

ENGLISH FOR MEDICAL PURPOSES
CLINICALLY
READING AND WRITING

医用英语读写教程

临床分册

亓兴华 窦岩 主编



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鉴于全国高校的教学资源、学生入学水平以及所面临的社会需求等都不尽相同,我国高等学校本科用《大学英语课程教学要求》(试行)要求各校参照《课程要求》,根据本校的实际情况,确定教学目标,制定科学的、系统的、个性化的大学英语教学大纲,要求尽可能地利用语言载体,强调通过大量的自主阅读来提高词汇量和增加知识,让学生了解科学技术、西方社会文化等知识,并创造条件,鼓励学生根据自己的学习情况,向较高要求或更高要求调整自己的学习目标。

在教学实践中,各医学院校也都在贯彻《大学英语课程教学要求》。但由于缺乏系统、实用的医用英语教材,在实现《课程要求》倡导的专业英语的教学方面存在一定缺憾。为此,我们编写了这套供医学院校使用的专业英语读写教材,包括《医用英语读写教程——基础分册》(ENGLISH FOR MEDICAL PURPOSES, Preclinically Reading and Writing)和《医用英语读写教程——临床分册》(ENGLISH FOR MEDICAL PURPOSES, Clinically Reading and Writing)两册。

本册为《医用英语读写教程——临床分册》,包括专业阅读和写作两个部分。“专业阅读”部分包括精读(TEXT A)、问题、讨论、随意自愿阅读(TEXT B)。所有阅读文章均选自相关专业的国外书刊,以原版教材为主,基本不作删改,为学

生提供地道的医用英语阅读素材。内容以专业知识为主,包括当前医学的热点、国外最新医学观点和科技发展动态等方面的知识。选材时结合语言知识和技能的输入和输出,所选阅读文章在难度控制上采用主题控制法(topic control),与医学专业相关的主题均选入,根据所开专业课的先后顺序进行排列,目的是为学生的医用英语阅读打下坚实的基础。“写作”部分主要为医用目的写作,包括会诊、转院等主题的书信写作和医学论文的基本构架及写作。此外,我们还在附录中提供了药品说明书、病历、手术报告、出院报告以及包括放射学报告、病理学报告、体检报告、实验室检测标准等在内的医学检验报告,这些医学文件为医科学生提供了大量丰富的实用医学英语素材。作为对于医用英语术语的总结,附录中还列出了医用英语词根、前缀和后缀总表。

我们希望《医用英语读写教程——基础分册》和《医用英语读写教程——临床分册》能够为医科学生的外语学习和专业学习之间架设一座桥梁。通过本套教材的学习,我们的学生能在听、说、读、写、译诸方面持续全面提高,并逐步具有阅读专业医学书刊、利用英语进行专业交流的能力,同时能够拓宽学术视野,培养学术兴趣和创新意识,提高学术品位,最终具备顺利运用英语进行交际活动——学术会议发言,撰写学术论文的能力,达到《大学英语课程教学要求》中的“更高要求的英语能力”要求。

本册教材的编写历时三年,其间我们一直得到来自各方面的关心和支持。在《医用英语读写教程——临床分册》的编写过程中,承蒙黄元华教授、曾慧明教授、姚震教授、郝新保教授、周延平教授、孙晓宁教授、钱士匀教授、李群教授、涂容教授、谭光宏教授、孟志斌教授、陈洛夫教授、张毅副教授、马波副教授等专家以精湛的技术和深厚的专业积淀惠予帮助和指导;涂容教授和郝美娟老师为收集资料和联络专家提供了热情的帮助;澳大利亚教师 Geoffrey Milne 校阅全书并提出了宝贵意见。在此,谨向他们和所有给予我们有益帮助和悉心指导的同行和朋友们致以诚挚的谢意。

