Passage 1

“I want to take him home.”

“He is 69 years old, on an experimental treatment for metastatic colon cancer, and he has free air,” explained the emergency department physician. It was a Sunday afternoon, and I was the surgeon on call.

The CT scan had been done without intravenous contrast, and the cava was flat, from which I inferred that his renal function was poor. He had liver metastases, but there was still plenty of normal liver, and the metastases alone would not explain this much ascites. There was scattered free air, but too much ascites to be from an acute perforation, and the pleural effusions suggested a more chronic process. There was so much edema of the soft tissues that the interface between fat, muscle, and bowel had been lost. This was not a man who had been holding his own against metastatic cancer; this was a man who had been in the process of dying for some time, and then he perforated.

From the scan, I knew that his lab results would show elevated creatinine, anemia, and profound hypoalbuminemia. I knew what the tissues would look like in the operating room, and I had a pretty good idea what the ICU would look like postoperatively—the ventilator, the drips, the days or weeks ahead. As I gathered myself and headed to his room, I realized that my job would be to explain to him that we could operate, but we could not heal him.

She was a quiet, elegant woman with shoulder-length, silver hair, a gray sweater, long wool skirt, and sensible shoes. She stood closely by his side, her arms clasping a notebook to her chest. His mouth agape, his breathing was deep and rhythmic, too regular, and too fast—a sign of sepsis. I introduced myself, confirmed that she was his wife, and gently shook him awake until his eyes opened. He focused, though only for a moment.

He didn’t respond to my questions, so his wife did the talking. I took my time, asking about more than I needed to: his symptoms, the onset of pain, past treatments and the experimental protocol, his strength, weight, quality of life these past days and weeks, how many children they had and where they lived, how long they had been married, what work he was doing or did. I listened to his lungs and his heart, and I looked for a long time at his hands—the fragile skin and the stark crevasses between the carpal bones where the interosseus muscles were supposed to be. I didn’t need to touch his abdomen; it was obvious from the way that he was breathing that he had peritonitis, and I knew from the CT that he had a perforation. I gathered the information carefully and methodically, because I needed to be certain that I had not made a mistake. Just as important, I needed them to be confident that I knew who he was, that I knew what had happened, and that I knew what we should do. I needed them to trust me with what I was about to tell them.

His wife had durable power of attorney, but they had not discussed limits on his care, how far to carry things, what to do when the treatment stopped

working, or when the end was in sight.

"This is what I believe has happened," I explained.

"These are the things that can be done. We can operate, but we would have to leave him on the ventilator."

Slowly, I shifted from talking about you to talking about him, when his eyes did not open, when he showed no sign that he heard what I was saying. I was taking care of her now, as much as I was taking care of him. I was touched by her bravery.

"Under the best of circumstances, I wouldn't expect to be able to take him off the ventilator for days or weeks; I doubt that he would leave the ICU. I would not expect him to survive to leave the hospital; he is not likely ever to be well enough to get more treatment for his cancer. Do you know what he would want?"

She had not asked a single question, and her expression gave me no hint of what she was feeling. I had tried to be gentle, but I felt cruel and blunt and ashamed of myself, as I bludgeoned her with this explanation. I was a stranger to this woman. What gave me the right to say these things?

"Can I take him home?" she asked. "I want to take him home." Just like that.

It took one call to hospice. Three hours later, he was home. He had pain medication. Their children arrived. That afternoon, he died peacefully in the bed that he had shared with his wife for more than 40 years.

"I want to take him home."

I am so grateful to this man's brave wife, who knew exactly what her husband would have wanted. She didn't need me to tell her what kind of man her husband was, to discuss with her the meaning of life or the nuances of medical futility. What she needed was someone to help her see what was about to happen in the world of medicine – a world that was foreign to her but one in which I travel every day. These conversations are difficult for me. They are so much harder than explaining the rationale for an operation, the side effects, or the risks; I don't feel that I am very good at them. But every one of my patients is going to die one day. Like it or not, I should have these conversations earlier, more often, and more comfortably.

