The Ultimate Guide to OET Writing
04. USING THE RIGHT GENRE AND STYLE FOR YOUR LETTER

05. ORGANISING AND LAYING OUT YOUR LETTER

06. USING THE RIGHT LANGUAGE
INTRODUCTION TO THE ULTIMATE GUIDE TO THE OET WRITING SUB-TEST

Welcome to the Ultimate Guide to the OET Writing sub-test! Each chapter is based on a section of the assessment criteria we use to score your letter.

The criteria are:

1. Purpose
2. Content
3. Conciseness & Clarity
4. Genre & Style
5. Organisation & Layout
6. Language

Each of the above is assigned a score from 0 to 7, except for Purpose, which is given a score of 0 to 3. If you are looking to get a score of 350 (grade B) in Writing, you need to get a high score across all sections.

This resource includes six chapters on the OET Writing sub-test covering each of the criterion, what writing skills you will need and how to improve them.
WRITING WITH PURPOSE

Purpose is the first of six assessment criteria that OET Assessors use to score your Writing sub-test performance. Understanding what we mean by purpose and what is expected of you can go a long way to helping you get the score you want.

In Chapter One, we will explain:

The two parts of Purpose

- How to identify and understand purpose
- How to show purpose in your writing

What are the two parts Purpose?

The first part of Purpose is making the reason for the letter “immediately apparent”. In other words, making it clear why you are writing the letter and why the reader should read it.

By starting your letter with a clear explanation of its purpose, the reader does not have to spend time searching for what is important. This is important for healthcare professionals who often are time poor.

The second part of Purpose is “sufficiently expanding” the reason for your letter. What we mean by this is that the letter should build on what is initially outlined as the reason for writing by adding relevant details.

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<th>IMMEDIATELY APPARENT</th>
<th>SUFFICIENTLY EXPANDING</th>
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<tr>
<td>Why are you writing the letter?</td>
<td>Will the reader understand the situation?</td>
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<td>Why should the letter be read?</td>
<td>Are your requests obvious to find?</td>
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<td>Does the letter start with a clear explanation?</td>
<td>Does the letter provide more detail than your opening explanation?</td>
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To effectively give the right kind of care to patients, healthcare professionals need more information than just the high-level overview outlined in the first paragraph. You also need to expand your opening, with relevant information.

OET uses a range of letter types to assess writing skills, including referral, discharge, transfer etc. You will also be writing about a unique patient who will have a unique set of healthcare needs.

This means the purpose of your next letter will be markedly different to others you have read or written yourself. Make sure you have a unique purpose for your unique letter.

**Part One: What needs to be made clear?**

Purpose is the ‘reason for writing’ or ‘why you are writing’. Importantly, it must be clear to the reader and personalised to the situation.

In most cases, the Writing task is the best way to understand the purpose of your letter. However, if the Writing task does not have all the information you need, do not panic. You should be able to find the rest of the information in the final section of the case notes.

Let us look at some examples that walk you through finding the purpose in the Writing task and the case notes.
1. Finding Purpose in the Writing task
The Writing task is located at the end of the case notes and will often include the type of letter you need to write as well as the letter’s main topic.

**EXAMPLE ONE**

**WRITING TASK**

Using the information in the case notes, write a letter of referral to Dr Smith, an endocrinologist at City Hospital, for further management of Mrs Sharma’s sugar levels. Address the letter to Dr Lisa Smith, Endocrinologist, City Hospital, Newtown.

In the above example, you can see this is a referral letter about further management of Mrs Sharma’s sugar levels.

**EXAMPLE TWO**

**WRITING TASK**

Using the information given in the case notes, write a letter to the Occupational Therapist at the Oldmeadows Extended Care Centre, 13 River Street, Oldmeadows, where Mr Spencer is to be discharged, detailing his treatment to date and other information the therapist may need. Date your letter 10 February 2019.

In this example, the Writing task tells you that this is a discharge letter about Mr Spencer’s recent treatment history.

Here are introductory sentences for each of the three examples

**EXAMPLE ONE**

Thank you for seeing Mrs Priya Sharma, a type 2 diabetic, for further management of her blood sugar levels.

