OCCUPATIONAL ENGLISH TEST

Sample Test 1

LISTENING SUB-TEST – AUDIO SCRIPT

OCCUPATIONAL ENGLISH TEST. SAMPLE TEST ONE. LISTENING TEST.

This test has three parts. In each part you'll hear a number of different extracts. At the start of each extract, you'll hear this sound: ---*---.**

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 answers.

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. Now, look at the notes for extract one.

PAUSE: 5 SECONDS

Extract one. Questions 1 to 12.

You hear a physiotherapist talking to a new patient called Ray Sands. For questions 1 to 12, complete the notes with a word or short phrase. You now have thirty seconds to look at the notes.

PAUSE: 30 SECONDS

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Physiotherapist: Come in - Mr Sands, isn't it?

Ray Sands: *Err...that's right. Err…Ray Sands.*

Physiotherapist: Now I think you've been referred to me because you're suffering from sciatica.

Ray Sands: *Err…That's right. Not for the first time actually.*

Physiotherapist: OK, well I've got some notes here, but perhaps you can tell me, in your own words, about any previous bouts of sciatica you've had, erm…what treatment you had, what worked for you, anything else you can remember.

Ray Sands: *Well, it all started when I hurt my back, oh about eighteen months ago now – I was giving somebody a hand with a heavy suitcase and I felt it give out. You know, just like that. Anyway, I slowly got over that despite occasional flares and then out of the blue, about a year ago, sciatica developed. And it was six months till that finally cleared up altogether. Now it's come back… in, well the last month or so, I'd say.*

Physiotherapist: I see. And your physician said it was sciatica?

Ray Sands: *Yeah, I had this pain all the way down my right leg, and she said the real problem was in my back cos the sciatic nerve was getting trapped. I mean, I'm telling you this was no ordinary pain, it was really intense. I mean to the extent that I couldn't stand for very long, couldn't walk hardly any distance, I couldn't sleep. The most frustrating bit for me was that I couldn't even turn over in bed, it just hurt so much, I just couldn't get comfortable, you know what I mean? Sometimes I'd have a sort of …erm… tingling feeling in my calves as well, but then at other times my whole leg just felt a bit numb really. It, it was weird. And, of course, I couldn't go to work. I'm an events organiser so I travel around a lot, I'm setting things up for conferences, lugging stuff around you know, and so there was no way I could manage any of that the state I was in.*

Physiotherapist: OK, erm... so how was this treated?

Ray Sands: *Well err, in the first instance, I was given painkillers, obviously, err… Ibuprofen as far as I remember… err, and I was told to put compression packs on the affected area. I mean that did ease the pain a little, but I was still housebound practically speaking.*

Physiotherapist: OK.

Ray Sands: *Err…The physician sent me to see an osteopath and then I got some treatment there, but it didn't seem to make much difference, so I was referred to a sports injury specialist, of all things, err… and he did erm a number of things that did seem to ease things a little, like working on my spine and lower legs, oh and he… he gave me a set of exercises to do at home.*

Physiotherapist: I see, erm…any other treatment?

Ray Sands: *Err… oh yeah, I almost forgot, there was this course of injections and I went for various other therapies like ultrasound and another one where they do… well they use like, electrical impulses. I can't remember exactly what it's called. At one point I even considered acupuncture, but by then the other things were beginning to take effect and the symptoms were subsiding, so I thought I'd skip it.*

Physiotherapist: So which of these various treatments do you feel was most effective? Err, what made the difference?

Ray Sands: *Well I couldn't say for certain, because it all went on for four months without much improvement really. Then it wasn't until suddenly in the fifth month, things changed quite dramatically. So to be honest with you, I think it was the combination of treatments gradually taking effect and coming together rather than one single thing making the difference.*

Physiotherapist: OK, and did anyone ever talk to you about what might be causing the problem?

Ray Sands: *Well, I think everyone assumed that a slipped disc was behind it all, but this was never actually confirmed as that. I mean, I know there is this other condition where you get a lot of pain in the buttocks, but that wasn't my experience.*

Physiotherapist: OK. And did anyone talk to you about aspects of your lifestyle that might be contributing to the problem?

Ray Sands: *Well, I remember… [fade]*

PAUSE: 10 SECONDS

Extract two. Questions 13 to 24.

