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Nursing English Nexus

Edited by Mike Guest & Mathew Porter



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Nursing English Nexus

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Including an introduction by Mike Guest and a message from our coordinator, Simon Capper.

Call for Papers

The next issue of Nursing English Nexus will be released in October 2018. We welcome articles in English and Japanese. The deadline for submissions is August 31, 2018.

We are seeking:

- Research articles (between 1500-3000 words)
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- Interviews with nursing educators (up to 1000 words)
- Reviews of nursing English materials and / or technologies (up to 1000 words)
- Short, practical teaching tips (up to 750 words)

Guidelines can be found at janetorg.com/nexus.



Michael Guest
Editor's Introduction

Welcome to the 2nd issue of NEXUS, the online magazine of the Japan Association of Nursing English Teachers (JANET).

This represents our first 'open issue' meaning that rather than being based around a central theme there are several very different papers included in this issue. Three of our contributors are Japanese. Tomoyuki Kawashima and Yoko Ichiyama both discuss pronunciation but from rather different perspectives. Kawashima introduces the value of using Pronunciation Tables in the classroom whereas Ichiyama discusses methods of assessing English graphophonemic awareness among nursing students. Shouzo Yokoyama brings a very different focus,

that of introducing more nuanced concepts of death to nursing English curricula, based on his use of the documentary, Gaia Symphony.

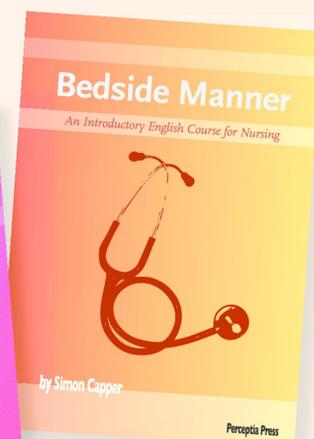
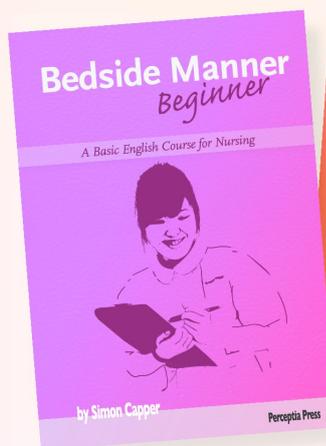
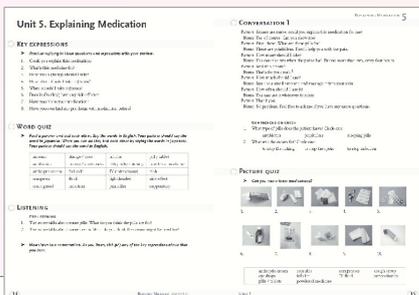
Margaret Chang delivers a commentary on prioritizing questions of 'why' in the English teaching classroom, based on inspiration from management and leadership guru Simon Sinek and, finally, my own paper, a retrospective look at how closely Nursing English textbooks imitate actual nursing discourse and address nursing speech events compared to those of a number of years ago.

Thanks go out to all contributors. So enjoy, please comment if you wish and be aware that we are always open to contributions for the next issue of NEXUS, slated for October 2018.

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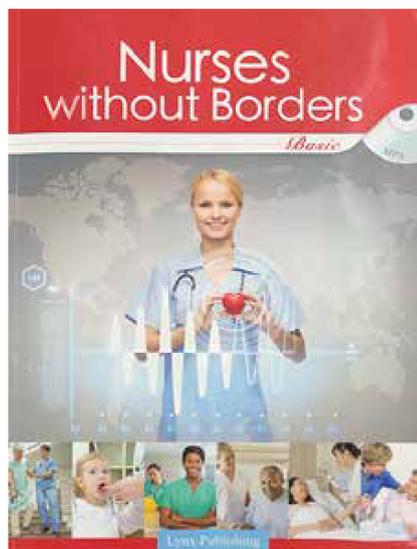
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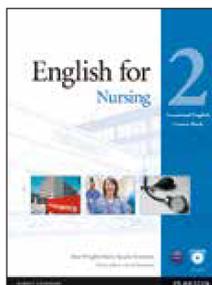
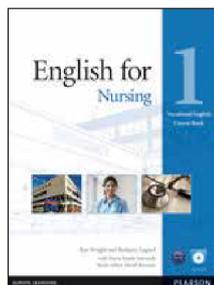
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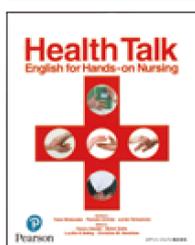
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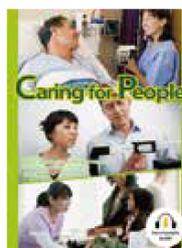
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Simon Capper

A Message from the JANET Coordinator

Welcome to the second volume of Nursing English Nexus. Coming as it does

at the start of a new school year, we hope you'll find it as stimulating and invigorating as the smiling faces of your new students!

JANET has now been in operation for nearly 18 months, and apart from our monthly newsletter and this e-Magazine, we're also approaching another milestone event, our first national conference for nursing English teaching, in Fukui city, June 23rd & 24th.

You may not be surprised to hear that we're feeling nervous but excited about the conference, and the prospect of

bringing together motivated, like-minded people who have a vested interest in improving the quality of nursing English education – not to mention supporting students who will pursue careers in one of the most noble arts known to humanity.

If you'd like to join us in Fukui, you can find more information and register for the conference at the JANET website, <https://www.janetorg.com/>. Please join us if you can, and even better, bring a friend!

Finally, this volume of Nexus celebrates the debut appearance of our two sponsors, Nellie's English Books and Perceptia Press. We're so grateful for the faith that they've shown in JANET, and sincerely hope that our members can reciprocate their support.

Mission

The Japan Association for Nursing English Teaching (JANET) was formed in order to provide a forum for improving the quality of teaching, learning and research in the field of nursing English education in Japan. We aim to encourage collaboration between English teachers and nursing professionals, and support teachers to better serve the needs of the Japanese nursing community.

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Using a Pronunciation Table to Make Medical Terms More Approachable



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'Medical terms are longer and more difficult to pronounce than the English words I have learned.' This is probably the first impression Japanese students majoring in medicine or healthcare commonly have when they learn new medical terms in class. Longer spelling means a greater number of syllables. Research has shown that errors in lexical stress reduce intelligibility of speech, and, due to insufficient knowledge about phonological differences between Japanese and English, students often fail to place lexical stress properly and tend to transfer English vowel sounds into Japanese vowel sounds. In order to enhance awareness about the importance of lexical stress in English and familiarize students with English vowel sounds, I designed a Pronunciation Table with 18 columns representing 18 English vowel sounds. Two versions of the Pronunciation Table (General English and Medical English) were developed and they were used with 82 university students specializing in health sciences in a semester-long medical English course. In addition, a pronunciation test was designed based on the Pronunciation Table. Student responses collected at the end of the semester confirmed the benefits of providing comprehensive instructions on pronunciation, as well as offering constructive points for further improvement of the tables

Keywords: Pronunciation, Lexical stress, Medical terms

Background

Incorrect placement or absence of stress in English words can hamper the intelligibility of speech. Cutler and Clifton (1984, cited in Field, 2005) reported that intelligibility of speech for native English listeners when listening to non-native English speakers was seriously impaired when the shift of stress was accompanied with a change of vowel quality. Later, the study was replicated by Field (2005) with both native and non-native listeners from 15 different first language backgrounds. Despite some differences in the methodology between the two studies (one focusing on reaction times, the other, transcription rates), Field substantiated the point that that stress misallocation affects the intelligibility of speech for both native and non-native listeners in a similar way. The spellings of medical terms tend to be longer than those of English words commonly used in daily life. Therefore, these findings suggest that teaching about lexical stress (i.e., the stressed syllable in a word) is of crucial importance to healthcare students.

Japanese learners of English need to exert great efforts to pronounce lengthy English medical terms intelligibly, since the fundamental factors of pronunciation differ enormously between Japanese and English. For example, Japanese has five vowel sounds (Ohata, 2004; Riney and Anderson-Hsieh, 1993; Saito, 2014), whereas English has at least 15 vowel sounds (Ohata, 2004; Saito, 2014). This wide gap in the number of vowel sounds between the two languages means that Japanese students have

sounds or phonemes they cannot identify or produce without explicit training. The troubles that Japanese learners of English suffer from have been widely documented in literature (Ohata, 2004; Saito, 2014). For example, according to Yuzawa (2007), many students could not distinguish between 'barn' and 'burn'. As a result, they pronounced the two English vowel phonemes identically, replacing them with the Japanese /a/ phoneme (p. 96).