**EXAMPLE TWO**

Mr Spencer has been a patient at this hospital for the past five weeks and will be discharged tomorrow. He requires your ongoing support and treatment during his rehabilitation.
3. Showing Purpose at the start of your letter

Each of these three examples has a different purpose which you must demonstrate at the beginning of your letter.

EXAMPLE THREE

WRITING TASK

Using the information given in the case notes, write a letter to the Community Health Nurse in Centreville, outlining the patient's history and requesting ongoing monitoring. Address the letter to the Community Health Nurse, Eastern Community Health Centre, 456 East Street, Centreville.

CASE NOTES

Letter to transfer the Pt to the care of the community health nurse in Centreville, where the Pt is moving to live with his daughter.

This example is a letter of transfer requesting ongoing monitoring for this patient.

This Writing task does not include the type of letter; however, it is supplied in the final note of the case notes just above the Writing task.

EXAMPLE THREE

Thank you for accepting Mr Dunbar into your care for the regular monitoring of his diabetes and encouragement to comply with his medication and dietary regimens.

TIP FROM REBECCA, OET TEACHING & LEARNING MANAGER

Using the right verbs

Many candidates start their letters with 'I am writing to refer...'. Sometimes, this is appropriate, but not all tasks ask you to write a referral letter.

Depending on the type of letter you are asked to write, there are other verbs which are equally or more appropriate.

Examples of these other verbs include:

- Transfer
- Discharge
- Update
- Recommend

- See
- Accept
- Request
- Provide

Each example is clearly personalised to the patient's situation and uses appropriate language to explain the reason for writing.
Part Two: Expanding on your purpose with the right details

The second part of Purpose is to sufficiently expand the reason for writing at the end of the letter and with more details.

When explaining the reason for writing the letter, it is normal to do this at a high level. For example:

- Further management of her blood sugar levels, ongoing support and treatment, regular monitoring of his diabetes.

The reader is clear about the situation from this high-level explanation but they will need more detail to continue caring for the patient adequately. This detail should be covered in the last paragraph.

Expanding the purpose includes providing details such as how often the reader should interact with the patient, what specific activities they should support the patient with etc.

Using our three examples, notice how the sample sentences below expand on the initial reason for writing:

EXAMPLE ONE
Her non-fasting blood sugars are 7–8mmol/L, but her fasting blood sugar levels are usually in the 16+ range, which is high. Therefore, I am referring her to you for your specialist advice.

EXAMPLE TWO
Prior to this injury, he received home help for all house cleaning tasks and was independent in all personal care and community tasks. He is keen to return home where he lives alone and maintain his independence.

EXAMPLE THREE
He was diagnosed with atrial fibrillation on the same admission and was subsequently prescribed warfarin and sotalol. His hypertension is controlled by Ramipril. As with his other medication, Mr Dunbar is intermittent in his compliance.

Again, the important point to notice is that all three examples are personalised to the situation and use language appropriate to describe it.

Achieving full marks in Purpose is based on whether you are prepared to be flexible in the test and not rely on pre-learned phrases and sentences. Using the case notes to help you to write something personalised and meaningful to the reader will help you achieve full marks for Purpose.
Content is the second criterion used to score your performance in the Writing sub-test. It covers what you put into your letter and how you refer to the case notes.

How to choose which content to use

The letter you write should provide the reader with all the information they need to continue caring for the patient and complete any requests you make of them. How you select this information depends on a couple of questions:

Q. Is there any existing professional relationship between the patient and the reader?

Q. What aspect of the patient’s care will the reader be involved with?

When reading through the case notes, you should keep these questions in mind when you decide whether each note is something you need to include. Keep an eye out for information that you think is new to the reader and directly supports their appropriate care of the patient.

For example:

• A hospital Occupational Therapist writes a letter discharging patient Jack Spencer to the Occupational Therapist at the Care Centre where he will receive rehabilitation. In this situation, the reader and the patient do not have an existing professional relationship so the letter will need to include information about the patient’s current abilities and inabilities for the reader to get a clear understanding. Although the case notes provide details of the patient’s children, grandchildren, job (before he retired) and financial status, these details will not be needed for the reader because they will not impact the care they provide.

