OCCUPATIONAL ENGLISH TEST

Sample Test 3

LISTENING SUB-TEST – ANSWER KEY
PARTS A, B & C

LISTENING SUB-TEST – ANSWER KEY

PART A: QUESTIONS 1-12

1 left knee

2 (an) insect bite

3 cholesterol

4 excruciating

5 drive

6 septicaemia

septicemia

7 rugby

8 anti(-)inflammatories

9 (awful) diarrhoea

diarrhea

10 liquid morphine

11 (an) ice pack

12 (a) skin rash

PART A: QUESTIONS 13-24

13 jet lag

14 meningitis

15 Malarone

16 sweating

17 splitting headache

18 jaundice

19 (really) racing

20 eyes

21 abdominal discomfort

abdominal pain

22 hepatitis A

23 cold sores (all over her upper lip)

cold sores (all over upper lip)

cold sores (all over her lip) cold

sores (all over lip)

24 (a) lumpectomy

LISTENING SUB-TEST – ANSWER KEY

PART B: QUESTIONS 25-30

25	A	worried that he may have damaged a filling
26	B	reassuring them that their workload won't increase
27	B	possible post-operative side effects
28	C	treating the side-effects of an operation
29	A	prompt preparation is the most effective way to minimise patient risk.
30	B	impressed by how little time he spent in the hospital.

PART C: QUESTIONS 31-36

31	B	He compared it to the experience of a relative dying.
32	A	Under-reporting by patients makes it hard to know how frequent it is.
33	B	is fixed in a strange position.
34	C	reported pain levels that impact on their daily lives.
35	C	made to move a simulation of the missing limb in their minds.
36	B	it can be used by patients after discharge.

PART C: QUESTIONS 37-42

37	A	is fairly common so should be more accurately diagnosed.
38	C	the effects of smoking.
39	B	diagnosis of HS may require a full patient history.
40	A	may recur after disappearing for many years.
41	A	reflected a lack of sympathy and understanding.
42	B	restrict their intake of dairy products.

END OF KEY

OCCUPATIONAL ENGLISH TEST

Sample Test 3

LISTENING SUB-TEST – AUDIO SCRIPT

OCCUPATIONAL ENGLISH TEST. 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 rheumatologist talking to a patient called Harry Davies, who suffers from gout and is attending for a medication review. 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

---*---

F: Now Mr Davies, I understand your GP has referred you to me so that we can review the medications you're taking for your gout.

M: That's right.

F: So tell me a bit about this gout. When did it start?

M: Well, my first serious attack was last year. My wife and I were on holiday, and I woke up one morning with a really bad pain in my left knee. Well, I never thought of gout, 'cause I always assumed that just happens somewhere like your big toe. And anyway, I'm only 40, I thought it was something only old people get. So anyway, it was all red and swollen, and I decided it must be an insect bite. But I couldn't think how that might've happened, you know, without me feeling something at the time. Or my wife suggested it might be something to do with the pills I take for my cholesterol.

F: Unlikely I think.

M: But anyway, the pain didn't get any better; in fact quite the opposite. I started to get frightened because I thought it might be a sign of something really serious – it was excruciating. So my wife thought I needed to get some help. So, she phoned the local clinic and told them about my symptoms. They told her to bring me in. It was a good thing she was there – I was in too much pain to drive. I mean, I could only just manage to walk from the house to the car.

Anyway, when we got there, the doctor took a look and said he wanted to take a blood sample. He said it might be an emergency, because it looked as if it could be septicaemia. So then we got really frightened, but about an hour later they came back and said no it wasn't, thankfully, but they thought I had gout. So actually, at that stage, we were quite relieved.

F: I can imagine.

M: And the doctor asked if I'd ever felt anything like it before. Well, actually, then I remembered that in the winter I play quite a bit of rugby, and sometimes I'd get some soreness in the same place the day after, but I'd just thought I'd sprained it or something. And it would go away after a couple of days. But this pain's much worse, and it comes even when I've been resting – I've had it quite a few times since my first attack.

