OCCUPATIONAL ENGLISH TEST

Sample Test 2

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

LISTENING SUB-TEST – ANSWER KEY

PART A: QUESTIONS 1-12

1 heartburn

2 bloating

3 constipation

4 unpredictable

5 migraines

6 accountant

7 anxious

8 energy

9 fibre/fiber

10 dairy (products)

11 (extensive) food allergy tests

12 anti(-)depressants

PART A: QUESTIONS 13-24

13 stiff

14 (a) heat pad
(a) heatpad

15 physiotherapy

16 untreatable

17 chiropractic treatment

18 Baclofen

19 (an orthopaedic/orthopedic) chair
(a) chair

20 botox

21 swallowing

22 (various) oral medications

23 loss of memory

24 (a) pump

LISTENING SUB-TEST – ANSWER KEY

PART B: QUESTIONS 25-30

25	A	his blurred vision
26	B	The patient is worried about a procedure.
27	C	patients not discussing all their concerns when meeting the doctor
28	C	have the fewest risks for the patient.
29	B	benefit from a specific anaesthetic procedure.
30	B	the financial impact that they are likely to have

PART C: QUESTIONS 31-36

31	C	to raise awareness of the symptoms of the illness
32	B	felt that he was too fit and well to be in need of it.
33	B	found it hard to cope with the wait for some results.
34	A	He found himself reacting in a way he hadn't anticipated.
35	C	a reluctance to talk about the embarrassing aspects of treatment
36	A	offer patients more personal aftercare.

PART C: QUESTIONS 37-42

37	B	come from a wide variety of backgrounds.
38	B	enable them to deal with patients more quickly.
39	C	fails to distinguish between different possible triggers.
40	C	they may interact adversely with patients' other medication.
41	A	the unsuitability of opioids for patients with particular conditions.
42	C	he lacked experience in dealing with problems like hers.

END OF KEY

OCCUPATIONAL ENGLISH TEST

Sample Test 2

LISTENING SUB-TEST – AUDIO SCRIPT

OCCUPATIONAL ENGLISH TEST. SAMPLE TEST TWO. 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 gastroenterologist talking to a patient called Andrew Taylor. 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

---*---**

Gastroenterologist: Good morning, Mr Taylor. Now, you've been referred to me because it's possible that you're suffering from irritable bowel syndrome or a related condition.

Andrew Taylor: *Err… yes, that's right.*

Gastroenterologist: Okay, could you start by giving me some background?

Andrew Taylor: *Well erm, this has been going on for many years. After meals, I've always tended to get heartburn, but I found that pretty easy to deal with by taking antacids from the pharmacy. But a year ago, things suddenly got worse and there were other problems I started to notice. The symptoms vary a lot and they can be quite hard to describe exactly, but the main problem is bloating.*

Gastroenterologist: I see.

Andrew Taylor: *I need to tell you about some other things related to my stomach. Although this isn't something that happens every day, I've been suffering from constipation in the last month. In the past, I've had the opposite problem and would rush to the toilet several times a day. I just never know how I'm going to feel from one day to the next. It's the way the symptoms are so… unpredictable that I hate. It's hard to plan my life.*

Gastroenterologist: Were there any other symptoms unrelated to your stomach and bowel?

Andrew Taylor: *Well, I have a skin condition that can flare up, and I know this could be related to irritable bowel syndrome. And the odd thing is that I often have migraines more or less at the same time as the stomach discomfort and these can go on for days. It's strange and I didn't, at first, think it was anything to do with my stomach problems.*

Gastroenterologist: Have you noticed anything that can intensify the symptoms in any way?

Andrew Taylor: *Well, I have a very demanding job as an accountant. I don't know whether this has a bearing on anything, but there's a chance I might lose my job in a re-organisation of my department, so that's obviously something that's making me anxious. I don't know what's going to happen.*

Gastroenterologist: What's the worst effect the condition has on you?

