くなかった/2. ほとんどなかった/3. どちらとも言えない/4. たまにあった/5. 時々あった/6. 頻繁にあった）の選択式とした。

さらに研修先の実際のコミュニケーション行動に関して「研修期間中，どれくらい，英語や外国語を話してコミュニケーションをとりましたか？」「そのうち，自分から話しかけたのは，何回くらいでしたか？」の 2 問を設定し，回答はそれぞれ，1. 0 回, 2. 1 〜 2 回, 3. 3 〜 5 回, 4. 6 〜 9 回, 5. 10 回以上の 5 件法の選択式とした。

また，研修先での実際の英語運用能力については，リスニング力について 6 段階（1. 話されていることをほとんど理解できなかった/2. 基本的な単語やフレーズは理解できた/3. お店やレストラン，駅やバス停などで言われていることが理解できた/4. 一般的な会話を理解することができた/5. 町の案内などで，ガイドさんの話す内容がほぼ理解できた/6. 研修先の複雑な説明が理解できた）からの選択式とした。スピーキング力についても同様に 6 段階とし（1. 英語を話すことがほとんどできなかった/2. 英語で自己紹介ができた/3. 買い物や交通機関を利用するために質問できた/4. ある程度自分の意見を表現できた/5. 会話をある程度続けることができた/6. 複雑な内容も説明しながら，流ちょうに会話ができた）からの選択式とした。

2.4 リサーチ・クエスチョン

本研究の目的は，医療学部生の短期海外研修が国際的志向性・WTC・英語運用能力に与える影響を明らかにし，研修中のコミュニケーション行動の決定因を探索することである。具体的なリサーチクエスチョン（RQ）は以下の通りである。

RQ1：研修前の WTC（学生生活を英語で説明したい意欲）は，英語力（リスニング・スピーキング）および国際的志向性によってどのように説明されるか。

RQ2：短期海外研修は，国際的志向性に有意な変化をもたらすか。さらに，英語力との交互作用は存在するか。

RQ3：研修中の英語での実行行動（自ら話しかけた回数）は，研修前の WTC・英語力・国際的志向性のどの指標によって予測されるか。

2.5 分析方法

本分析では，国際的志向性に関する質問項目を先行研究の例に倣って，[2] ①異文化接近回避傾向（AAT），②国際的職業・活動関心（IVA），③海外情報・出来事関心（IFA）の合成変数を作成し，さらにそれぞれについて研修前（Pre），研修後（Post）で合成変数を作成した。尺度の内的一貫性

は，Cronbach の α で検証し，PreAAT = 0.810，PreIVA = 0.784，PreIFA = 0.814，PostAAT = 0.858，PostIVA = 0.837，PostIFA = 0.861 と，妥当性が確認された。

　分析方法は，RQ1 に対して重回帰分析，RQ2 に対して繰り返し測定共分散分析，RQ3 に対して重回帰分析を行い，VIF や条件指数により多重共線性を点検した。回答は匿名で回収し，分析には SPSS 28 を使用した。有意水準は $p < 0.05$ とした。

3. 結　果

3.1　国際的志向性と英語力が WTC に与える影響（RQ1）

　研修前における学生の英語運用能力（リスニング力・スピーキング力）および国際的志向性が WTC にどのような影響を及ぼしているかを検討するため，独立変数に，リスニング力，スピーキング力，国際的志向性の 3 つの変数研修前における学生の異文化接近回避傾向（PreAAT），国際的職業・活動への関心（PreIVA），海外情報・出来事への関心（PreIFA），従属変数に WTC の指標として，研修前の「英語で学生生活を説明したいと思うか」という回答を用いて重回帰分析を行った。

　表 1 にあるように，説明変数の標準化係数 β と有意性をみると，PreAAT が最も強い正の影響を示し（β = 0.450，$t = 4.338$，$p < .001$），異文化への接近傾向が高い学生ほど，英語で自らの学生生活を説明したいという意欲が高いことが明らかになった。また，スピーキング力も準有意な正の影響を示し（β = 0.191，$t = 1.798$，$p = 0.075$），発話能力が高い学生は，英語での発信意欲が高まる傾向が認められた。一方，リスニング力（β = 0.004，$t = 0.039$，$p = 0.969$），PreIVA（β = 0.104，$t = 1.007$，$p = 0.316$），PreIFA（β = 0.035，$t = 0.417$，$p = 0.678$）はいずれも有意な影響を示さず，英語理解力や国際的職業・活動への関心，海外情報・出来事への関心は，WTC に対して統計的に意味のある寄与をしていなかった。

　モデル全体は有意であり（$R^2 = 0.391$，調整済 $R^2 = 0.360$，$F_{(5,97)} = 12.454$，$p < 0.001$），5 つの説明変数によって従属変数の約 39% の変動が説明されることが示された。調整済 R^2 も比較的高く，モデルの適合度は良好であった。多重

共線性の指標である VIF は 1.121 〜 1.801 の範囲に収まり，共線性による推定の不安定性は認められなかった。条件指数も最大 16.43 であり，30 を超える危険域には達していなかった。これらのことから，モデルの統計的妥当性に大きな問題はないと判断できる。

3.2　研修前後における国際的志向性の変化と英語力の影響（RQ2）

　海外保健福祉事情研修が国際的志向性に与える影響と，その変化に英語運用能力が関与するかを検討するため，異文化接近回避傾向（AAT），国際的職業・活動関心（IVA），海外情報・出来事関心（IFA）の 3 変数を従属変数とし，リスニング力・スピーキング力を共変量に設定して繰り返し測定共分散分析を行った。また，多変量検定により効果量の推定も行った。

　まず AAT について，被験者内効果の検定では研修前後に有意な変化が認められ（$F_{(1,100)} = 15.722$，$p < .001$，Pillai's Trace = 0.136），効果量は中程度と解釈された。平均値の変化は接近傾向の向上（＝回避傾向の低下）を示しており，短期研修であっても学生の異文化に対する心理的距離が縮まる可能性が示唆された。一方，英語力との交互作用はリスニング力（F = 0.011，$p = 0.917$），スピーキング力（F = 1.686，$p = 0.197$）ともに有意ではなく，研修効果の大小が英語力の高低によって異なるとはいえなかった。ただし被験者間効果ではスピーキング力に有意な主効果（$F_{(1,100)} = 7.290$，$p = 0.008$）が認められ，研修の有無にかかわらずスピーキング力の高い学生ほど AAT 得点が高く（＝異文化への接近傾向が強く）なる傾向が明らかになった。

　IVA については，研修前後の変化は非有意（$F_{(1,100)} = 1.868$，$p = 0.175$，Pillai's Trace = 0.018）であり，英語力との交互作用（リスニング力 F = 0.500，p = 0.481 ／スピーキング力 F = 0.487，p = .487）も認められなかった。国際的職業・活動関心は短期間では変化しにくく，今回の研修では職業的志向の大きな変容までは至らなかった可能性が高い。