在本书的编写过程中,我们参考并选用了其他一些教材和资料中的有关内容,在此谨向有关单位和人士表示感谢。由于编者学识所限,书中难免纰漏和谬误,请各位同行不吝指正。

编者

2005年12月

CONTENTS

PART ONE	READING	1
Unit 1	Text A: The Practice of Medicine	1
	Text B: Ethical Issues in Clinical Medicine	9
Unit 2	Text A: Vomiting in Infancy and Childhood	15
	Text B: Acute Poisoning	24
Unit 3	Text A: Resuscitation; Airway Management	29
	Text B: The Acute Abdomen	39
Unit 4	Text A: Urinary Stones—Diagnostic Evaluation	45
	Text B: Cholelithiasis and Chronic Cholecystitis	55
Unit 5	Text A: Preoperative Considerations in Orthopedic Surgery	59
	Text B: Postoperative Care for Orthopedic Patient	67
Unit 6	Text A: In Vitro Fertilization and Embryo Transfer	71
	Text B: Fibroids of the Uterus	81

Unit 7	Text A: Cesarean Section	85
	Text B: Diseases Related to Pregnancy	91
Unit 8	Text A: The Clinical Syndromes of AIDS	95
	Text B: Acute Viral Hepatitis	110
Unit 9	Text A: Diagnosis of Pneumonia	114
	Text B: Chronic Bronchitis	126
Unit 10	Text A: Serological Tests	129
	Text B: Urinalysis	137

PART TWO PRACTICAL WRITING FOR MEDICAL PURPOSES

Section I Letter Writing

- I. Letters of Inquiry 143
- II. Letters for Diagnostic Consultation 145
- III. Letters for Referring Patients 146

Section II The Structure of a Medical Paper

- I. Abstract 150
- II. Introduction 153
- III. Conclusion 157
- IV. Acknowledgements 159

PART THREE APPENDIX

Appendix I Medical Documents

- I. Drugs Instruction 163
- II. Case History 178
- III. Operation Report 183
- IV. Discharge Summary 185
- V. Medical Laboratory Reports 187

Appendix II Medical English Roots, Prefixes, and Suffixes

Appendix III Glossary

Appendix IV 参考译文

PART ONE READING

Unit One

Text A

The Practice of Medicine

WHAT IS EXPECTED OF THE PHYSICIAN?

The practice of medicine combines both science and art. The role of science in medicine is clear. Science-based technology is the foundation for the solution to many clinical problems; the dazzling advances in biochemical methodology and in biophysical imaging techniques that allow access to the remotest recesses of the body are the products of science. So too are the therapeutic maneuvers that increasingly are a major part of medical practice. Yet skill in the most sophisticated application of laboratory technology and in the use of the latest therapeutic modality alone does not make a good physician. To extract from a mass of contradictory physical signs and from the crowded computer printouts of laboratory data those items that are of crucial significance, to know in a difficult case whether to “treat” or to “watch”, to determine when a clinical clue is worth pursuing or to dismiss it, and to estimate in any given patient whether a proposed treatment entails a greater risk than the disease are all involved in the decisions that the clinician, skilled in the practice of medicine, must make many times each day. This combination of medical knowledge, intuition, and judgment defines the art of medicine. It is as necessary to the practice of medicine as a sound scientific base.



THE PATIENT-PHYSICIAN RELATIONSHIP

It may be trite to emphasize that physicians need to approach patients not as “cases” or “diseases” but as individuals whose problems all too often transcend the complaints that bring them to the doctor. Most patients are anxious and frightened. Often they go to great ends to convince themselves that illness does not exist, or unconsciously they set up elaborate defenses to divert attention from the real problem that they perceive to be serious or life-threatening. Some patients use illness to gain attention or to serve as a crutch to extricate themselves from a stressful situation; some even feign physical illness. Whatever the patient’s attitude is, the physician needs to consider the setting in which an illness occurs—in terms not only of the patients themselves but also of their families and social backgrounds. Medical workups and records often fail to include essential information about the patient’s origins, schooling, job, home and family, hopes and fears. Without this knowledge, it is difficult for the physician to gain rapport with the patient or to develop insight into the illness. The ideal physician-patient relationship is based on thorough knowledge of the patient, on mutual trust, and on the ability to communicate with one another.

