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FACULTÉ DE
PHARMACIE

ANGLAIS

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Déroulement des cours d'anglais

Introduction

La maîtrise de l'anglais est une nécessité, que vous soyez spécialisé en officine, industrie ou internat. A partir de la 4ème année des études de pharmacie, les cours d'anglais visent, à travers l'étude de thèmes des trois filières de pharmacie, l'industrie, l'internat et l'officine, à développer vos connaissances et compétences de communication professionnelles en anglais. Vos cours d'anglais (1h30) ont lieu chaque semaine le mercredi matin de 8H30 à 10H00, de 10H05 à 11H35, de 11H40 à 13H10 selon votre groupe : assurez-vous donc de bien vérifier vos emplois du temps et de prendre vos dispositions en conséquence.

Comme les années précédentes, les cours ont lieu dans le bâtiment Eiffel (Centrale Supélec), au Centre de Langues (3e et 4e étage du bâtiment).

Objectifs

L'accent sera mis sur vos compétences de communication, de sorte qu'à la fin de cette année universitaire, vous devriez être capable de cocher les compétences suivantes qui apparaissent dans le portfolio :

☐ I am able to present my research on a topic with ease and fluency in a group, in front of an audience.
☐ I am able to understand the main points of a video and a text (article) and to write a summary.
☐ I now understand the healthcare systems and the pharmaceutical industry in the UK, the USA and India.
☐ I am able to express my opinion about a number of ethical issues, using the appropriate vocabulary.
☐ I can read a research paper, understand the main points and present it in front of an audience.

Ce programme est ambitieux et le nombre d'heures de cours relativement faible (24h). C'est pourquoi nous attendons de votre part que vous fournissiez un travail personnel important.

Ressources à votre disposition

IL EST IMPERATIF DE VOUS MUNIR D'UNE VERSION PAPIER ou NUMERIQUE (publiée sur **Ecampus**) de ce fascicule que vous apporterez à chaque cours.

Vous visionnerez régulièrement des reportages vidéo sur des thèmes liés à la santé, aux traitements et à la recherche médicale, parfois en autonomie en classe. Vous aurez donc besoin d'**écouteurs** et d'un **ordinateur** (ou **tablette** ou **téléphone portable**) pour les cours.

English 4 You a lieu le lundi à l'heure du déjeuner, de 12h30 à 13h30, dans le bâtiment BPC. *English for You* n'est pas un cours, il est accessible à tous les étudiants, quelle que soit leur année d'étude et sans inscription préalable. Il

vous permet de travailler et d'utiliser librement les ressources du département de langues : documents audio et vidéo, dictionnaires, tests TOEIC, etc. Vous pouvez aussi vérifier votre travail et/ou poser des questions au(x) professeur(s) présent(s).

Modalités d'évaluation

Contrôle continu (60%) comprenant : un compte rendu de reportage vidéo, une compréhension de texte, une expression écrite, deux présentations orales et quatre tests de vocabulaire. Toute absence à l'une des évaluations donnera lieu à un zéro, sauf justificatif écrit envoyé à l'enseignant dans les 3 jours suivant votre retour à la faculté.

Les absences justifiées donnent lieu à un rattrapage au cours suivant ou sur une séance d'English for You.

Pour tout problème santé demandant des aménagements particuliers, merci de le signaler à votre enseignant dès le début de l'année, même si votre dossier médical n'est pas finalisé.

Vous conservez votre note de contrôle continu même si vous devez aller en 2ème session : ne négligez donc pas votre travail personnel.

Examen final oral (40%) : Individuellement, vous aurez 30 minutes de préparation pour préparer le compte-rendu et le commentaire (opinion personnelle) d'un article portant sur un thème étudié pendant l'année.

Toute absence à l'examen final entraîne un report automatique en 2e session.

2ème session : 25% Contrôle continu - 25 % Examen écrit (50% compte-rendu de vidéo + 10% compréhension écrite + 40% expression écrite) - 50% Présentation orale

Voici les justificatifs d'absence acceptés :
- Maladie : certificat médical. Une ordonnance ou la capture d'écran d'un rendez-vous Doctolib ne sont pas acceptés.
- Problème de transport : billet RATP ou SNCF
- Accidents divers: déclaration à l'assurance
- Funérailles : certificat de décès.

Il est demandé aux étudiants de prévenir leur enseignant de leur absence, même lorsqu'ils n'ont pas de justificatif. Si un problème de transport ne vous permet pas d'arriver à l'heure, votre enseignant pourra vous proposer d'assister au cours d'un autre de ses groupes, si cela est possible.

Liste des évaluations

Semestre 1 (9 cours)
2 tests de vocabulaire
1 test de compréhension orale

Semestre 2 (7 cours)
2 tests de vocabulaire
1 test de compréhension /expression écrite

Semestre 1 et 2 : présentations orales
- 'Research paper' : Présentation *individuelle* d'un article de recherche (essai clinique) publié à partir de mai 2024.
- 'Health news' : Présentation *à deux* d'un article de presse portant sur le thème de la santé : résumé et opinion (chaque étudiant.e résume une partie de l'article, et chacun.e donne son opinion)

Examen final
Présentation (résumé + opinion) d'un article de presse portant sur un thème étudié dans l'année. S'ensuit une conversation avec l'examinateur.

30 minutes de préparation
10 minutes de passage : 5 minutes de présentation et, au maximum, 5 minutes d'interaction avec l'examinateur.

Presentation techniques

Activity 1: Warm-up

1. In pairs, discuss the following questions:

- Do you like giving presentations? Why / Why not?
- How can you stop being nervous about a presentation?
- Do you like listening to presentations?
- What kind of slides are best – those with pictures or those with words?
- Do you think giving presentations makes you more confident?
- What is the most difficult thing about giving a presentation?
- What advice would you give to someone who is about to give a presentation?
- What do you think when people talk during your presentation?

Activity 2: 200 years in 4 minutes

1. Watch the video and answer the following questions:
- At the beginning of the video, Hans Rosling says "Having the data is not enough. I have to …." Can you complete the sentence?
- List all the elements (verbal + non verbal) that make this presentation both understandable and enjoyable.

2. Signposting
Look at the following phrases Hans Rosling uses during his presentation:
now I'm going to show – now we slow down - now I speed up to – We stop a bit to look at the world in 1948 – Look ! – Now we can see the world today –

How useful are they? What do they bring to the presentation? Can you think of more phrases that would have the same role?

3. Intonation is key to effective communication. The change in the pitch of your voice conveys meaning and information.

Falling intonation (↘) : The pitch of the voice falls at the end of the sentence.
Falling intonation is the sign that the speaker has finished talking.

Statements: Nice to meet ↘ you.
I'll be back in a ↘ minute.
She doesn't live here ↘ anymore.
We should work together more ↘ often

Commands: Write your name ↘ here.

Show me what you've ↘ written.
Leave it on the ↘ desk.
Put your books on the ↘ table.

Wh- questions: What country do you come ↘ from?
Where do you ↘ work?
How many books have you ↘ bought?
Whose bag is ↘ this?

Exclamations: How nice of ↘ you!
That's just what I ↘ need!
What a beautiful ↘ voice!
That's a ↘ surprise!

Rising Intonation (↗): The pitch of the voice rises at the end of a sentence. Rising intonation invites the speaker to continue talking.

Yes/no Questions: Do you like your new ↗ teacher?
Have you finished ↗ already?
May I borrow your ↗ dictionary?

Rise-Fall Intonation (↗↘): The intonation rises and then falls.

Choices: Does he speak ↗ German or ↘ French?
Is your name ↗ Ava or ↘ Eva?

Lists: I like ↗ football, tennis, basketball and ↘ volleyball.
I bought ↗ a tee-shirt, a skirt and a ↘ handbag.

Conditional sentences: If he ↗ calls, ask him to leave a ↘ message.
If you have any ↗ problems, just ↘ contact us.

4. Emphasis.

Our voice naturally emphasises certain words in a sentence. This emphasis tells the listener what is important in the sentence and brings clarity of meaning.

Let's use the old tongue twister ''Sally sells seashells by the seashore.''

a. The speaker might decide to emphasise *who* was selling the seashells.

b. Another choice is to emphasise *what* Sally is selling.

c. A third choice might be to emphasise *where* she is selling the seashells.

Practice saying these sentences using the emphasis techniques above. You can underline or bold the words you want to emphasise in each sentence on your speech outline.

5. It’s your time to shine!
Form 6 teams of 3. Each team will work on one paragraph below from the video.
Watch your passage again and use intonation basics (↗ and ↘) and emphasis techniques to prepare your speech, and get ready to perform in front of the class.

a- Visualization is right at the heart of my own work too. I teach global health. And I know having the data is not enough. I have to show it in ways people both enjoy and understand. Now, I'm going to try something I've never done before: animating the data in real space with a bit of technical assistance from the crew.

So here we go. First, an axis for health-- life expectancy from 25 years to 75 years. And down here, an axis for wealth-- income per person, $400, $4,000 and $40,000. So down here is poor and sick, up here is rich and healthy.

b- Now I'm going to show you the world 200 years ago in 1810. Here come all the countries-- Europe, brown; Asia, red; Middle East, green; Africa south of Sahara, blue; and the Americas, yellow. And the size of the country bubbles shows the size of the population. And in 1810, it was pretty crowded down there, wasn't it. All countries were sick and poor. Life expectancy was below 40 in all countries. And only the UK and the Netherlands were slightly better off, but not much.

And now I start the world.

c- The Industrial Revolution makes countries in Europe and elsewhere move away from the rest. But the colonized countries in Asia and Africa, they are stuck down there. And eventually, the Western countries get healthier and healthier.

And now, we slow down to show the impact of the First World War and the Spanish flu epidemic. What a catastrophe!

And now I speed up through the 1920s and the 1930s. And in spite of the Great Depression, Western countries forge on towards greater wealth and health. Japan and some others try to follow, but most countries stay down here.

d- Now after the tragedies of the Second World War, we stop a bit to look at the world in 1948. 1948 was a great year. The war was over. Sweden topped the medal table at the Winter Olympics, and I was born.

But the differences between the countries of the world were wider than ever. The United States was in the front. Japan was catching up. Brazil was way behind. Iran was getting a little richer from oil, but still had short lives. And the Asian giants-- China, India, Pakistan, Bangladesh, and Indonesia-- they were still poor and sick down here.

But look at what is about to happen. Here we go again.

e- In my lifetime, former colonies gained independence. And then finally, they started to get healthier, and healthier, and healthier. And in the 1970s, then countries in Asia and Latin America started to catch up with the Western countries. They became the emerging economies. Some in Africa follow. Some Africans were stuck in civil war and others hit by HIV. And now we can see the world today in the most up to date statistics.

Most people today live in the middle. But there are huge differences at the same time within the best of countries and the worst of countries. And there are also huge inequalities within countries. These bubbles show country averages. But I can split them.

f- Take China- I can split it into provinces. There goes Shanghai. It has the same wealth and health as Italy today. And there is the poor inland province Guizhou. It is like Pakistan. And if I split it further, the rural parts are like Ghana in Africa.

And yet, despite the enormous disparities today, we have seen 200 years of remarkable progress. That huge historical gap between the West and the rest is now closing. We have become an entirely new converging world. And I see a clear trend into the future with aid, trade, green technology, and peace. It's fully possible that everyone can make it to the healthy, wealthy corner.

Well, what you have just seen in the last few minutes is a story of 200 countries shown over 200 years and beyond. It involved plotting 120,000 numbers. Pretty neat, huh?

Activity 3: Two essential rhetorical devices

1. Here are two essential presentation techniques. In pairs, practice one each.

No. 1 Rhetorical question: Figure of speech that asks a question, not for the purpose of further discussion, but to assert or deny an answer implicitly; a question whose answer is obvious or implied.

We are actually doing it. This is paid for and will not add a dime to the deficit -- it will reduce the deficit. Now, is this bill perfect? Of course not. Will this solve every single problem in our health care system right away? No. There are all kinds of ideas that many of you have that aren't included in this legislation.

No. 2 Repetition

Here are some things I'd like to see that's not in this legislation. But is this the single most important step that we have taken on health care since Medicare? Absolutely. Is this the most important piece of domestic legislation in terms of giving a break to hardworking middle class families out there since Medicare? Absolutely. Is this a vast improvement over the status quo? Absolutely-

Barack Obama- Speech to House Democratic Caucus on Health Care 20 March 2010 https://www.youtube.com/watch?v=YiYUVdwoHu4&t=4s
14'28 to 15'59

2. Here are a few examples of rhetorical question starters:
Why (not)…? What about…?
What would happen if…? Did you know…?
Have you ever thought/wondered about…? Do you truly believe…?
Who doesn't want to…? Are you worried…? Isn't it time to…?

Turn the following statements into rhetorical questions:
1. You should know there are eleven mandatory vaccines in France.
→
2. People use illegal drugs for many reasons.
→
3. If you are worried about catching Covid, get vaccinated.
→
4. It is time we worried about climate change's impact on our health.
→
5. Everybody wants free healthcare.
→
6. I wonder how much smaller the population would be if we didn't have antibiotics.
→

Vocabulary list 1: Presentation techniques

https://quizlet.com/_bp86cn?x=1jqt&i=120vpl

1- I will be di**scu**ssing XYZ: je vais parler de XYZ.
2- I would like to start off by **out**lining a few points: je voudrais tout d'abord souligner quelques points
3- First of all, I am going to give you a brief **o**verview of: Tout d'abord, je vais vous donner un bref apercu de
4- I will be saying more about this **la**ter on: J'en dirai plus à ce sujet ultérieurement
5- What I want you to re**mem**ber is: Ce que je veux que vous reteniez, c'est
6- The point I am making is: ce que je veux dire, c'est
7- The main **i**ssue is: Le problème principal est
8- What I would like you to under**stand** is: Ce que j'aimerais que vous compreniez, c'est
9- Let's now **fo**cus on: concentrons-nous maintenant sur
10- Let's now move on to: Passons maintenant à
11- This leads me to my next point: cela m'amène au point suivant
12- As I **men**tioned **ear**lier: comme je l'ai mentionné précédemment
13- As you can see on the slide: comme vous pouvez le voir sur la diapositive
14- Let's take a look at: jetons un coup d'oeil à
15- I would like to point out XYZ: je voudrais souligner XYZ
16- Let me walk you through XYZ: permettez-moi de vous expliquer XYZ
17- What con**clu**sion can we draw from this?: quelle conclusion peut-on en tirer?

How to present a research paper

Activity 1: Brainstorming

In pairs, discuss the following questions:

- Have you ever read research papers in French / in English? How many? What were they about?
- What do you find most challenging when reading a research paper in French / in English?
- How do you approach reading a research paper?
- What do you do when there is something you do not understand?
- Do you ever feel overwhelmed reading research papers, and how do you deal with that?
- Do you have any tips you would like to share?

Activity 2: A randomized, controlled trial of oral propranolol in infantile hemangioma, from the *New England Journal of Medicine*.

1. Read the following research paper and answer the multiple-choice questions.

As a reminder, there are different kinds of trials. Match the following types of their definitions:

Placebo-controlled - Randomized - Phase 1 - Phase 2 - Phase 3 - Open-label – Multicenter – Adaptive - Double-blind

a. Subjects are randomly allocated to receive (or not) an experimental, preventive, therapeutic, or diagnostic procedure and then are followed to determine the effect of the intervention:_____

b. Neither the subject nor the study staff (those responsible for patient treatment and data collection) is aware of the group or intervention to which the subject has been assigned:_____

c. A trial in which there are two (or more) groups. One group gets the active treatment, the other gets the placebo:_____

d. The parameters and conduct of the trial for a candidate drug or vaccine may be changed based on an interim analysis:_____

e. Studies are conducted at multiple centers with several hundred to several thousand patients for whom the drug is intended, to confirm its effectiveness, monitor side effects, compare it with standard or similar treatments, and collect information that will allow the new drug or treatment to be used safely:_____

f. Studies determine the effectiveness of an experimental drug on a particular disease or condition in approximately 100 to 300 volunteers: _____

g. A clinical trial that involves more than one independent medical institution in enrolling and following trial participants:_____

h. A type of clinical trial in which information is not withheld from trial participants:_____

i. Researchers test a drug or treatment in a small group of people (20–80) for the first time. The purpose is to study the drug or treatment to learn about safety and identify side effects:_____

2. Read the research paper entitled "A randomized, controlled trial of oral propranolol in infantile hemangioma" and answer the following questions:

Question 1: define the type of study.
A- controlled, randomized trial.
B- phase 2 study.
C- phase 3 study.
D- open label. (*a type of clinical trial in which information is not withheld from trial participants*)
E- two-stage adaptive study.

Question 2: describe the goal of the study.
A- to determine the efficacy of propranolol over 24 weeks to reduce infantile hemangioma.
B- to determine the safety of the use of propranolol in infantile hemangioma.
C- to compare propranolol with standard treatment of infantile hemangioma.
D- to determine the optimal duration of treatment with propranolol to reduce infantile hemangioma.
E- to determine the optimal dose of propranolol to use to reduce infantile hemangioma.

Question 3: defining the inclusion criteria.
A- babies with a proliferating, severe infantile hemangioma.
B- babies without comorbidities.
C- babies with infantile hemangioma requiring systemic treatment.
D- babies aged 1 to 5 months with infantile hemangioma who have never been treated.
E- babies with infantile hemangioma under standard treatment.

Question 4: identifying the main evaluation criteria.
A- successful treatment at week 24.
B- successful treatment at week 24 without relapse.
C- unsuccessful treatment at week 24.
D- successful treatment at week 24 without any other systemic treatment.
E- successful or unsuccessful treatment at week 48.

Question 5: visualising the design of the study.
A- in stage 1, the patients were randomized to receive either placebo or propranolol, 1mg/kg or 3mg/kg, for either 3 or 6 months.
B- at the interim analysis, a dose was chosen for stage 2.
C- all patients in stage 1 were randomized to receive the new dose or the placebo.
D- at the interim analysis involved the 456 patients who were randomized in stage 1.
E- in stage 1, 60% of the infants in the propranolol group had successful treatment and only 4% in the placebo group.

Question 6: identifying the main result of the study
A- 60% of patients who were assigned to propranolol had successful treatment at week 24.
B- the results vary depending on the analysis (intention-to-treat / per-protocol), probably because of premature discontinuation of treatment.
C- 4% of patients assigned to placebo had successful treatment at week 24.
D- adverse events were significantly higher in the group assigned to propranolol then in the group assigned to placebo.
E- 10% of patients in whom treatment with propranolol was successful required systemic retreatment during follow-up.

Question 7: identifying the limitations of the study
A- a validated assessment tool was not used to assess the evolution of infantile hemangioma.
B- the authors have not included a dose frequently used in clinical practice
C- the authors haven't included severe cases.
D- the two groups of patients are not comparable.
E- the subjective analysis of results (photographs) was not assessed with adjudication. (*a standardized process for assessment of safety and efficacy of pharmacologic or device therapies in clinical trials*)

Question 8: identifying the conclusion of the study.
A- a dose of 3mg/kg/day of oral propranolol over 6 months is effective in the treatment of infantile hemangioma.
B- the result of the study has a clinical relevance. (*a result where a course of treatment has had genuine and quantifiable effects*)
C- the adverse events occurring in patients receiving propranolol are not an obstacle to its use.
D- patients with a severe form could benefit from the efficacy of propranolol.
E- a phase 4 randomized trial will be necessary in order to use it routinely.

Infantile hemangiomas are the most common soft-tissue tumors of childhood, occurring in 3 to 10% of infants.[1-4] Lesions are usually not developed at birth and are generally diagnosed during the first 4 to 6 weeks of life, with most growth during the first 5 months.[5] The characteristic evolution of nearly all infantile hemangiomas is proliferation, stabilization, and slow, spontaneous involution. Although most lesions follow an uncomplicated clinical course, approximately 12% result in complications requiring referral to a specialist.[6,7] Many infantile hemangiomas leave permanent sequelae, with potential psychological effects in the children and their parents.[8,9]

Historically, systemic glucocorticoids were the mainstay of treatment for complicated infantile hemangiomas,[10] with interferon alfa and vincristine used for lesions refractory to glucocorticoid therapy. The efficacy of these treatments is variable, and all have associated safety concerns.[9,11-14]

In 2008, several of the current authors reported cases of hemangioma regression in infants treated with oral propranolol, a nonselective β-adrenergic receptor–blocking agent.[15] Numerous retrospective studies and case reports[16-19] and two small, placebo-controlled trials[20,21] have subsequently supported the efficacy of this treatment (generally at a dose of 2 mg per kilogram of body weight per day). Propranolol is now widely considered to be first-line therapy for infantile hemangiomas, despite the paucity of randomized, controlled clinical trials and the previous lack of a pediatric formulation.[22] Here we report on a large, randomized, placebo-controlled trial involving patients treated for up to 24 weeks with a pediatric oral propranolol solution.

METHODS

PARTICIPANTS

Eligible patients were 35 to 150 days of age, with a proliferating infantile hemangioma requiring systemic therapy (i.e., an evaluated lesion with a minimal diameter of 1.5 cm). Patients with life-threatening, function-threatening, or severely ulcerated hemangiomas were excluded for ethical reasons owing to the inclusion in the trial of a placebo control. Detailed eligibility criteria are presented in the Supplementary Appendix, available with the full text of this article at NEJM.org.