　IFA については，研修前後の変化が準有意（$F_{(1,100)} = 3.877$，p = 0.052，Pillai's Trace = 0.037）で，海外情報・国際的出来事への関心がわずかに高まる傾向が見られた。ただし，統計的には有意水準に達していなかった。英語力との交互作用はリスニング力（F = 0.975，$p = 0.326$），スピーキング力（F = 0.314，$p = 0.577$）ともに非有意であり，被験者間効果においても両技能はいずれも IFA の水準に影響を与えなかった（表 2）。

表 1. 国際的志向性と英語力が WTC に与える影響

説明変数	標準化係数 β	t 値	p 値
PreAAT（異文化接近回避傾向）	**0.45**	4.338	< 0.001
PreIVA（国際的職業・活動関心）	0.104	1.007	0.316
PreIFA（海外情報・出来事関心）	0.035	0.417	0.678
スピーキング力	0.191	1.798	0.075
リスニング力	0.004	0.039	0.969

表2. 研修前後における国際的志向性の変化と英語力の影響

変数	研修前後の変化	リスニング力との交互作用	スピーキング力との交互作用	リスニング力の主効果	スピーキング力の主効果	モデルの適合度
AAT（異文化接近回避傾向）	**$F_{(1, 100)}$ = 15.722 (p < 0.001)**	F = 0.011 (p = 0.917)	F = 1.686 (p = 0.197)	$F_{(1, 100)}$ = 0.041 (p = 0.840)	**$F_{(1, 100)}$ = 7.29 (p = 0.008)**	**Pillai's trace = 0.136**
IVA（国際的職業・活動関心）	$F_{(1, 100)}$ = 1.868 (p = 0.175)	F = 0.500 (p = 0.481)	F = 0.487 (p = 0.487)	$F_{(1, 100)}$ = 0.395 (p = 0.531)	$F_{(1, 100)}$ = 2.422 (p = 0.123)	Pillai's trace = 0.018
IFA（海外情報・出来事関心）	**$F_{(1, 100)}$ = 3.877 (p = 0.052)**	F = 0.975 (p = 0.326)	F = 0.314 (p = 0.577)	$F_{(1, 100)}$ = 0.001 (p = 0.979)	$F_{(1, 100)}$ = 1.000 (p = 0.320)	Pillai's trace = 0.037

表3. WTC，英語力，国際的志向性が研修中のコミュニケーション行動に与える影響

	標準化係数 β	t 値	p 値
定数		3.115	0.002
WTC	−0.062	−0.527	0.6
リスニング力	0.099	0.836	0.405
スピーキング力	0.083	0.66	0.511
PreAAT（異文化接近回避傾向）	0.184	1.398	0.165
PreIVA（国際的職業・活動関心）	−0.008	−0.069	0.945
PreIFA（海外情報・出来事関心）	**0.311**	**3.18**	0.002

3.3 研修前の WTC，国際的志向性，英語力が研修中のコミュニケーション行動に与える影響（RQ3）

研修中の英語による自発的なコミュニケーション行動を測定するため，研修前の WTC（「日本での学生生活を英語で説明したいか」），英語力（リスニング力・スピーキング力），国際的志向性の 3 側面：異文化接近回避傾向（PreAAT），国際的職業・活動への関心（PreIVA），海外情報・出来事への関心（PreIFA）を説明変数，「自分から英語で話しかけた回数」を従属変数としとして重回帰分析を行った。

表3 で個々の説明変数をみると，PreIFA（海外情報・出来事への関心）のみが有意な正の影響を示した（β = 0.311，t = 3.18，p = 0.002）。すなわち，研修前の時点で海外ニュースや国際情勢に高い関心を持つ学生ほど，研修中に自発的に英語で話しかける回数が多かったことが明らかとなった。一方，PreAAT（β = 0.184，t = 1.398，p = 0.165），リスニング力（β = 0.099，t = 0.836，p = 0.405），スピーキング力（β = 0.083，t = 0.66，p = 0.511），PreIVA（β = −0.008，t = −0.069，p = 0.945），研修前の WTC（β = −0.062，t = −0.527，p = 0.600）はいずれも有意な影響を示さなかった。

多重共線性の検証では，VIF 値は全て 2.1 未満であり，条件指数も危険域に達していなかったため，推定の安定性に問題はなかった。モデル全体の結果は R^2 = 0.183（調整済 R^2 = 0.131）であり，説明変数は話しかけた回数の約 18％ を説明していた。$F_{(6,96)}$ = 3.572，p = 0.003 となり，モデル全体として統計的に有意であった。

4. 考　　察

国際的志向性と英語力が WTC に与える影響（RQ1）については，研修前の段階においては，国際的志向性のうち特に異文化接近傾向が WTC の最も重要な予測因子であることが明らかになった。また，スピーキング力は有意傾向を示し，英語を話す能力について自己評価が高いほど，学生生活の説明といった，内容が少し複雑になる可能性があっても，コミュニケーションを取りたい意欲につながる可能性が示唆された。一方で，リスニング力には有意な影響が確認されなかった。また，国際的職業的関心や国際情報への関心も WTC に対して直接的な影響を持たないことが確認された。これらの知見は，外国人と友達になりたい，といった個人的な心理的距離の縮小とスピーキング力の育成が，海外研修前から学生の WTC を高める鍵となることを示している。

研修前後における国際的志向性の変化と英語力の影響（RQ2）については，異文化接近傾向において明確な向上が確認され，研修によって，外国人とより親しくなりたい，という傾向が示された。一方，国際的職業・活動に対する関心には有意な変化がなく，海外情報・出来事に対する関心は統計的有意水準には達しないものの，向上傾向が見られた。英語力は研修による変化の度合いに影響を与えなかったが，スピーキング力の高い学生は研修前後を通じて異文化接近傾向が強いという個人特性が確認された。これらの結果は，短期研修によって実際に海外を経験することが異文化や外国人に対する態度の改善には効果的であることを示している。一方，国際的職業・活動への関心や国際的出来事への関心には強い影響を与えないことが示唆された。

研修前の WTC，国際的志向性，英語力が研修中のコミュニケーション行動に与える影響（RQ3）については，短期海外研修における自発的な英語使用行動は，英語運用能力や WTC よりも，国際的出来事への関心といった内面的志向によって促進される可能性を示している。研修前の WTC が必ずしも行動に直結していないことから，意欲と行動の間

には環境要因や心理的ハードルが介在していると考えられる。研修先によって，現地の学生とバディを組むように設定されるところとそうでないところがあり，そうした，気軽にコミュニケーションを取りやすい状況が設定されているか，といった要因が影響している可能性もある。

以上より本研究は，（a）医療学部生の短期海外研修が異文化接近傾向を高めること，（b）自発的なコミュニケーション行動については海外情報・出来事への関心が重要であることを同時に示した。

WTC は研修前の異文化接近回避傾向に強く規定される一方で，その WTC が直ちに自発的なコミュニケーション行動へ変換されるとは限らないという点は，意図と行動間のギャップの存在を示唆する。すなわち，異文化に前向きで英語で説明したいという意志があっても，実際の現場では相手・状況・機会の制約，心理的安全性，プログラム設計（発話機会の組み込み）等が行動化を左右する可能性が高い。

