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And What Did the Dr. Say? Readings, Exercises, and Activities for the Foreign Physician

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AND WHAT DID THE DOCTOR SAY?

Readings, Exercises, and Activities

for the Foreign Physician

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INTRODUCTION

My interest in preparing this textbook arose over a year ago, when I was involved in preparing and teaching a three week, intensive English as a Second Language (ESL) course to a group of eighteen Brazilian medical students who came to The School for International Training in Brattleboro, Vermont. Their program combined English language training with an additional three week homestay with American physicians and a period of observation in hospitals in Chicago, Illinois and Winston-Salem, North Carolina. They believed that they needed to improve their English in order to deal with their English-speaking patients and to read English textbooks and journals which were not available in Portuguese translations. During the fifteen days of language training, the students were exposed to the four language skills of speaking, listening, reading, and writing; with the exception of reading, the lessons were geared toward medically related conversations, vocabulary, and writing requirements. Their reading passages, however, were drawn from general texts on intermediate and advanced levels.

In evaluating the language training portion of the course, I regretted that I had been unable to find a reader related to the medical field and, in particular, a

reader which would present the foreign student with areas of medicine which are topical and of concern to the layman. Such a reader would have given us the opportunity to highlight the areas of medicine with which the American public is most concerned; this insight into American culture would have added an interesting dimension to the program.

This reader, And What Did the Doctor Say?, is intended to help fill that gap in ESL literature. It is a collection of fourteen readings related to the medical field, most of which have been adapted from articles previously published in popular magazines and newspapers. The readings are grouped by subject, not by length or difficulty. Each reading is accompanied by reading comprehension questions, vocabulary exercises, and a selection of suggested activities. Additional related readings have been indicated for many of the selections. A glossary of difficult words drawn from each reading is in the back of the book, and it corresponds with the underlined words in each reading selection.

The readings are aimed toward the high intermediate or upper level foreign student of English who needs more practice in dealing with material written in the contemporary English idiom. The sentence structures have been simplified from the original, although many of them still represent compound and compound-complex structures.

The vocabulary exercises are divided into two sections:

morphological charts and writing practices. The words have been drawn exclusively from the readings. Both exercises give the student the opportunity to expand his vocabulary and to create his own sentences by using actively the words which he previously read.

The suggested activities are designed to give the teacher and students additional opportunities to explore in conversation or in writing the general area which was introduced by the reading. Where multiple activities are suggested, it is by no means necessary to do all of them; they simply represent a variety of possibilities for additional classroom work.

I wish to thank Thomas Todd, Michael Jerald, and Raymond Clark of The School for International Training and John T. Riordan of Houghton Mifflin Company for their guidance and constructive criticisms. I want to extend very special thanks to my former student, Alex Pirela, for his encouragement and his assistance in preparing the glossary.

Karen Kale

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Brattleboro, Vermont

FOREIGN PHYSICIANS' ENGLISH IS DOCTORED

The words such as "thrombosis" and "biopsy" are not mysterious to the foreign-born physicians practicing in the United States. But "tummy ache" and "charley horse" are.

Many such physicians are discovering that the common English language can be an embarrassing or even dangerous barrier between them and their patients. So, to improve communication, Coney Island Hospital, whose staff is 90 per cent foreign, has begun tutoring its interns and residents in phonetics and slang.

"It wasn't until six months ago that I learned what a shrink was," said Dr. Jacques A. Durosier. Dr. Durosier is from Haiti, and he has been associated with the hospital for five years. He is one of the physicians participating in the hospital's experimental program. "But the main problem in talking with patients is still my pronunciation." The program is trying to help him and the other physicians with pronunciation, too.

Since last month, Dr. Durosier has had once-a-week individual speech sessions with his instructor, Dvorah Gellman. She is a graduate student in speech pathology at Brooklyn College. Miss Gellman receives academic credit for the hours she works with the doctors in the program.

During the lessons, they study the difference between "feet and fit" and "beat and bit." The pronunciation differences are small but difficult and important for the foreign doctors.

"Feet...feet..." Dr. Durosier slowly repeated as he watched his lips in a mirror.

"You can feel the tension in your mouth when you do it, can't you?" asked Miss Gellman.

"Yes, but it's hard," Dr. Durosier replied.

The program is an experiment, limited to twelve physicians and two graduate students. If it is successful, it will be expanded to include more of the hospital's doctors. Abraham H. Lass, the retired principal of Abraham Lincoln High School in Brooklyn, directs the program. He is assisted by Dr. David Mumford, the hospital's director of medical education, and Dr. Cornelis W. Koutstaal, director of the Speech and Hearing Center of Brooklyn College.

Thousands of foreign-born doctors are now practicing medicine in the New York metropolitan area. This number represents more than 50 per cent of all the interns and residents in many of the city's municipal hospitals. Many hospitals give staff positions to these foreign physicians because of the shortage of American-trained doctors. The foreign physicians come to the United States to receive medical training which does not exist or is

difficult to obtain in their own countries. Neither the American Medical Association nor the city's Health and Hospitals Corporation sponsors formal programs in remedial English for New York's foreign doctors. But some hospitals, such as Beth-Israel and New York, have recently started informal programs. These programs are conducted by volunteers from women's auxiliary groups. In addition, the International Center tutors some 100 doctors in English. The Center is a private, non-profit organization which serves foreigners temporarily living in New York.

The Center distributes a 19-page booklet, "Glossary of American Idioms for Foreign Medical Personnel," that seems to have become almost as important to the foreign doctors as their stethoscopes. The booklet is published by General Telephone and Electronics Corporation. It translates slang words for parts of the body into formal English, words such as "belly button," "shoulder blade," "tushy," "out like a light," and "feeling crummy." But even with help, communication can be hard.

"You always know what, when, and how to do something," said Dr. Marcos Camargo, a Brazilian who is in the language program. "But you don't always know how to say it."

If English also is a foreign language for the patient as well as the doctor, the problem is worse.

"You think he knew what you are saying," said Dr. Durosier. "But then all of a sudden your patient gives you a dirty look and you know something's got to be wrong somewhere."

"If I said 'saw float,' you won't know what that is," said Dr. Yuen Yau Ho, of Hong Kong and a resident at Coney Island Hospital.[1] "Now if I point here," ---he said with his finger on his throat--- "And ask you if you have a saw float, then you would know what I mean. But that takes too long. I've got a responsibility to improve my English."

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[1]All quotations are exactly as they appeared in the original articles. This quotation should be corrected to read: "If I said 'saw float,' you wouldn't know what that is....."

adapted from The New York Times, Friday, April 18, 1975.

COMPREHENSION

1. What percentage of the interns and residents in New York City hospitals are foreign-born?

2. Why do foreign physicians come to the United States to practice medicine?

3. What aspect of language production probably causes the most confusion between patients and doctors?

4. Why does Dr. Yuen Yau Ho say he is studying English?

VOCABULARY

Complete the following table:

Adjective	Noun	Adverb	Verb
1. experimental			
2.			remediate
3.	representation		
4.		XXX	distribute
5. limited			
6.			embarrass
7.	mystery		
8.	tension		
9.		XXX	translate
10.	responsibility		XXX

Writing Practice: Use each group of words in a sentence.

1. municipal, interns, tutor
2. pronunciation, barrier, patients
3. auxiliary, foreigners, idioms
4. remedial, communications, informal

SUGGESTED ACTIVITIES

1. Beginning with the slang words from the reading---tummy ache, charley horse, tushy, etc.---make a list of the slang words and expressions related to medicine which the students have personally heard from patients or colleagues. Have the class combine lists, develop definitions, and create its own idiom glossary.

2. Using a human skeleton and an anatomy chart, label the bones, organs, and body areas with the proper medical word or phrase and with the slang or common English words for each. Make the list for each part as complete as possible. For example: scapula---shoulder blade; axilla---armpit. Take index cards and place the technical word on one side and its common synonym on the opposite side; do this for the complete list.

When the project is complete, the students will have a set of flashcards which can be used for quick vocabulary review.

GETTING THE FACTS

Taking a medical history for the patient's permanent file is one of the most important functions of the physician. Not only does this history provide the doctor with the background information necessary to begin the diagnostic process, but also it forms a base upon which continuing medical care can be built. It is a collection of facts which can be used by a variety of physicians and nurses assigned to the case. For this reason, the doctor who takes the initial history is responsible for eliciting and recording medical information accurately and clearly.