The American Board of Internal Medicine has defined humanistic qualities as encompassing integrity, respect, and compassion. Availability, the expression of sincere concern, the willingness to take the time to explain all aspects of the illness, and an attitude of being nonjudgmental with patients who have lifestyle, attitudes, and values different from those of the physician and which he or she may in some instances even find repugnant are just a few of the characteristics of the humane physician. Every physician will, at times, be challenged by patients who evoke strongly negative (and occasionally strongly positive) emotional responses. Physicians should be alert to their own reactions to such patients and situations and should consciously monitor and control their behavior so that the patients’ best interests remain the principal motivation for their actions at all times.

CLINICAL SKILLS

History Taking The written history of an illness should embody all the facts of medical significance in the life of a patient. If the history is recorded in chronologic order, recent events should be given the most attention. Likewise, if a problem-oriented approach is used, the problems that are clinically dominant should be listed first. Ideally, the narration of symptoms or problems should be in the patient's own words. The physician must be alert to the possibility that any event related by the patient, however trivial or apparently remote, may be the key to the solution of the medical problem.

An informative history is more than an orderly listing of symptoms. Something is always gained by listening to patients and noting the way in which they describe their symptoms. Inflections of voice, facial expression, and attitude may betray important clues to the meaning of the symptoms to the patient. In listening to the history, the physician discovers not only something about the disease but also something about the patient.

However accurate and complete it is, the medical history does much more than providing facts of critical importance. The very act of taking the history provides the physician with the opportunity to establish or enhance the unique bond that is the basis for the physician-patient relationship. An effort should be made to place the patient at ease, regardless of the circumstances. The patient should, at some point, have the opportunity to tell his or her own story of the illness without frequent interruption and, when appropriate, receive expressions of interest, encouragement, and sympathy from the physician. It is helpful to develop an appreciation of the patient's perception of the illness, the patient's expectations of the physician and the medical care system, and the financial and social implications of the illness to the patient. The confidentiality of the physician-patient relationship should be emphasized, and the patient should be given the opportunity to identify any aspects of the history that should not be disclosed.

Physical Examination Physical signs are the objective indications of disease and represent solid, indisputable facts. Their significance



is enhanced when they confirm a functional or structural change already suggested by the patient's history. At times, the physical signs may be the only evidence of disease, especially when the history is inconsistent, confused, or lacking altogether.

The physical examination should be performed methodically and thoroughly, with consideration for the patient's comfort and modesty. Although attention is often directed by the history to the diseased organ or part of the body, the examination of a new patient must extend from head to toes in an objective search for abnormalities. The results of the examination, like the details of the history, should be recorded at the time they are elicited, not hours later when they are subject to the distortions of memory. Many inaccuracies stem from writing or dictating notes long after the examination has been concluded. Skill in physical diagnosis is acquired with experience, but it is not merely technique that determines success in eliciting signs. The detection of a few scattered petechiae, a faint diastolic murmur, or a small mass in the abdomen is not a question of keener eyes and ears or more sensitive fingers but of a mind alert to these findings. Skill in physical diagnosis reflects a way of thinking more than a way of doing. Physical findings are subject to change. Just because the examination is normal on one occasion does not guarantee that it will be normal on subsequent examinations. Likewise, abnormal findings may disappear during the course of illness. The physical examination should be repeated as frequently as the clinical situation warrants.

Laboratory Tests The increase in the number and availability of laboratory tests has increased our reliance on these studies for the solution of clinical problems. It is essential, however, to bear in mind the limitations of such procedures, which by virtue of their impersonal quality and complexity often gain an aura of authority regardless of the fallibility of the tests themselves, the instruments used in the tests, and the individuals performing or interpreting them. Moreover, the accumulation of laboratory data does not relieve the physician from the responsibility of careful observation and study of the patient. Physicians also must weigh the hazards and expense involved in the laboratory procedures they order. Moreover, laboratory tests are rarely ordered and reported singly. Rather, they are produced as "batteries" of multiple tests.

The various combinations of laboratory tests are often useful. For example, they may provide the clue to such nonspecific symptoms as generalized weakness and increased fatigability by revealing abnormalities of hepatic function, suggesting the diagnosis of chronic liver disease. Sometimes a single abnormality, such as an elevated serum calcium level, points to a specific disease, such as hyperparathyroidism.

