# 平成21年度入学試験問題

# 医　学　科　（前　期）

## 英　　語

（注　意）

1. 問題冊子及び解答用紙は試験開始の合図があるまで開かないでください。
2. 問題は全部で3問題あります。
3. 問題冊子は表紙を除いて11ページ，解答用紙は1枚です。
4. 監督者の指示に従い，解答用紙の所定欄に受験番号・氏名をはっきり記入してください。
5. 解答は，必ず解答用紙の指定されたところに横書きで記入してください。
6. 問題冊子は，持ち帰ってかまいません。
7. 下書きは，問題冊子の余白部分を使用してください。

I 次の文章を読み，下の設問に答えなさい。

Every time somebody asked me about my future ambitions when I was growing up in Pakistan, I always replied, "I want to become a doctor." The white coat and stethoscope attracted me so much — I would play with my toy doctor's kit for hours and hours.

My sister Maryam and I would often pretend that she was terminally ill and the only option left was an operation. The best part of it (1) was my declaration to our mother, in the most melodramatic tone I could muster, that Maryam had not survived. My mother always told me very gently that a doctor's first priority should be to save her patient's life, no matter what. "The rest lies in God's hands," she said.

When I was 18, my childhood dream took a step closer to reality when I was accepted into King Edward Medical University in Lahore. My mother's words about a doctor's duty rang in my ears on my first day at the college.

Clinical interaction with patients didn't begin until the third year, and when it was my batch's turn for the ward visit, I was almost hysterical with excitement. Beds were allotted to individual students. I walked over to my bed and encountered a very strange sight: a woman covered with a metal case on which a light cloth was placed. She was moaning with pain. I soon realized that she was a burns victim.

It was the first time I saw someone who was critically ill. I tried talking to her but she was barely conscious. Her mother, a gray-haired woman with a wrinkled face and a determined gaze, was standing by the bed. She told me a little about her daughter. Her name was Aisha. She was 22 years old. Her husband was a shopkeeper and she had two children — a two-year-old daughter and an infant son.

When I asked about the cause of the burns, the mother broke down. Covering her face with her hands to hide her tears, she told me that Aisha's husband had set her on fire (2). At that moment, Aisha, who was nearly comatose, raised her hand and grabbed her mother's shirt. "I told you, he put the fire out," she said weakly. "I was cooking — it was an accident."

"Why are you defending him?" the mother replied. "He is the one who did this to you. He should be punished for what he has done. You just tell me the truth!"

Her cries drew the attention of other patients in the ward. I tried to comfort her by telling her what was being done to save her daughter. It made no difference. Sobbing, she slowly moved towards the corner and collapsed on the floor.

I looked at Aisha's chart — it said she had suffered burns to 83 per cent of her body. Oh God! I thought. At 30 per cent, burns are regarded as life threatening. She was up against almost three times that! (3) Still, I tried to console Aisha's mother. "The senior doctors are

trying their level best to save your daughter's life. Please don't lose hope. If you cry, what will Aisha think? She needs you more than ever now."

With a heavy heart, I left the mother and daughter and returned to my classes. That night, I couldn't sleep. How will I face the mother if Aisha dies? I kept thinking. I considered Aisha to be my responsibility even though I was just a third-year student. I should have told the mother the truth, I thought. I shouldn't have given her false hope.(4)

The next day, Aisha's bed was empty. I asked the senior doctor what had happened. "She died last night," he replied. "Couldn't do much for her."

His easy tone shocked me. "How did you tell her relatives?" I hesitantly asked.

He eyed me with curiosity. "I just told them she was dead. What do you think I could have said?"

I was taken aback by his "professional" attitude,(5) which lacked the slightest touch of humanity. A mother who had lost her daughter to a violent and painful death had learned about it in such a cold-blooded manner. I left early that day and cried my heart out. When I was a child, telling my mother about the make-believe death of my sister was easy. Now I shuddered at the thought of what I would have done if I had been the one to tell Aisha's mother.

A few days later, I ran into Aisha's mother, who had come to the hospital to pick up some paperwork. She looked at me and smiled gently. Then, placing her hand on my head, she kissed my forehead and prayed for my long life. "You doctors did whatever you could," she said. "The rest was His will."

That was nearly three years ago, but her words(6) are still fresh in my mind. I have just finished my final year of medical school and I haven't seen another case as horrific as Aisha's. But I am not afraid anymore. Aisha's mother equipped me with something I already knew but didn't understand. My own mother had told me the same thing again and again, but it was lying dormant within me.

I will always be thankful to Aisha's mother for telling me the meaning of life: that we should do everything we can; the rest lies in God's hands.

