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Metamorphosis of Female Impersonators into Strangers in Japanese Popular Theatre

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Unexpectedly, the Kabuki-styled traveling popular theatre that is marginalized and stigmatized has gradually been receiving unprecedented popular recognition. Through the integration of traditional Kabuki style with modern fashion motifs, this theatre seeks to demonstrate the pleasure of acting in and viewing a theatrical performance. Not only does it cater to an audience that seeks enjoyment, but it also helps the audience perceive moving and inspiring truths about humanity. This theatre is denounced as being artistically unsophisticated, or is simply ignored by mainstream media and high-brow patrons of the arts alike.

But unlike mainstream Kabuki, this marginalized theatre makes efforts to develop its own acting style in order to engage the audience's aesthetic sense of beauty. Its talented performers, especially female impersonators, undergo a metamorphosis that involves a metaphysical joining of the performer and the "stranger". This enables the performers to transcend the everyday perception of humanity and frees them to express humanity crystallized in style. I will explore the metamorphosis in which the concept of the stranger plays a key role in the dynamics of this marginalized popular theatre from the past and to the present as well as medieval traditions on female impersonation in this marginalized theatre. In so doing, I will refer to the concept of "interbeing" that is situated in between what is same and different or inside and outside. This concept was developed by Richard Kearney who argues that the stranger always resides within every individual. It helps illumine how the stranger in the non-mainstream popular theatre is expressed and reaches out to the audience.

Key Words - Itinerant popular theatre; Female impersonators; Metamorphosis; Stranger; Interbeing

Introduction

Japanese classical theatre typically refers to Kabuki and Noh. Just as Noh can be divided into two types, authentic/mainstream and unsophisticated/nonmainstream, so too can Kabuki. For the general audience, Kabuki is more accessible than Noh because although Kabuki retains an academic atmosphere, the latter is perceived to be shrouded in both academic and aristocratic dignity. Yet, despite Kabuki's origins in the 17th century as a traditionally popular form of entertainment, in recent years the comparatively expensive admission price for even this traditional mainstream Kabuki has given it a more dignified air of authority than ever before. Unlike the more prestigious art forms of Kabuki and Noh, however, a much more popular, less formal version of Kabuki, presented by traveling troupes, has gained increasing popularity among a working-class, predominantly middle-aged and elderly female audience. This nonmainstream theatre is generically known as "popular theatre" as opposed to the so-called commercial theatre that is often supported by the media. Although it receives little media coverage, it makes a passionate appeal to a wider audience through the use of innovative themes and techniques.

This paper will discuss the ways in which this popular theatre ventures into the realm of a reality beyond what is perceptible to the senses. The primary focus of this discussion is on its female impersonators who play a key role in attaining this state of in-between-ness in which both female impersonators and the audience are placed.

1. Hospitality and hostility simultaneously extended to the stranger

Traditional Japanese folklore suggests that the stranger (the outsider) comes from the outside world and represents not only what the community perceives as a hostile environment, but also the world of the dead which commands awe and respect. Inspired by a special term denoting a visitor god in the literature of ancient Japan, poet, folklorist and scholar of ancient Japanese literature and culture, Shinobu Orikuchi (1887-1953), theorized about a certain kind of stranger who, he argued, was among the incarnated ancestral spirits of the Japanese people. In his theory, Orikuchi used the word "marebito," which is an archaic term for an uncommon visitor. He further explained that the divine stranger, in its seasonal visits, would bring blessings to rural communities. For the ancient Japanese, he argued, *marebito* referred to distinguished visitors, rather than to those who merely came on rare occasions. He defined the *marebito* as a "visiting god (or divine visitor)." He states:

> Primarily, [the *marebito*] refers to ancient spiritual beings from the mythical Eternal Land (*Tokoyo*) across vast oceans who were believed to pay a visit to villages to make people there happy and then return to their own realm.[1]

Thus, the *marebito* was believed to possess the power to rejuvenate and revitalize nature, human life and society.

Recent Japanese folkloric scholarship has expanded Orikuchi's interpretation of the *marebito* by focusing on the dual nature of this visitor deity. Among other scholars, Kazuhiko Komatsu and Norio Akasaka began to consider these *marebito*-like figures as strangers from an historical perspective. In Japanese folklore, the stranger was perceived by the community as ambiguous, as both threat and benefactor. They were believed to belong to the world of the dead, for which people felt a tangible sense of reverence and awe. They were also expected to bring comfort, hope, happiness and good fortune to agricultural communities. In other words, they were perceived as both benevolent and malevolent. Both Komatsu and Akasaka argue that this ambivalence tended to result in the mingling and intersecting of hospitality and hostility, with hospitality just as likely to be offered at any given moment as hostility.

Both Komatsu and Akasaka have chosen to name the stranger "ijin," literally meaning "foreigner" or "outsider." Perhaps this is because *marebito* primarily refers to those within the confines of ancient Japan, while the term *ijin* can be used to include various types of strangers, ancient or modern, and has become the preferred term which illustrates the continuity of this concept in the Japanese mind. In fact, the scope of their research covers not only historical, but also present-day, ghost and monster stories, scary tales, supernatural stories from traditional folklore, and urban legends.

Western Japanologists' scholarship has probed the idea of the *ijin* that Komatsu and Akasaka have conceptualized. Notably, British scholar of Japanese culture Carmen Blacker recognizes the key role played by the stranger in Japanese history and culture. She contends:

> The folklore of Japan is full of references to the mysterious figure of a Stranger, who wanders into a village from an unknown 'outside' world. The word for a Stranger in Japanese, *ijin* or 'different person' has a wide connotation. An *ijin* can be a traveler, for example, whose way of life is wandering, in contrast to the static agricultural life of the village. He may be a wandering woodcarver or tinker, a traveling priest or strolling player. An *ijin* can also be a foreigner from another country 'outside' Japan, a Dutchman, Portuguese, Chinese or Englishman. And he can also be an avowedly supernatural being, outside the human race.[2]

Blacker also notes the dual nature of this stranger:

> The person coming amongst us from this outside world, from which the known distinctions of life are obliterated, can never be of us. […] Our instant reaction is to see him as a

> threat, bringing perilous pollutions from his alien land, and to expel him from our midst. But a moment later we perceive that at the same time he possesses strange occult knowledge, magic or medicine, beyond our experience. We therefore refrain from expelling him, with curses and stones, and instead disarm him with hospitality; we treat him with all the ritual of a guest, which will elicit from him blessings rather than harmful enchantments.[3]

Thus in popular belief the visitor from the unknown world or the stranger brings about a transformation which results in a kind of spiritual rebirth for the host community.