TRIAL OVERSIGHT

The trial was performed in accordance with Good Clinical Practice guidelines. The study protocol was approved by the local ethics committee at each participating center and is available with the statistical analysis plan at NEJM.org. Parents or guardians gave written informed consent according to national regulations.

The sponsor (Pierre Fabre Dermatologie) was involved in the study design in collaboration with three of the academic authors and was responsible for trial management, analysis and interpretation of data, and the decision to submit the manuscript for publication. A data confidentiality agreement existed between the sponsor and the investigators during the trial. The first, penultimate, and last authors vouch for the integrity and completeness of the data and analyses and for the fidelity of this report to the protocol.

TRIAL DESIGN

This randomized, placebo-controlled, double-blind, phase 2–3 trial had a two-stage adaptive design, with selection of the propranolol regimen (dose and duration) at the end of stage 1 (interim analysis) and further evaluation of the selected regimen in stage 2.[23,24] Prespecified possible adaptations to be made after the interim analysis, as outlined in the protocol and statistical analysis plan, were selection of one or two regimens, sample-size reassessment, and nonbinding stopping for futility. The aim was to show superiority of propranolol over placebo and to document long-term efficacy and safety; 56 centers in 16 countries worldwide participated (see the Supplementary Appendix).

In stage 1, patients received either placebo twice daily for 6 months or one of four propranolol regimens (1 or 3 mg of propranolol base per kilogram per day, divided into two daily doses, for 3 or 6 months). Patients were assigned to treatment through an interactive voice-response system, with the use of block randomization stratified according to age group (35 to 90 days vs. 91 to 150 days) and hemangioma location (facial vs. nonfacial) and applied in a 2:2:2:2:1 ratio (propranolol at 1 mg per kilogram per day for 3 months, propranolol at 1 mg per kilogram per day for 6 months, propranolol at 3 mg per kilogram per day for 3 months, propranolol at 3 mg per kilogram per day for 6 months, and placebo, respectively).

Different concentrations of propranolol were used (1.25, 2.50, or 3.75 mg per milliliter) in order to administer the same volume to each patient and thereby maintain blinding; patients assigned to 3-month propranolol regimens received placebo for the second 3 months. Propranolol was administered in the morning and late afternoon, immediately before, during, or immediately after feeding. For patients assigned to a regimen of 3 mg of propranolol per kilogram per day, the doses of propranolol were adjusted as follows: 1 mg per kilogram per day on day 0, 2 mg per kilogram per day on day 7, and 3 mg per kilogram per day on day 14. Propranolol doses (1 and 3 mg per kilogram per day, spanning the range used in off-label practice) and durations (3 and 6 months) were determined in discussions with the regulatory agencies.

In stage 2, patients were to receive either the propranolol regimen selected after the interim analysis or placebo (in a 2:1 ratio). After the 6-month treatment period (or the premature end of treatment), patients were followed for 72 weeks (to week 96) and could receive another treatment for infantile hemangioma, at the investigators' discretion.

EFFICACY AND SAFETY ASSESSMENTS

Participation involved the following 15 visits: at screening; baseline (day 0); days 7, 14, and 21; and weeks 5, 8, 12, 16, 20, 24, 36, 48, 72, and 96. Primary efficacy was assessed by centralized evaluation of standardized digital photographs (taken by investigators at each visit) by two independent, trained, validated readers who were unaware of the study-group assignments, with adjudication for discrepancies; interreader and intrareader reliability were assessed (see the Supplementary Appendix for details of assessment). Complete or nearly complete resolution of the target hemangioma (with nearly complete resolution defined as a minimal degree of telangiectasis, erythema, skin thickening, soft-tissue swelling, and distortion of anatomical landmarks), hemangioma evolution (improvement, stabilization, or worsening), and change in hemangioma size and color were assessed centrally. At each visit, investigators assessed hemangioma evolution since the previous visit, complete resolution and complete or nearly complete resolution versus baseline, presence and extent of sequelae (e.g., telangiectasis) if complete resolution occurred, complications, and hemangioma appearance. Parents or guardians also assessed hemangioma evolution since the previous visit. Use of any other treatment for hemangioma was recorded through week 96.

Safety was assessed by analysis of adverse events (i.e., any adverse change in condition between the time of informed consent and the end of the trial or 5 days after the last trial treatment); laboratory investigations, including measurement of glucose levels from finger-prick blood samples; physical examination, including pulmonary auscultation, liver palpation, assessment of vital signs, and assessment of neurodevelopment (normal or abnormal); and electrocardiography (with findings assessed independently). All assessors were unaware of the study-group assignments. Patients were closely monitored for known important risks associated with propranolol therapy (hypoglycemia, hypotension, bradycardia, and bronchospasm) during the 4 hours after dose administration at initiation and at visits involving dosage increases; parents or guardians were informed of precautionary measures and warning signs (see the Supplementary Appendix).

OUTCOME MEASURES

The primary outcome was success (complete or nearly complete resolution of the target hemangioma) or failure of trial treatment at week 24 versus baseline according to centralized evaluation. Patients who were withdrawn from trial treatment or who used other hemangioma treatment before week 24 were considered to have had a failure of treatment. The key secondary outcome was success or failure of trial treatment according to onsite assessments by the investigator at week 48 versus baseline. Other prespecified secondary outcomes that were based on centralized, investigator, and parent or guardian assessments are presented in the Supplementary Appendix.

STATISTICAL ANALYSIS

The sample size was calculated on the basis of conservative estimated success rates of 10% (placebo),[25,26] 20% (1 mg of propranolol per kilogram per day for 3 months), 30% (1 mg per kilogram per day for 6 months), 40% (3 mg per kilogram per day for 3 months), and 55% (3 mg per kilogram per day for 6 months) (see the Supplementary Appendix).[24] The planned sample size was 450 randomly assigned patients.

After the first 188 patients (stage 1) had completed 24 weeks of trial therapy (or had been withdrawn prematurely from trial therapy), an independent data and safety monitoring committee conducted the interim analysis. By this time, recruitment targets had been exceeded and the necessary sample size had been reached (460 patients). However, the sponsor decided, before unblinding, to maintain the interim analysis and the adaptive nature of the trial so that recruitment could continue if sample-size reassessment became necessary (this was important, since minimal data were available to estimate the success rates). Therefore, the prespecified week 24 analysis was maintained, and outcome data were collected for all regimens.

The superiority of the selected regimen versus placebo was tested with the use of the closed testing procedure and combination tests for all intersection hypotheses, with application of the Simes adjustment[24,27] (see the Supplementary Appendix). This testing method guaranteed that the familywise type I error rate was below the nominal and stringent one-sided significance level of 0.005. The week 24 analysis was performed, as planned, on the intention-to-treat population: all patients in stage 1 (regardless of regimen) plus patients in stage 2 who were randomly assigned to placebo or the selected propranolol regimen and who had received at least one dose of trial therapy. Sensitivity analyses with a broader definition of treatment failure were performed on the per-protocol population. Prespecified analyses of the primary end point with adjustment for stratification factors (age group and hemangioma location) and the randomization ratio (changed to aid recruitment) used an extension of the combination test for logistic regression.[24] Combination tests were used for an adaptive design in analyses of secondary end points. Unless otherwise specified, P values in the efficacy analyses are one-sided, as is common in adaptive-design methods.[23,24,28]

RESULTS

PATIENTS

Between February 2010 and November 2011, a total of 460 patients underwent randomization. Of those, 456 patients received treatment, 323 completed 24 weeks of trial treatment, 391 entered follow-up, and 343 completed follow-up to week 96 (last visit, November 2013) (Fig. 1). Demographic and baseline disease characteristics were similar across the study groups (Table 1).

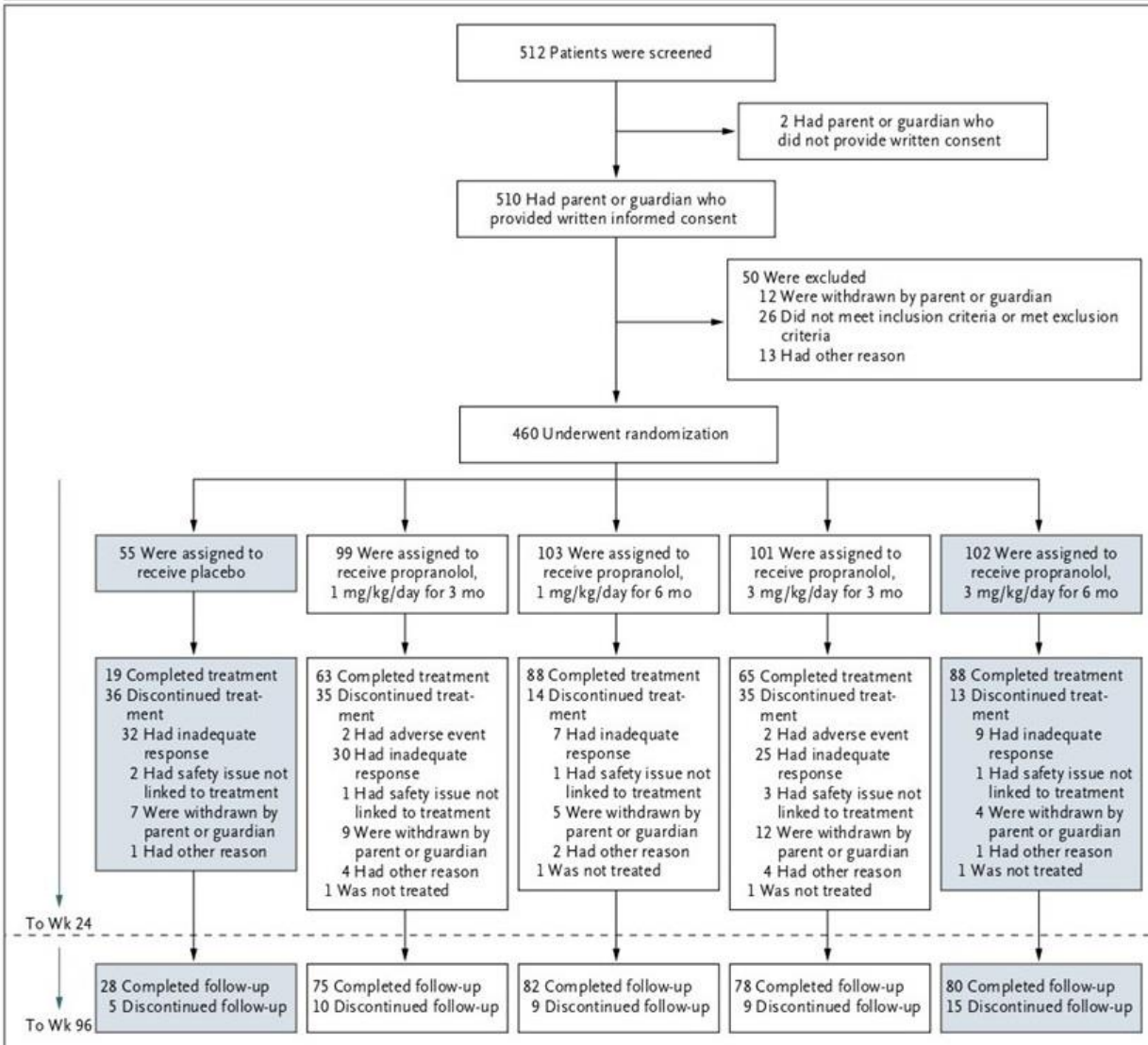
A total of 133 patients (29%) discontinued treatment prematurely, most frequently those receiving the 6-month placebo regimen (65%), with lower rates among those receiving the 3-month propranolol regimens (36% of patients receiving 1 mg per kilogram per day, and 35% of those receiving 3 mg per kilogram per day, mostly after the week-12 switch to placebo) and the lowest rates among those receiving the 6-month propranolol regimens (14% of patients receiving 1 mg per kilogram per day, and 13% of those receiving 3 mg per kilogram per day). Treatment inefficacy was the most frequent reason for discontinuation (Fig. S1 and Table S2 in the Supplementary Appendix).

EFFICACY

At the time of the interim analysis (January 2012), 2 of 25 patients (8%) receiving placebo had successful treatment at week 24, as compared with 4 of 41 patients (10%) receiving 1 mg of propranolol per kilogram per day for 3 months, 3 of 39 patients (8%) receiving 3 mg per kilogram per day for 3 months, 15 of 40 patients (38%) receiving 1 mg per kilogram per day for 6 months ($P=0.004$ for the comparison with placebo), and 27 of 43 patients (63%) receiving 3 mg per kilogram per day for 6 months ($P<0.001$ for the comparison with placebo) (Fig. 2A). The independent data and safety monitoring committee determined that the propranolol regimen with the highest benefit-to-risk ratio was 3 mg per kilogram per day for 6 months; the committee did not recommend adjusting the planned sample size. According to the prespecified plan, the week 24 efficacy analysis was conducted to test the superiority of the selected propranolol regimen over placebo.

Overall, 61 of 101 patients (60%) assigned to the selected propranolol regimen and 2 of 55 patients (4%) assigned to placebo had successful treatment at week 24 ($P<0.001$) (Fig. 2B). Results were consistent between trial stages, similar in the per-protocol population, and supported by sensitivity analysis (Tables S4 and S5 in the Supplementary Appendix).

The selected propranolol regimen remained



	Placebo	1 mg/kg/day for 3 Mo	1 mg/kg/day for 6 Mo	3 mg/kg/day for 3 Mo	3 mg/kg/day for 6 Mo	Total
	no. of patients					
Safety	55	98	102	100	101	456
Efficacy Stage 1 + Stage 2 — without Overrun (wk 24 analysis)						
Intention-to-Treat Population	55	41	40	39	101	276
Per-Protocol Population	53	38	38	37	93	259

Figure 1. Screening, Randomization, Treatment, and Follow-up of the Patients.

The safety population included all randomly assigned patients who received at least one dose of trial treatment. The intention-to-treat population included all randomly assigned patients in stage 1 (the phase 2 part of the trial, comparing each of the four propranolol regimens with placebo) plus all patients in stage 2 (the phase 3 part of the trial, comparing the selected regimen of propranolol [3 mg per kilogram per day for 6 months] with placebo) who received at least one dose of trial treatment. The per-protocol population included all patients in the intention-to-treat population with no major protocol deviation, except for prohibited treatments to treat infantile hemangiomas. "Overrun" indicates the subgroup of patients in stage 2 who were assigned to a regimen other than the selected regimen of propranolol or placebo. Patients could have more than one reason for study exclusion and for discontinuation of trial treatment. Shaded boxes indicate the week 24 efficacy analysis that was conducted to test the superiority of the selected propranolol regimen over placebo.

Table 1. **Baseline Characteristics of Study Patients and Hemangiomas.***

Characteristic	Placebo (N=55)	Propranolol (N=401)				Total (N=456)
		1 mg/kg/day for 3 mo (N=98)	1 mg/kg/day for 6 mo (N=102)	3 mg/kg/day for 3 mo (N=100)	3 mg/kg/day for 6 mo (N=101)	
Patients						
Sex — no. (%)						
Male	17 (31)	30 (31)	32 (31)	21 (21)	31 (31)	131 (29)
Female	38 (69)	68 (69)	70 (69)	79 (79)	70 (69)	325 (71)
Age at inclusion						
Days	103.9±31.1	103.6±33.1	102.6±30.1	107.5±30.1	101.6±31.0	103.8±31.0
35–90 days — no. (%)	20 (36)	36 (37)	38 (37)	36 (36)	37 (37)	167 (37)
>90 days — no. (%)	35 (64)	62 (63)	64 (63)	64 (64)	64 (63)	289 (63)
Hemangiomas						
Location — no. of patients (%)						
Facial	40 (73)	71 (72)	72 (71)	64 (64)	71 (70)	318 (70)
Nonfacial	15 (27)	27 (28)	30 (29)	36 (36)	30 (30)	138 (30)
Morphologic classification — no. of patients (%)						
Segmental	2 (4)	4 (4)	7 (7)	7 (7)	5 (5)	25 (5)
Localized	48 (87)	89 (91)	90 (88)	88 (88)	91 (90)	406 (89)
Indeterminate	5 (9)	5 (5)	5 (5)	5 (5)	5 (5)	25 (5)
Superficial component — no. of patients (%)						
Flat	4 (7)	9 (9)	6 (6)	9 (9)	9 (9)	37 (8)
Elevated						
Slightly	19 (35)	22 (22)	22 (22)	29 (29)	22 (22)	114 (25)
Moderately	15 (27)	35 (36)	43 (42)	24 (24)	31 (31)	148 (32)
Markedly	17 (31)	32 (33)	31 (30)	38 (38)	39 (39)	157 (34)
Deep component — no. of patients (%)†	35 (64)	74 (76)	66 (65)	79 (79)‡	72 (71)	326 (71)

* Plus–minus values are means ±SD. There were no significant differences among the study groups unless otherwise indicated.
† Values are for a possible or a definite deep component.
‡ P=0.04 for the comparison with placebo.

superior to placebo in analyses adjusting for age group, hemangioma location, and randomization ratio (Table S6 in the Supplementary Appendix). Improvement between baseline and week 5 (according to centralized assessment) occurred in 88% of patients assigned to the selected regimen and 5% of patients assigned to placebo (P<0.001); sustained improvement (maintained at each subsequent visit until week 24) occurred from week 5 in 73% and 5% of patients, respectively. A significantly greater mean reduction in hemangioma surface area and color intensity was achieved with the selected propranolol regimen than with placebo (Table S8 in the Supplementary Appendix). Results of an exploratory analysis of the primary end point for all regimens are shown in Table 2 (and Table S7 in the Supplementary Appendix).

On-site investigators' assessments of complete resolution (Table S9 in the Supplementary Appendix) and complete or nearly complete resolution (Table S8 in the Supplementary Appendix) of the target hemangioma differed from centralized assessments; 40% of the cases

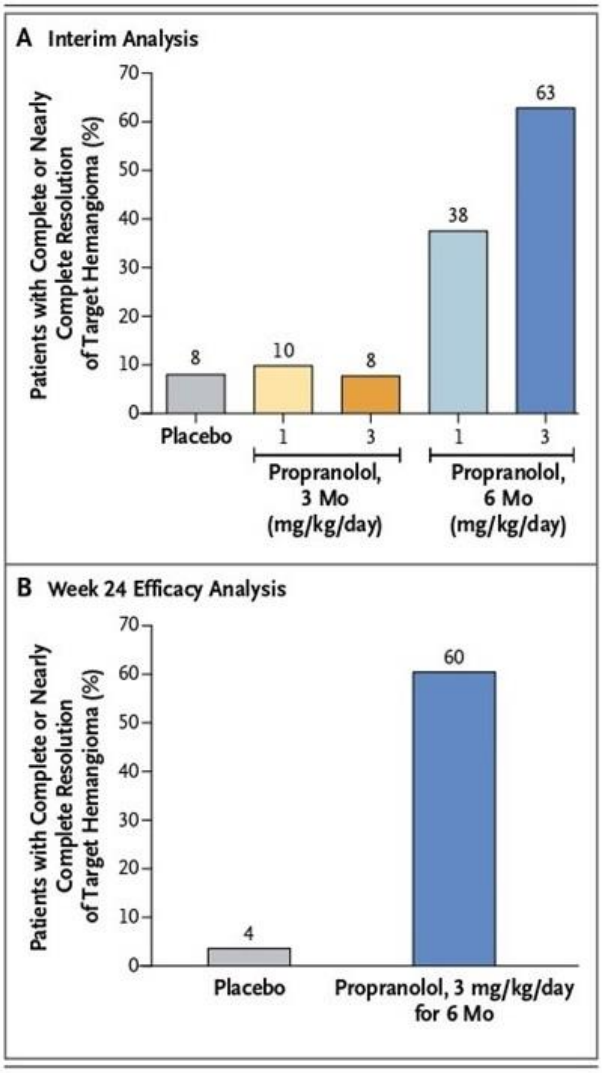


Figure 2. Interim Analysis and Week 24 Efficacy Analysis of Complete or Nearly Complete Resolution of the Target Hemangioma at Week 24 versus Baseline.

Nearly complete resolution was defined as a minimal degree of telangiectasis, erythema, skin thickening, soft-tissue swelling, and distortion of anatomical landmarks. In the interim analysis (Panel A), differences in complete or nearly complete resolution between patients receiving propranolol and those receiving placebo were significant only for the 6-month regimens (1 mg per kilogram per day for 3 months, P=0.40; 3 mg per kilogram per day for 3 months, P=0.52; 1 mg per kilogram per day for 6 months, P=0.004; and 3 mg per kilogram per day for 6 months, P<0.001). In accordance with the protocol and the statistical analysis plan, the interim analysis involved the first 188 patients assigned to any of the five treatment regimens (corresponding to the patients in stage 1) who received at least one dose of trial treatment and who either had completed the week 24 visit or had been withdrawn prematurely from the trial treatment (i.e., the intention-to-treat population in stage 1). For the primary efficacy end point of complete or nearly complete resolution of the target hemangioma at week 24 according to centralized assessment, the P values for the four propranolol regimens (vs. placebo) were calculated with the use of a one-sided z-test for proportions with pooled variance estimates. In the week 24 efficacy analysis (Panel B), the difference in complete or nearly complete resolution between patients receiving propranolol at a dose of 3 mg per kilogram per day for 6 months and those receiving placebo was significant (P<0.001). This analysis involved the intention-to-treat population for the selected regimens at an interim analysis (i.e., all patients in stage 1 [regardless of regimen] and patients in stage 2 who were assigned to either placebo or the selected regimen of propranolol and who received at least one dose of trial treatment). The objective was to test the superiority of the selected regimen ($H0,sel:\theta sel \leq 0$ against the alternative $H1,sel:\theta sel > 0$) with the use of the method described by Heritier et al.,[24] for an adaptive confirmatory design with a single selection at an interim analysis, guaranteeing that the familywise type I error rate was maintained at the nominal level of 0.005.

judged centrally as having been treated successfully were assessed by local investigators as showing complete or nearly complete resolution (Table S10 in the Supplementary Appendix; see also examples of discrepancies and discussion). However, the rate of investigator-assessed sustained improvement from week 5 to week 24 (71%) (Table S8 in the Supplementary Appendix) was similar to the rate determined by centralized assessments.