〔註〕

allot：割り当てる

batch：班

cold-blooded：冷酷な

comatose：昏睡状態の

dormant：休止状態の

make-believe：見せかけの

muster：奮い起こす

shudder：身震いする

stethoscope：聴診器

wrinkle：しわが寄る

設　問

1. 下線部(1) it の内容を具体的に日本語で説明しなさい。
2. 下線部(2)を日本語に直しなさい。
3. 下線部(3)を日本語に直しなさい。
4. 下線部(4)の内容を具体的に日本語で答えなさい。
5. 下線部(5)を具体的に日本語で説明しなさい。
6. 下線部(6)の内容を具体的に日本語で答えなさい。

Ⅱ　次の文章を読み，下の設問に答えなさい。

My brother-in-law Richard was a sculptor. For almost a year, he had been having vague symptoms, bloody noses and spots of numbness on the roof of his mouth, which he blamed on mold in his studio, the vagaries of New England weather, and a lifetime of exposure to epoxy-laden materials. In late March, we shared our weekly midday meal at Johnnie's Luncheonette. We each ordered the usual. For Richard, it was onion rings, which left his lips shiny, and a chocolate shake. I had a turkey sandwich, mashed potatoes, and water with a slice of lemon. As we skidded home in the snow, Richard told me that he had a rare form of sinus cancer. He looked no different than he had the week before: wild-haired and thick-nosed at fifty, an expressive face with deep lines slanting from his nostrils to the corners of his mouth. His hands, gripping the steering wheel, were large and knotty. His size had intimidated me as a boy; now as then, his dramatic voice was overshadowed by his yet bigger ideas about almost everything.

I had always thought of Richard as invincible, so at first I didn't believe he'd understood correctly what he'd been told. Then I realized he had just told me the impossible truth.(1) He seemed to have no more to say about it, and I had a sudden, panicky feeling that he was waiting for me to say something medical, to give him advice. But I was speechless, trying to collect what I knew about patients, cancer, the pervasive possibility of death, the experience of illness, and all the comforting things I'd told the strangers I had cared for in the five years since completing my medical training. I was a young doctor then and didn't know what to say. I didn't want him to die. I wanted to reassure my brother-in-law, offer him uncomplicated hope, as well as quell my already rising sorrow.

At the time, I was a general internist practicing at an innercity academic hospital, treating patients with AIDS and heart disease, colds, asthma, and chronic pain. I saw some of these patients in their homes; some in my dingy, green-carpeted, yellow-aired clinic; and some on the overcrowded hospital wards. During these early years of practice, I had, perhaps, concentrated too much on how people become ill and how their problems can be "fixed," without trying to imagine what it's like to *be* ill.(2) Whether out of self-pity or self-negligence, or because I was caring for too many patients in too little time, or because of the daily difficulty of seeing pain and terror, already I was no longer attempting to understand what my patients were communicating in gesture and expression, what was unsaid: why they were unhappy, what was bothering them most, how their bodies and lives had changed since they became sick.

Doctors feel obliged to strike the right emotional balance with patients(3): not too harsh, not too pitying. We are trained to hear and give grim news. From the first days of anatomy lab, we are inclined, even taught, to shut down. Rather than disclosing too much about ourselves — our judgments and contempt, our moods and fear — we are expected to keep our distance from patients. We deny that this distancing is a choice. Presented as a necessary rule, a requirement of composure, this self-protection disappoints patients interested in the interior world of their illness, the emotional life that's not on show. As doctors, we can't help being moved by the heartbreak of the individual medical moment, yet we never forget that patients are also examples of minutely studied biological processes. We refuse to be either impressed or surprised as we apply Joseph Brodsky's suggestion: "Keep eyes wide open, not so much in wonderment, or poised for revelation as in look-out for danger."

Early in my career, with the repetition of seeing twenty patients a day in a small exam room, I became like one of my ill patients: I had entered a world of black and white, a world without nuance, with only a two-word language—"sick" and "well." Gone were subtle gradations of color and dialect that an artist would appreciate. Then Richard got sick, and in the car that day I longed for a rich, fully formed vocabulary with which to speak to him about his illness and to help me understand it. I didn't have one(4).

The challenges of communication were well known to me. I had published two novels, been nominated for awards, and even taken up the subject of medicine in my second book. Richard bragged to everyone that it was the best book ever written about doctors, even though he had never read it. Still, before that drive from Johnnie's Luncheonette, I had never fully applied myself to the notion of illness, to traveling mindfully across its terrain. I was on automatic, doing my work with the cool precision of debridement. I spoke the language of medicine fluently but hadn't tried very hard to learn the idiom of the ill(5). I always thought that a doctor in good health could never quite appreciate illness. Each patient's emotions seemed just slightly out of my reach. I was inarticulate about the patient's experience of illness, but I was also holding back, in part because of my training and in part because I believed that I didn't have the right to ask or intrude.

