Theme : Social Ills

Article 1:

'Out there it's just me' : in the medical desert of rural America, one doctor for 11,000 square miles
The Washington Post, By Eli Slaslow, September 29, 2019

VAN HORN, Tex. — He woke up to the sound of an ambulance's siren, knowing that the ambulance would soon be delivering another patient to him. Ed Garner, 68, changed into medical scrubs and walked out to his truck. He dialed the hospital as he started driving toward the emergency room.

"Any idea what might be coming?" he asked, but all anyone knew for certain was that the ambulance was still on its way out to a patient. Sometimes the paramedics were back within minutes, and other trips took nearly two hours. Sometimes they delivered Garner a patient in minor distress, and other times they brought him unresponsive victims of car crashes, heart attacks, drug overdoses or ranching accidents.

"Do we know anything yet?" Garner asked again, a few minutes later. A stethoscope dangled from his rearview mirror. He checked his police scanner, but it was quiet. He looked toward the adjacent interstate but saw no obvious wrecks.

He lit a cigarette and rolled down the window as he drove by the dusty ranches and dry lakebeds of West Texas. He'd started smoking to cope with the stress of medical school, but now he'd been practicing rural family medicine for 41 years as the stresses continued to mount. He was the only working doctor left to care for three remote counties east of El Paso, an area similar in size to the entire state of Maryland, home to far-flung oil encampments, a desolate stretch of interstate, communities of drifters living off the electric grid, and highway towns made up of truck stops and budget motels. "A wild place of last resort," was how Garner described parts of his territory, and for every person in every kind of medical trouble, the true last resort was him.

Now his phone rang and he answered. "How bad is it?" he asked, and a nurse told him the ambulance was on its way back to the hospital with a truck driver who had collapsed at a gas station and couldn't move his legs.

"Just give me a minute," Garner said. "I'll be there as quick as I can."

In the medical desert that has become rural America, nothing is more basic or more essential than access to doctors, but they are increasingly difficult to find. The federal government now designates nearly 80 percent of rural America as "medically underserved." It is home to 20 percent of the U.S. population but fewer than 10 percent of its doctors, and that ratio is worsening each year because of what health experts refer to as "the gray wave." Rural doctors are three years older than urban doctors on average, with half over 50 and more than a quarter beyond 60. Health officials predict the number of rural doctors will decline by 23 percent over the next decade as the number of urban doctors remains flat.

In Texas alone, 159 of the state's 254 counties have no general surgeons, 121 counties have no medical specialists, and 35 counties have no doctors at all. Thirty more counties are each forced to rely on just a single doctor, like Garner, a family physician by training

who by necessity has become so much else: medical director of Culberson County. Head physician for a nearby immigration detention center. Director of a rural health clinic. Chief of staff for Culberson Hospital. And medical director for the hospital's emergency room, where the latest patient was being wheeled in as Garner introduced himself.

"We'll get you something for pain," he said, putting his hand on the truck driver's shoulder. "Let's figure out what's going on and how we can help."

"It feels like burning all the way up and down my legs," the patient said. He'd been hauling a load from Florida to Central California in an 18-wheeler when he stopped in Van Horn, population 1,700, and collapsed with sudden numbness in his back and his legs.

"Here I am in the middle of nowhere, and I can't even move," he said.

"In a way, you got lucky it happened here," Garner said, because there was no other hospital within at least 100 miles in any direction. "Let's get a CT scan and see what's going on."

A radiologist came to perform the CT scan, and Garner left to make his morning rounds in the hospital and the adjacent clinic. A 91-year old was complaining of dizziness. A teenager needed a doctor's signature on his mandatory high school sports physical. A U.S. Border Patrol agent arrived from the detention center with an undocumented immigrant complaining of dehydration and nausea. On most days, Garner saw about 20 patients with the help of a nursing staff and two physician assistants. The hospital had been trying to recruit a second doctor for almost five years. A new graduate from medical school had recently committed to work in Van Horn, but he was still awaiting his final licensing.

A nurse handed Garner a copy of the truck driver's CT scan, which showed two bulging discs in his back, and Garner walked in to share the diagnosis.

"You'd learn a lot more with an MRI, but we don't have an MRI machine here," he said.

"So now what?" the trucker said.

"Could be back surgery, but you need to get some more information and talk to a neurosurgeon or an ortho."