Successful treatment at week 24 was sustained to week 96 in 35 of 54 patients assigned to the selected propranolol regimen (65%) and in 2 of 2 patients assigned to placebo, without any additional hemangioma treatment. Only 6 patients assigned to the selected propranolol regimen (10%) required reintroduction of systemic hemangioma treatment from week 24 to week 96 (7 patients [11%] required any additional hemangioma treatment).

SAFETY

Corresponding to rates of premature discontinuation of trial treatment, mean exposure was lowest for placebo (83 days), higher for 3-month propranolol treatment (143 days for 1 mg per kilogram per day and 147 days for 3 mg per kilogram per day), and highest for 6-month propranolol treatment (157 days for 1 mg per kilogram per day and 161 days for 3 mg per kilogram per day). During treatment, 33 serious adverse events occurred in 26 patients, with no significant difference overall or according to individual events between the placebo group and the group receiv-

Table 2. Exploratory Analysis of the Primary Efficacy Outcome in the Intention-to-Treat Population with Overrun.*

Variable	Placebo (N=55)	Propranolol (N=401)			
		1 mg/kg/day for 3 mo (N=98)	1 mg/kg/day for 6 mo (N=102)	3 mg/kg/day for 3 mo (N=100)	3 mg/kg/day for 6 mo (N=101)
Complete or nearly complete resolution of target hemangioma at wk 24 — no. (%)†					
Yes	2 (4)	8 (8)	50 (49)	12 (12)	61 (60)
No	53 (96)	90 (92)	52 (51)	88 (88)	40 (40)
P value‡		0.14	<0.001	0.04	<0.001

* "Overrun" indicates patients in stage 2 of the trial who were assigned to a regimen other than the selected regimen of propranolol or placebo.
† Nearly complete resolution was defined as a minimal degree of telangiectasis, erythema, skin thickening, soft-tissue swelling, and distortion of anatomical landmarks.
‡ P values for the four propranolol regimens (vs. placebo) were calculated with the use of a one-sided z-test for proportions with pooled variance estimates.

ing the selected propranolol regimen (Table 3, and Tables S11 and S12 in the Supplementary Appendix).

The overall incidence of adverse events was higher among patients receiving the propranolol regimens (90% with 1 mg per kilogram per day for 6 months to 96% with 3 mg per kilogram per day for 6 months) than among patients receiving placebo (76%) (Table 3). The most common events were either expected in the infant population (e.g., nasopharyngitis, pyrexia, and teething) (Table S13 in the Supplementary Appendix) or known side effects of propranolol (e.g., diarrhea, sleep disorders, events potentially related to bronchial hyperreactivity, and cold hands and feet) (Table 3). Most events were classified as mild or moderate in severity, with onset within 3 months after treatment initiation. When events occurring only during propranolol treatment were considered (i.e., excluding events that occurred during the placebo phase of the 3-month propranolol regimens), infants receiving the 3-mg dose (vs. the 1-mg dose) appeared to have a higher incidence of diarrhea (22% vs. 14%) and of events potentially related to bronchial hyperreactivity (9% vs. 6%). Bronchospasm occurred in four patients (two receiving propranolol and two receiving placebo, including one who had previously received the regimen of 3 mg of propranolol per kilogram per day for 3 months), leading to temporary discontinuation of treatment in two patients (one receiving placebo).

In all propranolol groups during the 4 hours after the initial dose and after subsequent dose adjustments, the mean heart rate and mean systolic blood pressure decreased (by approximately 7 beats per minute and approximately 3 mm Hg across groups) and the PR interval increased, without appreciable differences between doses (Fig. S2, S4, and S5 in the Supplementary Appendix). Heart-rate decreases occurred within 1 hour after dose administration, with minimal changes thereafter. Overall differences observed in these variables as compared with placebo decreased between week 5 and week 8 and had disappeared by week 24. Bradycardia was reported in two patients assigned to propranolol during the dose-adjustment phase (one patient had a serious adverse event in the context of enterocolitis, and the other had no visible symptoms). One serious adverse event, second-degree atrioventricular block (with preexisting cardiac conditions later documented; see Tables S11 and S12 in the Supplementary Appendix), occurred after dose administration on day 0 (treatment was discontinued).

Hypotension (without apparent associated manifestations) occurred in seven patients (six of whom were receiving propranolol, four during the dose-adjustment phase). Mild hypoglycemia without visible manifestations occurred in two patients (both receiving propranolol during the dose-adjustment phase). No events of hypotension or hypoglycemia led to treatment discontinuation. During follow-up (Tables S14 and S15 in the Supplementary Appendix), no appreciable differences were noted between the propranolol groups and the placebo group in growth, neurodevelopment, or cardiovascular variables.

Table 3. Adverse and Serious Adverse Events with Propranolol or Placebo to Week 24 (Safety Population).*

Variable	Placebo (N=55)	Propranolol (N=401)			
		1 mg/kg/day for 3 mo (N=98)	1 mg/kg/day for 6 mo (N=102)	3 mg/kg/day for 3 mo (N=100)	3 mg/kg/day for 6 mo (N=101)
	number of patients (percent)				
Adverse-event summary†					
≥1 Serious adverse event	3 (5)	5 (5)	3 (3)	9 (9)	6 (6)
≥1 Adverse event that occurred during treatment	42 (76)	89 (91)	92 (90)	92 (92)	97 (96)
≥1 Adverse event that occurred during treatment, leading to definitive treatment discontinuation	6 (11)	4 (4)	2 (2)	6 (6)	3 (3)
Adverse events					
Known important risks associated with propranolol therapy					
Hypotension	1 (2)	2 (2)	1 (1)	3 (3)	0
Bronchospasm	1 (2)	0	0	2 (2)‡	1 (1)
Bradycardia	0	0	1 (1)	1 (1)	0
Hypoglycemia	0	0	1 (1)	0	1 (1)
Other risks associated with propranolol therapy§					
Diarrhea	4 (7)	16 (16)	14 (14)	17 (17)	28 (28)
Sleep disorder¶	7 (13)	28 (29)	14 (14)	19 (19)	22 (22)
Bronchitis	1 (2)	5 (5)	8 (8)	11 (11)	17 (17)
Vomiting	3 (5)	16 (16)	13 (13)	10 (10)	13 (13)
Bronchiolitis	3 (5)	6 (6)	7 (7)	6 (6)	10 (10)
Cold hands and feet	1 (2)	8 (8)	10 (10)	1 (1)	10 (10)
Agitation‖	6 (11)	12 (12)	18 (18)	8 (8)	7 (7)
Constipation	1 (2)	9 (9)	6 (6)	9 (9)	4 (4)
Decreased appetite	1 (2)	5 (5)	3 (3)	5 (5)	1 (1)
Somnolence	1 (2)	6 (6)	4 (4)	1 (1)	1 (1)

* The safety population included all randomly assigned patients who received at least one dose of trial therapy during stage 1 or 2. Adverse events were any events that occurred or worsened during trial treatment or up to 5 days after the last day of trial treatment; they were tabulated for each study group according to the preferred terms from the *Medical Dictionary for Regulatory Activities* (MedDRA).

† With regard to the 3-month propranolol regimens, the week 24 analysis did not separate events observed during the first 3 months (active-treatment phase) from those observed during the second 3 months (placebo phase).

‡ One event of bronchospasm occurred during the placebo phase, after the active-treatment phase had ended.

§ Shown are events observed in at least 5% of patients in any propranolol group, listed by decreasing order of incidence among patients who received 3 mg of propranolol per kilogram per day for 6 months.

¶ The term "sleep disorder" includes the following MedDRA preferred terms: sleep disorder, middle insomnia, hypersomnia, insomnia, poor quality sleep, initial insomnia, terminal insomnia, and nightmare.

‖ The term "agitation" includes the following MedDRA preferred terms: restlessness, agitation, anxiety, psychomotor hyperactivity, nervousness, stress, and irritability.

DISCUSSION

This large-scale, randomized, placebo-controlled trial showed that propranolol is effective in treating infantile hemangioma, with a favorable risk–benefit profile. Our adaptive design, involving an initial comparison of four propranolol regimens with placebo, allowed selection of a more effective dose (3 mg rather than 1 mg per kilogram per day) and treatment duration (6 months rather

than 3 months). Treatment with propranolol at a dose of 3 mg per kilogram per day for 6 months resulted in a significantly higher success rate (primary outcome) as compared with placebo (60% vs. 4%). Results were supported by a per-protocol analysis and a sensitivity analysis involving a broader definition of treatment failure.

The observed divergence between centralized and investigator evaluations of complete or nearly complete resolution of the target hemangioma after treatment with propranolol may be explained by limited investigator training and the lack of validation or monitoring (for logistic reasons) as compared with the training and validation of central readers. A review of the discrepant cases (see examples in the Supplementary Appendix) suggests that investigators applied a more stringent threshold for nearly complete resolution, especially regarding the presence of residual telangiectasis. Investigators' assessments of sustained improvement from week 5 to week 24 were highly concordant with the centralized assessments (both >70%).

Adverse events were more frequent among the patients who received propranolol than among those who received placebo; for some events, the greater frequency may be partly explained by the longer duration of treatment with propranolol than with placebo, largely owing to more frequent discontinuations for lack of efficacy in the placebo group. Important risks anticipated with the use of propranolol,[6] including bronchospasm, bradycardia, hypotension, and hypoglycemia, were infrequent but occurred more often in the propranolol groups than in the placebo group. With regard to these four risks, only one patient who received propranolol had a serious adverse event (bradycardia in the context of enterocolitis). Heart-rate decreases typically occurred within 1 hour after dose administration. The risk of hypoglycemia may be minimized with proper education of parents or guardians about the importance of administering propranolol as prescribed (i.e., during or right after feeding).

The current trial confirms and builds on the results of previous case series[16,18,19] and smaller placebo-controlled trials.[20,21] For example, one placebo-controlled trial involving 39 patients showed that the administration of propranolol (2 mg per kilogram per day) was associated with a 60.0% decrease in hemangioma volume at week 24, as compared with a 14.1% decrease with placebo.[20] In our study, only 10% of successfully treated hemangiomas required systemic retreatment within 72 weeks after the end of trial treatment. This finding is consistent with that of a prior report, in which 12% of the patients who had a response had relapses requiring retreatment.[29]

Limitations of this trial include the lack of a validated assessment for the evolution of infantile hemangiomas. However, assessment of our outcome involved standardized photographic procedures and independent, centralized, blinded, and validated reading. We did not include a group treated with 2 mg of propranolol per kilogram per day, a dose frequently used in practice, but the doses we studied (1 mg and 3 mg per kilogram per day) span the range used empirically in practice. Although patients with high-risk hemangiomas were excluded owing to the placebo control, other case series support the efficacy of oral propranolol in high-risk cases.[30-37]

In conclusion, this trial shows that oral propranolol at a dose of 3 mg per kilogram per day for 6 months is effective in the treatment of infantile hemangioma.

Supported by Pierre Fabre Dermatologie.
Disclosure forms provided by the authors are available with the full text of this article at NEJM.org.

Vocabulary list 2: Talking about a research paper

https://quizlet.com/_dch8my?x=1qqt&i=120vpl

1- effi**ca**cious: efficace (en essai clinique)
2- **e**fficacy: efficacité (en essai clinique)
3- **ran**domised: randomisé
4- **cli**nical trial: essai clinique
5- in**clu**sion cri**te**ria: critères d'inclusion
6- ex**clu**sion cri**te**ria: critères d'exclusion
7- at **base**line: au début
8- e**ffec**tiveness: efficacité (en vie réelle)
9- e**ffec**tive: efficace (en vie réelle)
10- at **stu**dy **en**try: au début de l'étude
11- at **stu**dy end: à la fin de l'étude
12- con**trol** group: groupe témoin
13- **o**pen-**la**bel trial: essai ouvert
14- **e**fficacy end point: critère d'efficacité
15- **dou**ble blind: en double aveugle
16- at **fo**llow-up: au suivi
17- de**ter**mine: déterminer
18- a**ssess**: évaluer
19- ad**mi**nister: administrer
20- a**ssign**: attribuer, affecter
21- en**rol**: inscrire
22- mean score: score moyen
23- plot: tracer
24- **mo**nitor: surveiller
25- **mea**sure: mesurer

☺ Efficacious VS effective.

- ➔ An efficacious drug: possession of a special quality or virtue that makes it possible to achieve a result; a molecule is proven efficacious in the lab.
- ➔ An effective treatment: power to produce or the actual production of a particular effect; a drug is effective if it has the intended effect in real life.

The American healthcare system

Activity 1: Warm-up

In pairs, discuss the following questions:

- What is your image of healthcare in the USA?
- What happens in your country if someone cannot afford an operation?
- Should there be an age limit for people to get free healthcare?
- Should your healthcare include the option of treatment overseas?
- Do you think healthcare should be provided by the government or by private health and insurance companies?
- Make a bet with your partner on what place the USA stands at in the 2024 ranking of healthcare systems. Then check the ranking online. Any surprises?

Activity 2: Writing a video summary

1. Look at the following title: "Joe Biden takes step to widen* Americans' access to healthcare.'' (January 2021)
**to widen = here, increase, expand.*

In pairs, try to guess:

- how Joe Biden did this,
- what governments programmes may be involved,
- whether he was successful.

2. You are going to hear the following words in the video. Can you explain what they refer to, or what they mean?

- Corporate health insurance
- Government-subsidised insurance
- The Affordable Care Act
- Medicaid

3. Watch the video and take notes in view of writing a summary.

Tips on how to summarize a video

- Before the first viewing, anticipate the content of the document from its title.
- Watch the video but also listen to it.
- During each viewing, only write key words and use symbols to link them (arrows, circles, crosses…)
- After the first viewing, check if you have the answers to the basic questions: *Who? What? Why? Where? When?* and *How?*
- During the time allocated to writing, first build the outline of your summary by ordering your notes and bunching up ideas into paragraphs.
- Then use linking words to make logical connections between paragraphs.
- In your introduction, announce the nature of the document, its author, source, and date if mentioned.
- Conclude with the take-home message of the video.
- Your summary must not include the following: anecdotes, comments about how the video is organized or what the journalists do, quotes, imagery, "we" (as in "we can see that…"), extra knowledge, personal opinions, and contracted forms.

If you need guidance, you can answer the questions provided below.

Help for B1 students

1) How many Americans get health insurance through their employer?

2) What have been the consequences of the pandemic for a lot of Americans?

3) What is Audree Hall's problem with healthcare?

4) What did Joe Biden do to help Americans who lost access to healthcare?

5) Does Audree Hall qualify for government-subsidised health insurance?

Help for A2 students

1) Half of Americans get health insurance through their employer: True / False.

2) Audree Hall lost her job during the pandemic. True / False.
3) Audree Hall has skin cancer. True / False.
4) Audree Hall had a surgery that was not covered by her health insurance. True/ False.
5) Joe Biden signed an executive order to widen the access to Medicare. True/False.
6) Audree Hall qualifies for Medicaid. True / False.

4. The following video summary has been jumbled up. Put the paragraphs in the right order, and underline the following elements:
- source.
- date.
- main theme.
- linkwords.
- take-home message.

a. More than half of Americans depend on their employers to sponsor their health insurance. With millions of people now unemployed because of the pandemic, more middle classes families are now struggling with low income and no way to pay the doctor, …… the Biden administration's help.
b. This 2021 Al Jazeera news report is about the access of the American middle class to healthcare after millions lost their jobs during the pandemic.
c. …… Joe Biden has widened Americans' access to healthcare, a lot of middle-class Americans feel like they have been left behind.
d. ……, Joe Biden has signed an executive order to allow some of those people to buy government-subsidised health insurance through the Affordable Care Act. ……, the help won't reach all who need it. It is still too expensive for Audree Hall's family, and they don't qualify for government's programmes intended for the poor. They are in the gap of the uninsured middle class.
e. Audree Hall was diagnosed with skin cancer three months before losing her job. …… work-sponsored insurance covered her surgery, she is now uninsured and unable to pay for follow-up appointments. ……, her husband has also been diagnosed with Covid. She would like to get the assistance to get the right healthcare. 28 million Americans did not have health insurance before the pandemic. That number has now grown by 5 to 10 million.

5. Fill the gaps in the summary with the following linking words: *moreover, as a result, even though, although, in spite of, nevertheless.*

According to what they express, place the linking words in the table below. Then contribute one more entry to each column.

Consequence	Contrast/ concession	Addition

Activity 3: Language work: compound adjectives

The video summary you have just reorganized contains many compound adjectives. These are convenient word groupings that help express an idea clearly and economically.

Compound adjectives often have the following structure: adjective/ adverb/ noun + past participle. Other possibilities include:

- Adjective/ noun + adjective: a dark-blue uniform.
- Adjective/ adverb/ noun + present participle: an old-looking hospital.
- Adjective + noun-ED: a bad-tempered doctor.
- noun + noun + adjective: a fifteen-year-old boy.
- noun + noun: a two-hour operation.

1. Read the video summary again and find the compound adjectives that correspond to the following paraphrases:

- insurance that is sponsored by work:
- health insurance that's subsidized by the government:

2. Form a compound adjective for each case below.

- This patient has a strong will:
- The pharmacist has a high level of education:
- This program lasts two months:
- Studying to be a pharmacist consumes a lot of time:
- This hospital has broken the record for most child deliveries in one year:
- This scheme is supposed to help you save money:
- This news broke my heart:
- This medical device is as thin as paper:

Vocabulary list 3: The American healthcare system

https://quizlet.com/fr/823031640/4y-quizlet4-the-american-healthcare-system-flash-cards/

1- phy**si**cian: médecin
2- **pri**mary care **doc**tor: médecin référent
3- **Me**dicare: federal health insurance for people 65 or older, some younger people with disabilities, people with End-Stage Renal Disease.
4- **Me**dicaid: federal health insurance program that provides health care coverage to low-income families
5- **co**verage **ra**tio: taux de couverture (de l'assurance)
6- in**su**rance claim: déclaration pour l'assurance
7- co-pay: ticket modérateur
8- non-**co**vered services: services non compris
9- out-of-**po**cket ex**pen**ses: frais non pris en charge par l'assurance
10- **pre**mium: forfait mensuel
11- de**duc**tible: franchise
12- out-of-**net**work pro**vi**der: fournisseur hors-réseau (a doctor or facility has no contract with your health plan, they're considered out-of-network and can charge you full price. It's usually much higher than the in-network discounted rate.)
13- **por**tion: part à la charge du patient
14- pre-certifi**ca**tion: aval de l'assurance
15- **in**voice: facture
16- in**su**rance **po**licy : police d'assurance
17- be left behind: être laissé pour compte
18- **sur**gery: opération chirurgicale
19- **in**come: revenus
20- de**pend** on: dépendre de
21- qualify for: remplir les conditions requises pour, pouvoir prétendre à
22- in**ten**ded for: destiné à
23- be e**li**gible for: avoir droit à
24- **wi**den: élargir
25- **cor**porate health in**su**rance: couverture santé de l'entreprise

The British healthcare system

Activity 1: Warm-up

1. In pairs, discuss the following questions:
- What is your image of healthcare in the UK?
- What do you know about the National Health Service (NHS) in Britain?
- Are you happy with your country's health system?
- How would you feel if you had no money to pay for healthcare?
- Do you think it is a government's duty to provide free healthcare for poor people?

Activity 2: The NHS then and now

1. Look at the following title: ''UK celebrates 70 years of National Health Service."

In pairs, try to guess:

- more or less when the NHS was created,
- why it was created.

2. You are going to hear the following words in the video. Can you explain what they refer to, or what they mean?

- Universal healthcare
- National insurance
- The medical establishment
- Wards
- A&E

3. Watch the video and summarise it. Do not forget to mention the source / date / main theme in your introduction and the take-home message in your conclusion. Use linkwords to connect your ideas.

If you need guidance, you can answer the questions provided below.

Help for B1 students
1) When was the NHS established?

2) Which political party established the NHS?

3) Which diseases were the biggest killers at the time?

4) What is the difference between the NHS then and now?

5) Can you give a few numbers about the NHS today?

6) What are the challenges the NHS faces today?

Help for A2 students:
1) Date when the NHS was established: 1942 – 1944 – 1948.
2) The political party Aneurin Bevan belonged to: Labour – Conservative.
3) The biggest killers in those days: infectious diseases – cancer – AIDS - cardiovascular diseases –bubonic plague.
4) The number of surgical treatments the NHS offers these days: 230 – 300 – 2000 – 2300.
5) The number of patients treated every 36 hours: 100 – 1,000 – 1,000 000.
6) The challenges today: elderly population – staff issues - expensive treatment options – budget – hygiene.