In private practice, a physician may use any organizational method he chooses because he and his associates in the office will probably be the only professionals using the history. Some doctors simply add sheets of paper to the files each time they treat the patients. Each paper is dated, and after the first complete history, this paper will show only the complaint or reason for consulting the physician, the results of the examination, the temporary diagnosis, and the treatment prescribed.

Large group practices and hospitals, however, may use pre-printed history forms. These forms are produced

by companies which specialize in creating standardized materials. Group practices and hospitals often purchase these materials to make their files and records uniform. Sufficient space is left on these forms for the physician to make notes on the specific points in question.

Regardless of the format, though, the medical history becomes an important and lasting part of the patient's information file. Therefore, accuracy, completeness, and clarity are essential to writing a good medical history.

Article written by author.

COMPREHENSION

1. Why is a complete and accurate medical history an important part of patient care?

2. Who is responsible for taking a complete and accurate medical history?

3. Explain the record-keeping procedure which many private practices use.

4. Why do group practices and hospitals purchase standardized forms for medical records?

VOCABULARY

Complete the following table:

Adjective	Noun	Adverb	Verb
1.	collection		
2.		XXX	choose
3.	complaint		
4.	profession		XXX
5.	clarity		
6. accurate			XXX
7.			diagnose
8. prescribed		XXX	
9.		XXX	consult
10.			create

Writing Practice: Use each group of words in a sentence.

1. elicit, history, inaccurate
2. file, format, paper
3. standardized, practices, provide
4. forms, physician, diagnosis

SUGGESTED ACTIVITIES

1. As a group, develop what would be considered a useful, complete, and well-organized medical history form. Duplicate the form for future class use.

2. Using the form created by the class, pair-off in class and practice taking medical histories.

3. For practice in dealing with a variety of native speakers, select someone outside of class and take his medical history.

MEDICAL SCHOOL PLIGHT

Lack of Funds and Rise in Applicants Forcing Americans to Study Abroad

Why are thousands of well-qualified, highly motivated American students unable to get into medical school? Why must many of these Americans go to Mexico, Italy, Spain, and other foreign countries to become doctors? The answers are complex and cause as many problems for the medical schools as they do for the rejected students.

There is great competition for the places in medical schools. Some schools receive 9,000 applications for 150 places. However, there has been a great increase in the number of openings in the last fifteen years. Since 1960, 27 medical schools have opened in the United States. Federal money has enabled other medical schools to expand their classes. At least eight new medical schools are being planned. As a result, the number of places for new medical students will have doubled to 14,700 by 1986.

Still, there are not enough places to seat all pre-medical students who are qualified for admission. There are serious problems which limit further growth of medical school enrollments. Perhaps the most important is economics.

Educators estimate that it would cost up to

$15-billion---which is not available---to build enough new medical schools for the qualified students who have been rejected from American schools. Private citizens have traditionally given the money for schools, but they do not have the resources now. Most of the existing 114 medical schools are state-supported. Forty-nine are private schools which receive a great deal of tax money. Of the 27 newest schools, just five are privately financed. Four out of five receive substantial state support.

Another problem is the time needed to start a medical school. It takes ten years to plan and construct a medical school and to organize the teaching staff of 350 doctors and scientists. Then the school must join hospitals to provide patients for the young doctors.

Accurate planning for medical school needs is difficult. It is also a problem to know whether expansion is desirable, even if it were possible. The United States relies more and more on foreign doctors for medical services. Nearly half the doctors receiving new licenses in the United States are foreigners, mainly from Asia. Thus, it is ironic that thousands of American students must go abroad to get M.D. degrees.

There are problems involved with the many Americans at foreign medical schools. The question is who is at fault: the American students or the foreign schools.

American graduates of the medical school in Guadalajara, Mexico, have not had good examination records. Only 65 of 1,066, or 6 per cent, of Guadalajara graduates passed the examinations needed to practice medicine in the United States. By contrast, 188 of 245, or 77 per cent, of the graduates of Dutch medical schools passed the same examinations.

There are many questions without answers about the medical school problem and the selection of the best students for medical schools. It is difficult to judge the winners in the competition for places.

adapted from an article by Lawrence K. Altman in The New York Times, Tuesday, March 4, 1975, p. 31.

COMPREHENSION

1. Why is competition one of the major reasons that so many U.S. medical students go to school in foreign countries?

2. How many medical schools are there in the United States?

3. Why are so few medical schools privately operated?

4. Approximately what percentage of newly licensed doctors in the United States are foreigners?

5. What solution does this article offer for the problem of getting a medical education in the United States?

VOCABULARY

Complete the following table:

Adjective	Noun	Adverb	Verb
1. ironic			XXX
2.		XXX	estimate
3. motivated		XXX	
4.	rejection		
5.	competition		
6.		expansively	
7.			finance
8.	admission		

9.	XXX	limit
10.		judge

Writing Practice: Use each group of words in a sentence.

1. resources, provide, expansion
2. support, complex, enrollment
3. select, plight, applications
4. relies, competition, openings

SUGGESTED ACTIVITIES

1. Arrange a trip to a nearby medical school. In addition to a tour of the facility, ask to spend some time with the dean to discuss, among other things:

   -admissions policies and statistics, e.g. number of applicants for the number of seats; qualities looked for in applicant;

   -admissions policy on acceptance of foreign students, especially in reference to admitting a foreign student instead of an equally qualified U.S. candidate.

If the school is associated with a hospital, gather information on:

   -number of foreign physicians on staff;

   -number of foreign physicians who intend to remain in the United States as practicing physicians;

-number of physicians on the staff who received their medical education in a foreign medical school.

2. Discuss the medical school situation in each of the students' home countries, particularly in regard to the features of this article: competition for places, number of U.S. medical students enrolled, cost of getting an education, quality of facilities and general reputation of the schools, etc.

3. In either a group discussion or in individual papers, discuss each student's reason for coming or wanting to come in the future to the U.S. for initial medical education, for advanced medical training, or for permanent residence as a practicing physician. Consider not only the advantages or positive aspects, but also the disadvantages or negative aspects of studying or working in medicine in the United States.

BEDSIDE MANNER

Although hospitals in the United States are crowded, they are not necessarily filled with critically ill patients. In many cases, the patients are admitted for tests and observation, procedures which cannot be conducted satisfactorily in the doctors' offices. For some of these patients, the hospital admission is a new experience, and if the patient is in fairly good health and aware of the work to be done on him, he may become considerably more apprehensive than the patient who is admitted in a more critical and less alert state. Although open and friendly professional contacts are essential for the well-being of all patients, the initial meeting between the alert patient and the resident physician is crucial for the development of a warm and cooperative relationship which must be sustained throughout the hospitalization.

Many patients place a great deal of importance on what is called the physician's "bedside manner." Bedside manner or the bearing, attitude, and personality of the attending physician has little or no correlation with his professional ability or skills; yet, it may make the difference between patient-doctor cooperation, confidence, and ease of treatment and patient anxiety

and uncooperativeness. Informal greetings and genuine interest in the patient's activities are useful ways for the physician to develop rapport between himself and the patient. Even the busiest physician will find these casual exchanges significant to the total care of his patient.

Article written by author.

COMPREHENSION

1. Why might the patient hospitalized for tests be more nervous than the critically ill, emergency case?

2. What is "bedside manner"?

3. How can a physician develop a good bedside manner or rapport toward his patients?

VOCABULARY

Complete the following table:

	Adjective	Noun	Adverb	Verb
1.				apprehend
2.		anxiety		XXX
3.	cooperative			
4.	critical			
5.			satisfactorily	
6.			necessarily	
7.				confide
8.	crucial			XXX
9.		hospitalization	XXX	
10.		ability		XXX

Writing Practice: Use each group of words in a sentence.

1. bearing, useful, relationship

2. procedures, apprehensive, aware

3. skills, rapport, important

4. casual, alert, contacts

SUGGESTED ACTIVITIES

1. Pair-off for a role-playing exercise, with one student portraying the physician and the other, the patient. In free conversation, demonstrate positive examples of bedside manner.

2. For contrast, select several role players to show the negative results of poor bedside manner during the first physician-patient meeting. The "patient" role-players should attempt to present the "physician" with many of the personalities and ways of behavior which a doctor encounters in the hospital.

ADDITIONAL RELATED READING

"The Education of Nancy Sokol" by Joyce Maynard. The New York Times Magazine, May 23, 1976.

TWO LIVES, ONE FACT: TERMINAL CANCER

Lois Jaffe has a good marriage and four children of whom she is very proud. She has a nice house and a job as associate professor at the University of Pittsburgh. She is 47 years old. Two years ago she was told that she had acute leukemia and less than a year and a half to live.

