DREAMS 'N MOTION
6841 Bristol Rd.
VENTURA CA 93003

From: Rick
To: IELTS Prep Group
*Subj: IELTS **Reading** lesson 11-29-2017*

Lesson Objective
The student shall be able to use "power words" as part of their oral vocabulary, read and comprehend both social and business language and demonstrate effective oral communication skills

Section One

Vocabulary
Match the correct word in column A with the definition in column B, then use in a sample sentence
Evaluation Criteria: Ability to understand definitions of English vocabulary

Column A	Column B
VOCABULARY	**DEFINITION**
1. PEDIATRICIAN (noun)	**A.** A resident member of the medical staff of a hospital, usually a recent medical school graduate serving under supervision.
2. INTERN (noun)	**B.** An individual occurrence or event.
3. INCIDENT (noun)	**C.** A person who is utterly intolerant of any differing creed, belief, or opinion.
4. INSTITUTIONAL (adjective)	**D.** A simplified and standardized conception or image invested with special meaning and held in common by members of a group.
5. DISCRIMINATE (verb)	**E.** the inclusion of individuals representing more than one national origin, color, religion, socioeconomic stratum, sexual orientation, etc.
6. BIGOT (noun)	**F.** To make a distinction in favor of or against a person or thing on the basis of the group, class, or category to which the person or thing belongs rather than according to actual merit; show partiality.
7. STEREOTYPE (noun)	**G.** Of or relating to organized establishments, foundations, societies, or the like, or to the buildings devoted to their work.
8. DIVERSITY (noun)	**H.** A physician who specializes in the care of children.

Section Two

Reading Comprehension and Pronunciation skills.

Evaluation Criteria: Ability to effectively read and comprehend written English in a social or business environment.

ARTICLE A

Racism in Medicine. An Open Secret

Source

(CNN) What happened on a hot summer day, two years ago still shakes Dr. Emily Whitgob to the core.

The Palo Alto, California-based pediatrician had just started supervising interns at Lucile Packard Children's Hospital Stanford. She was sitting in the doctors' workroom, listening to one of her interns describe a young patient in the emergency department.

"By the way," the intern said, "the dad just looked at my name tag and asked, 'Oh, is that a Jewish last name? I don't want a Jewish doctor.' " Whitgob said that she was surprised -- and not prepared -- to hear that. After all, though it turned out that the intern isn't Jewish, Whitgob is. "For the rest of the night, I think we both felt a little bit uncomfortable," Whitgob said. "I realized that I was a supervising resident and yet didn't have the tools to fully support my intern. Furthermore, our faculty attending also lacked the skills to debrief it."

1. As it weighed heavily on her mind, Whitgob mentioned the incident in an educational conference the following week.
"I would say there were 20 to 30 people in the room, and half of them were in tears by the end," she said, because they had either faced or witnessed similar discrimination when attempting to treat a patient.

"That right there made me think, 'Wow, we have to talk a lot more about this,' " said Whitgob, a research fellow in developmental-behavioral pediatrics at Stanford University. She decided to gather qualitative data and conduct a small survey on what physicians can do when they face discrimination by patients.

Now, the survey results and a call for strategies on how to effectively respond to discrimination have been published in a paper in the journal Academic Medicine.

The research, published Wednesday, comes on the heels of a doctor discrimination claim that went viral and the launch of the hashtag #WhatADoctorLooksLike.

2. About 15% of pediatric residents personally experienced prejudice by patients or their families, according to the survey, which involved all Stanford pediatric residents last year.

The issue of discrimination, especially against doctors, has not been adequately addressed in medical schools or residency training programs, said Dr. Sachin Jain, president of CareMore Health System in Cerritos, California, and a consulting professor of medicine at Stanford School of Medicine, who was not involved in the new paper.

"I applaud the authors' effort to give tools to faculty who train medical students and residents who are the subject of discrimination and abuse," Jain said, adding that he knows what it feels like to face racial prejudice as a physician.
When Jain was a third-year resident training in Boston, an angry patient told him to "go back to India."

"I am of Indian origin but was born in New York and raised in New Jersey. It was a very vivid and disturbing moment that cut deeply," Jain said.

3. "I regrettably reacted angrily towards the patient but was a bit disappointed when my colleagues minimized what had happened, taking the approach that it 'comes with the territory' of treating patients as a minority physician in America. Health care institutions have an obligation to set standards not only for how their staff interact with patients but also the reverse," he said. "Unfortunately, I think mistreatment and discrimination by patients is too common."