You hear a consultant dermatologist talking to a patient called Jake Ventor. For questions 13 to 24, complete the notes with a word or short phrase. You now have thirty seconds to look at the notes.

PAUSE: 30 SECONDS

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Dermatologist: Jake Ventor? Please come in and take a seat.

Jake Ventor: *Thanks.*

Dermatologist: OK, now, I understand from your GP that you've got a problem with your hand?

Jake Ventor: *Yes, I went to see her a couple of weeks ago because of a sore on my left hand. I've had it for years, but not all the while. You know, it appears, then it gets better, then it comes back. It's here on the palm, it's almost gone now, but she wasn't sure what it was, so she said I'd better see a dermatologist. She took a photo, did you get that?*

Dermatologist: I did, I did, yes. So... so tell me a bit about the condition, how it feels, and...

Jake Ventor: *Well, I always know when I'm going to get it because I have this itching beforehand, I wake up at night wanting to scratch the area, though I try to stop myself. Then, a few hours later, I get one or two little blisters, and they gradually get bigger and join up into one big one. It all feels a bit hot and the skin around it goes red. When I showed this to the doctor, she used the word 'chaotic' to describe it. Anyway, it gradually dries up and I get a scab. Then, after about two weeks, that falls off and there's just a little red patch, like you can see now.*

Dermatologist: OK.

Jake Ventor: *I've been getting it for years, um... I actually got it the first time when I was in China in the 1990s. I had a job there for a couple of years before I came back here. Err… That first time, I also had a similar sore on my chest, but that's never come back. But the one on my hand, that comes back every year or so, but never in exactly the same place. I thought it'd sorted itself out, 'cos I didn't get it for a couple of years – but then it came back. So, there's, there's no pattern, it's not getting more frequent or anything, and it doesn't seem linked to anything in my daily life, like it doesn't seem to happen when I'm run down for example, or because of anything in my diet, or if I'm under a lot of pressure at work, that sort of thing. So, the doctor thought you needed to have a look, also because I had a malignant melanoma on my back that was removed in 2006. It was at quite an early stage and it hadn't got too deep.*

Dermatologist: OK well, that's good. Still, I'll just have a look at your back… Was it down here?

Jake Ventor: *Yeah, that's right.*

Dermatologist: OK, well… Yep, that all looks absolutely fine. Well, I don't think you need to worry about anything sinister here. By the way, have you ever had cold sores?

Jake Ventor: *No, never. But I did wonder if this thing on my hand was something like that. In fact, I wanted to ask you about that. There's an antiviral cream you can use, isn't there, to stop them developing. I wondered if you could prescribe me something like that.*

Dermatologist: Look, the trouble is, these work well on the mouth because the skin's very thin there, but I'm afraid they won't have any effect in your case, because the skin on your hand's so much thicker.

Jake Ventor: *Oh, I see. And something else that worries me is whether there's a chance of infection. Should I be covering the place up?*

Dermatologist: No… No… You don't need to unless there's broken skin. It's fine.

Jake Ventor: *Good. And it's not actually having an impact on my quality of life or anything like that. It's something I can live with. I mean, I have done for all these years.*

Dermatologist: OK… so, so really, the reason you went to the doctor after all these years was just to see if there was any way we could prevent this happening. Ok, well… at this stage, the best thing to do is organise a biopsy, it might be a bit uncomfortable, but it means we can rule certain things out.

Jake Ventor: *OK.*

PAUSE: 10 SECONDS

That is the end of Part A. Now look at Part B.

PAUSE: 5 SECONDS

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 to 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. You hear a nurse briefing her colleague about a patient. Now read the question.

PAUSE: 15 SECONDS

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Nurse: Mrs Green was admitted last night for pneumonia. She came in yesterday with a cough, fever, dizziness, and chest discomfort. She's a healthy sixty-year-old with a history of right knee replacement five years ago. She's on a regular diet and has no allergies. She's at high risk for falls due to her dizziness. We changed her IV antibiotics to oral, which she's tolerating well. Her assessment is within normal limits, except for some mild shortness of breath and wheezing. Her vital signs are stable, oxygen saturation is 98% on one litre, and she's been comfortable during my shift. Around 5.30, I gave her two paracetamol for minor pain, with good results. She has an 18 gauge in her left arm. She's got normal saline at 15 mils per hour.

