

令和3年度入学者選抜学力検査問題
〈前期日程〉

外 国 語

英 語

(医学部 医学科)

注 意 事 項

- 1 試験開始の合図があるまでこの冊子を開いてはいけない。
- 2 問題はⅠからⅣまでである。
試験開始の合図のあとで問題冊子の頁数(1～13頁)を確認すること。
- 3 解答は必ず解答用紙の所定の欄に記入すること。
所定の欄以外に記入したものは無効である。
- 4 解答用紙は持ち帰ってはいけない。
- 5 問題冊子は持ち帰ってよい。

I 次の英文を読み、空所 (1) から (15) を補うのに適切な1語を下の語群内の(A)から(O)より選び、記号で答えなさい。なお、(1) と (3) は2か所あり、同じ語が入ります。

Have you ever thought about starting a new job or school, and found your heart pounding and your mind racing with a series of “what ifs”? If so, you may wonder “do I have anxiety?”

Anxiety is your body’s natural (1) response system. When your brain believes you are in danger, it sends out a series of signals to your body, resulting in the fight-or-flight response*.

Anxiety has three main components: emotional, physiological*, and cognitive.

Imagine you have a presentation coming up at work. You might notice feelings of fear and dread, two examples of the emotional component. You may also notice bodily sensations, such as heart palpitations*, sweating, or a tightness in your stomach, which represent the physiological component. Finally, you might be thinking, “I can’t do it,” or “I’m going to (2) myself.” Worries and negative thoughts like these about what might happen in the future are the cognitive component. So, while worry is an important part of anxiety, it is only one of the three main building blocks.

Anxiety in itself is not bad. Normal levels of anxiety lie on one end of a spectrum and may (3) as low levels of fear or apprehension, mild sensations of muscle tightness and sweating, or doubts about your ability to complete a task. Importantly, symptoms of normal anxiety do not negatively interfere with daily functioning. They may actually improve your attention and problem-solving, motivate you to work harder toward a goal, or warn you about a potential (1). For example, anxiety about an upcoming exam will likely (4) you to prepare fully, and the anxiety a hiker might experience when (5) a bear allows the hiker to run away to safety. These examples demonstrate how normal levels of anxiety can be adaptive* and helpful to your everyday life.

Clinical levels of anxiety fall toward the other end of the spectrum. Diagnosable* anxiety disorders occur when anxiety levels (6) enough to rapidly decrease performance and cause impairment.*

How would you know if you have crossed over into the zone of a full-blown* anxiety disorder? Anxiety disorders are characterized by severe, (7) worry that is excessive for the situation, and extreme avoidance of anxiety-provoking situations. These symptoms cause distress, impair* daily functioning, and occur for a (8) period. For instance, a person who needs to stay home from work several days in a row due to panic attacks is

likely suffering from an anxiety disorder.

Different evidence-based treatments are most effective for different anxiety disorders. For example, a man suffering from panic disorder would likely (9) from exposure therapy, while a woman suffering from social phobia* might be best treated with cognitive behavioral therapy (CBT). If you believe you may have an anxiety disorder, seek help as soon as possible.

As anxiety moves along the spectrum from normal to clinical, a gray area in the middle may still have a negative impact on your life: the “almost anxious” region. When the level of anxiety you experience is no longer adaptive or helpful to your performance and becomes a (10) to your enjoyment of life, but does not yet meet the diagnostic threshold* for an anxiety disorder, you are “almost anxious.” You might find yourself (11) to focus your attention on tasks, distracted by negative thoughts, fear, or unpleasant body sensations. For example, someone who is “almost anxious” may sit at their desk all day, making minimal (12) on an assignment due to constant worries and tightness in the stomach. While anxiety did not make it impossible to come to work, the level of anxiety experienced is making it hard to function. Using this (13) of “almost anxious” can help you catch anxiety before it becomes too extreme, and target it using evidence-based strategies that help move anxiety back along the spectrum to an adaptive level.

When you find yourself feeling too anxious, try evidence-based techniques to bring your anxiety levels back to normal. Here are a few tools to try:

- If you find yourself thinking, “I can’t do this,” “I’ll never get this assignment done,” or a similar negative thought, challenge this by asking if it is (14) or helpful. You will likely find that these thoughts are merely fueled by your anxious brain, so stopping them in their tracks is important.
- If your thoughts seem to be spiraling out of control, take a few minutes to practice mindfulness. Focusing on the (3) moment takes your thoughts away from the past and future, helping you re-center yourself.
- Identify situations that make you anxious, and (15) them instead of avoiding them. For example, if you are afraid of public speaking, talk in front of others as often as possible. Over time, you will find the discomfort fades away as you face the very things that used to cause you anxiety!