Vocabulary

metastatic *a.* 转移的
cavum *n.* 腔，洞
perforation *n.* 孔，穿孔
pleural *a.* 肋膜的；胸膜的
effusion *n.* 流出，积液
edema *n.* 浮肿，水肿
interface *n.* 界面，接口
creatinine *n.* 肌酸酐
ventilator *n.* 呼吸器

drip *n.* 输液
sepsis *n.* 败血症
crevasse *n.* 裂缝
interosseous *a.* 骨间的
peritonitis *n.* 腹膜炎
methodically *adv.* 有条不紊地
bludgeon *v.* 强迫
nuance *n.* 细微差别
futility *n.* 无用，无益

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. What was the immediate cause of the patient's fatal condition?
   A. Chronic poor renal function.
   B. Defective liver function.
   C. Acute perforation.
   D. Too much ascites.

2. The author took his time and did all that was needed to be done to_____.
   A. ascertain his diagnosis
   B. avoid a potential malpractice
   C. gather adequate information for the experiment
   D. build up the couple's confidence and trust in him

3. What do we learn about the patient's wife?
   A. She was brave.
   B. She was illogical.
   C. She was talkative.
   D. She was indifferent.

4. What can be said of the reaction of the wife?
   A. Similar reaction is expected of most people.
   B. She was ashamed of herself for her reaction.
   C. She was shocked speechless by the doctor's words.
   D. Her reaction was somewhat out of the author's expectation.

5. By writing the article, the author seemed to_____.
   A. remind people of the importance of hospice
   B. inform people of his wise decisions in practice
   C. advise people on how to face death when it is inevitable
   D. persuade people to give up treatment in case of advanced cancer

Passage 2

Listening to Braille

At 4 o'clock each morning, Laura J. Sloate begins her daily reading. She calls a phone service that reads newspapers aloud in a synthetic voice, and she listens to The Wall Street Journal at 300 words a minute, which is nearly twice the average pace of speech. Later, an assistant reads The Financial Times to her while she uses her computer's text-to-speech system to play The Economist aloud. She devotes one ear to the paper and the other to the magazine. The managing director of a Wall Street investment management firm, Sloate has been blind since age 6, and although she reads constantly, poring over the news and the economic reports for several hours every morning, she does not use Braille. "Knowledge goes from my ears to my brain, not from my finger to my brain," she says. As a child she learned how the letters of the alphabet sounded, not how they appeared or felt on the page. She doesn't think of a comma in terms of its written form but rather as "a stop on the way before continuing." This, she says, is the future of reading for the blind. "Literacy evolves," she told me. "When Braille was invented, in the 19th century, we had nothing else. We didn't even have radio. At that time, blindness was a disability. Now it's just a minor, minor impairment."

Until the 19th century, blind people were confined to an oral culture. Some tried to read letters carved in wood or wax, formed by wire or outlined in felt with pins. Dissatisfied with such makeshift methods, Louis Braille, a student at the Royal Institute for Blind Youth in Paris, began studying a cipher language of bumps, called night writing, developed by a French Army officer so soldiers could send messages in the dark. Braille modified the code so that it could be read more efficiently — each letter or punctuation symbol is represented by a pattern of one to six dots on a matrix of three rows and two columns — and added abbreviations for commonly used words like "knowledge," "people" and "Lord." Endowed with a reliable method of written communication for the first time in history, blind people had a significant rise in social status, and Louis Braille was embraced as a kind of liberator and spiritual savior. With his "godlike courage," Helen Keller wrote, Braille built a "firm stairway for millions of sense-crippled human beings to climb from hopeless darkness to the Mind Eternal."[0]

Our definition of a literate society inevitably shifts as our tools for reading and writing evolve, but the brief history of literacy for blind people makes the prospect of change particularly fraught. Since the 1820s, when Louis Braille invented his writing system — so that blind people would no longer be "despised or patronized by condescending sighted people," as he put it — there has always been, among blind people, a political and even moral dimension to learning to read. Braille is viewed by many as a mark of independence, a sign that blind people have moved away from an oral culture seen as primitive and isolating. In recent years, however, this narrative has been complicated.

Schoolchildren in developed countries, like the U.S. and Britain, are now thought to have lower Braille literacy than those in developing ones, like Indonesia and Botswana, where there are few alternatives to Braille. Tim Connell, the managing director of an assistive-technology company in Australia, told me that he has heard this described as “one of the advantages of being poor.”

While people like Laura Sloate or the governor of New York, David A. Paterson, who also reads by listening, may be able to achieve without the help of Braille, their success requires accommodations that many cannot afford. Like Sloate, Paterson dictates his memos, and his staff members select pertinent newspaper articles for him and read them aloud on his voice mail every morning. Among people with fewer resources, Braille-readers tend to form the blind elite, in part because it is more plausible for a blind person to find work doing intellectual rather than manual labor.