"All right. Let's do it," the truck driver said. He leaned back against the bed and looked behind Garner, as if expecting a team of physicians to come in through the door. Garner followed his eyes out into the empty hallway.

"I'm sorry, but the best we can do is transport you to El Paso," he said. "You need a specialist, and out here, it's just me."

His hospital shifts in Culberson County typically lasted 24 hours, and during the daytime he mostly did the work he'd imagined for himself when he chose to become a country doctor. He greeted patients by first name and handed out fruit cups to their children. They called him "Dr. G" and sometimes brought him homemade pies or Cheetos out of the hospital vending machine. He treated their common colds, their sunburns, their diabetes, their insect bites, their addictions, their muscle aches, and sometimes also their loneliness. "My door's always open for walk-ins," he often told patients. "There's no shame in coming just to talk."

It was at night when he could feel his job turning into something more unpredictable and ominous — when he remained on call as much of the hospital's support staff emptied out and the town's population doubled because of travelers staying overnight in the roadside motels. The interstate became a sporadic trail of headlights across the desert, and Van Horn's 24-hour truck stops turned into neon islands in the darkness. The only people who sought out medical care were those who urgently required it, and all Garner could do was go home with his emergency scanner and his hospital-issued cellphone to wait.

"Get some rest tonight," an aide told him as he packed up to go home. "Hopefully it'll be nice and qui—"

"Please," Garner said. "Not the Q-word. I know it's silly, but I'm superstitious."

He drove back to the small rental house where he'd lived for most of the past eight years. He'd left a busy clinic in Central Texas to take the job in Van Horn because it offered better pay, an adventure at the end of his career, and work that felt more essential, but his wife and four adult children still spent most of their time across the state, where Garner owned a small family ranch. Alone in Van Horn, he had little to do but eat a Subway sandwich, watch TV news and sit in a recliner with the cellphone on his lap. He checked the phone every few minutes to make sure he hadn't missed a call from the hospital. He got up to play his guitar. He checked the phone's ringer volume to make sure it was all the way up. He ate some more of his sandwich. He checked his phone again. He thought about all the medical emergencies that could happen in 11,000 square miles at night, which mostly meant remembering what he'd seen happen before.

There were elderly inpatients at the hospital with do-not-resuscitate orders who tended to die at 3 or 4 a.m., when the body was its weakest. There were babies who stopped breathing without warning in their sleep. There were women who went into labor while passing through on the highway, and there was one woman who had arrived complaining of acute stomach pain and then needed to be told that she was several months pregnant, and then that her baby was dead.

His cellphone rang. He sat up and answered.

"Hello," he said, and it was his wife. "Yep, just sitting at home, trying to close my eyes," he told her. "Haven't had anything yet."

There were migrants who arrived at the hospital in the custody of Border Patrol after spending a week or more hiking across the desert, with cactus spines embedded in their feet and spider bites on their arms. There was a teenage boy from Honduras whose major organs had shut down from dehydration, and who died despite three hours of emergency intervention. There was a Border Patrol agent who died of blunt-force trauma. There was a woman who'd been fatally stabbed by her husband at 5 in the morning, and then there was her husband, who had been shot by the Van Horn police. There was a sand truck that was struck by a train, and a fuel truck that caught fire on the interstate. There were tires that blew out in the heat and tires that skidded on black ice and an unending string of single-car rollovers at the posted speed limit of 85 mph. There was a motorcyclist who flew a few hundred feet and needed more than 30 staples in his head. There was a young girl who fell out of the bed of a pickup truck and was driven over by a semi. There was a highway pileup with so many victims it required a bus to transport them all to the hospital. There was an 11-year-old with two dislocated hips that needed to be forced back into place.

There were patients in a single year from 36 states and 68 Texas counties. There were dozens of people he had helped save with chest tubes, intubations and emergency blood transfusions before transferring them to the major trauma hospital in El Paso, and then there were others who went into a refrigerated room labeled “Body Holding.”

His phone rang again, and this time it was the immigration detention center. A woman was having an asthma attack and couldn’t breathe.

“I’ll be over,” Garner said. He stood up, and a minute later the detention center called again. The asthma attack had improved. The woman could wait until morning.

“Okay,” he said, and he sat back down and closed his eyes. A train blared its horn, and he checked the volume on his phone. A dog barked in the yard next door. Trucks rattled by on their way to the sand mine. His phone rang again, and this time when he answered, the sun had begun to rise, and it was a hospital administrator calling to remind him about a morning meeting to review emergency response protocols. Garner got dressed and drove back into the hospital.