Andrew Taylor: *The problem isn't just that it's nearly always on my mind, unless there's some pretty big distraction, but also that it's so draining. What I mean is, I often feel that I've got no energy at all. I just want to sit around and do nothing when I get home from work, to be honest. I go to bed tired but I'm frustrated because I have insomnia much more than I ever did before. I wouldn't say I've been suffering from depression, but a condition like this can make you feel rather down.*

Gastroenterologist: Mmm right, and I understand that you've investigated the possibility that your diet's responsible for your condition. Can you tell me about this?

Andrew Taylor: *I was told by a nutritionist I saw that people with irritable bowel syndrome often don't eat enough fibre. In my case, I don't feel that's an issue. I've followed the nutritionist's advice about taking more fluids during the day, especially water, and accept that, in the past, maybe I didn't do that enough. It's hard to say whether that's made a difference, but possibly it's caused a slight improvement. I'd read that dairy products can make things worse, so I tried cutting them out. But I wasn't convinced it made any difference. I've cut back on caffeine - though not much actually. I also paid for extensive food allergy tests, but they didn't show anything major. So that's not an area my doctor thought was worth investigating further.*

Gastroenterologist: What medications have you tried?

Andrew Taylor: *Well, I took something called an anti-spasmodic which my GP says helps to relax the muscular contractions which move food through the gut. But to be honest, I don't think it made much difference in my case.*

Gastroenterologist: Have you taken anything else?

Andrew Taylor: *Well, I've been given anti-depressants and I'm giving them a go. I wasn't sure I completely understood the reasons.*

Gastroenterologist: OK, well, a drug like that targets the signals being sent to and from the nerves in the digestive system. It has a calming effect on the muscles there. Did you find that this drug was effective?

Andrew Taylor: *Yes, I'd say it was on the whole, erm…. (fade)*

PAUSE: 10 SECONDS

Extract two. Questions 13 to 24.

You hear a hospital neurologist talking to a new patient called Kathy Tanner. 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

---***---

Neurologist: Hello Mrs Tanner. Pleased to meet you.

Kathy Tanner: *Hello.*

Neurologist: Do you mind if we start off by getting some background to your condition? Erm, just in your own words could you talk me through the reason you're here and how it all started?

Kathy Tanner: *Please, call me Kathy. So, erm…until two years ago my husband was in the army. We actually…we lived off-base and I had a job which involved a lot of driving.*

Neurologist: Right.

Kathy Tanner: *Whenever I was in the car, I noticed that my neck would get pretty stiff at times. It was hard to turn my head. To cut a long story short, when my husband left the army, we moved to a new house. My neck pain was still a problem, so I decided to visit an osteopath.*

Neurologist: Right.

Kathy Tanner: *He tried to fix the problem by a neck adjustment, but actually it just made things worse.*

Neurologist: Oh dear!

Kathy Tanner: *I found I was losing flexibility in my neck. Erm… Oh, I began to use a heat pad, which did help at first.*

Neurologist: Good, but, but what… so, not for long?

Kathy Tanner: *No. About a month or two on, I started to get this sort of feeling that something was pulling my head over towards my right shoulder.*

Neurologist: Right.

Kathy Tanner: *It was painful and embarrassing because I couldn't keep my head straight.*

Neurologist: Of course.

Kathy Tanner: *I'd managed to hide it from everyone around me until then. Erm, oh about this time one of the doctors I'd seen thought physiotherapy might help and sent me to a nearby clinic. So, I started going in regularly for treatments. And err…one day the head of the clinic looked at me while the therapist was trying to position my neck and whatever…and erm… he said, 'You know what your problem is, don't you?' and I replied that I didn't, err… and he told me that I had spasmodic torticollis, and I had no idea what that was.*

Neurologist: So what happened then?

Kathy Tanner: *So, so, he says 'Oh, it's untreatable. You just have to learn to live with it.' I went home in pain, feeling depressed and hopeless.*

Neurologist: Yes, of course.

Kathy Tanner: *He was just so unsympathetic and unhelpful.*

Neurologist: Well, I'm sorry to hear this.

