

## Occupational English Test

### Listening Test

This test has three parts. In each part you'll hear a number of different extracts. You'll have time to read the questions before you hear each extract and you'll hear each extract **ONCE ONLY**. Complete your answers as you listen.

At the end of the test you'll have two minutes to check your answer.

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### Part A

In this part of the test, you'll hear two different extracts. In each extract, a health professional is talking to a patient.

For **questions 1 to 24**, complete the notes with information you hear.

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## Extract 1: Questions 1-12

You hear an ophthalmologist talking to a patient called Dominic De Sousa. For **questions 1-12**, complete the notes with a word or short phrase that you hear.

You now have thirty seconds to look at the notes

**Patient:** Dominic De Sousa

### History of the condition

- has worn glasses for five years (age-related myopia)
- symptoms first apparent in poor **(1)** \_\_\_\_\_
- left eye affected
- rapid deterioration in vision
- has recently stopped working as a **(2)** \_\_\_\_\_

### Optician consultation

- possible **(3)** \_\_\_\_\_ observed in left eye
- lutein preparation prescribed
- increased intake of **(4)** \_\_\_\_\_ recommended
- **(5)** \_\_\_\_\_ suspected (cause for concern)

### Presenting Symptoms

#### Left Eye:

- problems judging **(6)** \_\_\_\_\_ of objects
- central vision is **(7)** \_\_\_\_\_
- describes changes as 'unnerving'

#### General Vision:

- **(8)** \_\_\_\_\_ vision unaffected
- has stopped **(9)** \_\_\_\_\_

### Treatment

- asked for clarification regarding **(10)** \_\_\_\_\_ (to be administered)
- to test for suspected leaking **(11)** \_\_\_\_\_ (treatment options explained)
- expressed concern about possible need for **(12)** \_\_\_\_\_

## Extract 2: Questions 13-24

You hear a neurologist talking to the father of a nine-year-old boy called Tony, who's recently started having seizures. For **questions 13-24**, complete the notes with a word or short phrase that you hear.

You now have thirty seconds to look at the notes.

**Patient:** Tony Fitzgerald (9 years old)

### Presenting symptoms

- Seizures started six weeks ago
- Described by paediatrician as **(13)** \_\_\_\_\_
- Seizures:
  - begin with a **(14)** \_\_\_\_\_ on face
  - he's unable to respond
  - his mouth makes **(15)** \_\_\_\_\_ movements
  - last for up to two minutes – recovery a little longer
- Post-seizure
  - limited recall of event
  - reports feeling **(16)** \_\_\_\_\_ during seizure
  - is tired afterwards
  - often suffers from **(17)** \_\_\_\_\_

### Social history

- performing well academically
- is **(18)** \_\_\_\_\_ (like maternal grandfather)
- recently diagnosed as **(19)** \_\_\_\_\_

### Medical history

- Birth:
  - born 42wks+ by emergency c-section
  - received **(20)** \_\_\_\_\_ straight afterwards
  - had mild **(21)** \_\_\_\_\_
- At 13 months:
  - had a viral infection
  - experienced a one-off **(22)** \_\_\_\_\_

### Family history

- mother is of **(23)** \_\_\_\_\_ heritage
- mother suffers from **(24)** \_\_\_\_\_

## Part B

In this part of the test, you'll hear six different extracts. In each extract, you'll hear people talking in a different healthcare setting.

For **questions 25-30**, choose the answer (**A**, **B** or **C**) which fits best according to what you hear. You'll have time to read each question before you listen. Complete your answers as you listen.

Now look at question 25.

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**25.** You hear a dentist talking to a trainee dental nurse.

What is he explaining?

- (A) what to do in the event of accidental injury to a patient
- (B) the need to put patients at ease before a procedure
- (C) the proper positioning of a piece of equipment

**26.** You hear two nurses in a GP surgery discussing a case of chicken pox.

What are they both concerned about?

- (A) the possibility of contagion amongst other patients
- (B) the risks to members of the patient's family
- (C) the severity of the patient's condition

**27.** You hear an anaesthetist talking to a patient.

What is she doing?

- (A) explaining why he must stop his regular medication before surgery
- (B) confirming a previous adverse reaction he experienced
- (C) advising him to discuss his concerns with the surgeon

28. You hear a woman telling a practice nurse about her son's ear condition.

What is she most concerned about?

- (A) the effects on her son's hearing
- (B) the use of certain medicines
- (C) the prospect of surgery

29. You hear an ear, nose and throat (ENT) consultant describing a recent cancer case he was involved in.

The unusual thing about the case was

- (A) shrinkage of the tumour occurring relatively quickly.
- (B) bone erosion not showing up immediately on the scans.
- (C) CSF leakage being detected so long after the first operation

30. You hear a surgeon and an anaesthetist briefing their team before an operation.

They point out that post-operative care may be complicated by the patient's

- (A) poor respiratory health.
- (B) previous surgical history.
- (C) problems with blood clotting.

**That is the end of Part B. Now look at Part C.**

## Part C

In this part of the test, you'll hear two different extracts. In each extract, you'll hear health professionals talking about aspects of their work.

For **questions 31-42**, choose the answer (**A**, **B** or **C**) which fits best according to what you hear. Complete your answers as you listen.

Now look at extract one.

