

Passage 1

Self-medication

Occasional self-medication has always been part of normal living. The making and selling of drugs has a long history and is closely linked, like medical practice itself, with belief in magic. Only during the last hundred years or so has the development of scientific techniques made it possible for some of the causes of symptoms to be understood, so that more accurate diagnosis has become possible. The doctor is now able to follow up the correct diagnosis of many illnesses with specific treatment of their causes. In many other illnesses, of which the causes remain unknown, he is still limited to the treatment of symptoms. The doctor is trained to decide when to treat symptoms only and when to attack the cause: this is the essential difference between medical prescribing and self-medication.

The advance of technology has brought about much progress in some fields of medicine, including the development of scientific drug therapy. In many countries public health organization is improving, and people's nutritional standards have risen. Parallel with such beneficial trends are two which have an adverse effect. One is the use of high pressure advertising by the pharmaceutical industry, which has tended to influence both patients and doctors and has led to the over-use of drugs generally. The other is the emergence of the sedentary society with its faulty ways of life: lack of exercise, over-eating, unsuitable eating, insufficient sleep, excessive smoking and drinking. People with disorders arising from faulty habits such as these, as well as from unhappy human relationships, often resort to self-medication and so add the taking of pharmaceuticals to the list.

These are the main reasons why laxatives, indigestion remedies, pain-killers, cough mixtures, tonics, vitamin and iron tablets, nose drops, ointments and many other preparations are found in quantity in many households. It is doubtful whether taking these things ever improves a person's health; it may even make it worse. Worse, because the preparation may contain unsuitable ingredients; worse because the taker may become dependent on them; worse because they might be taken in excess; worse because they may cause poisoning, and worst of all because symptoms of some serious underlying cause may be masked and therefore medical help may not be sought. Self-diagnosis is a greater danger than self-medication.

Vocabulary

pharmaceutical *adj.* 制药的

sedentary *adj.* 坐着的

laxative *n.* 泻药

tonic *n.* 补药

ointment *n.* 软膏

ingredient *n.* 成分

Reading Comprehension

Directions: *There are four suggested answers to each of the following questions. Choose the best one according to the passage you have just read.*

1. Accurate diagnosis was impossible _____
A. until drugs were available.
B. when self-medication was a part of life.
C. when medical practice was linked with belief in magic.
D. before the causes of certain symptoms were understood.
2. We can infer from the passage that _____.
A. doctors are influenced by drug advertisement.
B. doctors are usually prescribing more medications than necessary.
C. patients are under high pressure from the pharmaceutical companies.
D. better living standards make it possible for patients to take more drugs.
3. How many bad effects caused by self-medication are mentioned in the passage?
A. Two. B. Three. C. Four. D. Five.
4. People who tend to resort to self-medication are usually those _____.
A. who have bad human relationships
B. who drink and smoke excessively
C. who lead a sedentary lifestyle
D. all of the above
5. The writer's attitude towards self-medication can be best summarized as _____.
A. critical
B. skeptical
C. supportive
D. indifferent

Passage 2

Daring to Practice Low-Cost Medicine in a High-Tech Era

A child with chest pain or tics, a toddler who is limping, a 12-year-old girl with abdominal pain or headaches, an infant whose fever does not respond to antibiotics — these are age-old challenges that pediatricians face. I have been teaching pediatrics to residents and medical students for more than three decades, but over the past few years, as I've watched trainees at work, sitting at their computers, and ordering and monitoring tests, I've grown worried that the practice of medicine has tipped out of balance.

Recent advances in scientific knowledge and technology have resulted in the development of a vast array of new tests, new pharmacologic agents, and new diagnostic and therapeutic procedures. These are so accessible to us in the United States that few of us can resist using them at every opportunity. By being impatient, by mistrusting our hard-earned clinical skills and knowledge, and by giving in to the pressures and opportunities to test too much and treat too aggressively, we are bankrupting our health care system. Ironically, by practicing this way, we are perpetuating serious economic and racial disparities and have built a health care system that rates in the bottom tier among all developed countries in many categories of children's health outcomes.

