平成２９年度

愛媛大学医学部一般入試（前期日程）試験問題

外国語（医学科）

（14:10～16:10）

注意事項

（１）試験開始の合図があるまでは、次の頁を開いてはいけません。
（２）解答は、解答用紙の指定のところに横書きすること。
（３）受験番号は、解答用紙１枚ごとに、欄内に算用数字で横書きすること。
（４）問題冊子は、表紙を含めて８枚、解答用紙は４枚あります。

問題１．次の文章を読み、後の設問に答えなさい。なお「*」のついた単語については本文の後に語注がついているので参考にしなさい。

What makes some individuals and countries happier than others? Whether associated with increased personal wealth, social support, freedom of expression, or longer healthy life, the search for happiness varies as widely （ a ） the definition of happiness itself.

How to measure individual or national happiness, or related indices of wellbeing, is subject to debate. In the 2014 Lancet* Series on Ageing, Andrew Steptoe and colleagues distinguished between three aspects of wellbeing—life satisfaction, recent happiness or sadness, and purpose. However, happiness is already recognized （ b ） an important concept in global public policy. March 20 was declared by the UN to be International Happiness Day, Bhutan has a Gross National Happiness Index, and Bhutan, Ecuador, United Arab Emirates, and Venezuela have appointed Ministers of Happiness. ①Efforts to assess and improve wellbeing might, by using broader indicators than measures of income, poverty, health, education, and good governance viewed separately, help countries to understand and improve what really matters to people.

The fourth World Happiness Report 2016, released on March 16, aims to survey the science of measuring and understanding subjective wellbeing. Using life evaluations from Gallup World Poll annual surveys of 1000 residents （ c ） country (157 countries), people were asked to evaluate satisfaction with life (evaluative happiness) on a scale of 0 to 10 (Cantril ladder). The commonest answer was 5; worldwide, about a sixth were 0–3 (lowest) and a sixth were 8-10 (highest). Other variables—gross domestic product (GDP) per head, social support, healthy life expectancy, freedom to make life choices, generosity, and perceptions of corruption* were investigated to account for national differences in life satisfaction. Scandinavia topped the rankings, with Burundi, undergoing severe political unrest, last. In North America, Australia, and New Zealand, 6% answered at the lower end (0–3) compared with 49% (8–10) at the higher end. At the opposite extreme, in sub-Saharan Africa, 32% answered 0–3 and only 7% answered 8–10. Unsurprisingly, multiple regression* confirmed that this national average happiness score was strongly positively correlated with log GDP and healthy life expectancy. As to which factors determine average life satisfaction in countries, this is less clear. Richard Peto, University of Oxford, UK, told The Lancet that "the multiple regressions actually obscure the crudeness of the evidence". Therefore, it is difficult to draw national conclusions beyond what we might already expect based on social economic and life expectancy data. Furthermore, （ d ） a purely medical viewpoint, Bette Liu and colleagues recently reported from the prospective UK

Million Women Study that although chronic illness causes unhappiness, unhappiness itself has no direct effect on mortality* (unless it leads to damaging health behavior, such as smoking). ② After allowing for differences in health and lifestyle, the overall death rate in those who reported being unhappy was the same as the death rate in those who did not. Further research is required to make results generalizable cross culturally and to inform across age range and （ e ） sexes.

In this context, while in support of deepening global understanding of the study of happiness and health, ③The Lancet identifies two areas to focus priority attention on. First, the opportunity to reduce premature deaths globally must be taken. In 2015, Ole Norheim and colleagues showed that with continued international effort, the number of premature deaths (death in childhood or before age 70 years) could be reduced by 40% by 2030, where mortality is not dominated by new epidemics*, political disturbances, or disasters. Continuing efforts to control the targets of the Millenium Development Goals, non-communicable* diseases, and injuries, will improve healthy life expectancy, and contribute to improving individual and collective wellbeing.

The second priority is reducing inequality within and between countries in access to health care, including mental health. The World Happiness Report 2016 indicates that some regions have in recent years been experiencing progressively greater inequality of happiness. The Global Burden of Disease 2013 study reported mental and substance disorders (including tobacco and alcohol) as leading causes of the average number of years of life lost to premature death and disability. Further understanding of the association between happiness and health should contribute to progress in sustainable* development. However, indices of overall wellbeing must not obscure the need for ongoing progress in reducing disease, mental illness, and premature death. Without life, there is no （ A ） to be realized.

出典：Editorial. Health and happiness. Lancet 387; 1251, 2016より引用（一部改変）

［語注］

Lancet ランセット。世界五大医学雑誌の一つ。
corruption 贈収賄
multiple regression 重回帰分析（統計解析法の一つ）
mortality 死亡率
epidemics 感染症
non-communicable 感染性のない
sustainable 持続可能な

［設問１］（ａ）から（ｅ）に入る適当な単語を答えなさい。

［設問２］下線部①を日本語に訳しなさい。

［設問３］ブータン政府の幸福に関する特徴的政策を２つ述べなさい。

［設問４］サハラ砂漠以南のアフリカ諸国において低い幸福度を示す割合は、全体平均の何倍か。小数第１位までで答えなさい。

［設問５］下線部②を日本語に訳しなさい。

［設問６］下線部③が示す２つの注力点について、それぞれ句読点を含めて30字以内で簡潔に述べなさい。

［設問７］（　Ａ　）に入る適当な単語を、文章中から選びなさい。

問題２．次の文章を読み、後の設問に答えなさい。なお「*」のついた単語については本文の後に語注がついているので参考にしなさい。

Physicians should be in a better position than people without medical training to judge the likely value of health care services available near the end of life. Yet several studies have revealed a disconnect between the way physicians themselves wish to die and the way the patients they care for do in fact die.

