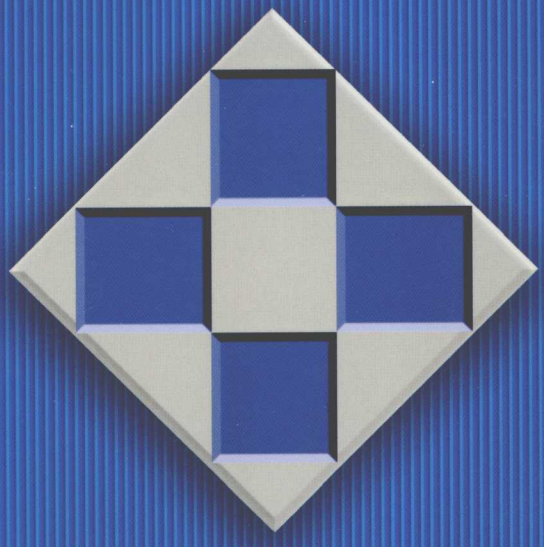
# 新编

# 临床医学英语



主编　邱陶生

中国协和医科大学出版社

# 新编临床医学英语

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# 前　言

本书是首都医科大学的高年级学生临床学习阶段专业英语课教材。由于专业英语课的课时有限，不可能有很多时间同时进行听、说、写、读、译的全面综合训练，因此我们现在编写的这本教材主要是供阅读使用，适当兼顾写译训练。我们希望，通过临床阶段专业英语课的学习能够使学生熟悉医学文章、积累并掌握更多医学词汇，为以后更熟练更顺利地阅读医学文献打下良好基础。

本书主要选自一些比较著名的医学教科书，也有一部分选自医学杂志和网络上的文章，内容涉及临床各科，以常见病、多发病为主；从专业上来说，也不是非常深奥，作为一名医学生，不管将来从事哪个专业，都是应该懂得的知识，而且书中所出现的医学词汇对于学生未来的工作也都会有很大的益处。

本教材选编的内容相对较多，主要是考虑到使用本书的不仅有五年制医学生，而且还有七年制医学生。不管是五年制还是七年制，学生中英语水平相差很大，学习能力、学习兴趣也不尽相同，因此，我们既要考虑老师作为课堂讲解的精读课文，也要考虑老师指定学生课外必读的泛读课文，更要考虑一部分学生自我发展、自主阅读的课文。由于每篇课文均有较详细的注释、词汇表以及练习，所以对学生的自主学习将会有更多的帮助。

参加本书编写工作的首都医科大学应用语言学系的各位老师自始至终都团结合作，为本出付出了辛勤的劳动，特向他们表示衷心的感谢！

本书编写过程中先后得到我校吕兆丰校长、王松灵副校长、线福华副校长的关心和支持，编写人员从中得到极大的鼓舞和教益。在此，我们向校领导表示衷心的感谢！我校教务处领导及各附属医院的教育处和临床外语教师也都给予大力协助和支持，在此谨向他们表示深深的谢意！

由于种种原因，书中疏误之处在所难免，期盼广大读者提出批评指正，编者在此预表衷心的谢忱！

邱陶生

2008 年 1 月于首都医科大学

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# 1. Internal Medicine and Today's Internist

## QUESTIONS/PLEAS OF THE PATIENT

"How can I find a good doctor?"

"How can I find a good doctor whom I can afford?"

"How can I find a good doctor who cares about me as a person?"

"How can I find a good doctor who will take the time to listen and understand?"

People who need medical care ask these questions throughout the world every day. They ask them because they face a health care system that is scientifically complex, organizationally overloaded, and generally not oriented to the patient as a *person*.[1] When an individual first becomes ill, regardless of the symptoms, he or she needs most someone who seems to say, "I am a good doctor; I charge a reasonable amount for my services; I care about you, the patient; and I will take the time to listen and understand."