海外情報・出来事への関心が自発的なコミュニケーション行動を予測したことは，学習者が持つ，世界への好奇心や社会的トピックへの関心が，対人コミュニケーションの動機づけとして機能することを示す。この知見は，英語教育における語彙・文法の訓練に加えて，国際ニュースに対する関心，現地課題の事前学習，医療制度・文化差への探究学習を通じて，海外や国際事情に対する関心を育てる必要性を示唆している。

また，異文化接近回避傾向が研修で向上したにもかかわらず，国際的職業・活動への関心および海外情報・出来事への関心の変化が限定的だった点は，短期研修の幅と深さに関わるといえる。すなわち，短期研修は異文化への心理的距離を縮める効果を持ち得るが，国際的職業・活動志向や海外情報・国際問題への持続的関心といった価値や態度の変容は，研修期間の長さや経験の質・内容のみならず，より広範な要因に左右されることが示唆される。

英語力に関しては，スピーキング力の主効果のみが異文化接近回避傾向の水準に関連し，交互作用がみられなかった。これは，発話における言語的自信が異文化接近の態度水準を規定する可能性を示す。一般的に，スピーキングが上手になりたいと希望する学生は多いが，スピーキング力が実際に異文化への態度形成にまで関わる可能性を示す点は，英語教育における言語技能と情意的側面の結びつきを考える上で重要な示唆を与えているといえる。

5. 限　　界

本研究においては，第一に，英語力・国際的志向性・WTC はいずれも自己報告に依拠しており，測定誤差や社会的望ましさバイアスを免れない。第二に，分析において受入体制，バディ制度等の介入要素を統制していないため，研修プログラムのデザイン差が効果に混入している可能性がある。第三に，実行行動（話しかけ回数）は数量化されているが，相互行為の質（相手役割，医療的専門性，会話の複雑性，情動負荷）を捉えていない。

今後は，こうした制約を踏まえつつ，より多面的なデータ収集や分析枠組みを導入し，海外研修の教育的効果を多角的に検証していくことが求められる。また，個人差や研修環境の多様性を考慮しながら，学生の学びのプロセスと成果を一層精緻に理解する方向性が望まれる。

6. 結　　論

本研究では，WTC は主として研修前の異文化接近傾向によって説明されることが明らかとなった。さらに，短期海外研修が医療学部生の異文化接近傾向を有意に高める効果をもつことも確認された。一方で，実際の自発的なコミュニケーション行動に至るには，国際的出来事や海外事情への関心が重要であり，言語技能や WTC そのものよりも，国際社会への好奇心が発話行為を促進する要因となる可能性が浮かび上がった。英語教育における実践的示唆としては，言語技能訓練と並行して国際的関心を育むカリキュラムやコンテンツをより重視して取り入れることが有効であると考えられる。

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"Connect" before "Correct": Introducing Nonviolent Communication (NVC) in Medical Communication in Japan

Shozo Yokoyama

University of Miyazaki, Faculty of Medicine

Abstract

Effective communication is increasingly vital in healthcare, with empathy-based dialogues enhancing treatment outcomes and patient satisfaction. This study explores the integration of Nonviolent Communication（NVC）, developed by Marshall B. Rosenberg, into Japanese medical education to foster empathy and trust in patient-provider relationships. NVC emphasizes identifying emotions and needs to resolve conflicts and deepen mutual understanding. Over four months（October 2024 to January 2025）, we implemented an NVC-based educational program for 23 first-year medical students at the University of Miyazaki. Through workshops, role-playing, and media like *Inside Out*, students practiced NVC's four components: observation, feelings, needs, and requests. Post-program surveys revealed significant improvements in students' empathy, communication skills, and recognition of emotions' role in trust-building. Over 85% of students reported intent to apply NVC in future patient and colleague interactions, despite initial cultural resistance to emotional expression. Challenges included English-language barriers and limited practice opportunities. These findings demonstrate NVC's potential as a transformative tool for fostering patient-centered care in Japan's medical education, offering a model for culturally adapted communication training to enhance treatment efficacy and patient satisfaction.

J Med Eng Educ (2025) 24 (3): 68-77

Keywords empathy, feeling, needs, medical students, non-violent communication

1. Introduction

1.1 Overview

In recent years, the importance of communication in healthcare settings has been increasingly recognized. Dialogues rooted in empathy and trust significantly influence treatment outcomes and patient satisfaction, as demonstrated by numerous studies.[1] Fostering empathy during medical education is critical for achieving patient-centered care and building trust. Empathy, defined as the ability to understand and appropriately respond to patients' emotions and perspectives, directly impacts interpersonal relationships and treatment outcomes in healthcare settings.[2] Against this backdrop, Nonviolent Communication (NVC), a communication approach proposed by Marshall

B. Rosenberg, has emerged as a valuable tool in medical education.[3] NVC aims to clarify the needs of oneself and others, resolve conflicts, and foster mutual understanding through empathy. This study implemented an NVC-based educational program for first-year medical students in Japan over four months (October 2024 to January 2025) and evaluated its effectiveness. This introduction outlines the theoretical background of NVC, its significance to medical education, challenges within the Japanese medical culture, and the purpose and significance of this study.

1.2 The Need for Empathy Education in Medical Students: Literature Review

Empathy in medical education is not merely an interpersonal skill but a critical factor influencing patient satisfaction, treatment adherence, and the mental health of healthcare professionals. Ekman and Krasner highlight that empathy is a neuro-scientifically supported ability that can be enhanced through training.[4] Their research suggests that empathy-related brain regions (e.g., prefrontal cortex and amygdala) are activated through training, improving healthcare professionals' emotional regulation. This neuroscientific evidence underscores that empathy education is not just an ethical obligation but a scientifically validated skill.

● **Corresponding author:**

Shozo Yokoyama
University of Miyazaki, Faculty of Medicine
5200 Kihara, Kiyotake-cho, Miyazaki-shi, Miyazaki, 889-1692 Japan
TEL: 0985-85-3595 FAX: 0985-85-3595
E-mail: yokoyama@med.miyazaki-u.ac.jp

However, studies have reported a decline in empathy among medical students as they progress through their education. Research by Keshtkar et al. at Leicester Medical School found that empathy scores significantly decreased among students entering clinical training.[5] This decline is attributed to stress, time constraints, and an overemphasis on technical skills. These findings highlight the need for early and sustained empathy education.

1.3 Current State of Empathy Education in Japanese Medical Education

In Japan, medical education has traditionally prioritized scientific knowledge, such as anatomy and pharmacology. However, the importance of communication skills and empathy training is increasingly recognized. Studies indicate that only a small proportion of patients in Japan perceive healthcare providers as engaging in patient-centered communication, underscoring the need for empathy education, particularly for younger medical students.[6] However, systematic NVC-based programs remain uncommon in Japan, and empirical research on their effectiveness is limited.

1.4 Theoretical Background of NVC

NVC is a framework designed to reduce conflict and misunderstanding in interpersonal relationships while fostering empathy-based communication. It consists of four components: (1) Observation (objectively identifying facts), (2) Feelings (recognizing one's emotions), (3) Needs (identifying the needs behind emotions), and (4) Requests (making clear, actionable requests).[3] By consciously applying these components, communicators can express their feelings and needs honestly without blaming or criticizing others. NVC also enables understanding of others' perspectives and emotions, fostering empathetic dialogue. This process is particularly effective in emotionally charged situations or when communicating with individuals holding differing values.