The thoughtful use of screening tests should not be confused with indiscriminate laboratory testing. The use of screening tests is based on the facts that a group of laboratory determinations can be carried out conveniently on a single specimen of blood at relatively low cost. Biochemical measurements, together with simple laboratory examinations such as blood count, urinalysis, and sedimentation rate, often provide the major clue to the presence of a pathologic process. At the same time, the physician must learn to evaluate occasional abnormalities among the screening tests that may not necessarily connote significant disease.

Imaging Techniques The availability of ultrasonography, a variety of scans that employ isotopes to visualize organs heretofore inaccessible, computed tomography with its varying permutations, magnetic resonance imaging, and positron emission tomography have opened new diagnostic vistas, and have benefited patients because these new techniques have largely supplanted more invasive ones. While the enthusiasm for noninvasive technology is understandably justified, the expense entailed in performing these imaging tests is often substantial and is not always considered when ordering them. These examinations should be used judiciously.

Continued Learning The conscientious physician must be a perpetual student since the body of medical knowledge is constantly expanding and being refined. The profession of medicine should be inherently linked to a career-long thirst for new knowledge that can be used for the good of the patient. It is the responsibility of a physician to pursue continually the acquisition of new knowledge by reading, attending conferences and courses, and consulting with colleagues. This is often a difficult task under the circumstances of a busy practice; however, such a commitment to continued learning is such an internal part of being a physician that it should be given the

highest priority.

Medicine on the Internet The explosion in use of the World Wide Web, or Internet, through personal computers has had an important impact on many practicing physicians. The “Net” provides almost instantaneous availability of a wide range of information directly to the desk of a physician at any time of day or night and from anywhere in the world. It holds enormous potential for providing useful up-to-date practice guidelines, information on state-of-the-art conferences, journal contents, textbook chapters, and direct communication with other physicians and specialists, thereby expanding the depth and breadth of information available to the physician about the diagnosis and care of patients. The potential benefit of this medium for the practicing physician is enormous, and it behooves physicians to become familiar with the use of the Internet.

New Words and Expressions

recess /rɪ'ses/ *n.* 隐窝;凹进处

maneuver /mə'nʊ:və/ *n.* 手法;操作法 (*syn.* conduct; scheme)

modality /məʊ'dælɪtɪ/ *n.* 用药方式

entail /ɪn'teɪl/ *vt.* 带来;引起;使……发生

intuition /'ɪntʃu(:)ʃən/ *n.* 直觉;直觉的知识

trite /traɪt/ *adj.* 陈腐的;无新意的 (*syn.* stereotyped; stale)

transcend /træn'send/ *vt.* 超越;超过

extricate /'ekstrikeɪt/ *vt.* 使解脱 (*syn.* release; disengage)

feign /feɪn/ *vt.* 假装;装作;捏造 (*syn.* fake; pretend)

rapprochement /ræ'pɔ:t/ *n.* 和谐;亲善

encompass /ɪn'kʌmpəs/ *vt.* 包含;包括 (*syn.* enclose; include)

repugnant /rɪ'pʌgnənt/ *adj.* 使人反感的;可憎的 (*syn.* offensive; repulsive)

petechia /pɪ'tɪ:kɪə/ *n.* (*pl.* petechiae) 瘀斑;瘀点

diastolic /daɪə'stɒlɪk/ *adj.* 心脏舒张的

aura /'ɔ:rə/ *n.* 氛围;气氛 (*syn.* atmosphere)

hyperparathyroidism /haɪpə'pærəθaɪrɔɪdɪzəm/ *n.* 甲状旁腺功能亢进

sedimentation /ˌsedɪmənt'eɪʃən/ *n.* 沉淀; 沉降

connote /kə'nəʊt/ *vt.* 暗示; 意味

isotope /'aɪsəʊtəʊp/ *n.* 同位素

tomography /tə'mɒgrəfi/ *n.* X 线断层摄影术

permutation /ˌpə:mju(:)'teɪʃən/ *n.* 改变; 置换; 排列

resonance /ˈrezənəns/ *n.* 共振; 共鸣

positron /'pɒzɪtrɒn/ *n.* (=antielectron) 正电子; 阳电子

vista /'vɪstə/ *n.* 展望; 回顾

supplant /sə'plɑ:nt/ *vt.* 代替; 取代

perpetual /pə'pɛtʃʊəl/ *adj.* 永久的 (*syn.* continual; lasting)