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### Extract 1: Questions 31-36

You hear an interview with Dr Pauline Lee about her research into the nature of pain.

You now have 90 seconds to read **questions 31-36**.

- 31.** Dr Lee refers to irritable bowel syndrome and fibromyalgia to make the point that
- (A) some types of pain have no obvious cause.
  - (B) pain may come from a combination of causes.
  - (C) some types of pain are more severe than others.
- 32.** What finding from an experiment on the nature of pain does Dr Lee describe?
- (A) People may exaggerate their pain to get faster treatment.
  - (B) Pain may be unrelated to the seriousness of an injury.
  - (C) Only a few types of injuries cause high levels of pain.
- 33.** Dr Lee says that one serious result of congenital insensitivity to pain is
- (A) infections resulting from joint immobility.
  - (B) internal bleeding caused by tissue harm.
  - (C) severe sprains due to inappropriate exercise.

34. Dr Lee says it is difficult to help people who feel no pain because

- (A) their bodies are unable to repair damaged nerves.
- (B) they often fail to understand the cause of their condition.
- (C) they find it difficult to learn to avoid dangerous situations

35. Dr Lee's team are trying to find out about pain-related brain activity in volunteers by

- (A) asking them to prick their arm or leg with a pin.
- (B) making them experience pain without any physical contact.
- (C) telling them to imagine that they are feeling different kinds of pain.

36. Dr Lee is involved in a new development which involves studying

- (A) why pain is worse when people's emotions are involved.
- (B) whether patients can be helped to develop a positive attitude to pain.
- (C) how the sensation of pain can be transferred from one person to another.

**Now look at extract two.**

### Part C

In this part of the test, you'll hear two different extracts. In each extract, you'll hear health professionals talking about aspects of their work.

For **questions 37-42**, choose the answer (**A**, **B** or **C**) which fits best according to what you hear. Complete your answers as you listen.

Now look at extract two.

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#### Extract 2: Questions 37-42

You hear a presentation by an orthopaedic specialist called John Bevan in which he describes the case of Lucy, a patient with osteoporosis.

You now have 90 seconds to read **questions 31-36**.

37. What convinced Lucy that she needed to see a doctor?
- A She felt her body shape was changing.
  - B She found her back pain unbearable.
  - C She was very tired all the time.
38. John thinks that Lucy's GP should have
- A referred her to a specialist sooner.
  - B asked her more questions.
  - C given her different advice.
39. The first time John met Lucy, he formed the impression that
- A she felt uncomfortable about revealing certain information.
  - B she understood what a healthy lifestyle involved.
  - C she was trying to do too much at home.

40. It was decided that Lucy should have back surgery because it would

- (A) slow the advance of her osteoporosis.
- (B) be less risky than alternative treatments.
- (C) have a good psychological impact on her.

41. How does John feel about Lucy's future prospects?

- (A) unsure whether she'll need to take medication long-term
- (B) worried about what her health will be like in old age
- (C) confident that she can return to a normal family life

42. John thinks Lucy's case is significant because it acts as a reminder of

- (A) how many younger people suffer from osteoporosis.
- (B) how rapidly treatments for osteoporosis are improving.
- (C) how little awareness the general public has of osteoporosis.

**This is the end of the listening test.**

## Hydration in the elderly in residential care: Texts

### Text A

#### Risk factors for dehydration in the elderly

Older people are vulnerable to dehydration due to physiological changes in the ageing process, but this can be complicated by many disease states, and mental and physical frailty.

Age-related changes include a reduced sensation of thirst, and this may be more pronounced in those with Alzheimer's disease or in those that have had a stroke. Thirst in older people may not be relied on as an indicator of dehydration.

Reduced renal function is also a risk factor. Difficulties with swallowing, dementia and poorly controlled diabetes are more common in older people and are all associated with poor hydration.

The likelihood of dehydration may also be exacerbated by medications including diuretics. Incontinence predisposes people to dehydration as they may limit their fluid intake.

Poor oral intake of fluids can be related to the inability to feed independently and having poor availability and access to fluids. This can be exacerbated in the residential care setting by inadequate staff training and lack of awareness of the importance of keeping residents well hydrated.

### Text B

#### Hydration assessment

On admission and at any time if there is a change in the resident's condition or symptoms of dehydration, conduct an assessment including:

medical history

current medications

cognitive status

continence status

the resident's usual hydration habits and current fluid intake patterns, functional ability and requirements for aids such as straws or 'special' cups

Conduct a physical examination that includes:

- lying/standing blood pressure ( low BP and/or postural hypotension may be an indicator of dehydration), temperature, pulse rate, respiration rate, capillary refill rate
- calculating the resident's BMI (body mass index)
- monitoring fluid input and urine output over 24-hour period (normal output should be >700mL)
- urinalysis (colour, specific gravity) (dehydration is indicated when the creatinine ratio is greater than 25 and/or sodium concentrate 148 mmol/L)
- identifying observable symptoms of dehydration:
  - dry oral mucosa and tongue
  - loss of skin turgor (elasticity): check by grasping skin on the back of the hand between two fingers so that it is tented up - skin with poor turgor takes time to return to its normal position
  - sunken eyes
  - muscle weakness and/or increased physical frailty
  - constipation and/or small amounts of dark, concentrated urine
  - change in mental status (confusion, disorientation, altered consciousness, headache) and drowsiness