4. Enter a dubbing competition!

Here is a partial transcript of the video. Listen to the video again, and use what you have learn about intonation and emphasis to prepare for the competition: add rising or falling arrows for intonation, highlight the words that are emphasised. Practice in pairs until you are ready, and then choose your champion. Champions enter the contest and the rest of the class vote for the best dubber.

"The National Health Service was nothing short of a revolution ↘. It provided universal healthcare for Britain's post-war population ↗ and funded it through a system of tax and national insurance ↘. By 1945 all three main

political parties were supporting the concept, but when the left-wing Labour party swept to power in the 1945 election, it fell to the young health minister Aneuran Bevin to take on the task of making the NHS a reality. In the face of bitter opposition from the medical establishment, and despite Britain's post-war financial hardship, Bevan's NHS was established in 1948….

In an era of tight budgets the NHS is struggling to cope with the cost of an increasingly elderly population and increasingly expensive treatment options. The medical need is clear, but as the NHS celebrates its seventieth year, its future is less clear.''

5. 'its future is less clear': according to you, what challenges does the NHS face today, apart from those already mentioned in the video ?

In pairs, watch the following video once and pick out three problems:

"The government's plan to address the NHS staffing crisis."

Activity 3: This is Going to Hurt

1. Read the following extract from *This is Going to Hurt* by Adam Kay (2017) and pay attention to the highlighted words.

I would always feel tremendously proud to say that I worked for the NHS – who doesn't love the NHS ? (Well, apart from the Secretary of State for Health.) It's unlike any other national asset ; no one talks in fond tones about the Bank of England or would think any less of you if you suggested suing Cardiff Airport. It's easy to work out why : the NHS does the most

amazing job and we've all benefitted from it. They delivered you when you were born and one day they'll zip you up in a bag, but not until they've done everything that medical science will allow to keep you on the road. From cradle to grave, just like your man Bevan promised back in 1948. They fixed your broken arm on sports day, they gave your nan chemo, they treated the chlamydia you brought back from Kavos, they started you on that inhaler, and all this wizardry was free at the point of service. You don't have to check your bank balance after booking an appointment : the NHS is always there for you.

On the other side of the fence, knowing you were working for the NHS took the sting out of so many things about the job : the vicious hours, the bureaucracy, the understaffing, the way they inexplicably blocked Gmail on all the computers in one hospital I worked at (thanks, guys !). I knew I was part of something good, important, irreplaceable, and so I did my bit. I don't have an amazing inbuilt work ethic, it's not applied to anything I've ever done since (as my publisher will attest), but the NHS is something special, and the alternative is horrifying.

We should see the skyscraper-high bills of America as the ghost of Christmas future* when it comes to NHS privatization. Politicians may act dumb, but they're not, and we'll be lured very stealthily into this particular gingerbread house. We'll be promised it's only little corners of the NHS that are changing, but there'll be no trail of breadcrumbs** to help us find our way back through the forest. One day you'll blink and the NHS will have completely evaporated – and if that blink turns out to be a stroke then you're totally screwed.

**The ghost of Christmas Future is a reference to Charles Dickens' A Christmas Carol: it is a metaphor for death and the legacy of our lives that we leave for others.*

***The trail of breadcrumbs could be a reference to the fairy tale Hansel and Gretel: Hansel and Gretel are taken deep into the forest by their parents in the hope they will not find their way back. However, clever Hansel has left a trail of breadcrumbs to show their return path.*

'Frank and funny, this is a moving tribute to the people who keep the NHS going'
The Guardian, 4th May 2018

2. In pairs, discuss the viewpoint both this text and the first video share regarding the NHS. Come up with one key word to summarise this common stance. Do you feel the same about your own country's healthcare system?

3. Read the last paragraph again and discuss the following: Do you think, like the narrator, that the privatization of healthcare is undesirable? Why (not)?

Vocabulary list 4: The British healthcare system

https://quizlet.com/_bor7g9?x=1qqt&i=120vpl

1- **Ge**neral Prac**ti**tioner or GP: a doctor who works in a local surgery or health centre, providing medical advice and treatment to patients registered on their list.
2- **A**ccidents and E**mer**gency or A&E: deals with people who need emergency treatment because of sudden illness or injury.
3- In**ten**sive Care **U**nit or ICU: where very seriously ill patients are looked after in a hospital; les urgences fund: provide money for; financer
4- Chief **Me**dical **Of**ficer or CMO: the Government's principal adviser on health and the professional lead for all medical staff.
5- Health **se**cretary: minister de la santé
6- uni**ver**sal **health**care: couverture maladie universelle
7- national in**su**rance: You pay National Insurance contributions to qualify for certain benefits and the State Pension; sécurité sociale
8- walk-in **cen**tre: medical centre that offers fast access to health advice and treatment, mainly from nurses
9- **pa**tient **re**cord: record of a patient's care and treatment (may be electronic); dossier médical
10- health **vi**sitor: a trained nurse whose job is to visit people in their homes, for example new parents, and give them advice on some areas of medical care; infirmier.ère à domicile
11- para**me**dic: secouriste
12- ward: room in hospital
13- **ma**tron: a trained nurse who leads the ward
14- **sur**gery: cabinet de médecine générale
15- **me**dical staff: licensed healthcare providers (physicians, nurses, allied health professionals, and other healthcare workers) who are authorized to provide medical care within a healthcare establishment; personnel médical
16- in**fec**tious di**sea**ses: maladies infectieuses
17- to cope with: gérer, s'occuper de
18- tight **bud**get: budget serré
19- struggle to (do something): avoir du mal à (faire quelque chose)
20- under**sta**ffed**:** en sous-effectif
21- start someone on (a treatment): instruct, cause, or compel someone to begin on something or to begin doing something as an initial starting point; mettre quelqu'un sous (traitement)

Idioms round the corner

The NHS was nothing short of a revolution = nothing less than a revolution ; rien de moins que

The Indian healthcare system

Activity 1: Warm-up

In pairs, discuss the following questions:

- What images spring to mind when you think of India?
- What is India famous for?
- What do you know about Indian history?
- Who is the Prime Minister?
- What do you think of Indian products and companies?
- What is the place of India in the pharmaceutical industry?
- Would you like to visit India, or live there?
- Who are the most famous Indian people you know?

Activity 2: Modicare

1. You are going to hear the following words in the video. Can you explain what they refer to, or what they mean?

Modicare
Money-lenders
The well-off
Government-funded healthcare scheme
GDP

2. In pairs, watch a video each and summarise it to your partner.

Video A: "Modicare." (August 2018)

Video B: "Modicare fails the poor." (January 2019)

Help for B1 students

Video A: Modicare
1) What is nicknamed Modicare?

2) According to Narendra Modi, how will Modicare change the life of the poor?

3) What is the government's role in Modicare?

4) How many Indian families will benefit from Modicare?

5) What amount of medical costs does the insurance policy cover?

6) What might happen to private hospitals?

7) How much of its GDP does India spend on healthcare, and how does it compare to other countries?

8) What are the two weak points of the Indian health sector?

Video B: Modicare fails the poor

1) Explain Munni Devi's situation

2) What is Modicare supposed to offer to India's poorest citizens?

3) What is the problem with Modicare?

4) How much of its GDP does India spend on healthcare, and how does it compare to other countries?

5) What are the two weak points of the health sector?

6) How many Indian people are pushed into poverty every year because of medical costs?

7) At the end of the video, the journalist gives a reason why healthcare is not well funded. What is this reason?

Help for A2 students

Video A: Modicare

1) Modicare is: the name / the nickname of the Indian healthcare system.

2) According to Narendra Modi, thanks to Modicare, the poor will have / will not have to borrow money from money-lenders.
3) The government will pay the premiums for health insurance for 100 / 1,000,000 / 100,000,000 Indian families.
4) The insurance policy given to each family will cover medical costs up to 700 / 7,000 / 7,000 000 a year.
6) Public / private hospitals might be overwhelmed by demand.
7) India spends 1.5 / 11.5 / 15.5 % of its GDP on healthcare.
8) What are the two weak points of the Indian health sector? Facilities / staffing levels / access to drugs.

Video B: Modicare fails the poor
1) How long has Munni Devi been sleeping in front of the hospital, waiting for an appointment for her heart condition? 6 days / 6 weeks / 6 months.
2) Modicare is supposed to offer help to make up half a million / half a billion poor people in India.
3) What is the main problem with Modicare? There is not enough money to support the scheme / It gets a lot of criticism.
4) India spends 1 / 11/ 15% of its GDP on healthcare, compared to a global average of 6 / 16 / 26 %.
5) What are the two weak points of the Indian health sector? Facilities / staffing levels / access to drugs.
6) How many Indian people are pushed into poverty every year because of medical costs? 3 / 60 / 63 million.
7) One of the reasons why there is not enough money to fund Modicare is that: there are too many billionaires / billionaires don't pay enough taxes.

3. Together, sum up the main characteristics of the Indian healthcare system.

Activity 3: Mini presentations

In groups of three: Now that you have more insight into the American, British and Indian healthcare systems, prepare one slide to compare the three systems. You can do more research if necessary. Be ready to present your slide to the class. Vote for the best presentation / the best slide.

Reminder: how to make a good slide

Think about:
- legibility (background colour, font size, font colour, font style).
- minimal text: key words only.
- clear visuals: good quality images.
- slide numbers (if several slides).

Vocabulary list 5: The Indian healthcare system

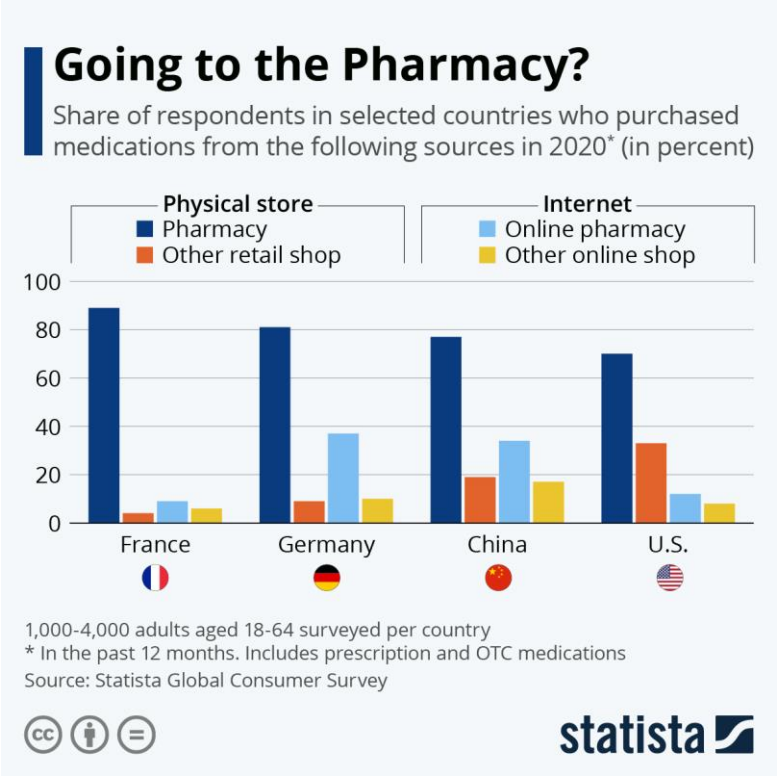
https://quizlet.com/fr/708084655/4y-quizlet5-health-inequalities-in-india-flash-cards/?funnelUUID=b39f2872-b030-422c-af80-967839ae43d3

1- Modicare: nickname for The National Health Protection Scheme (NHPS), which extends healthcare insurance to 100 million families.
2- **health**care scheme: régime de santé
3- **go**vernment-funded: financé par l'Etat
4- GDP (Gross Do**mes**tic **Pro**duct): produit intérieur brut
5- **co**ver **me**dical costs: couvrir les dépenses médicales
6- fa**ci**lities: équipements
7- **ba**sic care: soins élémentaires
8- ex**pen**diture: dépenses
9- fall sick: tomber malade
10- **mo**ney-lender: société de prêt
11- the well-off: les riches
12- the poor: les pauvres
13- be over**whelmed**: être submergé
14- **staff**ing: effectifs
15- be pushed into **po**verty: basculer dans la pauvreté
16- be worth **mo**ney: valoir de l'argent
17- a**chieve**ment: prouesse, réussité
18- fail someone: laisser tomber quelqu'un
19- su**pport**: subvenir aux besoins de
20- **a**verage: moyen.ne
21- I can't a**fford** to: je n'ai pas les moyens de

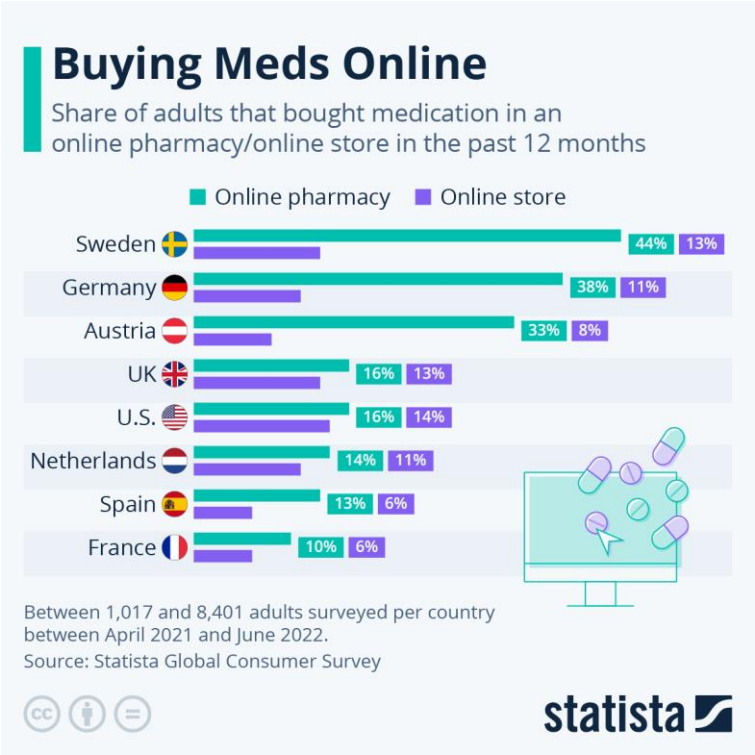
Pharmacies: online or local?

Activity 1: Warm-up

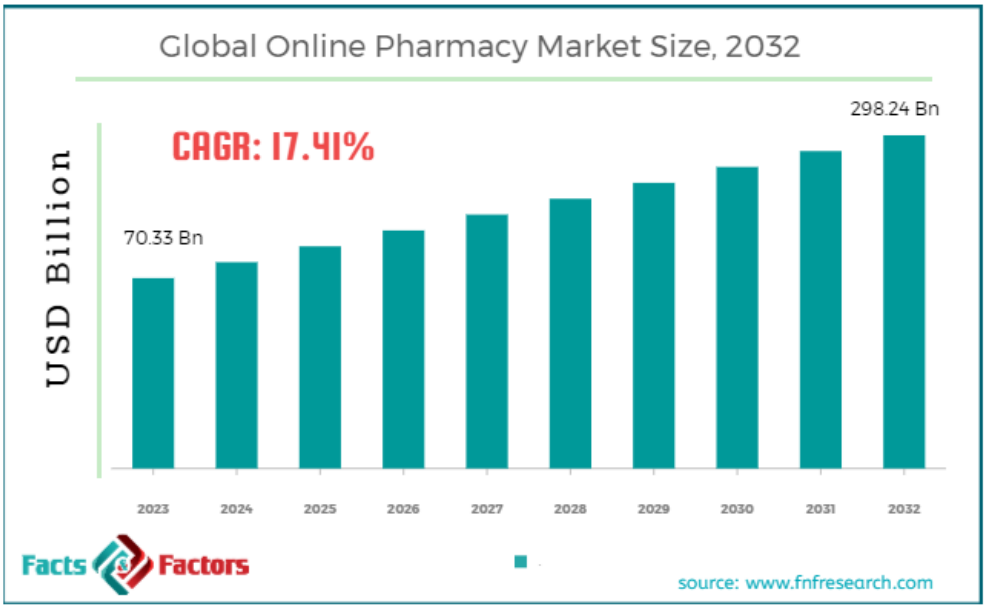
1.



2.



3.



In pairs, look at the graphs and discuss the following questions:
- What kind of items do you buy online?
- Are you surprised at the evolution of the online pharmacy market?
- Would you consider buying medication online? Why (not)?
- What are the advantages and disadvantages of online pharmacies?
- Are online pharmacies the future?

Activity 2: Online vs local community pharmacies

1. In pairs, watch a video each and summarise it to your partner. You can use the questions below if necessary.

Video A: "Here's why Amazon Pharmacy may be good for the healthcare industry." till 2'15

Video B: "Online Pharmacy VS Local Community Pharmacy." till 2'26

Video A

Help for B1 students
a) Identify the nature, the source and main topic of the video.

b) What does Amazon Pharmacy bring to the market?

c) Why is 'foot traffic' (= people walking around pharmacies) vital to local pharmacies?

d) According to the journalist, what is the consequence when tech overlords (=huge, successful tech companies) like Amazon move into an essential industry?

e) On the other hand, what are the upsides to Amazon Pharmacy?

f) What has the pandemic exposed, for businesses of all sizes?

Help for A2 students
a) Identify the nature, the source and main topic of the video.

b) What does Amazon Pharmacy bring to the health market? Low prices / delivery of medicines / more choices of medicines.

c) Why is 'foot traffic' (= people walking around pharmacies) vital to local pharmacies? Because pharmacies sell more medicines / pharmacies sell more products other than medicines.

d) According to the journalist, what is the consequence when tech overlords (=huge, successful tech companies) like Amazon move into an essential industry? They boost business / They lead to the disappearance of physical stores that are replaced with nothing.

e) On the other hand, what are the upsides to Amazon Pharmacy? It encourages Pharmacy giants like CVS to cut their prices / It makes everyone realise that all pharmacies need to offer fast delivery.

f) What has the pandemic exposed, for businesses of all sizes? The need for human contact / the need to embrace technology.

<u>Video B</u>

Help for B1 students

For each interviewee, pick out the main arguments for their preference towards either online or local pharmacies.
Interviewee 1:

Interviewee 2:

Interviewee 3:

Interviewee 4:

Help for A2 students:

For each interviewee, pick out the main arguments for their preference towards either online or local pharmacies.

Interviewee 1: local / online. Because: they can answer your questions / they can save your life.

Interviewee 2: local / online. Because: human-to-human contact is essential to build trust / it's fast and efficient / it's good for people who are computer-friendly.

Interviewee 3: local / online. Because: it saves time and travelling / it's nice to queue up and see people.

Interviewee 4: local / online. Because: you receive advice from the pharmacist / you save money because medicines are cheaper.

3. Together, recap the advantages and disadvantages of online pharmacies like Amazon.

Activity 3: Balancing arguments

1. In the TV programme named "On the other hand", the journalist looks at two sides of an issue.

You can say "On (the) one hand, Amazon Pharmacy could be a danger for local pharmacies. On the other hand, it might encourage local pharmacies to invest in delivery services."

Can you think of other ways of balancing arguments?

2. Writing practice: choose a subject below and write a balanced argument, using "on the one hand / on the other hand."

Pros and cons of: local pharmacies / being a pharmacist / vaccinating in pharmacies.

Be ready to submit your argument to the class.

Vocabulary list 6: Online vs local pharmacies

https://quizlet.com/fr/708106157/4y-quizlet6-onlineonsite-pharmacies-flash-cards/

1- **o**ver-the-**coun**ter drugs or OTC drugs: medicaments sans ordonnance
2- pres**crip**tion: ordonnance
3- to dis**pense me**dicine: délivrer des médicaments
4- to **coun**sel **pa**tients: conseiller les patients
5- aisle: allée
6- be**hind**-the-**coun**ter drugs: medicaments sur ordonnance
7- **phar**macy **own**er: pharmacien propriétaire
8- shelf life: durée de conservation
9- **coun**ter: comptoir
10- ex**pi**ry date (UK), expi**ra**tion date (US) : date limite d'utilisation
11- staff: le personnel
12- **per**sonal care **pro**ducts: parapharmacie
13- ge**ne**ric drugs: medicaments génériques
14- brand name: marque
15- re**fil**l: renouvellement (d'une ordonnance)
16- pill: pilule
17- **lo**zenge: pastille
18- **cap**sule: gélule
19- **ta**blet: comprimé
20- **up**sides: avantages
21- **down**sides: inconvénients
22- **life**line: bouée de sauvetage (sens fig. ex. Online delivery was a lifeline during Covid)
23- be in a tough spot: être dans une position difficile
24- de**li**very: livraison
25- em**brace**: adopter (une idée)

Idioms round the corner
To take something by storm: to attack and conquer (prendre d'assaut) To have one's legs cut out from under (one): to be knocked down (se faire couper l'herbe sous le pied)

Branded vs generic medicines

Activity 1: Warm-up

In pairs, discuss the following questions:

-Should all medicine be free?
-Do you think medicine is too expensive?
-What medicines are in your medicine cabinet?
-Do you think medicines are tested enough before they are put on the market?
-What is the difference between a brand-name drug and a generic drug?
-How do we know generic drugs are safe?
-Are generic drugs cheaper because they are lower quality?

