

READING SUB-TEST – QUESTION PAPER: PARTS B & C

TIME: 45 MINUTES

INSTRUCTIONS TO CANDIDATES

DO NOT open this **Question Paper** until you are told to do so.

One mark will be granted for each correct answer.

Answer **ALL** questions. Marks are **NOT** deducted for incorrect answers.

At the end of the test, hand in this **Question Paper**.

DO NOT remove OET material from the test room.

HOW TO ANSWER THE QUESTIONS

Mark your answers on this **Question Paper** by filling in the circle using a 2B pencil. **Example:**

(A)
(B)
(C)

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.

Fill the circle in completely. Example: ☐ A ☒ B ☐ C

1. What does the email tell staff about the update to asthma guidelines?

- ☐ A Objective testing is now given greater emphasis.
- ☐ B Comparison of medication types is now possible.
- ☐ C The stages of treatment are now easier to understand.

To:

All local GPs

From:

General Hospital

Subject:

Update to asthma guidelines

The updated national asthma guideline has now been published. The update focuses on the chapters on diagnosis and pharmacological therapy.

The updated Diagnosis chapter continues to reinforce the importance of proceeding towards a diagnosis based on the probability of asthma, and that asthma is a variable condition for which there is no definitive diagnostic test. It suggests that objective testing can be useful, but should take place in the context of a 'structured clinical assessment'.

In the Pharmacology chapter, there are some significant changes to the presentation of the familiar steps of asthma management, and to comparing inhaled corticosteroid (ICS) strengths. A phased approach to treatment is still recommended, but the numbering of the steps has been replaced by more helpful descriptions. The new banding of ICS by strength should be more accurate and straightforward in practice.

2. According to the policy document, valuables belonging to a hospital in-patient who dies should

- (A) be labelled and stored in a secure manner.
- (B) be documented and deposited for safekeeping.
- (C) be kept with the body until the family is contacted.

Patients' property

When a patient is admitted, relatives should be asked to take valuables/property home if possible. If this is not possible any valuables will be recorded in the Property Book and placed in a sealed envelope.

Where a patient dies in the care of the hospital and no relatives are present, valuables should be recorded using the Property Book and sent to the cashier's office. All clothing should be placed in a sealed bag marked with the patient's name and hospital and transferred with the body to the mortuary.

If a patient is certified dead on arrival then his/her property, clothing and valuables should not be removed, but should be transferred with the body to the mortuary.

3. What does the guideline extract tell medical staff about PPCA?

- ☐ A the limitations which are being introduced regarding its use
- ☐ B why it is now considered appropriate for certain patients
- ☐ C by which delivery methods it will be permitted

Proxy patient-controlled analgesia (PPCA) for paediatric patients

The utilisation of PPCA, where analgesia is controlled by a patient's parent, has historically been restricted due to concerns over patient safety. Parental participation has been limited to assessment and reporting of their child's pain to healthcare professionals, rather than their being trained to take on responsibility for the administration of bolus doses of analgesia. Although this is entirely appropriate in a patient population which is opiate naïve and with limited pain experience, the palliative care population has different characteristics. There, patients and parents are experienced in the assessment and management of pain, and in utilising oral, buccal and transdermal analgesic preparations including opioids. The children who may derive enhanced pain management from this method of analgesic delivery are recognised to have experience of opiates during their illness trajectory, and be more likely to require assistance in initiating bolus analgesia as a result of their illness.

4. What can staff find out from this policy statement?

- ☐ A where to transport different kinds of hospital waste
- ☐ B who is responsible for the disposal of infectious waste
- ☐ C how to identify the various categories of waste receptacle

Waste management policy

- The transportation of waste is a process that should begin at the site of generation where infectious (orange bag), offensive (yellow/black tiger stripe bag) and domestic (black bag) waste must be properly collected and segregated in specific bags and containers.
- The housekeeping staff/site manager/porter are to ensure that trolleys are checked for cleanliness after every use, cleaned if required and that all equipment has the periodic deep clean as per National Standards of Cleanliness.
- Waste bags must never be transported in the same trolley at the same time as sharps boxes, pharmacy waste containers (blue lidded bin) or placenta containers (red bin), as the hard containers are likely to split the plastic bags.
- All waste streams when being transported must be segregated at all times to ensure no contamination. A separate trolley/collection is required for each waste stream.