More interestingly, among other types of traditional strangers (*ijin*), itinerant theatrical performers devoted to the popular entertainment of Kabuki-inspired, working-class theatre, still remain in existence today. Although ignored by mainstream theatre-goers and seeking more mainstream media coverage, some troupes make every effort to be so inventive as to create ever newer performance styles and techniques. Hence, it is a small wonder that itinerant troupes continue to be viewed as traditional strangers, meeting with a peculiar mixture of hospitality and (unvoiced and unconscious) hostility from their enthusiasts. While greeted with enthusiasm at theatres of their own kind that are smaller and more technically underequipped than their commercial counterparts, subconsciously their audience still treats them as dreadful and awe-inspiring strangers because of their unusual and miraculous expertise as entertainers. Their itinerant lifestyle also tends to encourage the bias it causes in their audience's perception of them.

2. The stranger's endless wandering as demonstrated by itinerant theatrical performers

In the mid-19th century, when the nascent Western-oriented Japanese central government began to westernize the entire country, most types of traveling entertainment that had enjoyed several centuries of popularity rapidly became extinct. This political Westernization and modernization sought to abandon traditional values, institutions, and customs and adopt those that prevailed in the West. As such the new government's centralized political control of the arts turned out to be much tighter than that of its pre-Meiji era predecessors. Despite this fact, nonmainstream Kabuki-inspired popular theatre maintained its traditions largely because the performers, who were mostly illiterate and otherwise unable to earn a living, had to rely on this type of acting for their survival. They were also excluded from the mainstream theatre business because they were considered illegitimate, unsophisticated and less professional. They could not help but keep traveling on. Thus, itinerancy remained a permanent aspect of this beleaguered theatre. Even today, approximately two hundred troupes are continually traveling, and while unrecognized and/or financially unsuccessful troupes tend to disband, new ones continually come into being.

These traveling performers remain strangers in the eyes of the Japanese people, at least psychologically. Since they are perceived as such, they are still greeted ambivalently with a mixture of hospitality and (unconscious) hostility in the tradition of the visitor god.

The nomadic lifestyle of these itinerant performers seems extremely unusual to the typical, more settled people who live in one place (i.e. their homes) for months or years at a time. Switching performance venues on a monthly basis, these performers present a series of live stage shows every day, having no more than a single day off until the second to last day of each month. Currently, a typical weekday program consists of a two-hour long morning show and a one-hour long evening show, though on weekends a two-hour long show is performed twice per day. The average ticket now costs about 18 USD. In the last few days of each month, the company begins packing up its costumes and stage properties, and on the night of the penultimate day of the month, they complete the moving process and drive to the next location. On the first day of the next month, they begin their monthly schedule again. As long as a contract is available, this monthly process continues; otherwise the company spends a month or months unpaid, and is likely to be disbanded.

Marilyn Ivy, an American anthropologist who focuses primarily on Japanese culture and politics vis-à-vis the question of modernity, illustrates the typical lifestyle of itinerant theatrical companies in the early 1990s. She states:

> The life of a taishû engeki [i.e. popular theatre] troupe becomes all the more remarkable when one considers the special features of their art. They perform two different plays for their noon performance, which lasts until 3:30 P.M., and repeat these plays for the 5:00 P.M. show. The next day two completely different plays are performed.[4]

She thus notes the average long and busy day of the troupe, including the daily training practice that takes place after each evening show, ending as late as 2 o'clock the next morning. She continues:

> This devotedly itinerant life, with its unending round of performances is everything that contemporary middle-class Japan–with its ideals of lifetime employment, affluence, and achievement—is not. What gives taishû engeki its current appeal is undoubtedly linked to the image of the itinerant. It is an image that has enduring appeal for many Japanese […].[5]

Here, she brings to the fore the state of being itinerant that constitutes the very basis of the marginalized itinerant popular theatre. No doubt, for ordinary stay-at-homes, this mode of unusual and extraordinary itinerant living is beyond comprehension. More importantly, this endless itinerancy harkens back to

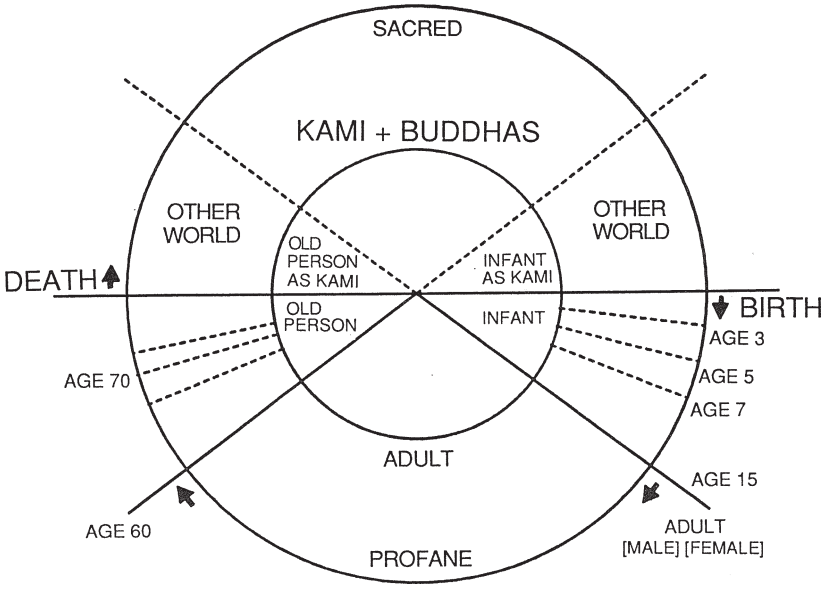
ancient ancestors who continuously wandered around Japan on foot and provided a variety of entertainment —acting and dancing included— to earn a living. It was this itinerancy that served to create an amalgam of awesome, bizarre and incredible beauty. Indeed, this rings true for today's itinerant theatre performers as well. In order to maintain the appealing mystery of the stranger, they need to keep wandering. If they settled on a home and used it as a base camp for their theatrical performances, they would be viciously exploited by mainstream entertainment promoters and surely lose their popularity. Although itinerancy has served as a source of their creative power in acting and dancing, it may dissipate the mysterious appeal that they traditionally hold for their settled audiences.

3. Historical conceptions of the stranger

Historically and traditionally Japanese society has included other sorts of stranger than Orikuchi's concept of the stranger, i.e. the seasonal visitor *marebito*. According to Japanese medieval—usually defined as the period from the mid-12th century to the late 16th century[6] —popular belief, children and elderly people were perceived as what is called "strangers" in the broad sense. These strangers, more accurately speaking, were popularly seen as being closer to divine beings like gods. In his exploration of medieval constructs of marginality (and in-betweenness) in social relationships and politicogeography, Hideo Kuroda has pointed out this social positioning of the very young and the elderly. These people were believed to partly belong to the sacred realm. It used to be said that children up until the age of seven belong to the family of god*s*.[7] They were believed to play a much less significant role in the medieval society. Because of the high infant mortality rate in the medieval period and their very minor role in the workforce, children were considered as mere half humans or immature social actor. Their physical incompleteness and poor nutrition tended to stop them from leading a happy and healthy childhood.