Activity 2: Generics litigation

1. Anticipate: look up the word ''litigation'' in the dictionary.

Pick out the words that are synonyms for ''litigation.''

lawsuit – compromise – legal action – violation.

Can you think of a drug company that was taken to court?

2. Watch the video "Generics litigation" and take notes (B2-C1) or answer the questions (A2 – B1) to prepare a summary. Then, share your summary with your partner.

1- Why are Americans spending less on prescription drugs?
a) They can't afford brand names.
b) They get prescribed more and more generic drugs.

2- What happened to Karen Bartlett after taking a generic pain drug?
a) She had an allergic reaction.
b) She became deaf.
c) She was fine.

3- What did she do after what happened?
a) She talked to the press.
b) She took the manufacturer to court.

4- She got a 21 million dollar judgement but *she hasn't seen a dime of it*. What does the sentence in italics mean?
a) She won her court case but didn't get any compensation money.
b) She lost her court case.

5- What was the 2011 Supreme Court ruling about?
a) Generic drugs manufacturers can't be held responsible for adverse events because they only copy a formula.
b) Generic drugs manufacturers are allowed to copy brand name drugs.

6- What kind of adverse events did Gabriel Drapos experience after taking the generic version of Accutane?
a) Internal bleeding.
b) Headache.
c) Digestion issues.

7- Why can't Gabriel Drapos find a lawyer to sue the manufacturer?
a) Because he can't afford a lawyer.
b) Because there is no legal recourse against generic drug manufacturers.

Activity 3: Role play

A patient who saw the TV report "Generics Litigation" wants the brand name of his medication, whereas the pharmacist recommends the generic drug. Take 5 minutes to prep (list reasons) and then play the dialogue.

Role 1: patient. The senior pharmacist, who is absent today, always gives you brand name medicines, but today the new student pharmacist insists on giving you the generic medicine. Yesterday, you watched the news and learnt about what happened to Karen Bartlett and Gabriel Drapos after they took a generic drug. Explain why you want the brand name.

Role 2: student pharmacist. You have to deal with a patient who insists on having the brand name medicine instead of the generic one. They watched a story in the news that scared them. Your role is to educate the patient in terms of generic drugs and list the reasons why they should have the generic drug / they should not be afraid of generic drugs.

Vocabulary list 7: Branded vs generic medicines

https://quizlet.com/_bpz10d?x=1qqt&i=120vpl

1- **pa**tent: brevet
2- pro**duc**tion line: chaîne de production
3- **pri**mary **pa**ckaging: emballage primaire
4- **whole**saler: grossiste
5- re**tai**ler: détaillant
6- clean room: chambre stérile

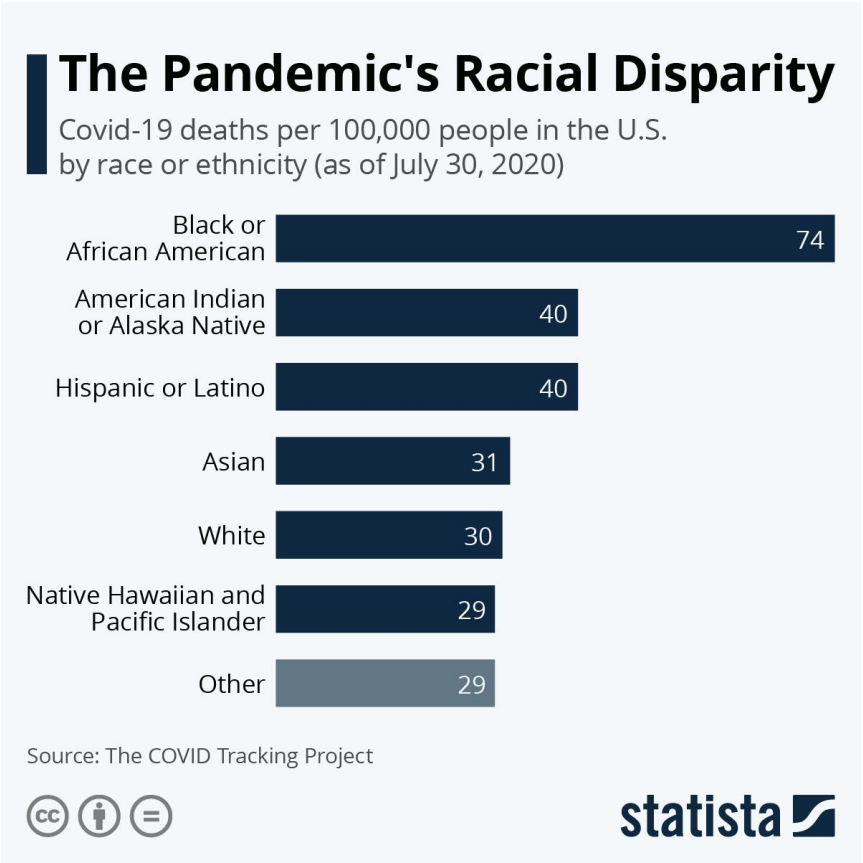
7- **air**lock: sas
8- manu**fac**turing plant: usine de fabrication
9- **che**mical compo**si**tion: composition chimique
10- **li**cense: permis
11- **co**pycat drug: copie de médicament
12- drug **ma**ker: fabriquant de médicaments
13- a**ffor**dable: abordable (financièrement)
14- **trade**mark: marque déposée
15- **ve**hicle: excipient
16- **for**mula: formule
17- active in**gre**dient: principe actif
18- **le**gal re**course**: recours légal
19- be taken to court: être poursuivi en justice
20- branded drug, brand drug: médicament princeps
21- be **li**able to prose**cu**tion: être passif de poursuites
22- liti**ga**tion: litige
23- **law**suit: procès
24- sue: poursuivre en justice
25- be held a**ccount**able for: être tenu pour responsable de

African-Americans' health outcomes

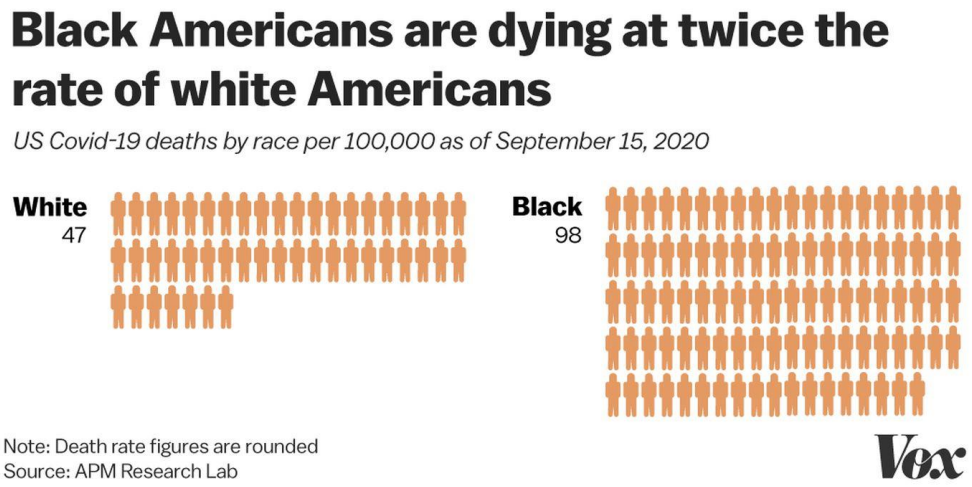
Activity 1: Warm-up

1. In pairs, look at the following graphs and discuss what could have been the reasons for African-Americans' health outcomes (= results) during the pandemic.

a.



b.



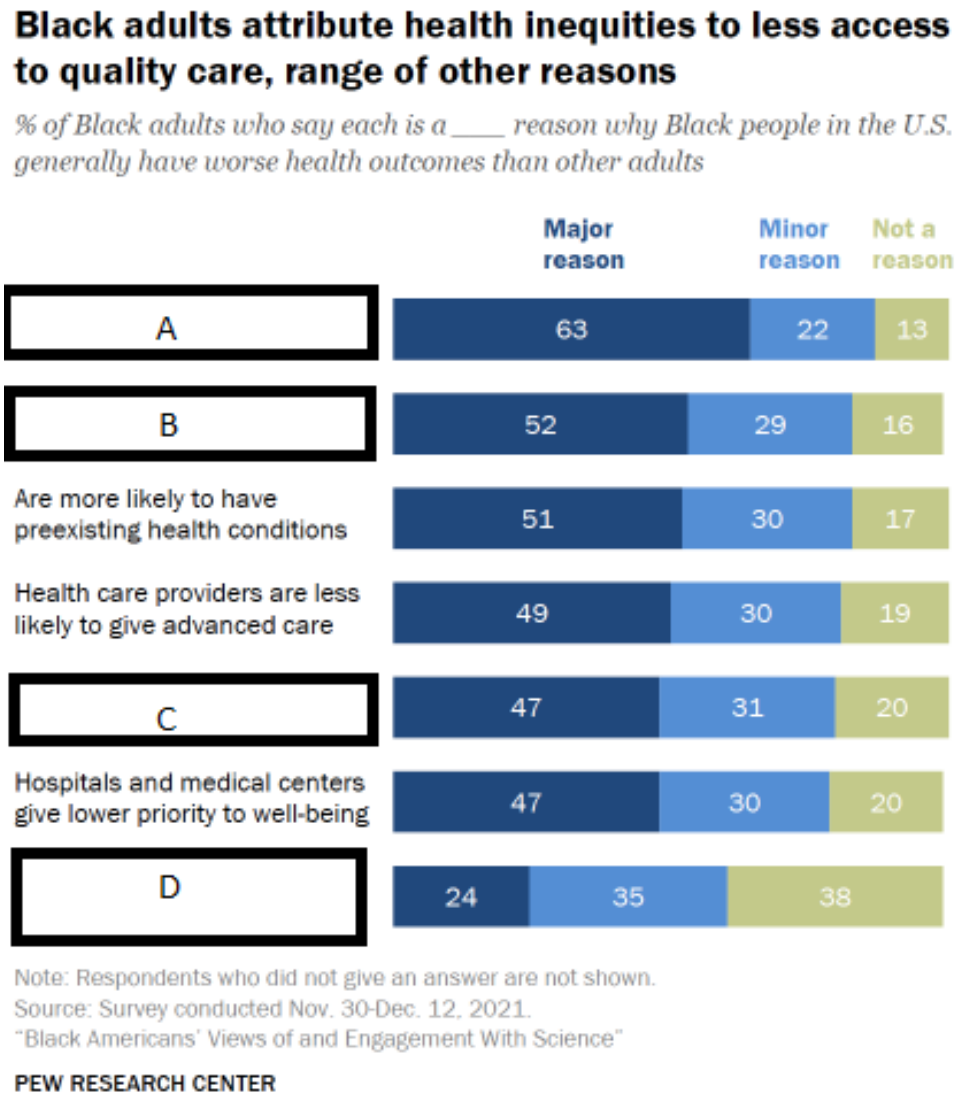
2. In pairs, look at the following survey and try to place the following reasons back into the graph (positions A, B, C, or D).

- More communication problems from language, cultural differences:

- Live in communities with more environmental problems:

- More likely to work in jobs with risks for health problems:

- Less access to quality medical care where they live:



Activity 2: Causes for health inequities

1. In pairs, read the culture boxes below about the Tuskegee Study (1932-1972).

The "Tuskegee Study of Untreated Syphilis in the Negro Male," was conducted by the United States Public Health Service (USPHS) and involved blood tests, x-rays, spinal taps and autopsies of the subjects. The goal was to "observe the natural history of untreated syphilis" in black populations, but the subjects were completely unaware and were instead told they were receiving treatment for bad blood when in fact, they received no treatment at all.

Edited from www.mcgill.ca, 25 January 2009

Research estimates that life expectancy at age 45 for black men fell by up to 1.4 years in direct response to the 1972 disclosure of the Tuskegee study. This decline in longevity could explain approximately 35 percent of the 1980 life-expectancy gap between black and white men. The disclosure of the Tuskegee project appears to have stalled, or even reversed, a pre-1972 trend toward narrowing of the racial health gap.

Edited from PBS, News Hour, Aug 8, 2016

How can you explain the drop in life expectancy in Black men after the disclosure (= act of revealing something) of the Tuskegee Study?

2. In pairs watch one video each and summarise it to each other. You may use the questions below if necessary.

Video A: "Racial segregation and health disparities."

a) What is black men's life expectancy compared to white men?

b) What happens every 7 minutes in the USA?

c) What happens to health disparities when African-Americans get more education?

d) Pick out the statistics given about Black American mothers with a college degree.

e) What are the consequences of residential segregation? (four elements)

f) Pick out the examples of unhealthy residential conditions (four elements)

g) What contributes to higher diabetes and obesity rates for Black people?

h) What is said about healthcare facilities in Black neighbourhoods (two elements), and what is the result of this situation (three elements)?

i) What is the final piece of information given about Black neighbourhoods?

Video B: "Disparities in dementia: Why African-Americans face higher rates of Alzheimer's."

a) What is the main theme of this document?

b) Pick out the following elements:

- how likely African-Americans are to get dementia compared to white people:

- what influences the diagnosis of dementia:

c) What is African-Americans' perception of dementia?

d) What percentage of Latinos and African-American families will be impacted by Alzheimer's disease by 2030?

e) What health factors of dementia are African-Americans particularly impacted by? (3 elements)

f) Why is an early diagnosis important?

g) Apart from comorbidities, what other factors influence the rise of dementia? (two elements)

h) Quote two reasons why African-Americans are not diagnosed early enough.

i) When African-Americans see healthcare professionals, what is their experience like?

3. Together, draw a list of health inequalities and their causes. If you think of more causes, add them to your list.

Health inequalities	Causes

Activity 4: Talking about health inequalities

When someone is "twice as likely to" die as someone else, it means that there is exactly double the chance of it happening.

If person A is "three times as fat as" person B, it means that if A weighs 40 kg, B weighs 120kg. Il also means that person B is "a third as fat as" person A.

Let's practice this phrase and similar ones with the following exercises.

Exercise 1: Match the phrases with their translations.

1. To be likely to:	a. Deux fois plus que
2. To be twice as likely to:	b. Avoir plus de chances de
3. To be half as likely to:	c. Deux fois moins que
4. To be less likely to:	d. Avoir des chances de
5. To be more likely to:	e. Avoir deux fois moins de
6. Twice as much/many (….as):	chances de
7. Half as much/many (…as):	f. Avoir moins de chances de
8. A tenth as much/many:	g. Avoir deux fois plus de chances
	h. Dix fois moins

Exercise 2: translate the following.

1.Les personnes non-vaccinées ont deux fois plus de chances d'attraper un virus.
→_____

2. Je mange deux fois plus rapidement que toi.
→_____

3. Ce médicament original est trois fois plus cher que le médicament générique.
→_____

4. Cette pharmacie a quatre fois plus de patients qu'il y a 20 ans.
→_____

5. Ils emploient trois fois moins d'infirmières que dans le passé.
→_____

6. Ce médecin gagne deux fois moins que moi.
→_____

Activity 5: Write a speech and deliver it

Your team has been invited to a conference about health inequalities between black Americans and white Americans. The theme is ''African-Americans: bridging the healthcare gap''.

Write a speech to explain what the problem is and what could be implemented to reduce health inequalities.

Choose a champion to deliver your speech to the class. Listen to everyone and vote for the best speaker!

Idioms round the corner
"Taking care of yourself can go a long way towards taking care of your brain" To go a long way = to be helpful (faire beaucoup)

Mental Health

Activity 1: Warm-up

In pairs, discuss the following:

- What comes to mind when you hear 'mental health'?
- What mental health disorders and problems do you know of?
- What affects your mental health on a daily basis?
- What do you do to maintain or improve your mental health?
- Do you think modern society increases the likelihood of mental health problems?
- What advice would you give to someone with mental health issues?
- One of the most common mental health problems is depression. How can we help people who suffer from this?

Activity 2: Mental health issues

1. In pairs, read one article each and summarise it orally to your partner.

Student A

Millions in England face 'second pandemic' of mental health issues

Exclusive: NHS leaders urge ministers to tackle huge rise in depression, anxiety, psychosis and eating disorders since Covid hit

Andrew Gregory *Health editor* Mon 21 Feb 2022, *The Guardian*

Millions of patients in England face dangerously long waits for mental health care unless ministers urgently draw up a recovery plan to tackle a "second pandemic" of depression, anxiety, psychosis and eating disorders, NHS leaders and doctors have warned.

The Covid crisis has sparked a dramatic rise in the numbers of people experiencing mental health problems, with 1.6 million waiting for specialised treatment and another 8 million who cannot get on the waiting list but would benefit from support, the heads of the NHS Confederation and the Royal College of Psychiatrists have told the Guardian.

In some parts of the country, specialist mental health services are so overwhelmed they are "bouncing back" even the most serious cases of patients at risk of suicide, self-harm and starvation to the GPs that referred them, prompting warnings from doctors that some patients will likely die as a result.

Sajid Javid, the health secretary, who has acknowledged that national levels of depression have almost doubled since the start of the pandemic, is facing pressure to rapidly develop a "comprehensive plan" to respond to the soaring demand for mental health care in England. (…)

Dr Adrian James, the president of the Royal College of Psychiatrists, said: "We urgently need a fully funded mental health recovery plan, backed by a long-term workforce plan, to ensure everyone with a mental illness can get the help they need when they need it.

"Millions of children, young people and adults are seeking help from mental health services that are overstretched and under-resourced. The situation is critical. The government cannot afford to neglect mental health recovery any longer."

Health leaders also believe a key element of a recovery plan should include a focus on providing early support for children and young people with mental health problems. There has been a 72% increase in children and teenagers referred for urgent support for eating disorders in one year, and a 52% rise in emergency referrals for under-18s to crisis care since the start of the pandemic. (…)

Dr Phil Moore, a GP and chair of the NHS Confederation's mental health, learning disability and autism system group, said he was concerned that the mounting backlog of care could see patients "deteriorating to the point of crisis". "No clinician wants to see this happen," he added. "This was a problem before Covid but things are a lot worse now."

The Department of Health and Social Care has been approached for comment.

Student B

The definition of mental health has been widened so much that it's now almost meaningless

In our newly aware world, serious conditions such as psychosis and schizophrenia are overlooked
Martha Gill, Sun 14 May 2023, *The Guardian*

The psychiatrist Simon Wessely once said his spirits sank every time there was a mental health awareness week. "We don't need people to be more aware. We can't deal with the ones who already are aware," he said.

Yet awareness spreads and propagates, even as queues outside psychiatrist offices trail around the block. This year's big week, run by the Mental Health Foundation, starts on Monday. Its theme is anxiety, a disorder affecting a quarter of adults, according to the foundation – a statistic that sounds unbelievably large until you read its description of the condition, which seems almost broad enough to take in the full sweep of human experience.

"Lots of things can lead to feelings of anxiety, including exam pressures, relationships, starting a new job (or losing one) or other big life events. We can also get anxious when it comes to things to do with money and not being able to meet our basic needs, like heating our home or buying food."

Britain is certainly more aware than it used to be. Diagnoses have broadened – more of us see grief and stress as mental illnesses than we did a decade ago. (…)

But behind this good news story is something more important. Mental health awareness has its limits. While attitudes towards milder and more common mental health conditions such as anxiety, low mood, stress or burnout have improved, more serious disorders such as schizophrenia and psychosis trail far behind. In fact, when it comes to schizophrenia, we seem to be getting less enlightened. A study of 10,000 people spanning the three decades to 2020 found that by nearly all measures, stigma towards the disorder had worsened. People were less likely to want someone with schizophrenia as a housemate or co-worker than in 1990. They felt more fear and less desire to help.

Other research backs this up. Some 88% of people with severe mental illness say they experience stigma. Few people would recommend someone living with schizophrenia for a job, and even mental health professionals hold negative attitudes towards them. A study last month, meanwhile, found that one in three people living with sufferers of severe mental illness were themselves discriminated against. (…)

Severe mental health disorders are therefore more in need of destigmatisation campaigns but get fewer of them. The theme of last year's mental health awareness week was loneliness. Previous years have covered nature and mental health, kindness and body image. ITV's Britain Get Talking campaign last year, Public Health England's Every Mind Matters, and the NHS Help! campaign all focused on milder conditions, such as low mood and sleep problems, urging people to talk to those around them. (…)

But there's a problem here. It might be that campaigners have not "normalised" mental illness so much as broadened the definition to the point that it includes the mentally well.

If the method of lessening stigma is to consider mental health disorders relatable and "sane", reactions to a stressful environment, illnesses out of the realm of common experience, such as schizophrenia, are left out. And with so many new anxiety and burnout sufferers, there's a risk that the severely ill are crowded out of the conversation altogether.

2. Together, choose one of the articles and practice writing a summary.

Reminder:
- Introduce the document (nature, source, date, main theme).
- Use linking words to link your key ideas together.
- Conclude with the take-home message of the document.