Joel Litsky is a 27-year-old Brooklyn school teacher. In December he began having difficulty in walking. The bones in his arms and legs began to hurt. He went to the hospital in January. He was given a number of tests. One day while doing a spinal tap, the doctor said, "You've got leukemia."

"You mean I might be dead within a year or two?" asked Mr. Litsky in horror.

"That's right," the doctor said and walked out of the room.

Recently in separate interviews, Mrs. Jaffe and Mr. Litsky talked about their experiences as terminal cancer patients. Mrs. Jaffe and her husband, Arthur, were special guests at a two-day symposium on "The Family and Death." The symposium was at the Columbia-Presbyterian Medical Center. Mr. Litsky addressed a group of 150 nurses at the Jewish Hospital and Medical Center of

Brooklyn. The subject of the symposium was the "Psychological Aspects of the Hospitalized Patient." These symposiums show that the medical profession is more and more concerned about terminal patients. Doctors want to know how to tell patients that they are dying and how to work with them during their terminal illnesses.

Mrs. Jaffe and Mr. Litsky are now in a period of remission. Doctors cannot know when they may have a relapse. Some patients with acute leukemia have lived seven years in remission. Mrs. Jaffe and Mr. Litsky are both having chemotherapy. With chemotherapy, drugs kill the abnormal cells in the bone marrow that cause leukemia. The drugs do not know the difference between various cells; therefore, they also kill off good cells, which are the ones that give immunity against diseases. This means that Mrs. Jaffe and Mr. Litsky are always in danger of infection.

Mrs. Jaffe first knew that there was something wrong with her two years ago. Black and blue marks appeared all over her body and she began feeling dizzy and very tired. Her doctor gave her a blood test and then immediately sent her to the hospital. The illness was diagnosed as acute leukemia the next day.

"My first thought was for my children and then there was a terrible sense of 'What can I do?', a sense of being out of control," she said. "At every other time

in my life when I faced a crisis, there was always something I could do about it.

"I called Art and told him, and he drove in. In the meantime, a friend who is a psychologist happened to visit and I told him and then I started crying and he let me sob. He didn't try to give me false assurances. He helped me get through that terrible sense of grief and panic."

Mr. Jaffe, who is a businessman, arrived at the hospital in about an hour. They held each other and cried. Then Mr. Jaffe said to his wife, "What would you like to do with the time you have left?"

"I think that is the most important question I've been asked in the last two years," Mrs. Jaffe said. "I realized immediately that I wanted to go back to doing what I had been doing. It gave me a hope and focus for getting into remission."

Since that time, Mrs. Jaffe, who is an associate professor at the University of Pittsburgh Graduate School of Social Work, has taught two 15-week seminars on "Methods of Intervention with the Dying." She has had one relapse, but is now in remission again. Her interest in her message about death helps her work long hours.

"Being able to talk about my fears and feelings has freed me and has given me great energy," said Mrs. Jaffe. "The worst thing is not being able to talk about it,

that's the feeling of isolation. But there are some people I want to scream at. I can accept that I am terminal and facing death. I want to say to them, 'Stop giving me your sweet words. I get so angry at the nice phrases about death with dignity. Death is ugly, bald, and miserable.'"

When Mr. Litsky was told that he had leukemia, he immediately began to get angry.

"I'm not ready to die," he said. "I'm being cheated."

All he could think of at first was the pain. But as he began to feel better, he became angrier. At one point, he began having very violent dreams. In his dreams, he performed the violence.

Mr. Litsky lives at home with his parents, and he is able to discuss this with them. He also discusses this with Herbert A. Nieburg, a staff psychologist at Jewish Hospital. Mr. Nieburg said that the dreams were a symptom of Mr. Litsky's anger.

Mr. Litsky has gone into remission. His anger has been replaced with a desire to overcome the disease and not to die.

"I'm confident that I'll beat it," he said. I plan on a full life, and I'm not prepared to die. I plan to live another 50 years."

adapted from an article by Deirdre Carmody, The New York Times, Saturday, April 12, 1975, p. 29.

COMPREHENSION

1. What is Mrs. Jaffe's and Mr. Litsky's problem?

2. Why were Mrs. Jaffe and Mr. Litsky chosen to give speeches?

3. How did Mrs. Jaffe feel at first about herself and her life when she learned that she had leukemia?

4. Why does Mrs. Jaffe feel that her friend, the psychologist, gave her such good help?

5. Why was Mr. Jaffe's question to his wife so important to her and her struggle against cancer?

6. What does Mrs. Jaffe do when she is not attending symposiums?

7. How did Mr. Litsky release his hostile feelings toward death?

8. How do Mrs. Jaffe and Mr. Litsky feel about death?

VOCABULARY

Complete the following table:

	Adjective	Noun	Adverb	Verb
1.			separately	

2.			die
3. immune		XXX	
4.	assurance		
5.		XXX	associate
6.	intervention	XXX	
7.		freely	
8.	isolation	XXX	
9.	symptom		XXX
10.			desire

Writing Practice: Use each group of words in a sentence.

1. symposium, address, relapse
2. grief, remission, accept
3. sob, control, miserable
4. overcome, symptom, dizzy

SUGGESTED ACTIVITIES

1. In order to simulate a situation in which one person learns that he has an incurable medical problem and little time to live, each student will select one of the following roles. He must develop the character in relation to the outline of the character's personality and his relation to the dying person. (If there are not enough parts, the instructor may add characters who might logically be associated with the patient. If there are too many parts, subtract from the bottom of the list.)

John Lewis---54, married and father of three children, owner and manager of a prosperous manufacturing company, active member of the local church and supporter of community art and music endeavors, recently bothered by fatigue and severe leg pains.

Mary Lewis---48, wife of John Lewis and mother of three children, has never worked outside the home because she wants to give all of her time to her family, sings in the church choir every Sunday, does not like Ann's career interest in art.

Bill Lewis---20, youngest son of John and Mary, attends expensive Eastern school, plans to work in father's business after graduation, claims to have no religious beliefs.

Ann Lewis---23, middle child of John and Mary, attends an art school in the city since high school graduation, father pays for art classes and attends showings, mother does not attend showings and refuses to discuss art career with Ann.

Mike Lewis---28, oldest son of John and Mary, widower because his wife died of multiple sclerosis after they had been married for six years, father of 3-year-old daughter, Jane.

Milton Hamilton, M.D.---36, specialist, responsible for testing, diagnosis, care and treatment of John Lewis, in private practice for only one and a half years.

Tom and Margie Todd---university classmates and close friends of John and Mary Lewis, Tom golfs with John, Margie volunteers three days a week at local social agency which helps unwed mothers.

Suggestions for other characters: in-laws, the minister of the Lewis's church, the Lewis's older, family physician.

There are at least three different settings or occasions for the characters to interact:

-doctor's office, when Dr. Hamilton informs Mr. and Mrs. Lewis of John's terminal illness.

-Lewis home when parents inform and discuss father's illness with children.

-small dinner party with Lewis family and the Todds, several weeks after John learns of his illness.

Students must study their characters and be ready to assume their roles in the three situations. They must also be prepared to continue the roles in follow-up discussions when the Lewis children discuss their family roles and circumstances in regard to father's imminent death and when Dr. Hamilton is asked to help the family members and John Lewis deal with their problems in the months before John's death.

2. Students might wish to follow the role-playing session with a discussion of the interpretations which they gave to their characters. They might want to

suggest other ways for the personalities to interact.

3. Each student is to interview three native English speakers, asking them how they would prefer to be told about their terminal illnesses. Following the interviews, the students are to report their findings to the class.

ADDITIONAL RELATED READING

"Death's a Finale, So Make It Good" by Melvin Maddocks. The National Observer, February 15, 1975.

HEALTH INSURANCE: PHYSICIAN AND MEDICARE

Medicare is currently the largest government health care program in the United States. "In 1973, Medicare outlays totaled $9.5 billion and financed 28 percent of the public health bill."[1] The government also sponsors another health care program, Medicaid, and these two programs pay "...about 54 percent of the public medical care bill."[2]

Medicare is a part of the social security program in this country, and it generally serves Americans age 65 and older. There are provisions, however, to aid severely disabled people who are under 65 years. Medicare is a two-part program of hospital insurance and medical insurance. The hospital insurance portion covers certain services and care in a hospital or skilled nursing facility, while the medical insurance portion covers physician expenses and other medical services not served by the hospital insurance.

