Medical Case Reports in English: An Exemplary Case of Learner Autonomy

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Abstract:

The author describes a self-directed learning setting he has been involved with for over 20 years. Doctors at a university hospital in Nagoya, Japan, conduct weekly case reports in English instead of Japanese, with a native speaker of English (the author) sitting in as monitor and advisor on language. The meetings have been effective in raising fluency, accuracy, and confidence in English. The effectiveness appears to be due to the regular practice opportunity, the context-rich, real life setting, the repetition of procedures and language, and the monitoring and advice by the native-speaker. Some elements of the meetings have been put to good use in more conventional classroom settings, but direct application among other medical professionals could be problematic; such ventures depend very much on administrative support and the consent of participants.

Introduction

For over 20 years I have participated in what is probably the most effective language learning venue I have been involved in, and certainly the most learner-directed. Doctors in the Department of Neurosurgery at a university hospital in Nagoya, Japan conduct their weekly discussion of cases in English instead of Japanese, with a native speaker of English (myself) sitting in as monitor and advisor on language use. Virtually every aspect of the learning setting originated from the head of the department and the other learners, from the idea of the meetings itself, to the soliciting of a native speaking monitor, to decisions about what the 'teacher' should do, where and when the meetings should take place, and finally to the format, procedures, materials, topics, and language itself.

The strongly learner-directed nature of the meetings struck me from the beginning, and was my informal introduction to the idea of learner autonomy. My first introduction to the literature was Dickinson (1987), a source which remains useful at a descriptive level, particularly the 'degrees of autonomy' schematic (p. 14), which places a learning situation within a chain of decision nodes regarding method, pace, when/where, materials, monitoring, and assessment. At each node, learners rank upward, toward more autonomy, or downward, toward external direction. The neurosurgeons, within Dickinson's scheme, comprise a self-help group that is highly autonomous because it is highly self-directed, and my somewhat unusual role in the learning is nicely accounted for: 'knower monitoring by request' (p. 14).

Over the last twenty years, the terms used to talk about learner autonomy within the language learning field have been refined. 'Independence' in the sense of learning alone, which constitutes maximum autonomy in Dickinson's system, is no longer seen as a self-evident good. Emphasis is placed on 'interdependence,' support, and the social nature of learning in general (Little & Dam, 1998; Little, 2003). The learning venture of the neurosurgeons is certainly a very socially embedded one, and this does seem to empower the learning, though it should also be noted that the learning environment retains a rather traditional social hierarchy: a department head initiated the venture and presides over it. Thus, the doctors are highly autonomous as a group,

in the sense of having undertaken their venture apart from a formal learning programme, but less obviously autonomous as individuals within the group itself.

Benson's (2007) overview of the growing learner autonomy literature notes a shift away from an earlier emphasis on individuals or groups, like the neurosurgeons, who sought independent learning solutions outside formal learning programmes, and towards the transformation of those institutions and programmes (as well as learners) themselves. Learner autonomy is seen now more as something to be fostered or facilitated within the classroom (Crabbe, 1993; Littlewood, 1996; Little, 2007) than pursued outside it. Though this development is important for classroom teachers like me, it leaves highly autonomous self-help groups like the neurosurgeons somewhat out of the conceptual loop. Their achievements are not easily accommodated in the present literature, and the extensive discussion on fostering and facilitating is essentially irrelevant in their case: the neurosurgeons needed no fostering, and their achievement--presentation and discussion of complex material in the target language, with sophisticated visual support--goes far beyond anything I could ever have facilitated.

In this sense, the example of the neurosurgeons might serve as a useful reminder that we may need to step aside when our facilitation is not needed. The original and still widely accepted definition of autonomy is ‘the ability to take charge of one's own learning’ (Holec, cited in Little, 2007, p. 15). Some learners have done just that, with more initiative and determination than teachers might expect, and without our pedagogical intervention.

For the remainder of this paper, I describe the medical case reports, discuss their effectiveness, and conclude with a brief consideration of applicability.

Weekly Medical Case Reports in English

In this section I present a brief history of the meetings, a description of the setting and routine, and some notes about the learners and learning styles.