NVC is rooted in humanistic psychology and conflict resolution studies, sharing similarities with Carl Rogers' client-centered therapy and Martin Buber's "I and Thou" philosophy.[7, 8] It views relationships as equal, emphasizing mutual respect and understanding over power or control. Thus, NVC transcends mere conversational techniques, serving as a philosophical approach to enhancing the quality of human relationships.

1.5 Significance of NVC in Medical Education

In healthcare, effective communication between physicians, patients, and colleagues directly impacts treatment success and patient satisfaction. Research shows that effective communication enhances treatment adherence and reduces the risk of misdiagnosis or medical errors.[9] However, traditional medical education has often prioritized technical and scientific knowledge, with insufficient focus on communication skills training.[10]

For early-stage medical students, developing empathy and interpersonal skills through patient interactions and teamwork is crucial. NVC provides a practical framework for students to understand their emotions and needs while maintaining an empathetic stance in relationships with patients and colleagues. Internationally, NVC-based programs have been shown to improve medical students' empathy and reduce stress.[11] However, its application in Japanese medical education remains limited, with few empirical studies on its effectiveness.

1.6 Challenges in Introducing NVC in Japanese Medical Culture

Japan's medical culture is influenced by unique cultural norms, such as hierarchical relationships and collectivism, which may suppress open emotional expression or needs articulation.[12] Physicians are often expected to maintain an authoritative role, creating emotional distance in patient interactions. These cultural norms pose challenges to implementing NVC in Japan.

Moreover, the demanding academic and clinical schedules of Japanese medical students limit the time available for communication skills training. Mastering NVC requires not only theoretical understanding but also repeated practice through workshops and role-playing.[3] Therefore, effectively integrating NVC into Japanese medical curricula requires cultural adaptation and consideration of time constraints.

1.7 Purpose and Significance of the Study

This study aims to implement a four-month NVC educational program for first-year medical students in Japan and evaluate its effectiveness. Specifically, it assesses the impact of NVC training on students' empathy, communication skills, and stress-coping abilities. It also examines how NVC is received in the context of Japanese medical education and identifies associated challenges. The study is significant for the following reasons:

1. It provides empirical evidence of NVC's applicability in Japanese medical education, offering a new model for communication training.
2. It establishes a foundation for studying the long-term impact of early NVC training on students' interpersonal skills and patient-centered care as future physicians.
3. It offers insights into developing culturally adapted NVC programs for Japan.

These outcomes have the potential to enhance the quality of medical education, patient satisfaction, and collaboration within healthcare teams.

2. Methods

Awareness of NVC among Japanese healthcare professionals is relatively low. Therefore, this section details the content of each class, student reflections, and the learning process through NVC practice. The program consisted of 15 ninety-minute sessions, with the final two sessions dedicated to an in-person empathy test conducted in English.

2.1 [Week 1] Introduction to NVC and Basic Concepts

< Session Overview >

The first session introduced the basic concepts of Nonviolent Communication (NVC). Students shared their communication experiences in groups and reflected on them from an NVC perspective. Topics included:

- NVC overview: Building connections based on emotions and needs.
- Instructor (Yokoyama)'s experience with NVC: Sharing real-life applications.
- Importance of emotional expression: Emphasizing the role of conscious emotional handling.
- Communication challenges and conflicts: Reflecting on students' experiences.
- NVC's four processes (Observation, Feelings, Needs, Requests): A simple yet profound framework.

< Student Reflections >

- Some students found the abstract nature of emotions and needs challenging, expressing resistance due to conflicting values.
- Others resonated with the instructor's anecdotes, noting increased self-awareness and recognition of self- or other-blaming tendencies.
- Students found the meaning of *Ahimsa*, which refers to the yogic philosophy of non-violence (ahimsa) and its spiritual principles mentioned in the text,[3] difficult to understand and NVC "formal and unapproachable."
- Cultural barriers were noted, with some students feeling that expressing needs was "uncool."

2.2 [Week 2] Everyday Communication and NVC Empathy

< Session Overview >

During these sessions, the instructor:
- Examined habits of "judgment" or "demanding" in daily communication.
- Introduced NVC's four approaches/ four "ears": (1) blaming others, (2) blaming oneself, (3) listening to others' needs, and (4) recognizing one's own needs.
- Used emotion and needs lists to explore the diversity of emotions and the universality of needs.
- Emphasized empathy as "deep listening" without advice or rebuttal. Students practiced verbalizing emotions and needs in workshops.

< Student Reflections >
- Students were surprised by the variety of emotions and noticed their unconscious judgmental habits.
- Some found NVC formal but expressed interest in mastering it, noting that it prompted self-reflection.
- Students recognized tendencies to blame others or themselves and were surprised by the commanding nature of "must."
- Students found the instructor's anecdotes about interactions with children engaging and appreciated NVC's perspective.
- Students expressed mixed feelings of cultural resistance and excitement about new empathy techniques.

2.3 [Week 3] Watching *Inside Out*

< Session Overview >

Students watched Pixar's *Inside Out* to visually explore the roles and interactions of emotions (Joy: *Yorokobi*, Sadness: *Kanashimi*, Anger: *Ikari*, Fear: *Bibiri*, Disgust: *Mukamuka*) and prepare to analyze emotions and needs from an NVC perspective. The importance of accepting emotions without judgment was introduced.

< Student Reflections >

Reflections were shared in Session 4.

2.4 [Week 4] Analysis and Discussion of *Inside Out*

< Session Overview >

The instructor analyzed and explained *Inside Out* from an NVC perspective, focusing on Riley's suppression of emotions (especially sadness) and Joy's realization of sadness's value. Key points included:

- The importance of acknowledging emotions and identifying needs.
- The interaction between Joy and Sadness: Sadness fulfills needs for connection and understanding.
- The scene where Sadness empathizes with Riley's imaginary friend Bing Bong's sense of loss, which was emphasized as a quintessential example of empathy in NVC.
- A quote was included from Eisuke Wakamatsu's *Kanashimi no higi* (The Mystery of Sadness): "There are doors that only open through sadness."[13]
- Riley's courage to express "loneliness" to her parents: The significance of articulating needs.
- Rosenberg's concept of "taking responsibility for one's own emotions," where responsibility is defined as "response + ability," with emotions rooted in one's needs, was discussed.
- Students speculated on Riley's needs (e.g., understanding, connection, security) in groups, shared personal emotional experiences, and discussed the acceptance of sadness and its relevance to healthcare.

< Student Reflections >

During these sessions, students:

- Recognized the necessity of sadness and the risks of suppressing emotions.
- Found verbalizing emotions and needs challenging but essential, noting that sadness fosters trust.
- Were moved by Joy's tears and expressed a desire for courage to accept their vulnerabilities.
- Found NVC practical but difficult to implement, particularly for those unaccustomed to emotional expression.
- Gained deeper insights from the film, such as the value of sadness in fostering kindness and the complexity of emotions.