Medicare protection is provided automatically for those over 65 who meet certain social security requirements; these requirements are based on the number of 3-month periods or quarters which one has worked. A person who cannot meet these quarter requirements may have Medicare coverage by paying a monthly premium. People under 65

may be eligible for Medicare benefits if they are disabled and are receiving social security or if they require dialysis treatments or a kidney transplant because of permanent kidney failure.[3]

The hospital insurance part of Medicare covers "...the cost of room and meals (including special diets) in semiprivate accommodations (2 to 4 beds), regular nursing services, and services in an intensive care unit of a hospital. They also include the cost of drugs, supplies, appliances, equipment, and any other services ordinarily furnished to inpatients of the hospital or skilled nursing facility....."[4]

Medical insurance will pay for physicians' services and supplies which he uses in his treatment, out-patient or clinic care, home health care visits, out-patient physical and speech therapy, and other health services prescribed by a doctor.[5] Neither medical insurance nor hospital insurance will cover treatment which is not directly related to an illness or injury; that is, a person cannot have regular physical check-ups, eye examinations and glasses, routine dental care and dentures, immunizations, and some other services charged to Medicare.

Medicare generally does not cover a person in a foreign country, unless he is closer to a Mexican or Canadian hospital than a U.S. one or is in transit through Canada from Alaska to another U.S. state.[6]

[1]B. S. Cooper, N. L. Worthington, and P. A. Piro, "National Health Expenditures, 1929-73," reprinted from Social Security Bulletin, February, 1974, DHEW Publication No. (SSA), 74-11700, p. 8.

[2]Ibid., p. 9.

[3]"A Brief Explanation of Medicare," DHEW Publication No. (SSA) 75-10043, January 1975, p. 2-3.

[4]Ibid., p. 6.

[5]Ibid., p. 9-10.

[6]Your Medicare Handbook, DHEW Publication No. (SSA) 74-10050, p. 16.

Article written by author. Medicare information taken from Your Medicare Handbook, U.S. Department of Health, Education, and Welfare; Social Security Administration; DHEW Publication No. (SSA) 74-10050; August, 1974.

COMPREHENSION

1. What are the two major government-sponsored health care programs in the U.S.?

2. Who is eligible for Medicare?

3. What are the two parts of Medicare coverage and the differences between each?

4. How does a person become eligible for Medicare coverage?

5. Why are certain medically related services and equipment not covered by Medicare?

VOCABULARY

Complete the following table:

Adjective	Noun	Adverb	Verb
1.		automatically	
2. disabled		XXX	
3.	accommodation	XXX	
4. related		XXX	
5.		XXX	cover
6.	security		
7.			include

8.	expenses	XXX	
9.		XXX	require
10. eligible			XXX

Writing Practice: Use each group of words in a sentence.

1. in transit, eligible, services
2. routine, dialysis, provisions
3. portion, facility, outlays
4. quarter, sponsors, therapy

SUGGESTED ACTIVITIES

1. Have the students outline the government-sponsored health care programs in their respective countries.

2. Compare these programs with Medicare in relation to citizen eligibility and coverage.

3. Have the students collect sample copies of the forms which physicians must fill out for Medicare patients. Practice reading them and filling them out.

THE GREAT MEDICAID SCANDAL

Medicaid is a blessing for 25 million Americans. The program provides medical services for the poor and their children, and nursing-home and extended hospital care for many old people. All of these services are paid for with $12.6 billion in federal and state money. Unfortunately, people who do not deserve it have benefited from the Medicaid program. The U.S. General Accounting Office (GAO) and agents have been investigating reports from twelve states that the program is being abused. Now they are finding these reports true. Investigations in New York, California, Minnesota, Florida, and Massachusetts show that a large number of doctors, dentists, druggists, and clinic and nursing-home operators are cheating the state and federal governments and taxpayers out of millions of dollars each year. Authorities in Illinois have discovered an even more serious problem. A Chicago dentist has been charged with arranging the murders of two men. These men were Medicaid profiteers, and the dentist believed that one of the men was cheating him on a business deal involving Medicaid.

The responsibility for this problem lies in Washington. The federal government has never placed

any real controls on the Medicaid program. The government has allowed each state to spend and control Medicaid money within its own welfare program. But most states cannot handle such a big program, making it easier for the cheaters to work.

Legally, only the poor are eligible for Medicaid. Many others take advantage of the program, though. Recently 28% of the people who wanted Medicaid help in New York City and Illinois' Cook County were actually ineligible. In California, young, pregnant girls are saying they are poor in order to get abortions through the Medi-Cal[1] program.

Doctors have taken advantage of the program to send in bills for goods and services they never provided. In New York, investigators are checking the activities of two chiropractors who operated nine ghetto clinics. These clinic operators are suspected of submitting forged bills and persuading other doctors at the clinics to make false treatment charts. The case may involve as many as 100 physicians; it may have cost Medicaid $4 million. A San Jose, California, psychiatrist recently went to jail because he would see eight or nine mental patients together. Then he would bill Medi-Cal separately for each patient.

Many clinics in city ghettos practice "Ping Ponging" and "family ganging." In Ping Ponging, the doctor

forces the patient to see all of the doctors in the clinic. In family ganging, the doctor examines all of the members in the family, although only one member is ill. Doctors also overprescribe medications and perform unnecessary tests and x-rays. Three New York podiatrists agreed to return 60% of the X-ray money they had received from Medicaid after investigators discovered that they had over-used x-rays.

Some states are trying to eliminate such abuses. The governor of Georgia has ordered an investigation of dentists whose bills seemed unusually large. Illinois investigators are checking connections between Medicaid profiteers and local officials. "It is almost unbelievable that corruption on such a large scale could exist without cooperation from the inside," says Robert O'Rourke, deputy to the Illinois Attorney General.

New York City, too, is trying to prevent further Medicaid abuses. The city will require accurate records of patient referrals and treatments. City authorities are using a computer to screen bills submitted to Medicaid and to look for examples of overbilling. The system appears to be working. Since it was begun last year, the city has been demanding---and receiving---more than $100,000 a month in repayments.

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[1]The name of the Medicaid program in California. Since each state administers its own program, some

have altered the original Medicaid name.

adapted from Time, May 26, 1975, p. 55.

COMPREHENSION

1. What is Medicaid?

2. Why are agents of the General Accounting Office investigating Medicaid services in twelve states?

3. Why are individual states having problems with cheaters?

4. Describe several ways in which physicians have cheated the Medicaid program.

5. According to Robert O'Rourke, why are some doctors successful in cheating the program?

VOCABULARY

Complete the following table:

Adjective	Noun	Adverb	Verb
1.		XXX	investigate
2.	abuse	XXX	
3. arranged		XXX	
4.		legally	
5.	advantage		XXX
6. pregnant			XXX
7.	abortion		

8.	XXX	forge
9.		persuade
10.	corruption	

Writing Practice: Use each group of words in a sentence.

1. screen, abuses, investigate
2. deputy, eliminate, referrals
3. clinic, provide, ghetto
4. medication, cheating, welfare

SUGGESTED ACTIVITY

1. Invite representatives from the local Medicare and Medicaid agencies to attend the class and to present their programs to the group, following their talks with a question-and-answer period.

NATIONAL HEALTH INSURANCE PROPOSALS

At least twenty-two national health insurance bills have been introduced in the Congress of the United States of America. These bills and their congressional sponsors approach the problem of financing high medical costs in a variety of ways. Some are a mixture of public and private financing and others are almost exclusively public supported health care plans. But, all of the bills have one common purpose: to make quality health care services available to Americans, regardless of race, creed, or economic position and to distribute these services equitably throughout a vast nation.

More than 20.6 million people are covered by Medicare, the health insurance previously discussed. Although 72 percent of Americans have some type of private insurance coverage, "...38 million Americans under age 65 still have no economic protection against hospital costs; 43 million have no insurance for medical care costs."[1] In general, therefore, the proposed congressional legislation is designed to provide protection for the currently unprotected people, many of whom cannot afford the cost of private insurance.

Of the twenty-two bills, the most comprehensive and perhaps the most controversial one was introduced

by Representative Martha W. Griffiths of Michigan and Senator Edward M. Kennedy of Massachusetts. Their bill, entitled "The Health Security Act," would create "...a national health insurance program covering the entire population and providing a broad range of health services, with no payment required of the patient. The program would be financed by a Federal payroll tax on employers and employees....."[2] and by other government revenues. Everyone who resides in the U.S.A. would be covered, including all categories of aliens, without regard to their contributions through payroll tax.