Activity 3: Giving one's opinion

1. When you take part in a conversation, you need to express your opinion, agreement or disagreement with the people you talk to. Here is a list of phrases you might want to use: can you copy them next to the right heading?

a- As I see it, …
b- I second that!
c- My exact thoughts!
d- I hold the view (that…)
e- Do you mind if I say something?
f- That's one way of looking at it, but…
g- I see your point, but…
h- I have mixed feelings about…
i- I see what you are getting at
j- That's one way of looking at it, but…
k- What I mean is…
l- I see things rather differently
m- I find that very difficult to accept
n- I don't mean to interrupt, but…
o- Absolutely!
p- I might be wrong, but…
q- I would say (that)…
r- That's a good point
s- I am under the impression (that)…
t- Sorry, but I'm not done yet
u- It seems to me
v- I wouldn't quite put it that way myself

Expressing your opinion	- - - - - - - -
Agreeing	- - - - -

Disagreeing	- - - - - -
Interrupting	- - -

2. In pairs, share your opinion about the following question:
Should the definition of mental health be restricted to severe mental health issues?

Activity 4: New treatments

1. Before reading, match these drugs with their definitions.
1) psylocibin.
2) MDMA.
3) ayahuasca.

a) commonly seen in tablet form (ecstasy) and crystal form (molly or mandy), this substance is a potent central nervous system (CNS) stimulant primarily used for recreational purposes.
b) a tropical vine of the Amazon region, noted for its hallucinogenic properties.
c) a hallucinogenic compound obtained from certain mushrooms

2. In pairs, read one article each and summarise it to your partner. Use the questionnaire below if necessary.

Student A

Psilocybin for depression could help brain break out of a rut, scientists say

The Guardian, Tue 12 Apr 2022

The psychedelic compound found in magic mushrooms helps to open up depressed people's brains and make them less fixed in negative thinking patterns, research suggests.
According to the findings, psilocybin makes the brain more flexible, working differently to regular antidepressants, even weeks after use. Researchers say the findings indicate that psilocybin could be a viable alternative to depression treatments.

They say patterns of brain activity in depression can become rigid and restricted, and psilocybin could help the brain to break out of the rut in a way traditional therapies cannot.

Prof David Nutt, the head of the Imperial Centre for Psychedelic Research, said: "These findings are important because for the first time we find that psilocybin works differently from conventional antidepressants, making the brain more flexible and fluid, and less entrenched in the negative thinking patterns associated with depression.

"This supports our initial predictions and confirms psilocybin could be a real alternative approach to depression treatments."

The paper's senior author, Prof Robin Carhart-Harris, a former head of the Imperial centre who is now based at the University of California, San Francisco, said: "The effect seen with psilocybin is consistent across two studies related to people getting better, and was not seen with a conventional antidepressant.

"In previous studies we had seen a similar effect in the brain when people were scanned whilst on a psychedelic, but here we're seeing it weeks after treatment for depression, which suggests a carryover of the acute drug action."

Psilocybin is one of a number of psychedelics being explored as a potential therapy for psychiatric disorders. The new findings are based on analysis of brain scans from about 60 people receiving treatment for depression, led by the Imperial centre. The team believes it may have untangled how psilocybin works on the brain.

People who responded to psilocybin-assisted therapy showed increased brain connectivity not just during their treatment but up to three weeks afterwards. This opening up effect was associated with people reporting improvements in their depression.

According to the researchers, similar changes in brain connectivity were not seen in those treated with a conventional antidepressant, escitalopram, suggesting the psychedelic works differently in treating depression.

The team say the findings, published in the journal Nature Medicine, are a promising advance for psilocybin therapy, with the effects replicated across two studies.

But the authors caution that while the findings are encouraging, patients with depression should not attempt to self-medicate with psilocybin, as taking magic mushrooms or psilocybin in the absence of trial conditions may not have a positive outcome.

1) Research shows that psilocybin can help treat depression: True / False.

2) Psilocybin can help the brain change the way it works: True / False.

3) Psilocybin only works for a short period of time: True / False.

4) Similar changes in brain connectivity have been observed in patients taking antidepressants: True / False.

5) The authors of the study warn patients against self-medication with mushrooms: True / False.

Student B

Psychedelic ayahuasca works against severe depression, study finds

By Luís Fernando Tófoli, Dráulio Barros de Araújo and Fernanda Palhano-Fontes, edited from *The Conversation* July 3, 2018

"Leon" is a young Brazilian man who has long struggled with depression. He keeps an anonymous blog, in Portuguese, where he describes the challenge of living with a mental illness that affects some 300 million people worldwide, according to the World Health Organization. Leon is among the roughly 30 percent of those patients with treatment-resistant depression. Available antidepressant drugs like selective serotonin reuptake inhibitors do not alleviate his depressed mood, fatigue, anxiety, low self-esteem and suicidal thoughts. A new study may offer hope for Leon and others like him. Our team of Brazilian scientists has conducted the first randomized, placebo-controlled clinical trial of ayahuasca – a psychedelic drink made of Amazonian plants. The results, recently published in the journal Psychological Medicine, suggest that ayahuasca can work for hard-to-treat depression.

Ayahuasca, a word from the indigenous Quechua language, means "the vine of the spirits." People in 10 the Amazonian region of Brazil, Peru, Colombia and Ecuador have for centuries used ayahuasca for therapeutic and spiritual purposes. The medicinal beverage's properties come from two plants. Banisteriopsis caapi, a vine that twists its way up to the treetops and across river banks of the Amazon basin, is boiled together with Psychotria viridis, a shrub whose leaves contain the psychoactive molecule DMT.

(…) For our study, which took place at Brazil's Federal University of Rio Grande do Norte, researchers recruited 218 patients with depression. Twenty-nine of them were selected to participate because they had treatment-resistant depression and no history of psychotic disorders like schizophrenia, which ayahuasca use may aggravate. These 29 people were randomly assigned to undergo a single treatment session, in which they were given either ayahuasca or a placebo substance to drink. The placebo was 20 a brownish liquid, bitter and sour to the taste, made of water, yeast, citric acid and caramel colorant. Zinc sulphate mimicked two well-known side effects of ayahuasca, nausea and vomiting. The sessions took place in a hospital, though we designed the space like a quiet and comfortable living room.

The acute effects of ayahuasca – which include dream-like visions, vomiting and intense introspection – last for about four hours. During this period, participants listened to two curated playlists, one featuring 25 instrumental music and another with songs sung in Portuguese.

Patients were monitored by two team members, who provided assistance to those experiencing anxiety during this intense emotional and physical experience. One day after the treatment session, we observed significant improvements in 50 percent of all patients, including reduced anxiety and improved mood. A week later, 64 percent of the patients who had received ayahuasca still felt that their depression had eased. Just 27 percent of those in the placebo group showed such effects. (…)

Ayahuasca is not a panacea. Such experiences may prove too physically and emotionally challenging for some people to use it regularly as treatment. We

have also observed regular ayahuasca users who still suffer from depression. But, as our study demonstrates, this Amazonian sacred plant has the potential to be used safely and effectively to treat even the hardest to treat depression.

1) According to a new study, ayahuasca can help treat patients with treatment-resistant depression: True / False.

2) Ayahuasca is made up of three plants: True / False.

3) You should not take ayahuasca if you have psychotic disorders: True / False.

4) The trial was not placebo-controlled: True / False.

5) Ayahuasca increases anxiety in the long-term: True / False.

6) Ayahuasca is a miracle drug: True / False.

Activity 5: Introduction to debating

1. You are going to discuss the following statement:

"You should not have to be sick in order to take a psychedelic legally."

2. In teams of 3 (= 6 teams of 3, 3 affirmative teams; 3 negative teams). Write your argument together, and practice delivering it.

Affirmative team: First speaker
☐ Introduces and defines the topic from affirmative point of view.
☐ Outlines the case of the affirmative.
☐ Summarises what each speaker will argue in favour of the topic.
☐ Introduces the major arguments for the affirmative team.

Negative team: First speaker
☐ Defines the topic from negative point of view.
☐ Outlines the case of the negative.
☐ Summarises what each speaker will argue against the topic.
☐ Introduces the major arguments for the negative team.
☐ May refute the definition of the topic of the affirmative team.

3. Play the debate:
The first speaker of affirmative team, then the first speaker of negative team present their arguments to the class. See "Debating structure" in Appendix.

A few articles to help prepare the line of arguments:
https://www.hmpgloballearningnetwork.com/site/pcn/videos/pharmacists-play-vital-role-psychedelic-medicines-emergence

https://www.pharmacytimes.com/view/expert-pharmacists-play-pivotal-role-in-supporting-safe-consumption-of-psychedelic-medicines-upon-their-fda-approval

Vocabulary list 8: Mental health

https://quizlet.com/_by2n9q?x=1jqt&i=120vpl

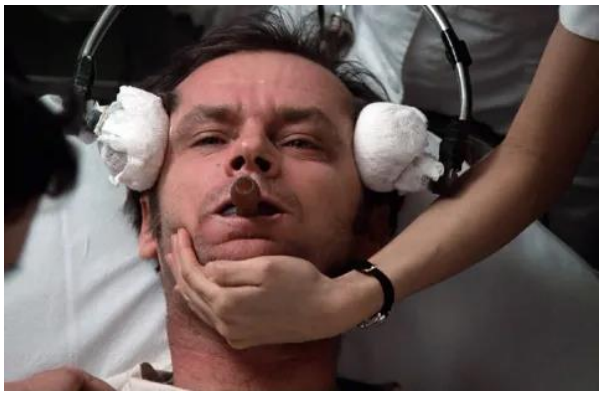
1- **ner**vous **break**down: dépression nerveuse
2- **eat**ing dis**or**ders: troubles du comportement alimentaire
3- **pa**ranoid: paranoïaque
4- split perso**na**lity: dédoublement de la personalité
5- OCD (ob**se**ssive com**pul**sive dis**or**der): TOC (Trouble Obsessionnel Compulsif)
6- well-being: bien-être
7- self-es**teem:** estime de soi
8- peer-**pre**ssure: pression des pairs
9- **bu**llying: harcèlement
10- co**mmit su**icide: se suicider
11- sui**ci**dal thoughts: pensées suicidaires
12- self-**in**jury: automutilation
13- **the**rapist: thérapeute
14- psy**chi**atrist: psychiatre
15- antide**pre**ssants: antidépresseurs
16- a**lle**viate: soulager
17- **trau**ma: traumatisme
18- hallucino**ge**nic drugs: drogues hallucinogènes
19- re**co**very: rétablissement
20- mood swings: sautes d'humeur
21- **stre**ssor: facteur de stress
22- get a re**fe**rral to a **spe**cialist: être adressé à un spécialiste
23- su**pport sys**tem: système d'entraide
24- **stig**ma: stigmatisation
25- PTSD (Post Trau**ma**tic Stress Dis**or**der): TSPT (Trouble de Stress Post Traumatique)

Mental health institutions

Activity 1: Warm-up

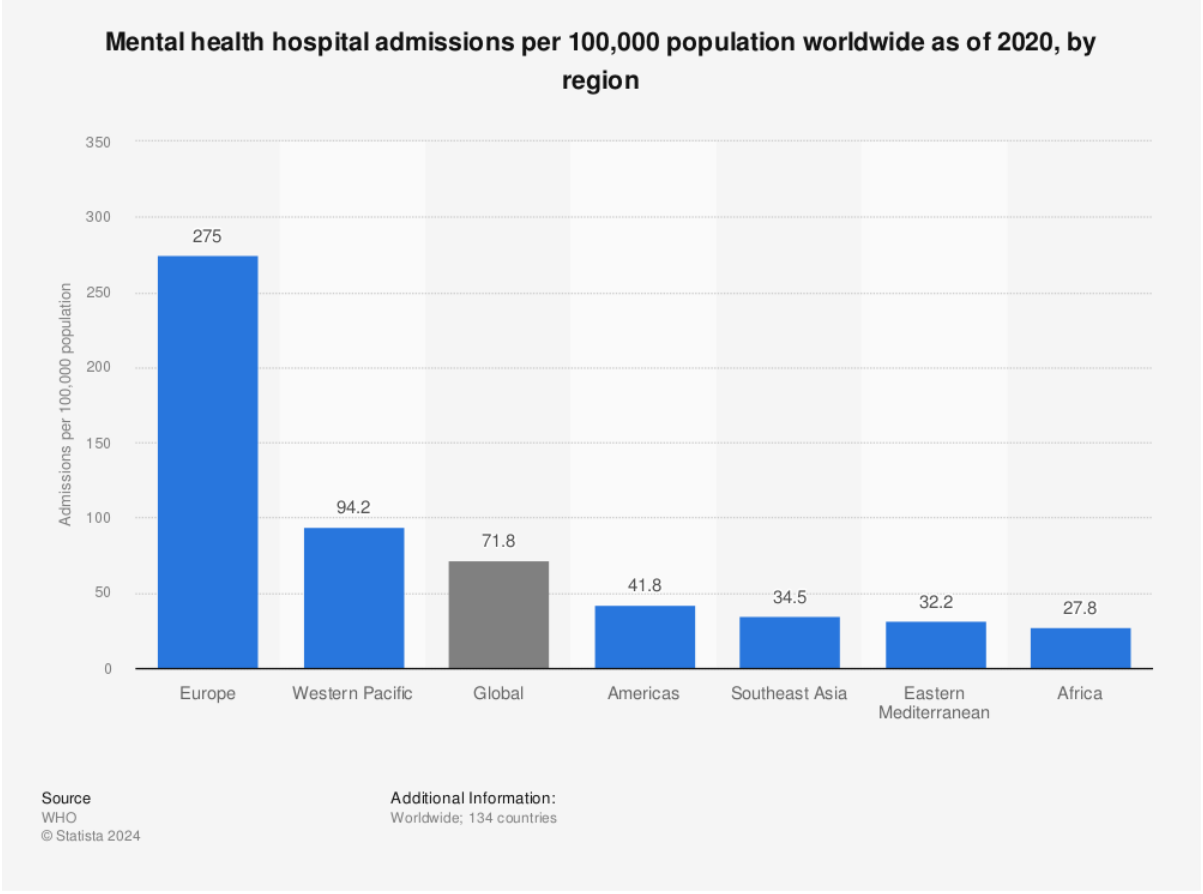
Look at the following pictures and discuss the following:

1.



2.

3.



- What are the common stereotypes about psychiatric wards? Where do these stereotypes come from?
- What is the reality about mental health institutions, in your opinion?
- How can society help people with mental health problems or stop people from developing them?
- Are murderers with mental health problems really murderers?
- If someone has a mental health disorder, should they be kept in a special mental health institution?

Activity 2: To deinstitutionalise, or not to deinstitutionalise

1. In pairs, study one document each and summarise it to your partner. You can use the questions below if necessary.

Document 1

Nation's psychiatric bed count falls to record low

The Washington Post, July 1st, 2016
By Lateshia Beachum

https://www.washingtonpost.com/news/to-your-health/wp/2016/07/01/nations-psychiatric-bed-count-falls-to-record-low/?noredirect=on&utm_term=.0b3cfff9369b

The number of psychiatric beds in state hospitals has dropped to a historic low, and nearly half of the beds that are available are filled with patients from the criminal justice system.

Both statistics, reported in a new national study, reflect the sweeping changes that have taken place in the half-century since the United States began deinstitutionalizing mental illness in favor of *outpatient treatment*. But the promise of that shift was never fulfilled, and experts and advocates say the result is seen even today in the increasing ranks of homeless and incarcerated Americans suffering from serious mental conditions.

Researchers for the Treatment Advocacy Center, a national nonprofit organization, found that states' psychiatric bed total had fallen by 17 percent since 2010 — from 43,318 in 2010 to 37,559 this year. That has left just 11.7 beds per 100,000 people, far below the count in other developed countries. (…) The study, which was released last month, recommends reforming *Medicaid* and *Medicare* regulations that it says have contributed to bed shortages. It also calls for greater use of interventions that could connect people with treatment before they need "the last resort of a state hospital bed." Doing so — through court-ordered outpatient treatment, use of mobile crisis teams and special "de-escalation" training for police — would not just keep individuals out of emergency rooms but potentially also out of jails, the study notes.

The diversion of beds to criminal justice needs keeps increasing. Of states' nearly 38,000 psychiatric beds early this year, 17,601 were only available for

forensic cases, whether arrested suspects, individuals in local jails or state prison inmates. That was several thousand beds more than in 2010.

(…) Psychiatrist Renee Binder, a professor at the University of California at San Francisco School of Medicine, who sees patients at one of its teaching hospitals, said they are often acutely suicidal, combative or unable to function."The patients who come to the ER can't be released," she said. "They sit in the middle of the emergency room. It's not good for the patients, because they aren't getting the treatment they need. "Yet the vast majority of states have lost beds since 2010. In nine, 16 state hospitals either shut down or were merged. (…)

New York saw the sharpest decline, shedding more than a third of the 4,958 beds it had available in 2010. It now has 3,217, according to the study. The decrease is part of the state's continuing effort to move mental health care to community-based models, according to the New York Department of Mental Health. The agency's most recent plan notes that inpatient psychiatric costs amount to about half of public spending on mental health. (…)

A three-year, $75 million demonstration project begun as part of the Affordable Care Act suggests that certain policy changes can be part of the remedy, according to the study. The project allowed 10 states plus the District of Columbia to get Medicaid reimbursement for patients receiving mental health care in private psychiatric institutions. One question was whether patient care and discharging practices, as well as the number of mental health patients waiting in emergency rooms, would improve.

A 2013 congressional report said the participating states all indicated that the demonstration had helped them expand inpatient care. This year, the project was extended three more years, although funds have not yet been appropriated. (…)

Under current law, Medicaid won't cover inpatient treatment in mental health facilities with more than 16 beds. Murphy's Helping Families Act would allow the program to reimburse *a standalone psychiatric hospital* of any size for up to 15 days of treatment provided to Medicaid managed-care patients, who are 80 percent of all Medicaid enrollees. "The key is compassion in dictating what we can do for people," Murphy said.

<u>Reading: answer the following questions. There may be one or several correct answers.</u>

1- What piece of news is broken at the beginning of the text?
a) Patients from the criminal justice system fill all the psychiatric beds in hospitals.
b) Half of psychiatric beds in hospitals are available.
c) The number of psychiatric beds in hospitals is as low as ever.

2- What is the reason for this drop?
a) More and more patients have been treated outside of hospitals.
b) The US decided to institutionalise fewer and fewer patients.
c) There have been fewer and fewer people with a mental illness in the US.

3- Deinstitutionalizing mental illnesses has been a success.
a) True.
b) False.

4- Regarding the number of psychiatric beds, the US is on a par with other developed countries.
a) True.
b) False.

5- What is needed to help patients connect with their treatment? (several answers)
a) family help.
b) the use of mobile phones.
c) police officers trained to deal with crises due to mental illness.
d) court orders.

6- How many beds were only available for the criminal justice system?
a) a little less than half.
b) more than half.
c) one third.

7- What is the main reason for the decline in institutionalization?
a) treating patients as inpatients is expensive.
b) patients are better taken care of in their community than in hospital.

8- What did the three-year project as part of the Affordable Care Act show?
a) Everyone agrees that funding inpatient care improves the situation in hospitals.
b) Some people are not sure it has been a success.
c) Not everybody agrees on the result of the demonstration.

Document 2:
Video: ''Compassion is the prescription for care.''

1- According to the medical director, San Diego County Psychiatric hospital:

a) corresponds to what people imagine about mental health institutions.

b) does not correspond to what people imagine about mental health institutions.

2- All nurses who work in this mental health hospital have a strong wish to work with this population of patients. What is the word used by the nurse?

a) They have a calling.
b) They are appalling.
c) They are galling.

3- How do patients arrive in the hospital? (several answers)
a) They come in voluntarily.
b) They are forced in by family members.
c) They are brought in by law enforcement.

4- What does the work require? (several answers)
a) consideration.
b) compassion.
c) collaboration.
d) dedication.

5- Which of the following are not part of the treatment team? (several answers)
a) psychiatrists.
b) psychologists.
c) social workers.
d) nurses.
e) recreation therapists.
f) dieticians.
g) pharmacists.
h) behavioural therapists.

6- What is the typical profile of patients? (several answers)
a) They experience difficulty.
b) They have been helped by the system but it hasn’t worked.
c) They come from families with mental health problems.
d) They are beyond help.
e) They have a history of abuse.

7- Long-term hospitalisation is often included in the treatment plans.
a) True.

b) False.

8- Before releasing patients, the team must make sure that they: (several answers)

a) are stable.

b) have completely recovered.

c) understand their treatment.

d) understand what their issues are.

e) are connected to services.

f) have a place to go to.

9- Because patients are adults with rights and freedoms, they are allowed to refuse treatment in every instance:

a) True.

b) False.

Activity 3: Debating

In teams, prepare a debate about the following motion:

"Outpatient treatment is the way forward for mental health patients."