**Text C**

<b>Recommended fluid intake for adults in residential care (Litres per day)</b>					
<b>Height:</b>	<b>150 cm</b>	<b>160 cm</b>	<b>170 cm</b>	<b>180 cm</b>	<b>190 cm</b>
<b>Weight:</b>					
<b>40 kg</b>	1.5	1.6	1.7	1.8	1.9
<b>50 kg</b>	1.6	1.8	1.9	2.0	2.1
<b>60 kg</b>	1.7	1.9	2.0	2.1	2.2
<b>70 kg</b>	1.9	2.0	2.1	2.3	2.4
<b>80 kg</b>	2.0	2.2	2.3	2.4	2.5
<b>90 kg</b>	2.1	2.3	2.4	2.5	2.6
<b>100 kg</b>	2.2	2.4	2.5	2.6	2.7

**Text D****Managing hydration in the residential care context**

Staff knowledge and education:

- Causes of dehydration in older people
- Maintaining adequate hydration
- Signs and symptoms of dehydration
- Fluid volumes of drinking vessels

If a resident is assessed as dehydrated:

- Establish severity of dehydration
- Review the daily intake goal, increasing oral fluids as tolerated
- Involve the resident to identify their preferred fluids and intake patterns
- Document and monitor the resident's fluid intake and output
- Refer to a GP to consider blood tests and withholding certain medications
- Monitor symptoms by repeating assessment
  - daily if there is no or only marginal improvement in fluid intake
  - in seven days if the daily intake goal is being achieved

When symptoms are relieved, monitor the resident for symptoms of overhydration:

- unexplained weight gain
- peripheral oedema
- distention of neck veins
- shortness of breath

## Part A

**TIME:** 15 minutes

- Look at the four texts, **A-D**, in the separate **Text Booklet**.
  - For each question, **1-20**, look through the texts, **A-D**, to find the relevant information
  - Write your answers in the spaces provided in this **Question Paper**.
  - Answer all the questions within the 15-minute time limit.
  - Your answers should **only** be taken from texts **A-D** and must be correctly spelt.
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### Hydration in the elderly in residential care

#### Questions 1-7

For each question, **1-7**, decide which text (**A, B, C** or **D**) the information comes from. Write the letter **A, B, C** or **D** in the space provided. You may use any letter more than once.

In which text can you find information about

- 1 how to determine whether a patient is suffering from dehydration? \_\_\_\_\_
- 2 the amount that patients should drink over a 24-hour period? \_\_\_\_\_
- 3 information to obtain when an individual enters residential care? \_\_\_\_\_
- 4 how to deal with a case of dehydration? \_\_\_\_\_
- 5 the correlation between body size and fluid intake? \_\_\_\_\_
- 6 indications that a patient may have consumed too much liquid? \_\_\_\_\_
- 7 conditions which increase the likelihood of dehydration? \_\_\_\_\_

#### Questions 8-14

Answer the following questions, **8-14**, with a word or short phrase from one of the texts. Each answer may include words, numbers or both.

- 8 What is the minimum volume of urine which a healthy patient should produce per day?  
\_\_\_\_\_
- 9 Which part of the body should be observed when assessing a patient's level of skin elasticity?  
\_\_\_\_\_
- 10 Which illness may affect patient's ability to judge when they are thirsty?  
\_\_\_\_\_

11 What condition may make patients reluctant to drink enough fluids?

\_\_\_\_\_

12 What analyses might a doctor recommend for a patient diagnosed with dehydration?

\_\_\_\_\_

13 If the daily intake goal is on target, how long should you wait before reassessing the patient?

\_\_\_\_\_

14 How much fluid should a 190cm man who weighs 70 kg drink each day?

\_\_\_\_\_

### Questions 15-20

Complete each of the sentences, **15-20**, with a word or short phrase from one of the texts. Each answer may include words, numbers or both.

15 Patients who have problems \_\_\_\_\_ may be at risk of dehydration.

16 Urinalysis results showing high levels of sodium or an elevated \_\_\_\_\_ are a sign of dehydration.

17 A patient who is overhydrated may have distended \_\_\_\_\_.

18 If the \_\_\_\_\_ and mucous membrane lining of the mouth are dry, this could be an indication of dehydration.

19 An increase in \_\_\_\_\_ is a possible sign of overhydration.

20 Staff should check whether a resident needs to use \_\_\_\_\_ or adapted drinking vessels.

**END OF PART A**

**THIS QUESTION PAPER WILL BE COLLECTED**

## Part B

In this part of the test, there are six short extracts relating to the work of health professionals. For **questions 1-6**, choose the answer (**A**, **B** or **C**) which you think fits best according to the text.

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1. What is the memo doing?

- (A) reminding staff of their obligations
- (B) issuing a warning to non-compliant staff
- (C) presenting new guidelines for staff to follow

### Memo

**To:** All staff

**Re:** Bare Below the Elbow policy

Hand hygiene remains the single, most effective means of preventing the transmission of healthcare associated infections. The hospital ensures that the Bare Below the Elbow policy is clearly defined and is widely available to all staff, at all levels and in all disciplines. Staff must make effective hand hygiene possible by ensuring full compliance with the Bare Below the Elbow policy. Uniforms and work wear must not impede effective hand hygiene and should not come into contact with patients during direct patient care activity. All staff must adopt the policy whenever they are engaged in a direct patient care activity.