The Griffiths-Kennedy Bill calls for the abolition of the Medicare program, since all citizens would be automatically insured. The benefits of the proposed bill, however, far exceed those of Medicare, including dental and optometric services and prescription drug coverage.

Perhaps the most controversial part of the bill is the payment to professional practitioners or, in other words, physicians, dentists, and other professionals. Such individuals would be licensed by each state, and they would receive payments or fees-for-service which would be predetermined by representative physicians from each field; in some cases, though, a practitioner could choose to take a salary from a regional office. There are provisions in the bill for independent physicians and dentists who might choose to maintain their private

practices. They would receive an annual amount from the government for treating eligible persons. Some medical groups resist this portion of the bill because they think it has socialized medicine overtones, which they consider objectionable.

In addition to providing health insurance for everyone, the Griffiths-Kennedy Bill provides money for establishing new medical centers in areas which have inadequate facilities and new medical training programs for students and paraprofessionals who could help staff health care facilities which need more trained people. This bill, like the other twenty-one, "...represents, in large part, efforts to reorganize the methods of financing medical care costs....."[3]

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[1] M. S. Mueller, "Private Health Insurance in 1972: Health Care Services, Enrollment, and Finances," reprinted from Social Security Bulletin, February, 1974, DHEW Publication No. (SSA), 74-11700, p. 20-21.

[2] National Health Insurance Proposals. Provisions of Bills Introduced in the 93rd Congress as of July 1974. DHEW Publication No. (SSA) 75-11920, p. 145.

[3] Ibid., p. iii.

Article written by author.

COMPREHENSION

1. How do 72 percent of the U.S. citizens currently pay for hospitalization and medical care costs?

2. What type of insurance coverage would U.S. residents have under the provisions of the Griffiths-Kennedy Bill?

3. What provisions of the Griffiths-Kennedy Bill exceed those of Medicare?

4. Why is there professional opposition to the payment-for-service part of the Griffiths-Kennedy Bill?

VOCABULARY

Complete the following table:

	Adjective	Noun	Adverb	Verb
1.			XXX	vary
2.			exclusively	
3.			equitably	
4.	proposed		XXX	
5.		legislation		
6.				comprehend
7.		race		XXX
8.				resist

9. legislation

10. protection

Writing Practice: Use each group of words in a sentence.

1. controversial, vast, bills

2. overtones, proposed, economic

3. mixture, paraprofessionals, office

4. revenue, equitably, distribute

SUGGESTED ACTIVITIES

1. Describe the public or national health services and the extent of private insurance programs in your country.

2. Describe the attitudes of physicians in your country toward national health insurance programs, particularly as it affects their professional status.

3. Invite representatives of Blue Cross-Blue Shield and other private health insurance programs to class to discuss their various insurance programs.

ADDITIONAL RELATED READING

"Health Insurance...Without It Illness May Wipe You Out" by Morton C. Paulson. The National Observer, May 3, 1975.

BACK TO THE BOONDOCKS

U.S. doctors have been more and more reluctant to practice medicine in the farming areas. Country doctors earn less money than city doctors; in addition, they must always be ready to work---on call. When there is an emergency, they must travel great distances. Without the help of experts and special equipment, they must treat many problems and give many services---from obstetrics to treating snake bites. They must also keep medical and financial records. Because there are so many duties, doctors do not go to rural communities, and these communities must exist without medical help. Some communities will take any doctor, and they may get a doctor who is "a bum, an alcoholic or a drug addict---somebody on the run."

Physicians and others from the University of Utah's College of Medicine have established a non-profit corporation called Health Systems Research Institute (H.S.R.I.) in order to attract qualified physicians into rural areas or the boondocks. From the beginning, H.S.R.I. has been a very successful organization. H.S.R.I. now operates three hospitals and eleven clinics in five Western states, and these health facilities have provided services for areas with small

populations. One institute doctor says, "It gives me an opportunity to practice medicine as it was meant to be practiced without all the garbage of fighting with insurance companies and the Government."

H.S.R.I. accomplishes its goal by agreeing to provide total medical services for a county. Under this agreement, the county government says it will supply buildings, equipment, and money and H.S.R.I. says it will provide the skilled people. H.S.R.I. recruits and pays all doctors, nurses, clerks, and other personnel. The doctor earns $40,000 to $60,000 a year. This may be lower than the income of a city doctor, but the H.S.R.I. doctor receives the following benefits:

-four weeks of vacation by his third year;

-two weeks per year for continuing professional education;

-personal insurance policies, including expensive malpractice insurance.

Dr. Minthorne D. Norton, age 38, is typical of the new country doctor. He quit a family practice in Kentucky to run a clinic in Battle Mountain, Nevada. Dr. Norton is helped by a physician's assistant, a licensed practical nurse, and three clerks, and they treat 200 patients a week. Last November, this clinic collected and paid to the county some $17,000 in patient fees,

which is $4,500 more than the county paid to maintain the clinic that month.

H.S.R.I. officials say that they need only four more community contracts before they can call themselves self-sufficient. Dozens of other rural counties in Western states have already inquired about the program.

adapted from Time, January 12, 1976, p. 35.

COMPREHENSION

1. Why do some rural communities have poorly qualified doctors or none at all?

2. How does Health Systems Research Institute operate?

3. How do the benefits to H.S.R.I. doctors compensate for earning a lesser income than a city doctor?

4. Is the Battle Mountain Clinic a financial burden or a financial asset to the county?

VOCABULARY

Complete the following table:

Adjective	Noun	Adverb	Verb
1.	contract		
2. XXX		XXX	inquire
3. successful			
4. personal			XXX
5.	operation		
6.	clinic		XXX
7.	facility		
8. popular			
9.			serve
10.	medicine		

Writing Practice: Use each group of words in a sentence.

1. attract, personnel, boondocks.
2. county, qualified, community
3. rural, facilities, self-sufficient
4. practice, bum, clinic.

SUGGESTED ACTIVITIES

1. Comment on your nation's programs for providing medical services to out-lying regions and for encouraging skilled professionals to practice in these regions.

2. Investigate the number and quality of health care services available in the metropolitan area in which your school is located. Compare your findings with information about the health care services in the smaller surrounding communities and rural areas.

RETURN OF THE PLAGUE

Recently federal authorities believed that the business of dealing in deadly heroin was at last slowing. Deaths related to heroin had fallen significantly. Average prices had increased---a sure sign of scarcity---and on the East Coast "white" heroin made from the Turkish opium poppy was in short supply. Government officials were confident that the number of heroin users was decreasing throughout the nation.

Now people are not as optimistic as they were. Recently Dr. Robert DuPont, director of the President's Drug Abuse Prevention Office, said, "We're sure heroin use has gone up. Just how much we don't know, but it is getting worse." The prospect for 1975, he said, is "ominous." One way of measuring this is the number of heroin-related deaths. Between 1971 and 1973, 709 fewer people died; the numbers went from 1,726 to 1,017. During the first six months of 1974 alone, the death toll was 691. Hospitals reported a 66% rise in overdose cases, as compared with the same period in 1973.

In the past, most of the heroin was in the nation's largest cities. Now arrests, evidence of addiction, and heroin-related crime happen more often in smaller cities. For example, addiction is rising in Des Moines, Iowa;

Eugene, Oregon; and Jackson, Mississippi.

The decline of 1973 was a result of Turkey's ban on the cultivation of the opium-poppy plant. This plant had been the source of 80% of the heroin in the U.S. After Turkey lifted the prohibition, farmers planted a new crop which will be harvested soon.

European heroin dealers had been saving Turkish heroin in case of a shortage and they released this supply as a result of Turkey's growing more poppies. Although Turkey promised to control processing of the new crop, U.S. drug officials predicted a serious increase in available heroin on the American market.

To replace the Turkish supplies, Mexican "brown" heroin---a cruder, more cheaply produced variety---was cultivated two years ago. Mexican officials have tried to stop its sale, even using soldiers and helicopters to search out illegal crops. Nevertheless, John Bartels Jr., head of the Justice Department's Drug Enforcement Administration, says that Mexican heroin has become "our No. 1 target."

The financial and human cost of the heroin plague is horrendous. In fiscal 1973, according to Bartels' estimate, heroin addicts needed $5.6 billion to support their drug habit. More than half of that, authorities believe, comes from crime. If DuPont is correct when he says that "we can no longer talk about turning the corner

on heroin anywhere," crime is likely to increase.

adapted from Time, January 13, 1975, p. 18.