PAUSE: 5 SECONDS

Question 26. You hear the manager of a care home for the elderly talking to the nursing staff. Now read the question.

PAUSE: 15 SECONDS

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Manager: Now, a quick word about the administration of medication. It's great to see how carefully you're all following the new guidelines and, thanks to this, error rates, which were always below average anyhow here, have dropped by 40%. The surveys we've done also throw up some interesting findings, like mistakes being more common in the morning than afternoons or evenings. We're not sure why, but there's a clear pattern. Also, we know that being disturbed for any reason while working out and preparing doses is a common reason for mistakes. So, please try and avoid distracting your colleagues while they're doing this. Finally, we must be on the lookout for drug interactions, side-effects and patient sensitivities. Fortunately, we haven't had too many problems of this nature, but the care needs of the vast majority of our residents are often quite complex.

PAUSE: 5 SECONDS

Question 27. You hear part of a morning briefing on a hospital ward. Now read the question.

PAUSE: 15 SECONDS

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Ward manager: Right, so overnight admissions to the ward. Greg, could you start us off?

Greg: *Sure. We have Sue Deans in bed five. She's a 54-year-old female who was brought into the Emergency Department by police overnight. She has a history of poorly controlled paranoid schizophrenia. She presents with chronic persecutory and paranoid delusions, and also significant thought disorder. She's to remain in High Dependency Unit care until the stabilisation of her symptoms. We'll be observing her every 15 minutes, and monitoring the level of her distress, psychosis and any response to interventions offered.*

Ward manager: OK. I'll review the clinical and detention status this afternoon. Now what's the plan for discharge?

Greg: *Social work intervention's required for placement and community support options, and that's been booked for tomorrow. Also an application for the appointment of legal guardian may be required.*

Ward manager: Right. We'll consider that at tomorrow's ward round.

PAUSE: 5 SECONDS

Question 28. You hear part of an ante-natal consultation at a GP practice. Now read the question.

PAUSE: 15 SECONDS

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GP: Mrs Summer, how can I help today?

Mrs Summer: *Well, I just wanted to check something.*

GP: OK. So, you're having a home birth?

Mrs Summer: *Yeah, though everyone's on at me about going into hospital. I had my last child there, but I'm determined to be at home this time to feel more relaxed as well as safe. But I wondered about an at-home epidural if I wanted it? Going without wouldn't put me off though.*

GP: An epidural's out, I'm afraid, 'cos we can't do it without an anaesthetist. Just pethidine or gas and air. But they're very effective painkillers.

Mrs Summer: *Yeah, pethidine's good.*

GP: And you had a bad patch after giving birth last time?

Mrs Summer: *Yeah, I got really depressed, I couldn't understand it. It was short-lived though, and I'm better prepared now. It can't be prevented, but I have read up about coping strategies.*

PAUSE: 5 SECONDS

Question 29. You hear a trainee doctor telling his supervisor about a problem he had carrying out a procedure. Now read the question.

PAUSE: 15 SECONDS

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Supervisor: So, how's today gone, Harry?

Harry: *Well, I'm afraid I had a problem taking blood from Mrs Harris. I've… I've done that procedure numerous times now, so I wasn't particularly worried. What I hadn't anticipated was the difficulty finding a vein. I suspect her illness means she'll have had a number of cannulas inserted over the weeks she's been here, and that's led to collapsed veins.*

Supervisor: Well, that can happen with long-term elderly patients. And it's distressing for them if the procedure isn't done quickly.

Harry: *Oh, she… she endured it without a murmur. I'm sure I would've made a fuss, in similar circumstances.*

Supervisor: Well, I'll supervise you the next time you do it.

PAUSE: 5 SECONDS

Question 30. You hear a doctor talking to a teenage boy who has a painful wrist. Now read the question.

PAUSE: 15 SECONDS

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Doctor: Now then, I understand you fell off your skateboard some days ago and injured your wrist, is that right?

Teenage boy: *Yes, I slipped and put my hand out to save myself. My mum says I've sprained it.*

Doctor: You've certainly got some swelling and bruising there, but I don't think your mum's right in this case. Does your wrist hurt?