Likewise, aged men and women were already prepared to leave this earthly world, whether conscious or not of their preparedness. Having closely examined pictorial hand-scrolls (*emaki*) that depict commoner's and nobility's physical and spiritual lives in medieval Japan. Children and old people, Kuroda argues that both the young and old were positioned on the social margin due to their physical and spiritual attributes which implied their close proximity to the Otherworld. Unlike infants placed at the beginning of the life cycle, aged persons are close to its end and thus approaching the sacred realm inhabited by divine being of popular belief derived from a mixture of Shinto, Buddhism and various indigenous beliefs. In addition, although without elaborating, Kuroda argues that because of their physical and psychological differences from men, women too were regarded as strangers.

The following diagram drawn by Kuroda illustrates this life cycle that was widely accepted by Japanese medieval society.[8]



With children, in particular, even today this tradition still persists on a subliminal level. It is clearly reflected in a Japanese children's festival, called "shichi-go-san". *Tradition and Tradition Theories: An International Discussion* explains this celebration:

> Held on November 15, *shichi-go-san* means "seven-five-three", and refers to the custom of taking children of those ages to shrines in a rite of passage. Generally boys who turn five years of age that year, and girls of the ages of three and seven are taken to their [local] tutelary shrine to express thanks for growth and health, and pray for divine protection in the future.[9]

In order to clarify the marginality represented by these strangers, he contends:

> To understand why *kami* (deities) manifest themselves in corporeal form, that is, an old person, child, or woman, we must pay special attention to the similarity of social status shared by these three. In other words, none of them were treated as a "mature person" in medieval society, and thus none had a place there. …they didn't participate, or weren't allowed to, in any rural community meeting or famine- or tax-victimized farmers' rebellion. Evidently they all were positioned in the margins of the male-dominated medieval hierarchy. Thus I've come to the conclusion that specifically because of their shared marginalization within the framework of medieval caste system, they were considered as being semi-sacred.[10]

In premodern societies as well, elderly people, children and women were perceived and portrayed as being socially marginalized and thus represented groups of stigmatized people.

4. Female traveling entertainers of medieval and premodern Japan marked as strangers

Needless to say, traditional traveling entertainers consisted of both men and women. They were considered to be gifted with extraordinary or superhuman skills (and/or powers). Their unusual skills and talents were admired but at the same time awed by their contemporaries. Thus, they turned out to be socially constructed strangers. Their occasional appearances in many different areas of Japan served to reinforce the conception of the stranger. The cultural tradition of itinerant entertainment is thought to have originated in the Japanese medieval period; it has been argued that the first literary record of this tradition can be found in *Kairaishi-no-ki* (a.k.a. *Kugutsuki* (*Record on Puppeteers*), written by the poet and scholar Ôe no Masafusa (1041-1111).[11]

But Kunio Yanagita (1875-1962) who, though originally a scholar of agricultural adminstration, was better known as a cultural anthropologist, delved into the important role played by women in the long history of Japanese folk culture. His theory of *imo no chikara* (women's spiritual power) argues that women possess inborn magical and spiritual powers. He takes special note of "women's innate magical powers that astound and amaze men near them".[12] He states:

> The vital portions of the religious actions of ritual and prayer all fell within the province of women. The shaman, among these people, was as a rule a woman [...]. The reason that women were thought especially suited to this duty must at first have been because they have an emotional nature that is easily moved. Thus, whenever some incident occurred, women were the first among these people to enter abnormal psychological states, and the first able to give voice to the mysterious. Sometimes gifted, sensitive children had an ability to see divinities and to declare oracles, but as they grew up, they quickly lost these special traits. Moreover, children like these were borne and raised by women, so women were constantly accorded esteem. The special physiology of women [deserves] a particular consideration, since it had a powerful influence on these kinds of mental states.[13]

According to this statement he was amazed by the reproductive powers of women. Prior to this in-depth folkloric probe, he hypothetically investigated how women's inborn powers express themselves at the intersection of shamanism and prostitution. His research suggests that there is a variety of myths and legends of women depicted as both shamans and prostitutes.[14]

In the mid-1980s, Japanese feminists who had seen as problematic his chauvinistic but perhaps subcon-

scious focus on the genetic and biological basis of gender difference, started to raise a critical voice mainly within the discourses of feminist studies and cultural anthropology. Many male and female feminist scholars strongly disapprove of and denounce his scholarship which, they argue, caters to and reinscribes a misogynistic ideology. They argue that he overemphasized and essentialized femininity which was deemed inferior to masculinity and thus sought to confine women to a subordinate status.

In a similar vein to Yanagita's *imo no chikara*, Yoshihiko Amino (1928-2004), a historian whose areas of specialty was medieval Japan, also puts a special emphasis on women's sacredness derived primarily from their genetic traits. This sacredness, he argues, was once embodied mainly by traveling prostitutes who reportedly engaged in not only less formal shamanic practices but also singing, dancing and puppeteering entertainment, to name a few, originating in ancient religious rituals and ceremonies. It is a traditional popular belief that these women can figuratively be identified as the lesser descendants of *Amaterasu*, the Goddess of the Sun deemed as the highest deity in Japanese *Shinto* mythology, and *Uzume*, the Goddess of Dawn, Mirth and Revelry, who is among other divinities subordinate to the Sun Goddess. These goddesses are verbally depicted in *Kojiki* (*Records of Ancient Matters*) and *Nihon-shoki* (*The Chronicles of Japan*), both dating from the early 8th century. Their mythological sanctity can in part be seen as a reflection of the biological /physiological and mental characteristics and peculiarities of women.