Syllabification (i.e., adding a vowel sound to a consonant) is another phonological characteristic of Japanese which requires constant care by Japanese students when speaking English. Though consonant clusters are typical of English specialist terms, due to the syllabic restrictions of monosyllabic Japanese katakana consonant clusters cannot be produced without putting vowel sounds in between them (Olah, 2007).

Finally, there is a marked difference in the way of pronouncing syllables. Japanese students tend to pronounce each syllable with equal stress (Saito, 2014) because stressed syllables are spoken at a higher pitch in Japanese (Ohata, 2004), while vowel sounds become longer and stronger in stressed syllables in English (Saito, 2014). Japanese students are not fully aware of these fundamental phonological differences between Japanese and English. Therefore, those teaching English should know that Japanese students need specific instructions on how to resolve these differences.

English teachers, both native and Japanese, agree on the importance of

raising awareness about lexical stress and explicitly teaching English vowel sounds. Saito (2014) asked 120 experienced English teachers to prioritize 25 pronunciation features in terms of their importance in teaching students in order to make their speech more intelligible. The results of the questionnaire survey demonstrated that teachers think that syllabification and cognates (i.e., unique pronunciation of loanwords of English origin used in Japanese) is the second most important area to be addressed pedagogically. Word stress, intonation, and sentence stress ranked fourth, and the English-specific vowel sounds /æ/ and /ʌ/ ranked fifth. This finding shows that many teachers feel the need to help Japanese students realize the peculiarity of syllabification and the importance of pronouncing stressed syllables with accurate vowel sounds in English.

Development of the Pronunciation Table

The idea of using tables for pronunciation instruction occurred to me when I attended a workshop held by Janjua (2016). She introduced an activity that included a list of medical terms. In the list, the original English words were contrasted with Japanized loanwords in *katakana*, and she asked participants to read them aloud, distinguishing English words clearly from Japanese *katakana* words. Her attempt to use *katakana* words for pronunciation training is methodologically sound, as Daulton (1998) has revealed that Japanese students' memory for pronunciation of English words was considerably improved

when the words were used in Japanese as *katakana*.

On the basis of my own learning and teaching experience, I'm convinced that Japanese students who are used to speaking loanwords of English origin as *katakana* need 1) to develop a full awareness that English words are syllable-stressed and, 2) to undertake appropriate pronunciation training consistently until they can confidently identify and produce vowel sounds which are non-existent in Japanese. In order to address these needs, I developed the Pronunciation Table (PT).

The PT consisted of 18 vowel sounds in the first row starting with simple vowel sounds such as /ʌ/, /æ/, /ɑ:/ and /ə:/, followed by diphthongs like /ou/, /au/, /iər/ and /uər/ (see Appendix). Three English words that students usually learn in junior high schools were listed under each phonetic symbol so that they could recognize the sound the symbols represented. Short monosyllabic words were selected for these samples. The unique characteristics of the PT were that 1) only words that were troublesome to pronounce were collected and 2) the words in a column had identical vowel sound for the stressed syllable. The criterion for selection of 'difficult words' was that the spelling should be long and/or tricky. However, due to space limitations and the need to lower the difficulty level, the lengths of words had to be controlled. I anticipated that my students might be overwhelmed to see too many lengthy words in the PT.

Two versions of the PT (General English

and Medical English) were subsequently developed. The General English version was produced based on student contributions. Students were asked to list as many English words as possible which they considered difficult to pronounce. On the other hand, the words for the Medical English version were chosen by the teacher from college textbooks. In addition to the two criteria for selection mentioned above, another criterion was adopted when choosing medical terms, this being the frequency with which we hear the word's equivalent in Japanese. There are many medical terms, ranging from those only used by healthcare professionals specializing in certain areas to more common items that ordinary people may hear in the news. However, finding medical terms which meet all of these three criterial conditions is time-consuming. For this reason, the Medical English version of the PT is yet to be fully completed and requires further updating.

Use of the Pronunciation Table for Teaching

The General English version was used first as teaching material, since students were more familiar with the words on the table. Less than 10 minutes was spent for the pronunciation training at the beginning of each lesson. In the earlier stages, the training started with pronouncing words vertically, i.e., reading aloud those words which had identical vowel sound in the stressed syllable. The PT was written in the two languages: English in the upper part of

the sheet and its Japanese counterparts below, so it could be used for pair work as well. One student said the meanings of words in Japanese while the other student pronounced corresponding English words without looking at the PT. The first student had to listen to his/her partner carefully and check whether the stress was on the right vowel sounds. When they became used to pronouncing the words in a column, they started reading the table horizontally. This time, students read the words clarifying the differences in vowel sounds even more carefully.

The distinction of the vowel sounds in the following three pairs seemed particularly difficult for Japanese students: /ʌ/ and /æ/, /ɑ:/ and /ə:/, and /ɔ:/ and /ou/. Therefore, in class, I supplied clearer instructions by demonstrating the differences and set a longer time for practice. It was particularly effective to use minimal pairs to practice items such as 'hut' /ʌ/ and 'hat' /æ/, 'hard' /ɑ:/ and 'heard' /ə:/, and 'bought' /ɔ:/ and 'boat' /ou/.

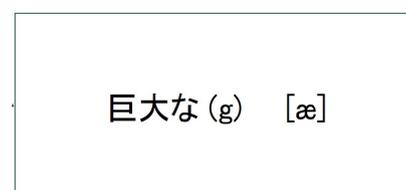
Application of the Pronunciation Table for Testing

In order to encourage students both to practice with a purpose in mind and to assess their progress, an oral examination was designed in the latter part of the semester. Students were tested on whether they could intelligibly pronounce the words in columns 1-5 of the General English version. The number of words on the test was limited to 50 for three

reasons. First, as mentioned earlier, the English vowels /ʌ/, /æ/, /ɔ/, /ɑ:/ and /ə:/ seemed more problematic for students to distinguish as they readily became transferred to the Japanese /a/ sound. Second, the large class size of 40 students generated time constraints. Third, the degree of difficulty of the task was adjusted so that it would not overwhelm students.

In the oral examination, individual cells of Microsoft Excel were projected on the screen, like flashcards. Three pieces of information about each word were shown: its meaning, the first letter, and the phonetic symbol of the stressed syllable. Students were required to say the word as soon as the information was projected. The students' ability to pronounce English words with stress on the correct vowel sound was tested using five words randomly selected by a computer. The same five words were not used for all students because the pronunciation test was conducted in a large classroom with other students. The oral examination was performed one-on-one in the classroom.

Figure 1. Sample of Oral Examination Question



Student Reactions

Students were asked to write their impressions freely about the use of the PT at the end of the semester. Their responses were mostly favorable, with the following

three benefits of using the PT emerging most often.

First, it seemed that the PT helped students to resolve their sense of ambiguity about English vowel sounds. For instance, a student wrote, "I was able to confirm the pronunciation which remained ambiguous before." Second, the PT reminded students of the importance of placing lexical stress with the correct vowel sounds. Typical statements included, "The table helped me understand the different phonological features between Japanese and English," and "I began to pay more attention to the differences in pronunciation than before." The third group of comments referred to its positive effect on student self-study. One student commented that he/she had started to vocalize English more often.

On the other hand, there were also a few negative comments. One student seemed to find the pronunciation training too easy. He/she wrote, "I wanted a table with the words shuffled and mixed up." The other negative response was, "I found English pronunciation even more difficult." This comment underlined the need to pay further attention to less proficient students, whose motivation to learn English is not strong.

There were two comments made about the testing. Both of them referred to the difficulty level of the examination. One response was about the information projected on the screen. This student suggested that English words, not Japanese meanings, should be shown on the screen. This comment is worth considering if the

teacher wants to check whether students can read certain words aloud, in which case showing English words is fine. In this study, however, the oral examination aimed at assessing whether the students could produce certain words confidently, so English words were not presented.

The other comment referred to word choice. The student felt that the choice was unfair because some words seemed easier than others. More consideration may be required to control the levels of difficulty among the items used on the test. However, overall, the majority of student responses were in favor of the use of the PT, while only a small number of negative comments suggested further alterations for improvement.