When deaf people began getting cochlear implants in the late 1980s, many in the deaf community felt betrayed. The new technology pushed people to think of the disability in a new way — as an identity and a culture. Technology has changed the nature of many disabilities, lifting the burdens but also complicating people’s sense of what is physically natural, because bodies can so often be tweaked until “fixed.” Arielle Silverman, a graduate student at the convention who has been blind since birth, told me that if she had the choice to have vision, she was not sure she would take it. Recently she purchased a pocket-size reading machine that takes photographs of text and then reads the words aloud, and she said she thought of vision like that, as “just another piece of technology.”

The modern history of blind people is in many ways a history of reading, with the scope of the disability — the extent to which you are viewed as ignorant or civilized, helpless or independent — determined largely by your ability to access the printed word. For 150 years, Braille books were designed to function as much as possible like print books. But now the computer has essentially done away with the limits of form, because information, once it has been digitized, can be conveyed through sound or touch. For sighted people, the transition from print to digital text has been relatively subtle, but for many blind people the shift to computerized speech is an unwelcome and uncharted experiment. In grappling with what has been lost, several federation members recited to me various takes on the classic expression *Scripta manent, verba volant*: What is written remains, what is spoken vanishes into air.

Vocabulary

synthetic *a.* 合成的
bump *n.* 隆起物
dot *n.* 小圆点
abbreviation *n.* 缩写词，略语
savior *n.* 救助者，救星

crippled *a.* 残废的
plausible *a.* 好像有道理的，似乎可信的
uncharted *a.* 未知的
grapple 抓住，格斗

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. Laura J. Sloate reads newspapers and magazines for hours every morning with the help of all the following EXCEPT _____.
   A. Braille
   B. a computer
   C. an assistant
   D. a phone service
2. About the Braille system, it can be said that _____.
   A. it is reliable but not efficient.
   B. it uses a pattern of one to six dots to represent a word
   C. Louis Braille invented a completely new code language
   D. it has improved dramatically the literacy among blind people
3. Schoolchildren in developed countries are now thought to have lower Braille literacy than those in developing ones because _____.
   A. they suffer from less discrimination from sighted people
   B. their history of literacy is comparatively shorter
   C. they have more alternatives to Braille
   D. their societies evolve faster
4. Cochlear implants are mentioned to illustrate that _____.
   A. the blind should embrace new technology
   B. similar products will be available soon for the blind
   C. new technology requires new perspective on the disability
   D. being physically natural differs little from being physically disabled
5. The author seems to remind the readers that digitalization of information _____.
   A. means uncertainty for some blind people
   B. makes Braille books harder to access
   C. makes information less lasting
   D. makes Braille books obsolete

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.

"How did that make you feel?"

"He was my best friend. It __1__ me so much."

I __2__ my right hand across the table and he grasped it tightly. Tell me about your friend, I said. Mpo was a wonderful historian, __3__ with vivid detail the memories of their childhood together, of how they had __4__ that winter when there was no money, of why they had grown apart. As we talked about the personal impact of this tragedy, I sensed that this was the first time Mpo had spoken to anyone about his grief, and I began to wonder __5__ he had opened up to me. Was it my white coat? The reassuring stethoscope around my neck? The __6__ of an exam room? Yet as he stood up, shaking my hand twice, and closed the door behind him, I knew none of those things could substitute __7__ the comfort and trust of a caring listener.

Mpo needed someone to give him a chance—just time and space—__8__ from the burden of his loss. I could not prescribe him medication __9__ order any tests, but I did not need to; for if our goal as physicians is to __10__, then perhaps six little words are the strongest medicine: **How does that make you feel?**

1.	A. impaired	B. wounded	C. damaged	D. hurt
2.	A. got	B. arrived at	C. reached	D. returned
3.	A. recalling	B. recalled	C. recalls	D. had recalled
4.	A. revived	B. surpassed	C. thrived	D. survived
5.	A. why	B. what	C. that	D. when
6.	A. pharmacy	B. privacy	C. provision	D. privilege
7.	A. as	B. for	C. with	D. to
8.	A. liberated	B. being liberated	C. to be liberated	D. to liberate
9.	A. but	B. either	C. and	D. or
10.	A. recover	B. heal	C. repair	D. rehabilitate