2. The notice warns staff not to

- (A) rely on information held on record without checking its accuracy.
- (B) order blood products before submitting the necessary samples.
- (C) collect both of the required blood samples at the same time.

**Staff notice: Confirming a patient's blood group prior to transfusion**

Guidelines on pre-transfusion compatibility procedures require that, prior to issue of blood/blood products, at least two samples have been received in order to confirm the patient's blood group. Many patients already have historical groups on the Local Information Management System (LIMS) and only one further sample is therefore required. Where no historical group is available, two samples are required that have been collected on separate occasions with the patient being fully identified on each occasion. The hospital does not currently recommend a set period of time between collection of these samples. Where it is suspected that the samples have been collected simultaneously, for example where the date of collection is the same on both, they will be treated as one sample and one will be discarded.

3. The instructions for sending materials to the laboratory emphasise the importance of

- (A) clearly identifying the contents of any packages.
- (B) ensuring that materials cannot leak from packages.
- (C) storing packages of samples in an appropriate place.

**County Pathology Laboratory user guide**

All samples coming to the laboratory must be packaged to a high standard of containment and in such a way as to contain the contents in the event of a breakage if they are roughly handled or dropped.

Pathology samples may contain infectious material and should be treated with care.

Samples should be transported in a suitable transport container, designed for the purpose, with sufficient absorbent material to absorb the entire liquid content. This should be placed in a zip lock bag.

The request form should be placed in a separate pouch.

Samples being taken by hand to the laboratory should be placed in a transparent transport box (to allow examination prior to opening), with the lid securely sealed.

4. The email reminds midwives that

- (A) they must put patient welfare above the wish to maintain good working relationships.
- (B) they can refer a patient to a senior member of staff directly if they feel it is necessary.
- (C) they should speak to the Labour Ward Co-ordinator if they are unhappy with the actions of junior staff.

**To:**

All midwives

**Subject:**

Patient referral

Please read the following:

Any midwife can refer a patient in their care to an obstetric consultant at any stage of intrapartum care if they have concerns for the welfare of the patient or her unborn baby. Referral is generally done via the Labour Ward Co-ordinator (LWC). However, the midwife may wish to refer directly if the LWC is not immediately available, or if the midwife feels that the LWC and/or junior medical staff have failed to respond appropriately to an emergency. In such circumstances, and in order to maintain good working relationships, the LWC should be informed of the referral as soon as possible, and an explanation presented to the team member in question. Any decisions between professionals should be open and honest and all actions taken should be for the welfare and safety of the patient and her unborn baby.

5. When is it unnecessary to report a suspected ADR?

- (A) where the patient's health record reveals a known allergy
- (B) in the case of a non-serious reaction to an established vaccine
- (C) if documentation shows the authorities have already been informed

#### **Immunisation policy - Adverse Reaction Reporting**

The Medicines and Healthcare products Regulations Agency (MHRA) encourages reporting of suspected adverse drug reactions (ADRs) even if there is uncertainty as to whether the vaccine or drug played a causal role. The Yellow Card scheme should be used for reporting. Any ADR that is suspected to be linked to an established vaccine should only be reported to the authorities if it is a serious ADR. For newly licensed vaccines labelled with a black triangle, ALL suspected adverse reactions should be reported. Any adverse reactions should also be documented in the patient's health record.

6. This extract from a training manual addresses the fact that some patients will

- (A) want a limited amount of detail about the recommended treatment.
- (B) look for information about treatment from sources outside of the hospital.
- (C) ask for assurances about treatment that the medical professional cannot give.

#### **Discussing treatments with patients**

Before a patient can consent to a particular treatment, investigation or procedure, they need information about what will happen, how long they will be in hospital, how they will feel afterwards and so on.

Patients and those close to them will vary in how much information they want: from those who wish to know as much as possible, including discussion of rare risks, to those who ask health professionals to make decisions for them. There will always be an element of clinical judgement in determining what information should be given. However, the presumption must be that the patient wishes to be well informed about the risks and benefits of the various options.

All information given should be documented. Sources of patient information include consultants, specialist nurses, specialist clinics and Patient Information Leaflets. Patient Information Leaflets are available within each speciality.

## Part C

In this part of the test, there are two texts about different aspects of healthcare. For **questions 7-22**, choose the answer (**A, B, C or D**) which you think fits best according to the text

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### Text 1: Physicians and drugs in sport

After years of doping scandals involving elite athletes such as cyclists and sprinters, the major role physicians have played in these doping cultures has received much less attention than it deserves, especially in medical circles. Physician involvement in these illicit, and often medically dangerous, practices will seem counter-intuitive to those who associate physicians with the task of healing and the injunction to do no harm. One rationalisation for physician-managed doping is the 'lesser harm' argument: since an athlete may not possess the self-discipline or knowledge to limit their intake of doping drugs, it is the physician's responsibility to exert some control over **this** and thereby limit medical harm. What such physicians do not understand is that at least some of these athletes will top off their medically sanctioned doses with drugs they obtain illegally on the black market.

