

2024(令和6)年度

【注意事項】

1. この問題冊子は「英語」である。
2. 試験時間は 60 分である。
3. 試験開始の合図まで、この問題冊子を開いてはいけない。ただし、表紙はあらかじめよく読んでおくこと。
4. 試験開始後すぐに、以下の 5 および 6 に記載されていることを確認すること。
5. この問題冊子の印刷は 1 ページから 6 ページまでである。
6. 解答用紙は問題冊子中央に 2 枚はさみこんである。
7. 問題冊子に落丁、乱丁、印刷不鮮明な箇所等があった場合および解答用紙が不足している場合は、手をあげて監督者に申し出ること。
8. 試験開始後、2 枚ある解答用紙の所定の欄に、受験番号と氏名を記入すること（1 枚につき受験番号は 2 箇所、氏名は 1 箇所）。
9. 解答は必ず解答用紙の指定された箇所に記入すること。解答用紙の裏面に記入してはいけない。
10. 問題番号に対応した解答用紙に解答していない場合は、採点されない場合もあるので注意すること。
11. 問題冊子の中の白紙部分は下書き等に使用してよい。
12. 解答用紙を切り離したり、持ち帰ってはいけない。
13. 試験終了時刻まで退室を認めない。試験中の気分不快やトイレ等、やむを得ない場合には、手をあげて監督者を呼び、指示に従うこと。
14. 試験終了後は問題冊子を持ち帰ること。



〔 I 〕 次の文章を読み、設問に答えなさい。

*が付いている語句には本文の後ろに注があります。

As much as I'm passionate about the ideas in this book, I didn't set out to study psychological safety on purpose. As a first-year *doctoral student in the process of clarifying my research interests for my eventual *dissertation, I had been fortunate to join a large team studying medical error in several hospitals. This was a great way to gain research experience and to sharpen my general interest in how organizations can learn and succeed in an increasingly challenging, fast-paced world. I had long been interested in the idea of learning from mistakes for achieving excellence.

My role in the research team was to examine the effects of teamwork^(A) on medical error rates. The team had numerous experts, including physicians who could judge whether human error had occurred and trained nurse investigators who would review *medical charts and interview frontline caregivers in patient care units in two hospitals to obtain error rates for each of these teams. These experts were, in effect, getting the data for what would be the *dependent variable in my study—the team-level error rates.

Going into the study, I *hypothesized, not surprisingly, that the most effective teams would make the fewest errors. Of course, I had to wait six months for the data on the dependent variable (the error rates) to be fully collected. And here is where the story took an unexpected turn.

First, the good news (from a research perspective anyway). There was *variance! Error rates across teams were strikingly different; indeed, there was a *10-fold difference in the number of human errors per thousand patient days (a standard measure) from the best to the worst unit on what I sincerely believed was an important performance measure. A wrong medicine *dosage, for example, might be reported every three weeks on one ward but every other day on another. Likewise, the team survey data also showed significant variance. Some teams were much stronger—their members reported more mutual respect, more *collaboration, more confidence in their ability to deliver great results, more satisfaction, and so on—than others.

When all of the error and survey data were *compiled, I was at first thrilled. Running the statistical analysis, I immediately saw that there was a significant *correlation between the independently collected error rates and the measures of team effectiveness from my survey. But then I looked closely and noticed something wrong. The direction of the correlation was exactly the opposite of what I had predicted.^(B) Better teams were apparently making *more*—not fewer—mistakes than less strong teams.

Did better teams *really* make more mistakes? I thought about the need for communication between doctors and nurses to produce safe, error-free care. The need to ask for help, to double-check each other's work to make sure, in this complex and customized work environment, that patients received the best care. I knew that great care meant that *clinicians had to team up effectively. It just didn't make sense that good teamwork would lead to more errors. I wondered for a moment whether better teams got overconfident over time and then became *sloppy. That might explain my *perplexing result. But why *else* might better teams have higher error rates? ^(C)

And then came the *eureka moment. What if the better teams had a climate of openness that made it easier to report and discuss error? The good teams, I suddenly thought, don't *make* more mistakes; they *report* more. But having this insight was a far cry from proving it.