2.5 [Week 5] Empathy Practice (Guessing Emotions and Needs)

< Session Overview >

Students practiced NVC's four processes concretely. During these sessions, the students

- Wrote emotions and needs on heart-shaped A4 sheets and guessed their partner's emotions and needs in pairs.
- Conducted empathy exercises with the instructor to experience identifying needs behind emotions.
- Explored needs essential for a "vibrant and fulfilling life" to deepen self-understanding.

< Student Reflections >

- Students found identifying needs behind emotions challenging but recognized the value of deep listening.
- Students noticed emotions like irritation or anger and struggled with verbalization.
- Students appreciated the perspective of supporting others' expression rather than guessing needs, seeing NVC's potential for mutual understanding.
- Some students were confused by the exercise's intent.

2.6 [Week 6] Textbook Review and Instructor Feedback

< Session Overview >

Students reflected on the pre-assigned text, Nonviolent Communication—A language of life,[3] to deepen understanding of emotions and needs. Students shared reflections, discussed empathy and the challenges of verbalization, and reaffirmed the importance of deep listening and the connection between emotions and needs.

< Student Reflections >

During these sessions, students:

- Understood the meaning of "listening properly" and found needs identification helpful for self-understanding.
- Noted that NVC facilitates smooth communication and found exploring others' needs less stressful.
- Struggled with verbalizing emotions and understanding the instructor's intent.

2.7 [Week 7] NVC's Four Processes and Emotional Responsibility

< Session Overview >

Students revisited NVC's four processes and explored "taking responsibility for one's emotions":

- The instructor introduced the perspective that emotions stem from one's needs, not others' actions. The Japanese term for 'responsibility,' *sekinin*, carries a significantly different meaning and nuance compared to the English concept of 'response + ability,' and students appeared to gain a new perspective with a sense of surprise.
- Students practiced distinguishing observation from evaluation and guessing emotions and needs in workshops.

< Student Reflections >

During these sessions, students:

- Felt relieved by the perspective that emotions stem from needs and appreciated the redefinition of responsibility.
- Recognized unconscious evaluation and judgment habits and found verbalizing emotions challenging.
- Noted NVC's lack of "human warmth" but valued its ability to bridge emotional distance, with some students reflecting on conflict avoidance as a barrier to self-expression.

2.8 [Week 8] Empathy Practice (Reflection and Needs Guessing)

< Session Overview >

Students conducted pair-based empathy exercises where one student shared joys or frustrations, and the other practiced reflection and guessing emotions and needs. Students learned to convert pseudo-feelings (e.g., "betrayed") into true feelings (e.g., "sad") and express their needs abstractly.

< Student Reflections >

- Students found converting pseudo-feelings challenging but appreciated the exercise's emotional relief.
- Students noted a lack of vocabulary for emotions and needs but valued the practice.

2.9 [Week 9] Judgment and NVC Practice

< Session Overview >

- Students watched the YouTube video "Short Introduction to Nonviolent Communication (NVC)" by Yoram Mosenzon, and learned how judgment hinders communication.
- The instructor quoted Rosenberg: "Judgment is a tragic expression of beautiful needs," and practiced non-judgmental expression.
- Students conducted self-empathy steps (observation, feelings, needs) in English.
- Students practiced guessing others' needs while listening.

< Student Reflections >
- Students found the video clarifying but noted the gap between theory and practice.
- Students felt self-empathy steps were embodied and appreciated concise needs expression.
- The perspective that everyone's needs is equally valuable resonated with students.

2.10 [Week 10] NVC Mediation
< Session Overview >

Students experienced NVC-based mediation, focusing on listening to both parties' emotions and needs rather than solutions. Students learned the mediator's role in translating aggressive language into needs and practiced the mediation process with emotion and needs vocabulary.
< Student Reflections >

During these sessions, students
- Found mediation challenging due to limited needs vocabulary and difficulty timing conclusions.
- Noted that concise needs expression deepened understanding and valued the mediator's role.
- Felt some discussions remained unresolved but saw mediation as "treasure hunting."

2.11 [Week 11] Separating Self-Expression and Empathy
< Session Overview >

The instructor conducted exercises to distinguish self-expression from empathy for others, using A4 sheets to organize "self-expression," "empathy for others," and "self-empathy." Students practiced with a histology test as a theme and strengthened emotion and needs vocabulary through English reflections.
< Student Reflections >
- Students found separating self-expression and empathy novel but struggled with English reflections.
- Students recognized the importance of first receiving others' perspectives.

2.12 [Week 12] Emotion and Needs Vocabulary Test
< Session Overview >

Students took a test focused on expressing emotions and needs in English, assessing the retention of NVC foundational skills, and aiming to enhance practical abilities.

2.13 [Week 13] Empathy Practice in English (Empathy 10 Knock)
< Session Overview >

Students practiced the activity "Empathy 10 Knock" in pairs, where one student shared frustrations, and the other practiced reflection and guessing emotions and needs. Students switched partners and repeated the same activity improve use of English expression.
< Student Reflections >
- Students found English empathy challenging but

noted vocabulary growth and the satisfaction of deep listening.
- Students recognized needs through sharing frustrations, enhancing self-understanding.

2.14 [Week 14-15] Empathy Test (Interview)
< Session Overview >

Students practiced empathy through reflection, identifying emotions, and guessing needs based on the instructor's two-minute English narrative about daily events. This served as a comprehensive assessment of NVC practical skills.

2.15 Post-program survey

A post-program survey was conducted; 21 of 23 participants responded to the survey to evaluate NVC learning outcomes, changes in understanding emotions and needs, and applicability in daily life and healthcare. The survey used a 5-point Likert scale to assess NVC's educational impact quantitatively and qualitatively, revealing changes in students' awareness.

3. Survey Results

3.1 Emotional Importance
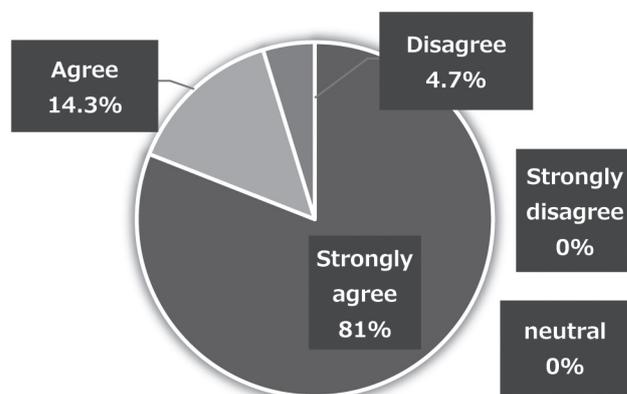3.1.1 "Knowing 'emotions' is important for deeply understanding others" (**Figure 1**)

Most students recognized emotions as key to empathy, reflecting the program's impact.

3.1.2 "All emotions, positive or negative, are clues to understanding what matters to oneself" (**Figure 2**)

Many students viewed emotions positively as needs indicators, influenced by *Inside Out*.

3.1.3 "Emotions and needs (what one values or desires) are closely connected" (**Figure 3**)

Over 85% recognized the emotion-needs connection, indicating NVC concept retention.