The proponents of legalising 'medically supervised' doping imagine that such arrangements between doctors and athletes are comparable to proper clinical relationships between doctors and patients. In fact, these are doctor-*client* relationships that can subordinate medical judgment and the client's health to the demands of performance. This mismatch is exacerbated when doctors become infatuated by the celebrity of their 'patients'. Some doctors identify so strongly with athletes' goals or derive so much satisfaction from the athlete's celebrity status that they willingly abandon medical norms in favour of the ambitions of athlete-clients who are now effectively in charge of their medical 'treatment'. This type of emotional dependence works in both directions. Just as doctors can succumb to the charismatic appeal of athletes, athletes can revere doctors as if they have all the answers.

There exists no scientific evidence that using 'performance-enhancing' drugs or methods for doping purposes is healthy, particularly in the mid- and long-term. A 'doped' athlete may be able to compete for a longer time, perform faster, tolerate higher workloads, or better withstand pain — but this is certainly far from beneficial to health. To illustrate this point, in a case of injury or fever, it is clear what the general medical practice should be. Why should it be any different in sport? Can one imagine a doctor prescribing amphetamines to a truck driver because he or she is too tired to continue driving? The use of even the most common drugs is associated with risks and potential side effects. To argue that medically supervised doping is safer because a doctor is in charge misses the point entirely. Every day, in hospitals and clinics, patients experience the side effects of drugs despite strict monitoring by highly experienced doctors.

The World Anti-Doping Agency (WADA), organised in 1999 by the International Olympic Committee, introduced the term *therapeutic exemption* and defines it as the use of a drug for the restoration of normal health. But one of the central problems in defining a therapeutic exemption lies in understanding the evolving power of medical science. Medicine historically has focused on restoring normative health for those with pathologic conditions. As medical science advances, however, the focus of treatment transcends the longstanding goal of normalising pathologic conditions and extends into the concept of wellness and helping individuals feel better than they have ever felt. So, from a medical therapeutic perspective, where does the restoration of normative function end and the beginning of performance enhancement start?

Further complicating this issue are the subtle ways in which performance-enhancing drugs are sport specific. For example, in sports like golf, archery, or pistol shooting, where a steady hand is critical, beta-blockers provide a performance-enhancing function that combats the normal physiologic tremor that is exacerbated in high-pressure situations. Conversely, in an endurance sport like cycling or long-distance running, beta-blockers adversely affect performance and would not necessarily be prohibited. An interesting question to consider is whether athletes with adult attention deficit hyperactivity disorder (ADHD) are better athletes when treated with stimulants. Some athletes actually perform better when their ADHD symptoms are not treated with medication. A basketball player who has symptomatic ADHD may be more spontaneous or unpredictable for the opponent while another player with ADHD may have difficulty disciplining him- or herself to stay in position unless his or her ADHD symptoms are treated with medication.

The global demand for androgenic anabolic steroids has grown to serve multiple niche markets that include the elite athlete population along with much greater numbers of people employed in physically demanding occupations and other 'action-oriented' subcultures. The involvement of physicians in the doping of athletes must be understood in the larger context of the promotion of hormonal enhancements for entire populations of prospective 'patients'. In an era when testosterone-replacement drugs are being touted as an elixir of youth, distinguishing between traditional therapy and enhancement procedures is becoming increasingly difficult. Warnings against indiscriminate testosterone supplementation from medical authorities cannot compete in the media marketplace with drug company advertising. 'Doping doctors' can be seen as the **vanguard** of an army of medical practitioners who are leaving the traditional practice of medicine for the cash-only business of male hormone replacement therapy.

## Text 1: Questions 7-14

7. In the first paragraph, the writer suggests that physician involvement in sports 'doping'

- (A) has been conducted irresponsibly.
- (B) has been well-intentioned but misguided.
- (C) has received more attention than it deserves.
- (D) has succeeded in reducing the potential dangers.

8. In the first paragraph, the word **this** refers to doctors

- (A) pointing out the risks of harm from a particular drug.
- (B) providing information about the effects of drug-taking.
- (C) attempting to regulate an individual's drug consumption.
- (D) supporting an individual's efforts to reduce their drug intake.

9. In the second paragraph, the writer suggests that doctors involved in 'doping' risk

- (A) compromising their medical standards.
- (B) believing the message that they know everything.
- (C) becoming dependent on income from celebrity patients.
- (D) placing unrealistic performance demands on their clients.

10. The example of the truck driver is given to underline the idea that

- (A) performance-enhancing drugs have few adverse effects.
- (B) appropriate practice should be followed in every situation.
- (C) experienced doctors sometimes make errors of judgement.
- (D) amphetamines are commonly overused throughout society.

11. In the fourth paragraph, the writer suggests that medical science has advanced to the extent that

- (A) certain therapies are no longer banned in sports.
- (B) people can be more confident about their own health
- (C) some pathologic conditions have become normalised.
- (D) traditional boundaries of therapy have been broadened.

12. Specific sports are referred to in the fifth paragraph to exemplify the idea that

- (A) many athletes would prefer all medications to be prohibited in their sport.
- (B) a lack of self-discipline may drive athletes to seek medication.
- (C) medication can both help and hinder sports performance.
- (D) medication is routinely used to overcome fatigue.

13. In the final paragraph, the writer expresses some unease about

- (A) misconceptions regarding what testosterone is.
- (B) widespread marketing of testosterone supplements.
- (C) support given to drug companies by medical authorities.
- (D) questionable financial practices within the drug therapy industry.