I decided to hire a research assistant to go out and study these patient care teams carefully, with no *preconceptions. He didn't know which units had made more mistakes, or which ones scored better on the team survey. He didn't even know my new hypothesis. ^(D) In research terms, he was "blind" to both the hypothesis and the previously collected data.

Here is what he found. Through quiet observation and open-ended interviews about all aspects of the work environment, he discovered that the teams varied wildly in whether people felt able to talk about mistakes. And these differences were almost perfectly correlated with the detected error rates. In short, people in the better teams talked openly about the risks of errors, often trying to find new ways to catch and prevent them. It would take another couple of years ^(E) before I labeled this climate difference psychological safety. But the accidental finding set me off on a new and fruitful research direction: to find out how *interpersonal climate might vary across groups in other workplaces, and whether it might matter for learning and speaking up in other industries—not just in healthcare.

(出典 Amy C. Edmondson The Fearless Organization : Creating Psychological Safety in the Workplace for Learning, Innovation, and Growth, Wiley, 2018 一部改変)

注

doctoral: 博士課程の.

dissertation: 学位論文.

medical charts: 医療記録, カルテ.

dependent variable: 従属変数(ある要因によって影響された結果として表れる変数).

hypothesize: 仮説を立てる.

variance: 相違, 不一致, 《数学》分散.

-fold: -倍.

dosage: 投薬量.
collaboration: 協力.
compile: 集める.
correlation: 相関関係.
clinician: 臨床医.
sloppy: だらしのない, いい加減な.
perplexing: 困惑させる, ややこしい.
eureka: わかった.
preconception: 先入観.
interpersonal: 対人関係の.

- (1) 下線部 (A) について, 筆者が計測した teamwork にはどのようなばらつきがあったか日本語で説明しなさい。
- (2) 下線部 (B) の内容について, 具体的に日本語で述べなさい。
- (3) 下線部 (C) を日本語に訳しなさい。
- (4) 下線部 (D) について, 筆者がたてた仮説の内容を日本語で説明しなさい。
- (5) 下線部 (E) の psychological safety とは何か, 筆者が行なった調査の結果に触れながら日本語で説明しなさい。



〔Ⅱ〕 次の文章を読み、設問に答えなさい。

*が付いている語句には本文の後ろに注があります。

The other day I found myself, as I often do, at a conference discussing *lagging wages and soaring inequality. There was a lot of interesting discussion. But one thing that struck me was how many of the participants just assumed that robots are a big part of the problem—that machines are taking away the good jobs, or even jobs in general. For the most part this wasn't even presented as a hypothesis, just as part of what everyone knows.

And this assumption has real implications for policy discussion. For example, a lot of the *agitation for a universal basic income comes from the belief that jobs will become ever scarcer as the robot *apocalypse overtakes the economy.

So it seems like a good idea to point out that in this case what everyone knows isn't true. Predictions are hard, especially about the future, and maybe the robots really will come for all our jobs one of these days. But automation just isn't a big part of the story of what happened to American workers over the past forty years.

We do have a big problem—but it has very little to do with technology, and a lot to do with politics and power.

Let's back up for a minute, and ask: What is a robot, anyway? Clearly, it doesn't have to be something that looks like *C-3PO, or rolls around saying "Exterminate! Exterminate!" From an economic point of view, a robot is anything that uses technology to do work formerly done by human beings.

And robots in that sense have been transforming our economy literally for centuries. David Ricardo, one of the founding fathers of economics, wrote about the *disruptive effects of machinery in 1821!

These days, when people talk about the robot apocalypse, they don't usually think of things like *strip mining and mountaintop removal. Yet these technologies utterly transformed coal mining: coal production almost doubled between 1950 and 2000 (it only began falling a few years ago), yet the number of coal miners fell from 470,000 to fewer than 80,000.