A prominent teacher/physician in a major medical center taught his students to "listen to the patient and he will tell you what is wrong, and he will tell you what he needs." Having found a physician who answers so profoundly to their needs, some patients are extremely grateful – but most are utterly overwhelmed. With the discovery of that relationship, the difference between a superb technician and a true physician really becomes evident to the patient. That physician/teacher was a scholarly gentleman with deep scientific insight and an active and stimulating clinical and research practice. Unfortunately, he developed crippling rheumatoid arthritis in the midst of[2] his career. Beyond question, his own disease sensitized him to the complex mix of expectations, needs, fears, and appreciation that patients feel when facing a physical-mental trial while at the same time looking for that perfect physician to help them.[3] Patients flocked to this doctor – not just for his accurate diagnoses, his correct therapies, or even his warmth, but for the intellect he expressed and the sheer joy of living that he extended in every encounter with another human being. He had a Shakespearean grasp of the qualities of being human and an uncommon ability to transmit love and respect for his fellow human beings.[4] He exhibited the ideal all physicians should emulate. Many readers know a physician with these characteristics; all should seek to know one and to develop their own professional persona so that human qualities are not lost to technical acumen.

## THE SCIENTIFIC AND TECHNOLOGIC BACKGROUND OF A "GOOD DOCTOR"

Since Flexner issued his famous report in 1910, American medical education has striven toward the development of a strong scientific base.[5] This intellectual prerequisite, therefore, has become an integral part of premedical, undergraduate, graduate, and, indeed, continuing medical education. Biomedical science is fundamental to understanding disease, making diagnoses, developing new therapies, and appreciating the complexities and contributions of new technologies. Physicians cannot be satisfied with simply knowing that a certain form of therapy works 80 to 90 per cent of the time. They must understand the basic physiology and pharmacology of any approach they use. They must possess the intellectual tools to follow reports of current research in medical journals so that they can continue to grasp the newest and latest approaches, no matter how complicated the field may become. That is why, in a textbook of medicine like this, strong emphasis is given to how things work, what goes amiss when pathologic processes ensue, and what effect a given therapy has in correcting that defect. We seek to create within the minds of our readers a yearning for a greater depth of understanding and a continuing commitment to stay at the frontier of scientific knowledge. These are, in fact, among the hallmarks of a professional in any scientific field.

We are moving into an era when pharmacotherapeutic agents are no longer merely wonders of organic chemistry, but increasingly often are biologic products. Some of these are isolated from nature; others are developed by recombinant DNA technology. On the horizon is the availability of a true replacement or supplement for defective or deficient biochemical constituents of the body. No physician can with intellectual honesty use these new classes of agents without fully understanding their action, their meaning, and their potential side effects.[6] The diagnostic and therapeutic contributions and potential, in clinical situations, of biocompatible prosthetic devices, nuclear magnetic resonance spectroscopy, high-frequency laser beams, and so on through developments not yet conceived, can be appreciated only by the mind that is disciplined in fundamental science.

## THE ORGANIZATION AND FINANCING OF TODAY's MEDICINE

Patients, as well as their representatives in government, industry, and managed-care[7] organizations, are concerned about the rising cost of medical care. The total bill for health care in America now rises at a rate of about 10 per cent per year, an increase that seems to continue unabated. Federal legislation instituting diagnosis-related groups (DRG's)[8] has clearly moderated the rise of hospital costs, but physician costs continue to rise at an ever-increasing rate. Every student of medicine should ask if this is realistic. Is it sustainable? Is it defensible? What will be the limits? Patients already ask, "Can I really afford the best doctors in the most prestigious practices, in the most famous medical centers?" "Can I afford to be referred to a subspecialist?" "Can I afford to be out of work and in the hospital?" "Can I afford to pay my rising insurance premiums?" "How

much deductible on my insurance can I afford?" Worse yet, an increasing number of patients have to make choices between seeking medical and dental care and getting food, clothing, shelter, and other essentials of daily living. These issues have become major concerns in American households and clearly represent one of the most disturbing weaknesses in our economy, of which now nearly 12 per cent (by annual gross national product) is devoted to health care, up from 8 per cent in 1975.[9]

Over the last two to three decades it has been a goal of our nation to promote ever increasing quality and cost-effectiveness of health care for all. Unfortunately, we have failed miserably. The United States spends more per capita[10] on health care than any other nation in the world. Yet in the major indices of health our population ranks nineteenth! At the same time we continue to see a wasteful maldistribution of physicians both by specialty and geographically and a growing number of medically indigent and medically uninsured people in our nation. Somehow, the costs of what we are trying to achieve – even though the goal is commendable – are not being placed in proper perspective by the medical profession, health-care managers, and representatives of the people in order to provide suitable care for all. Unfortunately, in the present system the real needs of the populace are not always met by affordable services. At the same time, overutilization of medical services may be the very engine that drives up the total cost of health care delivery. With the passage of the Medicare program for the elderly and the Medicaid plan[11] for the poor by Congress in 1965, we had hoped as a nation that we were moving toward a more just and efficient system. In fact, the opposite has been the trend. This societal goal must now be readdressed, reformulated, and restructured in terms of modern needs, reflecting fairly and fully measured cost/benefit ratios for every form of medical service.