14. The writer uses the word 'vanguard' in the final paragraph to suggest

- (A) a marketing initiative.
- (B) an economic incentive.
- (C) a likely future development.
- (D) an unexpected consequence.

## Text 2: Diagnostic errors in medicine

Mistakes happen, in medicine as in any other field. But medicine may be unique in the extent to which the scale of errors is contentious and perhaps unappreciated. A contributory factor, in many countries, is that deaths caused by medical errors can't be identified as such on the death certificate – there is simply no option to do so. And if you're not keeping records, you can't know the scale of the problem. However, even indirect methods of assessing error-associated mortality suggest that the figures are startlingly high, and that diagnostic errors represent an increasing proportion of the total.

This may be partly due to the nature of modern healthcare. After the patient presents with the initial complaint, each step in the diagnostic investigation presents the physician with a bewildering array of possible paths to take, in terms of what questions to ask and which investigations to order. In addition, the process is not linear in the way it is normally presented in textbooks. It is likely that a doctor will have to take a few steps back to find the right route, especially with more challenging cases. And it seems doctors often jump ahead as well as back – one study has shown that treatment alternatives are often evoked during the diagnostic assessment, before a final diagnosis has even been reached.

This latter finding is **counter-intuitive**, but could be relevant to the question of medical error. A well-understood characteristic of decision-making is that the initial hypothesis generation stage is very important. If we see someone behaving oddly in the street, we immediately form an idea as to why this might be. And once we have mentally structured a problem in a specific way, it can be very difficult to restructure it. This is exactly the same in a diagnostic situation. So, for example, a doctor who has not explicitly considered cancer at the start of a diagnostic process, will be much less likely to diagnose it at the end and refer the patient to a specialist.

So, how might diagnostic error be reduced? The first problem is disclosure, as without openness the problem cannot be tackled. Surveys suggest that an overwhelming majority of practitioners agree that serious errors should be disclosed to patients. Yet, while in one study 47% of pathologists questioned had been involved with a serious error, only 17% had actually disclosed a serious error to the patient. Clearly, the system prevents doctors from being as transparent as they would wish. Why should this be?

Firstly, it is natural to be concerned about one's reputation, and therefore, when things go wrong, instinct may tell us to keep quiet. But above and beyond this are fears for one's actual livelihood. In an age where an individual physician's error record may be posted on the internet, error disclosure could result in a fall-off in patients for that physician – not good in cultures where physician payment is based on the fee-for-service system. Compare this with the airline industry – it gives pilots a medal for admitting that they had a near miss, because it helps everyone to understand where the risks are. What's more, there's no risk to the pilot's job because the near misses aren't publicised per person - there is much to be said for this approach.

Even in situations where a doctor wasn't responsible for the error, it can still be difficult for them to disclose one that comes to their attention. They are faced with the option of talking to the physician at fault themselves, or going to the institution's risk management office . Generally they pick option one, as risk management is their absolute last choice. But **this** can contribute to errors remaining hidden, because it leaves the choice of how to proceed with the physician. And unsurprisingly – given the disclosure disincentives outlined above – sometimes the error report goes no further.

Then there is the fear of litigation. This is a consequence of the 'deny and defend' status quo, in which the default reaction of healthcare organizations is to deny responsibility for errors or any harm therefrom. From the patient perspective, 'deny and defend' has been said to be slow, inequitable, and inefficient; from the physician perspective, expensive, stressful and inclined to incentivize 'defensive medicine' i.e., the avoidance of higher-risk patients or procedures. In fact, most physicians have a very powerful moral compass and don't need fear of litigation to drive their behaviour in the right direction. For example, in a survey of 2,000 doctors in the US and Canada, disclosure rates were identical in these two countries despite their very different litigation environments. Perhaps then the litigation environment merely acts as a general stressor, which contributes to an environment of non-disclosure, but only drives non-disclosure in particular circumstances.

## Text 2: Questions 15-22

15. What point does the writer make about medical error in the first paragraph?
- (A) It varies enormously from country to country.
  - (B) Methods of reporting it are beginning to improve.
  - (C) Errors relating to diagnosis outnumber all others.
  - (D) The problem is likely to be worse than many believe.
16. What aspect of the diagnostic process is the writer drawing attention to in the second paragraph?
- (A) the input that patients like to have in it
  - (B) the time it takes to perform all the steps
  - (C) the indirect way conclusions are reached
  - (D) the quantity of data that needs to be analysed
17. Why does the writer use the word 'counter-intuitive' in the third paragraph?
- (A) He finds it worrying that doctors make diagnoses so quickly.
  - (B) He was surprised at the variation in doctor's treatment choices.
  - (C) He feels the study looked at the problem from an unusual angle.
  - (D) He would expect a doctor to diagnose a patient before treating them.
18. What potential problem is the writer describing in the third paragraph?
- (A) a natural preference for an easy solution
  - (B) people having a tendency to jump to conclusions
  - (C) causes of disease manifesting in very different ways
  - (D) doctors being wary of generating multiple hypotheses

19. What do the figures provided in the fourth paragraph reveal

- (A) There is a gap between doctors' intentions and their actions.
- (B) It is unclear why some types of error remain so under-reported.
- (C) Many doctors don't believe it necessary to report medical error.
- (D) The rates of medical error vary considerably across different fields

20. In the fifth paragraph, the writer praises the airline industry for

- (A) presenting errors to the public in a way that can be readily understood.
- (B) allowing those who acknowledge mistakes to remain anonymous.
- (C) making sure that all employees are aware of risk factors.
- (D) paying pilots in a way that is not linked to performance.