Conclusions

Pronunciation training is one area which needs to be emphasized more in EFL classrooms. Not many Japanese students have received comprehensive instruction on the phonological differences between English and Japanese. Moreover, medical terms tend to be lengthy, so many Japanese healthcare students may find it more difficult to pronounce medical terms than general English terms. Therefore, there is a great need for adequate pedagogical support in the case of teaching medical terms.

In this study, problematic words in both General and Medical English were compiled into tables and were used repeatedly for teaching and testing. Student reactions to the use of the PT for teaching and testing

suggested that there is still room for further improvement in terms of the word choice on the PT, the classroom activities, and their application to testing. At the same time, it was revealed that classroom pronunciation instruction with the help of the PT contributes to a keener awareness of English vowel sounds, a clearer understanding of the importance of lexical stress in English, and a greater willingness to speak English. It is hoped that this small classroom project will lead to further attempts to produce Japanese students who will find medical English approachable and speak intelligible English with greater confidence.

Note

The Pronunciation Tables and the Excel worksheet used for the oral examinations are available on request from the author.

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Appendix

	1	2	3	4	5	6	7	8	9
	[ʌ]	[æ]	[ɔ]/[ɑ]	[a:]/[a:r]	[ə:]/[ə:r]	[i]	[i:]	[u:]/[ju:]	[e]
	<i>just</i>	<i>fat</i>	<i>pocket</i>	<i>hard</i>	<i>heard</i>	<i>ill</i>	<i>see/sea/c</i>	<i>true</i>	<i>head</i>
	<i>son/sun</i>	<i>Japan</i>	<i>stop</i>	<i>heart</i>	<i>hurt</i>	<i>begin</i>	<i>eat</i>	<i>food</i>	<i>many</i>
	<i>front</i>	<i>laugh</i>	<i>want</i>	<i>father</i>	<i>further</i>	<i>mystery</i>	<i>believe</i>	<i>use</i>	<i>enter</i>
A	thumb	appetite	consciousness	heartbeat	insert	pediatrician	feverish	solution	consent
B	pulse	paralysis	frostbite	gargle	allergic	malnutrition	measles	wound	stethoscope
C	tongue	asthma	suppository	pharmacy	hypothermia	shiver	diabetes	fluid	rubella
D	ultrasound	abdomen	thermometer	palm	gurney	intestine	anesthesia	rheumatism	endoscope
E	ulcer	vaccinate	insomnia	massage	emergency	prescription	fatigue	bruise	hypertension
F	mumps	allergy	chronic	electrocardiogram	surgeon	dizzy	intravenous	urate	phlegm
G	concussion	calf	tonsils	armpit		arrhythmia	anemia	mucus	tendon
H	numb	fracture	esophagus			limb	tweezers	immune	breath
I	crutches	swallow	tomography			dislocate	orthopedics	tumor	undressed
J	muscle	laxative	abdominal			syrup	vaccine	sputum	anesthetic
	1	2	3	4	5	6	7	8	9
	[ʌ]	[æ]	[ɔ]/[ɑ]	[a:]/[a:r]	[ə:]/[ə:r]	[i]	[i:]	[u:]/[ju:]	[e]
	ちようど	太った	ポケット	固い	聞こえた	病気の	見える/海	正しい	頭
	息子/太陽	日本	止める	心	傷つける	始める	食べる	食料	たくさんの
	前面	笑う	欲する	父親	さらに	神秘	信じる	使う	入る
A	親指	食欲	意識	心臓の鼓動	挿入する	小児科医	熱っぽい	溶液	同意書
B	脈	麻痺	凍傷	うがい(をする)	アレルギーの	栄養不良	はしか、麻疹	けが	聴診器
C	舌	ぜんそく	座薬	薬局	低体温症	寒気	下痢	体液	風疹
D	超音波	腹部	体温計	手のひら	車輪付き担架	腸	麻酔	リニューマチ	内視鏡
E	潰瘍	予防接種をする	不眠症	マッサージ	緊急事態	処方箋	疲労	打撲傷	高血圧
F	おたふく風邪	アレルギー	慢性の	心電図	外科医	めまいがする	静脈注射の	排尿する	たん
G	脳しんとう	ふくらはぎ	扁桃腺	わきの下		不整脈	貧血	粘液	腱
H	麻痺している	骨折(する)	横隔膜			手足(腕と脚)	ピンセット	免疫を持つ	息
I	松葉づえ	飲み込む	X線断層写真撮影			脱臼する	整形外科	腫瘍	服を脱いだ
J	筋肉	下剤	腹部の			シロップ	ワクチン	つば、たん	麻酔の

The Development of Test Items to Assess Students' Graphophonemic Awareness of Nursing English-Language Vocabulary



Yoko Ichiyama,
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Although assessing learner graphophonemic awareness of English-language vocabulary has been widely acknowledged in the field of assessing reading, little attention has been paid to developing test items that assess learners' proficiency of graphophonemic awareness in Nursing English-language vocabulary. In response, the aim of the present study was to develop test items to assess learners' graphophonemic awareness of such vocabulary using a Rasch analysis. The results revealed that of 40 test items, only 17 (42.5%) items corresponded with the learners' ability measure. The study indicates the need to develop test items that match students' proficiency in Nursing English-language vocabulary.

Keywords: *graphophonemic awareness, nursing English-language vocabulary, Rasch analysis*

Several researchers (i.e., Bishop, 2003; Zoccolotti, De Luca, Marinelli, & Spinelli, 2014) argue that identifying learners at risk of reading failure is crucial to provide them with adequate support and intervention. Bishop (2003) reports that graphophonemic awareness — that is, the ability to match letters (or graphemes) and sounds (or phonemes) in words — ranks among the best predictors in assessments of kindergarten students' reading proficiency.

Greenberg, Ehri, and Perin (2002) add that their study on adult readers' reading difficulties revealed that deficient graphophonemic awareness contributes to difficulties in reading.

In English-language classrooms that teach nursing English reading, increased attention has been paid to learners' acquisition of vocabulary specific to nursing (Willey, McCrohan, & Shibata 2009). Little attention, however, has been paid to improving learners' graphophonemic awareness (Ichiyama, 2018a, b). Assessing graphophonemic awareness is crucial to provide adequate help and support to students at risk of reading failure. (Greenberg, Ehri, & Perin, 2002; Doughty, Bouck, Bassette, Szwed, & Flanagan, 2013).

Unlike the English language, which has a deep orthographic structure in which the relationships between graphemes and phonemes are irregular, the Japanese language has a shallow orthography, involving one-to-one relationships between graphemes and phonemes (Kessler & Treiman, 2001). As Ichiyama (2016) points out, more than 50% of English-language vowel graphemes in Nursing English vocabulary in her study have phonemes that do not exist in Japanese-language pronunciation.

Developed by George Rasch (1980), a Rasch analysis is a statistical measurement technique that provides a log odds ratio of probability. As Wright and Linacre (1989) point out, a Rasch analysis transforms the raw scores (i.e., on nominal measures

without an equal interval scale so that item scores cannot be totaled) of items and persons (e.g., examinees) into measures with interval scales on which, for example, a point for Question 1 is equivalent to a point for Question 2 as well. Hendriks, Fyfe, Styles, Skinner, and Merriman (2012) argue that nominal or ordinal scales traditionally used in assessment are less precise measures than interval or ratio scales and the use of Rasch analysis should therefore be encouraged.

A Rasch analysis provides fit statistics to assess the unidimensionality, or the extent to which the items measure a single construct (i.e., an attribute or variable that a test attempts to assess), such as graphophonemic awareness, of test items. Fit statistics provide information regarding the extent to which an observed response corresponds to the expected response based on the Rasch model. As Linacre (2013) suggests, deleting items and persons that do not fit the Rasch model leads to the removal of items and persons that do not assess graphophonemic awareness, and, in turn, the requirement of unidimensionality was met.

Using a Rasch analysis also benefits small-scale research. As Hambleton, Swaminathan, and Rogers (1991) point out, a Rasch analysis requires relatively few participants (e.g., 30 persons) to obtain useful, reasonable estimates.

This paper describes the process of developing and analyzing 40 test items to assess the graphophonemic awareness of nursing students at a tertiary-level institution

in Japan.

Methods

The computer program WINSTEPS, Rasch version 3.81.0, developed by Linacre (2006) was used to analyze all data. A total of 40 test items were administered to 84 students as part of a final test in Nursing English during the Fall Term of 2016 at a tertiary-level institution in Japan. Words used in the study were chosen from the nursing English vocabulary book *Nursing Terms and Expressions Everybody Uses* (Onjo, Kawagoe, & White, 2007). Because participants in the study were first-year students in the Faculty of Nursing, words categorized as basic by Onjo et. al. (2007) were selected. Each item consisted of two English words with an underlined letter, as shown in the following example:

If the sounds of the underlined letters of both words are the same, then write "Y"; if different, then write "X" instead. If you do not know the sound of the letter on the left, then write "L"; if you do not know the sound of the letter on the right, then write "R". And if you do not know the sounds of both letters, then write "B".