Kathy Tanner: *Thanks… so my diagnosis of spasmodic torticollis was in June. Err, so I began to research, you know, what I could do. Erm, I tried chiropractic treatment until December. It cost a fortune but did no good. The pulling and pain continued to increase. Erm, I saw a couple of neurologists and I was put on a drug called… Baclofen, but it…it really didn't make any difference.*

Neurologist: Yes, that wouldn't do much for your condition.

Kathy Tanner: *Oh right. Anyway, the one really good thing I did at that time… was to join a support group for spasmodic torticollis patients, so at least I knew I wasn't alone with the condition. But mostly, I just sat at home a lot. In order to get a bit of pain relief I got myself an orthopaedic chair and err, that did give me some support. Erm, In November I saw something in a magazine – in the medical section. Err…It mentioned some new treatments being done at the university hospital to treat things like spasmodic torticollis with botox. Erm…we mentioned this to our GP, got a referral, and in December, I had the…erm the first injection…in my neck.*

Neurologist: And... How did the treatment go?

Kathy Tanner: *Well, the injections really helped the pain, you know. My head returned to almost a normal position.*

Neurologist: Right.

Kathy Tanner: *It did give me a few problems like erm…problems swallowing, but that was OK. I thought I'd received a miracle cure. I was devastated when everything started to come back like before, and err… I went back to the hospital in May. This time the results weren't quite as good, even though they'd upped the dosages. I ended up having nine lots of injections erm ... plus the… you know, various oral medications, — sorry, I can't remember what they were…*

Neurologist: No, doesn't matter.

Kathy Tanner: *…but nothing really made much difference. I just got more and more confused and loss of memory became a problem too. Erm, just for pain relief they ended up giving me a pump so I could give myself morphine. Finally, I saw something in my ST support group's magazine, about a relatively new type of surgery being done by a local neurologist, and that would be you! So, here I am..*

Neurologist: ...and we will do our best to help you! Now…just a few more questions...
[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 an optometrist talking to a patient who's trying contact lenses for the first time. Now read the question.

PAUSE: 15 SECONDS

---*---**

Optomertrist: Now, you've had the lenses in for a few minutes. How are they feeling?

Patient: *Not bad. I thought I'd feel them actually touching my eyes; that they'd be sore or prickly, but I… can't feel much at all. My eyes do feel a bit watery though.*

Optometrist: It's OK - you've just used too much solution. Now, in a few minutes, I'll get you to try taking them out and inserting them again by yourself.

Patient: *I had no trouble taking them out earlier, but I'm not confident about putting them in. I worry I'll press too hard.*

Optometrist: That's unlikely to happen.

Patient: *Things look rather distorted though. I mean, I can't make out the letters on that chart.*

Optometrist: Any of them?

Patient: *Those lower down.*

Optometrist: Let's give things another minute to settle down.

PAUSE: 5 SECONDS

Question 26. You hear a nurse asking a colleague for help with a patient. Now read the question.

PAUSE: 15 SECONDS

---*---**

Male: Kathy, could you help me with the patient in Bed 103? The woman who had surgery two days ago?

Female: *Oh, yes – she's due for discharge today, isn't she? Does her pain relief need topping up again? I thought she wasn't very comfortable this morning.*

Male: Oh, she's on a reasonably low dose – but she's coping. She needs her chest drains removing, though, and she's got herself into a bit of a state.

Female: *Well, that's a two-person job anyway, so I'll come with you. Has the consultant seen her? I know there was some concern yesterday about her condition, and the level of the fluids draining into the bags.*

Male: Oh, he's cleared her for removal of them today – but I think some reassurance might be needed first.

Female: *Right – I might just check her analgesia and give her more before we go ahead.*

Male: OK.

PAUSE: 5 SECONDS

Question 27. You hear a senior nurse talking about a new initiative that has been introduced on her ward. Now read the question.