The medical case reports in English were initiated in 1987 by the head of the Department of Neurosurgery at a university hospital in Nagoya. The department head was concerned about the poor performance of Japanese doctors at international conferences. He decided to ‘kill two birds with one stone’ by giving the busy doctors under him a practice opportunity in medical English without interrupting the normal routine of their work; the department's weekly case reports were to be conducted in English rather than Japanese. He felt that a native speaker of English should serve as advisor, and I was sought out for this role through a mutual acquaintance. After proposing the idea and obtaining the support of most participating doctors (two older doctors apparently resisted), the meetings began, and have continued regularly ever since. There was some question as to whether the meetings would continue when the head of the department retired, but the new department head gave his enthusiastic mandate. Like his predecessor, he was a doctor with international experience and a global vision for the Japanese medical community.

The venue is a major university hospital, and the doctors in the department are specialised, engaged in ongoing research, active in medical conferences and regular contributors to medical literature. The hierarchy of the department is pyramidal: one department head, a handful of senior doctors under the head, and a larger number of younger doctors under them. Between four and twenty doctors, and periodically a few medical students, are present at the weekly meetings. Attendance is irregular due to shifts, vacations, conferences, or surgeries in progress. English ability varies widely, from a few very advanced speakers, to very good speakers, to those at the false beginner level.

The doctors meet once a week on a weekday evening, and the meetings last anywhere from 10-90 minutes, with the average meeting lasting between 40 and 50 minutes. Up to eight cases are presented with each case lasting from five to 30 minutes. Time varies widely depending on the number of cases, and their relative

complexity. When the chief doctor concerned with a case is absent, the case is typically not presented. The day, time and place of the meetings have changed over time, but not the basic routine, which is described below. The visual format has altered substantially due to advances in imaging and data retrieval technology.

Cases are presented in a common area with one large-screen television. A variety of visual material can be displayed on it via connections to a computer with access to an electronic data base of medical records, to a DVD player, to personal laptops, to an overhead video camera, and to a microscope for pathology slides. A very large amount of visual material is presented and discussed, including a substantial array of medical imaging, electronic readings, DVD recordings or digital photos of surgery, anatomical sketches, pages from reference books, anatomical models, surgical or pathological specimens, and, occasionally, explanatory English notes.

Presentations nearly always follow the same routine. First, a doctor presents a case, presenting pre-operative history, a description of surgery, and post-operative status. Then, there is a discussion of the case and related medical issues, led by the department head, or, in his absence, a senior doctor. Finally, there is a brief correction period, in which I point out language problems, make corrections, offer advice, or ask about medical details. During presentations and discussion I note language issues on a memo pad so that I can remember them during my segment, and leave them with the presenting doctor so that they can have some sort of reference. A recent innovation introduced by the department head is to have medical students, who periodically rotate through the department for two weeks as observers, present cases they have observed in their rounds with the doctors.

The meetings entail no formal or sequenced language instruction or follow-up. English language issues come up in the context of cases. The language instruction could be considered secondary (i.e. not the main point of the meetings), ad hoc, and cumulative through repetition, meaning that similar errors come up and get pointed out and corrected. Doctors appear to take corrections and suggestions seriously, and to make an effort to attend to them (see the next section). However, it is not clear whether doctors follow up corrections with personal language study. I would speculate that this is relatively uncommon, or, if done, done very briefly, e.g. by checking a dictionary or reference book.

Language and usage, as well as presentation and learning styles, vary widely. Doctors who have practiced abroad speak fluently and confidently, but have some ingrained fossilization errors. Advanced or moderately advanced speakers with no experience abroad speak with somewhat less fluency but often with more grammatical precision. A few doctors have, or gradually attain, a high level of structural mastery in English but have pronunciation problems that are deeply ingrained and hard to correct, while other doctors, even with substantial pronunciation problems, can make improvements in their pronunciation relatively quickly. Though there are some errors or problems common to many or most doctors, doctors appear to be very individualised in their profile of language difficulties.

As for presentation and learning styles, some younger doctors who are not particularly confident in English initially read their presentation from a scribbled summary or translation, but usually stop doing so after some months. Visiting medical students also read from their own prepared English text. Doctors that have become somewhat more confident in English will often use Japanese text in the medical records as a verbal cue, and paraphrase or summarise in English as they go. Advanced and moderately advanced English speakers nearly always speak extemporaneously.

Benefits of the Weekly Case Reports

In this section I enumerate what I perceive to be the benefits of the weekly case reports. My observations are impressionistic, but, since I monitor constantly and notice

individual development over time, more confidently impressionistic than might normally be the case. Progress is clearly perceivable, but would not be easy to assess.