In the new paper, the researchers recommended that discussions about discrimination should be introduced early in medical training, and institutions should develop procedures for how discrimination should be addressed at trainee, faculty, staff and hospital administration levels.

Task forces could be developed to create institutional policies on how to interact with patients who discriminate against providers, the researchers recommended.

"Because these things come up in the heat of the moment, we really need to prepare people so they're ready to handle it no matter what the situation may be," said Dr. Rebecca Blankenburg, a clinical associate professor of pediatrics at Stanford School of Medicine and a co-author of the new paper.

"What we were really struck by was that everyone has at least experienced discrimination or witnessed discrimination, so even if they aren't the one being discriminated against, we all need tools," she said. "There are some papers that look at faculty or staff discrimination, but to specifically look at how patients and families discriminate against providers, this is the first of its kind."

4. In addition to the survey, Whitgob and her colleagues interviewed 13 pediatric faculty members at Stanford University about discrimination and how they would respond to clinical scenarios of families discriminating against doctors.

The researchers analyzed the interview transcripts, comparing them with each other and identifying trends in responses. Whitgob said their findings could translate to the rest of the medical field. "A lot of foreign medical graduates had stories about their accents

and being discriminated against," she said. "Other stories were from people who were Latino, but they didn't have Hispanic last names, and they heard from their own patients about other Latino providers, like, 'Oh, I don't want those kind to take care of me.' So being stuck in that position where you are 'those kind' but the patients don't know, you almost hear worse comments because they don't know who they're talking to."

Whitgob also conducted an extensive literature review to determine whether any existing research offered guidance on how doctors or hospitals should address discrimination.

5. Although hospitals have policies about staff members discriminating against each other, many lack policies about patients discriminating against staff, she said.

Additionally, the American Medical Association said in an email to CNN that its Code of Medical Ethics doesn't specifically address discrimination against doctors by patients, but it does offer ethical guidance for disruptive behavior by patients (PDF).
The code recommends to "terminate the patient-physician relationship with a patient who uses derogatory language or acts in a prejudicial manner only if the patient will not modify the conduct. In such cases, the physician should arrange to transfer the patient's care."

Without any clearly defined policies or guidelines in place, some hospitals might put themselves at legal risk.Spend less than you earn

6. In 2013, a neonatal nurse sued Hurley Medical Center in Flint, Michigan, claiming that she was reassigned when a man requested that no black people care for his baby. The nurse had been working at the hospital for 25 years.

"I recently spoke to physicians at a major New York area medical center and found that roughly 40% of the physicians in attendance had experienced this themselves or knew someone who had been rejected by a patient based on race or ethnicity," said Kimani Paul-Emile, an associate professor at Fordham University School of Law and associate director of the university's Center on Race, Law and Justice, who was not involved in the new paper.

"Scenarios such as this are more common than one might think and occur at hospitals throughout the country," she said of physician reassignments. "I call it one of medicine's open secrets, because you would be hard-pressed to find a physician, particularly a physician of color, who hasn't had this experience or who doesn't know someone who has. "More than 3/4 of full-time workers were living paycheck to paycheck in 2017, and 71% of U.S. workers were in debt according to a CareerBuilder survey.

7. In a paper published in the New England Journal of Medicine in March, Paul-Emile and her co-authors suggested that medical institutions should not accommodate a patient's prejudiced reassignment demands, because doing so might violate physicians' employment rights.

Rather, individual physicians may accommodate the demands if all involved physicians are comfortable with the decision and accommodation does not compromise effective medical treatment.

"For many physicians of color, rejection by patients based on bigotry can be distressing and demeaning experiences, which cumulatively contribute to moral distress and burnout," Paul-Emile said.

Often, when discrimination in the medical field is discussed, the conversation focuses on how doctors might have biases against patients. For instance, black patients are often prescribed less pain medication than white patients, several studies show.

8. As a result of this racial bias history, many patients of color often request or would prefer doctors of their same race. A 2002 study from the Johns Hopkins Bloomberg School of Public Health found that patients who are of the same race as their doctor report more satisfaction with their physician.
"I would love to live in a world where racism, sexism and bigotry doesn't exist," Blankenburg said. "We really need action around these issues, being able to explicitly say 'this is not tolerated' and having the faculty development and staff development to be able to role model appropriate behavior in order to combat racism, sexism and other bigotry."

It turns out that such bigotry also can happen outside the medical setting.

Jamika Cross, a Houston-based black obstetrician and gynecologist, said this month that she was discriminated against while aboard a Delta flight departing from Detroit. She wrote about the incident in a Facebook post that has been shared more than 48,000 times.
Unfortunately, it's impossible to ever get ahead if you're spending as much -- or more -- than you're bringing in. To be able to save, you must have money left at the end of the month. This means you need to either increase your income or reduce your spending.