1. health breathe

In this study, as Wright (1994) proposes, items that did not fit the Rasch model (i.e., with an infit value greater than 1.3 or less than 0.7) were deleted until all items fit the Rasch model.

Results

Table 1 shows the number of test items and persons (that is, examinees) excluded from the analysis.

Table 1
Number of test items and persons excluded from a Rasch analysis

Analysis	Deleted Person		Deleted Item
	0.7 < Infit < 1.3	N	0.7 < Infit < 1.3
1st	8, 13, 16, 18, 30, 31, 32, 34, 40, 42, 43, 47, 53, 58, 59, 64, 66, 68, 79, 83, 84	22	n.a.
2nd	19, 35, 45, 60, 63, 72, 75	7	n.a.

1st Analysis

Figure 1 displays the result of the first analysis in the distribution map. The map illustrates all 84 examinees and all 40 items on a common logit scale. Examinees are located on the right side of the scale and items on the left-hand side. The locations of the examinees and items correspond to the level of examinee proficiency and item difficulty. Each “#” on the left-hand side of the scale indicates the location of 2 examinees, and each dot indicates the location of one person. Each item is represented by a number with grapheme (s) and a number followed by a letter or letters. For example, “40ea” in the middle of Figure 1 indicates that Item 40’s difficulty level is approximately medium level and that the item assesses how to pronounce a diphthong “ea.” An “M” indicates the location of the mean measure, “S” indicates the one sample

standard deviation away from the mean, and “T” indicates two sample standard deviations away from the mean.

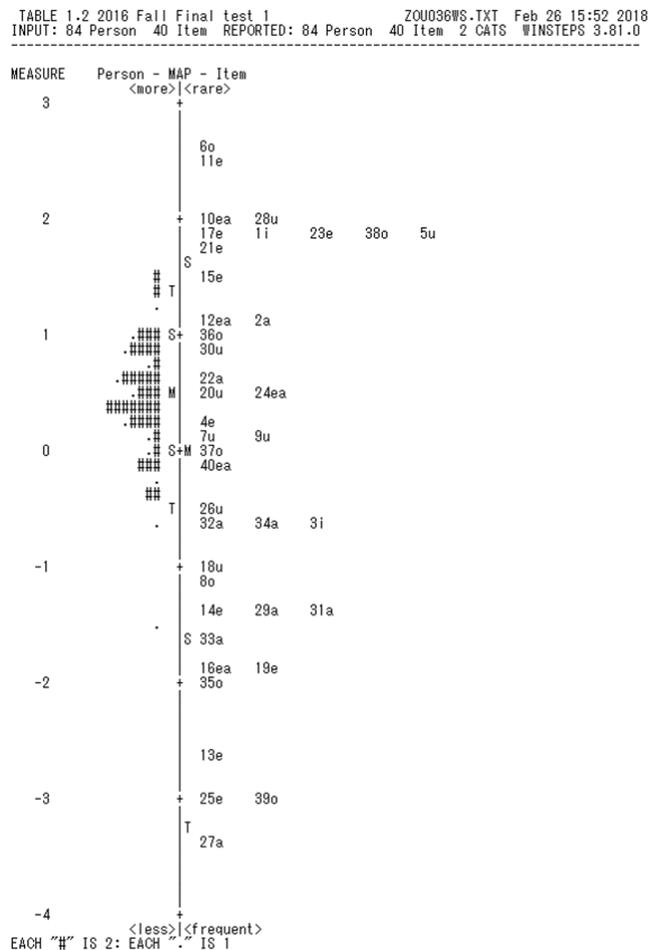


Figure 1. The distribution map (1st analysis).

In the 1st analysis, of the 84 persons measured, the infit ranges fell between 0.7–1.3 except for 22 persons, as shown in Table 1. This possibly indicates that these examinees are among the mismatched persons, examinees that do not fit the Rasch model. Of the 40 items measured, all ranges fell between 0.7–1.3. The remaining items and examinees were put on the same difficulty scale through a Rasch analysis.

2nd Analysis

Figure 2 displays the result of the second analysis in the distribution map. The map illustrates all 62 persons and all 40 items on a common logit scale. Examinees are located on the right side of the scale and items on the left-hand side. The locations of the examinees and items correspond to the levels of examinee proficiency and item difficulty. Each "X" on the left hand side of the scale indicates the location of one examinee. Each item is represented by a number with grapheme(s).

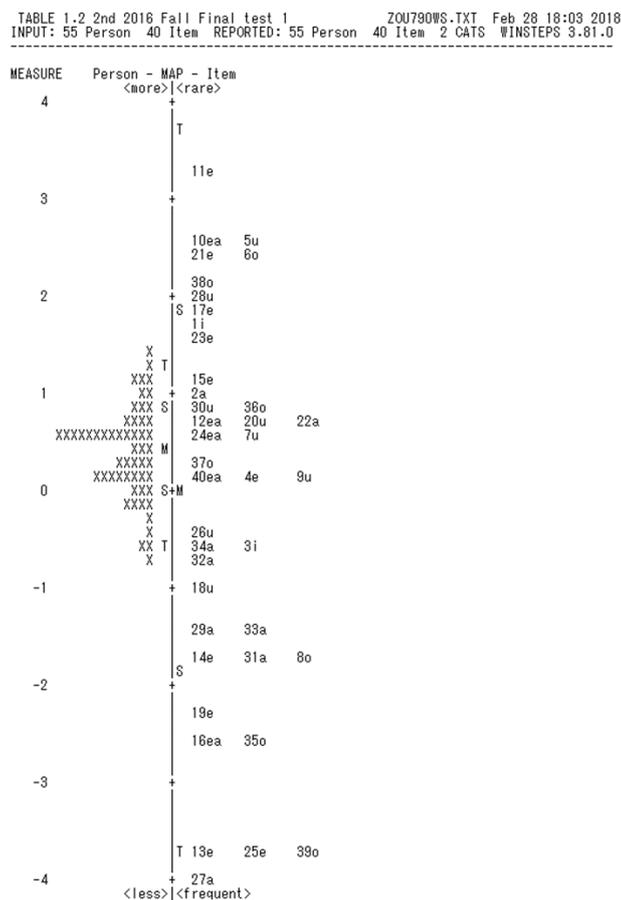


Figure 2. The distribution map (2nd analysis).

In the 2nd analysis, of the 62 examinees measured, all infit ranges fell between 0.7–1.3, except for 7 examinees, as shown in Table 1, possibly indicating a mismatch, an

examinee that do not fit the Rasch model. Of the 40 items measured, all ranges fell between 0.7–1.3. The remaining items and examinees were put on the same difficulty scale through a Rasch analysis.

Discussion

As can be seen in Figure 2, 17 (42.5%) items match the examinee measures, indicating a moderate match between the examinee proficiency and item difficulty. The relatively large gaps, indicated by arrows in the figure, however, indicate the need to develop items that fill the space. As Jackson, Draugails, Slack, and Zachry (2002) point out, visible gaps (i.e., >0.3 logit) in the map indicate the need to add items in order to improve the measurement of the construct.

Conclusion

The study indicates that the items included are of a quality suitable for assessing students' graphophonemic awareness. The study, however, posed several limitations, including those concerning the amount of items developed and their implications to pedagogy. More items specific to Nursing English should be developed, and the question as to whether there are appropriate ways to teach graphophonemic awareness in order to support non-proficient readers in Nursing English courses should be explored.

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Developing an Awareness of Death for Nursing Students Through English Education



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This paper aims to bridge language education with life/death education, which should be one of the most important issues for any health care student. Currently, the mortality rate between hospitals versus other locations (such as patients' homes) exceeds 80% (Yamate, 2014). Therefore, clinical nurses will have many opportunities to come into contact with terminally ill or dying patients. However, even though nursing students will study the rationale of palliative and terminal care in nursing curricula lectures and practice, they rarely witness actual scenes of death in hospitals. Moreover, few of them have experienced death in modern society due to the proliferation of nuclear households (Yamate, 2014). However, when they graduate from nursing college and start their careers as nurses at hospitals, they will routinely be faced with death.