—From Luana Marques, “Do I have anxiety or worry: What’s the difference?” July 23, 2018, <https://www.health.harvard.edu/blog/do-i-have-anxiety-or-worry-whats-the-difference-2018072314303>, 一部改変.

| | | | |
|---------------------------------|---------|----------------------|-------|
| Notes: fight-or-flight response | 闘争・逃走反応 | physiological | 生理的な |
| palpitation | 動悸 | adaptive | 適応できる |
| diagnosable | 診断可能な | impairment | 障害 |
| full-blown | 深刻な | impair | 損なう |
| phobia | 恐怖症 | diagnostic threshold | 診断基準 |

語 群

- | | | | |
|----------------|---------------|------------------|-----------------|
| (A) approach | (B) barrier | (C) benefit | (D) concept |
| (E) drive | (F) embarrass | (G) encountering | (H) persistent |
| (I) present | (J) progress | (K) rise | (L) significant |
| (M) struggling | (N) threat | (O) valid | |

(白 紙 頁)

II

次の英文を読んで下の質問に答えなさい。問1以外、すべて日本語で解答すること。

The second-year students are learning about the cardiac* exam today. They file into a large classroom, where they will first learn about heart murmurs* — their location, quality, and meaning. Then, as part of their session, they will have the opportunity to work in small groups examining several patients who have good examples of “classic” murmurs. As they listen to each patient, they will be guided by a fellow* in ⁽¹⁾cardiology*. They are excited to be able to listen to real patients’ hearts instead of just each others’.

Over the years, I have watched my students examine these patients, many of whom are my own, who have so kindly offered their hearts for an afternoon of student education. When the students are introduced to their first patient, they are unfailingly polite, concerned about the patient’s comfort, grateful for the opportunity to listen to a real heart. Then they settle into the process of performing the exam: observing the chest wall*, feeling for the apical impulse*, trying to understand its character and what it might tell them about the heart they are about to hear. Finally, using their stethoscopes*, they listen to the sounds beneath. They are awkward and nervous as they listen, brows furrowed* in concentration. Suddenly, their faces light up: they have recognized the mitral regurgitation* that, until that ⁽²⁾moment, had been a mere description in a textbook, a manufactured sound on a simulator*. Over and over again throughout the course of the afternoon, they will greet patients and then eagerly bend over their hearts, listening intently.

A few years ago, after one of these sessions, I had an office visit with one of my patients who had graciously volunteered to let my students examine her. I thanked her again for her time. She said, “Kate, tell me, how bad is my heart?” This woman is in her ⁽³⁾70s now, but I have known her since I was an intern*. She has had severe mitral regurgitation for years and, remarkably, has never been symptomatic. I follow her with periodic echocardiograms* and discuss the possibility of a valve* replacement in the future — an option she has vehemently resisted.

“Why do you ask?” I said.

“Well, when one of the students had listened to my heart, she turned to the cardiac fellow and asked, ‘How can she live if her heart is that bad?’”

There it was. The moment when, in her enthusiasm and intense interest in the problem before her, the student forgot there was a patient. How easy it was for this to happen — and how potentially devastating for the patient. I reassured my patient about her health, talked with her about how I would use the event as a teaching opportunity, and thanked her for telling me.

So today, before I send my students to meet their patients and listen to their hearts, I tell them this story. There is an audible gasp when I repeat the student's question, "How can she live if her heart is that bad?" I know that most of them are horrified—how could anyone say such a thing? They're certain they would never do that. But of course they could do it, and they almost certainly will someday.⁽⁵⁾

"The student who said this was not a bad person, was not insensitive or uncaring," I say. "She did what I myself have done and what every one of you will do as you go on in your training. The process of learning about the problem was so engrossing that she simply forgot the patient was lying there listening. Perhaps, also, as a student, she had not yet learned how powerful her words could be. This is a wonderful example of the dilemma that will face all of you as you go on in your training. As you acquire more medical knowledge and responsibility, you will focus more and more on the problem and forget the patient attached to it. As you strive to take a good history, get the facts straight, perform a good physical exam, and put it all together into a comprehensive clinical picture, you will find that with all the anxiety involved in wanting to do it right, the patient becomes further and further away. Use this story to remember that there is always a patient and that you have not finished your work until you have taken care of the patient, not just the problem."