On the other hand, if the scenario was slightly different:

• The hospital Occupational Therapist was writing a letter to the patient’s regular GP to update them on their progress. In this example, the information provided would change. While the patient’s social history is still not necessary, the details provided about the patient’s current abilities and inabilities would also be altered. The letter would need to provide an update about how these have changed since the GP last saw the patient rather than presented as new information.
In both instances, the reader should have by the end of the letter:
• a clear understanding of the situation
• no more questions about further care.
If they do have any questions, then you have not included enough information and they will not have a clear understanding of the situation.

How to accurately represent the case notes

The second key part of Content is accurately representing the case notes. By doing this, you ensure that the reader has a clear understanding of the situation.

During the Writing sub-test, you will summarise, or paraphrase parts of the case notes you think are relevant and important to the reader. However, it is important to represent the case notes accurately by not changing the meaning of the information.

During the process of paraphrasing, you can affect accuracy by:
• Not matching the exact meaning of words in the case notes with another word
• Altering the timeframe of the situation by changing the tense used.
Let us look at some examples to better understand what we mean by this.

**Example one**

- **Case Notes**
  Pt moving to Centreville to live with daughter & her husband.

- **Letter**
  Mr Dunbar is relocating to Centreville to be nearer his daughter and son-in-law.

While the sentence is grammatically accurate, it is an inaccurate representation of the patient’s living arrangements. Specifically, the phrases ‘living near his daughter’ and ‘with his daughter’ are very different and would impact the reader’s understanding of the situation.

**Example two**

- **Case Notes**
  Atorvastatin (Lipitor) 20mg 1 mane added Glipizide 5mg 2 mane

- **Letter**
  Glipizade 5mg taken every morning, will be added to the Atorvastatin, 20mg also taken in the morning.

The sentence is grammatically accurate but the use of ‘will be’ suggests the addition will take place in the future. The sentence then provides the reader with incorrect information about the patient’s medications.

**Example three**

- **Case Notes**
  Under surgeon’s recommendation: Pt not to mobilise L arm until last wk when plaster removed.

- **Letter**
  Mr Spencer has been resuming use of his left arm since last week following the surgeon’s recommendations.

As with the other examples, the sentence is grammatically accurate but fails to say that the cast has been removed. Not only will this impact the continued care of the patient, it does not give the reader an accurate description of the situation.

**REBECCA’S TIP**

**Keep the reader in mind!**

Getting full marks in Content is about keeping the reader in mind when choosing the information to add to your letter. A good tip is to finish your letter with a few minutes to spare. This should give you enough time to read through your letter as the reader and ask the following questions:

- How would the reader feel at the end?
- Will the reader know what they need to do to continue care?
- Do they have the right information to action this?
- Are the facts correct?
- Have you represented the information using accurate grammar and vocabulary?

If you can answer yes to all these, you’re well on your way to scoring high on Content.
In Chapter Three, we will look at:

Whether you have not included unnecessary information

How clearly you have summarised the case notes

How clearly this summary is communicated to the reader.

We tend to pair Content and Conciseness & Clarity together because many of the skills, strategies, and questions you apply are similar.

Content is the criterion that assesses the information you have included in your letter. Conciseness and Clarity assesses the information you have omitted from your letter.

Confused?! Are you thinking: ‘How can I be assessed on something that isn’t there?’

If certain information from the case notes is not omitted, then the important information can become hidden and the reader may end up misunderstanding what is required.

Let us take a closer look through some of the mistakes candidates make when writing their letter.

Leaving out irrelevant information

When it comes to deciding what is and what is not relevant, test-takers tend to make three mistakes:

1. Including information the reader already knows or is outside the scope of the patient’s care.

2. Providing too much background or historical detail to the current situation.

3. Not grouping similar information together.
EXAMPLE ONE

INFORMATION NOT NEEDED FOR CARE

Mrs Sharma's case notes cover 6 visits to her GP over a two-month period. The first visit mentions this detail:

29/12/18

Discussion: Concerned that her glucose levels are not well enough controlled – checks levels often (worried?) Attends health centre – feels not taking her concerns seriously

The Writing task is to write a letter referring the patient to the endocrinologist. We can break this case note into what is and what is not relevant to the endocrinologist.

• Relevant: Mrs Sharma is concerned that her glucose levels were not well controlled causing her to present on the 29 December
• Not relevant: Mrs Sharma felt the health centre was not taking her concerns seriously.