F: Right. So what have you been taking to deal with the pain?

M: Well at first the doctor at the clinic suggested I took some anti-inflammatories, but I can't say they made much difference. So when I got the next attack I was at home and I went to my GP. She suggested I took… I can't remember the name, Col something

F: Colchicine?

M: That's the one. So that dealt with the pain better, but it gave me awful diarrhoea.

F: **Yeah.**

M: I'd never take it again. And then I had a really bad attack. I think the doctor had got to the stage where, you know, she was already giving me really powerful medicines to no effect - so, she gave me liquid morphine to take. It made me feel quite sick actually, and I was a little bit 'away with the fairies', you know, walking around not quite knowing where I was?

F: Right. Did you try any other sort of treatment apart from the medications?

M: Yes, my GP said I could try using an ice pack and that did make a bit of difference, but you can't have it on all the time. So anyway, after that she said let's try Allopurinol, see how you get on with that. So I started taking that, but I didn't get on with it. It gave me a

skin rash, so I rang her up and she told me to stop taking it – that I'd better see a specialist. So, I here I am. Is there's anything more you can do?

F: Well, I'm sure we can find…[fade]

PAUSE: 10 SECONDS

Extract two. Questions 13 to 24.

You hear a doctor in an emergency department talking to a patient called Gail Kennedy. 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

---*---**

Mrs Kennedy?

Yes.

I'm Doctor Arroyo. Sorry to keep you waiting. Now, can you tell me what brings you here today?

Well, erm... I got back from vacation two weeks ago, and I've been feeling awful ever since. It was a long haul flight because we'd been to South America, and when I got back I felt awful. I thought it must be jet lag, but brutal, much worse than I remember having before. Anyway, I thought I'd get over it, but it actually got worse. After a few days, I was getting bad chills, non-stop shivering and achy muscles. I just felt lousy. I mean normally I'm pretty healthy, I don't get a lot of illnesses, so I started to worry. I thought maybe I'd got meningitis. So I called the doctor. When I told him where I'd been, he said I should come in and see him because it might be malaria. So I said, well it can't be because I've been taking Malarone – I'd started on that two weeks before going away. I tried Larium a few years ago, but it gave me really odd dreams, so I didn't want to take that again. Anyway the doctor said some sorts of malaria are resistant to these drugs, and I know I did get a few bites when we were there. He gave me some pills to take for three days just in case it was malaria.

Right. Can you tell me what they were?

Art something …

Artesunate?

That's right. And something else. Hang on, I've got the box here… mefloquine.

OK.

So I went home and I took the pills, but I didn't feel any better, in fact I got worse. I felt really weak and I was sweating a lot, just dripping with it. I finished the pills yesterday morning. Since then, I've been really bad. I haven't been able to keep anything down. I was throwing up all day yesterday and had the most splitting headache, I've never had anything like it. So I called the doctor again and he said the blood test had come back negative, but if I wasn't feeling better today I should come in to the emergency department, and get some more tests done.

Right. Well I'll just do a brief examination… (pause)

OK, so your skin's a good colour, I can't see any signs of jaundice, and your breathing's sounding pretty good – you haven't had any episodes of breathlessness, have you?

No. But yesterday my heart was really racing.

Yes, there's some evidence of that, now.

Oh, and something else, all this week I've felt as if there was something scratchy in my eyes, like sand or something, and they feel really dry.

I see. And have you had any abdominal discomfort?

Well there's no pain, but I don't have any appetite – I can't really keep anything down, like I said.

Right. Now, apart from taking the anti-malarials, did you have any vaccinations before you went?