A few notes about the difficulty of assessment in this setting may be in order. The doctors do not take, nor am I in a position to make them take, proficiency tests in connection with the meetings. In addition, attendance and the number and length of presentations are highly irregular, as has been noted, and this would make quantitative assessment difficult, since progress could not be consistently or meaningfully measured against hours of instruction. Qualitative data in this setting might also be obtained by recording, transcription, analysis, and longitudinal comparison. However, I feel that this would be intrusive and beyond my mandate. I am, after all, a *guest*, of the doctors. Trying to gain their permission to be research participants would be ethical but rather impolite in my situation, and would strain an otherwise pleasant working relationship.

Taking these caveats into account, the meetings appear to be effective in at least five ways:

1) Efficient Use of Time
The weekly meetings are an extremely efficient use of time. The doctors get very focused practice in the target language through presenting, listening, or discussing, while getting work done. There seems to be tangible improvement in the target language, to be discussed below, despite a relatively small amount of speaking time for each participant.

2) Improved Performance at Target Venue
First, second and third hand reports from the doctors are that they could present with more confidence and were better able to handle post-presentation questions at international conferences.

3) Improvement in English Ability
My impression is that there is clear and steady, though not necessarily smooth, improvement in the doctors' English, specifically in fluency, confidence, and accuracy (e.g. grammar, usage, vocabulary, pronunciation, stress, intonation, and the like). I attribute the apparent improvement to five factors: i) the regular practice opportunity both in speaking and listening, ii) the focussed content and format, iii) the context-rich environment, iv) recycling (meaning repetition of the routine, key language, correction, etc.) and v) monitoring and correction by the native speaker. Correction appears to be far more effective here than in other teaching settings I work with, because it is timely, relevant to the immediate context, and persistent in the sense that the same errors get pointed out repeatedly, yet non-intrusive, i.e. it does not interrupt presentation or discussion.

4) Success with a Mixed-ability Group
The meetings appear to succeed with a group that is quite mixed in English ability, a situation which my experience has shown can be challenging in other learning settings. I attribute this to the context, content and shared expertise, which trump any differences in English language ability.

5) Staying in the Target Language
The doctors present and discuss highly complex material, yet stay almost entirely in English. I believe that my presence as the native English speaking monitor is the key factor here; I give the group a reason to speak English. To appropriate Woody Allen's famous observation, ‘Ninety percent of life is just showing up’ (Famous Quotes, 2008), ninety percent of my effectiveness in the

meetings may simply be my ‘showing up’; the group is able to use English without it feeling strained, unnatural, or absurd.

Conclusion: Issues of Applicability

From the time I wrote (1991) and presented (1992) on the case reports in the early years, a continual concern of mine has been how to apply the apparent success of the medical case reports to the more conventional classroom settings I normally work with, EFL courses in Japanese universities. A presentation course developed by Juanita Heigham and associates (Heigham, 2007, pp. 140-141) involves a regular presentation routine using student-created visuals, and is the nearest equivalent I have observed, in an institutional classroom, to the doctors' case reports. Heigham draws on a project-based pedagogy (Fried-Booth, 2002) and a task based, experiential approach (Legutke and Thomas 1997) that recapitulate in many ways what the neurosurgeons have happened upon independently. I structure my own teacher training courses and content-based courses increasingly on Heigham’s model, though behind that influence is the inspiration provided by the neurosurgeons. My colleague David Kluge and I (2003) have also developed a series of presentation templates by which learners in a first year speaking class present and answer questions about their lives, with learner-generated visuals (personalized scrapbooks) (2007, 2008). Thus, simplified applications of the neurosurgeons' presentation routine appear to work well, though these are applications more of technique than autonomy per se.

Surprisingly, it may be much harder to apply the autonomous learning of the neurosurgeons more directly to other medical contexts. This became evident when I was approached by two doctors who wanted to start similar meetings in their respective departments. Though I expressed enthusiasm, I never heard from either of them on the subject again. I could only conclude that they were unable to obtain approval from their department head and/or participating department members. This underscored for me how crucial had been the mandate of the two department heads and the general consent of participating doctors in the Department of Neurosurgery. Autonomous learning, no matter how unconventional the setting, seems to depend very much on administrative support from above and participatory consent from below.

Acknowledgements

I am deeply indebted to the comments of my anonymous reviewers, and especially to the encouragement and assistance of my editor Lucy Cooker.

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