But these idiosyncrasies were, in turn, most likely derived from the traditionally male-centered perceptions and constructions of womanhood and femininity, more specifically their menstruation, reproductive power and strong natural tendency to become emotionally aroused. Aware of women's biological peculiarities and their possible association with shamanism, prostitution and traveling entertainment in the mid-1990s Amino began to postulate that in the ancient and medieval periods, so-called "outcasts" including female itinerant song-and-dance performers/sexual entertainers, were closely associated with the imperial court and thus contributed to the maintenance of the imperial power structure at its lowest level.[15] Because of the highly hypothetical nature of this theory, it invited feminist academics to engage in lively, often heated debate on whether female entertainers as both performers and prostitutes helped maintain the emperor's hegemony in the ancient capital of Kyoto. This feminist criticism, it might seem, derives from these feminists' subconscious fear of being seen as covert accomplices. Although trying to provide historical evidence, the medieval historian Haruko Wakita provocatively repudiated Amino's argument about the close relationship between the Imperial court and the female traveling entertainers/prostitutes and characterized these women as "outcasts completely separated from the medieval imperial political power" and thus implied that these women were by no means involved in sustaining the imperial power structure.[16]

But despite such still ongoing feminist criticism of male chauvinistic views of femininity, especially

female sexuality, as sacred or at least otherworldly, this perceived linkage between femininity and sacredness/otherworldliness still persists in the Japanese popular mind at least. It has continued to influence a wide variety of popular culture. In the singing profession, for example, there are *uta-hime* (a young queen of singing or perhaps "diva") to whom a certain kind of "sacredness" is attached. The term *uta-hime* still remains of crucial importance in Japanese pop culture today. Examples include the anime film *Makurosu Furontia: Itsuwari no Utahime* [*Macross Frontier: The Young Diva Gifted with a Beautiful Voice and Amazing Miracle Powers that are Beyond Human Comprehension*] (dir. Shôji Kawamori, 2009) adapted from a popular anime TV series that depicts the roles played by two young divas gifted with a beautiful and miraculous voices in a space war. On the other hand, although there are highly acclaimed male singers, usually they don't have equivalent titles to clarify their privileged status. In the popular mind today, women are subliminally believed to be gifted with sacred spiritual powers.

Although admitting that the conventional short-sighted celebration of the sacred feminine deserves criticism, Yanagita's and Amino's individual explorations, I would argue, can contribute to the consideration of female impersonation of non-mainstream popular theatre today. This style of impersonation that is being develop by successful young actors, while reflecting popular constructs of women's gender identity in folk traditions, challenges these norms in order to demonstrate its own charm. These talented female impersonators portray idealized images of women gifted with supernatural, spiritual, sacred powers. Their performing styles imply a freedom from existing constructions of femininity, and thus these impersonators are able to offer new conceptions of femininity and the allure of artistic and sensual beauty derived from such new femininity. They present themselves as "strangers" who explore new perspectives on construction and representation of femininity in non-mainstream popular theatre today. In non-mainstream female impersonation discussed so far, Yanagita's concept of *imo no chikara* that purports to form the underlying layer of the traditional Japanese mentality helps illumine the spiritual and sacred aspect of femininity and plays an important role in demonstrating the strength and fascination of this impersonation.

5. The stranger that resides within the performer, but at the same time remains interconnected with the reality beyond them

How do these strangers express themselves and where are they situated? It is true that the privileged position of today's itinerant theatre's wandering strangers, as argued above, plays a vital role in their popular acclaim among enthusiasts. However, this privilege does not necessarily guarantee the individual performer's artistic maturity and success. In order to achieve this, each performer must try to perceive the stranger lurking within. Yet, whereas these performers are perceived as strangers by their audience, they tend to be unwilling to accept this position themselves because it conflicts with their general self-image

as human beings. In daily life, their self-image as that of a stranger is extremely hard to accept.

But for the past few decades, the postmodernist discourses on the other, otherness, and alterity that are closely linked with the issue of the stranger have gained visibility. Consequently, an extensive critique of the self-other dichotomy has permeated postmodern scholarship in such fields as postcolonial studies and feminist studies. Yet, recently some critics have begun to problematize the ideology of modernism. They argue that by eulogizing the status of an "other," this ideology disdainfully dismisses the notion of unity and self-identity (i.e. sameness as opposed to otherness) as being illusory. It is ironic that this critical reconsideration of the self-other dichotomy leads to a slighting of self-sameness or self-identity and to an extreme foregrounding of otherness. Kearney has recognized this plight, arguing that "[t]he threat to a genuine relation to others comes in fetishizing the Other as much as it does in glorifying the Ego".[17] In this vein, he argues, "The challenge now is to acknowledge a difference between self and other without separating them so schismatically that *no* relation at all is possible."[18] He emphasizes the importance of the attempt "to discover the other in our self and our self in the other–without abjuring either".[19] Put differently, "strangers are *within* us and *beyond* us,"[20] in which case the self and the other intermingle rather than exclude each other.

In a manner related to Kearney's concept of the interconnectedness between self and other, a few acclaimed itinerant performers rise above their peers and transcend the so called self-other dichotomy. Without denigrating, or *othering*, them*selves*, they transform into "strangers" that are foreign to both the audience and themselves. It should be noted that their artistic perfection lies beyond the confines of ordinary reality. In other words, while on stage, the performer metaphorically undergoes metamorphosis and becomes a sort of divine being, albeit only temporarily. This metamorphosis can be developed through, in Kearney's words, "dialogical interbeing between self and other." According to Kearney, the word "interbeing" refers to "the way between",[21] which he borrowed from the Vietnamese Zen Buddhist and thinker-activist Thich Nhat Hanh. Concerning the principle of "interbeing," Hanh himself states that "[t]here is no longer any discrimination between self and nonself".[22] The itinerant popular theatre today demonstrates this notion of interbeing in a way that depicts the vital poetry of life, which remains imperceptible and inaudible in daily reality. Thus, it continues to inherit the tradition of its ancestors by creatively revitalizing the audience's perceptions of humanity rather than merely duplicating it.

Conclusion

The state of "interbeing" conceptualized by Thich and Kearney represents where the stranger emerges as the female impersonator in non-mainstream popular theatre. By choosing this state while on the stage, female impersonators separate themselves from the confines of real world gender norms, and thus purely artistic freedom and self-expression are encouraged. On the other hand, this choice urges them to give up

the vital protection provided when adhering to commonsensical gender norms, but this risk is worth taking. It is undeniable that female impersonators and their peers of itinerant popular theatre today are still influenced by their cultural ancestors. In appearance, they blindly maintain the traditions of their cultural forebears' lifestyle, but those who are successful performers are aware that unless they observe the principle of "interbeing," they won't be able to develop greater skill in their stage performances. They need to abandon the daily self but at the same time, seek the intermingling of self and the other at a deeper, and perhaps truer, level. That is where the female impersonator as the stranger should seek to explore.

Endnotes

[1] Shinobu Orikuchi,. *Orikuchi Shinobu Zenshû* [*The Complete Works of Shinobu Orikuchi*], vol. 1 (Tokyo: Chûôkôron Shinsha, 1975) 58 (translation mine).

[2] Carmen Blacker, 'The Folklore of the Stranger: A Consideration of a Disguised Wandering Saint'. *Folklore* vol.101-2, 1990: 162.

[3] Blacker 162.

[4] Marilyn Ivy, *Discourses of the Vanishing: Modernity*, *Phantasm, Japan*, (Chicago: U of Chicago Pr, 1995) 203.

[5] Ivy 203.