Mrs Sharma’s feelings on the health centre are outside of the endocrinologist’s role. It does not have any impact on the assessment or treatment they will provide her.

EXAMPLE TWO

TOO MUCH HISTORICAL DETAIL

Avoiding unnecessary or repeated information is also an important part of this criterion. In many sets of case notes, multiple visits to or by the patient will be reported.

Some of the information in the earlier visits will have been superseded by how the patient’s condition progressed. Summarising the information to only include the details which remain relevant is therefore important.

Mr Spencer’s case notes cover his medical presentation:

Case Note

Admitted to hospital with L fractured humerus & olecranon process following fall at home. Surgery completed on olecranon process, screw inserted 4 wks ago.

• Relevant: Mr Spencer’s injuries were a left fractured humerus & olecranon process
• Not relevant: The type of surgery.

The OT needs to know what injuries the patient sustained because it will help them correctly care for Mr Spencer. However, details of the surgery are not relevant as they will not impact the type of care provided post-discharge.
EXAMPLE THREE

GROUPING SIMILAR INFORMATION IN YOUR LETTER

The final element of this criterion is to group similar information together for the reader.

Grouping information will help your summary be quick and easy to read, ensuring your reader does not have to re-read the letter to understand it.

For example, patient Mr Dunbar’s case notes record he is non-compliant with his diet and medication and that this is discussed with him on three separate visits including:

March 2018
Non-compliant with diet. Non-compliant with medication. Blames poor memory

October 2018
Resumed medications but still only taking intermittently. Again provided education re importance of adherence to drug regimen

The task is to transfer the patient into the care of the Community Nurse in the area where he will be moving to. The Community Nurse is requested to provide ongoing monitoring.

• **Relevant:** Mr Dunbar’s medication and diet compliance need monitoring
• **Not relevant:** The frequency or specific dates when the patient has been recorded as non-compliant.

REBECCA’S TIP

To score high in the OET Writing sub-test, you need to choose only the relevant information from the case notes, while also leaving out irrelevant information.

The **best way** to do this is to avoid information that:

• is outside the scope of the reader’s role
• focuses too heavily on their history or background
• not grouping similar information.

If you avoid these mistakes and follow the guide for Content, you are well on your way to scoring high in the Writing sub-test.
Genre and Style is the fourth criterion used to assess your Writing and looks at whether your writing aligns with the reader’s knowledge and expertise.

In the healthcare industry, the type of letter you tend to write is formal and OET’s Writing sub-test reflects this by asking you to do the same.

In Chapter Four, we will explain:

What formal writing is

How to use the right register (level of formality) and tone for your reader

How your grammar can help you to sound formal

**Writing formally**

When writing from professional to professional or even from professional to patient (for some OET professions), you are expected to use formal language.

Towards the end of the case notes, you will find reminders of what genre and style you should use in the Writing task, including:

- expand the relevant notes into complete sentences
- do not use note form.

Formal writing is polite, respectful, and non-judgemental. You show this in the language you use to make requests of the reader, how you present information to the reader and how you present information about the patient.

Let us look at some examples of informal and formal phrases and sentences:

**Informal:**
- Thanks for having a look at Priya
- I’ve sent her to you because she needs to lose some weight.

These phrases use the patient’s first name and are not respectful toward her condition.

**Formal:**
- Thank you for seeing Mrs Priya Sharma
- I am referring her to you for your specialist advice.

Both these phrases are respectful to the reader’s role and are polite expressions about the patient, using her full name as part of the introduction.

To help you better understand genre and style, let’s take a look at some ways you can identify the register (formality) and tone of your letter as well as how to choose the right language during the Writing sub-test.
Using facts and not making judgements

When you present patient information, one way to be respectful and non-judgemental is to use facts:

- He writes with his left hand and drove a manual car before the fall.
- She works on her computer every day and carries a heavy laptop home.

When describing a patient’s lifestyle choices, use facts instead of words which sound judgemental:

**Judgement:**
- Mr X is a heavy smoker
- Mrs Y is a binge drinker OR Mrs Y is an alcoholic
- Ms Z does not exercise enough

**Fact-based:**
- Mr X smokes 30 cigarettes a day
- Mrs Y avoids drinking in the week but drinks 15 units of alcohol on an average weekend
- Ms Z admits she is only physically active once every three-months.