5. What should determine whether or not to use a wipe to disinfect an ICMD?

- (A) the design of the device
- (B) the number of devices available
- (C) the time needed to disinfect the device

Guidelines for the disinfection of ICMDs (intracavity medical devices)

It is important that the disinfectant is in contact with all surfaces of the ICMD and that it remains liquid for the recommended contact time. This is more easily achievable with an automated washer-disinfector or by partial immersion in disinfectant. Disinfectant-impregnated wipes are widely used, but the assurance that all surfaces are in contact with liquid disinfectant for the required time is not easy to achieve as a high-quality assurance standardized process. Therefore, best practice is the use of an automated system or partial immersion, with manual disinfection of any parts that cannot be thus treated. If this is not practical due to the complexity of the device, then wipes may be used. The lack of sufficient devices and requirement for a rapid turnaround should not be seen as the sole reasons for the acceptability of disinfectant wipes.

6. What does this extract from the new guidelines mention?

- (A) criteria for determining whether enteral feeding is appropriate
- (B) procedures for administering enteral feeding to malnourished patients
- (C) problems which may occur when enteral feeding continues over an extended period

MEMO
To: All Staff
<p>Please see below for the latest amendments to the hospital's Indications for Enteral Feeding Guidelines:</p> <ul style="list-style-type: none"> • Decisions on route, content, and management of nutritional support are best made by multidisciplinary nutrition teams. • Healthcare professionals should aim to provide adequate nutrition to every patient unless prolongation of life is not in the patient's best interest. • Results of admission nutritional screening are recorded in the notes of all patients with serious illness or those needing major surgery. • Artificial nutrition support is needed when oral intake is absent or likely to be absent for a period of 5–7 days. • Earlier instigation may be needed in malnourished patients. Support may also be needed in patients with inadequate oral intake over longer periods.

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.

(A)
(B)
(C)
(D)

Fill the circle in completely. Example:

Text 1: Organ Donation in Australia

Australia has some of the world's highest organ transplant success rates, but rates of organ donation from the deceased are among the lowest in the developed world. For many years now, enormous attention - and funding - has been devoted to finding ways of raising low organ donation rates. Between 1989 and 2008, more than twenty public and government-led initiatives were launched to address matters believed to be its cause. Unfortunately, they proved ineffective and cumulatively resulted not in an increase, but rather in a decline of around 20%. These outcomes illustrate some fundamental misconceptions about why Australia has such a low rate of organ donation, based on five myths.

The first myth is the assumption that Australians are less altruistic than other people. The truth, however, is that Australia compares favourably with other developed countries in terms of how much money is given to those in need. In fact, it ranks sixteenth in the world for Official Development Assistance donations, ahead of the USA, Portugal and Italy – countries leading the world in organ donation rates. What's more, Australia's living-kidney donation rates are high — several times higher, in fact, than those in Spain, France, Austria and Italy, which have the world's highest deceased organ donor rates.

A second myth concerns the consent rate: the percentage of people who agree to donate their deceased relatives' organs. Many believe that Australia has a very low consent rate for organ donation and, as a result, a low deceased donation rate. In fact, whilst Australia's current consent rate of 57% is not as high as world-leading Spain (82%), it's similar to other top donor countries such as France (63%) and the USA (50%). And the fact that other countries maintain much higher donation rates with similar or even lower rates of consent shows that consent alone isn't a sufficient explanation for Australia's low rate of deceased organ donation.

Another myth is the idea that the registration of one's wishes regarding organ donation ensures that individuals will become donors when they die. This is false, for two important but very different reasons. First, the odds that an individual's death will lead to donation is slim (less than one in four-hundred) because types of death that allow donation are very rare, and typically involve very specific types of brain trauma. Second, even if a person has registered with all the relevant bodies and stipulated in their will that they wish to be a donor, should the opportunity arise, their family will make the final decision. Australian families refuse organ donation requests about 40% -50% of the time.

Yet another myth is the theory that Australia has such a low organ-donor rate because of its low death rate. In other words, young people who could become donors don't die as often in Australia due to high levels of public health and safety. While it's true that Australia's death rate is lower than many countries in the world, it's on a par with that of countries such as the USA, which has a high organ-donation rate as well as a low death rate. Moreover, only certain infrequent types of death can lead to donation — most often linked to specific forms of trauma - such as accidents, gunshots and strokes. Rates for these types of deaths are similar in most developed countries.

