UNIT 6 Life and Medicine

Teaching Objectives

After learning Unit 6, Ss are expected to accomplish the following objectives:

Professional knowledge	▪ To know various models of end-of-life care and the commonalities and differences between them ▪ To learn varied opinions on end-of-life care and euthanasia
Reading	▪ To get acquainted with terms like palliative care, hospice care, comfort care, and be able to tell the similarities and differences between them ▪ To learn the story of an old woman who believed in euthanasia but whose physician found it hard to accept
Academic vocabulary and discourse	▪ To gain some knowledge about medical terminology in the aspects of building blocks and etymology ▪ To be able to recognize signpost language of giving examples ▪ To further develop awareness of formal and informal language
Viewing	To learn how to deal with unfamiliar words while watching a video clip
Speaking	To learn how to make effective arguments in academic speaking
Writing	To learn how to write a discussion / comment section in a research paper
Researching	To conduct a survey about living wills in China concerning their existence, feasibility, implementation, and possible obstacles, etc.

Teaching Activities and Resources

Part 1 Reading

Text A

Lead-in

Suggested teaching plan

1. To begin with, ask Ss to discuss some terms: palliative care, hospice care, comfort care and symptom care. Given the likelihood that Ss may have little understanding of what these terms mean, a good alternative is to play a video clip about hospice care or end-of-life care in general. If video clips are unavailable, the easiest way is to elicit discussion by asking Ss questions like, "How would a dying patient be taken care of?", "Where is the right place, at home, in hospital, or somewhere else?"
2. Check Ss' answers.

Key to the task

1.

Palliative care is an area of health care that focuses on relieving and preventing the suffering of patients. Unlike hospice care, palliative medicine is appropriate for patients in all disease stages, including those undergoing treatment for curable illnesses and those living with chronic diseases, as well as patients who are nearing the end of life. Palliative medicine utilizes a multidisciplinary approach to patient care, relying on input from physicians, pharmacists, nurses, chaplains, social workers, psychologists, and other allied health professionals in formulating a plan of care to relieve suffering in all areas of a patient's life. This multidisciplinary approach allows the palliative care team to address physical, emotional, spiritual, and social concerns that arise with the advanced illness.

2.

Hospice care is end-of-life care provided by health professionals and volunteers. They give medical, psychological, and spiritual support. The goal of the care is to help people who are dying have peace, comfort, and dignity. The caregivers try to control pain and other symptoms so a patient can remain as alert and comfortable as possible. Hospice programs also provide services to support a patient's family. Usually, a hospice patient is expected to live six months or less. Hospice care can take place at home, at a hospice center, in a hospital, or in a skilled nursing facility.

3.

Comfort care is a kind of medical care that is focused on relieving symptoms and optimizing patient comfort. Comfort care does not seek to cure or aggressively treat illness or disease. Comfort care can be given at home, in nursing facilities, or in hospitals. Hospice care is one model of comfort care.

4.

Symptom care, also called symptom management, is a narrow and precious sense of palliative care. It is provided to address symptoms, including pain, agitation, dyspnea, nausea and vomiting, etc. by the palliative care team.

Text Comprehension

Suggested teaching plan

1. Analyze the text and lead Ss to discuss, integrating **Task 2 / Critical reading and thinking / Text A** into analysis and discussion. The presentation topics should be assigned to individual Ss for preparation at least one week in advance. Ask other Ss to preview the text with the guidance of the presentation topics.
2. Integrate **Task 2 / Language building-up / Text A** when the signpost language of giving examples is covered.
3. To conclude the discussion of the text, lead Ss to do **Task 1 / Critical reading and thinking / Text A**, so that Ss will not only be able to understand individual words, sentences, and paragraphs in the text, but also see its structure clearly.