Keywords: *belief systems, death education, patient care*

Yanagisawa et al (2012) conducted a meta-analytical study on the conflicts that nurses face regarding terminally ill patients and their families. According to the study, nurses interact with terminally ill patients and their families based upon idealistic notions of nursing care, but they struggle with the fact they cannot maintain these

ideals because of a deficiency in skills, a lack of collaboration with other medical staff, or an inadequate healthcare environment, leading many of them to feel 'guilty'. Kitano et al. (2012) also reports that, in addition to their concern and empathy regarding the reduction of the patients' pain, many terminal care nurses carry out their duties trying to contain their emotions simply by putting on a smile.

It seems reasonable then that, as the research above indicates, regardless of how much knowledge and skill nursing practitioners can gain in palliative care and terminal care, related stress and psychological conflicts will never disappear, at least as long as they regard death as something that one should detest and/or avoid. Thus, for college nursing students, having an opportunity to think about death or 'views of life and death' at an early stage in their education could play an instrumental role in preparing them before experiencing direct contact with terminal patients, either in clinical training or practice.

The World Health Organization (n.d.) defines palliative care as follows:

Palliative care is an approach that improves the quality of life of patients and their families facing problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and accurate assessment and treatment of pain and related problems: physical, psychosocial, and spiritual.

In line with this definition, this paper will argue that English education can contribute to the field of terminal patient care by initially enabling nursing students to develop a positive attitude toward death. This was achieved in the author's nursing English class primarily by making use of the documentary video *Gaia Symphony*. During the 2017 academic year at the University of Miyazaki, *Gaia Symphony No.3* was introduced to first-year nursing students in order to enable them to more deeply consider life and death. The basic contents and philosophy of the video is explained in the following section.

The Philosophy of 'Gaia Symphony'

According to the film director Jin Tatsumura, *Gaia Symphony* is a series about individuals with very insightful messages for the future of the Earth in the 21st century. Each one of them features an ordinary person who is making an extraordinary contribution to help create an ideal future for the planet. Tatsumura mentions the reason that it is becoming harder for human beings to feel a sense of being alive on mother earth ('Gaia') can be attributed to the fact that death has become obscure in everyday life. Rather, the fact that we live depends on the reality that every moment of life is made up of countless deaths. Our lives now depend totally on the infinitely continuing ring of a 'life or death' cycle, and we are kept temporary alive by Gaia. But this cold, hard fact cannot easily be realized in the current era. The message is that 'death' is not a defeat,

'death' is not the end, but rather, 'death' is the moment that encourages 'life' in those who keep living, and it is this moment that the gratitude and joy for being alive on the Mother Earth Gaia should awaken (Tatsumura, n.d.)

One part of the series, *Gaia Symphony No. 3*, is dedicated to the late Michio Hoshino, a photographer of Alaskan wildlife, who died immediately before the production of this film began. The film traces Hoshino's life and death while introducing people surrounding him, such as a native American storyteller, a wildlife guide, a whale researcher, a canoe builder, and others who chose to live their lives according to the rhythms of nature. Their stories eloquently illustrate the eternal cycles of life on Mother Earth, or 'Gaia'.

One of the people introduced here is Freeman Dyson, an astrophysicist and mathematician, who talks about the meaning of life on a cosmic scale, incorporating both his broad scientific views and deep insights into human nature. Although in the author's classes topics on both Hoshino and Dyson were employed, this paper reports only on the section based on Dyson due to space considerations. Dyson intends to, "...awaken our deeply-stored memories from over five thousand years ago, and take our thoughts to the 'mind of Gaia' and the 'mystery of life'" (No.3, 2007).

To do so, in the characteristic manner of a scientist, Dyson explains and compares the life and death of Gaia and those of human beings on a grand time scale. He

says:

We have to live with Gaia. That is to say, we are part of the earth and the earth has its own processes, which are very slow compared with our own. So, for example, there was a huge disaster which happened 200 million years ago when something went wrong with the oceans (...) We really don't know how it happened. But what we do know is that Gaia recovered, that the earth after this disaster recovered, and new creatures arose to take the place of those that died. It took 5 or 10 million years to recover, and it's hard for us to even be aware of what was going on because it's too slow -- our lifetimes are so short in comparison. We don't see very much change within a human lifetime, but it is still happening. We have to learn that we have to live on the long timescale as well as on the short timescale, and that is not easy (Tatsumura, 1997).

Dyson thereafter mentions three important factors in the evolution of life: death sex, and diversity. He notes that:

...when life was started, of course, it was immortal, there were just little... bacterial cells which divided, but did not die a natural death. Except for accidents, they would continue living forever. Also in the early times there was no sex. So for life to become more complicated, to become more advanced, three factors had to be

introduced. First of all, death, to enable the future to be different from the past, so the old memories would die and new ideas could originate. It is important that we don't live forever. It means a very much more rapid evolution, and more chances for interesting new developments to happen. And, of course, life itself on the earth has been so successful because it has always produced such a huge variety of creatures. If it were not for death, sex, and diversity, early disasters would perhaps have removed life altogether from the planet (Tatsumura, 1997).

This seemingly paradoxical but intriguing scientific fact invites us to reformulate our concept of death, one distinct from that which seems to be commonly shared by the majority, namely that death is a defeat and the end of everything. Instead of taking life and death as finite, self-contained, and isolated events, Dyson positions them in a much broader spectrum and depicts them as ceaseless revolving cycle of lives, created and succeeded by Gaia. Answering the question posed by the director as to 'why must people die', Dyson claims that it is "*...lucky that we die, because we have to make room for the young people. It is a very healthy thing that death exists -- it's not accidental that all creatures beyond a certain degree of evolution have natural deaths*" (Tatsumura, 1997).

But, while Dyson employs an analytical and intellectual point of view, he is also

mindful of the humanistic perspective toward death. For example, in the video he says:

So why should one despair? It's very stupid to lose hope. I mean, hope is, of course, so important. Not that one should be always expecting everything to be beautiful ...I mean, the world is tragic. One has to have a tragic view of the world, because that is reality. But tragedy is not the same thing as hopelessness (Tatsumura, 1997).

Despite this perhaps imparting viewers with a sense of sadness, given the cold hard fact that we all, in the end, have to depart from loved ones, these encouraging messages from Dyson are accompanied, in the final scene, by the vista of an orca leisurely swimming in sunset, with the calming tones of the tune *Unchained Melody* playing in the background. This conveys to the audience a sense of life's eternity.

Course Content and Theoretical Background

In late 1997, the DeSeCo Project (Definition and Selection of Competencies: Theoretical and Conceptual Foundations) was started by the Organization for Economic Cooperation and Development (OECD) who stated that their aims were to provide, "...a sound conceptual framework to 1) inform educators about key learning

competencies, 2) to strengthen international assessments, and 3) to help to define overarching goals for education systems and lifelong learning" (DeSeCo, n.d.). Three categories of those 'key competencies' – interacting in socially heterogeneous groups, acting autonomously, and using tools interactively – are grounded in a holistic model of competence, constituting a core element of DeSeCo's overarching conceptual framework. The Japanese Ministry of Education, Culture, Sports, Science, and Technology explicitly advocates this approach, described as 'Ikiru Chikara (strength to live)', in its educational guidelines.

According to the OECD's definition of key competencies, as articulated by the Program for International Student Assessment (PISA), "Acting autonomously is particularly important in the modern world, where each person's position is not as well-defined as was the case traditionally. Individuals need to create a personal identity in order to give their lives meaning, to define how they fit in" (PISA, n.d., p. 14). In other words, one of the required competencies described is to act within a big picture. Thus, English education should also be designed to facilitate these learner competencies such that students can declare their 'positions' explicitly in the world, draw their own scenarios of life, and move forward in their lives by themselves using language(s) as a tool. It is this theoretical foundation that informed the author/teacher's pedagogical focus, the use of the video, and the accompanying

classroom contents.

Students in the author's class were shown the video of Freeman Dyson, which was divided into four parts, constituting four classroom sessions. The video was played in English, although specific sections were occasionally sub-titled in Japanese. For each part of the video, corresponding written in-house materials were distributed. These included English skill tasks involving the following activities:

1. word and phrase comprehension based upon the video text, involving matching terminology with general terms
2. dictations of short sections of the video
3. true or false questions based on the video contents
4. general comprehension questions based on the video contents

All of these activities and materials were developed by the author (Yokoyama). Since some of the concepts presented in the video seemed to be unfamiliar to, and difficult to understand for, first-year college students, these lessons were further conducted by including both peer and instructor support, such as sharing both language and concept questions among students in small groups, student-student discussions on set topics related to the video content, plus further explanation by the instructor while monitoring student comprehension. These support activities were generally conducted in Japanese.

