前期日程

令和6年度個別学力試験問題

英　　語

（医　学　部）
医　学　科
先進医療科学科

解答時間　80分
配　点　100点

注意事項

1. 解答開始の合図があるまで，この問題冊子の中を見てはいけません。
2. 受験番号を解答用紙の所定の欄に記入してください。
3. 解答は解答用紙の指定された解答欄に記入してください。
4. 問題冊子及び解答用紙の印刷不鮮明，ページの落丁及び汚損等に気付いた場合は，手を挙げて監督者に知らせてください。
5. 問題冊子は持ち帰ってください。

1 次の英文を読んで，あとの問いに答えなさい。

Some children pick reading up quickly, but some find it hard, even at age seven, due to special needs of various kinds. When this (happen)①, Finnish* teachers get straight to it. Before they even start school, children are screened for learning difficulties to allow for early intervention*. Marjo-Rita told me, 'Students who are struggling in reading or writing have extra lessons with the class teacher. We give these once a week, before or after school, and we can also ask the special teacher to help support them (A) if they need it.' This is pretty special. These special teachers are trained intervention experts—they are qualified teachers who have completed further training in the kinds of difficulties students face and how to help children to overcome them, and as they don't teach their own classes, they are available to offer support where needed. 'All the schools have these resource teachers these days; we are very lucky in that way.'

However, this is not just a case of throwing money (in the form of [(B)]) at the problem. Class teachers don't just call on the special teachers to take children out whenever they have an issue—they give them as much support as they personally can first (and must record the support that they give before they can request extra help—a source of some grumbling*). There are three different levels of support available to children who are struggling: general, extra and extra extra (not the official terms). General support (C) is provided by the teacher, making use of all the strategies available to her: giving extra lessons after school, sitting the struggling child next to a more able one who can help them, offering extra support to complete tasks during the lesson and more sophisticated strategies that they learn during their teacher training. Another teacher told me, 'Many times I think it's about the methods, you know, you have to know the methods, you have to learn the methods. Of course you can think of ideas yourself, but it's always easier if you've (see)② examples.'

If after all this the child is still struggling, they get 'frequent' support, which includes (have)③ extra support from the special teacher once a week, and a special plan written for the student by the class teacher which they discuss with the parents. Only if all of this has not had its desired impact (of supporting the child to keep up with the rest of the class) is a different curriculum offered for one or more subjects—the assumption is that they will do everything they can to support children to access the usual, national curriculum expectations, (D) acknowledging that the child's difficulties make this impossible. If the parents agree, and it is passed by the student care team, the child may then be taught in a separate, smaller class, where they can be given more attention.

This is a relatively new system. Students with special needs used to be taught in separate classes as a matter of course, but there (be)④ now more of an emphasis on inclusion*—hence the

various stages before students are given this extra help and different teaching. This has had a mixed reaction from teachers. It obviously makes their job harder, as they are having to cope with a greater range of needs within one class. I also spoke to a special teacher, Mikael, who was concerned that the delay caused by the obligation of teachers to record their initial attempts at (address)⑤ the problems themselves meant that children didn't get the intensive specialist support they needed as soon as they needed it(E): 'It takes such a long time to get to step three that it might take a student who is struggling in seventh grade until the end of eighth grade to get this status. It needs to start from the first grade that it's noticed.'

(出典：Crehan, Lucy. *Clever Lands*, Unbound, 2016 より抜粋，一部改変)

〔注〕

Finnish：フィンランドの　　intervention：介入　　grumbling：不平

inclusion：多様なニーズを持つ子どもを地域の学校，学級の中で教育すること

問 1　①～⑤の(　　)内の単語を適切な形(1 語)に直し，解答欄に記入しなさい。

問 2　下線部(A)を最も具体的に表す語句を，第 1 段落から 5 語以上の英語で抜き出して記入しなさい。

問 3　[(B)] に入れる最も適切な語句を(ア)～(エ)の中から 1 つ選び，その記号を記入しなさい。

(ア) a tuition fee rise　　(イ) lots of children's books

(ウ) professionals' salaries　　(エ) school renovations

問 4　下線部(C)の具体的内容を 4 つ日本語で記入しなさい。

問 5　(　D　)に入れるのに最も適切な語を(ア)～(エ)の中から 1 つ選び，その記号を記入しなさい。

(ア) after　(イ) before　(ウ) through　(エ) because

問 6　下線部(E)を日本語に訳しなさい。

問 7　以下の(ア)～(オ)の文を読み，本文の内容と合致しているものに T，そうでないものに F を記入しなさい。

(ア) On the day they enter elementary school, children are carefully checked for delays in reading and writing.