Language focus

1. **There is no “right” place to die. And, of course, where we die is not usually something we get to decide. But, if given the choice, each person and / or … (P138, Para. 2)**

   此文选自机构自己的出版物，所针对的读者对象是普通大众，所以学术性并非特别强，表现在语言使用上有些用法并非特别正式，如此处的 And 和 But 放在句首就是很好的说明。这种现象参考 Unit 1 中有关 Formality 的解释和练习。

2. **George is sixty-four and has a history of congestive heart failure. (P138, Para. 3)**

   此句中 history 为病史，在医学中很常用，如 past history 既往史、family history 家族史等。

3. **George and those closest to him had previously decided that, no matter what, the doctor should try to do everything … (P138, Para. 3)**

   no matter what 作为插入语，强调做事的决心。

4. **In order to make comfort care available at home, you will have to arrange for services (such as visiting nurses) and special equipment (like a hospital bed or bedside commode). (P139, Para. 7)**

   两个括号都是举例以提供补充性的信息，而作者分别用了 such as 和 like 不同的表述进行举例，体现了英语语言的多样性这一特点。

Supplementary information

a new model of end-of-life care

Partners for Children (PFC), a California public health program for terminally ill children on Medicaid, removed the six-month time limit for a typical Medicaid beneficiary to be eligible for both treatment and hospice care and increased home and community-based care.

Individuals up to 21 years old who had been diagnosed with life-threatening illnesses, such as cystic fibrosis, cancer and neuromuscular and cardiac disorders, were eligible to participate in the program. As part of the program, participants' families are assigned a liaison who coordinates the child's care and are given 24-hour access to a nurse familiar with the child's situation.

By reducing the volume of inpatient care, medical expenses are saved not only for the families but the local and federal governments. Meanwhile the improved quality of home- and community-based care increases satisfaction with the program overall and with each of the individual services among both families and providers.

Key to the tasks

Critical reading and thinking

Task 1

1.

	Advantages	**Disadvantages**
Hospital	Availability of medical resources, including doctors, nurses and facility around the clock	• Hospital rules • Limited space • Privacy issue
Nursing home	• Prearranged plans for end-of-life care • Closer relationship with	• Limited access to doctors • Privacy issue

	nursing staff • More personalized care	
Home	• Familiar environment • Flexible visiting for family and friends	Physical, emotional, and financial burden for family and friends

2.

	Similarities	**Differences**
Palliative care	• Treatment of symptoms • Multidisciplinary service • Provided at home, in hospitals, and in specialized care centers • Reversible choice	• Service provided as long as possible • Having hopes for a cure
Hospice care		• Service usually provided to patients who have only six months to live • No hope for a cure

Task 2

1.

In the past, most people died at home. But now, more and more people are cared in hospitals or nursing homes at the end of their lives.

2.

- Sixty-four years old with a history of congestive heart failure
- Deciding to do everything medically possible to extend his life
- Availability of around-the-clock medical services and a full range of treatment choices, tests, and other medical care
- Relaxed visiting hours, personal items from home, and more privacy, if needed

3.

Availability of medical resources, including doctors, nurses, and facility around the clock.

4.

- Taking on a big job which is physical, emotional, and financial
- Hiring a home nurse for additional help
- Arranging for services (such as visiting nurses) and special equipment (like a hospital bed or bedside commode)

5.

- Health insurance
- Planning by a professional, such as a hospital discharge planner
- Help from local governmental agencies
- Doctor’s supervision at home

6.

- Traditionally, it is only about symptom care.
- Recently, it is a comprehensive approach to improving the quality of life for people who are living with potentially fatal diseases.

7.

- Stopping treatment specifically aimed at curing an illness equals discontinuing all treatment.
- Choosing hospice is a permanent decision.

Language Building-up

Suggested teaching plan

1. Medical terminology
    1) Give a brief introduction to the medical terminology.
    2) Ask Ss to do **Task 1 / Language building-up / Text A**.
    3) Check Ss' work and provide more examples, if necessary.
2. Signpost language
    1) **Task 2 / Language building-up / Text A** could be integrated into the analysis and discussion of Text A.
    2) The task may be done quickly by locating the examples in Text A.
3. Formal English
    1) Ask Ss to do **Task 3 / Language building-up / Text A**.
    2) Check Ss' work.
    3) T should make clear that formality of language is relative.

Key to the tasks

Task 1

2.