By presenting the facts, the reader will know what this means in terms of recommended norms. It allows you to avoid passing judgement on the patient and their lifestyle.

Starting and ending your letter

How you start and end the letter is important to getting the formal tone right from the start and to leave the right impression at the end. It is also common to end with a closing sentence that offers the reader the opportunity to contact you or to show appreciation for their involvement.

For example:
- If you require further information, please do not hesitate to contact me.
- Thank you for your continued management of this patient.
- This handy tip guides you to the correct starting and ending language for your letter.

Being formal with the right grammar

The punctuation you use will demonstrate whether you are writing in an appropriately formal style. This means avoiding contracted forms and being careful about how you use brackets and abbreviations.

Let us look at some examples of formal and informal grammar:

**Contractions:**
Contractions are considered informal and should be avoided while writing.

**Informal:**
- He’s keen to return home.
- She’s looking forward to holding her baby.
- She didn’t follow the care plan correctly.

**Formal:**
- He is keen to return home.
- She is looking forward to holding her baby.
- She did not follow the care plan correctly.
Abbreviations:

It is really important to take into account the reader when deciding when and where you abbreviate. Below are some examples to help you get a better idea of what we mean by this.

EXAMPLE ONE

**READER: ENDOCRINOLOGIST**

Mrs Sharma was diagnosed with NIDDM in 1999. As you are writing to an endocrinologist, this abbreviation would be very familiar and the condition is central to the patient’s reason for seeing them, so it is appropriate to abbreviate. For an orthopaedic surgeon perhaps, the abbreviation is less appropriate. Any mention of the condition, because it may have some impact on the treatment the patient receives, should therefore be in full form.

EXAMPLE TWO

**READER: COMMUNITY NURSE**

He was diagnosed with atrial fibrillation. There is more than one abbreviation used globally for Atrial Fibrillation: AF or AFib. As a result, it is best to use the full form of this condition rather than abbreviating it. If you think your reader might not know what the abbreviation is, it is best to not abbreviate, otherwise, it will interrupt their reading.

**REBECCA’S TIP**

*Keep the Reader in mind!*

Genre and style are about being formal, using facts and refraining from judgement as well as starting and ending your letter correctly. If you follow the steps laid out above, you should have the understanding you need to get a good score in the test.
05.

ORGANISING AND LAYING OUT YOUR LETTER

The fifth criterion used by assessors to score your Writing performance is Organisation and Layout. It covers how you order your letter and helps assessors decide whether your structure makes it easier or harder for the reader to understand.

In Chapter Five, we will explain:

- Learn why organisation and layout are important
- Learn how to order information in your letter
- Learn how to group information together into paragraphs

Putting your information in the right place

Once you have decided the information to include and not include from the case notes, you now need to decide in what order you will present the information.

As each writing task and its case notes are different, the situation you are describing and the requests you are making are not the same. As a result, each letter will be structured slightly differently.

One way to think about your letter is that it is the patient’s story. We often tell the patient’s story when handing over a patient to colleagues at a shift change or over the phone when referring the patient to a specialist.

We adjust the order of the information in the story depending on who we are telling it to. We do this because we want to grab their attention and keep them engaged while we present the rest of the information. This is what you need to do with your letter.

Put yourself in the reader’s shoes. If you received this letter, which information would you want first, second and so on?
Let us go through some different ways you can put the letter together depending on the patient’s situation.

**CHRONOLOGICALLY**

In some situations, the clearest way to organise the letter is around time. You start at the beginning and continue up to the present day, for example:

**Reader:** Endocrinologist

**Paragraph one:** Mrs Sharma initially presented on 29/12/18...

**Paragraph two:** A pathology report received on 05/01/2019...

**Paragraph three:** On 12/01/19...

Mrs Sharma’s situation is quite routine to the reader. The writer uses dates at the start of each paragraph to separate the details of her visits. By doing this, the information is formed into a timeline that is clear to the reader and easy to follow.

**THEMATICALLY**

Another way to organise a letter is by putting the most important information first. You would organise the letter this way if there are several different aspects to the patient’s current situation. For example, the patient’s living and family situation, co-morbidities etc.