“Did you get some sleep?” the administrator asked.

“I did,” Garner said.

During the eight years he’d spent in Van Horn, hospital managers had done whatever they could to extend Garner’s career as one of the few country doctors left in West Texas. They’d increased his pay and recruited traveling physicians to take occasional shifts in the ER so he could go back to his ranch. They’d hired a full team of nurses and physician assistants to share his patient load and help in the ER. They’d even lobbied the state of Texas to change its laws regulating telemedicine and then installed video cameras and fiber optic cables in the ER so that, on some nights, the only doctor on call in Van Horn was actually a doctor from out of state who appeared on a video screen.

But what they wanted most of all was a second doctor, someone who could support Garner and one day succeed him, and after a nationwide search and five years of disappointments, that second doctor was finally pulling his car up to the hospital in Van Horn. David Cummings, 43, grabbed a few boxes out of his trunk, carried them into his new office, and surveyed the empty walls.

“We’re so thrilled you’re actually here,” said Rick Gray, the hospital administrator. “You should start hanging up your things, put your mark on the place.”

“I’m still waiting on my certificates and stuff,” Cummings said. He had just finished his medical school residency in Nevada, and he wasn’t scheduled to see patients for another few weeks. “What should I hang up, anyway?” he asked. “I don’t know this stuff. I’m a rookie. ”

“You’re the doctor,” Gray said. “You hang whatever you want.”

Cummings had grown up in Central Texas as the son of an auto mechanic, and he’d worked in a factory for a few years before taking out nearly $500,000 in loans to scrap his way from community college all the way through medical school in El Paso. He was the first in his family with a college degree, and he’d never earned more than $50,000 a year, but in the past months he’d become the focus of a nonstop medical bidding war. Fewer

than 2 percent of medical school students want to practice in towns smaller than 25,000 people, according to national studies, so when Cummings accepted a rural family medicine residency in tiny Winnemucca, Nev., recruitment emails began piling up in his email inbox, sometimes as many as 20 each day.

“Be the STAR of a Midwest waterfront community with 252K proven income!”

“Have a great job and a great life. Less than two hours from Tallahassee! 300K earning potential.”

“280K in small-town Minnesota with easy commute. Two songs on the radio and you’re at work!”

“Have you ever dreamed of immersing yourself in the stunning panoramic views of the Alaskan Ranges and Northern Lights? 50K signing bonus and 33 paid days off each year.”

“Ozark town with nearby symphony orchestra, wineries, and museums. Ask about our 3-day work week!”

What Van Horn offered was a three-year contract with $300,000 guaranteed for the first year, which was about 50 percent more than Cummings could have earned in a big city. He wanted to practice in a small town where he could get to know his patients. His wife liked the nearby mountains. They would be close enough to drive back to Central Texas to visit family. The federal government would forgive much of his student debt as a reward for his working in a medically underserved area. Van Horn had sealed the deal with a $5,000 signing bonus and a $3,000 monthly stipend during the final year of his residency.

One of the other reasons Cummings had chosen Van Horn was that there was another doctor in the office down the hall. He had never practiced without a supervising physician, and he didn’t want to start his career as the area’s only doctor.

“Got a minute, doc?” he asked, as he knocked on Garner’s open door and Garner motioned him in. They had met during Cummings’s interview, but they had spoken only a few times in the months since.

“They treating you okay?” Garner asked.

“You bet,” Cummings said. “But I’m tired of paperwork. I’m ready to get started.”

He said he needed to take an emergency medicine course later in the fall before he would be allowed to treat patients on his own in the ER, but in the meantime, he hoped to shadow Garner during a few overnight shifts.

“I’ll probably have questions,” Cummings said.

“Ask anything,” Garner said. “Nobody wants this to work out more than me.”

So Cummings decided to ask a question that had been on his mind ever since he landed at the airport in El Paso and began driving into the empty desert and out toward Van Horn.

“I know you see it all out here,” Cummings said. “How do you deal with being on your own?”

“Reps, experience,” Garner said. He shrugged. “I’m not sure I’ve gotten totally comfortable with it yet.”