Yeah, I had all the injections – typhoid, what else?… not yellow fever because I'd already had that before,.. but I did have one for hepatitis A. And they were fine, I don't usually have any problems with things like that. Then, while we were away, I did get cold sores all over my upper lip. I've had them before and I'd got some over-the-counter stuff for them so I just used that. Apart from that, I was fine during the vacation. I'm normally very healthy. I did have breast cancer a few years ago - that was in 2011. I had a lumpectomy, so I was taking tamoxifen for five years, but I don't have to take it now.

OK. So it's possible that this might be a reaction to certain drugs, but we'll need to ……. [fade]

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 patient talking to a dental receptionist. Now read the question.

PAUSE: 15 SECONDS

---*---**

M Hi, I'd like an urgent appointment, please.

F Let's see. Who's your usual dentist?

M Mr García.

F You say it's urgent – are you in pain?

M Yeah – it's the tooth Mr García filled last week.

F Well, he's away today I'm afraid, but there's a free slot this afternoon with his colleague Mrs Brown.

M That would be OK. But are you saying Mr García could fit me in tomorrow?

F That's right – we'd get you in first thing. Can you wait?

M Well, I'm not chewing on that side and I'm taking paracetamol, which is helping. The pain started when I was eating a steak so I'm frightened I might've upset Mr Garcia's work. It makes sense for him to check it out.

F OK. We'll book you in for tomorrow morning at….. [fade]

PAUSE: 5 SECONDS

Question 26. You hear part of a presentation to nursing staff about an extension to visiting hours. Now read the question.

PAUSE: 15 SECONDS

---*---**

F Now, you'll have received the survey asking your opinion about extending visiting hours and doubtless you've got your own ideas about the possible impact on your work. You're probably aware of the evidence pointing to the positive effects on patient recovery rates of increased contact with loved ones. This isn't in question, but of course things must be managed properly. I've heard concerns about how busy everyone is; that you've got enough on your plates without having to worry about extra demands from visitors. Well, we've carefully planned things to prevent you being overrun with queries, interruptions and so on. Visitors will be given a list of 'do's' and 'don'ts' outlining what's expected of them. Meanwhile, managers will be monitoring things carefully to make sure routines aren't disrupted at all.

PAUSE: 5 SECONDS

Question 27. You hear a surgeon discussing a patient with a nurse in the recovery ward. Now read the question.

PAUSE: 15 SECONDS

---*---**

M: It looks like Mrs Jones is still a bit groggy after her thyroidectomy. Will she be going up to the ward soon?

F: Yes, I'm going to call a porter. She should be going up in fifteen minutes.

M: OK. I've added some extra post-op pathology orders. She may have problems with a drop in her calcium. Her thyroid was just huge. We didn't see all four parathyroid glands and we need to check that they haven't been affected by the procedure. She seems OK, but I want her calcium level checked twice a day. She needs to be monitored for any breathing problems, muscle cramping and numbness, and for tingling in her fingers.

F: OK, I'll make sure a report to watch out for hypocalcaemia is passed on.

M: OK. If you need me, call me.

PAUSE: 5 SECONDS

Question 28. You hear a chiropractor briefing a colleague about a patient called Ryan. Now read the question.

PAUSE: 15 SECONDS

---*---**

M Today, we're going to start with Ryan. He's two weeks post-surgery for a torn rotator cuff. He also had a spur on his acromion process removed. This is his first time in rehab, post- surgery I believe?

F That's correct.

M OK, so today, we're going to begin utilising high-frequency vibration to break up the scar tissue forming in his left shoulder joint following the surgery. We're going to do each of his treatments that way, so you'll see a progression over time – how we get him back to a point where he's able to live his normal life. Movement's the key to rehabilitation, and this treatment resonates with the nerves too, so it should eventually help them heal quicker and reduce his discomfort.

PAUSE: 5 SECONDS

Question 29. You hear a surgeon talking to a group of medical students about patient risk in emergency surgery. Now read the question.