PAUSE: 15 SECONDS

---*---**

Female: One of our key priorities is improving communications between staff, patients and patients' families. We recently introduced a scheme called 'Dear Doctor', which involves giving each patient a card where they can make a note of any questions or concerns that they, themselves, have. They can also talk to their families during visiting time or even on the phone and see if there's anything else they'd like to add. The cards are then collected and given to the doctor before the ward round. We're really pleased with the response – patients used to say they only thought of the things they felt they needed to discuss when it was too late, so the cards give them a better chance to bring up whatever's on their minds. In fact, it's been so successful that we're going to roll it out on all wards in the hospital.

PAUSE: 5 SECONDS

Question 28. You hear two radiologists talking about the type of scan to be given to a patient. Now read the question.

PAUSE: 15 SECONDS

---*---**

Female: *I've just had a phone call from Emergency. They have an 11-year-old boy with right lower quadrant abdominal pain. They're concerned about appendicitis and they'd like to order an abdominal CT for him.*

Male: Mmm… do you think that's a good idea?

Female: *I was thinking maybe we should recommend an abdominal ultrasound, because then we can spare him the radiation.*

Male: Is there any concern in this case around using ultrasound instead of CT? Accuracy, for example?

Female: *The sensitivity's slightly less than the CT, but the specificity's almost the same, so I think we can rely on the results.*

Male: OK. It means we can avoid the child being subject to contrast exposure as well. But what would we do if the ultrasound doesn't answer the question?

Female: *If we can't visualise the complete appendix, then we can recommend an abdominal CT.*

Male: OK, we have a plan. Call them back and let them know.

PAUSE: 5 SECONDS

Question 29. You hear part of a surgical team's briefing. Now read the question.

PAUSE: 15 SECONDS

---*---**

Male: OK. Next is Mr Kumar's repeat laparotomy. Any anaesthesia issues?

Female: *We don't expect any particular problems; he's relatively fit and well, except for his epilepsy, which is under good control. His BMI is 35, but ...*

Male: Will we need the obesity bed?

Female: *It shouldn't be an issue.*

Male: And, what about the epilepsy post-operative management?

Female: *He's taking his oral medications and we can use an IV if necessary.*

Male: I know he was in a lot of discomfort after his last surgery and this time he's going to need a larger mid-line incision. It may be worth thinking about an epidural. He's certainly at the extremely low edge in terms of pain threshold.

PAUSE: 5 SECONDS

Question 30. You hear a senior research associate talking about a proposal to introduce inter-professional, primary healthcare teams. Now read the question.

PAUSE: 15 SECONDS

---*---**

Female: We're looking at opportunities to improve the effectiveness of health and healthcare systems here in Canada. One of the interventions we're looking at is inter-professional, primary-care teams; groups of professionals working together collaboratively to provide services including healthcare, social services and advice to patients within the primary-care setting.

There's evidence that teams like these can improve chronic disease outcomes, including diabetes, hypertension and heart disease, as well as mental-health problems. There's also evidence that improvements can be made in terms of both access to and coordination of care. Now, the extent to which these teams could affect the costs of healthcare in such areas isn't quite clear within the evidence, but the work we're doing aims to address such issues, while looking at the challenges of implementation and evaluation.

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 a presentation by a specialist cancer nurse called Sandra Morton, who's talking about her work with prostate cancer patients, including a man called Harry.

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

PAUSE: 90 SECONDS

---*---**

Sandra Morton: My name's Sandra Morton, and I'm a specialist cancer nurse, helping cancer patients deal with their diagnosis and treatment. I'd like to tell you about the type of work I do, and particularly about one of my patients, recently diagnosed with prostate cancer – let's call him Harry – to illustrate the sort of things I get involved with.

Now, before we get on to Harry, I'll give you a bit of background. Clearly, my job covers many aspects of patient care, but what's the priority? Firstly, prostate cancer is in fact the most common cancer in men in the US, with almost 300,000 new cases diagnosed every year – that's a staggering number. One problem is that this type of cancer actually develops very slowly, so there may be absolutely no sign that you have it for years. So if we're going to reduce the number of cases, it's vital that people like me get the word out to as many men as possible; that we tell them how to spot the signs of prostate cancer, like an increased need to urinate, or straining while urinating. Unfortunately, the cancer can be at an advanced stage by the time patients come in for tests, at which point the available treatments are far less effective.