	English	**Chinese**
1.	chemotherapy	化疗
2.	disinfection	消毒；杀菌
3.	coronary	冠状动脉的
4.	curative	治疗的；治愈的
5.	dialysis	透析

6.	anemia	贫血（症）
7.	palliative	姑息 / 缓和的
8.	Medicare	（美国）联邦医疗保险
9.	pulmonary	肺的
10.	multidisciplinary	多学科的；跨学科的

Task 2

1. In order to make comfort care available at home, you will have to arrange for services (such as visiting nurses) and special equipment (like a hospital bed or bedside commode). (Para. 7)
2. These patients also receive symptom care or palliative care. For example, in time George developed anemia along with his heart failure. Managing the anemia can improve some of the symptoms troubling George. (Para. 9)
3. It can be offered in two types of settings – at home or in a facility such as a nursing home, hospital, or even in a separate hospice center. (Para.16)
4. It is important to remember that stopping treatment specifically aimed at curing an illness does not mean discontinuing all treatment. A good example is an older person with cancer. (Para. 17)
5. If the doctor determines that the cancer is not responding to chemotherapy and the patient chooses to enter into hospice care, then the chemotherapy will stop, but other medical care may continue. For example, if the person has high blood pressure, he or she will still get medicine for that. (Para.17)
6. Choosing hospice does not have to be a permanent decision. For example, Delores was eighty-two when she learned that her kidneys were failing … (Para. 18)

Task 3

1. But you can make plans for end-of-life care early, so that when the time comes, you don’t have to ask a doctor before they can provide necessary care.
2. If the dying person has lived in the facility for a while, the staff and family have probably become as close as friends.
3. In a palliative care program, a healthcare team is made up of people from different disciplines gives both the patient and family medical, social, and emotional support so that the patient can live with a deadly disease.
4. Palliative care could be shifted to hospice care. Even if the palliative care continued, the emphasis should be gradually put on comfort care, not on medical treatment aimed at a cure.
5. If you choose hospice now, you can change it later.

Translation of the Text

寻求临终护理

美国国家衰老研究所（National Institute on Aging）

数十年前，大多数人在自己家中去世，但是医疗方面的进步已经改变了这一情况。如今，大多数美国人在医院或是疗养院中度过生命的最后时光。他们中有些人是为了治疗疾病进了医院，有些可能是选择长期住在疗养院。越来越多的人在生命的尽头开始选择临终关怀。

死亡没有一个称得上“合适”的地点。何况，我们死亡的地方，大多数情况下也并非我们可以决定的。但如果有选择的机会，每个人及其家人都应该考虑究竟怎样的临终护理最为适合，在哪里可以享受到这样的关怀，家人和朋友能否提供帮助，以及他们应该如何支付相应的费用。

医院及疗养院

64 岁的乔治有充血性心力衰竭病史。一天晚上，他因为胸痛被送入医院。他与他最亲近的人事先便已决定，在任何情况下都要让医生使用最大努力来延续他的生命。所以当他需要相应的治疗时，他选择了医院，因为那里有全天候工作的医生和护士。医院提供一整套的治疗、检查及其他医疗照护。一旦乔治的心脏出现持续衰竭，医院的重症监护病房（ICU）或冠心病重症监护病房（CCU）就可以提供及时的救护。尽管医院有相关的规定，但在有些情况下执行可以具有一定的弹性。如果乔治的医生认为他的病情并没有因为治疗有所好转，并濒临死亡，他的家人可以要求更加宽松的探视时间。如果他的家人想从家中给他带一些私人物品，可以向工作人员询问物品的尺寸限制或是否需要消毒。不论乔治住在 ICU、CCU 还是两病床的病房，其家人都可以要求更多的私人空间。

在医院环境中，对临终病人来说，身边永远会有知道该如何照料他的医务人员。这一点令病人、家人及其朋友得以安心。

已有越来越多的人在生命尽头的时候选择疗养院，因为在这里，护理人员是随叫随到的。疗养院有时也被称为专业护理所，在临终护理方面有利有弊。与医院不同，疗养院里并不是全天候都有医生在场。然而，由于临终护理可以事先安排，在病人濒临死亡时，不需要事先咨询医生而开展照护。如果临终病人已经在

疗养院住了一段时间，家人很可能已经和护理人员建立了一定的关系，因而与医院相比，这里的护理工作更具个性化。如同在医院里一样，隐私也可能是个问题。有需要的话，你可以询问是否可以安排更多与家人单独相处的时间。

家

对于需要临终护理的人来说，家可能是最熟悉的环境。家人和朋友可以来去自由。从精力、情感和经济的角度来说，居家护理对于家人和朋友可以是一件艰巨的任务，但这样做也有好处，况且他们通常愿意承担这样的任务。如果需要额外帮助，他们还可以选择雇用家庭护工。