PAUSE: 15 SECONDS

---*---**

M If you look at the risks of elective surgery, they're really very low compared to emergencies. Clearly then, we can make the biggest difference in reducing risk and improving outcomes in emergency surgery. Our mortality outcomes here are actually below average. We're at 8% compared to around 13% nationally. The emergency patients I handle tend to be older, so they're at higher risk. And when they come in, we haven't got long to prepare them in order to reduce any risks. Maybe an hour or two. In terms of patient safety, every minute, every half-hour we can use to get them ready counts. That's because the patients we're thinking about are prone to developing post-operative complications given that they have a range of associated heart, kidney and lung problems.

PAUSE: 5 SECONDS

Question 30. You hear a surgeon talking to a patient who's just had a knee operation. Now read the question.

PAUSE: 15 SECONDS

---*---**

F How are you feeling Mr Shaw?

M Exhausted. But the pain-killers must be working – I can't feel my knee, as you predicted.

F You're bound to feel weary after an operation. It went well, though. We cleaned out loose cartilage from the joint. You can go home now.

M Oh, thanks. I had an arthroscopy on the other knee several years ago, so I know what it's like. The idea that it gets done in less than a day is still pretty mind-boggling, though.

F You'll need crutches for two weeks, but you should be walking OK within a month. Give it four months before you put any serious impact on it though.

M Four months? After my last op, I started running again within a month. Thinking about it though, I guess I paid for it. That knee had a lot of niggles for months afterwards.

F If your body's hurting, it's telling you something.

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 Dr Helen Sands, about her work with patients who are learning to cope with amputation.

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

PAUSE: 90 SECONDS

---*---

M I'm joined today by Dr Helen Sands, who works with patients who've had limbs amputated. Now, amputation is an extremely traumatic experience for patients. Helen, in your experience, how do younger patients tend to react to it?

F Well, in a range of ways, depending on whether the loss was expected, if it was due to chronic illness, or to something sudden, like an accident. One of my young patients in that situation – let's call him David – said losing his leg suddenly was like the pain of an unexpected death in the family. And although this didn't really apply to him, for many young people, even watching a football game can make them feel shut out of activities they once took for granted. But then others come to terms with the fact that for them, normality will be something different from what it was before the operation.

M And patients can still suffer pain from a missing limb, can't they, even after the limb's been amputated – what's called phantom limb syndrome. How common is this?

F Well, the phenomenon was first observed many years ago in soldiers who'd lost a limb in combat. The majority reported pain coming from the missing limb. Obviously surgical techniques have improved, but a large number of amputees still report suffering from a degree of pain from the missing limb. In a few instances, this might be due to a poorly-fitting prosthetic for example, or residual limb pain, but the majority of cases are harder to explain. And patients are reluctant to talk about it, in case medical professionals doubt their mental state, so it's not very easy to say just how often it occurs. However, I still tend to think it's large numbers.

M And you must have come across examples of this phantom limb syndrome in your own patients who have missing limbs.

F Yes, of course. Many patients report feeling as if the missing limb is still attached to their body, even years after the amputation. Some patients have reported actually trying to use it just as they did before. And in the case of other patients they feel as though the missing limb is permanently at an abnormal angle, and they have to make allowances for it when moving around. I've come across a number of instances of that. And other patients experience what we call telescoping – the sensation that the limb is still there as normal, but it's become smaller… shrunk, somehow.

M And I understand that you have a treatment trial going on in the hospital at the moment.

F Well, yes. I mean, in the normal course of treatment, we administer analgesia, and we also make use of local injection therapy, using pain-blocking agents.

Unfortunately, though, these don't always work as well as we might like. So we're working with a group of patients who have reached the point where the pain's badly affecting normal activities such as sleeping and going to work. All patients in the group have suffered from phantom-limb pain for ten years on average – so they're the most extreme cases we could find.

M So how did you set about treating the patients in the trial group?