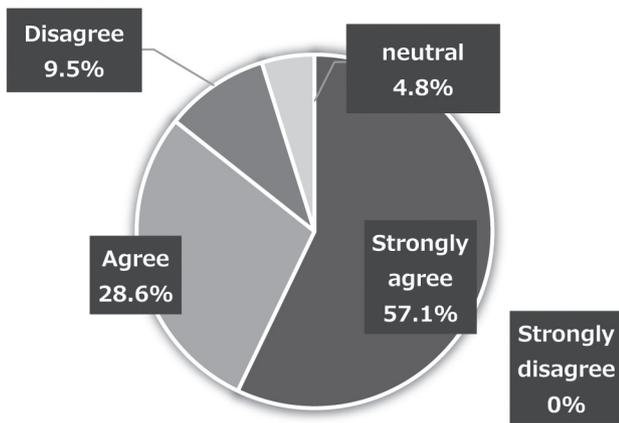**Figure 1. "Knowing 'emotions' is important for deeply understanding others' perspectives." (*n* = 21)**

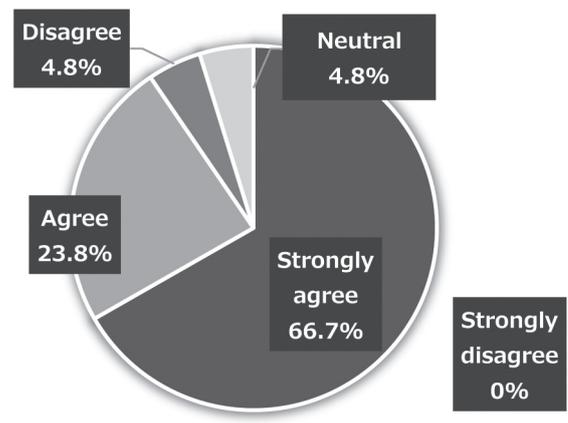**Figure 2.** "All emotions, whether positive or negative, serve as clues to understanding what matters to oneself." (*n* = 21)

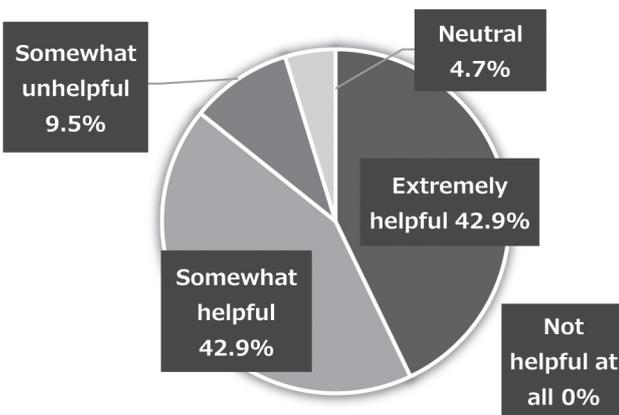**Figure 3.** "There is a close connection between people's emotions and their needs (what they value or desire)." (*n* = 21)

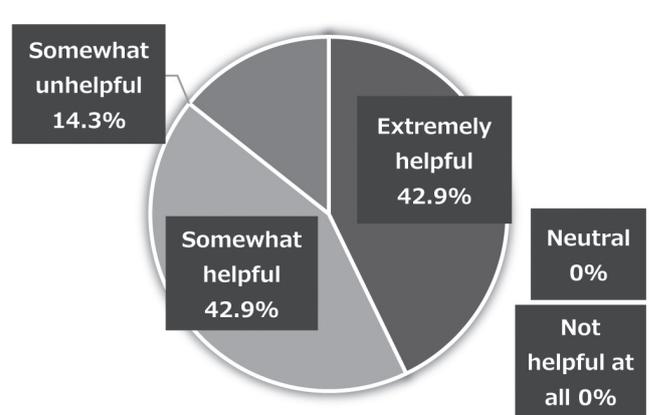**Figure 4.** "Did the 'emotion and needs cards' used in class help with NVC empathy practice?" (*n* = 21)

Figure 5. "Did the one-on-one empathy exercises conducted with peers help you understand NVC's concept of 'empathy'?" (*n* = 21)

3.2 Effectiveness of Tools and Exercises

3.2.1 "Did the 'emotion and needs cards' used in class help with NVC empathy practice?" (**Figure 4**)

Over 85% found the cards effective in addressing vocabulary gaps.

3.2.2 "Did the one-on-one empathy exercises help you to understand NVC's 'empathy'?" (**Figure 5**)

Exercises aided empathy understanding, though 14% cited partner motivation or English barriers.

3.3 Changes in Perception of Anger and Frustration

3.3.1 (Pre-program) "How did you feel/think about people expressing anger or frustration?" (**Figure 6**)

Pre-program, students judged negative emotions negatively.

3.3.2 (Post-program) "How do you feel/think about people expressing anger or frustration?" (**Figure 7**)

Post-program, judgmental labels decreased, and recognition of unmet needs increased, reflecting NVC's non-judgmental and inquisitive stance perspective.

3.4 Intent to Apply NVC

3.4.1 "Would you use NVC listening (even partially) when a friend seeks advice?" (**Figure 8**)

Over 80% of students intended to use NVC in friend consultations, indicating high applicability.

3.4.2 "Would you use NVC listening (even partially) when listening to patients' difficult stories?" (**Figure 9**)

High intent to apply NVC in healthcare suggests its perceived utility.

3.5 Changes in Perception of Sadness

3.5.1 (Pre-program) "Did you think 'sadness' was an important emotion?" (**Figure 10**)

Nearly 90% (**Strongly agree 42.9%**, Somewhat agree 47.6%) of students viewed sadness positively pre-program, with some dissent.

Figure 6. (Before taking this course) "How did you feel or think about people who expressed 'anger or frustration' through their attitude or words?" (Multiple responses allowed) (*n* = 21)

Figure 7. (After taking this course) "How do you feel or think about people who express 'anger or frustration' through their attitude or words?" (Multiple responses allowed) (*n* = 21)
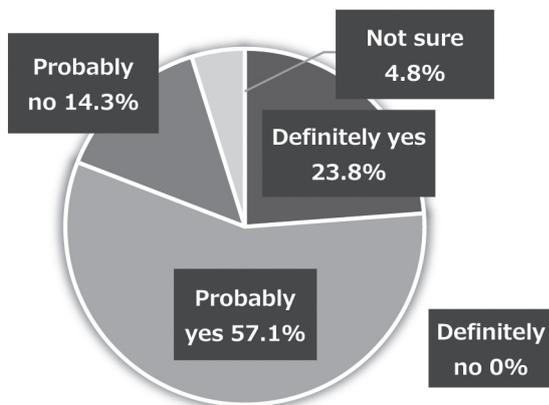

Figure 8. "If a friend seeks your advice, would you use NVC-style listening (even partially)?" (*n* = 21)
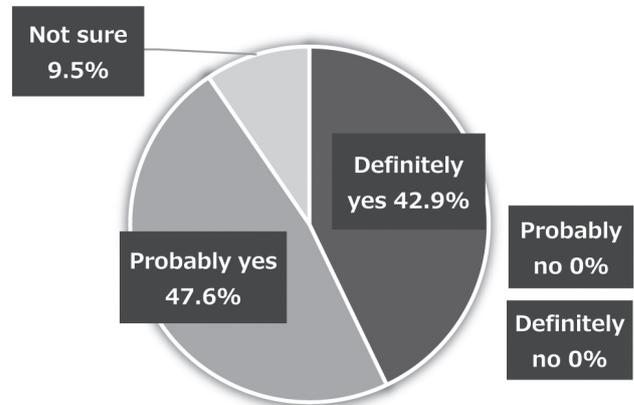
Figure 9. "If you listen to a patient's difficult stories in the future, would you use NVC-style listening (even partially)?" (*n* = 21)

3.5.2 (Post-program) "Do you think 'sadness' is an important emotion?" (**Figure 11**)

Post-program, over 95% (**Strongly agree 66.7%**, Somewhat agree 28.6%) viewed sadness positively, with *Inside Out* reinforcing its value.

