МИНОБРНАУКИ РОССИИ

федеральное государственное бюджетное образовательное учреждение высшего образования «Национальный исследовательский Мордовский государственный университет им. Н.П. Огарёва»

НАЦИОНАЛЬНЫЙ ИССЛЕДОВАТЕЛЬСКИЙ МОРДОВСКИЙ ГОСУДАРСТВЕННЫЙ УНИВЕРСИТЕТ ИМЕНИ Н. П. ОГАРЁВА

УТВЕРЖДАЮ
и.о. проректора по научной работе
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ФГБОУ ВО «МГУ им. Н.П. Огарёва»
_____ Д.В. Окунев
31 марта 2017 г.

Программа вступительного испытания

по программе подготовки научно-педагогических кадров

в аспирантуре

по специальной дисциплине

Иностранный (английский) язык

Направление подготовки
30.06.01 Фундаментальная медицина

Саранск 2017

РАЗРАБОТАНО:

Профессор кафедры английского языка
для профессиональной коммуникации
_____ Лемайкина Л.М.
29 марта 2017

СОГЛАСОВАНО:

Зав. кафедрой английского языка
для профессиональной коммуникации
_____ Цыбина Л.В.
29 марта 2017

Декан факультета иностранных языков
_____ Буренина Н.В.
29 марта 2017

Начальник управления подготовки
кадров высшей квалификации
_____ Агеева О.Н.
30 марта 2017

Пояснительная записка

Программа вступительного испытания в аспирантуру по английскому языку разработана в соответствии с Федеральными государственными образовательными стандартами высшего образования по программам специалитета или магистратуры.

Цель вступительного испытания — определить у поступающих уровень развития коммуникативной компетенции. Под коммуникативной компетенцией понимается умение соотносить языковые средства с конкретными сферами, ситуациями, условиями и задачами общения, рассматривать языковой материал как средство реализации речевого общения.

Требования к поступающим:

На вступительном испытании поступающий должен продемонстрировать умение пользоваться английским языком как средством культурного и профессионального общения. Поступающий должен владеть орфографическими, лексическими и грамматическими нормами английского языка и правильно использовать их во всех видах речевой деятельности, представленных в сфере профессионального: и научного общения.

Учитывая перспективы практической и научной деятельности аспирантов, требования к знаниям и умениям на вступительном испытании осуществляются в соответствии с уровнем следующих языковых компетенций:

Говорение и аудирование - на вступительном испытании поступающий должен показать владение неподготовленной диалогической речью в ситуации официального общения в пределах вузовской программной тематики. Оценивается умение адекватно воспринимать речь и давать логически обоснованные развёрнутые и краткие ответы на вопросы комиссии по приему вступительного испытания.

Чтение – контролируются навыки изучающего и просмотрового чтения. В первом случае поступающий должен продемонстрировать умение читать оригинальную литературу по специальности, максимально полно и точно переводить её на русский язык, пользуясь словарём и опираясь на профессиональные знания и навыки языковой и контекстуальной догадки. При просмотровом /беглом/ чтении оценивается умение в течение ограниченного времени определить круг рассматриваемых в тексте вопросов, выявить основные положения автора и перевести текст на русский язык без предварительной подготовки, без словаря. Как письменный, так и устный переводы должны соответствовать нормам русского языка.

Критерии оценки вступительного испытания

На испытании оцениваются:

- объем остаточных знаний по курсу «Иностранный язык»;
- умение использовать теоретические знания в предложенной речевой ситуации;
- полнота ответа, логика в его изложении, умение четко, грамотно и по существу излагать свои мысли на иностранном языке.

Оценки «отлично» заслуживает испытуемый, обнаруживший всестороннее, систематическое и глубокое знание учебного материала, умение свободно выполнять задания, предусмотренные программой, усвоивший основную, и знакомый с дополнительной литературой, рекомендованной программой.

Оценки «хорошо» заслуживает испытуемый, обнаруживший полные знания учебного материала, успешно выполняющий предусмотренные в программе задания, усвоивший основную литературу, рекомендованную в программе. Оценка «хорошо» выставляется испытуемым, показавшим систематический характер знаний по дисциплине и способным к их самостоятельному пополнению и обновлению в ходе дальнейшей учебной работы.