为了在家中进行舒适护理，需要事先安排一些服务（如上门护士）和特殊设备（如病床和床边马桶）。医疗保险也许只能支付由医生指定的服务和设备。建议事先和医生商量哪些是病人在家中舒适护理所需要的。如果临终的病人是从医院回到家里，有时医院的出院计划专员，一般是社工，可以帮你做出院计划。地区老人服务办事处也可能推荐其他渠道的帮助。

医生必须掌握患者在家的护理状况，他 / 她会安排新服务、调整治疗及按需开药。为了使临终病人尽可能舒适，遵从医生的计划非常重要。如果你认为一项治疗已经不再有用，应及时与医生沟通。

姑息治疗和临终关怀

为了有望治愈病人，医生对重症患者予以尽可能长时间的治疗。这些病人还会接受症状护理或姑息治疗。例如，乔治的心脏衰竭后来还并发了贫血症。治疗贫血症可以改善一些困扰他的病症，也可以让他轻松做一些事情，比如自己穿衣服或者洗澡。治疗贫血就是姑息治疗的一部分。

近来，姑息治疗这个词语不仅仅意味着治疗一些症状，在美国，如今姑息治疗常指那些提升患有致命疾病的人的生活质量的综合办法。它为家庭成员提供支持，与临终关怀的概念非常类似。

在姑息治疗方案中，一个多学科健康护理小组与病人及其家人共同努力，为病人提供可能患有致命疾病所需要的任何支持，不管是医疗的、社会的、还是情感上的。根据需要，健康护理小组可以由医生、护士、治疗师、顾问和社工等人组成。

姑息治疗可以由医院、疗养院、姑息护理门诊、其他一些专业诊所或家庭提供。联邦医疗保险可以支付一部分治疗和药物的费用，退伍军人可以通过退伍军人事务部有资格享受姑息治疗。私人医疗保险可能会支付一部分服务费用。可以向医疗保险公司咨询相关的保险范围。

姑息治疗并不要求在绝症治疗与舒适护理之间做出抉择。如果医生认为治疗对病人不起作用，并且病人只剩 6 个月的时间，这时就有两种选择。一是将姑息治疗转换为临终关怀；二是继续姑息治疗，但侧重于舒适护理而不是针对治愈的医学治疗。

这就是杰克所面临的情形。他从美国空军退役，70 岁时被诊断患有慢性阻塞性肺病。随着疾病的发展，杰克的呼吸变得越来越困难，于是他希望尝试采用实验性治疗来缓解这种疾病。杰克获得了由美国退伍军人健康管理局所提供的姑息治疗。在治疗肺病的同时，他接受了舒适护理及战胜病魔所需要的情感支持。该姑息治疗方案也在日常家庭事务及其他方面为杰克的妻子提供支持，更便于她在家中照顾杰克。

有时，治愈性治疗可能不再有意义：它可能对患者没有任何帮助，或者反而给患者带来不适。临终关怀正是为这种情况而设置的。准备接受临终关怀的患者明白，临床治疗已经不能治愈或缓解自己的病情。在临终护理中，临终关怀类似于姑息疗法，它不仅为患者提供全方位的舒适护理，而且也为其家人提供帮助，但临终关怀并不会治愈病人。

临终关怀是一种临终护理的方式，它并不局限于特定的场所。它可以在两种环境下实施：一是在家里，一是在一些机构，如疗养院、医院，甚至是单独的临终关怀中心。临终关怀汇聚了一个拥有特殊专业技能的团队，包括护士、医生、社工、心灵顾问及经过培训的志愿者。每个团队成员都与临终患者、照料人员及家人共同努力，为他们提供所需的医疗、情感及精神上的帮助。团队中有成员会定期看望患者，并全天 24 小时保持电话联络，随时候命。

谨记一点：不进行针对疾病的治疗并不代表放弃所有治疗。以一个老年肿瘤患者为例。如果医生觉得肿瘤对化疗不敏感，病人选择临终关怀，那么化疗会即刻停止，但其余治疗还将继续。例如，如果此患者患有高血压，那他 / 她需要照常服用降压药。