F Well, when a limb is lost, that affects a number of brain functions, and we wanted to try to restore those functions. So we attached electrodes to the remaining muscles of the stump and then asked patients to try to move the phantom limb. And patients could view their virtual limb moving on a computer. But they couldn't just *imagine* moving the limb – they actually had to *force* their brain, if you like, to perform the action, because only then would these circuits, these pathways, be restored in their brains. So the patient controlled the virtual limb just as they would have with their own limb. And slowly, they got better at doing this, in a way that was productive to the brain. And patients invariably reported that as a result, their pain diminished.

M So the treatment was useful. Does it have any other advantages?

F Well, we followed up patients after different periods of time, and the improvements were still there, but not to the same degree – but the decrease in pain levels was still statistically significant. But this kind of treatment is very easy for patients to do at home once they've left the hospital. They only need a computer with a webcam, and the programme.

M And this research is ongoing, of course, so we [fade] …….

PAUSE: 10 SECONDS

Now look at extract two.

Extract two. Questions 37 to 42. You hear a dermatologist called Dr Jake Cooper talking about a skin condition called Hidradenitis Suppurativa (HS).

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

PAUSE: 90 SECONDS

---*---

Hello, my name's Jake Cooper. I'm a dermatologist and I'm going to talk about a skin condition called Hidradenitis Suppurativa, commonly abbreviated to HS.

Let me tell you a bit about this condition. HS is a chronic inflammatory disorder characterised by painful swollen lumps on the skin, which may break open, releasing fluid or pus. It's also called acne inversa, and in fact sufferers often think they've got acne or pimples. But unlike acne, HS affects apocrine gland-bearing sites, in particular the armpits and the pubic regions. It's not a very well-known disease in the medical community, which is surprising as it affects about one per cent of the population, and early occurrences are commonly misdiagnosed as simple nodules or abscesses. This is unfortunate as the condition can be very distressing for the patient.

We don't know exactly what causes HS, though it seems to be linked to blocking of the hair follicles in the affected area. It tends to occur most often in younger females, and it's often found in patients who are overweight. Studies carried out into a possible link between deodorant use and HS have so far been inconclusive, but the condition is more prevalent amongst smokers and there's some evidence that nicotine may affect the follicles. Patients sometimes worry that they've caused the condition by shaving or possibly by using depilatory creams, but there's no evidence that either is a contributing factor.

Let me tell you about one case I encountered recently. This was a 22-year-old woman called Sophie who came to see me because she had a number of painful boils in her groin. These had been occurring, with fluctuating severity, for the previous three years. When I questioned her further, I learnt that she'd previously undergone incision and drainage of various lesions on multiple occasions, at various medical centres. She also told me she'd taken a course of an unknown oral antibiotic to treat an abscess about two months earlier. So I was able to put two and two together and make a connection with HS. Then we could start to think about the right sort of long-term treatment for her.

When treating patients with HS, it's important to be aware of the impact it can have on them. Many studies have confirmed that patients with HS commonly experience depression as a result of their condition. Additionally, HS has a significant psycho-social impact. Patients reported feeling 'unworthy' and 'unlovable' and described their lesions as 'ugly, smelly, and embarrassing'. In some cases, symptoms may spontaneously resolve themselves for long periods of time. But both doctor and patient need to remember that there could be a flare up years or even decades later - and that currently, treatment is limited to finding a way to manage the condition.

HS may present itself in younger patients too. In another case, I saw a 14-year-old girl called Emily, who came to see me with her mother following a diagnosis of HS by her GP.

We needed to confirm the diagnosis and decide on the most appropriate treatment. Her mother expressed concerns about what she referred to as ‘Emily's unappealing hygiene'. This was said *in front of* the girl. Now, we know that HS is notably *not* due to poor hygiene. While HS is a skin disease, it’s happening lower in the dermis than just the surface level. In this case, Emily had a lesion on the mons pubis, which required surgical intervention. Following incision and drainage, her condition improved, but this does illustrate the need to consider not just the patient, but also the attitude of family members.