My formal training in talking with patients took place at the end of the second year of medical school when I finally put my textbooks aside and began the requisite course on medical interviewing. Clinical information-gathering, I learned, has its own stiff anatomy and order — chief complaint, history of present illness, past medical history, review of symptoms. I memorized the list of topics to be covered when speaking with a new patient and watched my supervisor, a senior doctor, perform a series of interviews. Finally, the day arrived. My teacher escorted me to the bedside of an elderly woman with heart failure and sat in a chair

behind me. Glancing down at my notes so as not to forget any important details, I spoke with this patient. Caught up in the excitement of my first encounter, trying hard to keep moving through my list of questions and at the same time to write down her responses, I sometimes neglected to talk slowly or to nod in sympathy, simple human behaviors that, I was to learn, patients depend on.

For years after this course, my interviewing style remained close to what I had practiced as a student. Only as my experience with patients increased did I begin to understand that trying to make a patient feel better sometimes only makes him feel worse. Intent on teaching me the basics in four weeks, [how, difficult, a patient, the opportunity, my teacher, I, disarm, discuss, humor, never, use, had, it, is, and, to, to, to]$^{(6)}$, or how to foster an ill person's determination, or how to make a patient believe he still rules his own body.

Illness arrives, literally, out of nowhere. Newly ill, the patient immediately recalls the sick days of childhood, the afternoons asleep and the midnights awake, the disturbance of the natural daily rhythm. As an adult, illness makes him feel out of place, unaccountably absent, far outside existence. The patient expects illness to enforce a sense of restlessness and fluidity, but groggy and passive, he soon feels taken over, trapped, imprisoned. The patient expects to be dependent on others, but not the humiliation and indignity this sometimes brings. After a very short time, the patient wants to pretend he's well, to look the other way rather than face the new reality that the body can be hurt, attacked, scarred, that he and his body can fail.

Understanding the emotional cascade of illness would not only help patients communicate with their health care providers, families, and friends but also provide them with the vocabulary necessary to describe their responses to illness. Patients may not be able to control the malfunctioning of their bodies, but they can have a chance to harness their ways of thinking. Illness that is articulated may lead to feelings of coherence and safety during stressful times and thus relieve the sense of loneliness. A patient's capacity to carry on is critically dependent on satisfying emotional needs for understanding, love, expression, and respect.

During this last decade, it has become commonplace to hear celebrities speak of their colonoscopies, for our leaders to have their hearts and prostates described in the newspaper, and for cable channels to broadcast close-ups of surgery. But even today the emotional side of illness is rarely mentioned. Thinking of Richard, I have realized that during illness certain human experiences are intensified, and four feelings in particular: betrayal, terror, loss, and loneliness. Patients must change their relationship with doctors and loved ones so that they$^{(7)}$ are able to discuss these feelings and avoid being taken over by them. When we are ill, we

are filled with a perplexed sense of difference — from what we were before, and from those around us — and too often this sense of difference is ignored at the risk of worsening isolation.

〔註〕

anatomy lab：解剖学実習
articulate：明確に表現する
asthma：喘息
cascade：次々と生じる連鎖的なもの
chronic：慢性の
colonoscopy：結腸鏡検査
composure：落ち着き
debridement：傷から異物や死んだ組織を切除すること
dingy：暗い
epoxy-laden：エポキシ樹脂たっぷりの
fluidity：流動性
groggy：ふらふらする
harness：利用する
inarticulate：言葉にならない
internist：内科医
intimidate：威圧する
invincible：無敵の
mold：カビ
negligence：怠慢
nostril：鼻孔
numbness：無感覚
pervasive：広く行き渡っている
poise：用意をする
prostate：前立腺
quell：抑える
sinus：副鼻腔
skid：横滑りする
slant：斜めに横切る
terrain：領域
vagary：気まぐれな変動

設　問

1. 下線部(1)の内容を具体的に日本語で説明しなさい。
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5. 下線部(5)を具体的に日本語で説明しなさい。
6. (6)の［　　］内の下線部の語句を正しく並べ替えなさい。
7. 下線部(7)中 these feelings の内容を具体的に日本語で説明しなさい。

Ⅲ 次の文章の空欄(1)～(8)に入る最も適切な語を下の語群から選び，必要に応じて適切な形にして，解答用紙に書き入れなさい。(同じ語を2度以上使わないこと。)

One night at the beginning of my first internal medicine clerkship of third year, a resident, a stocky, cocksure man, ( 1 ) a patient from the emergency room. "See if you can figure him out," he said to me on his way out of the hospital the next morning.

The patient couldn't tell me what was wrong, and neither could his eighty-year-old mother. "He's been lying on the sofa for weeks," she complained when I went to see him. "He just won't get up." Sloth was a sin, but was it a reason to be admitted to the hospital?