The final myth is the misconception that the countries with high rates of organ donations from deceased individuals are those that have 'presumed-consent' systems. An individual is presumed to have given consent to donating their organs if they haven't informed authorities that they're opting out. While it's true that the majority of countries with the highest donation rates have presumed consent (or 'opt out') legislation, so too do many of the worst-performing countries. It's also incorrect to assume that presumed consent means that organs will necessarily be removed from deceased persons in these countries unless they've expressed prior written opposition to donation. Virtually all presumed consent countries won't proceed with donation unless the family of the deceased approves.

Australia's failure to increase organ-donation rates despite decades of effort suggests that many things aren't understood about how to increase rates of donation there. But the idea that the country is somehow fundamentally different to world leading donor countries, in ways that make it impossible for it to become a world leader in organ donation, is false. The fact that there are similar rates of deaths that lead to high rates of organ donation in other countries represents a very real opportunity for Australia. By converting the tragedy of these deaths into opportunities to save the lives of others, Australia can become a world leader in organ donation – just as it currently leads the world in transplantation success. Taking this lead means abandoning the convenient mythologies of the past and the adoption of proven practices from other countries.

7. The first paragraph refers to organ donation schemes which
- (A) failed in their objectives.
 - (B) produced misleading results.
 - (C) were managed in an inefficient way.
 - (D) were introduced at an inappropriate time.
8. In the second paragraph, the writer dismisses the idea that
- (A) Australians are unaware of the shortage of deceased organ donors.
 - (B) people in developed countries are more likely to help those in need.
 - (C) there is a correlation between social attitudes and living kidney donation.
 - (D) inhabitants of Australia are not as generous as those of other countries.
9. In the third paragraph, the writer mentions France and the USA to make the point that
- (A) it is essential for Australia to increase its consent rate.
 - (B) consent rates vary considerably from one country to another.
 - (C) a low consent rate does not necessarily result in a low donation rate.
 - (D) countries with high donation rates generally have high consent rates.
10. What particular issue related to organ donation is highlighted in the fourth paragraph?
- (A) lack of clarity regarding the wishes of the deceased
 - (B) the likelihood that the cause of death will make it impossible
 - (C) the small number of individuals who confirm their willingness
 - (D) disagreement among surviving relatives about whether to go ahead

11. The writer uses the phrase 'on a par' in the fifth paragraph to suggest that
- (A) a figure is surprisingly high.
 - (B) the figures may be misleading
 - (C) two figures are roughly similar.
 - (D) it's hard to arrive at an exact figure.
12. What does the word 'those' in the sixth paragraph refer to?
- (A) countries
 - (B) high rates
 - (C) organ donations
 - (D) deceased individuals
13. What is stated in the sixth paragraph about 'presumed consent' countries?
- (A) A large proportion of their citizens choose to opt out.
 - (B) The legislation they require is unnecessarily complex.
 - (C) Their authorities may overrule families' objections.
 - (D) Some of them have rather poor donation rates.
14. What is the writer doing in the final paragraph?
- (A) expressing optimism about Australia's potential to improve donation rates
 - (B) outlining differences between Australia and countries with higher donation rates
 - (C) recommending a range of specific strategies for boosting Australia's donation rates
 - (D) analysing the mistakes made in previous attempts to raise Australia's donation rates

Text 2: Breaking bad news

No one seems to find it easy to talk about bad news with a patient, and although much has been published about patients' reactions, there is relatively little documentation of medical professionals' feelings in this situation. By 'bad news' I mean any information likely to drastically alter a patient's view of their future, whether at the time of diagnosis or when facing the failure of curative intention. Naturally, how bad the news is will depend to some extent on the patient's expectations at the time, on how ill they actually feel, and on whether or not they already know or suspect their diagnosis or current state.

The worst fear for medical professionals - particularly less experienced ones - is that the patient will blame them personally for the bad news that they bring. Of course, the phenomenon of identifying the bad news with the bearer of it isn't unique to our profession. At its heart is the issue of how easy it is to find a target for the blame: if someone officially in authority conveys the bad news, it becomes easier to direct the anger aroused by the news itself at this person. Therefore, as medical professionals, we should naturally expect this kind of reaction from our patients when it falls to us to deliver bad news.