[6] The Japanese historian Katsurô Hara (1871-1924), while specializing in European and U.S, history, devotedly sought to reexamine the traditional understanding of Japanese history. In so doing, he, for the first time in Japanese scholarship, employed the western term "medieval" in *Nihon chûseishi* [*The History of Medieval Japan*] (1906). This book was republished in 1969.

[7] The anthropologist Yuki Ôtô notes this popular saying in *Koyarai* [*Sending One's Child into the World*](1944; Tokyo: Iwasaki Bijutsu shuppansha, 1968) 249.

[8] Kuroda 228. This diagram's English translation was made by William LaFleur in *Liquid Life: Abortion and Buddhism in Japan* (Princeton: Princeton UP, 1994) 35.

[9] *Tradition and Tradition Theories: An International Discussion*, eds. Thorsten Larbig and Siegfried Wiedenhofer (Münster: LIT Verlag) 58.

[10] *Kyôkai no chûsei, shôchô no chûsei* [*The Symbolic Conceptions of the Demarcation of Boundary between Center and Margin*] (Tokyo: Tokyo Daigaku Shuppankai, 1986) 228 (translation mine).

[11] *Kodaishisô* in *Nihon shisôtaikei*, vol 8. (Tokyo: Iwanami Shoten, 1979) 158-159 in its modernized transcription and 308 in its original form.

[12] *Teihon Yanagita Kunio shu* [*The Standard Collection of the Works of Yanagita Kunio*], vol. 9 (Tokyo: Chikuma Shobô, 1962) 13. Its English translation was made by Noriko Kawahashi (*A Companion to*

the Anthropology of Japan, ed. Jennifer Robertson [Hoboken, NJ: Wiley -Blackwell, 2005] 459-460).

[13] Yanagita Kunio 14.

[14] In “Imo no chikara” and “Fujo-kô [A treatise on female shamans]”, Yanagita intensively examined women’s dual identity as both shamans and prostitutes. These writings are included in *Teihon Yanagita Kunio shû*, vol. 9: 3-219 and 221-304.

[15] See Amino, *Chûsei no hinin to yûjo* [*Outcastes and prostitutes in the Medieval times*’], 1994 (Tokyo” Kôdansha, 2005).

[16] Haruko Wakita, “Chûsei ni okeru seibetu-yakuwari-bunntann to joseikan [The Divison of Labor by Gender Role and Social Construction in the Medieval Period”, *Nihon-josei -shi*[*The History of Japanese Women*], vol. 2 *Chûsei* [*The Medieval Period*], ed. Josei –shi sôgô kenkyûkai [Comprehensive research organization on women’s history] (Tokyo: Tôdaishuppankai, 1982) 101. *Nihon-chûsei-josei-shi* (Tokyo: Tôdaishuppankai, 1992: 127. She created the term “kegai no tami [a kind of outcast or those excluded from the Imperial State]”, *Josei Geinô no Genryû* [*The Origins of Entertainment/ Performing Arts by Women*] (Tokyo: Kadokawa Shoten, 2001) 87.

[17] Rihard Kearney, *Strangers, Gods and Monsters: Interpreting Otherness* (London and New York: Routledge, 2002) 229.

[18] Kearney 9.

[19] Kearney 10.

[20] Kearney 229.

[21] Kearney 46.

[22] Hanh, Thich Nhat and Rachel Neumann, *Understanding Our Mind*. Parallax, Berkeley, 2001, p. 182.

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Doctor-Patient Conversations: Dealing with Difficult Patients

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Abstract

This paper provides some important insights into the dynamics of how doctors deal with difficult patients and how they can improve their relationship with such patients to achieve better health outcomes.

Keywords

Doctor, difficult patients, consultations, patient management

Introduction

Doctor spends their whole working lives dealing with people; sick people, their families, other doctors, nurses, medical staff, and many others. However, the dynamics of their human interactions with patients and their families is anything but normal; people seek out a doctor's care usually when they feel abnormal or when they are hurt and vulnerable. Add to this emotional stress, time pressures, lack of information, lack of options, financial concerns, and family pressures, to name a few, and the interactions become quite complex. It therefore stands to reason that doctors should be both good communicators and good at human relationships in order to have a successful career. Nevertheless, not every doctor-patient interaction goes smoothly for reasons, on both sides, that are only now being investigated. The focus of this paper is on the difficulties doctors have in dealing with patients who they classify as "difficult to deal with", describe a variety of types of difficult patients, and outline approaches they can use to more effectively handle such patients. The author has engaged in this research in order to be able to include these issues in the communicative studies of his medical students in the hope that it will better prepare these future doctors for the challenges that lie ahead of them in their medical careers.

The "difficult" patient

The doctor-patient relationship ideally has a common goal, to get the patient better as soon as possible. Nevertheless, it is a common reality for doctors to have to deal with difficult patients on an almost daily basis throughout their working lives. So what is it that makes someone who is unwell and seeking a doctor's attention a "difficult" patient? Recognizing what makes some patients "difficult" and responding therapeutically are key elements in dealing with such challenging patients.

Difficult patients definitely stand out. They can be aggressive, angry, demanding, manipulative, noncompliant, rude, self-destructive, and even threatening. What such patients have in common is their demand for excessive amounts of the doctor's time and attention. Doctors frequently find themselves frustrated and exhausted after interactions with such patients and may sense that the patients themselves may harbour similar bad or hurt feelings. The following comments, taken from a Reader's Digest (March 2009) survey of doctor's opinions as well as from my own research data collection taken from Australia, exemplify the various frustrations felt by doctors after their encounters with difficult patients:

> "*I get irritated when a patient doubts my evaluation and relates the opinion of a less qualified doctor…(the patient) should just ask me to explain why there is a difference in opinion instead of doubting me*."
> *"If patients won't listen to my advice, preferring to go their own way, why did they come to me in the first place?"*
> "*I'm not a mind reader. Playing stump the doctor is a waste of everyone's time. Try to sort out the chronology of an illness before you come in. When do you think it started? Is it getting better or worse? What makes it better? What makes it worse? Where is the pain?*"
> *"Some patients believe that there is a pill for every ill, and that medicine has no adverse effects."*
> "*We explain most things to our patient's family members but some seem to have selective hearing….they invariably say the doctor never explained anything and they still don't know the diagnosis. They should just ask if they're unclear about anything*."
> "*What bothers me most is when patients don't have the motivation to participate in their own health care. They leave all the work to their doctors as if they only need medication to control their chronic diseases. In reality, they have a big role to play like watching their diet, quitting smoking, and engaging in physical activity*."
> *"Sometimes it is easier for a doctor to write a prescription for a medicine than to explain why the patient doesn't need it.*"

In all these comments, the clear message that comes through is that, in the opinion of the doctor, it is the patient who is at fault; it is a very one-sided interpretation of the difficulty experienced. It probably did

not occur to the doctors that there was actually a lot they could have done to help their patients be better behaved. Indeed, without some positive changes in the doctors' approaches to consultations with difficult patients, these doctors will experience more frequent compassion fatigue and unwittingly be a step closer to burnout.