Teenage boy: *It aches, but the pain's worse when I try to grip something.*

Doctor: Right, well, I suspect you've broken what's called your scaphoid bone. It's a classic injury resulting from what you describe. I can't feel any other fractures, but you'll need an X-ray to see where the two ends of the bone are. If they're not meeting up properly, you'll need an operation to sort that out, but let's see the results first.

Teenage boy: *Oh, OK.*

PAUSE: 10 SECONDS

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

PAUSE: 5 SECONDS

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 to 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.

Extract one. Questions 31 to 36. You hear an interview with a cardiologist called Dr Jack Robson, who's an expert on Chagas disease.

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

PAUSE: 90 SECONDS

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Interviewer: Today we're talking to Dr Jack Robson, a cardiologist and Chagas disease specialist in the USA. Dr Robson, what is Chagas disease and why is it referred to as a neglected disease?

Dr Jack Robson: *Chagas is caused by a parasite called Trypanosoma cruzi. Most sufferers become infected when they're bitten by an insect, commonly known as the kissing bug, which carries the parasite. People often don't realise they've been bitten, and during the initial phase of the infection, symptoms are normally mild or absent. Seventy per cent of those infected never develop complications. For the other thirty per cent, the disease tends to remain silent for a long time, often thirty years, but it eventually enters a chronic phase characterised by serious cardiac, digestive system and neurological disorders. About seven million people worldwide are thought to have Chagas, but it attracts relatively little publicity or funding for research. This indifference is largely down to it being primarily a disease of marginalised communities in Latin America, where it's endemic. You need resources to force significant action.*

Interviewer: Right, I see. Are there concerns in the USA about Chagas?

Dr Jack Robson: *Yes. The insect carrying the parasite is actually endemic to the southern US states. Since 1955, however, no more than thirty people have been bitten and infected while in the USA. The alarming thing, though, is that it's become apparent that large numbers of first generation, and some second generation, immigrants from Latin America carry Chagas*

– around 300,000. These people won't infect others apart from congenitally and possibly through blood transfusion, but a significant proportion end up chronically ill.

Interviewer: And, for the benefit of our listeners, can you describe an individual case?

Dr Jack Robson: Well, this year a Bolivian woman, let's call her Marisol, asked me if she could be tested for Chagas. She's a long-term US resident, but she'd recently been on vacation in Bolivia and, at one point, had felt unwell. This often occurs with changes in diet and living conditions, and that's what Marisol assumed was the cause. She'd actually been planning to donate blood in Bolivia, but changed her mind at the last minute. Ironically, if she'd gone ahead, the screening would've detected Chagas. Hearing, from relatives, that Chagas can be transmitted congenitally was what prompted Marisol to come to my clinic – she and her partner wanted to start a family and she was scared that she might pass the parasite on. Tests then showed she did indeed have intermediate-stage Chagas.

Interviewer: And what issues can arise in treating Chagas?

Dr Jack Robson: Well, another patient, I'll call her Jennifer, felt unwell following a vacation in a region where Chagas is endemic. Tests indicated she was Chagas-positive. Jennifer was then referred to my clinic where we do further tests. Meanwhile, she looked up Chagas online and, understandably, was distressed by what she read, 'why me?' she once said to me. She was also fearful about taking benznidazole, the main drug used for Chagas, because it has potentially harmful side-effects. For optimum impact, it should be taken in the first two months of the disease, but by the time the testing had been completed, ten weeks had passed since the likely date of the bite. For information, Jennifer took benznidazole and didn't react badly to it.

Interviewer: And do you deal with patients in later stages of the illness?

Dr Jack Robson: Yes. I have a sixty-two-year-old patient called Juan. Eight years ago, he was diagnosed with dilated cardiomyopathy, and Chagas was also detected in him. If he'd been tested for Chagas earlier in his life, his long-term prospects would've been better. A year after the diagnosis, Juan was found to have type-two diabetes. This was dealt with relatively well, though his body did initially reject insulin. Juan took drugs for his heart, and for several years was reasonably stable, but eventually, monitoring revealed severe cardiac deterioration. His experience is very much what you'd expect in someone who's had the disease for years and it's reached the latter stages. There's no cure and the main recommendations are rest, exercise and appropriate diet.