Feedback from Students and Pedagogical Implications

At the end of the semester, a questionnaire survey was carried out regarding the students' impressions of the video and any resultant changes in their beliefs about death. This was conducted anonymously using a 6-point scale ranging from the most positive (1: Strongly agree) to the most negative (6: Strongly disagree). One of the questions the students (n=30) responded to was, 'My beliefs about death have changed through this film/class' (see Figure 1).

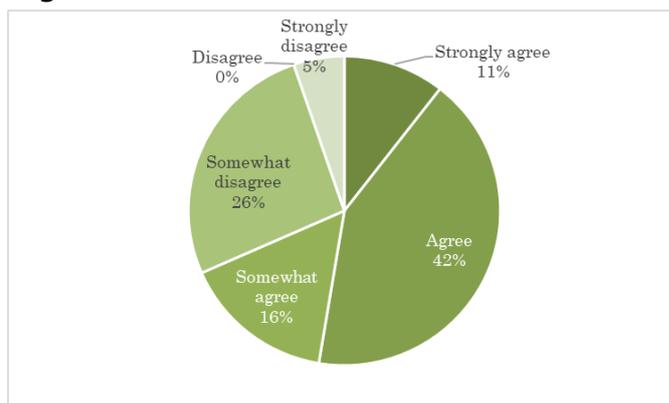


Figure 1. Changes in beliefs about death

The result shows that 69% of the students feel that their views about death have changed in varying degrees. The most striking point of this result is that the students who agreed seemed to have absorbed the message of the film and instructor's intention positively. Some of these thoughts were expressed in detail in the free response section provided below the questions. Following are some excerpts (translated from Japanese):

Excerpts from 'Strongly Agree'

I thought of death as sad and pitiful and have been avoiding it in talking and thought. The lives of Hoshino and Freeman reminded me of many senses of values in life and therefore the variety of attitudes toward death. This helped to dissolve my own belief that death is scary, and I started to think about facing my life along with death.

I used to have a fear of death. When I thought about my death or that of my family, I was scared to even imagine that time advances. But, now that the lessons have finished, that idea has changed a bit and it seems that a positive idea about death can be somewhat possible. I think it beautiful and amazing to be able to think that time never stops and keeps proceeding, that evolution continues, even after I die.

Excerpts from 'Agree'

I have long been interested in views of life and death. When I was a high school student, I once had a chance to think about death and realized that religions in different countries teach us that death is not something we should be afraid of, but I understood this only as knowledge. Since I was impressed by Dyson's idea to consider Gaia or the earth as a life comparable to our own, it seems that a new view has been introduced to me.

I had a scary feeling toward death, but

in the course of learning Dyson's ideas, I started to feel that death is indispensable.

I have had doubts about why we have to die until now, but through this classes' lessons, I learned and understood that the future is brought about by death.

Although I did not have a positive impression of death, I realized it was somebody else's death and evolution that supported our lives. It is, nonetheless, still neither negative nor positive.

I came to see death as a part of my life-cycle.

I used to think that all of us hold a negative image of death, but found out in the class that there were people who view it positively. I came to see that not all about death is bad.

Excerpts from 'Somewhat Agree'

Dyson's assertion that it is lucky that we die sounded very stimulating to me.

I used to think that death means a liberation or release from pain and suffering, but I never thought of it as lucky. That way of thinking is not necessarily acceptable to me yet, but I started to think that death is not only a painful thing.

I had held a vague anxiety or despair

regarding death, but I started to think that death brings us some hope.

In this class, I had a chance to think about death over the long term.

I had a chance to learn that there can be a positive attitude towards death.

Many of the students mentioned that they were inspired by Freeman's unique points of view and philosophy, which reminded the students of their own limited perspectives about life and death. It seemed that the characters' words often resonated with them, as if a new horizon had appeared. This may suggest that for many modern students, rather than providing words of comfort or a story of life after death based on religion, a scientific 'narrative', such as the one in which Dyson positions the finite individual life in the larger cycle of evolution created by Gaia, will resonate in students' minds (and hopefully hearts) as a natural and healthy interpretation of life and death. As Dyson mentions in the film, "there are two windows looking out at the universe, which are looking from different sides, and we cannot look through both together. You have to choose: sometimes religion, sometimes science, but we cannot see them both at the same time. And that is true with Gaia. She has her religious side and her scientific side, and they are separate. But nevertheless, they work together."

This might be something that teachers

should take into consideration if and when we take up the topic of death with college students because some of them feel immediate resistance to it, labeling it as a topic of 'religion'. But whether treated as a religious narrative or in the manner expressed by Dyson, they will all have to confront the notion of death themselves at some point in order to become effective nurses.

Conclusions

Death often presents us with profound questions, such as the meaning of life, the existence of the soul, and the possibility of an afterlife. Individuals faced with death, including those of their relatives, and their families, often rely on ingrained belief systems that help them meet the challenging concepts related to dying and death (Jafari et al., 2015). But before giving specialized education for terminal patient care, it might be a good start for nursing students to more deeply explore their own beliefs about death and establish their own healthy belief systems, which will become a foundation when caring for the dying. It is also believed that this approach will contribute, in due course, to the more comprehensive palliative care education to be delivered to students later on. In this sense, the type of English lessons described here could play a new and significant role in English for Nursing Purposes courses.

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Effective Communication from the Inside Out: Start with Why



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When teacher-practitioners prepare for lessons, the first thing that often comes to mind is 'what' as in, "What main points am I going to teach?" or "What parts of the book do I have to cover today?" After that, the next question would most likely be 'how' as in, "How am I going to teach this concept?" Very rarely does the question 'why' come first or anywhere in the early stages of lesson planning. In my own experience, 'why' has often appeared in post-lesson reflection as in, "Why did that happen?"

In nursing practice as well, the foremost question when routinely working with patients would also most often begin with 'what' as in "What procedure needs to be done?" or "What should the patient be instructed or cautioned about?" In actual practice, the question 'why' would less likely be an initial consideration in nursing communication, especially concerning hospital routines with in-patients, when the reasons for the set procedures are often assumed to be understood.

However, a consultant in business management, sales and marketing — specialties in which working with people is

central to the nature of operations — has found significance and success in starting with the question, 'Why?' instead of 'What?' (which is what not only corporate managers, but also teachers and nurses do). In this paper, I would like to introduce some major concepts of Simon Sinek, which are rich in implications for informing and guiding effective English teaching practice and communication in nursing.

Start with Why

Simon Sinek, a well-known and highly respected management theorist and leadership expert, makes a very strong case for businesses to start with the question, 'why.' He convincingly states that companies which excel and leaders who inspire have a clear vision for their existence and why they do what they do. As an example, he compares and contrasts two types of sales approaches, one typically based on 'what' and another which is more persuasively based on 'why.'

- (What) "If Apple were like everyone else, a marketing message from them might sound like this: *'We make great computers. They're beautifully designed, simple to use and user friendly. Want to buy one?'*"
- (Why) "Here's how Apple actually communicates. *'Everything we do, we believe in challenging the status quo. We believe in thinking differently. The way we challenge the status quo is by making our products beautifully designed, simple to use and user friendly. We just happen*

to make great computers. Want to buy one?"

He points out that the latter statement appeals to our emotions and inspires us, thus creating buy-in.

Sinek explains that unlike questions of 'what', which are processed by our outer brain (the neocortex), considerations of 'why' tap into the limbic area of our brain, the centermost part of the brain responsible for human feelings, decision-making and behavior, for example, in deciding whether or not to buy something or join a cause. In marketing and lesson-planning alike, we tend to begin with 'what,' which is less effective in its ability to motivate and inspire.

Sinek's message is, "People don't buy what you do, they buy why you do it," so, in order to communicate effectively, go from the inside out and start with 'why' you do what you do, then proceed to 'how' you do it, and then finally to the 'what' of your product or whatever you are promoting or endeavoring to accomplish. This order of progression will help your message reach your listeners (and students) more effectively, and motivate and inspire them to take action.