In these situations, presenting the information thematically will be most appropriate to the reader. Let us look at an example:

**Reader:** Doctor

**Paragraph One:** Since October 2018, Mr Dunbar has shown signs of diabetic neuropathy... and has not been compliant with his medication regimen...

**Paragraph Two:** In June 2018, he had a myocardial infarction...His hypertension is controlled by Ramipril.

In this letter, there is a timeline of the patient’s history like the last example because it remains important for the reader to understand what happened and when. However, the information is laid out thematically rather than chronologically.

The first paragraph covers the patient’s diabetes and non-compliance with both his medication and diet, as per the purpose of the letter (write a letter outlining the patient’s history and requesting ongoing monitoring). The second paragraph focuses on related medical events and co-morbidities which are relevant background detail for the reader but of less importance.

In other letters, thematic paragraphs could focus on the patient’s social history, previous advice, and education they have received, relevant family history and the impact this has on how the patient feels about their condition etc.

If the case notes are describing an emergency, what happened six months ago becomes much less important to the reader. Instead, they are interested in what has just happened, what treatment has been provided and details of the patient’s current situation.

Once they have this in mind, they can then scan through the rest of the letter to see if the history presents any additional insight.
Review your paragraphs…

There is no limit to the paragraphs you include. Use as many as are necessary to clearly communicate the information to the reader. Some situations may need less, and some may need more.

If you find you have a very long paragraph in your letter, use the few minutes at the end to:

• make sure it is only covering one time period or one theme
• decide if you should break the paragraph into two.

…and the order of your sentences

It’s not just about structuring the paragraphs in the clearest order for the reader. You also want to make sure that the important details don’t get hidden within the paragraph. Apply the same approach to the order of your sentences. The sentence containing the most important information for that paragraph comes first, the next most important sentence comes in second and so on.

Choosing how to order your information is what is being assessed in this criterion. Even if you have included all the information the reader needs, but not in the order they need, then you will not have demonstrated this criterion correctly.
06.

USING THE RIGHT LANGUAGE

The final criterion of the OET Writing sub-test is Language, which includes grammar, vocabulary, punctuation, and spelling. Each of these language elements forms part of the assessment criteria.

Grammar
Grammar structures the English language and is an important element to get to know. While a lot of native speakers never formally study grammar, it can help you learn English more quickly.

Take a look at our three top read articles below:
- How to use connectors and improve your clarity in writing
- Do you know how to correctly write passive forms?
- Do you know how to use a relative clause?

Vocabulary
Vocabulary is an important part of OET because it shapes how to communicate with the audience of your Writing and Speaking sub-test.

Take a look at this example:
- Can you get these medication names correct?

Punctuation
Punctuation adds clarity to your writing. It can help you better communicate your message to your reader. Read through these top-read articles below.
- Use semicolons to write clear lists
- Are you worried about using your punctuation?

Spelling
Spelling is important in Writing, and some misspelled words will stand out more than others. However, you won’t need to be perfect to achieve a B.
Additional tips

Assessment
Writing is assessed against specific criteria. These are available for you to read and it is important that you do. The descriptors available tell you what it is the assessor is looking for and how to demonstrate this in your responses. To get the grade you want, you must score highly across ALL the criteria so make sure you do not just focus on the obvious ones like Language. Accurate grammar is important but not more important than any of the other criteria.

Completing your answers
You can complete the paper-based Writing test in either pen or pencil depending on your personal preference. Your handwriting is not assessed but it does need to be clear enough for the assessor to be able to read. You might find it quicker and clearer to cross out any mistakes you make while writing and carry on with the correction rather than erasing and writing over the top. Only the answer written on the lined paper in the answer booklet will be assessed so make sure you only use the blank page for planning.

For OET on Computer at a venue or OET@Home®, you will type your letter into the answer box provided on your screen.

Top tip for Writing
It is important by the time you get to the Writing test, that you still have some energy left. Make sure you build up your stamina by practising Listening for 40 minutes then Reading for 60 minutes then Writing for 40 minutes at least once a week.

For more information about the Writing sub-test, you can find a wide range of guides, articles, tips, and tricks on the OET Blog.
The leading English test specifically for healthcare professionals

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