21. What does the word '**this**' in the sixth paragraph refer to?

- (A) a private conversation
- (B) postponing a decision
- (C) speaking to senior staff
- (D) passing the problem on

22. What conclusion does the writer come to about the fear of litigation?

- (A) It has had some positive impact on how doctors practise.
- (B) It is more of a problem for patients than doctors.
- (C) It is less of an issue than might be expected.
- (D) It drives some doctors out of the profession.

# WRITING SUB-TEST – TEST BOOKLET

## INSTRUCTIONS TO CANDIDATES

You must write your answer for the Writing sub-test in the **Writing Answer Booklet**.

You must **NOT** remove OET material from the test room.

## Occupational English Test

**WRITING SUB-TEST: MEDICINE**

**TIME ALLOWED: READING TIME: 5 MINUTES**

**WRITING TIME: 40 MINUTES**

Read the case notes and complete the writing task which follows.

### Notes:

Assume that today's date is 6 October 2021. Mr William McGuire (born on 23 May 1956) is a patient in your general practice.

#### PATIENT DETAILS:

**Name:** Mr William McGuire

**Residence:** 275 Queens Parade, Bay City

#### Social background:

65-year-old retired school teacher

Married, lives at home with wife

Ex-smoker (40 cigs/day for 40 years, quite 5 years ago)

**Family history:** Sister 72 y.o. – mild chronic obstructive pulmonary disease (COPD)

Sister 66 y.o. – rheumatoid arthritis & bronchiectasis

**Immunisation:** Fluvax up-to-date (no known allergies)

#### Past medical history:

(2017) Gout

#### History of presenting complaint:

**Aug 2019:** 4-month history chronic cough, ↑ dyspnoea  
Diagnosed with COPD

**Sep 2020:** 1st infective exacerbation of COPD  
Hospitalisation & IV antibiotics

**Jul 2021:** 2nd infective exacerbation of COPD  
Hospitalisation  
Sputum – pseudomonas aeruginosa  
IV antibiotics (ceftazidime & gentamicin) antibiotics; 6-week course of pulmonary rehabilitation with physiotherapist

#### Medications:

**COPD:** salbutamol (Ventolin) 100mcg 2 puffs p.r.n.  
salmeterol/fluticasone (Seretide) 500mcg/50mcg 1 puff b.d.  
tiotropium bromide (Spiriva) 18mcg 1 puff b.d.

**Gout:** allopurinol (Progout) 100mg 1 tablet b.d.

## Current presenting complaint:

06 Oct 2021:

- Subjective:** Slowly ↑ dyspnoea since last hospital admission  
No paroxysmal nocturnal dyspnoea (difficulty breathing at night)  
No orthopnoea (difficulty breathing when lying down)  
No haemoptysis, perirectal bleeding or melaena (dark, tarry stools)  
↓↓↓ ADL, loss of appetite, ↑ anxiety, ?depression
- Objective:** T – 36.7°C, P – 83 regular, Ht – 170cm, Wt – 78kg  
Hyperinflation, ↑ resonance, ↓ chest expansion, ↓ breath sounds)  
No wheezes/crepitations  
Jugular venous pressure not elevated (JVPNE), dual heart sounds; no murmurs, BP 140/80  
No anaemia
- Test results:** Normal – ECG & troponin (nil ischaemia), FBC (nil anaemia), CXR (nil pneumothorax/cancer)  
Peak expiratory flow rate (PEFR) – 320, FEV<sub>1</sub>% of 47%
- Assessment:** ↓ respiratory function with significant ↓ ADL  
Mild depression
- Plan:** ?psychologist for depression treatment  
Refer to respiratory specialist for assessment and advice on management:  
?intensification of treatment ?home oxygen therapy

## Writing Task:

Using the information given in the case notes, write a letter of referral to the respiratory physician, Dr Sutton, seeking follow-up assessment and advice on management. Address the letter to Dr Mandy Sutton, Department of Respiratory Medicine, Central Hospital, Bay City.

In your answer:

- Expand the relevant notes into complete sentences
- Do not use note form
- Use letter format

The body of the letter should be approximately 180–200 words.

Any answers recorded here will not be marked.

BLANK

**Occupational English Test****WRITING SUB-TEST: MEDICINE****SAMPLE RESPONSE: LETTER OF REFERRAL**

Dr Mandy Sutton  
Department of Respiratory Medicine  
Central Hospital  
Bay City

6 October 2021

Re: Mr William McGuire DOB: 23.05.56

Dear Dr Sutton

I am writing to refer Mr McGuire, who presented today with deteriorating respiratory function, for assessment and advice on management of his condition.

Mr McGuire was diagnosed with COPD two years ago. His risk factors include: smoking, for 40 years until 2013, and a relevant family history, sisters with COPD and bronchiectasis.

Mr McGuire has had two infective exacerbations of COPD (more than one year ago and three months ago), both requiring hospitalisation and IV antibiotics. He has undergone six weeks of pulmonary rehabilitation. He is immunised with Fluvax and currently managed on Spiriva, Seretide and Ventolin.