One of the benefits of teaching, I have found, is that it requires reflection on these sorts of issues—and, inevitably, on my own practice. How many times have I been so intent on solving a clinical puzzle that I have forgotten that the patient may be worried or anxious? How many times has impatience crept into my voice when I've called a woman to tell her that she needs additional mammographic* views because of what is, in all likelihood, a benign* "vague density" and she has a hundred questions about what it means? For me, this is just another task to do; I am not worried. For the patient, I have just raised the terrifying possibility of breast cancer. It requires a conscious act to shift my mindset* to that of my patient—to grasp her vulnerability, confusion, and need.

While I am busy treating the bodies of my patients, I try to remember to treat the patients as well—to touch them in small ways as well as large. It is critically important to treat the hypertension*, the diabetes*, or the heart disease skillfully, but when I remember to treat the patient as well, I experience the essence of being a physician. Caring for my patient as a person provides a comforting connection for both of us—the doctor and the patient facing the fears and managing the problems together. I know this alliance is at the heart of our calling, of why we went to medical school all those years ago.

As I look out at the earnest, eager students in front of me with their shiny stethoscopes around their necks, I think about the hearts they will hear and the hearts they

will touch — including their own.

— From Katherine Treadway, “Heart Sounds,” *New England Journal of Medicine*, 354, March 16, 2006.

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|----------------------|----------|----------------|--------|
| Notes: cardiac | 心臓の | heart murmur | 心雑音 |
| fellow | 専門医 | cardiology | 心臓病学 |
| chest wall | 胸壁 | apical impulse | 心尖拍動 |
| stethoscope | 聴診器 | furrow | 皺が寄る |
| mitral regurgitation | 僧帽弁閉鎖不全症 | simulator | 模擬訓練装置 |
| intern | 研修医 | echocardiogram | 心エコー図 |
| valve | 弁膜 | mammographic | 乳房撮影の |
| benign | 良性の | mindset | 考え方 |
| hypertension | 高血圧 | diabetes | 糖尿病 |

問1 下線部(1)(4)(6)の単語に最も近い意味を持つ単語・表現を(A)~(D)から選び、記号で答えなさい。

- (1) classic: (A) antique (B) impressive
(C) typical (D) explicit
- (4) audible: (A) capable of being heard (B) sensitive to sound
(C) subject to change (D) related to defect
- (6) engrossing: (A) conspicuous (B) stubborn
(C) rigid (D) fascinating

問2 下線部(2)のようになぜ医学生が反応したのかを説明しなさい。

問3 患者が筆者に下線部(3)のように尋ねた理由を示しなさい。

問4 下線部(5)について下記の質問に答えなさい。

- 文中の it および省略された部分を補い、筆者が伝えなかったことを明らかにしながら和訳しなさい。
- 下線部(5)のように筆者が述べた理由を示しなさい。

問5 下線部(7) the dilemma の具体的な内容を述べなさい。

問6 患者への心的ケアの提供が医師に何をもたらすと筆者は考えているのかを述べなさい。

(白 紙 頁)

III

次の英文を読んで下の質問に答えなさい。問6以外、すべて日本語で解答すること。[...] は省略を示します。

Uniquely human emotions don't exist. More and more, I believe that we share all emotions with other species in the same way that we share virtually every organ in our bodies with them. No exceptions.

Like organs, the emotions evolved over millions of years to serve essential functions. Their usefulness has been tested again and again, giving them the wisdom of ages. They nudge* us to do what is best for us. Some emotions may be more developed in humans, or apply to a wider range of circumstances, but none is fundamentally new.

⁽¹⁾This is not the prevailing view in science, though. The most popular theory proposes only six "primary" or "basic" emotions, which are universally recognized by their facial expressions, like anger (frowning stare), happiness (laugh and smile), and fear (eyes wide open, lips stretched horizontally). All other emotions are "secondary," which means that they are cultural constructs that make us human.

But does anyone truly believe that just because an emotion lacks a specific face, we can claim it for ourselves? Open your front door and tell your dog that you are going out for a walk, then close the door and return to your seat. Your dog, who had been barking and wriggling* with excitement, now slinks* back to his basket and puts his head down on his paws. You have just witnessed both hope and disappointment in another species, even though neither counts as a basic emotion.

You may say that it is impossible to know what a dog feels. True, yet his behavior clearly reflects an abrupt* change in his emotional state. Expressed in the body, these states are perfectly observable and measurable even if the associated private experiences are not.

In fact, the possibility of animal hope was experimented upon nearly a century ago by the psychologist Otto Tinklepaugh. He first let a monkey watch a banana being hidden under a cup, then allowed her into the room where this had been done. If she found the banana, everything proceeded smoothly. But if the experimenter had surreptitiously* replaced the banana with a piece of lettuce, the monkey would frantically* look around, lifting up the cup, while shrieking at* the experimenter. Her expectations had been violated, for which she rightly blamed the sneaky* experimenter.