9. In the post, Cross wrote that a man sitting two rows in front of her was unresponsive, and flight attendants asked whether there was a physician on board the plane to help him.

When Cross raised her hand, a flight attendant told her, "Oh, no, sweetie, put your hand down, we are looking for actual physicians or nurses or some type of medical personnel; we don't have time to talk to you."

"I tried to inform her that I was a physician, but I was continually cut off by condescending remarks," Cross wrote in the Facebook post, adding that the flight attendant eventually asked for Cross' "credentials."
Then, Cross wrote, a white man approached the attendant and said that he was a doctor. Cross was promptly told that he would help, and she stayed seated.

After Cross' Facebook post went viral, medical professionals across the country showed support on social media by posting selfies of themselves with the hashtag #WhatADoctorLooksLike.

10. Whitgob, the Stanford pediatrician, said that "because there was so much conversation about the event on the airplane, I think it just highlights that this is a conversation that has to happen."

In a statement responding to Cross' post, Delta indicated that a full investigation into the incident was underway and "the experience Dr. Cross has described is not reflective of Delta's culture or of the values our employees live out every day."

"What would be a really interesting thing to study is discrimination against physicians outside of the hospital setting, and outside of just physicians and patients and families, but how other people in the community discriminate or perceive doctors and who is a doctor," Whitgob said.

"If we turn on the news any day, there are current events that are happening that have discrimination at the core of them," she said. "This is one more area where it's happening, and it's not being talked about when it should be."

ARTICLE B

Training Doctors to Spot Their Own Racial Bias

Source

Jane Lazarre was pacing the hospital waiting room. Her son Khary, 18, had just had knee surgery, but the nurses weren't letting her in to see him.

"They told us he would be out of anesthesia in a few minutes," she remembered. "The minutes became an hour, the hour became two hours."
She and her husband called the surgeon in a panic. He said that Khary had come out of anesthesia violently — thrashing and flailing about. He told Lazarre that with most young people Khary's age, there wouldn't have been a problem. The doctors and nurses would have gently held him down.

"But with our son, since he was so 'large and powerful,' they were worried he might injure the medical staff," Lazarre said. "So they had to keep sending him back under the anesthesia."
Khary was 6 feet tall. But he was slim.

1. "He wasn't the giant they were describing him as," Lazarre said.
Lazarre is white. Her husband is black. Lazarre says there's no doubt in her mind that the medical team's fear of Khary was because of race.
"I understood, certainly not for the first time, that my son — and my sons both — were viewed as being dangerous, being potentially frightening to people who were white," she said.

She's also sure the surgeon didn't see it that way."Like most white people, I don't think he was conscious of it at all," Lazarre said. She and her husband insisted on seeing Khary. They saw right away that he wasn't angry or violent.

"He was scared," Lazarre said. She and her husband leaned over and whispered in Khary's ear: "'It's going to be OK, you can calm down.' And he began coming out of the anesthesia more normally."
Lazarre first wrote about this experience in her book "Beyond the Whiteness of Whiteness: Memoir of a White Mother of Black Sons."
Though it's been years since Khary's surgery, Lazarre says there's still so much that hasn't changed.

2. Even as the health of Americans has improved, the disparities in treatment and outcomes between white patients and black and Latino patients are almost as big as they were 50 years ago.
A growing body of research suggests that doctors' unconscious behavior plays a role in these statistics, and the Institute of Medicine of the National Academy of Sciences has called for more studies looking at discrimination and prejudice in health care.

For example, several studies show that African-American patients are often prescribed less pain medication than white patients with the same complaints. Black patients with chest pain are referred for advanced cardiac care less often than white patients with identical symptoms.
Doctors, nurses and other health workers don't mean to treat people differently, says Howard Ross, founder of management consulting firm Cook Ross, who has worked with many groups on diversity issues. But all these professionals harbor stereotypes that they're not aware they have, he says. Everybody does. "This is normal human behavior," Ross said. "We can no more stop having bias than we can stop breathing."

3. Unconscious bias often surfaces when we're multitasking or when we're stressed, research shows. It comes up in tense situations where we don't have time to think — which can happen frequently in a hospital.

"You're dealing with people who are frightened, they're reactive," Ross said. "If you're doing triage in the emergency room, for example, you don't have time to sit back and contemplate, 'Why am I thinking about this?' You have to instantaneously react."
Doctors are trained to think fast, and to be confident in their decisions. "There's almost a trained arrogance," Ross said.