临终关怀并不一定是最终决定。比如，德洛丽丝 82 岁的时候，发现她的肾功能正在衰竭。她觉得自己足够长寿，生活幸福，不愿进行透析治疗，于是她开始接受临终关怀。一周之后，她得知孙女怀孕的消息，随即改变主意，不再接受临终关怀，而是开始透析治疗，她希望有一天能够抱上自己的第一个重孙。

Text B

Text Comprehension

Suggested teaching plan

1. In the warming-up stage, T may ask Ss the question "Which should be valued more, the quality of life or the quantity of life?" to elicit discussion concerning euthanasia.
2. Lead Ss to discuss the text and summarize the beliefs, feelings, and arguments of the mother, the doctors and the author respectively with respect to euthanasia in **Task 1 / Critical reading and thinking / Text B**.
3. Divide Ss into groups of four or five, and ask them to do **Task 2 / Critical reading and thinking / Text B**.
4. Divide Ss into groups of four or five, and ask them to do **Task / Researching** after class. If T wants to check their work through presentation, T may put the presentation in Part 3 **Speaking**.

Language focus

1. **The path she chose was not untrodden — publicized widely were the relatively recent case of the 92-year-old mother of a former French Prime Minister, Mireille Jospin, and that of 77-year-old retired Columbia University scholar, Carolyn Heilbrun. (P147, Para. 5)**

   … publicized widely were the relatively recent case of the 92-year-old mother of a former French Prime Minister, Mireille Jospin, and that of 77-year-old retired Columbia University scholar, Carolyn Heilbrun. 是倒装结构，正常语序应该是：

   … the relatively recent case of the 92-year-old mother of a former French Prime Minister, Mireille Jospin, and that of 77-year-old retired Columbia University scholar, Carolyn Heilbrun were widely publicized. 因为主语太长，所以谓语部分提前，使句子平衡，符合英语的句尾重心原则。

2. **It could all have been different … (P149, Para. 17)**

   该句用了虚拟语气，这段话除了最后一句话，其他句子用的都是虚拟语气。

3. **She walked far off the beaten path, yet lessons can often be learned from outliers. (P150, Para. 23)**

   这句话和前文 The path she chose was not untrodden …（P147, Para. 5）遥相呼应，说明作者母亲做了与常人不同的选择，走了不同寻常之路。

Supplementary information

summary of opinions on euthanasia

Euthanasia, generally known as mercy killing, has been mainly debated from various perspectives, ethically, medically, economically, legally and philosophically.

Traditional values, best represented by the Hippocratic Oath, define it unethical for any physician to assist his or her patient, whether the patient is in critical illness or not, to die or quicken the process of death. However, it also seems equally unethical for the physician to ignore the patient's autonomy, or to withdraw treatments and watch the patient dying in a slow and painful way.

Opponents of euthanasia tend to believe in the progress of the medicine and the advent of new therapy that will turn incurable diseases today curable tomorrow. In addition, they have another bizarre yet plausible argument that if every critically ill patient would be allowed for euthanasia, progress in medicine would suffer, for it is usually in the heroic and aggressive treatments of critical cases that medical breakthroughs have been made. Of course, such argument is regarded by the proponents as either unrealistically optimistic or callous to individual sufferings.

When it comes to medical costs and resources, euthanasia seems to have gained an increasing number of supporters, who hold that euthanasia not only prevents the family of the critically ill patient from going bankrupt, but leads to reduced medical costs, optimized medical resources and improved efficiency of health care.

Opponents of euthanasia may conjure that once euthanasia is legalized, physicians will become murderers or accomplices if they have some conflicts of interest with the patients. The advocates would consider this concern naive and argue by citing the success of legalizing euthanasia in the Netherlands and Belgium.

Finally, the debate over euthanasia may return to the fundamental question: What is the meaning of life? For people in some cultures who believe to live is to suffer, euthanasia is definitely a taboo. Those who think it is the quality instead of quantity of life that really counts may find it not so difficult to accept euthanasia.

Key to the tasks

Critical reading and thinking

Task 1

The mother:

The quality of life outweighs the quantity of life. People are all terminal in their own ways, and staying terminally healthy is vital. Patient-centered care should prevail over the so-called "full-service primary care." She is afraid of being forced into a cycle of testing and treating, of having her living will ignored, of being hospitalized without her consent, of having "heroic" measures taken to assuage the values of strangers, of having her maxim (quality over quantity) turned on its head.