Most doctors are intensely risk-averse. We don't tolerate uncertainty. Not wanting anything bad to happen, we reflexively over-test and over-treat in order to protect our patients — and ourselves. We feel judged by everyone — ourselves, our colleagues, our patients, the health care system, and the lawyers. The meaning of "first do no harm" has changed for us. We feel that "doing everything" is the best practice and the way to prevent harm, and we believe that it will shelter us from blame. We order tests and treatments because they are available to us, well before their importance has been established, their safety has been determined, and their cost-benefit ratio has been calculated.

The evaluation of a child with fever and cough is a good example. There are many possible causes, and we have a huge battery of available tests that might give us potentially relevant information. But why should we no longer trust our physical exam, our knowledge of the possible causes and their usual courses, and our clinical judgment? How much will we gain by seeing an x-ray, now, and how likely is it that the result will necessitate a change in our management? How dangerous would it be if we chose to perform certain tests later or not at all? Might our residents not learn more by thinking, waiting, and watching? Who is actually benefiting when we order a test — the patient, the laboratory, the drug company, the health plan administrators, or their investors? And who is losing health care as we spend these dollars? We need to ask these questions of ourselves and our

residents at every step of the clinical process.

I believe that we must rediscover the value of clinical judgment and relearn the importance of the personal, intellectual, scientific, and administrative thought that is central to the best practice of medicine. We need comparative-effectiveness research, as well as cost-benefit and long-term-benefit analyses, to inform us how to integrate traditional clinical skills with the use of new tests and therapies. Our time and attention have been diverted to the task of sorting out data instead of sorting out what is important to our patients, their families, and the community at large. This new style of test-avid, cover-all-possibilities practice is bankrupting our health care system and depriving many families of access to health care and a medical home. Not having a medical home can be as devastating as not having a physical home. If children have no primary care, we have no way to prevent their asthma attacks, poisonings, obesity, or suicides, and if they are unimmunized, they may spread vaccine-preventable illnesses to their young siblings and aged grandparents. Society as a whole is the loser.

We as clinicians must change our practice patterns, but first the medical community, through standard-of-practice guidelines, must give us permission (or better yet, encourage us) to practice in a less costly way, so we don't feel we are expected and incentivized to order expensive tests or treatments. Similarly, clinician-teachers must develop the confidence (or be given the imperative) to teach students, residents, and fellows how to practice in the most knowledge-based, least invasive, most frugal fashion possible and to seek input from physicians with more clinical experience when they feel the urge to order a test or initiate a treatment.

Education of the public is also critically important. We need to admit to our fellow citizens that the United States, despite its wealth, technology, and research expertise, is 21st in the world in terms of many indicators of health, and we must convince them that population-wide changes designed to improve health outcomes would be in everyone's best interest. We need to teach our patients that more medicine is not better medicine, that it is poor health care for doctors to order too many tests or too many interventions, and that costly efforts do not equal better health care. As we address their personal needs, we need to explain to our patients that we have to use new medical technology with care and wisdom. Indiscriminate health care spending is not fiscally sustainable at a national level and actually hampers the achievement of many universal health benefits.

Every participant in our health care system must focus on ways to optimize health while decreasing cost, at every step of the process. We need to change the financial incentives currently embedded in health care reimbursement systems that reward the use of tests, procedures, consultations, and high-cost therapies. And finally, the legal system needs to be more restrained about pursuing lawsuits when a difficult diagnosis is

missed or a treatment fails, to diminish the pressure on health care providers to practice expensive, defensive medicine at every turn.

These are major changes, but today we are far from providing good care for all our citizens and far from achieving health care equal to that in many other countries. We need to incorporate more realistic clinical, scientific, and financial information into practice in order to bring our health care practices, and our health care system, back into balance.