COMPREHENSION

1. What indicator shows the government that heroin use is declining?

2. What statistic best proves that heroin use is increasing?

3. Which country now has more of its heroin on the U.S. market than Turkey?

4. How do addicts earn most of the money to support their drug habits?

VOCABULARY

Complete the following table:

Adjective	Noun	Adverb	Verb
1.		significantly	
2. increasing			
3. ominous			XXX
4.		XXX	measure
5.			compare
6.		XXX	cultivate
7.	prohibition		
8. illegal			XXX

9. habituate

10. related XXX

Writing Practice: Use each group of words in a sentence.

1. fiscal, estimate, support
2. cruder, target, poppy
3. death toll, significantly, ban
4. shortage, increase, evidence

SUGGESTED ACTIVITIES

1. Have the students contact representatives from law enforcement agencies, drug treatment centers, and, if possible, addicts under treatment. Invite these people to class to present a panel discussion on the drug situation in this country: current laws for the drug user and the drug pusher, current treatment and rehabilitation programs, and the social acceptance of or stigma against the addict.

2. Have the students contact public school systems and drug treatment centers for samples of the materials and approaches used in drug education programs.

3. Discuss the differences between drug use/addiction and drug abuse, and outline the physician's role and responsibility in relation to his patients who are abusers or users. Consider, in particular, relaxers and

tranquillizers, diet pills, and medicine for the hyperactive child.

CANCER VACCINE QUEST

Some day, the worst thing about cancer
may be the shot you get to prevent it.

Even before this very optimistic statement appeared in an American Cancer Society advertisement, researchers were working to make it come true. In 1969, scientists succeeded in immunizing chickens against an avian-cancer virus. German researchers have gone even further by immunizing monkeys---which are several evolutionary steps closer to man---against a virus that causes cancer in primates. The hope is that eventually similar vaccines can be developed for use in humans.

The German scientists experimented with cotton-topped marmosets. Marmosets are South American monkeys that develop lymphoma, a cancer of the lymphatic system, when they are exposed to two viruses of the herpes family. The report on their research appeared in the British journal "Nature." They injected 42 of the animals with a vaccine made from killed herpes saimiri viruses. Some of the immunized animals and control animals were exposed to live, cell-free viruses. Most of the non-immunized monkeys developed malignant lymphoma and died of the disease. The immunized animals remained healthy.

The work of the German researchers is also

significant because it shows that killed viruses apparently stimulate the monkeys' immune system. This system manufactures antibodies against cancer viruses.

Viruses are submicroscopic packets of nucleic acids similar to the DNA found in chromosomes. For a long time, doctors have suspected that viruses are a part of human as well as animal cancers. It is believed that virus-like particles can be found in just about every human cancer. It has been difficult to prove that these particles cause cancers. Several viruses have been suspected, but the case against them has been dismissed for lack of scientific proof. There is largely statistical evidence against others: herpes simplex Type I, responsible for cold sores, and herpes simplex Type II, which causes genital infections. Both are somewhat related to a variety of cancers. One virus has been isolated, but further proof is needed to show that it is a human-cancer virus.

Even if it is proved that viruses cause human cancer, it may be years before science can develop a safe, successful vaccine against them. Probably cancer viruses will be identified long before vaccines become practical. Viral particles are unique to each type of cancer. The presence of viral particles may give doctors effective methods of detecting cancer in its earliest stages. This detection would happen before cancer could be

diagnosed by x-rays and more conventional methods. That development by itself could save many of the Americans who die of cancer every year.

adapted from Time, February 17, 1975.

COMPREHENSION

1. Why are the experiments with marmosets more significant than the earlier experiments with chickens?

2. Which viruses have been suspected of being cancer producing?

3. Are cancer virus particles the same in every form of cancer?

4. How can virus particles identification be useful to researchers besides their use in vaccine production?

VOCABULARY

Complete the following table:

	Adjective	Noun	Adverb	Verb
1.	optimistic			XXX
2.			XXX	evolve
3.			XXX	expose
4.				malign
5.	scientific			XXX
6.			XXX	prove
7.			XXX	stimulate
8.		cause		

9. injected XXX

10. system

Writing Practice: Use each group of words in a sentence.

1. packets, evidence, appeared
2. conventional, development, exposed
3. particles, vaccine, presence
4. antibodies, injected, stimulate

SUGGESTED ACTIVITIES

1. Become familiar with the literature and public education programs on cancer. Have a representative of the American Cancer Society bring copies of all such materials to class.

2. Recent research suggests that certain cancers are more prevalent in one section of the country than in another and that incidence varies between the sexes and among certain age groups. Divide the country into areas and assign students to each area. Ask the student to present a survey of his area, noting the statistics on cancers within this area and suggesting possible reasons for the increased incidence of one type over another, e.g. presence of a certain type of manufacturing or industry, urban conditions, etc.

SETBACK FOR ABORTION

As a doctor, Kenneth Edelin, 36, has spent his career at Boston City Hospital. He has attempted to preserve and prolong life. Recently he was convicted of taking a life. The jury deliberated for seven hours. The nine men and three women in Boston found him guilty of manslaughter in the death of the fetus that he had aborted. As a result, the popular obstetrician may be in prison up to 20 years. If the decision is upheld and if it becomes a legal precedent, many women in the United States will not be able to get late-term abortions.

No one questioned the legality of the abortion which Edelin performed in October, 1973. The abortion came after the U.S. Supreme Court ruling which made abortions legal and before the Massachusetts law which forbids abortions after the 24th week of pregnancy. The way Edelin acted during and after the operation was the issue. Edelin said the male fetus was 20 to 22 weeks old. But it was, in fact, older. The prosecution said that the fetus could have lived outside the womb and that Dr. Edelin was responsible for keeping it alive after the abortion. He did not do this; therefore, he caused the baby's death and was guilty of manslaughter.

The trial showed two very different views about

when a fetus becomes viable (capable of independent life outside the womb) and when a fetus becomes a person. Dr. Edelin's lawyer said that any abortion results in the death of a fetus. The prosecution argued that abortion means the end of a pregnancy and does not always mean the death of the fetus as well. Conflicting evidence was presented on whether the fetus involved in the specific abortion was viable. Dr. John B. Ward, a Pittsburgh pathologist, said that the fetus had breathed and that the 700 gram (1 lb. 8 oz.) unborn infant could have survived. Witnesses for Dr. Edelin said that the fetus had not breathed. Medical experts testified that fetuses weighing less than 1,000 grams (2 lbs. 3 oz.) rarely, if ever, survive.

A former Boston City Hospital resident, Dr. Enrique Gimenez-Jimeno, said that he had watched as Edelin held the aborted fetus inside the patient's uterus and counted off three minutes by the operatingroom clock. But his statement was difficult to believe because Edelin could not have easily seen the clock and furthermore, it was not there on the day of the operation. It had been removed for repairs.

Many observers expected Dr. Edelin to be acquitted. The verdict shocked the courtroom. Dr. Edelin will appeal it. But the jury's decision means that a fetus which is almost viable is a person. As a person, the

fetus is then entitled to the full protection of the law.

The implications of the ruling are enormous. Doctors will probably continue to perform early abortions, if they are certain that the fetus could not live outside the womb. But they may not want to perform late-term abortions because they will be afraid to take the same risks which Dr. Edelin took. The Boston legal decision will please the anti-abortionists, who do not like the Supreme Court abortion laws. But thousands of women will have problems receiving late-term abortions. Although the abortions are legal, few doctors will want to perform them.

adapted from Time, February 24, 1975.

COMPREHENSION

1. Why was Dr. Edelin found guilty of manslaughter, if abortions are legal?

2. Based on the testimony of its witnesses, did the prosecution believe the fetus in question was viable or not viable?

3. What was questionable about the testimony of Dr. Enrique Gimenez-Jimeno?

4. If abortions are still legal, why will doctors probably now be unwilling to perform late-term abortions?

VOCABULARY

Complete the following table:

	Adjective	Noun	Adverb	Verb
1.	convicted		XXX	
2.	viable			XXX
3.		prosecution	XXX	
4.		XXX	XXX	forbid
5.			XXX	preserve
6.				deliberate
7.				question

8. arguable		XXX
9.	conflict	XXX
10.		easily

Writing Practice: Use each group of words in a sentence.

1. precedent, ruling, legal
2. manslaughter, guilty, patient
3. verdict, implications, physicians
4. acquitted, entitled, jury

SUGGESTED ACTIVITIES

1. Compare the laws relating to abortions as they now exist in the students' countries. Would the verdict in the Edelin case have been the same in each country?