Medical professionals often attribute overutilization to patient behavior. In fact, however, physicians control 70 per cent of health expenditures. A few patients with hypochondriasis, for example, may visit physicians too often, and many older patients may seek medical help at times when a friendly, reassuring chat is their real desire, but in the final analysis[12] utilization of the health care system is in the hands of physicians. Ironically, although physician competence is often equated to mastery of expensive techniques and technologies, physicians are actually at their professional best when listening to the patient and responding to what they hear and see with medicine's most comprehensive armamentarium.[13] Overutilization, when it occurs, is thus most likely to be our fault as physicians. Our responsibility as professionals is to be absolutely certain that our errors in this direction are driven by well-founded concern for the health of our patients, not by the financial interests of our practices or the hospitals where we work.

Individual physicians, then, must take a personal and professional interest in[14] the control of health care costs – not only because it is right for the nation, but because it is right for the patient. In our litigious society, a legalistically defensive approach to medical practice has become too prevalent. The conditions that engender this tendency must be altered. Physicians must use all of their diagnostic skills to focus on the very best approach to medical diagnosis and therapy and to steer a-

way from[15] unnecessary use or repetition of expensive procedures such as computed tomography, magnetic resonance imaging,[16] and cardiac catheterization. The physician must use intellect – scientific knowledge and analytical skills – to best serve the patient without inundating the system with unnecessary costs and the patient with a financial burden he simply cannot continue to bear.[17]

Costs can be controlled only if physicians are convinced of the need and are willing to participate in providing this vital service. One aspect of this control is attention to various possible means of health care finance, including prepaid plans, preferred provider organizations, health maintenance organizations,[18] and other managed care systems. All of these must be carefully explored with a view to[19] making health care accessible where it is most needed. Clearly, multiple tools and programs may be necessary, but they should not be thrust upon[20] the patient simply to satisfy doctrines of free enterprise. To provide the best health care in a finite economy we need systems that provide such care in the most efficient way, regardless of the payment scheme.

Another aspect of our cost-control job is to support and participate in research on outcomes, aiming toward systematic evaluation of cost-effectiveness of the medical procedures we choose in the light of[21] *all* the interests of our patient. For example, we do not know why treatment of prostatic hypertrophy is more commonly medical in some parts of the nation, surgical in others. Why does the incidence of caesarean sections[22] vary so widely? The costs and benefits of coronary angioplasty versus bypass surgery remain obscure. Every year *billions* of dollars are spent as a result of clinical decisions that may hinge on[23] these or similar issues. Physicians must involve themselves in the processes of change with an eye first to[24] the individual patient and then to society.

## THOSE WHO CARE

"How can I find a good doctor who cares about me as a person?"

When speaking of caring, one has to define specifically what is meant. A physician can diagnose and prescribe in a technically correct and scientific but insensitive way, and the patient may be made better – even cured. On the other hand, when the patient asks the question, "Does my physician really care?" the patient means, "Does it matter to the physician what happens to me? Does my doctor show sensitivity and compassion beyond the mere technical qualities of medicine?" It is in this sense that we address ourselves to the nature of those who care.[25] .

It may seem odd to talk about caring as a skill, but in a real sense it is just that. Those involved in the education of students realize that at least some forms of compassion have to be learned. The developing physician must see such traits in action in order to acquire and apply them in interaction with patients and their families. Sometimes this involves *learning how* to demonstrate compassion. Kahlil Gibran has taught us, "You give but little when you give of your possessions – it is when you give of yourself that you truly give."[26] Giving of ourselves – with ease, with grace, and with meaning – is for most of us an acquired skill. Sometimes it involves a deep sense of reawakening within, to bring out an innate sensitivity and compassion that perhaps has not expressed itself since

childhood. At other times, learning to care may involve a complete transformation of behavior and attitudes toward people, particularly those who are not from our own cultural background. Many believe that the greatest responsibility in medical education today is to foster compassion within the student of medicine.