Оценки «удовлетворительно» заслуживает испытуемый, обнаруживший знание учебного материала в объеме, необходимом для дальнейшей учебы, справляющийся с выполнением заданий, предусмотренных программой, знакомый с основной литературой, рекомендованной программой. Оценка «удовлетворительно» выставляется испытуемым, допустившим погрешность в ответе на экзамене и при выполнении экзаменационных заданий, но обладающим необходимыми знаниями для их устранения под руководством преподавателя.

Оценка «неудовлетворительно» выставляется испытуемому, обнаружившему пробелы в знаниях основного учебного материала, допустившему принципиальные ошибки в выполнении предусмотренных программой заданий. Оценка «неудовлетворительно» ставится испытуемым, которые не могут продолжить обучение без дополнительных занятий по соответствующей дисциплине

Содержание вступительного испытания:

1. Письменный перевод текста /со словарём/ по направлению подготовки 30.06.01-Фундаментальная медицина**.** Объём текста – 2000 печатных знаков, время выполнения - 45 минут (см.Приложение 1).

2. Устный перевод с листа текста общенаучного содержания объёмом 1000 печатных знаков, без словаря, время подготовки - 5 минут.

3. Краткая беседа с преподавателем на одну из следующих тем:

- *Научно-исследовательский Мордовский государственный университет им. Н.П. Огарева;*
- *Научная деятельность института (факультета);*
- *Круг научных интересов поступающего;*
- *Известные ученые (зарубежные и отечественные) в данном направлении;*
- *Важнейшие достижения научной мысли в избранной области.*

Рекомендуемая литература:

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Информационно-справочные и поисковые системы

www.onelook.com
www.infoplease.com
http://www.cogsci.princeton.edu/~wn — WordNet
http://thetis.bl.uk/lookup.html — British National Corpus
http://wordweb.info/WW2 — WordWeb,
http://www.multitran.ru

http://ww.webster.com
http://www.foreign-languages.com
http://www.language.ru

ПРИЛОЖЕНИЕ 1

Текст 1.

Sudden cardiac death in young athletes

For many years the medical community has disputed the cost effectiveness, feasibility, and accuracy of including 12 lead electrocardiography in the cardiovascular screening of athletes. Discordant recommendations from the American Heart Association and the European Society of Cardiology have fuelled a global debate about the usefulness of such screening in athletes.1 2 In the linked study, Sofi and colleagues analyse data from 30 065 Italian athletes who underwent a complete pre-participation cardiovascular evaluation including resting and exercise electrocardiography.3

Sudden cardiac death in young athletes (<35 years) is caused by a diverse set of structural diseases of the heart (such as cardiomyopathies) and electrical defects (such as ion channelopathies). In the United States alone, one young competitive athlete dies every three days from an unrecognised cardiovascular disorder.4 American and European authorities have recommended a comprehensive pre-participation evaluation, which includes a detailed patient and family history and a physical examination, in all athletes of 12 years or more.1 2

Warning symptoms of underlying cardiovascular disease—exertional chest pain, syncope or near syncope, palpitations, excessive dyspnoea, and unexplained seizures—warrant cessation of sports activity pending the results of diagnostic tests. A family history of sudden unexplained death or sudden death before the age of 50 as a result of cardiac problems may also indicate the presence of a genetic cardiovascular disorder. Unfortunately, standardised questionnaires developed to help healthcare providers perform a comprehensive pre-participation evaluation are underused.5 Thus, important elements of the athlete's history often go unrecognised.

A substantial challenge to screening is that apparently healthy asymptomatic athletes may have unsuspected cardiovascular disease—death is the first clinical manifestation of cardiac disease in up to 60-80% of athletes with sudden cardiac death.6 To date, no study monitoring sudden cardiac death has shown that a pre-participation evaluation based on history and physical examination can prevent or detect athletes at risk for sudden death.

The value of adding non-invasive cardiovascular tests such as electrocardiography to the screening process in athletes is widely debated. In 2007, the American Heart Association reaffirmed its recommendations against universal electrocardiographic screening in athletes, citing a low prevalence of disease, poor sensitivity, high false positive rate, poor cost effectiveness, and a lack of clinicians to interpret the results.

Текст 2.