Cummings thought for a moment. Even during his residency in tiny Winnemucca, population 7,400, he had worked with a medical team of emergency physicians, hospitalists and general surgeons. Once he started in Van Horn, he would eventually become the only doctor on call.

“So what do you do?” Cummings asked.

“Mostly try not to think about it,” Garner said. “You operate in denial. You treat one patient and move on to the next.”

The next: A roofer who had fallen at work and broken his foot.

The next: A mother and her 2-year-old son from El Salvador, who’d spent 16 days hiking from Presidio, Tex., before being caught by Border Patrol agents near Van Horn. The mother wore tattered sandals and needed an air cast for a sprained ankle. The baby had diaper rash and insect bites on his back. “You’ll feel better after rest and some Benadryl,” Garner told them.

He kept moving back and forth between the ER and the adjacent clinic to see patients, traveling the long hallway that encompassed the entirety of health care in Van Horn. Each appointment began with a nurse filling out one of the hospital’s intake forms, which were categorized by patient symptom, 142 different versions of medical need in a small town: “wheezing,” “seizure,” “animal bite,” “puncture wound,” “fever,” “altered mental status,” “major burn,” “sexual assault,” “overdose.” Garner walked to the ER to treat a mechanic with a sinus infection. He walked to the clinic to see a truck driver for an annual physical. He walked back to the ER to evaluate a prison inmate with a potentially broken nose.

On some days, it seemed to Garner like the hallway was always getting longer, and so was the distance between Van Horn and his ranch in Central Texas. He’d worn out two cars making the 400-mile commute back and forth and wrecked his small airplane in a hard landing, but still he kept coming back.

“I’ll try to keep going at least until I’m 70,” Garner told his last patient of the day, a drifter who’d moved from out of state after he saw a classified advertisement for cheap land in West Texas. He’d spent the last several months stuck in town with no savings, worsening arthritis and breathing troubles.

“If not for you, I might be gone already,” he told Garner. “You should keep going until you’re 80.”

Garner checked the patient’s oxygen levels and wrote refills for his prescriptions. He noticed a growth on the patient’s hand and told him it would require a follow-up appointment.

“I can come back tomorrow,” the patient said.

“I won’t be here,” Garner said. He explained he had his own doctor’s appointment, which required traveling more than 100 miles from Van Horn, which meant that for at least a little while a county with only one practicing doctor would have none.

“Don’t worry,” Garner said. “I won’t be gone long.”

Article 2:

Thousands of California seniors are 'one disaster away' from homelessness. What can the state do ?
USA Today, By Kristin Lam, October 3, 2019

In 2013, Madlynn Johnson had her own apartment and a steady job. A car accident changed everything.

Her job gave her months off work. She drained her savings. She couldn't catch up on rent and other bills. Depression took hold.

In 2014, she lost her housing in the San Francisco Bay Area.

Nationally, Johnson was one of the 40,000 people age 65 and older who were homeless in 2017, according to a study by researchers in Los Angeles, New York and Boston. That number is expected to nearly triple by 2030.

Homelessness experts say California’s low-income seniors are especially vulnerable because of the state's housing affordability crisis: With fixed income and high rent prices, an illness or job loss can quickly put them on the streets.

The state already accounts for about a quarter of the nation's homeless population, according to the U.S. Department of Housing and Urban Development, and 69% of the 130,000 homeless Californians were unsheltered on a single night last year.

Even so, methods exist to prevent and reduce senior homelessness, said Sharon Cornu, executive director of St. Mary's Center in Oakland, which provides services for adults 55 and older who are homeless or at risk of homelessness.

"As we get ready for generations with less retirement savings and lower incomes along the way, we need to be planning for the challenges that we're going to face among senior populations," Cornu said.

“It's been a real godsend”

For three years, Johnson lived in and out of her Honda Accord. She kept her wheelchair in the view of her window as she slept, or at least tried to rest when the fear of being assaulted didn't keep her awake.

Finally, in October 2017, she moved into transitional housing for seniors at St. Mary's Center. Johnson, now 73, sleeps in her own room and shares a kitchen and bathroom with others around her age.

"It's been a real godsend," she said.

But no landlord has accepted any of the about 100 rental applications Johnson said she has submitted with the support of case management at the center. With Social Security Disability Insurance (SSDI) and no pension – the mental health contract agency she worked for didn't offer one – Johnson said it's almost impossible to afford a place of her

own in the county she has called home since 1965.