But some medical schools are now training budding physicians and other health professionals to be a bit more reflective — more alert to their own prejudice. Places like the University of Texas Medical School at Houston, the University of Massachusetts, and the University of California, San Francisco now include formal lessons on unconscious bias as part of the curriculum.

4. At UCSF, all first-year medical school students take a workshop led by Dr. Rene Salazar, who coaches other members of the medical team, too.

"A lot of folks come to San Francisco thinking, 'Oh it's such an open-minded place, there are no biases here,'" he tells a class of newly arrived pharmacy residents. "That's not true. You're going to see this in every hospital. It's going to be an issue."
What Salazar wants these students to talk about isn't other people's biases, but their own. And not just the biases they know they have. But the ones they don't know — or don't believe — they have.

"Like it or not, all of us hold unconscious beliefs about various social and identity groups," he says to the class. "Many times we think about bias and unconscious bias — they are incompatible with our conscious values, right?"
Before the class, students were asked to take an implicit association test, a series of timed computer tests that measure unconscious attitudes around race, gender, age, weight and other categories. Salazar asks who wants to share their results.

5. The students study their fingernails.

Salazar clears his throat. "Well, I can share with you my story," he says. When he took the test for the first time, it showed that he had a preference for whites — or a bias against African-Americans. Research shows that 75% of people who take the race test show an automatic preference for whites.

"I was struck," he tells the students. "Particularly being in the health professions and wanting to serve diverse communities, to learn that I had these biases — it was a bit disheartening." So, he began to explore where these biases came from.

"I grew up in south Texas — 99% Mexican-American. Mostly Latino. In my high school, we had one black student," he tells the pharmacy residents. "And so, up until age 18, you can imagine, a lot of my ideas — a lot of my attitudes, a lot of my beliefs — about folks who were black came from what? The media."

A student named Amanda raises her hand. She asked that we not use her last name because she's afraid that what she learned about herself could harm her career.

6. Amanda explains to the class that her parents made their way to the U.S. from Iran, and settled in Marin County, north of San Francisco. She took the version of the test that measures bias against Muslims, and another on light and dark skin tone.

"I kind of went in thinking that these are two areas that I would probably not have a bias, and that's kind of why I chose them," she said. But the results were not what she expected. "It was like, actually, 'You're biased, and you don't like brown people and you don't like Muslims,'" she said. "Which is interesting for me — because that's, kind of, the two things that I am."

The UCSF curriculum is based on a training program designed by Howard Ross, the diversity consultant. He says he developed the new "unconscious bias" approach to sensitizing people to their own predjudices after realizing that the traditional diversity training he was doing in the '80s and '90s wasn't working.

"People who seemed to have transformative responses to those [earlier] trainings, to have that kind of 'aha' moment — particularly people in the dominant group, [of] whites, men, heterosexuals — often, if you talk to them a month or two later, they actually felt quite wounded by the experience," Ross said. In some cases, he adds, participants seemed to become more defensive and hardened in their biases after those early trainings, not less prejudiced.

7. A 2007 study described in the Harvard Business Review examined diversity training programs at more than 800 companies over 30 years, and the results underscore Ross's point. Overall, such programs seemed to do nothing to change people's prejudices or improve diversity. Instead, in some cases, they reinforced bias.

"What happens is, ultimately, we feel bad about ourselves, or bad about the person that made us feel that way," Ross said.
So rather than making people feel bad or awkward, Ross and Salazar say that, more than anything, they want people to accept that having biases is part of being human.

"You know we all have them," Salazar tells his class in San Francisco. "It's important to pause for a second and normalize this. And be OK with this." Salazar emphasizes that unconscious bias can't be eliminated, but it can be managed. "So how do we address our bias? What do we do?" One student says, "Slow down."

8. "Yeah," Salazar responds. "A trick that I use is that I pause before I walk in, take 10 seconds even, 15 seconds, just to try to clear your mind and go in with that clean slate."

It's too early to know if these new types of trainings that explore unconscious bias are actually having any effect on what goes on in the exam room. Participants fill out evaluation forms after the class, and these anecdotal self-reports are often positive. But, so far, there have been no formal studies to measure if anything in patient care has actually changed.

"What happens when that door closes? What happens in the interaction when I can't see the patient and the doctor talking?" Salazar said. "That's a little hard to capture."

Still, UCSF is betting the technique will help. Salazar and other leaders believe the younger generation of health care providers could help shift medicine — by learning early how to keep their own biases in check.