Interviewer: I see and um... what can be done to combat Chagas generally?

Dr Jack Robson: Plenty. Researchers are working on improved drugs to treat it, and a vaccine, none currently exists, but it takes at least ten years to supply a new drug. Another idea is to develop the existing drugs in tablets of different sizes. That could and should be done almost overnight. What's currently available is designed for adults, even though infants often have the disease. There are also some very important programmes using insecticides and other methods to wipe out the bugs that transfer Chagas to humans, but initiatives like those take decades rather than years.

Interviewer: Well, Dr Jack Robson. Thank you very much for speaking to us today.

PAUSE: 10 SECONDS

Now look at extract two.

Extract two. Questions 37 to 42. You hear an occupational therapist called Anna Matthews giving a presentation to a group of trainee doctors.

You now have 90 seconds to read questions 37 to 42.

PAUSE: 90 SECONDS

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Anna Matthews: Hi. My name's Anna Matthews. I'm an occupational therapist working here in the hospital. In a moment, I'm going to present a case study to you, to show you the type of work I do. But first, let's think about what we understand by occupational therapy and the part it plays in patients' recovery.

In simple terms, therapists like me help patients of all ages to participate in the things they want or need to do, through the therapeutic use of a range of recognised activities. For example, this could be helping patients who are recovering from illness or injury to regain skills and get back to work; or it could be supporting older adults who are going through physical and cognitive changes. What I always have to keep in mind, however, is what the individual wants to achieve. I always say that a doctor's first question is 'What's the matter with you?', whereas my first question is 'What matters to you?'

Now, on to my case study. It involves a patient called Ted, a sixty-year-old man whose motorbike was in collision with a car. Luckily, the accident happened at moderate speed, but he still suffered compound fractures in both legs, in one arm, and several broken ribs. When I first met him, after two weeks in hospital, he was physically and emotionally broken. After all, not only was his mobility in question but, much more importantly, so was his style. Doctors had told him that he might never be able to squeeze into his motorbike leathers again, so he'd given up. Imagine how he must've felt. One day totally independent and the next, suddenly unable to do things any more.

Ted showed little interest in receiving treatment. Some colleagues at the hospital took the view that if he stubbornly refused to help himself, there was little they could do, it was his right, they said. But I didn't agree. Since Ted couldn't use his legs or right arm, I made sure we concentrated on what he could do with his left hand. For example, I worked on strategies to help him dress himself, and things like that. We even worked on fine motor skills, like writing with his left hand. I wanted to make sure that even if he didn't ever regain use of his right arm, I could at least get him to function by whatever other means were open to him.

So how did my therapy help? Well, I worked with Ted on his hands, putting playing cards on a table and getting him to pick one up, which he couldn't do. But he then resorted to sliding the cards off the table and picking them up that way, finding a way of compensating for what he couldn't do. He'd become upset about what he felt was his lack of progress, relearning to do things you used to do with ease can be frustrating. But, in time, I got him to see that if he didn't work with me, then he'd stay as he was for the rest of his life. That was a big motivating factor.

Ted had therapy for eight months, and he had his ups and downs. For example, the day when he finally had the plaster casts removed from his legs. He built it up in his mind into a great step towards independence. In reality, of course, it wasn't. He was still unable to stand because he'd lost a lot of strength, and the doctors were still predicting he'd remain in a wheelchair. Although I'd warned him about all this, that moment still came as a big disappointment. But strangely, when something like that happens, it can be a turning point. Like many patients, Ted became even more determined to regain mobility after that.

Anyway, you'll be delighted to know that Ted's story had a happy ending. He's now back at home and back at work too. Learning to walk again took every ounce of energy he had, but patients like Ted, with that fighting spirit, go from strength to strength after discharge. That's where the support of family can be invaluable – as long as they don't inhibit the patient by warning them of potential dangers at every turn! But patients like Ted tend to take charge of their own ongoing recovery, gym membership, therapy regime, that kind of thing. Seeing that gives me a real sense of pride in the work I do and the difference it can make to people.

PAUSE: 10 SECONDS

That is the end of Part C.

You now have two minutes to check your answers.

PAUSE: 120 SECONDS

That is the end of the Listening test.