2. Invite representatives of pro-abortion groups and anti-abortion groups, such as Right to Life, to debate the abortion issue in class, or have the students research both sides of the issue and conduct their own debate on the legal, moral, and ethical aspects of abortion.

3. Invite a representative of Planned Parenthood to class to discuss its program of medical assistance and counselling in family planning and contraception.

ADDITIONAL RELATED READINGS

"Strategy on Abortion." Time, December 1, 1975.

"Abortion and the Law." Newsweek, March 3, 1975.

"'Abortion' Trial's Issue: Definition of Birth," by Diane K. Shah. The National Observer, January 25, 1975.

"Senate Is Battleground In Fight Over Abortion," by Barbara J. Katz. The National Observer, February 1, 1975.

"Inside an Abortion Clinic," by Pamela Dillett. The National Observer, February 15, 1975.

SENTENCED TO LIFE

For eleven days, Superior Court Judge Robert Muir Jr. of Morris County, New Jersey thought about the painful, unprecedented legal problem. Did the parents of 21-year-old Karen Anne Quinlan have the right to turn off the respirator? The respirator had kept Karen Anne alive since she went into a deep coma in April, 1975. Recently Muir announced his decision. In a 44-page ruling, he said sadly that he had to forget "the compassion, empathy, sympathy" he felt for the Quinlan family. According to his "judicial conscience and morality," Karen's life was being properly handled by "the treating physician." Robert J. Morse, her doctor, refused to stop using the respirator. Therefore, the judge's decision meant that at least for now, Karen must live.

Doctors at the trial agreed that Karen is in a "persistent vegetative state." Her chances of recovery are remote. Even so, tests show slight brain activity. Therefore, the judge said that Karen is "not brain dead by present known medical criteria." Judge Muir said that "humanitarian motives" cannot justify taking life. If the respirator were removed, it "would result in the taking of the life of Karen Quinlan when the law of the state indicates that...would be a homicide."

The judge rejected all of the arguments of Joseph Quinlan's lawyer. Karen apparently once said that she would not want to have her life artificially prolonged. The judge said that statement was "too theoretical." The United States Constitution protects against cruel and unusual punishment. But the judge said that this did not apply to Karen's case. Medical treatment "where its goal is the sustenance of life is not something degrading, arbitrarily inflicted, unacceptable to contemporary society or unnecessary." Muir stated that a few other courts had allowed patients the right to die, but only when death was chosen by the dying person. "There is no constitutional right to die that can be asserted by a parent for his incompetent adult child."

The Quinlans have time to decide on an appeal. Meanwhile, Judge Muir has relieved them of the responsibility of making decisions about Karen's treatment. That power has been given to Karen's court-appointed attorney and guardian.

adapted from Time, November 24, 1975, p. 70.

COMPREHENSION

1. Based on Judge Muir's decision, why will Karen Ann Quinlan continue to live?

2. Why is removal of the respirator equal to homicide in Judge Muir's opinion?

3. Under what circumstances and on what precedent might Judge Muir have decided to give permission to remove the respirator?

4. What powers do Mr. and Mrs. Quinlan now have to decide on Karen's treatment?

VOCABULARY

Complete the following table:

	Adjective	Noun	Adverb	Verb
1.		sympathy		
2.	judicial			
3.	vegetative			
4.	theoretical			
5.		sustenance	XXX	
6.	degrading			
7.		compassion		XXX

8. morality

9. decision

10. arbitrarily

Writing Practice: Use each group of words in a sentence.

1. decision, criteria, respirator
2. appeal, prolonged, attorney
3. incompetent, treatment, legal
4. asserted, judicial, ruling

SUGGESTED ACTIVITIES

1. The Oath of Hippocrates states the following:

   ...I will follow that method of treatment which, according to my ability and judgment, I consider for the benefit of my patients, and abstain from whatever is deleterious and mischievous. I will give no deadly medicine to anyone if asked, nor suggest any such counsel.....

Discuss this section of the oath and its various interpretations in relation to the physician and euthanasia or mercy killing. Is the doctor morally and ethically limited by this oath or does it free him to take life under certain conditions? Describe these conditions, if they do exist.

2. Invite a representative of the American Medical

Association to class to discuss the AMA's views and rulings on euthanasia and living wills, documents which state that the patient be allowed to die if there is no reasonable expectation of recovery.

ADDITIONAL RELATED READINGS

"Before Karen's Coma." Time, December 29, 1975.

"What's Right? Medical Progress Muddles the Ethics of Life and Death," by Patick Young. The National Observer, September 27, 1975.

"Post-Death Giving: Med Schools Rely on Willed Bodies," by David W. Hacker. The National Observer, May 3, 1975.

VD: THE EPIDEMIC

The Los Angeles coach could not understand. His high school football team could not win a game, although it had been very successful during other seasons. The players showed little spirit and energy during practice, and by the middle of the season, the team had lost three games in a row.

Medical "detectives" discovered the reason for the team's problem only after one player went to a public-health clinic, complaining of swollen testicles. The diagnosis: gonorrhea. Investigators found that nine members of the team had the disease. All were quickly cured by penicillin and the team started winning again.

Now the coach is happy. But public-health doctors in Los Angeles and throughout the United States are very alarmed. If venereal disease continues to increase at the present rate, approximately one out of every five high school students will have contracted gonorrhea or syphilis by the time they graduate. The entire nation is involved in a massive VD epidemic and no one at any level of society is immune.

Dr. John Grover, a Harvard University gynecologist, says, "We have treated doctor's wives, bank president's wives, the daughter of the professor as well as the daughter

of the milkman." Michael R., a young lawyer from San Francisco, says, "VD doesn't have anything to do with being 'nice' any more. The girl I got the clap from is a lovely person---she was sleeping with one other guy and figures he gave it to her."

The common cold is the only infectious disease with more victims than syphilis and gonorrhea; and VD is now first among the reported communicable diseases. Each year there are more reported cases of VD than there are of strep throat, scarlet fever, measles, mumps, hepatitis, and tuberculosis combined. This year, 624,000 new cases of gonorrhea will be reported. However, probably only one case is reported for every five which occur, so the real number is probably more than 2 million. The figures for syphilis are even more disturbing. There are a half a million Americans with untreated syphilis today, and this number will increase by 85,000 during the year. The number of new cases currently being reported represents an increase of 16 per cent over last year, the biggest increase in twenty years.

VD is moving rapidly from the inner city to the outer suburbs. VD is particularly prevalent among young Americans. At least one in five persons with gonorrhea is under 20. Last year, more than 5,000 cases were discovered among children between 10 and 14 and 2,000 cases among children under 9. "The probability that a

person will acquire VD by the time he is 25," says Dr. Walter Smartt, chief of the Los Angeles County Venereal Disease Control Division, "is about 50 per cent."

It is difficult to understand why the disease is now an epidemic, because both syphilis and gonorrhea can be cured with penicillin and antibiotics. After 1947, the number of cases decreased steadily for ten years because these drugs were used. Then the government, the medical profession, and the public became complacent. Less money was given to VD control, and the disease rate increased. "They provide money when the statistics are high, when you're getting a lot of syphilis for your money," says Myron Arnold, a District of Columbia VD-control adviser.

Prostitutes are no longer blamed for the spread of VD. In fact, most public-health experts think prostitutes are unusually careful about avoiding VD and getting treatment if they do contract it. Only 2 per cent of the VD patients treated in St. Louis clinics are prostitutes. "Prostitution is not where it's at with VD today," says Robert M. Nellis, an investigator with the San Francisco City Clinic. "It's Johnny next door and Susie up the street."

Public attitudes toward VD range from ignorance to repugnance and help make the current epidemic worse. "We even have doctors who don't want to treat or have

anything to do with VD," says Phillip Wactor, director of VD control for the Illinois Health Department.

Many public-health officials believe that the basic causes of the VD epidemic are the "three P's---the Pill, promiscuity and permissiveness." By removing the fear of pregnancy, the argument states, the Pill has encouraged greater sexual activity---particularly among the young. The Pill has decreased the use of condoms, and the condom is the most efficient and effective barrier to the transmission of VD. Researchers say that the hormones in the Pill increase the alkalinity and moisture of the female genital tract, and this helps the growth of gonorrhea bacteria. According to one estimate, a woman who has one act of unprotected intercourse with an infected man has a 40 per cent chance of contracting gonorrhea. A woman who is taking the Pill has a 100 per cent chance of contracting gonorrhea.