Thus, dealing with difficult patients can become a significant burden on doctors, especially as compassion fatigue sets in during long days with seemingly endless lines of patients. The solution to this situation is more likely to be found if the friction between the doctor and patient is viewed with shared responsibility, rather than attributing particular problems encountered by the doctor to the shortcomings of the patient alone.

Experience is not necessarily the best teacher

How do doctors learn to deal with difficult patients? Doctors have told me that their training at their medical university did not prepare them for encounters with difficult patients; rather, it was something they had to "pick up" during their working hours. As noted in his anecdotes (1988, 2000), Dr Edward E. Rosenbaum tells medical students that young doctors are often frustrated at their inability to get patients to "cooperate" with them. As it is impossible to "put an old head on young shoulders", that is, to quickly endow young doctors with the collective wisdom of their seniors, it has been unavoidable for them to take the long, hard road in learning how to cope with difficult patients. This is why doctors like Dr Rosenbaum, such as Patch Adams (1992), Bernard Lown (1996), and Barbara Korsch (1997), have committed to print vital lessons accumulated over a lifetime of experience to give young doctors a short cut to better medical practice and relationship building with their patients.

I.C.E. and the patient iceberg

When the doctor sees a patient, they can observe only what they see in front of them. Like an iceberg, only about 10 percent is visible above the waterline while the majority 90 percent is hidden from view beneath the water. Patients are very similar; doctors can observe the visible 10% for signs and symptoms but cannot see the many other factors also in play. Indeed, as Dr. Bernard Lown, professor emeritus at Harvard School of Public Health and author of *The Lost Art of Healing* (1996) cautions doctors, patients desire to be recognized and treated as a human being (90%) and not merely for the outer wrappings for the disease that is troubling them (10%).

In order for the doctor to be able to make a diagnosis, the doctor must first elicit a lot of critical information from the patient about the nature of their complaint, which forms part of the larger body of important information about the patient, called the case history. In the past, doctors concerned themselves with only the signs and symptoms exhibited by the patient at the time of the consultation. However,

doctors now recognize the need during a consultation to give patients the opportunity to express their own ideas (I) and concerns (C) about their specific health problem as well as any expectations (E) they may harbor.

The current textbook used by the medical students at Hamamatsu University School of Medicine in their English Conversation program, *Professional English in Use: Medicine*, includes the I.C.E. concept and lists some typical questions doctors could ask patients (p.106) to uncover what they cannot see:

Ideas

1. *What do you know about this problem/condition/illness?*
2. *Do you have any ideas about this?*
3. *How do you think you got this problem?*
4. *What do you mean by.....?*

Concerns

1. *What are your worries about this?*
2. *Do you have any concerns?*
3. *How might this affect the rest of your family?*

Expectations

1. *What do you think will happen?*
2. *What do you expect from me?*
3. *What were you hoping we could do for you?*

However, it is necessary to think more broadly about the ideas, concerns and expectations held by patients. Second year medical students taking my English class brainstormed the following considerations from the patients' point of view:

Ideas

1. My health problem cannot be so serious.
2. Doctors should be up-to-date on treatment methods.
3. My health problem is not related to my lifestyle (i.e. diet, lack of exercise, alcohol, smoking, sexual habits, substance abuse, etc.)
4. I shouldn't have to change my lifestyle.
5. Pills will fix my ills.
6. Doctors should look professional but not be arrogant.
7. Doctors will find the health problem quickly and easily.

Concerns

1. Will the treatment hurt?
2. Financial concerns regarding the cost of treatment or hospitalization.

3. Time concerns regarding the duration of treatment (e.g. for chronic diseases, cancer, etc).
4. They can't take time off from work that would jeopardize their employment.
5. How will my current lifestyle be affected?
6. Young doctors may lack experience and knowledge.
7. Older doctors may be old-fashioned in their approaches and treatments.
8. That the health problem may be more serious or ultimately fatal.

Expectations

1. To be able to return home quickly after treatment.
2. To get the best care for the lowest cost.
3. To have no interruptions to their lifestyle.
4. Medicine will work quickly and without side effects.
5. To get the best treatment options.
6. To be treated kindly and humanely by all medical staff.
7. Their life expectancy will not be reduced.

If doctors could include some discussion of the patient's ideas, concerns and expectations during the consultation, it would go along way to defusing potential problems with their patients.

Why do patients sometimes behave badly? A likely factor is because they do not understand that modern medicine cannot always fulfill their high expectations. And they seem unaware that their poor reaction to this inability to fulfill their expectations has adverse affects on the performance of the medical services provided to them. Doctors need to realize that it is part of their job to educate patients about what modern medicine can and cannot do for them and help them make their expectations more realistic without removing all hope.

Types of difficult patients

Difficult patients present to doctors with a wide range of persona. Some of the most common types of difficult patient can be categorized as the following.

The **Angry** patient has a short fuse and is ready to lash out at anyone who doesn't tell them what they want to hear.

The **Anxious** patient lets their worries get the better of them and they are often not attentive to what the doctor is trying to tell them.

The **Denial** patient doesn't want to hear bad news or change their ways.

The **Dependent and Demanding** patient expects the doctor to care for them by bending to their demands.

The **Depressed** or **Sad** patient presents with symptoms clearly linked to depression but without realizing it.

The **Dramatic or Manipulative** patient seeks attention and their own way rather than listening to what the doctor has to say.

The **Drug-seeking** patient. The most repeated reason doctors will turn a patient away has to do with drug-seeking patients. Even the best doctors with the highest integrity can be fooled by drug-seekers who are really only searching for drugs to feed their habit and give them their next high.

The **Guarded Paranoid** patient doesn't believe that the doctor is working for their best interests and instead challenges each finding or symptom.

The **Hypochondriac** patient seeks constant attention and medicines for imaginary illnesses.

The **Long Suffering, Masochistic** patient looks to gain sympathy or pity for their self-inflicted plight.

The **Manic, Restless** patient is overactive and can be difficult to conduct a conversation with.

The **Orderly and Controlled** patient presents a cool front and demands strict adherence to procedures that may not be necessary.

The **Pain-fearing and Overly-sensitive** patient is extremely squeamish about any invasive procedures and reacts strongly to the slightest discomfort.

The **Rambling** or **Talkative** patient will dominate the consultation with long stories and pointless details. It can be difficult to ask the necessary questions as this patient steam rolls the consultation with voluminous detail while ignoring the doctor's attempts to elicit information that may refine the diagnosis of the condition.