A 1998 survey of participants in the Precursors Study, which enrolled* 999 physicians who graduated （ A ） Johns Hopkins University School of Medicine between 1948 and 1964, revealed that 70% had not had a conversation （ B ） their own personal physician about end-of-life care. But 64% had an advance directive that they'd discussed with their spouse or family, and more than 80% indicated that they would choose to receive pain medication* but would refuse life-sustaining medical treatments at the end of life. Similar preferences were expressed in a 2013 survey of 1147 younger academic physicians (a group that was more diverse and included more women): 88.3% indicated that they would （ ① ） high-intensity end-of-life treatment.

Although physicians ought not assume that their views about dying should apply to others, public surveys and research studies have shown that 80% of Americans, like the large majority （ C ） surveyed physicians, say they'd like to die at home and （ ② ） high-intensity care and hospitalization*. Yet their wishes are too frequently overridden* by the physicians caring for them, who undertake more medical interventions* than patients desire. Physicians also sometimes find themselves responding （ D ） the wishes and demands of patients' families who want more medical therapy than medical providers believe is indicated or beneficial. In ③ a study examining the care of more than 848,000 people who had died in 2000, 2005, or 2009 while covered by fee-for-service* medical insurance, Teno et al. noted that the rate of acute care hospitalization decreased from 32.6% in 2000 to 24.6% in 2009 but that use of intensive care in the last month of life increased from 24.3% to 29.2%. Although hospice use increased during this period, 28.4% of the decedents* studied had used hospice for 3 days or less in 2009.

Complex social, cultural, economic, geographic, and health system factors and impediments* contribute to this discordance* between how doctors treat their patients and how they themselves (and the majority of surveyed Americans) wish to be cared for at the end of life. We are experiencing the greatest demographic* shift in U.S. history. According to current projections, by 2030, 20% of Americans will be more than 65 years old. Cultural diversity is also increasing, as is the percentage of people with one or more chronic illnesses. It is therefore imperative* that the medical community listen to patients and recognize that their end-of-life preferences may change over time, especially as longevity increases. ④The goal should be to

help people receive care in keeping with their personal preferences as they near the end of life.

In *Dying in America: Improving Quality and Honoring Individual Preferences near the End of Life,* an Institute of Medicine (IOM) committee concluded that the U.S. health care system is （ ⑤ ） designed to meet the needs of patients and their families at the end of life and that major changes are needed. We need to begin by fostering patients' ability to take control of their quality of life throughout their life and to choose the care they desire near the end of life. The committee recognized that these goals could be achieved only by making major changes to the education, training, and practice of health care professionals, as well as changes in health care policy and payment systems. Simultaneously, individual and public education would have to be radically reformed to reshape expectations and allow patients and clinicians* to have meaningful discussions about end-of-life planning.

Ideally, physicians would initiate discussions about advance directives with their patients at key milestones* throughout their lives — perhaps when they get a driver's license, get married, begin a new job, relocate, or become eligible for medical insurance — not just when advanced illness or death is imminent*. Many physicians need to learn how to conduct these conversations respectfully and successfully. ⑥Physicians can then make their patients' preferences known to all members of the health care team. Physicians should be compensated for the time required to have these discussions — a change they can prod* the government and other payers to make.

Physicians' experiences with medical care and dying patients have helped crystallize* their desires for their own end-of-life experiences. As *Dying in America* makes clear, ⑦physicians should now practice what they profess, to ensure that their patients have the same options that they themselves, and a majority of Americans, would choose and that they honor patients' preferences at the end of life.

出典：Should we practice what we profess? Care near the end of life. N Engl J Med 372:595-598, 2015 より引用（一部改変）

「語注」

enroll　登録する
medication　薬物治療
hospitalization　入院
overridden 覆させられる
intervention　治療介入
fee-for-service　医療費の出来高払い
decedent 死者
impediment　身体障害
discordance 不一致
demographic 人口統計上の
imperative　絶対必要な
clinician　臨床医（医師）
milestone　（重要な）出来事
imminent　切迫した
prod 促す
crystalize　はっきりとさせる

［設問１］（ Ａ ）から（ Ｄ ）に入る適切な前置詞を答えなさい。

［設問２］文章中の（ ① ）に入る適切な動詞を次から１つ選びなさい。

a. accept
b. demand
c. undergo
d. forgo
e. endure

［設問３］文章中の（ ② ）に入る適切な動詞を次から１つ選びなさい。

a. expect
b. avoid
c. take
d. allow
e. evaluate

［設問４］下線部③の研究から、著者はここでどんなことを言いたいのか。次から１つ選びなさい。

a. 急病で入院する患者は減少してきているので救急医療の充実が望まれる。
b. 濃厚治療のできる設備の利用が増加しており、救命率が上がっている。
c. ホスピスの利用が増加し、患者が次々に入ってきて活動的になっている。
d. 終末期患者に対して濃厚な治療が多く行われるようになってきている。
e. 濃厚な治療を必要とする患者がホスピスにいる状況の是正が望まれる。

［設問５］下線部④を日本語に訳しなさい。

［設問６］文章中の（ ⑤ ）に入る適切な単語を次から１つ選びなさい。

a. only
b. poorly
c. fairly
d. well
e. easily

［設問７］下線部⑥を日本語に訳しなさい。

［設問８］下線部⑦について、具体的にどのようなことをすべきだと指摘しているのか。本文の内容を踏まえて句読点を含めて 100 字以内で述べなさい。