behoove /br'həʊv/ *vt.* 有需要; 有必要

Exercises

I. Answer the following questions:

1. According to the author, what makes a good physician?
2. Different patients have a different attitude to their disease. What are the different attitudes listed in the article?
3. What is the ideal physician-patient relationship based on?
4. What are the characteristics of a humane physician?
5. Why should the narration of symptoms or problems be in the patient's own words?
6. Besides a patient's description of his/her symptoms, what else should be given special attention to in history taking? Why?
7. A person's medical history does much more than providing facts of critical importance. What does it mean?
8. Why should the results of a physical examination be recorded at the time they are elicited?
9. What should be born in mind by a physician while ordering laboratory tests?
10. How do new imaging techniques, such as ultrasonography, benefit patients?
11. Why should a conscientious physician be a perpetual student?



II. Topics for discussion:

1. The combination of medical knowledge, intuition, and judgment defines the art of medicine. What is your comment about this viewpoint? As a medical student, what do you think is expected of the physician?
2. Skill in physical diagnosis reflects a way of thinking more than a way of doing. Do you agree? Please give examples to support your view.
3. In what way does the Internet benefit the practicing physician?

Text B — Free Voluntary Reading**Ethical Issues in Clinical Medicine**

Physicians frequently confront ethical issues in clinical practice that are perplexing, time-consuming, and emotionally draining. Experience, common sense, and simply being a good person do not guarantee that physicians can identify or resolve ethical dilemmas. Knowledge about common ethical dilemmas is also essential.

FUNDAMENTAL ETHICAL GUIDELINES

In patient care, physicians should follow two fundamental but frequently conflicting ethical guidelines: respecting patient autonomy and acting in the patient's best interests.

Respecting Patient Autonomy Competent, informed patients may exercise their self-determination and liberty by refusing recommended interventions and choosing among the available alternatives.

Informed consent Informed consent requires physicians to discuss with the patient the nature of the proposed care, the alternatives, the risks and benefits of each, and the likely consequences and to obtain the patient's agreement to care. Informed consent involves more than obtaining patients' signatures on consent forms. Physicians need to educate patients, discuss options with them, answer questions, make recommendations, and help them deliberate. Patients can be overwhelmed with medical jargon, needlessly complicated explanations, or too much information at once.

Nondisclosure of information Physicians may consider withholding a serious diagnosis, misrepresenting it, or limiting discussions of prognosis or



risks out of fear that a patient will develop severe anxiety or depression or refuse needed care. Patients should not be forced to receive information against their will. Most people, however, want to know their diagnosis and prognosis, even if they are terminally ill. Generally, physicians should provide relevant information, while offering empathy and hope and helping patients cope with bad news.

Emergency care Informed consent is not required when patients cannot give consent and delaying treatment would place their life or health in peril. People are presumed to want such emergency care, unless they have indicated otherwise.

Futile interventions Autonomy does not entitle patients to insist on whatever care they want. Physicians are not obligated to provide futile interventions that have no physiologic rationale or when maximal treatment is failing. For example, cardiopulmonary resuscitation would be futile in a patient with multisystem failure that is worsening despite maximal therapy.

Acting in the Best Interests of Patients The guideline of beneficence requires physicians to take actions for patients' benefit. Laypeople do not possess medical expertise and may be vulnerable because of their illness. They justifiably rely on physicians to provide sound advice and to promote their well-being. Physicians encourage such trust. For these reasons, physicians have a fiduciary duty to act in the best interests of their patients. Furthermore, the interests of the patient should take priority over physicians' self-interest or the interests of third parties, such as hospitals or insurers. These fiduciary obligations contrast sharply with the business world, where the goal is to maximize profits, not to act in the best interests of customers. The guideline of "do no harm" forbids physicians from providing ineffective interventions or acting without due care. This precept, while often cited, provides only limited guidance, because many beneficial interventions also have serious risks.

Conflicts Between Beneficence and Autonomy

Patients' refusals of care may thwart their own goals or cause them serious harm. For example, a young man with asthma may refuse mechanical ventilation for reversible respiratory failure. Simply to accept such refusals, in