Vocabulary

tic *n.* 痉挛

toddler *n.* 初学走路的孩子

abdominal *a.* 腹部的

antibiotic *n.* 抗生素

pediatrician *n.* 儿科医师

pharmacologic *n.* 药理学的

therapeutic *a.* 治疗的

procedure *n.* 流程, 方法

perpetuate *v.* 使永存, 使不朽

tier *n.* 层, 等级

averse *a.* 厌恶的

ratio *n.* 比率

asthma *n.* 哮喘

unimmunized *a.* 未接受免疫接种的

imperative *n.* 命令, 义务

invasive *a.* 侵入的, 侵袭的; 扩散的

expertise *n.* 专门知识, 专门技术

intervention *n.* 干预, 介入

fiscally *adv.* 财政方面

sustainable *a.* 可持续的, 可承受的

optimize *v.* 完善, 优化

reimbursement *n.* 偿还, 偿付

Reading Comprehension

Directions: *There are four suggested answers to each of the following questions. Choose the best one according to the passage you have just read.*

1. The author mentions his observation of the trainees at work to illustrate that_____.
 - A. the practice of medicine has tipped out of balance
 - B. he is an experienced teacher of pediatrics
 - C. they are challenged pediatricians
 - D. they have more resources

2. The author implies that American health care system might have been better if_____.
 - A. doctors had resisted the use of medical advances
 - B. doctors had taken every opportunity to advance medicine
 - C. doctors had prescribed fewer tests and treated less aggressively
 - D. doctors had relied less on their hard-earned clinical skills and knowledge

3. What is the ultimate reason that doctors believe “doing everything” is the best practice?
 - A. They want to play safe in the practice.
 - B. They do not tolerate uncertainty.
 - C. They want to protect patients.
 - D. They are judged by everyone.

4. The author cites the evaluation of a child with fever and cough to exemplify_____.
 - A. that the condition can have many possible causes
 - B. that tests are unnecessary for such minor conditions
 - C. that clinical judgment deserves more consideration
 - D. that the residents should start with such minor conditions

5. Which of the following is NOT suggested by the author to change the current patterns of medical practice?
 - A. The medical community must permit doctors to practice in a less costly way.
 - B. The current health care reimbursement systems must be changed.
 - C. The public must be educated about what is better health care.
 - D. More efforts should be made to improve the available tests.

Passage 3

Directions: There are 10 blanks in the following passage. For each blank there are four choices marked **A**, **B**, **C**, and **D**. You should choose the ONE that best fits into the passage.

The remarkable economic growth, with a degree of openness, has helped change eye care in China 1 a dramatic pace. In the 1990s, the most common 2 of blindness was cataract. Great 3 have been made to reduce the incidence of cataract blindness in the population in the past decades. Just as light is appearing at the end of the 4 for cataract blindness, a new challenge appears. Among the chronic diseases that are major burdens to the Chinese society, a dramatic increase of diabetes mellitus and diabetes-associated eye disease is noted as the lifestyle of the population rapidly changes from a rural agricultural background to that in a 5 urban setting. Ninety-two million people are 6 to have developed diabetes, the largest diabetic population in the world in 2009. The 7 of diabetic retinopathy ranges from 16.9% to 27.3% of the diabetic population, 8 on the geographic locations and methods of screening. Although there are many global 9 to develop new approaches to manage diabetic retinopathy, sustainable management remains difficult because long-term care is needed, and the clinical recovery in diabetic retinopathy is not as dramatic as 10 is in cataract extraction.

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|-----|----------------|------------------|---------------|----------------|
| 1. | A. in | B. at | C. with | D. of |
| 2. | A. reason | B. cause | C. factor | D. disease |
| 3. | A. changes | B. experiments | C. efforts | D. discoveries |
| 4. | A. tunnel | B. channel | C. panel | D. funnel |
| 5. | A. secretary | B. stationary | C. secondary | D. sedentary |
| 6. | A. assessed | B. estimated | C. evaluated | D. calculated |
| 7. | A. persistence | B. pertinence | C. prevalence | D. preference |
| 8. | A. dependent | B. depending | C. depends | D. independent |
| 9. | A. methods | B. opportunities | C. chances | D. attempts |
| 10. | A. what | B. which | C. it | D. that |