(イ) "Special teachers" usually do not have their own class to teach in a school.

(ウ) Classroom teachers must write down the help they give to struggling students.

(エ) Classroom teachers must give students additional support before requesting a special teacher.

(オ) A "special teacher" will provide a special plan for the student who needs reading and writing support.

2 次の英文を読んで，あとの問いに答えなさい。

Anyone who has ever visited a nursing home* will have seen them, trapped in their recliners*, mouths open and eyes blank, being fed liquids from sippy cups*: elderly people who are entirely dependent on their carers. Some look close to death; arguably*, their quality of life is so diminished they may as well be. It can be difficult to see these people. None of us want to envisage* ourselves spending our final years that way.

But we ought to be envisaging it, says Canadian-American doctor and longevity* expert Peter Attia. He believes we should be spending more time with those who are in their final 10 years—what he terms (A)"the marginal decade"—and thinking about what we want for that time in our own lives. We need to focus on our endgame*, says Attia.

"I ask every single one of my patients what they want to be doing in their marginal decade," he explains. "The answers are usually quite ambitious. (B)They might say they (　　), for example. And so, I make them reverse engineer*, and examine what they need to be doing now so that they have the strength, the lateral* stability, the cardiovascular fitness*, to still be skiing then. I'm not going to tell them they can't do it. But if they are 50 and still skiing with ease now, then they need to build up their resources to cope with the next decade or two of decline, because decline is coming and it's actually quite nonlinear*. It really starts to hit us when we're 75."

Attia is based in Austin, Texas. At his practice, Early Medical, the focus is on guiding patients towards transforming their marginal decade into bonus years by building up their health and fitness to put them at a higher starting point, ready for when that inevitable decline kicks in*. Generally, he asks them to list 10 to 15 late-life goals before coming up with a personalised* strategy to achieve them.

This is healthcare for a wealthy elite. Every one of his patients undergoes a thorough investigation to see what their risks may be, then a team of experts develops an individual plan to mitigate* those risks as much as possible. (中略)

Attia, who studied at Stanford Medical School, had set out to become a cancer surgeon, but was plagued by (C)a recurring dream. In it, he was trying to catch eggs that were being flung* at him from above, and was unable to prevent many of them crashing to the ground and breaking. This seemed to him to be an analogy* for the kind of work he was doing. Because no matter how clever the surgery, many of his cancer patients would still die within the next few years. Those eggs were going to hit the ground.

Disillusioned*, he quit medicine and worked in management consulting for a while. When he returned, it was with a rigorously* preventive and proactive* approach that he terms Medicine 3.0. He became a longevity doctor.

As he explains it, Medicine 1.0 was the first primitive era of healthcare, when physicians believed most illness was spread by miasmas* in the air. Medicine 2.0 is the form still practised today, made possible by the invention of the microscope, which led to germ* theory and antibiotics. Medicine 3.0 is the future, and it is going to require a major mind shift before we all have access to it.

The problem with Medicine 2.0 is that it tends to intervene* well after the disease has taken hold. Odds are that most of us will die of one of the chronic diseases of ageing: heart disease, cancer, neurodegenerative* disease and metabolic dysfunction*—Attia calls them the Four Horsemen. "We want to delay or prevent these conditions so we can live longer without disease rather than (D) lingering* with disease," he says. (中略)

Attia turned his health around at 36, and his wife Jill was the prompt. One day when they were at a beach together, she suggested that he needed to work on being "a little less not-thin". At first, he was shocked. He was into long-distance ocean swimming and physically very fit. Still, he had developed a "Dad bod*", his blood sugar was high, his coronary arteries* were clogging up* and he recognised the trajectory* he was on. It wouldn't end well.

Doing nothing is not his style. Driven and obsessive*, he turned his laser* focus on the science of longevity. Cardiovascular diseases run in his family, so he developed a strategy to try to avoid them. (E) He lost weight and (　　).

"My long, comprehensive programme of prevention seems to have paid off," he writes in *Outlive*. "I feel a lot better now at age 50 than I did at 36, and my risk [of cardiovascular disease] is a lot lower by any other metric* than age. One major reason for this is that I started early, well before Medicine 2.0 would have suggested any intervention*."