The **Silent** or **Reticent** patient is often unresponsive to the doctor's questioning and may well be purposefully holding back important information out of fear or being thought foolish.

The **Superior** patient believes they know better than the doctor and may insult and try to belittle younger doctors.

The **Vague** patient does not provide accurate information the doctor needs for the diagnosis.

Some factors that may contribute to these persona types include the age of the patient, level of education, their social status, past experience (usually bad) with medical attention, and pre-existing medical conditions (such as Alzheimer's Disease, Bipolar state, dementia, depression, etc.).

It is not always the patient's fault

The doctor's first duty in the care of a difficult patient is to consider that it is possible that the aspects of the patient's presentation that make them "difficult" are actually clinical signs; that is, an observable manifestation of the patient's underlying health problem. In other words, there could be a differential diagnosis stemming from the patient's difficult behavior. For example, a patient who exhibits aggressive

or threatening behavior toward medical staff may in fact be simply intoxicated, overmedicated or delirious; alternately, the patient could be experiencing the symptoms of irritability or fear rooted in some undiagnosed neurosis. Some “noncompliant” patient do so because they have different religious beliefs about acceptable treatments (e.g. blood transfusions or transplants), or may have previously experienced unpleasant side effects of prescribed medicines; this was the case with my own mother who resisted her doctor’s advice because the medicines he prescribed her adversely affected her routine life. Other patients may not have the necessary information about their need for more intensive treatment, or, as with many young people and pensioners, may simply not have the financial resources to purchase expensive drugs. And some difficult patients are that way because they are traumatized individuals (e.g. abused children) whose past experiences resurface in the context of their current lives. Through their difficult behaviors, patients often give substance to their core psychological issues right in front of the doctor whose duty is to recognize and understand such clinical phenomena. Such difficult behaviors should be examined in a dispassionate, nonjudgmental manner, as they are indeed observable clinical signs that should not simply be ignored. Nevertheless, as Rotter (1993) pointed out, doctors are only human too, and can be profoundly influenced by the demeanor, remarks, and attitudes of patients; indeed, Rotter found that difficult patients who are consistently rude and irritable almost certainly do not receive the same level of medical care and attention as patients who showed more positive attitudes.

How to deal with difficult patients

Doctors should first remember the position the patient is in; they are sick, often in pain, feel frustrated, and many are worried or scared. And when they finally get to see the doctor, they may feel that they are not getting the attention they deserve from the doctor or that the doctor isn’t listening to their concerns. The following is a patient anecdote related by the family member of a Japanese patient:

> *“We (my parents and I) had been waiting for over two hours before we were finally called for my father’s consultation. Obviously, the doctor was rushed for time when he started the consultation but my parents felt it was their time to talk and so they didn’t try to hurry up. My parents were not answering the doctor’s questions directly, but I didn’t want to interrupt the doctor’s questioning. The doctor didn’t seem to mind my parents were not answering his questions. Did he really understand their situation or was he just trying to finish quickly so he could call the next patient in?”*

In this case, the doctor is obviously not fulfilling his duty of care to the patient, regardless of whatever excuse the doctor may offer in his own defense.

It’s not by choice that people become patients, but it is the doctor’s job to attend to them and their medical

needs. To be as effective as possible, doctors, after graduating from medical school, need to continually improve not only their medical knowledge but also their people skills (e.g. empathy) and their communication skills, both in questioning patients and listening to them. They need to read books written by other doctors, such as Dr Rosenbaum (1988, 2000) and even Patch Adams (1992), as well as by patient advocates such as Debra Rotter and Judith Hall (1993) to gain insights and new perspectives on dealing with all types of patients. The lessons they could learn could be as simple as initially showing some empathy to the patient to establish some common ground and lower the patient's barriers to be more receptive to the doctor's questions and advice.

Doctors should not react angrily if provoked, and should not treat patients like children. If they do, matters could become much worse. Doctors should treat all patients with respect and as responsible adults, and gradually difficult patients will become more reasonable. In a typical battle of wits, each side usually tries to prove themselves right and the other person wrong. Of course, the usual end result is that each side ends up more entrenched in their views, regardless of the evidence offered, and the relationship could be damaged seriously. An argument with a difficult patient cannot be won with resistance and counter attack as this will only strengthen the patient's resolve to remain unmoved. The way to "win" them over is to aim for a goal other than the victory of being right. I suggest the doctor set the goal of attempting to raise the patient's awareness of their issues while maintaining their elevated authority as a doctor. By this I mean focusing on helping the patient become aware of the full extent of their behavior and how it affects the doctor and others as they try to restore the patient to better health. The doctor should stay focused on the patient and their feelings and not on their own wounded pride. It does take practice and patience to master this type of approach, and it hinges upon the doctor's ability to keep themselves in a high state of awareness, focusing on compassion for the patient who needs their help to overcome their affliction.

It is also very important for the doctor to listen more to their patients. And not just hearing what the patient says to questions, but to really listen with concentration and interest. Let the patient know that you are really listening by maintaining eye contact as they talk. If the patient indicates they are upset, give them a little time to talk and express their concerns; by listening, the doctor may find out what is making the situation more difficult for the patient.

It's been said that approximately 80% of our communication is nonverbal, that is, through our body language. Doctors should therefore be more mindful of their body language as well as the expressions they use to patients, as patients are often quick to pick up on such cues. Dr Rosenbaum gives several good

examples of such occurrences. And doctors should also watch for the patient's nonverbal cues for more insights into how the patient is reacting to the discourse. I tell my medical students that when they become doctors, they should use all of the senses at their disposal to get information from the patient, starting with sight, hearing, touch, smell and even taste (although much less used by doctors these days) as well as the doctor's sixth sense derived from the combination of knowledge plus experience plus humanity. For it is with these tools that the doctor shall fight illness and disease and bring comfort to their patients.

Finally, doctors should be courteous and caring. Common courtesy goes a long way and shows the patient that the doctor respects them in turn. Treat patients with warmth, understanding and consideration. Make them feel that you are genuinely interested in helping them get better. Doctors should also not forget their role is not merely to provide a safe cure, but also to provide information, support, and reassurance to the patients. Doctors have made a commitment to do these things when they first chose to become a doctor Taking these small steps will help to establish a level of trust and enhance the effectiveness of doctor/patient communication.