The life-style of many young people includes plenty of sex and lots of mobility. "One day they are in San Francisco, the next week L.A., then on to Denver," says Jan Cobble of the Bay Area Venereal Disease Association.

VD experts hope to develop a vaccine. "No communicable disease," says Smartt, "has ever been eradicated unless there was a preventive vaccine to do so." Researchers have been unable to grow the syphilis spirochete in cultures to date. There seems to be even less chance

to control gonorrhea by vaccine. "Our basic lack of knowledge is incredible," says Dr. Leslie Norins, chief of the Venereal Disease Research Laboratory at the National Communicable Disease Center in Atlanta. "There is a crying need for fundamental research."

Public education about gonorrhea and syphilis is needed as much as research. Most people agree that the education program should be held in the schools. Washington, D.C. has begun one of the most realistic school VD programs. Students even learn how to use condoms. "Our purpose," says District VD adviser Myron Arnold, "is to teach the student something he'll remember on a Saturday night, not necessarily on an examination."

adapted from U.S. Department of Health, Education, and Welfare Public Health Service from Newsweek, Vol. LXXIV, No. 4, January 24, 1972.

COMPREHENSION

1. Why are the reported statistics on gonorrhea and syphilis cases inaccurate?

2. Why has venereal disease reached epidemic proportions if it can be cured with penicillin and antibiotics?

3. Why do many public-health officials blame the birth-control pill for the present VD epidemic?

4. How does mobility contribute to the VD epidemic?

5. What is currently preventing the development of a vaccine against VD?

VOCABULARY

Complete the following table:

Adjective	Noun	Adverb	Verb
1.		approximately	
2. infectious			
3. communicable			
4. prevalent			
5.	probability		XXX
6. complacent			XXX
7.	prostitution	XXX	

8.	repugnance	XXX
9.	permissiveness	
10.	promiscuity	XXX

Writing Practice: Use each group of words in a sentence.

1. alarmed, investigators, massive
2. mobility, incredible, contracting
3. complacent, treatment, repugnance
4. epidemic, promiscuity, transmission

SUGGESTED ACTIVITIES

1. Survey local public and private schools about the nature and extent of their VD education programs.

2. Discover what other community programs exist for public education and treatment of venereal disease.

3. As a class, develop and administer a questionnaire to the "man-on-the-street" regarding his knowledge of venereal disease: its causes, its cure, his/her attitude toward seeking treatment, his/her attitude toward VD education programs in the schools. Attempt to survey a cross-section of people by age, sex, occupation, and educational level. Compile these statistics and comments into a report on public awareness of the venereal disease problem.

ADDITIONAL RELATED READING

"What We Want To Know About Venereal Diseases," by William F. Schwartz. Reprinted by the U.S. Department of Health, Education, and Welfare, Public Health Service from The PTA Magazine, Vol. 66, No. 5, January, 1972.

USEFUL ADDRESSES FOR FURTHER RESEARCH AND INFORMATION

Acupuncture Information Bureau of America
Washington, D.C.

Alcohol
Rockville, Maryland 20850

American Cancer Society, Incorporated
National Office
219 East 42nd Street
New York, New York 10017

American Heart Association
2 East 64th Street
New York, New York 10021

Communicable Disease Center
Information Department
1600 Clifton Road, N.E.
Atlanta, Georgia 30322

Social Security Administration
Medical Services Administration Information
330 "C" Street, S.W.
Washington, D.C.

U.S. Department of Health, Education, and Welfare
Public Inquiries
400 Maryland Avenue, S.W.
Washington, D.C. 20201

GLOSSARY

ABUSES---incorrect uses, misuses.

ACQUITTED---set free, dismissed, allowed to go because a legal charge cannot be proved.

ALARMED---concerned, worried, frightened.

ALERT---aware of activity around him, able to understand.

ANXIETY---worry, concern, uneasiness in the mind.

APPEAL---a request for a new trial in court.

APPREHENSIVE---fearful, worried that something might happen.

ASSERTED---stated positively, affirmed.

ATTORNEY---lawyer, legal counsel.

AUXILIARY---supporting group of interested people who are not directly involved in the work.

BALD---naked, undisguised, plain.

BAN---a prohibition against something, a statement which forbids or outlaws.

BARRIER---an obstacle, an obstruction in the way.

BEARING---behavior, the way a person carries himself or acts.

BILLS---drafts of proposed laws which have been sent to the legislature; also, statements or invoices for money.

BUM---a person without money or position in society, gets food and money from other people.

CASUAL---informal, unplanned, friendly.

CLAP---slang term for gonorrhea.

CONTROVERSIAL---debatable, something about which people have many opinions.

CONVENTIONAL---normal, ordinary, according to custom.

COUNTY---a legal and political unit within a state.

CREED---a statement of religious beliefs.

CRUCIAL---critical, very important.

CRUDER---less refined, rougher.

DEATH TOLL---the number of dead.

DELIBERATED---considered, thought about carefully.

DEPUTY---an assistant to a higher official or a substitute for this official.

DIALYSIS---the process of separation, cleaning or purification, in this case of waste products from the blood.

ELICITING---getting, drawing out.

EMPATHY---the process of placing oneself into another person's situation.

EQUITABLY---fairly, evenly.

ERADICATED---destroyed, wiped out.

ESSENTIAL---necessary, required.

FILE---a collection of information and papers on one person or one subject.

FISCAL---the period of time between the beginning and end of a financial year.

FOCUS---the clear, central point; the reason; the goal.

FORGED---illegally made copies of an original.

FORMAT---the design, the arrangement.

GHETTO---a poor area of a city, a slum, an area where certain types of people or nationalities live.

GOODS AND SERVICES---an economics phrase for "manufactured items and work done."

GRIEF---extreme sadness, sorrow.

HARVESTED---brought in from the fields after the growing season is over.

HORRENDOUS---horrible, frightful.

INCOMPETENT---not able to act or to do because of physical or mental deficiencies.

IN TRANSIT---in progress, in the process of going from one place to another.

IRONIC---opposite from what it should be or seems to be.

JUDICIAL---related to judges, courts, and the law.

MANSLAUGHTER---homicide, killing a man without desire to or without intending to.

MOBILITY---movement.

MUNICIPAL---self-governing city.

OMINOUS---fearful.

OUTLAYS---expenses, expenditures (usually of money).

OVERTONES---suggestions, characteristics.

PACKET---package, group.

PARAPROFESSIONALS---people who work with professionals,

but who do not have enough training or education to be a professional; helpers.

PARTICLES---tiny pieces, fragments.

PERMISSIVENESS---allowed to behave in any way, condition where there are few limits or restrictions.

PERSISTENT---continuous, repeated, enduring.

PLIGHT---bad condition or state.

POPPY---plant which produces raw material for opium and heroin.

PORTION---a segment, part, section, share.

PRECEDENT---something which comes before or precedes, something which serves as an example.

PREVALENT---prevailing, happening frequently.

PROFITEERS---people who profit or gain from a situation.

PROLONGED---continued for a long time, sustained.

PROMISCUITY---behavior which is freer and characteristic of an older, more mature group of people; indiscriminate.

PROSECUTION---the state's or the government's side in a legal case.

PROVISIONS---stipulations, previous agreements.

RAPPORT---harmonious relationship between people.

RECRUIT---locates and selects for a specific job.

REFERRALS---names which have been sent or directed from one place to another.

RELAPSE---a return to a former condition.

RELIES---depends upon, trusts.

RELUCTANT---hesitant, resisting, unwilling.

REMEDIAL---doing something again in order to improve.

REMISSION---returning to original conditions of an illness from a healthy state, relapse.

REPUGNANCE---strong dislike, revulsion, aversion.

RESPIRATOR---a machine to help a patient breathe.

REVENUES---income, yield, returns from an investment.

ROUTINE---repeated action on a regular schedule.

SCREEN---to select, to sort according to certain criteria.

SELF-SUFFICIENT---able to get along unassisted, lives without the help of others.

SEMINAR---a meeting or educational session on one subject.

SHORTAGE---a deficiency, a lack, a deficit.

SOB---uncontrolled crying or weeping.

STANDARDIZED---regular, conforming to a certain style or process.

SUSTENANCE---food, nourishment, support.

SYMPOSIUM---a conference on a particular subject.

TARGET---an area to aim at or to shoot at.

TUTORING---teaching, instructing.

VAST---great, wide, immense.

VERDICT---answer, decision, judgment.