Vocabulary list 9: Mental health institutions

https://quizlet.com/_by2nmj?x=1jqt&i=120vpl

1- mental health institution: institut psychiatrique
2- **strait**jacket: camisole de force
3- **so**litary con**fi**nement: isolement
4- lock up: enfermer
5- bed **short**age: pénurie de lits
6- lack of **fun**ding: manque de financement
7- **sec**tion (UK): faire interner
8- insti**tu**tionalise : placer (dans une institution)
9- **po**licy : politique (ex. de santé)
10- dis**charge** a patient : laisser sortir (un patient)
11- **in**patient **treat**ment: traitement avec hospitalisation
12- **out**patient **treat**ment: traitement ambulatoire
13- se**date:** mettre sous sédatif

14- de**lu**sion: délire
15- **pa**nic a**ttack:** crise d'angoisse
16- psychi**a**tric ward: service psychiatrique (d'un hôpital)
17- cut costs: réduire les coûts
18- e**lec**troshock **the**rapy: traitement par électrochocs
19- be**ha**vioural therapy: thérapie comportementale
20- have a **call**ing: avoir la vocation
21- compre**hen**sive **treat**ment plan: programme de traitement complet
22- re**lease**: libérer, relâcher

Birth control and abortion

Activity 1: Warm-up

Read the following culture boxes and in pairs, discuss the questions below:

Roe v. Wade is the name of the lawsuit that led to the landmark 1973 U.S. Supreme Court decision establishing a constitutional right to abortion in the United States. The majority opinion found an absolute right to abortion during the first trimester of pregnancy.

Dobbs v Jackson Women's Health Organization is a U.S. Supreme Court ruling issued on June 24, 2022, taking away the constitutional right to abortion, abandoning almost 50 years of precedent, and paving the way for states to ban abortion.

- What do you know about the US Supreme Court?
- Who appoints the Justices (= judges) of the Supreme Court?
- How long does a Justice stay in the Supreme Court?
- What does "overturning Roe v Wade" mean?

Activity 2: Access to abortion pills

1. Read the following 'dilemma':

Kayla is 18 years old and lives in Austin, Texas, USA. She is a high achiever: she has just obtained a grant to go to Harvard University. However, she has just found out she is 8 weeks pregnant. She wants to have an abortion, but both surgical and medical abortions are banned in Texas.
She calls up John Taylor, her pharmacist and family friend, and asks him for help: she needs the abortion pill.
John is in two minds about it. He has known Kayla since she was born, and his own niece died last year after she had a clandestine surgical abortion.
If he helps Kayla and they are caught, he risks going to jail (first-degree felony punishable by five to 99 years in prison) and losing his pharmacy license.

Do you think John should provide Kayla with the abortion pill?
1) Poll.
2) Write down your arguments to explain your choice.
3) Share your arguments with the class.

2. In pairs, study one document each and then share your finding with your partner.

Document 1

Explainer: What's next for abortion pills after the fall of Roe

https://www.washingtonpost.com/health/2022/07/09/abortions-pills-explainer-after-roe-abortion-decision/

By Praveena Somasundaram July 9, 2022

The Supreme Court's overturning of *Roe v. Wade* has brought a flurry of changes to abortion laws across the country, opening the gates for legal battles in states with or without "trigger bans" on the procedure.

On Friday, President Joe Biden signed an executive order to protect access to reproductive health care services, but the effort does little for people in states that have already banned abortion.

Now, medical abortion — ending pregnancy through the use of medication — is the next focus of questions surrounding abortion care.

Why are people talking about this now?

Abortion pills were used in more than half of abortions in the United States as of 2020, according to data from the Guttmacher Institute, a research organization that supports abortion rights.

After the *Dobbs v. Jackson Women's Health Organization* decision, which overturned *Roe*, demand for abortion pills has continued to rise, as some Republican lawmakers look to restrict access moving forward.

How do medical abortions work?

The most common medical abortion regimen uses two drugs, mifepristone and misoprostol.

The Food and Drug Administration approved mifepristone in 2000, then the two-drug protocol in 2016 to end early pregnancies. It can be used through 70 days, or 10 weeks gestation, which begins on the first day of a person's last menstrual cycle. The protocol involves taking mifepristone on the first day, then misoprostol 24 to 48 hours after.

The protocol can be done at home, said Holli Jakalow, a professor of obstetrics and gynecology at the Columbia University's Irving Medical Center. She added that patients can consult a provider or take a pregnancy test four weeks after the regimen to check that it was successful.

Mifepristone blocks the hormone progesterone, making the uterus unable to support a pregnancy, Jakalow said. Misoprostol then causes the uterus to contract and expel the pregnancy.

"People can safely take these pills and safely pass the pregnancy at home and not have any issues like bleeding or needing urgent medical care," said Emily Godfrey, a primary care physician and family planning researcher at the University of Washington School of Medicine. "It's a very, very safe way to pass a pregnancy."

Jakalow added that, in cases when mifepristone is not available, it possible to follow a medical abortion protocol with only misoprostol. Both mifepristone and misoprostol require a prescription from a certified health-care provider.

[…] Stephanie Rand, a New-York based OB/GYN and family planning specialist, said people usually don't experience symptoms after the first medication but will feel cramping and bleeding after taking misoprostol as their pregnancy passes. Other possible symptoms within 24 hours of taking misoprostol include increased nausea and vomiting, diarrhea, fever and chills, Rand said.

In rare cases, people may experience excessive bleeding and infections. In the case of mifepristone, the FDA has stated that the adverse events reported to the organizations "cannot with certainty be causally attributed" to the drug.

Are medical abortions safe?

While antiabortion activists have questioned the safety of medical abortions, studies have shown that medical abortion is highly effective and has a low complication rate, particularly for pregnancies in the first trimester. One study found over a five-year period that more than 13,000 women who used the two-drug regimen through 63 days gestation had high success rates. […]

Rand isn't worried about the safety of the procedure — she's worried about its legality.

"I'm not worried if these medications will be safe for people," Rand said. "I'm worried about: Will people be safe, or will they be criminalized?"

Are abortion pills still legal?

The short answer — it depends on where you live, and it will be the subject of litigation in the future.

The Supreme Court decision placed the discretion of abortion access in the hands of states. For people living in places with trigger bans — laws designed to prohibit abortion if *Roe* were to fall — abortion by any method is illegal, with some exceptions depending on state law.

Since the Supreme Court ruling, 15 states have banned or mostly banned abortion, which includes medical abortions because the trigger laws largely include medicine and drugs that end pregnancy in their definitions of abortion. […]

What happens next?

Even with legal questions left to be resolved, the Supreme Court decision has limited access to abortion pills in the United States, leading some patients to drive across state lines for telehealth appointments to access the drugs where they're still legal. […]

Health experts say the Supreme Court decision will lead to surges in telehealth consultations for medical abortions, purchasing the pills online and "self-managed" medication abortion — when someone seeks out the drugs themselves and does the protocol on their own.

"That's been happening already," Sobel said. "That's going to be very hard to monitor or to enforce any state laws against, because it's through mail and mail is private."

<u>Reading: answer the following questions. There may be one or several correct answers.</u>

1- What is a medical abortion?

a) a surgical procedure to end pregnancy which requires going to a clinic.
b) a procedure to end pregnancy which requires the use of medication.

2- Since Roe V Wade was overturned in June 2022, the demand for abortion pills has increased.

a) True. b) False.

3- What do we learn about medical abortions?

a) They can be used through 12 weeks of gestation in the US.

b) The most common protocol involves the use of a single pill.
c) They have no side effects.
d) The most common protocol involves the combined use of two pills.
e) They can be done at home.

4- Medical abortions are safe.

a) True. b) False.

5- Abortion pills are now illegal everywhere in the US.

a) True. b) False.

6- What are the solutions for patients who live in a state where abortion pills are now banned?

a) Getting the pills mailed to them from another state where abortion pills are still legal.
b) Driving to other states to get a prescription.
c) Ordering fake prescriptions online.

Document 2:
Video: ''After Roe: What About Abortion Pills?''

1- ..... of all abortions carried out in the US in 2020 were by abortion pills.

a) 54%. b) 55%. c) 45%. d) 44%.

2- How many states are trying to ban or restrict access to abortion pills?

a) 30. b) 13.

3- Initially, the use the abortion pills was approved only for medical abortions carried out in clinics.

a) True. b) False.

4- With the pandemic, abortion pills were made available by mail order for at-home use.

a) True. b) False.

5- What are the implications of having abortion pills delivered at home in states where abortion is now illegal?

a) Women might be committing a crime.
b) The pharmacy sending the abortion pills might lose its license.
c) Women might be able to have an abortion even though it is illegal.

6- According to the Justice Department, states can block access to an abortion pill even if it is FDA approved.

a) True. b) False.

7- What are the strategies some states are using in order to make it difficult to obtain abortion pills?

a) You need to visit a clinic several times before obtaining a pill.
b) The mailing of pills is banned.
c) You need to get an authorisation from a court of justice.
d) Women need to provide a letter from the father to get a pill.
e) Abortion pills need to be prescribed by a doctor.
f) A doctor needs to be present when the abortion pill is used.

8- Why might women's access to effective healthcare be compromised, in case of bleeding after a medical abortion?

a) Because women won't be allowed into clinics after a medical abortion at home.
b) Because women might not get the best healthcare if doctors don't know which drug is causing the bleeding (which they might not want to disclose).

3. Read the dilemma again. Have your changed your mind? Write a line of argument supporting your viewpoint and share it with the class.

Vocabulary list 10: Birth control and abortion

https://quizlet.com/fr/722360745/4y-quizlet-10-birth-control-and-abortion-pills-flash-cards/?i=120vpl&x=1jqt

1- birth con**trol:** contraception
2- be on the pill: prendre la pilule
3- **mor**ning-**af**ter pill: pilule du lendemain
4- IUD (intra**u**terine de**vi**ce): stérilet
5- **men**struate: avoir ses règles
6- have an a**bor**tion: avorter
7- **em**bryo: embryon
8- **pre**gnancy: grossesse
9- a**bor**tion pill: pilule abortive
10- mis**ca**rriage: fausse couche
11- **ul**trasound: échographie
12- be pro-choice: être pour l'avortement
13- be pro-life: être contre l'avortement
14- rape: violer
15- over**turn**: casser (un jugement)
16- **ter**minate a **pre**gnancy: mettre fin à une grossesse
17- a**bort**: avorter
18- **coat**hanger: cintre
19- bleed: saigner
20- ex**pel** a **pre**gnancy: expulser une grossesse (arrêtée)
21- chills: frissons
22- **fe**ver: fièvre

Caring for the elderly

Activity 1: Warm-up

In pairs, discuss the following:

- What comes to mind when you hear 'old age'?
- When does old age start?
- How is old age different from being middle-aged?
- Is it important to prepare financially for old age?
- What can people in old age teach younger people?
- What social problems are associated with old age?
- Would you consider living in an old age home when you are older?
- How would the world be different if life-prolonging drugs meant old age stared at the age of 105?

Activity 2: When I'm 64

Will you still need me, will you still feed me
When I'm sixty-four?
(The Beatles)

Have you noticed the difference between French and English?

You can't use "will" after "when" (but also after: as soon as, as long as, until…) when "when" introduces a temporal clause.
Ex. When I **am** sixty-four, I will move to a care home

You can use "when" with "will":
-In a direct question: ex. When will you move to a care home?
-In an indirect question: ex. I wonder when he will move to a care home
- when "when" introduces a relative clause: ex. There will come day when everyone will move into a care home.

Let's get some practice!

1- When all the residents arrive _____ in the dining-room, the staff will serve tea
a) arrived
b) will arrive
c) arrive

2- What will you do when you _____ from your job?
a) retires
b) retire
c) will retire

3- Children won't be reassured until their parents _____ to a care home.
a) move
b) will move
c) moved
d) moves

4- When you _____ at the hospital, you will start feeling better.
a) arrive
b) will arrive
c) arrived
d) arrives

5- When _____ discuss your end-of-life care?
a) will we
b) are we
c) will be

6- I wonder how he _____ to the news.
a) will react
b) reacts
c) react

7- There will be a day when you _____ your own decisions.
a) make
b) will make
c) makes

Activity 3: Growing old

1. Read the following "dilemma":

Mr and Mrs Riley's GP has referred them to the family service agency. The GP worries about their increasing frailty and dementia and believes they need home care services or care in a nursing home. Mr and Mrs Riley live alone in a two-bedroom garden apartment in Greater London.

When the social worker visited their apartment, Mr Riley, age 85, was dishevelled, dirty, and dressed in an undershirt and trousers. He was obviously cognitively impaired. Mrs Riley, age eighty, was greatly depressed and indicated that she wanted to die. The apartment was dirty and piled with papers. The floor was covered with various other items. A closet filled with laundry smelled of urine. Mrs Riley told the social worker that she sends out the laundry once a month. She also indicated she hires a housekeeper occasionally.
The urine-infested state of their living conditions is clearly unhealthy and probably contributes to their deteriorating physical and mental state. And yet, even under these conditions, Mrs Riley is able to cook for her husband and herself. They have managed to live this way for years. They don't have any children who can look after them.

Their only child, Mary, lives in Australia and can't look after them. She wants them to move to a nursing home.

Although their income indicates that they could afford to pay for either home care or a nursing home, Mr and Mrs Riley refuse both.

This family needs counselling.

Should Mr and Mrs Riley's autonomy be supported?
When do issues of safety override their right to live as they choose?

A major reason for placing elderly clients involuntarily in nursing homes is the assessment of their lack of decision-making capacity. The ethical dilemma is whether to respect the couple's decision or override it. Is the couple's refusal of moving to a nursing home the autonomous decision of "mentally competent" persons who are aware of their circumstances, and what are the possible consequences of their decision?

1) Poll: would you force Mr and Mrs Riley to move to a nursing home?

2) Write down a line of argument to explain your vote.

3) Share your thought process with the class.

2. In pairs, read one text each (documents 1 and 2) and watch the video (document 3), then share what you have understood. Use the questions if necessary.

Document 1

"We Have Medicalized Aging, and That Experiment Is Failing Us"

Edited from https://www.motherjones.com/media/2014/10/atul-gawande-being-mortal-interview-assisted-living/

In his book Being Mortal, Atul Gawande, a (…) writer for the New Yorker, (…) gives us a lesson on the basic physiology of aging and on the social and technological changes that led to most of us dying in hospitals and institutions rather than at home with our loved ones. And he chronicles the rise of the nursing home and the creation of assisted living as its antidote. (…)

Mother Jones: In the book, you point out that as of 1945 most people still died at home. By the 1980s, we were mostly dying in hospitals and nursing homes. How did we end up outsourcing* our mortality?

Atul Gawande: I think the story goes back a long way, and I see it happening in India, where my family is from. When we lived in a society where we had large families that lived together, especially in agricultural societies like my grandfather and father grew up in, the result is you always had family around to take care of you. My grandfather died at 110, still in the family home. He sat at the head of the table, and people brought decisions to him about the business and about the family, marriages, and he

was tremendously respected even though he was still someone who needed help getting to the bathroom and putting his clothes on.

We're nostalgic for that time, but the reason it worked is because young people were enslaved, especially young women. And the economic progress of society—ours in the 19th century, India/China/Korea in the present time—has come because we've allowed young people to follow their dreams: work where they want, live where they want, marry whom they want. They've moved to the cities, they've left the elderly behind, and we don't have a plan. The plan that we therefore default to is, well, as long as they can live independently, things are fine, but if they start having trouble that's a medical problem.

Medicine's core value is to sacrifice your time now for the sake of possible time later. It has not been oriented toward saying, "What do we do to make it possible for someone to have their best possible day now, as they face the waning of their years or the limitations of their body?" We created nursing homes in that image. Heck, we call them *nursing* homes out of an inability to admit that they exist for managing the process of being a mortal person. So that's the place we ended up: We have medicalized aging. And that experiment is failing us.

MJ: On the positive side, you profile folks who've kind of figured things out, like Keren Wilson, one of the pioneers of assisted living, who set out to eliminate nursing homes. What's the primary difference between her version of assisted living and a lot of what now passes for assisted living?

AG: I think the key difference is the recognition that you're doing more than just keeping people safe. Part of the idea is that you might be able to get up and go to the kitchen and open the refrigerator and pick out something you want to eat. Well, for many people in nursing homes, we'll say, "That's not safe." They might end up drinking a soda, and that's not healthy if you're diabetic. Or you might have an Alzheimer's patient who goes to the refrigerator and instead of grabbing the pureed options, they grab a cookie and try to eat it. The pleasure of having some solid food, even if it's risky, is a choice that people want to still be able to make. (…) But assisted living today has ended up most often being subsumed** by this idea that safety comes first.(…)

MJ: You also profile this doctor, Bill Thomas, who takes a job in a nursing home, finds it horribly depressing, and then proceeds to try something as simple as it is radical. Give us the elevator version.

AG: He decided that what he wanted to do to combat what he called "the three plagues"—hopelessness, helplessness, and boredom—was to bring animals into the nursing home! He brought in dogs and cats and 100 parakeets. And would hand out a pair of parakeets that would actually be owned by the residents themselves to look after. Treating them as if they were capable of caring for something, not just passive wards of the caregivers, was dramatically transformative. People came out of their shells. They had a purpose. They ended up achieving lower amounts of medication use for things like anxiety and psychosis. They not only became more active and found life having more worth to it, they also lived longer. (…)

MJ: Do you think this book might help pave a path that makes things different when you're old and infirm?

AG: I certainly hope so. You know, the idea that just because you can't walk anymore or you can't eat the food you used to eat, that therefore you don't have a contribution to make or you can't be the leader of your own life?

That *is* depressing. And I think the existence of places and people who are showing you how it's possible to be otherwise is incredibly helpful. But it's still only a minority of what's available. It doesn't cost more. It's mostly about changing what our goals are. It's focusing on helping people achieve the priorities that are most important in their lives. And that's what I want when I'm older.

**outsource: sous-traiter*
***subsume: engloutir*

There is only <u>one</u> correct answer to each question

1- In the past, caring for the elderly was less of a problem because:
a) They lived longer in a better health.
b) Families took care of their elders.
c) There were many more care homes.

2- According to Atul Gawande, what is authentic "assisted living"?
a) Keeping elderly people safe in care homes.
b) Allowing elderly people to make choices even if they are risky.
c) Keeping elderly people healthy in a safe environment.

3- Why did the act of introducing animals into Bill Thomas's nursing home change the lives of the residents?
a) The animals provided company to the residents.
b) The animals provided therapeutic care to the residents.
c) The animals provided a goal to the residents.

4- According to Atul Gawande, what should be the priority when it comes to caring for the elderly?
a) Helping them to keep doing what they consider crucial in their lives.
b) Keeping them safe.
c) Helping them to walk and eat properly.

Document 2

Why we need to rethink the nursing home model

Aug 4, 2014 by Verena Menec, edited from www.healthdebate.ca

How many nursing home beds are needed in Canada to care for frail, elderly people with high care needs? That's a question that policy makers across the country are grappling with, given the aging population and especially the rapidly growing number of very elderly people over the age of 85.
Many people as they age eventually need some help with daily activities like housework or shopping, but with some help they can stay in their own homes. Some people, though, particularly those who reach their eighties or nineties, or even a hundred, eventually need more help than that, such as help with getting in and out of bed, eating, and using the toilet. When care needs are this great, admission to a nursing home — or what are also sometimes called long-term care facilities or personal care homes — is usually the only option.

Should we really be talking about how many nursing home beds are needed — as politicians, media and health policy people all do? Or shouldn't the question be, "How many more homes are needed for frail older people who need care?" One might argue that "bed" is just a manner of speaking, a way to simplify the language. But language does matter; it reflects assumptions and it limits thinking.

The language of "beds" fits with a medical model. It evokes images of institutions, people who are sick lying in beds, long impersonal hallways. The idea of a "home" brings to mind entirely different images. The smell of homemade cooking, a favorite arm chair, a window to look out of and watch people going by and, ultimately, the feeling of a place where one is comfortable and safe.

There have been considerable strides in the last few decades in making nursing homes feel less institutional. Older institutions have been refurbished so most, if not all, residents have a room to themselves, people are encouraged to personalize their rooms, and the staff is often very caring. Newer nursing homes sometimes consist of smaller units to create a more intimate feel. Yet, fundamentally, they are still institutions.

What if the starting point for thinking about nursing homes is to take the idea of the "home" seriously? Would the result be different?

Models that do just that exist, but they are still the minority. Some use the language of "villages," suggestive of a small, intimate community where everybody knows each other and looks after each other. In the Netherlands, a village has been created for people with dementia where they can shop, go eat in a restaurant, and live as normally as possible for as long as possible.

Other models offer self-contained housing units, each accommodating a small number of residents, akin to a group home. The emphasis is on re-creating the home experience by being small scale and home-like in layout and furnishings. The philosophy of care in these settings emphasizes people's dignity and right to continue to live life to the fullest, despite care needs. […]

The vast majority of older people want to age in place in their own home. When staying in their own home is no longer possible, should people not have the option of living in a home-like setting, rather than an institution? Would we not want that for our mother, father, grandmother or grandfather?

The crux of the matter is, of course, that there are typically few choices. Elderly individuals and their family members are restricted by what is currently available. When a bed in a nursing home becomes available, there is not much choice but to take that option. And there is tremendous pressure on hospitals to discharge elderly people who can no longer go home to nursing homes — they are sometimes called "bed blockers," yet another word that evokes many negative images.

We need a different philosophy to underlie nursing homes. And it starts with the language that is used. We don't need more nursing home beds. What we do need are homes and care options so people have choices. We need creative thinking of what might be possible to accommodate diverse needs and preferences.

There are examples that can be built on, but there needs to be a willingness on the part of policy makers to support innovative thinking. Elderly people themselves and family members need to speak up and voice their preferences. In thinking about new approaches, the question we have to ask is really quite simple: "Would I want to live here?"

1- Why do people in their eighties or nineties often need to be admitted to a care home? (several correct answers)
a) They need help with daily activities.
b) They need help with the housework.
c) They need help with getting up and going to bed.
d) They need help with eating.
e) They need help with going to the toilet.