"I worked hard in life and a lot in the city of Oakland, Alameda County," Johnson said. "I'm in crisis in terms of housing, and buildings are going up all over the city. It's unfortunate that because of limited income resources, that I'm not able to live in one of them."

Blaming shelters and street sleeping: Donald Trump blasts California for homeless crisis

Recognizing the need, Johnson advocates for additional low-income housing along with other seniors at St. Mary's Center. Her peers in transitional housing face similar struggles: 95% of them rely on Supplemental Security Income (SSI) of $932 each month as their only income source, Cornu said.

Those types of mostly fixed incomes don't keep up with rising rents, said Kevin Prindiville, executive director of Justice in Aging, a national nonprofit based in California focusing on senior poverty. While wages may increase for people who can work, seniors who cannot tend to struggle financially as housing markets become more expensive and strain their budgets.

Opinion: Only the federal government can fix the affordable housing crisis. Where's the pressure?

For the one in five state residents age 65 and up who live in poverty, according to a 2018 Kaiser Family Foundation analysis, Prindiville said an emergency could jeopardize their housing when they might already be dealing with hunger or healthcare issues.

"There are many people paying a huge proportion of their income on rent who really need relief from that because they're one disaster away from being homeless," said Dr. Margot Kushel, professor of medicine at University of California, San Francisco and director of its Center for Vulnerable Populations. "We need to get to people right after the disaster happens, so before they become homeless, and try to intervene and prevent their homelessness."

Follow Santa Monica's lead?

In coastal Santa Monica, many older longtime residents can barely pay for food and basic necessities after paying rent, city employees discovered through a 2016 survey. That group faces the danger of becoming homeless every month, said Eduardo Lizarraga, housing specialist in Santa Monica's Housing Division, because they'll be evicted or forced to move if they can't afford rising costs.

The city set out to create change by creating a basic needs subsidy program that Lizarraga said is the first of its kind nationally.

Motels as homeless shelters?: More local governments are housing people in motel rooms

Two years ago, Santa Monica began giving cash to low-income people age 65 and up who were living in rent-controlled apartments since at least 2000. The income subsidies helped alleviate 21 participants' rent burden, plus program coordinators helped connect them with services and benefits.

Based on initial results, the City Council voted to expand the program in August. Moving

from a $300,000 allocation to $2 million, Lizarraga said, the program will support as many as 400 seniors through June 2021. Eligible participants will be enrolled on a rolling basis as the city sorts through applications.

Expanding rental subsidy programs throughout the county, however, isn't feasible, said Heidi Marston, chief programming officer of the Los Angeles Homeless Services Authority.

The authority offers a subsidy meant to serve as a temporary intervention, so people can afford rent increases while finding ways to boost their income. But knowing more than 700,000 households in Los Angeles County pay more than half their income on rent serves as a reminder of the program's limitations.

"The reality is we wouldn't have enough resources to serve all of them if they ran into that situation," Marston said. "So targeting it to seniors has been a good way for us to start and build it out from there."

Federal support?: Trump officials look to fix California homeless problem, state officials say back off

Underlying the efforts is the fact rent in Los Angeles County has outpaced income increases for older adults. From 2012 to 2017, average rents in L.A. County increased at three times the rate of the cost-of-living adjustments to Social Security income, and twice the rate of median household income for seniors, according to a Los Angeles Homeless Services Authority report.

On the move?

To avert homelessness, some California seniors do move to lower-cost areas, said Kushel, the San Francisco college professor.

But more affordable, rural areas tend to offer fewer medical facilities and less public transportation. Finding community in an unfamiliar place, Kushel said, can also be particularly disorienting for seniors with cognitive impairments or physical disabilities.

"They're away from their church, they're away from their families, they're away from everything that they knew," Kushel said.

$700K for an apartment?: The cost to solve the homeless crisis is soaring in Los Angeles

Nearby family does not guarantee a safety net for those at the risk of homelessness, either, said Prindiville of Justice in Aging. Sons and daughters might not have the means to take in an older parent, he said, especially when the racial wealth gap comes into play for people of color.

"If you're an older adult who was working low-wage jobs, it was hard for you to make sure that your kid was set up for an education and had all the opportunities to then be more economically secure," Prindiville said.

Jerome McIntosh, 59, has a brother and a sister living in Oakland, as well as sons in nearby Berkeley and Sacramento. But when he returned home to Oakland after a heart attack left him physically unable to work a construction job, McIntosh went to social services and then the winter shelter at St. Mary's.