The doctors:

Prescription without full physical and lab tests is not a practice of ethical medicine.

The author:

Patients' (including her mother's) decision is understandable, though it may cause mixed feelings in their family, relatives, and friends. Doctors should listen to and respect patients' definition of health and life.

Task 2

1.

controlled hypertension

2.

1) her particular healthcare needs defined by herself
2) "full-service primary care"

3.

1) discourage her mother from doing it
2) the logic in her mother's ideas
3) past life experience and the desire to take control of her future life

4.

PAP smear

5.

1) taking her clothes off in front of someone she had only met once
2) suck up too much of the extremely valuable time that she had left

Translation of the Text

把每天都当作末日来生活

克里斯蒂娜・W. 哈特曼（Christine W. Hartmann）

我的母亲知道她什么时候会去世，她知道确切的日期，甚至知道大致的时间。

母亲很瘦却生机勃勃，仅患有可控的高血压，身体相当健康，神志也非常正常，这一点毋庸置疑。用她的话讲，“比起寿命长短，她更看重生活质量”。因此，母亲 50 岁的时候，提前 20 年就选择将在 70 岁时了却此生。

在她的计划中，有一点很关键，直到生命的最后一刻，她都要活出自己想要的精彩。但 60 岁以后，她却遇到问题，一个医生看不了几次她就不再去看了。

这与她要结束自己生命的计划毫无关系，因为不管计划对错，她自己在医生面前都一直坚守这些想法。母亲频繁换医生是因为她实际上不想再接受“全面初级保健服务”，她想要“以患者为中心”的保健服务，这种服务要考虑她的具体医疗需求，满足她所界定和描述的那些需求。

母亲所选的这条路并不是没人走过。最近，92 岁的法国前总统的母亲米雷耶・若斯潘的例子广为人知，77 岁的哥伦比亚大学退休学者卡罗琳・海尔布伦的故事也为人熟知。我妈妈的死法和这些女性的死法一样：亲手而为。她这么做只是因为不想受尽各种折磨却迟迟无法死去。尽管母亲的决定并非独一无二的，可我明白母亲的想法和行为非常极端。不过，母亲一生见过很多卒中后的亲朋好友，他们只能坐在轮椅或住在养老院里，大小便失禁，需要人照顾并且精神错乱。她并不想自己最后落得无法行动，或者不能自己做主。她只是觉得，能够享受人生到 70 岁已经够长了，但 70 岁还没有老到需要面临慢慢死去的高风险。

我很爱母亲，看到她按部就班一步步实施她的计划我非常痛苦。我试着劝过她不要这样，但真正了解母亲的人都知道她一旦为像这种生死攸关的事下定决心就不可能听得进别人劝说。我很害怕她的计划，因为很多年前我就不用猜母亲 70 岁以后可能不在了，我知道她确实不在了。对此我也很生气，因为我失去母亲的原因不是命运，而是母亲自私的决定。

可是抛开这些情绪，我还是可以看到她的想法里的逻辑。一想到未来难卜，可能充满她不愿意承受的痛苦，她就感到恐惧。一想到将来可能没有人会听她的，她就感到恐惧。身不由己让她感到恐惧。所以她出手控制。

即便我并不完全赞同母亲的想法，不过当她去看医生，为高血压拿药时，我还会陪同。穿着白大褂的陌生医生一开始总是对母亲很热情，握着母亲的手对她说：“你六十多岁了，但看上去还非常健康。”

“我身体不错，就是有点高血压。”母亲会笑着回答。为了避免医生谈论她的总体健康状况，她想尽量把话题聚焦在她所需要的高血压药上。她会接着说：“我有这个药方，药方上写着我正在吃的药，您的助手已经给我量过血压，一切正常，我只是需要再开些这些药。”

医生快速翻翻母亲那几张少得可怜的病例，回答说，“嗯，你说得对，这些药物似乎对你管用。你说你没有副作用吗？”

“没有副作用，我觉得很好。所以您能不能把上次的处方再开一次？我不想占据您太多宝贵的时间。”

“嗯，不错，你的血压控制让我满意。但是，……你上次乳房 X 线检查是什么时候做的？”医生会满脸疑惑地问她，“做过结肠镜检查吗？你填写的内容中没有提到。你说你对过去做的检查从来没做过记录？一个也没有吗？还是你从来没做过检查？”