2- Why do traditional nursing homes feel like medical institutions rather than homes? (several correct answers)
a) You can't cook your own meals.
b) You can't bring your own furniture.
c) You can't invite your friends.
d) You are not free.

3- What would make nursing homes feel more like homes?
(several correct answers)
a) The sense of community.
b) The ability to personalise one's room.
c) The freedom to go out.
d) Less medical staff.

4- According to the author of the article, the main problem that policy makers need solving is: (several correct answers)
a) The lack of care options.
b) The lack of funding.
c) The lack of imagination.
d) The lack of political will to change.

Document 3:

Video: ''Inside Canada's first dementia village.''

3. Read the dilemma again and vote. Have you changed your mind? Write a line of argument supporting your viewpoint and share it with the class.

Vocabulary list 11: Caring for the elderly

https://quizlet.com/fr/722359231/4y-quizlet-11-caring-for-the-elderly-flash-cards/?i=120vpl&x=1jqt

1- grow old: vieillir
2- **pen**sioner: retraité (nom)
3- re**ti**re: partir à la retraite
4- care home, nursing home: maison de retraite (médicalisée), EHPAD
5- **a**geing: vieillissement
6- the **el**derly: les personnes âgées
7- de**pen**dence: dépendance
8- **lo**neliness: (sentiment de) solitude
9- de**men**tia: démence

10- domiciliary care, live-in care: soins à domicile
11- old age: vieillesse
12- se**ni**lity: sénilité
13- **se**nior **ci**tizen: personne du troisième âge
14- be in one's de**cli**ning years: être dans les dernières années de sa vie
Nb. I am in my declining years, you are in your declining years, he is in his declining years, she is in her declining years, we are in our declining years, they are in their declining years.
15- re**ti**rement: retraite
16- be re**luc**tant to: être réticent à
17- **ca**rer: auxiliaire de vie
18- **stair**lift: monte-escaliers
19- resi**den**tial home: maison de retraite (non médicalisée), residence senior
20- **ou**ting: excursion, sortie

End of life care

Activity 1: Warm-up

In pairs, discuss the following:
- What comes to mind when you hear the word 'euthanasia'?
- What is the legal status of euthanasia in your country?
- Do you agree with euthanasia?
- Do you understand why people choose euthanasia to end their life?
- The Ancient Greek for euthanasia is 'good death'. What do you think of this meaning?
- What is the difference between euthanasia and suicide?
- Is there a difference between euthanasia and murder?
- Does a family member or a doctor have the right to turn off a life support machine?
- How long should doctors keep someone alive who is brain dead?
- Why not allow euthanasia to save on health care costs?
- Do people have a right to die?

Activity 2: Being Mortal

1. In pairs, read one document each and summarise it to each other orally. Use the questions below if necessary.

Document 1

Dr. Atul Gawande: "Hope is Not a Plan" When Doctors, Patients Talk Death

February 10, 2015 by Jason M. Breslow

This is the edited transcript of a two-part interview conducted on July 12, 2014 and Sept. 14, 2014

The United States has a problem when it comes to conversations around death and dying, says Dr. Atul Gawande. Patients with life-threatening illnesses tend to focus on how to beat the steep odds against them, he says, without hearing from their doctors about how certain kinds of treatment might actually worsen their remaining time alive. It's understandable, says Gawande, but "hope is not a plan." (…)

As a doctor, do you find that [peers] are motivated by patients' expectations of extending life?

What happens when you get sick is that you're governed most of all by your fears, and of course your biggest fear is that you might die. People are becoming more aware of the ways in which their care can take away other things that sometimes are even more important to them, and those things can be their ability to be aware and communicate with others ; their ability

to be at home and in control of their lives ; their ability to interact and work and do things important to them. …

There's a lot of folks for whom there's nothing else except, "Look whatever it takes, I want to be aggressive, and give me everything that we've got," as the starting point, but these are journeys. The first round of effort succeeds, then you're happy. It's really what happens when the first round of what you think is going to work doesn't work, and then you get to the second round, and then you get to the third round. And somewhere around there your life has become your disease and your treatment, and the possibilities that you're going to win the lottery with your ticket start to diminish. That's where most people start to be concerned about losing things that are really important to them. But they have a hard time talking about it with their families, sometimes have a hard time talking about it with themselves, and certainly have a hard time talking about it with their doctors.

Why is that ?

Because we're afraid of talking to the patient about these problems as well. We're afraid of our anxieties. Our anxieties include wanting to seem competent — and to us competence means "I can fix this." In fact, there's often a kind of implicit promise : I'm going to be able to fix this. I'm going to certainly give you the best shot you can have. Nobody could have given you a better shot. And then when things aren't working, part of your anxiety is : "Was there something I missed ? Was there anything else I could have done ?"

A second anxiety is not only one of competence, it's anxiety about talking to people about death, about the possibility that this won't work. There's a lot of emotion in the room, when people can cry or get angry, and we don't know what to do with that. …

It's kind of surprising to hear that doctors can't handle this.

I wouldn't say that doctors don't feel they can't handle it. There's a couple ways that I see it playing out. One is that a lot of doctors feel like: I know how to have this conversation. I know exactly what I'm doing. I tell people: "This could go badly. You could die. You could end up in the intensive care unit. But the other alternative is, you're going to die anyway." So we've laid it out: What do you want to choose? …

The big difference in the way that palliative care doctors are asking us to have these conversations with patients is to move from the facts and figures, the risks and the benefits to helping people cope with their anxieties about illness and about death. And that means helping them articulate their goals, which comes out of a conversation about: Well, what do you understand the prognosis to be for you? What do you think are your fears? What are your goals? What are the trade-offs you're willing to make in your life and not willing to make in your life at this point?

Those are hard conversations. I think partly we haven't had the words. We hadn't literally known the questions to ask the right way. …

1- When are most terminally ill patients ready to have conversations about dying? (several correct answers)

a) From the start.
b) When chemo has failed once.
c) When chemo has failed several times.
d) When their lives boil down to their disease.

2- What are the reasons why most patients find it hard to have these conversations about dying? (several correct answers)

a) They hope they are going to survive.
b) They don’t always get informed that their treatment is going to make their end of life worse.
c) They are afraid of dying.
d) Doctors makes them believe they are going to save them.

3- Why do doctors have a hard time talking about death with their patients? (several correct answers)

a) A lot of patients don’t want to talk about it.
b) Doctors feel incompetent when they can’t save their patients.
c) Doctors simply don’t know how to talk about it.
d) Doctors feel it’s not their role to talk about it.

4- According to palliative care doctors, what should doctors do to for their dying patients? (several correct answers)

a) Give them the facts and figures about their chances of surviving.
b) Help them weigh the risks and benefits of treatments.
c) Help them deal with their fear of dying.
d) Help them understand what is important to them at this point.

Document 2

Mum admits ending life of terminally ill son

By Sophie Law, Charlotte Andrews & Marcus White, BBC News, July 2024

A mother has admitted giving her terminally ill seven-year-old son a large dose of morphine to stop his suffering and "quietly end his life".

Antonya Cooper, from Abingdon, Oxfordshire, said her son Hamish had stage 4 cancer and was in “a lot of pain” before his death in 1981.

Now facing a terminal diagnosis herself, she made the admission to BBC Radio Oxford as part of an effort to change the law on assisted dying.

Police said they were investigating her case. Assisted suicide - intentionally helping another person to end their life - and euthanasia - deliberately ending a person's life - are illegal in England.

Hamish had neuroblastoma, a rare cancer that mostly affects children.

He was five when diagnosed and was initially given a prognosis of three months.

Following 16 months of "beastly" cancer treatment at Great Ormond Street Hospital, his life was extended but he was left in great pain, according to his mother.

She said: "On Hamish's last night, when he said he was in a lot of pain, I said: 'Would you like me to remove the pain?' and he said: 'Yes please, mama.'

"And through his Hickman Catheter, I gave him a large dose of morphine that did quietly end his life."

BBC Radio Oxford asked the 77-year-old if she believed her son knew she was intending to end his life.

She replied: "I feel very strongly that at the point of Hamish telling me he was in pain, and asking me if I could remove his pain, he knew, he knew somewhere what was going to happen.

"But I cannot obviously tell you why or how, but I was his mother, he loved his mother, and I totally loved him, and I was not going to let him suffer, and I feel he really knew where he was going."

She continued: "It was the right thing to do. My son was facing the most horrendous suffering and intense pain, I was not going to allow him to go through that."

Asked if she understood she was potentially admitting to manslaughter or murder, she replied: "Yes."

"If they come 43 years after I have allowed Hamish to die peacefully, then I would have to face the consequences. But they would have to be quick, because I'm dying too," she added.

Four decades after Hamish's death, his mother is coming to terms with her own incurable cancer.

She said his suffering and her own ill health had cemented her feelings on assisted deaths.

"We don't do it to our pets. Why should we do it to humans?" she said.

Campaigners for a so-called "right to die" have argued that people should be able to choose when and how to die in order to avoid suffering.

Critics have said changing the law would "place pressure on vulnerable people to end their lives" for fear of being a financial or emotional burden.

MPs recently discussed the issue at a parliamentary debate, at which the government said it was a matter of conscience for individual parliamentarians rather than one for government policy.

In a statement, Thames Valley Police said it was "aware of reports relating to an apparent case of assisted dying of a seven-year-old boy in 1981". It added: "At this early stage, the force is making inquiries into these reports and is not in a position to comment further while these investigations continue."

Analysis - Alastair Fee, BBC South Health Correspondent

This is a hugely complex and highly controversial subject, and yet it is one that is gaining momentum.

Assisted dying is the phrase used to describe a situation where someone who is terminally ill seeks medical help to obtain lethal drugs which they administer themselves. Assisted suicide, is helping another person end their life.

Both are illegal in the UK but recently, Scotland, Jersey and the Isle of Man all announced they are considering changing the law to let terminally ill people end their lives.

One hundred and ninety cases have been referred to the Crown Prosecution Service over a 15 year period. Most were not taken forward, there have been four successful prosecutions.

1- What were the circumstances of Hamish Cooper's death?
a) Hamish was dying.
b) Hamish was in pain.
c) His mum had terminal cancer.

2- Why did Antonya Cooper decide to speak more 43 years after her son's death?
a) She is dying herself.
b) She wants to raise awareness about assisted dying.
c) She feels guilty and wants to be jailed.

3- What is the main fear around legalising assisted dying?
a) You can never be sure if a person really wants to die.
b) Some people might want to end their lives for reasons other than suffering.
c) It might lead to a lot of prosecutions.

2. In pairs, discuss the following:

"Is active assistance in dying a continuity of care, or the opposite?"

Here are common arguments for and against euthanasia and physician-assisted suicide:

Arguments for

Freedom of choice: Advocates argue that the person should be able to make their own choice.

Quality of life: Only the individual really knows how they feel, and how the physical and emotional pain of illness and prolonged death impacts their quality of life.
Dignity: Every individual should be able to die with dignity.
Witnesses: Many who witness the slow death of others believe that assisted death should be allowed.
Resources: It makes more sense to channel the resources of highly skilled staff, equipment, hospital beds, and medications toward lifesaving treatments for those who wish to live, rather than those who do not.
Humane: It is more humane to allow a person with intractable suffering to be allowed to choose to end that suffering.
Loved ones: It can help to shorten the grief and suffering of loved ones.
We already do it: If a beloved pet has intractable suffering, it is seen as an act of kindness to put it to sleep. Why should this kindness be denied to humans?

Arguments against
The doctor's role: Healthcare professionals may be unwilling to compromise their professional roles, especially in the light of the Hippocratic Oath.
Moral and religious arguments: Several faiths see euthanasia as a form of murder and morally unacceptable. Suicide, too, is "illegal" in some religions. Morally, there is an argument that euthanasia will weaken society's respect for the sanctity of life.
Patient competence: Euthanasia is only voluntary if the patient is mentally competent, with a lucid understanding of available options and consequences, and the ability to express that understanding and their wish to terminate their own life. Determining or defining competence is not straightforward.
Guilt: Patients may feel they are a burden on resources and are psychologically pressured into consenting. They may feel that the financial, emotional, and mental burden on their family is too great. Even if the costs of treatment are provided by the state, there is a risk that hospital personnel may have an economic incentive to encourage euthanasia consent.
Mental illness: A person with depression is more likely to ask for assisted suicide, and this can complicate the decision.
Slippery slope: There is a risk that physician-assisted suicide will start with those who are terminally ill and wish to die because of intractable suffering, but then begin to include other individuals.
Possible recovery: Very occasionally, a patient recovers, against all the odds. The diagnosis might be wrong.
Palliative care: Good palliative care makes euthanasia unnecessary.
Regulation: Euthanasia cannot be properly regulated.

Appendix

Signposting and signalling

In an oral presentation, you need to **make the topic clear** to your audience, **identify the main sections** of your talk, and **link in your ideas and information** so that the presentation flows.
This can be done with the use of signalling or transition words, which show your audience how the presentation is structured and how ideas relate to each other.
This is a form of signposting that **creates a path through your discussion**, to show your audience how everything fits together.

Examples of useful language you can use to assist your audience to follow your oral presentation are listed below. You could use these examples as a resource when you are preparing and practising your oral presentation.

Introduction of an oral presentation

Introduce the topic
This presentation will investigate/ examine/ identify/ the effects of …
My topic today is …
The topic I intend to discuss is …
Our team/group will be discussing …

Provide an outline of the presentation
I want to start by …,and then I'll …
Let's begin by … , before looking at …
I'm going to divide this talk into three parts.
There a four main points I'd like to discuss: X, Y, Z and A.
The effects of … will be shown by a comparison of x and y.

Language for the body of an oral presentation

Introduce a main point
A major concern is …
The crux of the matter ...
Fundamentally ...
The central problem is that …
A basic point was …
A significant issue has been ...

Rephrase a main point
That is to say ...
So now what we have is ...
The point I am making is ...
Let me put that another way ...
In other words ...
As I have been saying

Move to another main point
Now let's consider ...
I'd like to move on to/look at …
If I could now turn to ...
My next point is ...
Now, turning to ...
Now what about …
Let me move on to ...

Introduce a digression
I might just mention ...
Incidentally ...
That reminds me to..

Introduce an example
Let me illustrate this by ...
A case in point is …
Take the case of …
This is illustrated by. ..
This is demonstrated by …
I refer you to the X, which illustrates…
An example of this is …

Include summaries before moving on to another point
So, that's the general picture for X, now let's look at Y
That completes my overview of X, so now I 'd like to move on to Y…

Language for referring to visual aids

You will need to integrate your visual materials, such as diagrams, tables and other illustrations, into the presentation by preparing the audience for what they are going to see. You need to make sure that the audience is alert and ready for the visual, and stimulate their interest. Don't just show a visual aid; you should with comment on it or provide an explanation.

Draw the audience's attention to the visual
Now, let's look at the position for ...
Now, I'll show you …
As you can see here …
I'd like to point out …
The diagram indicates …
Let's move on and look at the graph of …
The next slide indicates ...

Explain what the visual is indicating
This chart compares the production in two countries ...
The upper part of the slide illustrates ...
You can see here the development over the past ten years …

Language for the conclusion of an oral presentation

To sum up ...
Therefore …
In conclusion ...
As a result ...
To recapitulate ... To conclude ...
In summary ...
Thus, we can see ...
To summarise ...
Finally, I want to say ...

Language for inviting questions

Are there any questions you'd like to ask?
Does anyone have any questions?
I'm happy to take any questions.
Would anyone like me to explain anything further
Any questions?
If you have any questions, please ask.

Transition Words and Phrases

Agreement / Addition / Similarity

in the first place	again	moreover
not only ... but also	to	as well as
as a matter of fact	and	together with
in like manner	also	of course
in addition	then	likewise
coupled with	equally	comparatively
in the same fashion / way	identically	correspondingly
first, second, third	uniquely	similarly
in the light of	like	furthermore
not to mention	as	additionally
to say nothing of	too	
equally important		
by the same token		

Examples / Support / Emphasis

in other words	notably	in fact
to put it differently	including	in general
for one thing	like	in particular
as an illustration	to be sure	in detail
in this case	namely	to demonstrate
for this reason	chiefly	to emphasize
to put it another way	truly	to repeat
that is to say	indeed	to clarify
with attention to	certainly	to explain
by all means	surely	to enumerate
important to realize	markedly	such as
another key point	especially	for example
first thing to remember	specifically	for instance
most compelling evidence	expressively	to point out
must be remembered	surprisingly	with this in mind
point often overlooked	frequently	
on the negative side	significantly	
on the positives ide		

Effect / Result / Consequence

as a result	for	consequently
under those circumstances	thus	therefore
in that case	because the	thereupon
for this reason	then	forthwith
henceforth	hence	accordingly

Opposition / Limitation / Contradiction

although this may be true	but	although
in contrast	(and) still	instead
different from	unlike	whereas
of course ..., but	or	despite
on the other hand	(and) yet	conversely
on the contrary	while	otherwise
at the same time	albeit	however
in spite of	besides	rather
even so / though	as much as	nevertheless
be that as it may	even though	nonetheless
then again		regardless
above all		notwithstanding
in reality		
after all		

Cause / Condition / Purpose

in the event that	if	in case
granted (that)	... then	provided that
as / so long as	unless	given that
on (the) condition (that)		only / even if
for the purpose of	when	so that
with this intention	whenever	so as to
with this in mind	since	owing to
in the hope that	while	due to
to the end that		
for fear that	because of	inasmuch as
in order to	as	
seeing / being that	since	
in view of	while	
	lest	

Space / Location / Place

in the middle
to the left/right
in front of
on this side
in the distance
here and there
in the foreground
in the background
in the center of

adjacent to
opposite to

here
there
next
where
from
over
near
above
below
down
up
under
between

further
beyond
nearby
wherever
around
before
alongside
amid
among
beneath
beside
behind
across

Time / Chronology / Sequence

at the present time
from time to time
sooner or later
at the same time
up to the present time
to begin with
in due time
until now
as soon as
as long as
in the meantime
in a moment
without delay
in the first place
all of a sudden
at this instant

immediately
quickly
finally

after
later
last
until
till
since
then
before
hence

when
once
about
next
now
now that

formerly
suddenly
shortly

henceforth
whenever
eventually
meanwhile
further
during
first, second
in time
prior to
forthwith
straightaway

by the time
whenever

instantly
presently
occasionally

Conclusion / Summary / Restatement

as can be seen
generally speaking
in the final analysis
all things considered
as shown above
in the long run
given these points
as has been noted
in a word
for the most part

after all
in fact
in summary
in conclusion
in short
in brief
in essence
to summarize
on balance
altogether

overall
ordinarily
usually
by and large
to sum up
on the whole
in any event
in either case
all in all

Conjunctions

Subordinating

than	Comparison	That	Rel.Pro.	after	Time
rather than		what		as long as	
whether		whatever		as soon as	
as much as		which		before	
whereas		whichever		by the time	
				now that	
though	Concession	Who	Rel.Adj.	once	
although		whoever		since	
even though		whom		till	
while		whomever		until	
		whose		when	
if	Condition	where	Place	whenever	
only if		wherever		while	
unless					
until		how	Manner	because	Reason
provided that		as though		since	
assuming that		as if		so that	
even if				in order (that)	
in case (that)				why	
lest					

Correlative

as . . . as	either . . . or	what with . . . and
just as . . . so	neither . . . nor	whether . . . or
both . . . and		not only . . . but also
hardly . . . when	if . . . then	no sooner . . . than
scarcely . . . when	not . . . but	rather . . . than

Coordinating

F	A	N	B	O	Y	S
For	And	Nor	But	Or	Yet	So

Debating

Debating
Structure

Affirmative team (government)	Negative team (opposition)
First speaker ■ Introduces and defines the topic from affirmative point of view. ■ Outlines the case of the affirmative. ■ Summarises what each speaker will argue in favour of the topic. ■ Introduces the major arguments for the affirmative team.	**First speaker** ■ Defines the topic from negative point of view. ■ Outlines the case of the negative. ■ Summarises what each speaker will argue against the topic. ■ Introduces the major arguments for the negative team. ■ May refute the definition of the topic of the affirmative team.
Second speaker ■ Refutes arguments presented by the first speaker for the negative team. ■ Provides examples to support the points made in the argument of the affirmative team.	**Second speaker** ■ Refutes arguments presented by the second (and first) speaker(s) for the negative team. ■ Supports the major arguments of the negative team, providing examples to demonstrate the points made.
Third speaker ■ Refutes arguments presented by the second and first speakers for the negative team. ■ Supports the major arguments of the affirmative team, providing examples to demonstrate the points made. ■ Sums up the case for the affirmative team, concluding on a strong note.	**Third speaker** ■ Refutes arguments presented by the third (and first and second) speaker(s) for the affirmative team. ■ Shows how each of the major arguments of the affirmative team are false. Does not introduce new material – the role is to rebut only. ■ Sums up the case for the negative team, concluding on a strong note.
Fourth speaker ■ Listens carefully to all ideas presented by the negative team. ■ Jots down ideas on palm cards to assist the affirmative team speakers to refute arguments put forward by the negative team.	**Fourth speaker** ■ Listens carefully to all ideas presented by the affirmative team. ■ Jots down ideas on palm cards to help the negative team speakers to refute arguments put forward by the affirmative team.