To receive medical care, patients must trust their bodies and their very lives to physicians, and so to be in an honest position to[27] give medical care, physicians must earn such radical trust. Mere technical treatment of disease does not suffice. Patients must be able reasonably to believe that their physicians care about them in an extraordinarily personal way. This exchange of care for trust, while not identical to[28] friendship or love, is equally binding. From it develops an interdependence that is far from unwholesome; rather, it potentiates care and promotes healing. Our late twentieth century sophistication and technologic orientation have too often cost us warmth, humor, and humanity, leaving us in social isolation. We do far better as professionals to err on the side of being human with our patients than to try to play *deus ex machina*, the god from the machine.[29]

## THE SOCIAL RESPONSIBILITIES AND HUMANISTIC QUALITIES OF "THE GOOD DOCTOR"

The patient says, "Take charge,[30] make me well, help me feel comfortable, show me compassion, listen to my problems and I will give you trust." Dag Hammarskjold reminds us of "the humility which comes from others having faith in you".[31] The natural outcome of this giving and receiving of trust is that the physician must accept some degree of obligation to the patient. Of course, the patient, if able, keeps some responsibility for the healing process, but the physician must be willing to answer the patient's needs, however demanding, however changing, however at times unreasonable or falsely perceived. Generalists in internal medicine undertake a long-term commitment to a patient's care. They are reminded daily that this commitment continues beyond a particularly insightful diagnosis or the completion of an endoscopic procedure; that the patient still needs care when the numbers are back from the most recent cardiac catheterization or when the final stitch is completed in a complex procedure and the patient is rolled from the operating suite. The internist continues to care for and nurture the patient through the whole process of healing in a way that requires enormous skill in close personal interaction.

### Help with Family Interactions

The woman who comes into her physician's office with a history of fatigue, listlessness, inability to sleep, and irritability may be describing the early symptoms of a morbid disease. She may, however, be showing signs of depression secondary to her inability to cope any longer with an alcoholic husband, with a teenage son addicted to cocaine, or with an elderly mother for whom she must care. The wise physician considers organic pathology but also realizes that presenting symptoms may be only part of what is really troubling the patient. This requires an unusual sensitivity and an ability to pursue in a cautious, understanding, and careful way and to listen to the concerns and needs

the patient describes – traits, again, that can and must be developed and practiced.[32] The physician's role is to help the patient understand the connections between unpleasant situations, emotional disturbances, and organic symptoms. Sometimes patients are helped simply by understanding those relationships and being aware that the doctor appreciates them and reassures, listens with a sympathetic ear, and seldom advises in a direct way, but does express concern.[33] In earlier days, when most medical care was delivered at home, the physician was quickly made aware of living situations and family interactions – if he or she did not already know the entire family and their circumstances. Today when the patient comes to the office, generally alone and certainly out of socioeconomic context, it is much more difficult to perceive what is going on. The physician must exercise a much greater degree of skill and understanding in exploring family interrelationships during a history and physical examination or in an even shorter visit.

**Help with Obtaining Necessary Additional Professional Services**

The warm and intimate relationship that any patient seeks is not one that a typical patient can have with many physicians at the same time. The internist must demonstrate a variety of skills, attitudes, and abilities and a store of diverse information that allows him or her to be the patient's health care *manager* as well as his confidant, keeping in mind that the average patient does not understand the system of medical referrals for subspecialty consultation.[34]

An oncologist/internist recently described for me how she weaves the fabric of health care management for a patient who has been referred with a positive biopsy for a malignant disease. In this situation the oncologist has to view herself as the captain of a rather complicated ship. She has to talk with the referring physician, obtain the biopsy slides, have them re-read by her own consulting pathologist, and review them herself. She then has to review the chart and the radiographs with a consulting radiologist and decide, given all the data, how best to institute therapy. This may require interaction with the surgeon, with the radiation oncologist, and with additional specialists with the skills for exploration, including various techniques for interventional radiology or endoscopy. Having decided on the course to take, she then has to become the patient's advocate and interact with the surgeon, the radiation oncologist, or other consultants on the patient's behalf and with the patient's best interests in mind. It is then necessary to spend time with the patient to explain the disease and what is to be expected and with the family to answer their questions and as much as possible to enlist them as allies for the hard times to come. Further, she has to commit herself to the long-term counseling, reassurance, and constant caring needed by a patient with a chronic and possibly fatal disease. This physician's role is much different form that of a physician-technician who performs a procedure and then sends the patient back to the doctor who will care for the long-term needs. While technicians' roles in this process are often crucial, their interactions with the patient are brief. The health care manager, in this case the oncologist, knits the technical information together and confers with her patient about the best way to proceed.