Not every patient responds to bad news by blaming the medical professional who is caring for them, but it happens often enough for many of us to fear it before we start the conversation, or possibly not to have the conversation at all. Even those of us with many years' experience may find ourselves relieved when a patient says something like 'actually I knew it was cancer anyway', and we realise that we have been **let off the hook**. However, all of us need to bear in mind that the act of blaming is simply another reaction to be dealt with, as we would inflammation or haemorrhage, and isn't to be taken personally.

By the time they qualify, all medical practitioners should have been trained in the management of common medical crises. Nevertheless, many of us may not have had any specific training in communication skills in general, or in talking to dying patients in particular. As we progress professionally, and get better at doing the things that we've been trained for, we feel more and more awkward when we encounter problems for which we haven't been prepared, and this may put us off trying to face up to them.

There is also concern about what may happen once the conversation actually starts. What happens if the patient has a 'bad reaction', such as bursting into tears in the middle of a ward or a busy clinic? Not knowing how to deal with the consequences of what we say breaks one of the most important rules of accepted professional behaviour. It makes us appear inadequate in our own eyes and those of others. It's generally regarded as better for all involved if interactions with patients go 'smoothly'.

We are trained to behave calmly in emergencies, to suppress any panic that we may be feeling. This is unarguably appropriate professional conduct. It can, however, make it difficult to learn to express sympathy and other emotions that might sometimes be helpful to patients. I don't wish to imply that any medical professionals are unsympathetic, merely that, having learnt how not to express panic or anger, it may sometimes be necessary to make a conscious effort to relearn how to show common human sympathy. I've often heard doctors say how much easier it is to talk to a friend or a neighbour about the way a disease is affecting them than it is to talk to a hospital patient with the same condition. Perhaps in the clinical setting it's easy to become overwhelmed by the weight of clinical responsibility and to use authoritative language to cover up therapeutic failure. The unintended consequence may then be that **this** also serves to disguise sympathy.

There is a most unfortunate particularity of the English language that makes this difficulty even worse: the words 'I'm sorry' have two quite distinct meanings. They may be used to mean 'I'm sorry that I did this,' which implies responsibility; or they may be used to mean 'I'm sorry for you' – to express sympathy. This means that even if a practitioner overcomes their professional reserve, they may feel that by saying 'sorry', they may be inviting the patient to blame them. The knack of expressing sympathy clearly without inadvertently accepting responsibility is a difficult tightrope to walk and needs to be taught and demonstrated to all those in our profession. Talking to seriously ill patients isn't a divine gift – it can be taught like any other aspect of medical care.

15. In the first paragraph, what point is made about patients who have received bad news?

- (A) Their demands cannot always be met.
- (B) Their responses have been thoroughly investigated.
- (C) They may not always be honest about their experiences.
- (D) They have complained about the way they were spoken to.

16. What is the writer doing in the second paragraph?

- (A) describing a means of solving a problem
- (B) explaining why something often happens
- (C) justifying a suggestion which has been made
- (D) giving an example of something already mentioned

17. The phrase 'let off the hook' in the third paragraph suggests that someone has

- (A) made an unwise decision
- (B) failed in their duty of care
- (C) avoided a difficult situation
- (D) shown they can solve a problem

18. The writer's main point in the fourth paragraph is that medical practitioners

- (A) risk forgetting what they initially learned.
- (B) are encouraged to specialise too narrowly.
- (C) are given too few opportunities to gain expertise.
- (D) become increasingly uncomfortable with the unfamiliar.

19. In the fifth paragraph, the writer suggests that medical practitioners worry about

- (A) wasting people's time.
- (B) losing people's respect.
- (C) hurting people's feelings.
- (D) revealing people's details.

20. What feeling does the writer express in the sixth paragraph?

- (A) understanding of the reasons for certain behaviour
- (B) surprise at the differences in approach to a problem
- (C) concern for the welfare of patients in certain settings
- (D) impatience with some critics of the medical profession

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

- (A) becoming overwhelmed
- (B) using authoritative language
- (C) covering up therapeutic failure
- (D) the weight of clinical responsibility

22. In the final paragraph, what does the writer say about communicating bad news?

- (A) It should only be done by suitably qualified people.
- (B) It can be regarded as rather unkind.
- (C) It requires a great deal of courage.
- (D) It is a skill that can be learned.

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