瘦小的母亲就会摇摇头，齐耳的金色染发在脸颊上晃来晃去，“我真的不太信这些检查，”母亲叹口气继续说，“我就是不想中风，所以要帮我您只需要……”

“嗯，如果你从没做过乳房 X 线检查或结肠镜检查，我们可以立刻给你安排。做个子宫颈涂片检查怎么样？我现在就可以给你做。要不了多长时间，你只需穿上这件衣服，我马上就回来……”

这预示着又一段医患情谊开始走向终结。母亲绝不会接受子宫颈涂片检查，她觉得她这样的年纪在只见过一次的陌生人面前脱光衣服很不舒服。母亲装作非常认真查看医生开的检查单，她会保证一定会预约做检查，心里却一本账，知道一回到家就会把这些检查单扔到厨房的垃圾桶里。母亲一直很固执，而且年龄越大，越发固执。这些检查可能会让医生和其他病人安心，而母亲根本不愿做，在她看来，这可能浪费太多她所剩不多的异常珍贵的时间。

当然，每个医生都不一样，因此母亲和每个医生的关系也都不一样。一些医生给她看病的时间比其他医生要长。一些会问她更多的问题，问她为什么不想做检查。可每次母亲的拒不配合最后都成为绊脚石，使得医生不能对她进行惯常医

护。因为医生对此束手无策，也找不到其他的出路，这种僵持越来越严重，直到最后陷入僵局。

事情可能有完全不同的结果。我的一个医生同事支着儿说，如果是他的话他会这样解决这个问题：先征得母亲的同意，在母亲每次就医的时候重申预防性检查的风险和好处，这样他既可以表达自己的担心，同时也尊重了母亲的选择。我觉得这个方法可能对母亲有用。太让母亲害怕的是被迫接受一轮又一轮的检查与治疗，害怕别人完全无视她的生前预嘱，害怕未经同意就强迫她住院，害怕医院采取“逞能”的措施来满足陌生人的价值观，害怕她的信条被彻底颠覆：寿命长短比生活质量更重要。

母亲和医生最后的对话具体内容都不一样，但大概意思是这样的。医生会问：“你从来没做过这些检查？除了给你量量血压，你没打算让我给你做其他的检查？那好吧，这样的话恐怕这事情确实有点棘手。”

母亲会反驳医生：“我就是来开点高血压药的。”

医生会恳求母亲：“但是你可能还有许多其他疾病。如果你想让我做你的基础保健医生的话，我就必须给你做全身检查，否则我的做法就有悖医德。给你做个全身体检也不行吗？”

“我不用检查那些会让我丧命的疾病。”母亲会一边向医生解释，一边站起来向门口走去，“我们都要如愿而终，我只是想无疾而终。”

对母亲来说，健康意味着每天步行四英里，睡觉不做噩梦，从不犯头疼。健康也意味着血压控制良好。她不知道体内各器官是否运作良好，对此她并不害怕，她害怕的是医生对她如何处理（或干脆不理）这些未知置若罔闻。

许多病人都渴望医生能听取他们的意见，尽管他们的原因与母亲的不一样。母亲的行事太异于常人，但我们往往可以从这种人身上学到些东西。尽管母亲不想知道她体内有没有潜在的结节、阻塞或肿瘤，她却十分想与医生建立良好的关系。就像一天下午，母亲最后一次找某位医生看病之后，在电话里对我说，“亲爱的，我知道他们觉得我是个怪人，可是对身体健康我有我自己的定义。我花了很久才确定了健康的含义，我明白其中的道理。他们为什么就不能接受呢？”

“我也不知道，妈妈。”我静静地吐了口气。“你想要的东西不能被塑造成与预制的盒子相吻合的样子。也许你要求的太多了。”

但是，为了她好，我希望她的要求并非太多。

Part 2 Viewing

Suggested teaching plan

1. Discuss experiences of running into unfamiliar words while watching video clips. Suggest ways to cope with them in the future. For the purposes of both illustrating the topic and warming Ss up for **Task 1 / Viewing**, some statements or short conversations with one or two difficult words in each of them can be played and then T can ask Ss to use the newly-learned approaches for a better understanding of the words.
2. Ask Ss to do **Task 1 / Viewing** and compare their work with a partner.
3. Play the video clip again and ask Ss to do **Task 2 / Viewing**.
4. Check Ss' work.
5. Get feedback on coping with unfamiliar words from Ss and suggest methods for further training.