Imported malaria in the UK

Malaria is endemic in more than 105 countries. With travel predicted to grow to nearly 1.6 billion international arrivals by 2020, travellers will be at increased risk of exposure.1 2 The linked observational study by Smith and colleagues substantiates the public health concerns regarding the prevention of malaria in migrant families in the United Kingdom.3 4 The authors report that cases of imported malaria significantly increased between 1987 and 2006, with an increasing proportion attributable to *Plasmodium falciparum*rather than *Plasmodium vivax*.

The increase in cases of imported malaria is not unexpected. It reflects the increase in the number of visits abroad by UK residents—70.5 million in 2007—together with a 150% increase in UK residents travelling to malaria endemic areas during the past decade.5 One notable change is that with improved vector control in Asia, most cases are now acquired in Africa. As severe acute respiratory syndrome showed, 21st century threats to global public health and travel are inextricably interlinked, and they present ready opportunities for the rapid spread of infectious disease.6

Although people visiting friends and relatives formed the largest group returning with malaria during 2007, business and holiday travel accounted for 5% and 14% of cases.4 People visiting friends and relatives are at particular risk—despite a 12% fall in the number of malaria cases reported in UK travellers during 2007, 72% of cases were in such people.4 7

European sentinel surveillance data and other studies worldwide have reported up to 10 000 cases of imported malaria in industrialised countries as a result of international travel, with a case fatality of around 1%.8 9 The increase in cases in the UK reported by Smith and colleagues occurred despite the availability for decades of effective methods of malaria prevention.3 People visiting friends and relatives accounted for 64.5% of all reported cases of malaria, and travel to West Africa accounted for 76% of cases in this high risk group.3 Large clusters of *P falciparum* cases were located in London, mirroring UK migrant demography. The sustained increase in migration to the UK has contributed to the increasing incidence of imported malaria, as more migrant families travel to countries of their ethnic origin, where malaria is endemic. The study probably underestimates the true burden of malaria in UK travellers, and unless migration patterns to the UK change, this can be expected to increase.

Текст 3

Genetic engineering in athletes

Athletes who want to maximise their performance are continually tempted to use illegal drugs to gain competitive advantage and to aid recovery from training and injuries. Recent revelations of widespread doping arising from investigations of the distribution of the anabolic steroid tetrahydrogestrinone by the American company BALCO (Bay Area Laboratory Co-operative) demonstrate the extent of this problem in world class athletes.1

Some commentators have raised concerns that genetic modification or “gene doping” will be the next step in the search for enhanced performance.2-5 These concerns are based on some impressive studies in genetically modified rodents where manipulation of individual genes has increased muscle mass, muscle strength, or running endurance, depending on the gene that was manipulated. Reviews of these animal studies conclude that such genetic manipulations could also improve human athletic performance.6 7

How likely is it that athletes will use genetic modification? About 10% of athletes have used existing drugs,8 so it is likely that some will be tempted to experiment with genetic modification. However, translating studies performed in rodents into effective treatments in humans will not be easy. Some of the rodent studies were performed in transgenic mice in which the genetic modification was introduced into the germline and transmitted from one generation to the next. For practical and ethical reasons it is not possible to do this in humans.

Widespread genetic modification of somatic rather than germline tissues can be achieved in mice by using modified viruses to deliver the genetic modification, but only when used at very high doses. Scaling up such doses from a 25 g mouse to a 75 kg human will prove challenging, both

in terms of the facilities needed to generate such viral vectors and the potential difference in immune responses to such viruses between mice and humans. It is also not known how well these vectors will work in humans.

Current clinical trials—for example, those targeted at muscular dystrophies—use only small amounts of these viral vectors, and they are early stage safety trials that will not tell us whether we can achieve the high efficiencies needed to improve muscle function.9 It will be many years before agents for gene therapy are available for general clinical use.

Текст 4.