Or consider freight containerization. Longshoremen used to be a big part of the scene in major port cities. But while global trade has soared since the 1970s, the share of U.S. workers engaged in "marine cargo handling" has fallen by two-thirds.

Technological disruption, then, isn't a new phenomenon. Still, is it accelerating? Not according to the data. If robots really were replacing workers *en masse, we'd expect to see the amount of stuff produced by each remaining worker—labor productivity—soaring. In fact, productivity grew a lot faster from the mid-1990s to the mid-2000s than it has since.

So technological change is an old story. What's new is the failure of workers to share in the fruits of that technological change.

I'm not saying that coping with change was ever easy. The decline of coal employment had devastating effects on many families, and much of what used to be coal country has never ^(A) recovered. The loss of manual jobs in port cities surely contributed to the urban social crisis of the seventies and eighties.

But while there have always been some victims of technological progress, until the 1970s rising productivity translated into rising wages for a great majority of workers. Then the connection was broken. And it wasn't the robots that did it.

What did? There is a growing though incomplete consensus among economists that a key factor in wage *stagnation has been workers' declining bargaining power—a decline whose roots are ultimately political.

Most obviously, the federal minimum wage, adjusted for inflation, has fallen by a third over the past half century, even as worker productivity has risen 150 percent. That divergence was politics, pure and simple.

The decline of unions, which covered a quarter of private-sector workers in 1973 but only 6 percent now, may not be as obviously political. But other countries haven't seen the same kind of decline. Canada is as unionized now as the U.S. was in 1973; in the *Nordic nations unions cover two-thirds of the work force. What made America exceptional was a political environment deeply hostile to labor organizing and friendly toward *union-busting employers.

And the decline of unions has made a huge difference. Consider the case of trucking, which used to be a good job but now pays a third less than it did in the 1970s, with terrible working conditions. What made the difference? ^(B) De-unionization was a big part of the story.

And these easily *quantifiable factors are just indicators of a sustained, *across-the-board anti-worker bias in our politics.

Which brings me back to the question of why we're talking so much about robots. The answer, I'd argue, is that it's a diversionary tactic—a way to avoid facing up to the way our system is *rigged against workers, similar to the way talk of a "skills gap" was a way to divert attention from bad policies that kept unemployment high.

And progressives, above all, shouldn't fall for this *facile *fatalism. American workers can and should be getting a much better deal than they are. And to the extent that they aren't, the fault lies not in our robots, but in our political leaders. ^(C)

(出典 Paul Krugman: Don't Blame Robots for Low Wages (The New York Times , 14 March 2019)

注

lagging: 低迷.

agitation: 扇動.

apocalypse: 黙示録, 破壊的な状況.

C-3PO: 映画に登場したロボットの名前.

disruptive: 破壊的な.

strip mining: 露天採鉱.

en masse: 一斉に.

stagnation: 不振, 停滞.

Nordic: 北欧の.

union-busting: 組合潰し.

quantifiable: 定量化できる.

across-the-board: 全体的に.

rig: 仕掛ける.

facile: 安易な.

fatalism: 運命論.

(1) 下線部 (A) に最も近い意味の単語を, 次の(ア)~(エ)のうちから一つ選び, 記号で答えなさい。

- (ア) amazing
- (イ) decreasing
- (ウ) annoying
- (エ) damaging

(2) 下線部 (B) に対する筆者の答えを日本語でわかりやすく説明しなさい。

(3) 下線部 (C) を日本語に訳しなさい。

(4) 本文のタイトルとして最も適切なものを, 次の(ア)~(エ)のうちから一つ選び, 記号で答えなさい。

- (ア) 技術革新の遅れを組合のせいにするな
- (イ) 生産性の低下を組合のせいにするな
- (ウ) 賃金の低迷をロボットのせいにするな
- (エ) 格差の拡大をロボットのせいにするな