On examination, Mr McGuire had signs of hyperinflation, decreased chest expansion, increased resonance and decreased breath sounds. No wheezes or crepitations were audible. He has a PEFr of 320 and a FEV<sub>1</sub>% of 47%.

Mr McGuire's lung function has declined significantly since his last lung function test (FEV<sub>1</sub>% 66% in July). His daily activities are becoming severely curtailed and he appears to be experiencing mild depression. There is no evidence of an acute exacerbation or reversible cause of increasing dyspnoea (normal FBC/ECG).

Please review and advise regarding the need for potential intensification of treatment and/or home oxygen therapy

Yours sincerely

Doctor

**ROLEPLAYER CARD**

SETTING

TASK



**CANDIDATE CARD**

SETTING

TASK



# WRITING SUB-TEST – TEST BOOKLET

## INSTRUCTIONS TO CANDIDATES

You must write your answer for the Writing sub-test in the **Writing Answer Booklet**.

You must **NOT** remove OET material from the test room.

## Occupational English Test

**WRITING SUB-TEST: NURSING**

**TIME ALLOWED: READING TIME: 5 MINUTES**

**WRITING TIME: 40 MINUTES**

Read the case notes and complete the writing task which follows.

### **Notes:**

**Assume that today's date is 6 October 2021.** You are a community nurse in a rural town. Ms Patricia Wood is one of your patients. Today, she brought her mother, Ms Betty Wood, to see you.

#### **PATIENT DETAILS:**

**Name:** Betty Woods (Ms)  
**DOB:** 5 Jan 1962 (59 y.o.)  
**Address:** 15 Mayston Street, Nixville

**Medical history:** Lump right (R) breast last 6 months  
Post-menopausal

**Medications:** For 3mths taking mixture from natural medicine practitioner (on label: echinacea, garlic, turmeric, burdock, rose hip, ginseng, black cohosh)

**Family history:** No known family history breast cancer

**Social history:** Widow, lives alone; 2 daughters

#### **Presenting complaint:**

- Pt's daughter concerned:
- mother (Ms Betty Wood) has breast cancer
  - mother refusing to see a doctor

#### **Treatment record**

**06 Oct 2021** Pt reports lump has enlarged over last 6mths – convinced herbal medicine will fix it

**Subjective:** Doesn't want to see doctor – believes in naturopathic treatments. Fears being forced to have treatment she doesn't want, e.g., mammogram – frightened of machinery & distrusts technology

**Objective:** Post-menopausal woman, clean, dressed appropriately; physically fit and active  
Examination by nurse (after prolonged discussion): lump in R breast 5cm diameter, fixed, hard, not painful. Bloody discharge from nipple.  
Axillary lymph nodes non-palpable  
RR16, BP140/90 (moderate hypertension)

**Concern:** Unidentified lesion in R breast  
Pt refuses to see doctor

**Management:**

Long discussion with Pt:

- Pt finally agrees to 'think about' seeing doctor
- Must be female doctor (suggest daughter's doctor)
- Pt to discuss with doctor pharmaceutical/non-pharmaceutical management options
- Provided Pt advice: emphasis on decision about accepting treatment is hers; doctor can't coerce
- Worried about Pt's welfare; tried to build trust and rapport
- Pt agreed to return for monitoring of BP in three months

**Plan:**

Refer to daughter's GP; explain situation and Pt's concerns

**Writing Task:**

Using the information given in the case notes, write a letter of referral to Dr Mary Brown for assessment and management of the breast lump, briefly outlining your consultation with Ms Betty Wood today, and your concerns. Address the letter to Dr Mary Brown, Nixville Medical Centre, 15 Green Street, Nixville.

**In your answer:**

- **Expand the relevant notes into complete sentences**
- **Do not use note form**
- **Use letter format**

**The body of the letter should be approximately 180–200 words.**

Any answers recorded here will not be marked.

BLANK

**WRITING SUB-TEST: NURSING**  
**SAMPLE RESPONSE: LETTER OF REFERRAL**

Dr Mary Brown  
Nixville Medical Centre  
15 Green Street  
Nixville

6 October 2021

Dear Dr Brown

Re: Ms Betty Wood DOB: 05.01.62

Today your patient, Ms Patricia Wood, brought her mother, Ms Betty Wood, to see me because of her concern about a breast lump that her mother has had for six months.

Ms Betty Wood is a post-menopausal woman, who is physically fit. She generally refuses to see a doctor, but has agreed, after lengthy discussion, to consider seeing you to discuss management options for the breast lump. She has said that she does not want a mammogram because she does not trust technology and is generally anxious about being forced to have treatment she does not want.

Examination of Ms Betty Wood's right breast revealed a 5cm lump which was fixed, hard and not painful. She said it has enlarged over the six months. There was bloody discharge from the nipple but the axillary nodes were non-palpable. For the last three months, Ms Betty Wood has been taking a mixture provided by her naturopath. There is no known history of breast cancer in the family.

Please assess and manage Ms Betty Wood in relation to the breast lump. She would like to know about both pharmaceutical and non-pharmaceutical options.

Yours sincerely

Doctor

**ROLEPLAYER CARD**

SETTING

TASK



**CANDIDATE CARD**

SETTING

TASK