They had been living together in a house in East St. Louis. He was fifty-six and single, working mostly odd jobs until recently, when he started spending his days on the couch, watching television. According to his mother, he seemed sleepy most of the time. He forgot appointments and ( 2 ) chores unfinished. When confronted, he became irritable and withdrawn.

She suspected he was using drugs, but he never left the house long enough to buy any. Sometimes he seemed to be responding to visual hallucinations. She begged him to see a doctor, but he wouldn't go. When he stopped bathing, she called 911.

Though it was my first third year clinical rotation, even I could tell that this wasn't the usual midsummer lethargy. He was lying in bed, almost expressionless. His movements were slow and listless. When he spoke, he slurred his words.

He denied using drugs and said he didn't have any previous medical problems. He vaguely ( 3 ) taking a medication, but given his current state, he couldn't remember what it was. I asked his mother to ( 4 ) in the bottle.

Meanwhile, I asked him a few standard questions. He knew where he was and the year, but not the month or the president. I asked him to count backwards from one hundred by seven, a test of attentiveness, but he stopped at ninety-three. I asked him to spell "world" backwards, but he started and stopped at "w." The mental status tests I had learned in class were useless on a patient with such poor mental status.

The differential diagnosis of his delirium was almost impossibly long. Some of the usual suspects had already been ruled out. He wasn't intoxicated or hypoglycemic. A CAT scan of his brain ( 5 ) no stroke, tumor, or bleeding. Seizures could explain the lethargy and confusion, but his mother had never seen him shake.

Of all the diagnostic possibilities, infections were probably the most serious. AIDS could cause a kind of premature dementia, but he didn't have the usual risk factors. Lyme disease was unlikely; *Ixodes* ticks weren't endemic to St. Louis. What about meningitis, I thought, or,

worse, syphilis? Untreated syphilis could infect the spinal cord and brain, causing severe nerve damage and dementia. Syphilis was one of the "great masqueraders," along with tuberculosis and lupus, diseases with such protean manifestations that they could almost never be ( 6 ) with certainty. In fact, syphilis was enjoying a resurgence in urban areas like St. Louis. The only way to rule it out was to do a spinal tap.

With help from another resident, I had the man sit on the side of his bed, leaning forward onto a table. I scrubbed his lower back with antiseptic soap and then ( 7 ) local anesthetic into the tissue between the third and fourth vertebrae. It was my first spinal tap, and I gingerly pushed the needle and trocar through the soft tissue, worrying that I was going to pierce the spinal cord. My hands shook in a fine tremor; beads of perspiration wet my brow. I advanced the needle in micron-size increments. It must have taken ten minutes to go an inch. When the needle finally perforated the sac around the spinal column, clear fluid bubbled back through the hub. The resident congratulated me on a "champagne tap," free of blood. We sent the fluid off to the laboratory.

Later that evening, test results started coming back. Blood tests for kidney and liver disease were negative. The spinal fluid was clean, ruling out an infection. But when the level of thyroid-stimulating hormone came back, it was off the scale. My patient had the worst case of hypothyroidism the doctors had ever seen.

The next day, his mother brought in a brown bag. Inside it was an empty prescription bottle. Sure enough, it was for thyroid hormone; he had been taking the medicine at home but had stopped six months earlier after it ( 8 ) out, slowly sinking into an amnesiac delirium that made him forget he needed it, a lapse that almost cost him his life. Hypothyroid coma has a 20 percent mortality rate even if diagnosed and treated appropriately.

〔註〕

amnesiac：記憶喪失の

anesthetic：麻酔剤

antiseptic：消毒用の

bleeding：出血

cocksure：自信満々の

delirium：意識の混濁状態

dementia：認知症

differential diagnosis：鑑別診断

endemic：その土地固有の

gingerly：用心深く

hallucination：幻覚
hub：注射器の針を装着する中心部
hypoglycemic：低血糖症の
hypothyroidism：甲状腺機能低下症
increment：増加
intoxicated：酔った
*Ixodes* tick：マダニ
lapse：過失
lethargy：無気力
listless：物憂げな
lupus：狼瘡
Lyme disease：ライム病
masquerader：仮装者
meningitis：髄膜炎
mortality rate：死亡率
perforate：突き刺す
protean：変幻自在な
resident：研修医
resurgence：復活
sac：嚢(のう)
seizure：痙攣発作
sloth：怠惰
slur：不明瞭に発音する
spinal tap：腰椎穿刺
stocky：ずんぐりした
stroke：(脳)卒中
syphilis：梅毒
thyroid：甲状腺
trocar：「套管(とうかん)針」穿刺術で用いる器具
tuberculosis：結核
tumor：腫瘍
vertebra：椎骨

〔語　群〕

| | | | |
|---|---|---|---|
| admit | bring | exclude | inject |
| leave | recall | reveal | run |