We share so many so-called secondary emotions with other species that the whole concept is questionable. There is one exception, though, which keeps being proposed as definitely cultural: guilt.

This is despite the many dog owners who seem to recognize it in their pets when they hide under the table after a transgression*. One expert in animal cognition at Barnard, Alexandra Horowitz, tested this out by having dogs meet an angry owner both when they had not broken any rules and when they had; she also had them meet a relaxed owner in the same two situations. Dr. Horowitz concluded that whether dogs take on a guilty look—lowered gaze, ears pressed back, tail rapidly beating between the legs—is unrelated to whether or not they followed orders. If the owner scolds them, they look extremely guilty. If the owner doesn't, they still sometimes look like this, but less often.

⁽²⁾One problem, however, is that our rules are of our own making, such as “Don't jump on that couch!” or “Keep your nails off my leather chair!” It must be as tough for our pets to grasp these prohibitions as it was for me to understand why I couldn't chew gum in Singapore.

It would be better to test behavior that is wrong by almost any standard, including that of their own species. The ⁽³⁾Austrian ethologist Konrad Lorenz gave one of my favorite examples, about his dog, Bully, who broke the fundamental rule never to bite your superior.

Humans don't need to teach this rule, and indeed Bully had never been punished for it. The dog bit his master's hand when Dr. Lorenz tried to break up a dogfight. Even though Dr. Lorenz petted him right away, Bully suffered a complete nervous breakdown. For days, he was virtually paralyzed* and ignored his food. He would lie on the rug breathing shallowly, occasionally interrupted by a deep sigh. He had violated a natural taboo, which among ancestral canines* could have had the worst imaginable consequences, such as expulsion* from the pack*.

Among the primates*, the most suggestive cases of (A) concern bonobos. These apes are as close to us as chimpanzees, but far more peaceful and gentle, which means that they almost never hurt one another. Whereas in most primates reconciliation* after a fight is typically sought by the subordinate party, in bonobos it is the dominant animal that seeks to make amends, especially if he has inflicted an injury. He may return to his victim and unerringly* reach for the exact same toe that he has bitten and carefully inspect the damage. He obviously knows precisely what he has done and where. Then he spends half an hour or more licking and cleaning the wound that he himself inflicted.

[...]

For the longest time, science has depicted animals as stimulus-response machines while declaring their inner lives barren*. This has helped us sustain our customary “anthropodenial”: the denial that we are animals. We like to see ourselves as special, but ⁽⁴⁾whatever the difference between humans and animals may be, it is unlikely to be found in

the emotional domain.

—From Frans de Waal, “Your Dog Feels as Guilty as She Looks,” *The New York Times*, March 8, 2019.

| | |
|-----------------------|--------------------|
| Notes: nudge 促す | wriggle ぐねぐね小刻みに動く |
| slink こそこそ逃げる | abrupt 突然の |
| surreptitiously こっそりと | frantically 必死に |
| shriek at 金切り声をあげる | sneaky 卑劣な |
| transgression 罪 | paralyzed 身動きがとれない |
| canine 犬 | expulsion 追放 |
| pack 群れ | primate 霊長類 |
| reconciliation 仲直り | unerringly 間違うことなく |
| barren 中身がない | |

- 問1 下線部(1)の This は何を指しますか。本文の内容に沿って述べなさい。
- 問2 第3段落では、感情には primary と secondary の区別があると述べられています。この区別はどのようなものですか。本文の内容に沿って説明しなさい。
- 問3 第4段落から第6段落では、動物が二種類の感情を表している可能性があることが論じられています。
- 1) それらの感情はどのようなものですか。
 - 2) それらの感情をどのように表しているか、本文の内容に沿って説明しなさい。
- 問4 下線部(2)の One problem とはどのようなものですか。第8段落から第10段落の内容に沿って説明しなさい。
- 問5 下線部(3)の behavior that is wrong by almost any standard の例として、本文でどのようなものが取り上げられていますか。本文の内容に沿って説明しなさい。
- 問6 (A) に入る感情は何ですか。本文中から単語を抜き出しなさい。
- 問7 下線部(4)の anthropodenial は何を意味しますか。本文の内容に沿って述べなさい。

(白 紙 頁)

IV Each language has its own set of idioms and phrases associated with its culture and society. Take one Japanese idiom or phrase, and state it in English, along with an explanation of the meaning of the expression and the cultural and social context in which it is used. Your explanation should be written in English, in 90-100 words. Please indicate the number of words used at the end of the sentence.