Antipsychotics for people with dementia

Should be reserved for severe and persistent symptoms after assessment of risk and benefit

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Competing interests: JO'B has received honorariums and hospitality from the manufacturers of drugs mentioned in this editorial (olanzapine, risperidone, cholinesterase inhibitors, and memantine). He was a member of the NICE/SCIE Dementia Guideline Development Group.
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More than 25 million people worldwide have dementia, with a new case developing every seven seconds.1 While putative disease modifying agents are being developed, we are limited to symptomatic treatments for cognitive and non-cognitive features. Non-cognitive symptoms—referred to as behavioural and psychological symptoms of dementia—including agitation, psychosis, depression, and aggression, occur in up to half of those with dementia in the community and an even higher proportion in residential care. Antipsychotics have been widely prescribed off licence for these symptoms, and 20-50% of people with dementia in institutional care receive them.2 What is the evidence for their efficacy?

Several placebo controlled, randomised controlled trials (RCTs), especially of newer "atypical" antipsychotics like risperidone, show an improvement in agitation, aggression, and psychosis.3 But, even before current concerns over their side effects, the strength of the evidence supporting widespread prescribing in dementia was questioned. Efficacy is modest, and most studies have assessed behavioural and psychological symptoms of dementia as a general outcome rather than targeting specific symptoms.

Side effects include extrapyramidal features, sedation, metabolic disturbances, increased cognitive impairment, and severe sensitivity reactions in dementia with Lewy bodies. In 2004 it emerged that the risk of cerebrovascular events and stroke was three times higher in people treated with the atypicals olanzapine and risperidone. A subsequent meta-analysis showed increased mortality in people treated with atypical antipsychotics compared with placebo, with a number needed to harm of around 100.4

These findings combined with high prescribing rates for people with dementia led to warnings about the use of these drugs in many countries. In the United Kingdom, the Committee on Safety of Medicines went further than most to advise that "risperidone or olanzapine should not be used

for the treatment of behavioural symptoms of dementia."5 Subsequently, patients had their drugs withdrawn or were switched to typical antipsychotics, often without considering individual circumstances. This led to further guidance from professional organisations supporting the continued use of atypical antipsychotics in some circumstances.6

So where are we now? Cohort studies suggest that typical antipsychotics have a similar cerebrovascular risk to atypical antipsychotics, and possibly even higher mortality.7 8 So switching from atypical antipsychotics to typical antipsychotics is unlikely to be a sensible strategy. Questions over efficacy remain. A large pragmatic double blind placebo controlled trial, using an outcome measure of "time to treatment discontinuation," found that the benefits of atypical antipsychotics on efficacy were largely offset by discontinuation because of side effects.

Текст 5.

Enhancing the quality and transparency of health research

EQUATOR is an essential web resource for researchers, editors, and readers

A young woman, just making ends meet and coping with four children, signed up to a breast cancer study where she would have to take two big pills every day for two years and show up for numerous frequent tests. Why would she put herself through that, wondered the researcher who went to obtain her consent. "I'm doing it for my daughter" said the mother, clearly expecting the study to yield usable, meaningful, and accessible evidence that might help prevent breast cancer in young women. Would she have consented so readily if she knew that some studies are never published and that many are reported so poorly that they are barely read and never used? This tale was told by that same researcher, Davina Ghersi, coordinator of the World Health Organization international clinical trials registry,1 at a meeting in London last month. Dr Ghersi was there to help launch the EQUATOR (enhancing the quality and transparency of health research) international network, which seeks to improve the quality of scientific publications by promoting transparent and accurate reporting of health research.

Registration, publication, and publicly available reporting of health research are already mandated by several sponsors and funders,2 3 some legislators,4 and many editors,5 particularly for clinical trials. The next big challenge is to decide when and how to disclose the results of a trial at a publicly available research registry, and what should go into a minimum dataset.6 Yet even journals, some of which have reported research for many decades, are still not producing articles that are clear enough to really judge a study's conduct, quality, and importance—let alone to allow other researchers to reproduce it or build on it. With help from EQUATOR, journals should now be able to do a much better job and give authors the specific guidance they need to write up research properly.

Editors already provide instructions to authors, but this advice tends to be either unhelpfully vague and brief or comprehensively long and daunting—for instance, the BMJ's advice currently extends to well over 20 000 words (http://resources.bmj.com/bmj/authors). The development of more than 80 guidelines for reporting different study types, many of them labelled by acronyms, adds to the confusion. Do authors know where to find these guidelines, and do editors and reviewers know how to use them? Do you know your MOOSE (meta-analysis of observational studies in epidemiology) from your STROBE (strengthening the reporting of observational studies in epidemiology)?