Preparing medical students

As an educator of medical students in communication studies, it is my responsibility to help prepare them for the challenges that await them in their future medical careers, such as dealing with difficult patients. This means going beyond what is in the standard medical communication textbooks by including the findings of my developing research into doctor-patient conversations (O'Dowd, 2004). Indeed, by introducing elements of real-life into the classroom context, the students find the materials both more interesting and motivating. For example, after giving students a dialogue template that covers all the elements of a typical doctor-patient conversation, from initial greeting to the prognosis, we examine sample dialogues and critique where the doctor has lapsed and missed important patient cues. Later, the students are asked to make their own doctor-patient dialogues and ensure their not only cover all the elements in the template but expand the discourse so they get a better "feel" of the patients condition by including the elements of ideas, concerns and expectations mentioned earlier in this paper. This allows students to both explore the dimensions of the template framework and at the same time discover that such discourse is multifaceted. The outcome should be medical students who are keen to talk with patients and deal with them as human beings and not merely as a disease or burden.

Conclusion

Getting along with people generally calls for flexibility, humility, patience, self-control, understanding,

and unselfishness, all qualities a good physician should possess. Indeed, doctors should engage these attributes particularly when dealing with difficult patients and treat them professionally and politely to minimize difficulties as much as possible. Even so, some difficult patients may not respond as is hoped. Although it may sound harsh, doctors do not always have to like all the patients they have to provide care for; however, doctors still have a responsibility to provide the best possible patient care while maintaining an appropriate level of compassion and professionalism. To this end, doctor should strive to improve their communication skills and understanding of patient ideas, concerns and expectations as a means to fulfilling their life calling of helping the sick and curing what ails them. It is my hope that by increasing my medical students' awareness of these issues that they will develop a greater sensitivity towards patients and become the doctors they have always dreamed of being in their future medical careers.

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浜松医科大学紀要一般教育の編集，刊行に関する申し合わせ

（平成15年3月3日改訂）

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Ⅰ．紀要の発行

1．名称は「浜松医科大学紀要一般教育」とする。英語の名称は Bulletin of Liberal Arts Hamamatsu University School of Medicine とする。

2．発行者は浜松医科大学とする。

3．編集は情報・広報企画室が行う。

4．投稿資格者は，本学の教員，非常勤講師（他に本務を有さない者に限る。）並びに共同研究者又は研究協力者とし，投稿論文は未公刊のものに限る。

5．収録範囲は一般教育科目等及び関連諸学科領域とする。但し，非実験系科目を優先的に収録するものとする。

6．発行回数は原則として年 1 回とする。

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1．誌面の大きさはA4とし，組版は横1段とする。

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5）共著のときは和文ならばナカグロ「・」で連ね，欧文ならばandで連ねる。3名以上の場合はコンマ「，」とandで連ねる。

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共著で各著者の所属が異なる場合は，それぞれの著者名の右肩に［＊］，［＊＊］を付し，所属名の左肩に同じ印を入れ，間を和文ならばナカグロ［・］，欧文ならばセミコロン［；］で切る。

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① 引用文献を指示する場合は，原則として本文該当筒所の右肩に）を付し，その左に通し番号をアラビア数字で記す。

② 文献は一括して末尾の文献欄に列記する。

③ 記載の形式は，次のとおりとする。

A．雑誌論文の場合

著者名：論文題名，雑誌名　巻(号)：最初のページ－最後のページ，発行年.

（和文例）半田　肇，長沢史朗：脳死の診断とその問題点：脳神経外科医の立場から，臨床

成人病**14**(4)：30－31，2002.

（欧文例）Cranford RE, Jackson DL: Neurolongists and the hospital ethics committee. *Semin Neuro* **4** (1) :15–22, 2002.

注　1. 著者多数の場合は，鈴木二郎(他)，Youngner SJ, et al 等としてもよい。

注　2. 雑誌名の略記は慣行に従う。なお，欧文雑誌名はイタリックとする。

注　3. ページ数は通巻ページを記す。各号ページの場合は**14**(4)：30－31のように巻数の後に号数を(　)に入れて表示する。なお，巻数はゴシックとする。

B．図書の場合

a．図書全体を引用する場合

著(編)者名：書名．[出版地：]出版者，出版年．

（和文例）河野友信，河野博臣(編)：生と死の医療，朝倉書店，2002.

（欧文例）Bondeson WB, et al, eds: *New Knowledge in the Biomedical Science*. Boston: D.Reidel, 2002.

注　1. 編者名には(編)，ed[s]を付記する。

注　2. 洋書の場合は書名をイタリックとし，出版地と出版者名をBoston: D.Reidelのように記す。

b．図書の一部分を引用する場合

分担著者名：論文題名．[In]編者名：書名．[出版地：]出版者，出版年，引用ページ

（和文例）浜松太郎：現代医学と倫理．日本倫理学会(編)：技術と倫理．以文社，2002，P173－193.

（欧文例）Cassell EJ: Heart disease; the ethical quandaries of treated the aged. In Reiser SJ, Anbar M, eds: The Machine at the Bedside. New York: Cambridge University Press, 2002, P327–331.

3）表，図，写真

可能な限り本文中に取込むものとする。これによりがたい場合は，下記のとおりとする。

①　別紙とする場合は，A4の用紙にそれぞれ作成又は貼るものとし，
表Ⅰ(TableⅠ)，表Ⅱ(TableⅡ)又は図Ⅰ(FigⅠ)，図Ⅱ(FigⅡ)と表記する。

②　1枚ごとに著者名を表記する。

③　本文中のおおよその該当箇所を枠取りし，表Ⅰ，図Ⅰと表記する。

7．原稿の提出，受理

1）原稿は電子情報とプリントアウトしたもの(2部)を提出するものとし，次の順序に並べて通し番号を付す。

表題，要約，本文，注，文献，表，図，写真

2）原稿の枚数は，表題から写真まで全てを含みA4版40枚以内とする。なお，出来上がり1ページの体裁は，

和文　　42字×34行＝1,428字

欧文　　84字×34行＝2,856字

3）原稿がページ制限を越える場合，あるいは特別の印刷（多色刷，別添図等）を要する場合等，差額を著者負担とすることがある。

4）提出された原稿は査読者に提出し，掲載の是非，修正の必要性及びその箇所を指摘した査読意見書の提出を求める。査読者は情報・広報企画室長が定める。査読意見書の書式は別に定める。

5）受理年月日は，完成原稿を情報・広報企画室に提出した日をReceived，査読者の同意を得て情報・広報企画室長が掲載を決定した日をAcceptedとし，原稿の末尾に記す。

6）印刷の形式等で特例を必要とする場合は，原稿提出時に情報・広報企画室にその旨連絡するものとする。

8. 校　正

1）論文の著者校正は初校のみとする。

2）別刷を実費著者負担において要求する場合は，第1校返却時に情報・広報企画室にその旨連絡するものとする。

9. 論文の公開

1）掲載された論文は，浜松医科大学ホームページ，浜松医科大学学術機関リポジトリ及び国立情報学研究所が実施している論文情報ナビゲータ（CiNii）により公開するものとする。

2）著者は，このことを了解したうえで原稿を提出するものとする。

Contents

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