Deterioration* is preventable and largely optional, in Attia's thinking. He believes we all need a strategy tailored to* our individual goals—there is no blueprint* of what to eat, how to exercise, etc, to stave off* decline. In fact, he is constantly fine-tuning his own approach. (中略)

Attia's key message is that change is possible. Maybe not all the changes, all at once, but if we focus on our lifestyles and routines, then we're in with a chance of rerouting* the trajectory we're on so that we get to that active, independent older age that everyone hopes for.

The earlier you start, the more you can mould* that trajectory for the better, but it is almost never too late to make some degree of improvement.

"What's the alternative? To accelerate the decline by doing nothing? That sounds awful. If you're going to go down, then go down swinging, right? Do everything in your power."

"I think people don't appreciate how much you can move the needle*. (F) Everybody knows exercise is good, but probably they aren't aware just how good it is. I also don't think most people are spending enough time considering what their marginal decade looks like."

（出典：Pellegrino, Nicky. The longevity guru, *The NZ Listener*, 2023 より抜粋，一部改変）

〔注〕

nursing home：老人ホーム　recliner：リクライニングチェアー
sippy cup：蓋付きカップ　arguably：ほぼ間違いなく　envisage：～を想像する
longevity：長寿　endgame：終盤　reverse engineer：逆行分析する
lateral：横方向の　cardiovascular fitness：心臓血管の健康
nonlinear：直線的でない　kick in：始まる　personalised：個別の
mitigate：～を軽減する　fling：～を投げつける　analogy：例え
disillusioned：幻滅して　rigorously：徹底的に　proactive：前向きな
miasma：しょう気，（病気を引き起こす）悪い空気　germ：細菌
intervene：介入する　neurodegenerative：神経変性の
metabolic dysfunction：代謝機能不全　lingering：長く続く
Dad bod：中年太り　coronary artery：冠（状）動脈
clog up：塞がる，詰まる　trajectory：（人生の）軌跡　obsessive：取りつかれて
laser：レーザー　metric：基準，指標　intervention：治療介入
deterioration：劣化，老化　tailored to：～に合わせた
blueprint：青写真　stave off：～を防ぐ，食い止める
reroute：～を軌道修正する　mould：～を作る
move the needle：目立った変化をもたらす

問 1　下線部(A)の“the marginal decade”の内容を日本語で具体的に説明しなさい。

問 2　本文の意味に合うように，下線部(B)の(　　)内に英単語 3 語以上を用いて英文を完成させなさい。

問 3　下線部(C)の「繰り返し見た夢」は実生活のどのようなことを暗示していると Attia は考えたのか。日本語で簡潔に説明しなさい。

問 4　下線部(D)を，“these conditions”の内容を具体的に説明しながら，日本語に訳しなさい。

問 5　本文の意味に合うように，下線部(E)の(　　)内に Attia が行ったと考えられることを，英単語 3 語以上を用いて英文を完成させなさい。

問 6　下線部(F)を日本語に訳しなさい。

3 次の英文を読んで，あとのａ～ｆの〔　　〕内の語(句)を正しく並べ替え，本文中の【 (1) 】～【 (6) 】の適切な場所に入れなさい。解答欄には，ａ，ｂなどの記号は書かず，並べ替えた英文のみを記入しなさい。

In the fall of 1997, after I graduated from college, I began experiencing what I called "electric shocks"—stabbing* sensations that flickered* over my legs and arms every morning, as if I were being stung by tiny bees. The shocks were so extreme that as I walked to work from my East Village basement apartment, I often had to stop and rub my legs against a parking meter; if I didn't, my muscles would twitch* and my legs would jerk*. My doctor couldn't figure out what was wrong—dry skin, he proposed—and eventually the shocks went away. A year later, they returned for a few months, only to stop again just【 (1) 】.

In my twenties, the shocks and other strange symptoms—bouts* of vertigo*, fatigue, joint pain, memory problems, night sweats, tremors*—came and went. For a year, every night around two a.m., I would wake up in a sweat to find hives* covering my legs, leaving me itchy* and wide awake, my pajamas and sheets so wet I had to change them. Doctors prescribed a daily dose of antihistamines*. There was a test that suggested lupus*, and then a follow-up that showed nothing was wrong; my lab work* looked fine. "The tests were all negative. It's just one of those things that will go away," a specialist told me. I remember thinking, "Don't【 (2) 】hives?"