In general, when it comes to treatment, once we make a diagnosis, there are multiple therapies indicated, depending on the severity of the disease and patient presentation. One thing patients often ask me is whether they need to make changes to their diet. One small-scale study followed twelve HS sufferers who cut out beer from their diet, together with other foods containing yeast, such as bread and some types of cake. And this did appear to have an effect on their symptoms. It’s also known that over-production of one group of hormones called androgens may contribute to the symptoms of HS. These hormones are linked to insulin, and foods such as milk and cheese can raise insulin levels, so reducing these types of foods might be helpful. However, a controlled diet which leads to weight loss, is certainly recommended for patients who are overweight or obese.

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.

OCCUPATIONAL ENGLISH TEST

Sample Test 3

READING SUB-TEST – ANSWER KEY
PART A

READING SUB-TEST – ANSWER KEY

PART A: QUESTIONS 1-20

1	B
2	C
3	D
4	D
5	A
6	tissue damage
7	scarring
8	sensation
9	hot clothing
10	hypothermia
11	tetanus
12	blisters
13	antibiotics
14	thickness
15	two
16	20 ml
17	10%
18	Tramadol
19	orally
20	72 hours

OCCUPATIONAL ENGLISH TEST

Sample Test 3

READING SUB-TEST – ANSWER KEY
PARTS B & C

READING SUB-TEST - ANSWER KEY

PART B: QUESTIONS 1-6

1	A	failure to do so would put other people in danger.
2	B	ensure that the patient's personal care plan is also transferred.
3	C	care providers being unaware of an issue.
4	B	can order medicines from the pharmacy in some cases.
5	C	the ICU is fully responsible for a patient in their care.
6	B	speculating on the possible causes of the incident.

PART C: QUESTIONS 7-14

7	C	can cause debilitating symptoms.
8	D	The distinction between them and allergies is not widely appreciated.
9	C	why the skin-prick test may not accurately diagnose food intolerance.
10	A	the factors triggering an allergic reaction still remain unclear.
11	B	They directly contradict each other.
12	D	the order of events most commonly found prior to allergic attacks
13	C	It may be avoidable if certain precautions are taken.
14	A	attempts to improve eating habits.

PART C: QUESTIONS 15-22

15	A	reference to some recent findings relating to heart disease
16	D	reduced growth.
17	A	Their focus has been too narrow.
18	B	to assess the relative significance of two risk factors for newborns
19	A	Lower-income mothers generally give birth to lower weight babies.
20	D	Poorer residents have a genetic advantage over those with higher incomes.
21	C	an explanation for a finding.
22	D	the speed with which results are seen

RADSAMPLE03

Occupational English Test

WRITING SUB-TEST: RADIOGRAPHY
SAMPLE RESPONSE: LETTER

Ms Sandy French
Staff Radiographer
Department of Diagnostic Radiology
Meeden Heights Public Hospital

30 August 2019

Dear Ms French

I am writing to provide you with important information about Mr Brad Jenkins, who is scheduled for an X-ray of the ribcage tomorrow. Mr Jenkins is a 47-year-old psychiatric patient with a history of aggressive behaviour, therefore his X-ray should be conducted with caution. Mrs Finn, a psychiatric nurse, will accompany him to the X-ray tomorrow.

The Chief Radiographer, Mrs Hilda Vickers, has instructed that the patient not be left alone with a single staff member and that both a radiographer and a non-radiation worker be present in the X-ray room for the procedure. If a non-radiation worker is unavailable, a staff member from another ward can be called upon to assist with the X-ray.

The X-ray, originally scheduled for today, was delayed when the orderly in attendance was called away to assist with an urgent image intensifier procedure. When told of the delay (anticipated one hour), Mr Jenkins became angry and threw a chair in the waiting room. Security was called. Mr Jenkins also caused a violent incident earlier today at his Care Centre, which was the cause of the injury to his ribs.

Please ensure care is taken when X-raying this patient and that security is present.

Yours sincerely

Radiographer