So, let me tell you a bit more about my patient, Harry. Like many middle-aged men, Harry was offered a routine health check at his local doctors' office. As far as he was concerned, he had no particular health problems or obvious symptoms at the time, and so he almost ignored the invitation. But he'd promised his family he'd look after himself - his partner had died of skin cancer some years before - so he felt obliged to go. It was during his appointment that, based on a few symptoms he mentioned, Harry's doctor decided that he'd need further investigation for prostate cancer, and referred him to a specialist clinic at the hospital.

Harry's trip to the clinic started with a routine blood test, which initially showed a slightly low haemoglobin level. A further test then revealed that his PSA, the prostate-specific antigen, was high at 20. He then saw a urologist, who conducted a digital rectal

examination and biopsy – a procedure that I always try to explain to patients may be uncomfortable but is entirely necessary. In fact, though, Harry said the three-week interval between having a biopsy taken and hearing the outcome was far more of an ordeal.

Harry told me that when he went to see the urologist to get his results, he immediately sensed he was in trouble. Although the urologist was very considerate in delivering the news, unfortunately the indications were that Harry did indeed have prostate cancer. He was assured that the cancer was low-grade and not aggressive. Harry had suspected the worst, and though he'd tried to prepare himself for it by doing some online research, finally hearing that confirmation was still a shock. In fact, the very mention of the word sent Harry into panic, which was very unlike him. So at the time I first met him, he was very vulnerable, and grateful to have someone to talk to.

Of course, the response to the illness amongst prostate cancer patients like Harry can vary enormously. I've dealt with some men, for example, who haven't really realised the importance of keeping up their medication because they've felt relatively well – especially if they've been experiencing unwanted side-effects. Unfortunately, though, any break gives the disease the perfect opportunity to spread into the bones, making it much more difficult to treat, and a successful outcome less likely. And some treatments do cause some unfortunate effects, such as erectile dysfunction, which some men really feel uncomfortable discussing, because it's a sensitive issue. Other patients have mentioned that, even though they've been given a lot of help, it's still difficult to weigh up the pros and cons of the various treatment options they're offered, from ultrasound or radiotherapy, right through to radical prostatectomy. So responses like these need to be taken into account by specialist nurses when talking to patients.

For me, these factors really underline the importance of the community follow-up clinics we have in my area, which address many of these issues in the provision of health care for cancer patients. Staff at these clinics see patients during their recovery, and only send them back to hospital for treatment if they develop significant new symptoms. Seeing patients in the clinics means staff get to know each patient and build a relationship with them, which enables nurses like me to dispense advice and answer questions. And although we have no firm evidence, staff feel that's far more beneficial to patients than attending a large hospital clinic. So we're hoping more clinics like these can become available.

PAUSE: 10 SECONDS

Now look at extract two.

Extract two. Questions 37 to 42. You hear a neurologist called Dr Frank Madison giving a presentation about the overuse of painkillers.

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

---*---**

Frank Madison: I'm Dr Frank Madison, and I'm a neurologist with a special interest in the overuse of painkillers, particularly of opioids, something experts are now calling the 'silent epidemic'.

Now, we've all seen the stereotypical images of addicts hooked on recreational drugs, but addiction to painkillers like opioids has a much less familiar public face. From what I've seen, one reason for this is that the range of people affected makes them less easy to pigeonhole – I mean, there's no typical age, social class and so on. And, of course, most people seeking

help for opioid overuse were initially prescribed the medication by their own doctors for pain relief. This highlights a major part of the problem. Physicians often pay little attention to the possible risk of addiction. They need to look carefully at patients' personal histories and assess the risk, considering things like depression and anxiety disorders before prescribing opioids.