In the way of women who have internalized* disordered ideas about food and control, I associated my strange bouts of fatigue and discomfort* with eating poorly (even though I ate a reasonably healthy diet). It was easy, in those years, to feel that a lack of dietary* discipline played a role in my exhaustion, because I could tell that certain foods made me feel worse, leading me to assume responsibility for my own unwellness*. I toggled* between the conviction that something had to be wrong—I didn't *feel* OK—and the conviction that I was to blame, and if I just stopped eating sugar, or pizza, say, I'd be fine. (中略)

When I was twenty-four, I started waking up with a feeling that a foggy* miasma* filled my brain. I would go for long runs before work to clear my head, lacing up my shoes, sweating off the sleep hangover*. I thought everyone felt this way, that I was just fighting a cold. But why was I so often on the verge of* a cold—more than anyone else I knew? Periodically*, I would start digging a little. In 2005, around the time of my twenty-ninth birthday, I was strangely enervated*. I remember googling my symptoms and being struck by how much they matched those of several autoimmune* diseases. But then my doctors would reassure me that my lab work looked fine, and I'd return to trying to power through.

My tendency to ignore my symptoms derived in part from the fact that I grew up【 (3) 】.

As a child in Brooklyn—my parents were teachers at the school I attended—I had been raised not to think too much about my body. My parents had moved to the city from New Jersey, where they had grown up in large Irish American Catholic families. They were pragmatic* and rather stoical*. Like many in their baby boomer generation, they saw doctors as unquestionable experts. You didn't go to them unless you had a high fever or a bad fall or a wound that needed stitching*. In that case, you got a diagnosis, you took medicine or had surgery, and you got better, more or less in that order. But【 (4) 】, nothing was wrong. My parents believed in the power of Western medicine, and therefore so did I.

Ours was a family where health was not ever thought of as something to optimize* or even talk about. So they took us to the doctor regularly and handed out Tylenol* for fevers, but if the problem at hand was vague or seemingly minor, they tended to ignore it, telling us to buck up*. As a kid, I had lots of "small things" wrong—bad allergies, muscle pain, poor digestion—which in retrospect* I suspect were subtle clues about what was coming, but my parents did not pay much mind to them. I got used to being uncomfortable, and I internalized the idea that my mentioning my discomfort made me fussy*—"The princess and the pea," my mother once said, in irritation, making it【 (5) 】.

Still, there were moments that suggested something was not right. In July 2008, I had an early dinner with my mother—who was then on her fourth round of chemotherapy* for stage 4 colorectal cancer*—and my father on their patio* in Connecticut. It was ninety degrees, and the sun was still up. The patio smelled of mint and basil and the air was thickly humid*. I was shivering* so much I put on a sweater. "You look more uncomfortable than I do," said my mother, giving me a sharp glance, her dark eyes tightening with unusual concern. "Are you OK?" I wasn't sure. When I woke up the next morning, I was exhausted and foggy-headed. My mother knocked on the door, wanting to take a walk on the beach. Her black【 (6) 】, and I found myself thinking that it seemed like my mother, despite undergoing chemotherapy, had more energy than I did.

(出典：O'Rourke, Meghan. *The Invisible Kingdom: Reimagining Chronic Illness*, Riverhead Books, 2023 より抜粋，一部改変)

〔注〕

stabbing：突き刺すような　flicker：(少しの間)現れる
twitch：ひきつる　jerk：けいれんする　bout：発作
vertigo：めまい　tremor：振戦，震え　hives：じんましん
itchy：かゆい　antihistamine：抗ヒスタミン薬
lupus：ループス，狼瘡　lab work：臨床検査　internalize：～を内に秘める
discomfort：不快感　dietary：食事の　unwellness：体調不良
toggle：ゆれ動く　foggy：ぼんやりとした
miasma：しょう気，(病気を引き起こす)悪い空気　sleep hangover：寝疲れ
on the verge of：～になりかけて　periodically：定期的に
enervated：衰弱した　autoimmune：自己免疫の　pragmatic：現実的な
stoical：感情を表に出さない　stitching：縫合
optimize：～を最適にする　Tylenol：タイレノール(薬品名)
buck up：元気を出す　in retrospect：思い返してみると
fussy：イライラしやすい　chemotherapy：化学療法　colorectal cancer：大腸がん
patio：中庭，テラス　humid：湿度の高い　shiver：震える

a．〔have / to know / severe / why I / you want〕

b．〔live / bright with / eyes / eagerness to / were / the〕

c．〔you nothing / told / wrong / if the / was / doctor〕

d．〔them any / couldn't / when / bear / felt I / longer / I〕

e．〔I / demanding too / that I / complained / was / clear / much when〕

f．〔was / matters of / largely indifferent / in a / to / health / family that〕