Implications for teaching and nursing

Sinek's advice runs contrary to what most teachers logically and intuitively do by starting with 'what' instead of 'why' in the planning process. We need to first reflect upon 'why' we do what we do. By changing my focus from 'what' to 'why,' my own

lesson activities have taken on a new dimension as the class atmosphere changes from practicing routine linguistic exercises to building a community. Learners begin to develop meaningful ongoing conversation threads which flow from their taking an interest and getting to know each other through the medium of English as the language of real communication and exchange, a process which continues throughout the other lessons of the course. In starting with 'why,' students are no longer merely practicing textbook English sentence patterns (what), but rather, their purpose or 'why' for talking is to truly learn more about each other.

This realization of the effectiveness of starting with 'why' in communication has great implications for nursing as well. Patients, during clinical visits, and even more so in cases of hospitalization, are bombarded with 'what' statements such as, "I'm going to take a blood sample now" or "The doctor ordered...." In many of these instances, the natural patient reaction is the often unaddressed: 'Why?' In their daily interactions as healthcare providers, nurses must communicate in a way so as to achieve patient understanding and agreement with the prescribed treatment.

In a survey of 6,722 adults in the continental U.S., 24% or approximately one in four respondents reported having failed to follow doctor's advice or treatment. Of those self-reported cases of non-compliance or non-adherence, the most frequently given reason was that the patient disagreed with the clinician's

prescribed course of treatment (Davis et al, 2002). In other words, although the patients understood 'what' the doctor wanted to do, they failed to understand or buy in to the reason, or 'why,' the prescribed treatment was deemed most appropriate by the attending healthcare professional.

The new school year offers a good opportunity for educators to consider and clarify our teaching purposes. We must also inform and educate our nursing students about the importance of 'why' in effective communication. Although the concepts that Sinek introduces are drawn from business and marketing, the practicality and applicability of his proposal can be summed up in his TED talk (2009) observation that: "... if you don't know why you do what you do, and people respond to why you do what you do, then how will you ever get people to vote for you, or buy something from you, or, more importantly, be loyal and want to be a part of what it is that you do."

This statement also rings quite true in both teaching and nursing where we must communicate in a way that makes students or patients feel included and "want to be a part" of what we do.

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Authentic Nursing English Spoken Discourse and Its Representation in Textbooks



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In 2010 and 2011 the author and a colleague conducted fieldwork aimed at uncovering the types of workplace speech events that nurses most frequently participated in, as well as how these discourses were typically managed. One major finding (Guest & Nambu, 2011a and 2011b) was that the speech events that constituted the majority of actual spoken nursing discourses observed were rarely or only marginally addressed in commercial textbooks. Moreover, where they were addressed, they often failed to conform to the standards and norms of nursing English discourse management that had been noted in the field work. In 2017, as a follow-up to this earlier research, the author analyzed six nursing English textbooks that had been published within the interim period (2009-2017) in order to compare their presentation of nursing speech events and the management thereof with those noted in the previous study. The author found that recent textbooks were addressing nursing spoken discourse in a much more comprehensive and accurate manner than previous materials had. As a result of this, it is argued that nursing English teachers should become more aware of the roles and functions of these discursive features when choosing textbooks or making their own nursing English classroom materials.

Keywords: *nursing discourse, ESP textbooks, materials development, discourse analysis*

In 2010, the present author and a colleague conducted a series of interviews with nursing professionals in Japan, the U.S., Singapore, The Philippines, and Malaysia aimed at discovering what types of spoken discourses were typically carried out in the nursing workplace. This was combined with field reports analyzing these interactions in terms of participants, speech events, and discourse management.

The observation of discourse management entailed a focus upon external factors such as power relations, politeness strategies, symmetry, and turn-taking. Internal factors observed included the use of informal discourse markers, ellipsis, strategic competencies such as repair, and illocutionary acts.

Among the salient findings uncovered in the earlier research (Guest & Nambu, 20010a, 2011b) was that approximately 90% of all nursing discourse observed in all locales was conducted nurse-to-nurse or nurse-to-allied health professional (AHPs - including doctors, technicians, caretakers, case workers etc.), with under 10% being conducted nurse-to-patient. Prominent among nurse-nurse (as well as AHP) interactions were the speech events of 1) Handover (also known as handoff or pass-off) — the nurse-to-nurse briefing performed when turning over patient monitoring at the end/beginning of a shift, 2) Roll call – the debriefing sessions held at beginning of a dayshift, generally led by a senior member in which daily priorities, including updates and concerns, were conveyed to the departmental nursing team, and 3) Preceptor-Preceptee training sessions, in

which a junior or trainee is examined either formally or informally by a senior member as a part of the instructional process (Guest & Nambu, 2011a). Authentic samples of these speech events are included in the appendix.

In terms of discourse management, it was noted that spoken interactions were rarely symmetrical. Power differentials were particularly marked in events such as roll call. Adjacency pairs initiated by the preceptor were a standard feature of training sessions. Both handover and roll call employed ellipsis, indirect speech, abbreviated forms, and repair/confirmation strategies (Guest & Nambu, 2011b). Even nurse-patient and nurse-patient family were rarely symmetrical, with most such interactions initiated by the nurse, whose turns were more elaborate and extended when compared the patients' often brief or truncated responses. Authentic samples of these forms also appear in the appendix.

In the same study, the current author further compared these findings to the manner in which spoken nursing discourse was portrayed in a number of Nursing English textbooks. These covered both international and local (Japan-based) publications, keeping in mind that target audiences will differ according to the intended readership. We found that the major speech events were rarely addressed in any of the texts, particularly as model dialogues. Instead the emphasis was placed almost exclusively upon nurse-patient encounters, which constituted almost 90% of the speech model texts, a

near 180-degree departure from what our field research had indicated. Moreover, these nurse-patient interactions were portrayed as highly symmetrical in terms of power and turn-taking, utilized fully-formed syntactical structures, and never required the speakers to utilize strategic competence such as clarifying, confirming, or repairing discourse breakdown — all in contrast to our findings. As a result, we called for greater attention to be paid to both nurse-nurse interactions and the development of more realistic interactive speech models in teaching materials.

The Follow-Up Analysis of Nursing English Textbooks — Methods and Materials

In 2017, the author performed a similar analysis of six current Nursing English textbooks. Two were newer, updated versions of the same publications analyzed in the previous investigation. Added to that were four new publications. Three of the 6 total publications were offerings from major international publishers, while three were from smaller, local publishers. Two of these locally published textbooks were aimed solely at Japanese nursing students. I did not name the textbooks analyzed in the previous study in order to avoid drawing negative or positive attention to the authors/publishers or their commercial interests and I will maintain the same principle while reporting the follow-up data. It should be noted that not all of the textbooks analyzed were explicitly written 'for nurses' but that some

were expanded to cover healthcare workers or caregivers more generally.

For the follow-up analysis, I noted only those texts that modeled spoken discourse or those that were directly connected to speech tasks. From these texts, I initially calculated the number of speech models according to both participants and speech events. I then further analyzed model speech texts to determine if any, and to what degree, the features of nursing speech discourse management described earlier had been incorporated into the textbooks. These results were then compared to the results obtained seven years previously. Where publishers offered differing proficiency levels of textbooks, it was the lowest level that was analyzed.

It is important to distinguish texts that are presented primarily for modeling purposes from those which are tied to tasks in which learners are required to answer comprehension questions or asked to provide a socio-cognitive analysis of a text (e.g., *'Why do you think Ms. Brown refused the drink? Do you agree with her decision? What would you say in this case?'*). In my analysis, discourse management emphasis was applied to the former type but not to the latter.

Results

The most salient result of the recent analysis was the increase in the variety of participants in the spoken texts. Nurse-patient (or 'client') interactions accounted for just over half of the model texts. This

was particularly pronounced in the international publishers' offerings, where up to 75% of the speech texts involved nurses speaking with allied health professionals, clinicians, or other working staff.

One reason that the international textbooks would emphasize this more diverse participant orientation is because their target audience consists of not only nursing students learning English as a foreign language but also due to the very great possibility that their students/learners will be aiming to research or practice in English-speaking locales (such as Cambodian or Indonesian nurses seeking employment in Singapore or Hong Kong). This would require using English as a working language. Workplace English proficiency may also be desired in order for non-native English-speaking nurses to gain positions at prestigious international hospitals in their own countries.

However, even the locally-produced textbooks displayed a greater awareness of the variety of participants within the nursing workplace than previously published versions had. One Japan-published textbook contained a welcome section on interactions with foreign students, researchers and clinicians, as opposed to the solely Japanese nurse-foreign patient interactions that had dominated the discourse in earlier textbooks.

