

'17

前期日程

小論文

(医学部医学科)

注意事項

1. 試験開始の合図があるまで、この問題冊子を開いてはいけません。
2. 問題冊子は1冊(6頁)、解答用紙は2枚、下書用紙は2枚です。落丁、乱丁、印刷不鮮明の箇所等があった場合には申し出てください。
3. 氏名と受験番号は解答用紙の所定の欄に記入してください。
4. 解答は指定の解答用紙に記入してください。
 - (1) 文字はわかりやすく、横書きで、はっきり記入してください。
 - (2) 解答の字数に制限がある場合には、それを守ってください。
 - (3) 訂正、挿入の語句は余白に記入してください。
 - (4) ローマ字、数字を使用するときは、マス目にとらわれなくてもかまいません。
5. 解答用紙は持ち帰ってはいけません。
6. 問題冊子と下書用紙は持ち帰ってください。

次の文章を読んで、設問A～Iに答えなさい。*のついた言葉には文末に訳注があります。

Frederick Taylor, a son of Philadelphia aristocrats* who lived at the turn of the last century, became known as the “father of scientific management” — the original “efficiency expert.” He believed that the components of every job could and should be scientifically studied, measured, timed, and standardized to maximize efficiency and profit. Central to Taylor’s system is the notion that there is one best way to do every task and that it is the manager’s responsibility to ensure that no worker deviates* from it. “In the past, the man has been first; in the future, the system must be first,” Taylor asserted.

Toyota, inspired by these principles of “Taylorism,” successfully applied them to the manufacture of cars, thereby improving quality, eliminating waste, and cutting costs. As health care comes under increasing economic pressure to achieve these same goals, Taylorism has begun permeating the culture of medicine.

Advocates lecture clinicians about Toyota’s “Lean” practices, arguing that patient care should follow standardized systems like those deployed in manufacturing automobiles. Colleagues have told us, for example, that managers with stopwatches have been placed in their clinics and emergency departments to measure the duration of patient visits. Their aim is to determine the optimal time for patient–doctor interactions so that they can be standardized.

Meanwhile, the electronic health record (EHR)—introduced with the laudable* goals of making patient information readily available and improving safety by identifying dangerous drug–drug interactions — has become a key instrument for measuring the duration and standardizing the content of patient–doctor interactions in pursuit of “the one best way.” Encounters have been restructured around the demands of the EHR: specific questions must be asked, and answer boxes filled in, to demonstrate to payers the “value” of care. (C) interviews, vital for obtaining accurate clinical information and understanding patients’ mindsets, have

become almost impossible, given the limited time allotted for visits — often only 15 to 20 minutes. Instead, patients are frequently given checklists in an effort to streamline* the interaction and save precious minutes. The EHR was supposed to save time, but surveys of nurses and doctors show that it has increased the clinical workload and, more important, taken time and attention away from patients.

Physicians sense that the clock is always ticking, and patients are feeling the effect. One of our patients recently told us that when she came in for a yearly “wellness visit,” she had jotted down* a few questions so she wouldn’t forget to ask them. She was upset and frustrated when she didn’t get the chance: her physician told her there was no time for her questions because a standardized list had to be addressed — she’d need to schedule a separate visit to discuss her concerns.

We believe that the standardization integral to Taylorism and the Toyota
(D) manufacturing process cannot be applied to many vital aspects of medicine. If patients were [(E)], we would all be used [(E)] of different years and models, with different and often multiple problems, many of which had previously been repaired by various mechanics. Moreover, those [(E)] would all communicate in different languages and express individual preferences regarding when, how, and even whether they wanted to be fixed. The inescapable truth of medicine is that patients are genetically, physiologically, psychologically, and culturally diverse. It’s no wonder that experts disagree about the best ways to diagnose and treat many medical conditions, including hypertension, hyperlipidemia*, and cancer, among others.

To be sure, certain aspects of medicine have benefited from Taylor’s principles. Strict adherence to standardized protocols has reduced hospital-acquired infections, and timely care of patients with stroke* or myocardial infarction* has saved lives. It may be possible to find one best way in such areas. But this aim cannot be generalized to all of medicine, least of all to such cognitive tasks as eliciting an accurate history, synthesizing* clinical and laboratory data to make a diagnosis, and weighing the risks and benefits of a given treatment for an individual patient.

Good thinking takes time, and the time pressure of Taylorism creates a fertile field for the sorts of cognitive errors that result in medical mistakes. Moreover, rushed clinicians are likely to take actions that (F) patients' preferences.

Part of the original promise of scientific management was that increased efficiency and standardization would not only result in a better product at lower cost, but would also give workers more free time to enjoy life. Lillian Gilbreth, who with her husband Frank championed motion studies of workers to boost their efficiency, called this outcome saving time for "happiness minutes". Similarly, some prominent policy-makers have claimed that implementing scientific management in medicine would free doctors, nurses, and other members of the clinical team to spend more time with their patients. In fact, the opposite seems to be happening. Yet some of the greatest rewards of working in medicine come from spending unstructured time with our patients, sharing their joys and sorrows.