"They just don't have the room for me," McIntosh said of his family. "I wouldn't want to put that on anyone. I'm not made that way."

McIntosh, who has lived in the center's transitional housing since 2016, said he puts out about 10 applications a month. With an income of $1,070 a month from Social Security Disability Insurance, McIntosh said he qualifies for apartment waiting lists that are sometimes years long.

“Seniors made this world”

Ultimately, California desperately needs more deeply affordable housing, Kushel said, or subsidized housing for people with lower incomes.

Cities and counties will gain more authority to build supportive housing and shelters under a package of bills signed in September by Gov. Gavin Newsom, but none specifically focus on seniors.

The opportunity to develop a state strategy for senior homelessness lies in the Master Plan for Aging, Prindiville said. That plan is scheduled to be completed by October 2020, per an executive order from Newsom.

"We need to have some insurance that seniors in America can live at home," McIntosh said. "Seniors made this world, as far as I'm concerned, and they need to be treated well."

Vocabulary from the articles

to dial: composer (un numéro)
paramedics: secouristes / équivalent du SAMU
to deliver: distribuer / livrer / prononcer / rendre / faire ce qu'on attend de soi / s'exécuter
unresponsive: qui ne réagit pas / insensible / inconscient
to dangle: pendre / pendouiller
wreck: épave / ruine / naufrage / accident
dusty: poussiéreux
to cope with: gérer / s'occuper de / lutter / se battre
remote: reculé / loin
encampment: campement
highway: grande route
a stretch: une étendue
to live off: vivre de
last resort: dernier recours
on average: en moyenne
surgeon: chirurgien
physician: docteur / médecin
emergency room: les urgences
to haul: tirer / porter / traîner / transporter
numbness: engourdissement
rounds: tours de garde / visites
dizziness: vertige / étourdissement
mandatory: obligatoire
undocumented: sans papiers
dehydration: déshydratation

staff: le personnel
to hand: tendre
bulging: globuleux / bourré, bien rempli / protubérant
diagnosis: diagnostique
hallway: grande salle / hall
to lean back: se pencher en arrière
sunburn: coup de soleil
bites: morsures
aches: douleurs
loneliness: solitude
walk-ins: qui reçoit sans rendez-vous
ominous: de mauvais augure / menaçant
to stay overnight: passer la nuit
headlights: phare (de véhicule)
to seek out: chercher
to rest: se reposer
silly: stupide
rental house: maison de location
every few minutes: à quelques minutes d'intervalle / toutes les deux trois minutes
custody: garde / garde à vue
blunt: direct
to stab: poignarder
labeled: étiqueté / désigné
to rattle: faire s'entrechoquer / cliqueter
to pull up: se garer
to survey: interroger / mener une enquête auprès de / sonder
thrilled: ravi / aux anges
to hang up: accrocher / raccrocher
rookie: un bleu
loan: emprunt
bidding war: guerre d'enchères
college degree: diplôme universitaire
to seal the deal: conclure l'affaire
stipend: traitement / salaire
residency: internat (de médecine)
paperwork: papiers / paperasse
a shift: une garde
tattered: en lambeaux / en piteux état
sprain: entorse / foulure
rash: rougeur / irritation
to encompass: inclure / concerner
intake: ration / prise / apport / consommation
assault: agression
inmate: détenu / prisonnier / patient / interné
to commute: faire la navette (entre son domicile et son travail)
savings: économies
appointment: rendez-vous
bills: factures
to drain: vider / épuiser
homelessness: absence de domicile
affordability: accessibilité / caractère abordable
housing: logement

income: revenu
to provide: fournir
wheelchair: chaise roulante
to blame: tenir pour responsable
to blast: abattre / faire sauter
shelter: abri
wages: salaire
to strain: faire un effort / tirer de toutes ses forces
to jeopardize: mettre en danger
hunger: faim
subsidy: subvention
to alleviate: soulager
burden: poids
benefits: avantages
household: ménage / famille / maisonnée / foyer
feasible: faisable
reminder: rappel / pense-bête / relance
to back off: dégager / reculer / se retirer
impairment: déficience / trouble / détérioration / affaiblissement
scheduled: programmé / prévu

Thematic vocabulary : Social Ills (Chapter 10)