The physician who takes responsibility for the total oversight of the patient's needs as related to the

disease is the one who really must captain the ship and with whom the patient needs a very special, trusting relationship. [35] Too often in modern medicine, with its exquisitely developed technologies, a degree of impersonal behavior creeps in. The skilled cardiac surgeon, the superb master of angioplasty, the excellent endoscopist, the impressive neurosurgeon all touch "our" patients from time to time, exercise their skills in their one intervention, and then go on to the next patient. The general internist must define the need for the procedural intervention, give support during its execution, and most importantly continue to care following the procedure. When the consulting surgeon or specialist is no longer available, the one-on-one interaction between the patient and the internist, "*his or her doctor*," must remain inviolate.

## Help with Suffering

Most chronic diseases involve physical, mental, and emotional suffering to some degree during their courses. Some patients do beautifully because of their own intrinsic personalities, strong wills, or deep convictions. Others have great difficulty and sometimes even the toughest break under the severe suffering of a chronic illness. Physicians must develop skills of interpersonal relationship based on familiarity with all sides of life and especially with suffering. They need to *participate* in suffering. They need to be able to relate it to a broad range of experience so that they can deal with an enormous variety of patients at many different stages of coping with their suffering. Students sometimes get a glimpse of this in dealing with patients on inpatient services, but most often in outpatient clinics where they treat chronic diseases that continue unabated for many years. Often the physician has little specific therapy to offer except a kind touch, a gentle presence, and a knowing acknowledgement. Students of medicine learn through experience with patients as their own involvement in the practice of medicine grows through the years. The best physicians are always learning, because each patient teaches something new about the way in which a particular kind of suffering must be considered and ameliorated.

In the last two decades, patient support groups have become more numerous and more widely sought by patients. Many are now associated with major medical centers. These groups play a vitally important role in allowing patients to express their concerns and fears and to hear other patients in similar situations share their concerns and frustrations. As important as these are, as constructive as they are, and as meaningful as they have become in the overall care of patients, physicians still must understand the circumstances and the degree of suffering of each patient. [36] Each one's needs are unique. Merely sharing them does not make them go away, and merely knowing that someone else also carries burdens does not solve the problem. The physician must be interactive and supportive – even when the ways to change the physical situation may be sadly limited.

## Helping with Aging

The past several decades have seen a remarkable increase in the proportion of the population over 65, over 75, and even over 85 years of age – the last being the fastest-growing of all age groups.

These proportions will continue to increase significantly. Already the average age of the practice population in the offices of many general internists exceeds 70 years. This demographic shift has been accompanied by increasing awareness of the general field of geriatric medicine and expanding knowledge of the biologic processes involved in aging. [37] Projected population trends indicate that every general internist must become experienced in the needs of the geriatric population, as the aging process involves essentially every organ system. However, there are at least two – the nervous system and the musculoskeletal system – with which essentially every person reaching the seventh, eighth, and ninth decades of life will experience trouble to an increasing degree.

Memory loss of some degree is essentially universal in the elderly, although it clearly is more pronounced in some than others and may or may not be associated with the true clinical syndrome of Alzheimer's disease. [38] Memory loss affects the individual's self-perception, ability to interact with friends and family, and ability to accommodate to the pressures of our changing world. It can put barriers between the individual and those he or she most needs. This is true even for the very luck individual who is able to maintain work activities, friends, and family as he or she did in his prime. [39] The same situation develops with osteoarthritis, as gait problems, muscle fatigue, and weakness become more prevalent with advancing age. These effectively limit the individual's ability to get away from home and sustain a normally active lifestyle. Physical difficulties simply prohibit him or her from doing the things he or she likes to do. Much of the focus of the general internist, therefore, is to keep the elderly individual as physically and mentally active and as personally and emotionally interactive with others as possible.