Key to the tasks

Task 1

1.	announce, tell 公布；告知
2.	sum up, summarize 概述
3.	incurable 患绝症的
4.	an acceptable balance 权衡
5.	a wrong idea 错误概念
6.	a sudden understanding 顿悟

Task 2

1) What are their fears about what is to come?
2) What are their goals? What would they like to do as time runs short?
3) The conversation is about hard choices.
4) It's a conversation about asking people about what they want to look forward to as time runs short and what they fear the most.
5) What we want at the end is a kind of epiphany.

Script

These are hard conversations. I've blown them many times myself. I've not known what to do. And with this study coming out from the Mass. General where the patients had seen a palliative care physician, I realized what, that, that the gain they'd gotten was that really they'd seen six people who knew how to, that, that's the staff at Mass. General for palliative care, that they'd seen one of these six people who knew how to talk to them about the end of life.

So what I did was, I went to those doctors and just said, "I'm really bad at this. If you had to make a little list for me of what it is that I should talk about with people facing these problems, what would you put on that list?" One of the doctors that I spoke to was a palliative care physician at the Dana-Farber Cancer Institute named Susan Bloch, and Susan encapsulated that (what) I thought the best for me, at least in a way that I could use. She said that there were four things that she has as a little mental list in her head that she wants to talk about with the patient who's terminally ill.

Number one: Do they know their prognosis? Number two: What are their fears about what is to come? Number three: What are their goals? What would they like to do as time runs short? And fourth: What are the trade-offs they're willing to make? How much suffering are they willing to go through for the sake of the possibility of added time?

That list was really interesting to me. It was not a list asking: Do you want a ventilator? Do you not want a ventilator as you come to the end? Do you want your heart shocked? Do you not want your heart shocked? Her point was: If you tell me the answers to those questions, I can make a recommendation to you that says you would not want this toward the end, if these are your goals.

Our misconception is that the conversation is about hard choices. Really it's a conversation about asking people about what they want to look forward to as time runs short and what they fear the most. The second misconception is that, it say (says) that, that arriving at what we want at the end is a kind of epiphany. "Sign here." "Do you want hospice?" "Do you not want hospice?" It's not an epiphany. It's a process. It's a series of conversations, and ups and downs as we go through a very hard, uh, series of, uh, er, sequence of things that happen to you as you become ill and, and have things come to an end.

Part 3 Speaking

Suggested teaching plan

1. Present the knowledge of making an argument by explaining the pragmatic function, definition, components, and frequently used expressions.

2. Ask Ss to practice making arguments by discussing the three topics listed in **Task / Speaking**.

3. Ask Ss to do **Task / Speaking** to practice their speaking skill.
4. If time allows, T may integrate **Researching / Text B** into this part by asking Ss to do group presentations.
5. Ask one group to deliver their presentation based on their research work.

Part 4 Writing

Suggested teaching plan

1. Explain the importance, difficulties, features, components of a discussion / comment section. Special attention should be paid to make Ss be able to tell the differences between the sections of discussion, results, and summary.
2. Ask Ss to study the Sample. Make Ss familiarize themselves with the steps of the discussion / comment section.
3. Ask Ss to find extra discussion / comment paragraphs from journal articles, analyze these paragraphs and bring the printed discussion / comment paragraphs with their marks or comments in the margin to the classroom next time.

Key to the task

1. No
2. Yes (Para. 1)
3. Yes (Para. 2-4)
4. Yes (Para. 2-4)
5. Yes (Conclusions)
6. Yes (Para. 5)

Vocabulary Test

Key to the tasks

Task 1

1. flexible
2. administration
3. range
4. facilities
5. Volunteers
6. specifically

7. issue
8. Adjusting
9. respond
10. emphasis
11. transitioned
12. terminal

Task 2

1. nursing
2. hospice
3. failure
4. around the clock
5. coronary
6. respond
7. facility
8. end-of-life
9. comfort
10. discharge
11. care
12. palliative
13. fatal
14. pulmonary
15. experimental
16. advisor
17. discontinue
18. dialysis
19. smear
20. provider
21. care-as-usual
22. preventive
23. beaten
24. mold
25. renew / refill