Instead of gaining happiness minutes, clinicians are increasingly experiencing dissatisfaction and burnout as they're subjected to the time pressures of Taylorism and scientific management in the name of efficiency. We have watched colleagues fleeing to concierge* practices, where they have control over their schedules. Others have taken early retirement, unwilling to compromise on what they believe is the time needed to deliver compassionate* care. Some have moved into management or consulting positions, where they tell others how to practice while unburdening themselves of their clinical load. Just as Taylor enriched himself by consulting for companies, a growing and lucrative* industry has emerged to generate and enforce metrics in medicine. By 2014, the Centers for Medicare and Medicaid Services* alone had mandated* the use of more than 1000 performance measures*. As the Institute of Medicine recently reported, such metrics have proliferated, though many of them have little proven value.

There is a certain hypocrisy among some of the most impassioned advocates for efficiency and standardization in health care, as Boston neurologist Martin Samuels recently pointed out. "They come from many different backgrounds:

conservatives, liberals, academics, business people, doctors, politicians, and more often all the time various combinations of these. But they all have one characteristic in common. They all want a different kind of health care for themselves and their families than they profess for everyone else.” What they want is what every patient wants: unpressured time from their doctor or nurse and individualized care rather than generic* protocols for testing and treatment.

^(G) Yet students are now taught the principles of Taylorism and Toyota Lean as early as their first year of medical school. They enter clinical rotations believing that there must be one best way to diagnose and treat every medical condition. In residency* training and beyond, they discover that's not the case, and they face a steep learning curve as they take on primary responsibility for patient care. We learn how to modify and individualize care in the real world, recognizing the variety of clinical presentations, the reality of multiple coexisting conditions, the variability of human biology, the effects of social and cultural contexts, and the diversity of patients' preferences regarding risk and benefit, all of which defy rigid protocols.

Medical Taylorism began with good intentions — to improve patient safety and care. But it has gone too far. To continue to train excellent physicians and give patients the care they want and deserve, we must reject its blanket application.^(H) We need to recognize where efficiency and standardization efforts are appropriate and where they are not. Good medical care takes time, and there is no one best way to treat many disorders. When it comes to medicine, Taylor was wrong:

(I-1) must be first, not **(I-2)**.

* 訳注一覧

aristocrat : 貴族

deviate : それる, 逸脱する

laudable : あっばれな

streamline : 合理化する, 簡素化する

jot down : 手早く書き留める

hyperlipidemia : 脂質異常症

stroke : 脳卒中

myocardial infarction : 心筋梗塞

synthesize : まとめる concierge : 管理人 compassionate : 情け深い
lucrative : 有利な, 得な Centers for Medicare and Medicaid Services :
米国保健社会福祉省(厚生省)内の組織の一つ(部局) mandate : 義務付ける
performance measure : 業績指標 generic : 包括的な, 一般的な
residency : (医師としての)研修

(出典 : The New England Journal of Medicine 374; 2: 106-108, 2016 より一部改変)

設 問

- A. 下線部(A)について, 解答用紙 の A 欄に日本語 200 字以内(句読点を含む)で説明しなさい。
- B. 下線部(B)について, そのようになった背景を, 解答用紙 の B 欄に日本語 60 字以内(句読点を含む)で記しなさい。
- C. 空欄(C)に入るふさわしい語句は下の 1) ~ 5) のいずれか。解答用紙 の C 欄に数字で記しなさい。
- 1) Closed-ended 2) Competency based 3) Case
4) Open-ended 5) Group discussion
- D. 下線部(D)について, そのように著者が考える理由はなにか。解答用紙 の D 欄に日本語 30 字以内(句読点を含む)で記しなさい。
- E. 空欄(E)には全て同じ英単語が入る。適切な英単語を解答用紙 の E 欄に記しなさい。

F. 空欄(F)に入るふさわしい語句は下の1)～5)のいずれか。解答用紙 の F 欄に数字で記しなさい。

- 1) accept 2) approve 3) ignore
4) object 5) sympathize

G. 下線部(G)について、以下のG-1とG-2の2つの問いにそれぞれ答えなさい。

G-1. 下線部(G)の結果として、医学生が医療現場に出る際に医療に対してどのように考えると著者は述べているか。解答用紙 のG-1欄に日本語60字以内(句読点を含む)で記しなさい。

G-2. その後、臨床経験を積むことによりどのような変化がもたらされると著者は述べているか。解答用紙 のG-2欄に日本語160字以内(句読点を含む)で記しなさい。

H. 下線部(H)について、その具体的な内容を、解答用紙 のH欄に日本語60字以内(句読点を含む)で記しなさい。

I. 空欄(I-1)および空欄(I-2)に当てはまる語句を本文中から選んで、解答用紙 のI-1欄とI-2欄にそれぞれ記しなさい。