The textbooks from major international publishers also contained significant sections on handover and informational

briefing interactions that mirrored roll call - these events covering a larger percentage of the total text than they did in previous versions of the book. Likewise, the Japan-produced books now contained small sections related to handover, albeit focusing more on reading, writing and discussion skills related to this event rather than creating practice or study models of the speech event itself. Nonetheless, this represents an improvement in terms of workplace scope over the textbooks analyzed in the previous study.

Preceptor-preceptee interactions were also more notable in the follow-up analysis. Dialogues involving supervisors and nurses or nurses and nurses' aides that focused upon instructional content or similar training scenarios appeared in four of the textbooks, including all of the international publications.

In terms of displaying authentic or realistic examples of spoken discourse management, two of the international publishers' textbooks claimed to base their models on authentic language. This was most evident in the accurate application of turn-taking and symmetry; power differentials in the participants were rendered such that those giving orders or providing advice or information took longer turns than their counterparts.

Strategic competence, particularly in terms of checking and confirming functions, was also more visible in all the textbooks analyzed. However, breakdowns, misunderstandings, and subsequent repair, whether initiated by the speaker or the

interlocutor, were still not in evidence in any of the textbooks.

While the use of medical shorthand terms was well distributed throughout the speech models in 4 of the 6 textbooks, the use of situational ellipsis, which was very widespread in our earlier field research, was largely limited to informational responses; the models were not otherwise indicative of the type of truncated speech patterns that typically marks real-time interactions between in-service professionals, which often involves the use of indirect speech and illocutions. It might be argued, though, that these forms are dependant upon the immediate environment of the interactants and therefore do not readily lend themselves to models for use in textbooks, where the immediate surrounding context is not shared by the reader/student.

One feature of spoken discourse that was notable in some of the local textbooks was extemporaneous speech, perhaps better described as extended social chat, between nurses and patients/clients – often operating symmetrically in both directions. However, these types of interactions were exceedingly rare in our field research. These constructions were particularly in evidence when the textbooks writers were attempting to illuminate certain sociolinguistic features of speech, such as politeness, distance, and backchanneling.

Discussion

The increasing awareness of the variety of nursing English discourse events, the diversity of participants, and modes of discourse management manifested in these more recent publications was a welcome sign that materials writers are becoming increasingly aware of applying specialized discourse analysis to teaching materials. This will benefit nurses who plan to work in internationalized environments such as those who plan to train or practice abroad or work at large, international hospitals in Japan, as well as those who may work in medical tourism.

One critique of this extended focus might be that Japanese nursing students or trainees would only use English in interactions with patients, whereas they would use their native language for work-related functions. This is true, but one must also be cognizant of the increasing number of non-Japanese caretakers and other healthcare workers, as well as trainees and researchers from abroad, in Japan, in which case English might well serve as a lingua franca. Certainly, Japanese trainee nurses or students who hope to train or practice elsewhere, even on a temporary basis, would be better served by this more wide-reaching approach.

The positive impact, however, is not limited to the development of more authentic or wide-ranging English speech skills. An increased awareness of the various workplace roles and functions that a nurse may encounter in any language or culture can have a positive washback effect

onto the trainee or student nurse's first language and culture, helping novice nurses to strengthen cognitive awareness, both social and medical, in relation to their current or future workplaces.

Therefore, this expanded approach to nursing discourse also provides benefits for those majority of Japanese nursing students who will not train or practice abroad, nor work in fully internationalized workplaces, in that their cognition as nurses become engaged in a more holistic manner. I would argue that this focus holds greater long-term value than what I call the 'retrieval' notion of pedagogy — in which language forms are taught with the hope that particular terms or set phrases learned as a student might be retrieved and appropriately deployed by Japanese nurses based on the small chance of them encountering non-Japanese speaking patients at some indeterminate point in the future.

One suggestion that can be made based upon this analysis is that model texts would do well to provide examples of misunderstandings and breakdowns, with models as to how repair might be achieved. The world of spoken discourse is rarely as perfect as the textbook models indicate and the strategic competence required to manage such discourse is a skill worthy of address.

Finally, one must remain cognizant of the fact that applying discourse authenticity should not be an end in itself and does not automatically validate language teaching materials. 'Authentic' language is not necessarily more suitable

language for teaching purposes, particularly within EFL environments. Language models informed by authentic data, and thereafter judiciously applied to classroom materials, however, have certain obvious benefits. Not only do they prepare the learner more adequately for actual in-service encounters but they also allow learners to internalize the ebb and flow of interactive discourse in a way that more stilted, artificial models cannot.

Conclusions

Our earlier research on the nature of English nursing spoken discourse seems to have been validated by the growing number of informed materials makers and textbook writers who are incorporating a wider variety of participants, a greater number of workplace speech events, and a deeper understanding of specialist discourse management into their textbooks. Nursing English teachers should take these factors into consideration when making materials or when choosing a textbook for their learners, as the productive value of English for Specific Purposes (ESP) research is most readily manifested when findings can be realized in more pedagogically sound materials.

Although I would not claim that our small-scale previous research is in any way directly responsible for the present shift towards a more nuanced presentation of nursing spoken discourse in textbooks, it is evident that there is a conscious movement towards understanding the management of specialized discourses in a

manner that can aid in developing more accurate and suitable teaching materials. The true beneficiaries will be, of course, the students themselves.

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Appendix

1. Authentic Roll Call sample text

(senior nurse to junior nurses – Philippines.

Note that the numbers are written as originally stated and refer to beds. X and Y refer to medical terms/variables):

SN: Ok, 7- maintain x, avoid y, x removed, decrease y. 8,9- on liquid diet, start IVM, 9 discharge expected PM. 10- x expected tomorrow, y to start 4 pm, CBC 12, x positive. 11- ongoing IV, (no.) minimum, ultrasound scheduled (time). 12- painkiller to follow X at same rate, Y 1 liter at 54cc per hour, may go ahead with contemplative surgery, loss of blood, limited fluids at (no.) per day. Post-partum (?), now prescribing y.

JN: Prescribed y?

SN: Y. 12 is the issue. Suggest panadol.

JN: Then we can give panadol? What if there is a reaction to the panadol?

SN: Then you cannot initiate X and you inform the doctor. So, unless there's anything else, that's all.

2. Authentic handover sample text (nurse-nurse, Singapore):

A: So, still radiating, now extending to lower leg. Hypertensive meds. Y stable. PTOP (?) was just now so just document it. And x was restarted again.

B: So, so far no z. She already knows, yeah?

A: No, the x is still there. So today's review is x, tomorrow blood, and they'll do the x-ray. So far blister still isn't broken.

B: So, now how long? Is the family asking?

A: They are agreeable to y, so I noted it and will confirm with Dr. Z. Suggestion was y. Refer the

patient to cognitive assessment. Initial level was (number). Follow-up. Trace blood CS and echo. Update after repeat echo.

B: So, this is a case of y.

3. Samples of repair by confirmation/clarification as noted in the author's original field research:

N1: We're now prescribing X.

N2: You prescribed X?

N1: The initial assessment was (inaudible)

N2: Initial assessment was...?

N1: Discharge is expected tomorrow.

N2: Tomorrow?

Preceptor: So what is the priority?

Preceptee: We must remove it. But (pause) what if response is minimum?

Preceptor: Minimal response?

4. Common self-initiated repair signals:

Well, ...

You know,...

It's like..,

What I mean is...

5. Common checking/confirming signals and strategies

We can bring the drip, yeah?

Only for tomorrow, right?

I'm not sure I understand.

Did you mean..?

Just to clarify....

So, it's like... right?

So, my understanding is that...,

Is it OK if...

Any questions?

Only for tomorrow, yeah?

Anything else?

Hypertension has been noted, right?

6. Authentic samples of ellipsis

(Did you) make rounds already?

(Have) You finished the dressing?

(Do) You want the new one?

(I) Don't have it with me. (I) Need twenty.

(There is) No need for x.

(It's the) Same diagnosis.

(There is) Nobody there I know.

7. Samples of turn taking (indicating power relations)

- a. The use of negative questions as a face-saving strategy:

"Wouldn't it be in the patient's best interest if...?"

- b. Preceptor-Preceptee adjacency pairs

Preceptor- *What are some of the related factors?*

Preceptee- *Heredity. Gender...*

Preceptor- *What are the manifestations?*

Preceptee- *Difficulty in breathing.*

Preceptor- *What else aside from that? What other risks?*

- c. Trainer-Trainee (open-ended forms)

So then, this is a case of...?

And so what you will do next is...?

- d. Trainer-trainee session/Roll call closing signals

So, that's it.

That's all.

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