Loneliness, despair, chronic illness, and depression are all prevalent in the geriatric population. Our effort must be to treat individual symptoms and organ system failure as they appear – but, most importantly, to help aging individuals develop an overall lifestyle that gives them a sense of well-being – of being useful, of being appreciated, and of having meaning in their lives. The internist must devote increasing time and effort to aging patients and must be particularly sensitive to subtle changes in their environments, including the loss of a loved one, shrinking income relative to cost of living, dislocation from their homes, and the despair that comes from being unable to adjust to new surroundings such as a retirement center or nursing home. Each of these profoundly affects the way a patient reacts to physical diseases. The responsibility of the internist extends beyond the usual in this situation and requires a very special integration of medical knowledge and knowledge of how people adjust to their changing needs.

**Help with Dying**

Rarely does an individual really wish to die, but when the time does come patients want to die with dignity. What most of us desire above all is not just life, but a satisfactory quality of life, and we may sometimes quite rationally risk death to escape an unacceptable life. Issues surrounding dying patients and even the realistic definition of death are topics frequently encountered by today's internist.

It is an often if sometimes faintly praised triumph for modern medicine that we now have the technologic skills and instrumentation to keep essential body functions such as circulation and respiration operating almost indefinitely. [40] The ability to continue these functions regardless of the expected outcome for the patient has produced considerable ethical conflict for many who deal with patients in critical life support areas and intensive care units. [41]

Young people in medical training must make an effort to become "comfortable" with the process and the event of dying. The problems of when to withdraw life support mechanisms or to withhold resuscitation may present deep emotional conflicts for medical students – as well as for many very experienced physicians. Although medical ethics touches almost every aspect of health and the practice of medicine, the particular problems related to dying patients, stemming in part from legal considerations and from highly publicized special cases, put the physician in an especially difficult position. Only recently have objective conclusions begun to emerge from clinical investigation of outcomes from intensive care units. Although striking successes do occur, the survival rate with a high quality of life upon discharge from intensive care units is less than one would hope. Therefore, the physician frequently may be required to make difficult decisions for or with the patient and his or her family. Ultimately, society at large[42] will have to make policy regarding those decisions, using information based on careful clinical studies and analyses of the costs of sustaining life in truly hopeless situations. But that policy has not yet been established. In this area the skilled internist plays a uniquely personal role in preparing patients for terminal situations, becoming their teacher and confidant as they come to understand the disease process and what to expect. The physician is also called upon to help the patient's loved ones prepare for the outcome.

Each patient must be considered individually, keeping in mind previously expressed wishes, the nature of the terminal illness, the likelihood of recovery with an acceptable quality of life, and family wishes and interactions. Although these factors are difficult to weigh in the care of dying patients, objective evaluation and an unswerving concern for the patient will lead the physician to the best course of action.

## SUMMARY

While an internist may be defined as one trained in the principles and practice of medicine, a fuller description emphasizes his possession of uncommon knowledge of biologic science ranging from molecular events to whole organ system physiology, a special appreciation for human life and the needs of suffering people, and a comprehensive perspective on modern society – its influence on our lives and its stresses on our social structure. Although this chapter has emphasized patient/physician interaction, we must recognize that basic biomedical science provides the infrastructure for our profession. We must first and foremost[43] master our science if we are to be good physicians. We must know what is best to offer to correct the disease; then we weave the fabric of the physician's social and ethical responsibilities into the context of current medical care organization. Few physicians

function well merely as knowledgeable scientists or talented technicians, but none functions well simply as a crutch on which the patient can lean. The good physician – the one patients seek – must combine working scientific techniques with compassion and social responsibility.