3.6 NVC Use Outside Class
3.6.1 "Did you try using NVC outside of class during the semester?" (**Figure 12**)

Over 80% used NVC outside class, indicating integration into daily life.

3.6.2 For those who used NVC: "In what situations?" (12 free responses)
- "When a friend shared a serious concern, to lower their barriers."
- "When a friend became emotional during a conflict."
- "When a friend sought advice."
- "When a friend was stressed before an exam."
- "During a fight with a friend, asking what they needed instead of reacting."
- "When listening to emotional people."
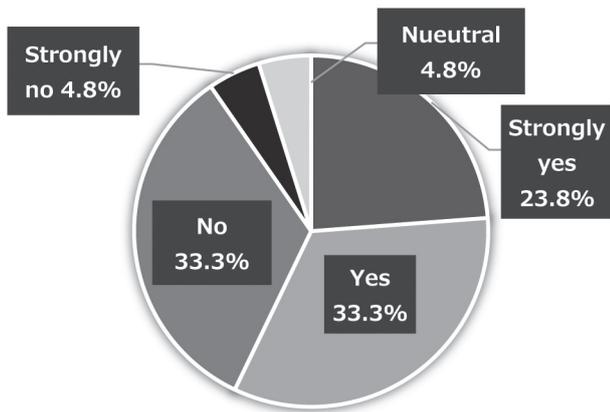- "With a withdrawn elementary school student at my

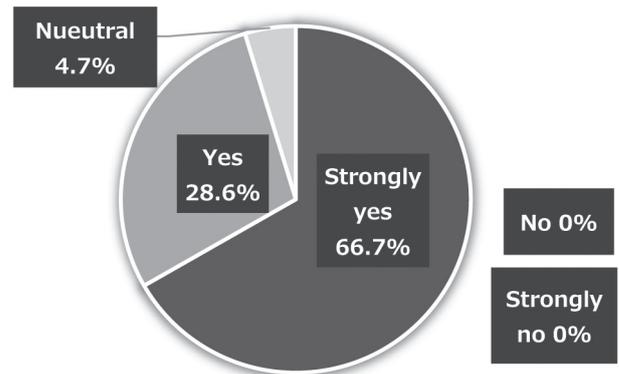**Figure 10.** (Before taking this course) "Did you think 'sadness' was an important emotion?" (n=21)

Figure 11. (After taking this course) "Do you think 'sadness' is an important emotion?" (*n* = 21)
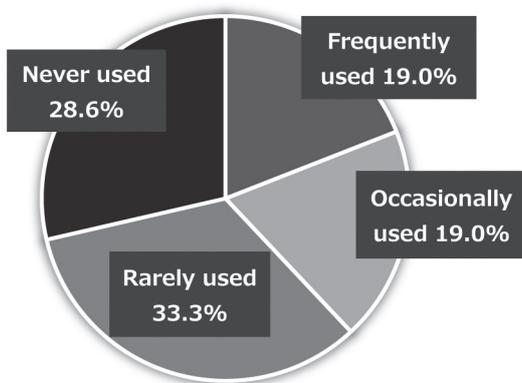
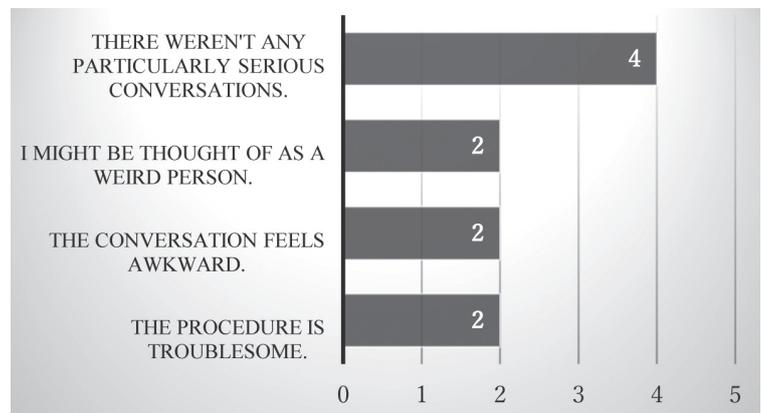**Figure 12.** "During the semester, did you try using NVC outside of class?" (*n* = 21)

Figure 13. For those who answered "did not use" to the previous question: "Why not?" (Multiple responses allowed) (*n* = 21)
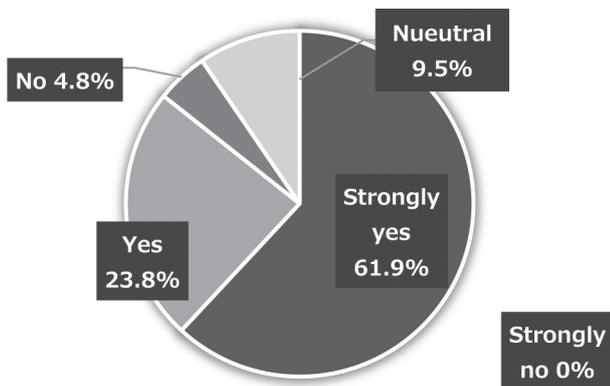
Figure 14. "In the final empathy test (interview), do you think you could have empathized better if it was conducted in Japanese instead of English?" (n=21)

tutoring job."
- "During a friend conflict."
- "When I couldn't understand someone's emotions."
- "To organize my feelings or communicate with someone less expressive."
- "With a classmate from the EMP class."
- "With myself, when irritated or reflecting."

These responses show NVC's use in consultations with friends, conflicts, self-reflection, and interactions with children, confirming its effectiveness in emotional situations.

3.6.3 For those who didn't use NVC: "Why not?" (Figure 13)
Non-use was primarily due to lack of opportunity or unfamiliarity, not NVC's difficulty.

3.7 Language Challenges in Empathy Test
3.7.1 "Would you have performed better in the empathy test in Japanese instead of English?" (Figure 14)
Over 85% felt Japanese would be more effective, highlighting English as a barrier.

3.7.2 For those who preferred Japanese: "Which parts?" (Figure 15)
Emotion and needs identification were particularly language-dependent.