## Notes

1. They ask them because they face a health care system that is scientifically complex, organizationally overloaded, and generally not oriented to the patient as a *person*. 本句中的 them 是指上句的 these questions。全句的意思是：他们之所以问这些问题，是因为他们所面对的医疗保健体系技术深奥、机构臃肿，而且一般都没有意识到病人首先是一个“人”。
2. in the midst of：在…中，在…当中
3. Beyond question, his own disease sensitized him to the complex mix of expectations, needs, fears, and appreciation that patients feel when facing a physical-mental trial while at the same time looking for that perfect physician to help them. 本句中 beyond question 的意思是“毫无疑问地”；sensitize sb to sth 意思是“使某人对某事敏感起来”。that 引导的定语从句修饰 the complex mix of expectations, needs, fears, and appreciation；when 引导两个分词短语 facing…和 looking for…作定语从句的时间状语。全句的意思是：毫无疑问，他自己的疾病使他在接受身心检测时对感受到的期待、需要、恐惧和感激等复杂心情十分敏感，并与此同时还希望有一位医术精湛的医生来帮助他们。
4. He had a Shakespearean grasp of the qualities of being human and an uncommon ability to transmit love and respect for his fellow human beings. 他像文坛巨匠莎士比亚一样对人有着深刻的理解；他有着非凡的能力向人类同胞传递关爱和尊重。

   威廉·莎士比亚（William Shakespeare，1564～1616），戏剧家，诗人。生于艾冯河畔的斯特拉福德。从 1590 年起至 1613 年，他一共创作了 38 部（一说 39 部）戏剧，包括喜剧、编年史剧、悲剧、传奇剧等。莎士比亚还创作了 154 首十四行诗和 7 首长诗。与莎士比亚同时代的戏剧家本·琼生说，“他不属于一个时代，而是属于永远”，说明了数百年来莎士比亚在世界文明和文学中的地位。
5. Since Flexner issued his famous report in 1910, American medical education has striven toward the development of a strong scientific base. 自从 1910 年弗莱克斯纳（Simon Flexner）的著名研究报告问世以来，美国的医学教育就一直在坚实的科技基础上发展。本句中提到的“Flexner issued his famous report in 1910”指的是他所撰写出版的 *Medical Education in the United States and Canada*.（New York, NY: Carnegie Foundation for the Advancement of Teaching; 1910.）他的这份研究报告通常被称为 the Flexner Report，它对 the Standardization of American Medical Education 有巨大贡献。他有一句名言：“If the sick are to reap the full benefit of recent progress in medicine, a more uniformly arduous and expensive medical education is demanded.”（“如果想要病人从医学的最新进展中获得充分的益处，那就需要将更多的人力、物力投入到医学教育中去。”）
6. No physician can with intellectual honesty use these new classes of agents without fully under-

standing their action, their meaning, and their potential side effects. 本句中有 no 和 without，是双重否定句，表示肯定意义，相当于 Every physician with intellectual honesty will use these new classes of agents with fully understanding their action, their meaning, and their potential side effects. 本句意思是：任何一位有学术诚信的医生都不会在没有充分了解它们的作用方式、治疗意图以及可能具有的副作用的情况下使用这些新型制剂。

7. 此处的 managed-care 是指 managed health care（管理型医疗保险），它是美国的一种医疗保障模式。管理型医疗保险出现于 20 世纪 60 年代，初衷是提高医疗服务的质量，并提供预防保健服务，后来逐渐发展成为一种以控制医疗费用为主要目的的医疗保障模式。确切地说，管理型医疗保险是一种集医疗服务的提供和经费管理于一体的医疗保险模式，关键在于保险人直接参与医疗服务体系的管理。它具备以下几个要素：根据明确的选择标准来挑选医疗服务的提供者（医院、诊所、医生）；将挑选出的医疗服务的提供者组织起来，为被保险人提供医疗服务；有正式的规章以保证服务质量，并反复检查医疗服务的提供情况；被保险人按规定程序找指定的医疗服务提供者，有病时可享受经济上的优惠。
8. diagnosis-related groups（DRG's）：诊断相关组。诊断相关组按照性质不同的病种对住院病人进行分类，根据对病人的基本诊断、治疗措施、年龄、性别以及出院后可能出现的状况来安排每一个病人。
9. These issues have become major concern in American households and clearly represent one of the most disturbing weaknesses in our economy, of which now nearly 12 per cent (by annual gross national product) is devoted to health care, up from 8 per cent in 1975. 本句的主语是 These issues；谓语有两个：have become 和 represent；of which 引导的定语从句修饰 our economy。全句意思是：这些问题已经成为美国家庭关心的主要问题，并且是美国经济中最令人担心的薄弱环节。医疗费用占每年国民生产总值的比例已由 1975 年的 8% 增加到现在的 12%。
10. per capita 每人，按人口（计算）
11. 这里提到的 Medicare program 和 Medicaid plan 以及前面提到的 Managed-care 都是美国的医疗补助制度。Medicare 是政府用于补助老人的退休医疗福利，本人需要承担小部分医疗费用；Medicaid 则是政府用于补助穷人的医疗补助，可以免除全部医疗费用；Managed-care 是管理型医疗保险，前面（注释 7）已作过介绍。
12. in/at/on the final/last analysis：归根结底
13. Ironically, although physician competence is often equated to mastery of expensive techniques and technologies, physicians are actually at their professional best when listening to the patient and responding to what they hear and see with medicine's most comprehensive armamentarium. 具有讽刺意味的是，虽然医术常常等同于高超的技艺与手段，但实际上医生职业的最高境界是在倾听患者心声，并应用最先进的医疗设备对所见所闻采取措施的时候。at one's best：处于最佳状态；armamentarium 指医疗机构的全套配备，包括图书，药品和器械，它的复数形式是 armamentariums 或 armamentaria。
14. take（an）interest in：对…感兴趣

15. steer away from ( = steer clear of)：绕开，避开，避免
16. computed tomography（CT)：计算机体层摄影（术）
magnetic resonance imaging（MRI)：磁共振成像
17. The physician must use intellect – scientific knowledge and analytical skills – to best serve the patient without inundating the system with unnecessary costs and the patient with a financial burden he simply cannot continue to bear. 本句中 must use 的宾语是 intellect；scientific knowledge and analytical skills 是它的同位语。without inundating 后面有两个并列的成分：一个是 the system with unnecessary costs；另一个是 the patient with a financial burden he simply cannot continue to bear，其中 he simply cannot continue to bear 是定语从句，修饰 a financial burden。本句意思是：医生必须运用智慧（包括科学知识和分析能力）来为病人提供最佳服务，既不要给医疗保健体系增加不必要的费用，也不要给病人造成不必要的、无法继续承受的经济负担。
18. health maintenance organization（HMO)：健康维护组织。20 世纪 70 年代以来，由于医疗服务费用的急速上涨，管理型医疗保险模式受到愈来愈多的重视。采用这种模式的医疗保险机构也大量涌现，健康维护组织（HMO)、重点服务计划（POS)、优先医疗服务提供者组织（PPO)、专项服务提供者组织（EPO）等，甚至部分政府提供的老人医疗照顾计划和穷人医疗资助计划也采用了管理型医疗保健模式。到目前为止，加入管理型医疗保险各种机构和计划的投保人已接近全国人口的一半。而且管理型医疗保险所覆盖的内容也从传统的一般住院和门诊服务扩展到了理疗、精神治疗、眼科、牙科、推拿等专科治疗，在管理制度和管理方法上也日臻成熟。
19. with a view to（doing sth.)：为了要…，目的在于…
20. be thrust on/upon：把…强加于…
21. in the light of：按照，根据；考虑到，鉴于
22. caesarean section：剖腹产（术）
23. hinge on/upon：靠…转动；以…为转移，随…而定
24. with an eye to/on：着眼于，考虑到；对…有企图，打…主意
25. It is in this sense that we address ourselves to the nature of those who care. 本句是 it is …that …的强调句型，所强调的是状语 in this sense。address oneself to 的意思是“向…讲话，论述；致力于，着手”。本句意思是：正是在这一点上才促使我们自己来谈一下提供医疗服务的人们所应具有的品质。
26. Kahlil Gibran has taught us，“You give but little when you give of your possessions – it is when you give of yourself that you truly give.”纪伯伦教导过我们：“给予财产算不上给予，只有当你献出自己，那才算是真正的给予。”Kahlil Gibran 纪伯伦（1883 – 1931）是黎巴嫩文坛骄子，是一位哲理诗人兼杰出画家，和泰戈尔一样是近代东方文学走向世界的先驱。同时，他又是阿拉伯现代小说和艺术散文的主要奠基人，二十世纪阿拉伯新文学道路的开拓者之一。本世纪二十年代初，以纪伯伦为中坚和代表形成的阿拉伯第一个文学流派“叙美派”（即“阿拉伯侨民文学”）曾闻名全球。
27. in an honest position to（do sth)：完全能够