3.8 NVC's Future Potential
3.8.1 "Will NVC be useful for communicating with patients as a future healthcare professional?" (Figure 16)
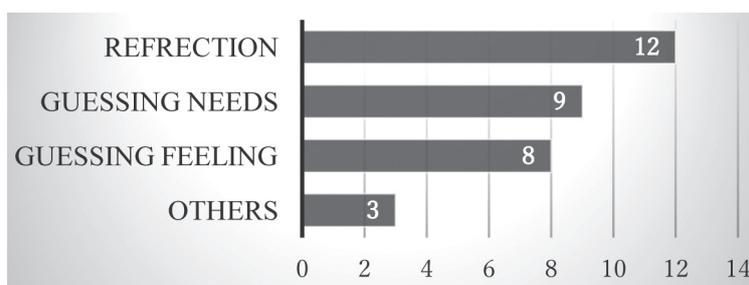Over 85% saw NVC as useful for patient communication.

Figure 15. For those who answered "strongly agree" or "somewhat agree" to the previous question: "Which parts?" (Multiple responses allowed) (*n* = 21)
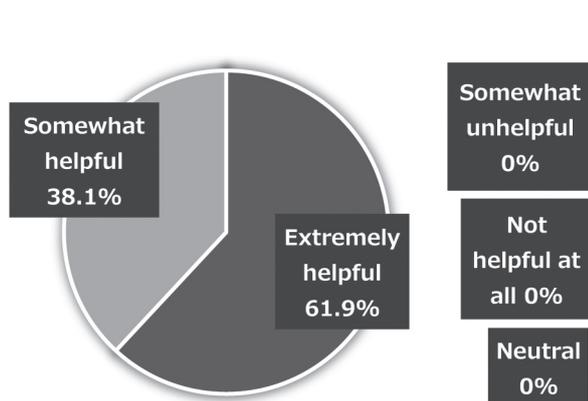

Figure 16. "Do you think the NVC learned in this course will be useful for communicating with patients as a future healthcare professional?" (*n* = 21)
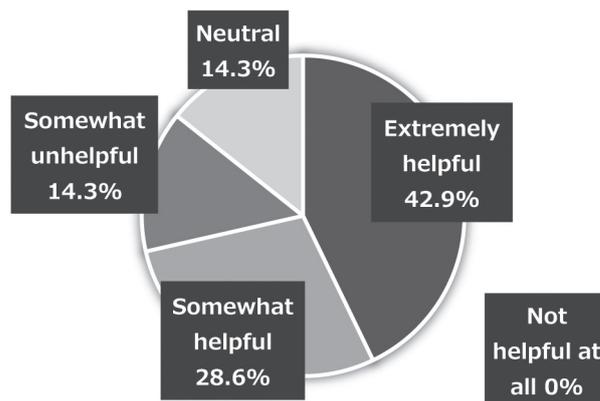

Figure 17. "Do you think the NVC learned in this course will be useful for communicating with colleagues or superiors as a future healthcare professional?" (*n* = 21)

3.8.2 "Will NVC be useful for communicating with colleagues or superiors as a future healthcare professional?" (**Figure 17**)

All students viewed NVC as effective for resolving workplace conflicts.

3.9 Fulfilled and Unfulfilled Needs

3.9.1 "What needs were fulfilled in this course?"
- "Understanding and being understood: I hadn't considered emotions in communication before."
- "Connection: I learned ways to communicate more easily with others."
- "Stimulation, growth, care: Exploring new communication methods was enjoyable."
- "Exploration: I learned many new things."
- "Practicality: The course will be useful after graduation."
- "Mutual understanding: Listening deepened my interest in others."
- "Awareness: Recognizing that needs underlie emotions."
- "Knowledge, integration, self-connection."
- "Connection: Sharing emotions and needs with unfamiliar classmates."
- "Self-connection."
- "Knowledge: I hadn't formally studied communication

before."

These responses indicate that NVC fulfilled needs for exploration, connection, and growth, enhancing self- and mutual understanding.

3.9.2 "What needs were unfulfilled in this course?"
- "Expressing thoughts: I struggled to convey ideas effectively."
- "Competence: I couldn't fully demonstrate NVC skills in the English test."
- "Clarity: The course felt less meaningful initially due to NVC's complexity."
- "Reducing future anxiety: I gained some insight into patient interactions."
- "Practice: I wanted more English conversation opportunities."
- "English proficiency: My limited conversational skills made reflection challenging."
- "Clarity: Understanding NVC took time due to my lack of prior experience."
- "Exploration and collaboration: Learning varied with unmotivated partners."

Language barriers, initial complexity, and limited practice opportunities were key issues, suggesting areas for course improvement.

3.10 Overall Course Reflections

- "The new communication approach was confusing but changed my perspective."
- "Learning about NVC was valuable; I feel lucky to have taken this EMP course."
- "It felt formal, but I enjoyed using NVC to listen to concerns."
- "A highly insightful and meaningful experience."
- "I'm satisfied with the new communication method."
- "I was confused by the mix of English and Japanese, but it was challenging."
- "I learned true empathy."
- "It was applicable to daily life."
- "I understood that needs underlie negative emotions."
- "It was initially confusing, but I grasped NVC's essence."
- "An opportunity to deeply reflect on communication, which was interesting."
- "It expanded my communication tools."
- "I understood the theory but need practice for implementation."
- "Despite English challenges, it was meaningful."
- "It was interesting but with some skepticism; gaining knowledge was a key outcome."

These reflections highlight NVC's novelty and utility, with English and practice challenges noted. Overall, students reported significant awareness shifts and high satisfaction.

3.11 Survey Summary

Through 15 sessions and the survey, students progressed from NVC theory to practice, developing a mindset of acknowledging emotions and needs. Initial resistance to NVC's abstract nature was overcome through *Inside Out* and practical exercises, with students showing increased intent to apply NVC in daily life and healthcare. The survey confirmed heightened recognition of the importance of emotions, shifts in perspectives on sadness and anger, and challenges with English and practice opportunities. NVC proved effective in fostering connection as a tool for medical students' growth.

4. Conclusion

Before concluding, a remarkable example of NVC in healthcare is noteworthy. In a Wisconsin forensic psychiatric ward, an NVC-based program reduced patient seclusion and restraint incidents from 33 in 2003 to 6 in 2006, with seclusion time dropping from 92.57 hours to 6.4 hours. Workplace injuries from violence fell to zero, and the need for costly one-on-one staffing was eliminated.[14] This challenging setting demonstrates a shift from a "stimulus-response" or "coercion" worldview, underscoring NVC's transformative potential. We hope NVC's broader adoption in Japanese medical education will advance connection-based healthcare.

This study implemented a four-month NVC educational program for first-year Japanese medical students, demonstrating its effectiveness. Initially, students resisted NVC's abstract concepts and faced cultural barriers to verbalizing emotions and needs. However, through *Inside Out*, empathy exercises, and emotion-needs cards, they became familiar with NVC techniques and recognized their value. Understanding the needs behind emotions and building empathic dialogue became integral to fostering trust and improving treatment outcomes. Survey results showed increased recognition of the importance of emotions, the value of sadness, reduced judgmental attitudes toward anger, and strong intent to apply NVC in daily life and healthcare. Despite cultural barriers to open emotional expression in Japan, NVC offers a powerful tool to overcome these challenges and achieve patient-centered care.

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