In recent years, there's been a dramatic increase in opioid prescriptions. I see a pattern not just of GPs *over*-prescribing, but of GPs inappropriately prescribing. Sure, people want their pain relieved immediately – that's understandable. But proper pain management requires lengthy face-to-face input, which time pressures don't allow, so easier alternatives have become the default option. What's more, although opioids can provide effective relief in the short term, they shouldn't be the automatic first-line therapy. Many alternatives do exist, and they're no more costly.

People generally think of pain as a direct symptom of a problem in the affected area. But pain is an extremely complex subject, and it's one that used to be under-represented in medical education. Thankfully, that's no longer the case and doctors now realise that when a patient complains of acute back pain, that pain may not be due to a clear and treatable disease, but that such pain often presents in people with other medical problems – and these need investigation. Although there are distinct types of physical pain, all too often I see sufferers lumped together in one category, which means that, unfortunately, not all treatments are going to work equally well. For example, we first need to know, is the pain caused by inflammation as opposed to nerve damage? Establishing this makes initial mistreatment far less likely, meaning that treatment is more effective and the risks of long-term problems are reduced.

But it's not just opioids we need to watch. Patients often self-treat with readily available painkillers like paracetamol and, while such drugs play an essential role in pain management, people still need to know more about them. We've been pretty successful in publicising the dangers of accidental overdose, and clear information's given about the effects of taking these drugs long-term, so public awareness about increased tolerance levels is also gradually improving. Many doctors also now actively *warn* patients about the spiral of taking higher and higher doses for pain relief. Worryingly though, I've seen cases where people on drug regimes for other conditions inadvertently take painkillers which add a potentially hazardous ingredient to the mix already in their system. This is something which needs urgent attention.

I'd like now to talk about an osteoarthritic patient who was referred to me – a thirty-year-old woman, let's call her Ann, suffering from sarcoidosis, an auto-immune disease leading to chronic organ inflammation. She was prescribed various drugs but, though the disease was soon brought under control, the pain lingered, with Ann gradually becoming dependent on prescription opioids. Typically, she was terrified of stopping them, yet the more she took, the worse she felt. The thing is, her prescription would've been ideal for short-term pain, like that following surgery, but should never have been given for the chronic pain she was experiencing. And we all know that living with medication dependency has devastating consequences not only on social wellbeing but also on ability to function professionally, as was the case for Ann. She eventually went on long-term sick leave, as often happens in such cases.

Thankfully, Ann's now much better. Having recognised her dependence and with the necessary support, tools and techniques, she's now off painkillers. The crucial thing is to prevent dependence in the first place. Ann's GP prescribed opioids in good faith, aiming at pain reduction, but failed to set an end-date for these. He hadn't anticipated the possibility of eventual drug reliance, this being new territory to him. Ann couldn't hide the visible results of the quantities she was eventually taking, so her GP questioned her about intake. She reluctantly admitted supplementing her prescription from sources like friends and

family, something her GP had suspected but hadn't investigated. Ann now realises that drugs weren't fixing her problem and, though withdrawal took several tough months, her determination to succeed has paid dividends.

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 2

READING SUB-TEST – ANSWER KEY
PART A

READING SUB-TEST – ANSWER KEY

PART A: QUESTIONS: 1 – 20

1 D

2 C

3 B

4 D

5 A

6 B

7 C

8 headache

9 hepatitis C

10 ALF

acute liver failure

11 renal failure (**NOT**: renal dysfunction)

12 methionine

13 (activated) charcoal

14 speed of absorption

15 right upper quadrant

16 nausea and vomiting

17 enzyme-inducing

18 100

one hundred

19 12

twelve

20 supportive

OCCUPATIONAL ENGLISH TEST

Sample Test 2

READING SUB-TEST – ANSWER KEY
PARTS B & C

READING SUB-TEST – ANSWER KEY

PART B: QUESTIONS 1-6

1	C	can delegate responsibility for the cupboard keys to another ward.
2	A	give a valid reason for conducting it.
3	A	help maximise its efficiency.
4	B	They enable a patient to receive more of the prescribed medicine.
5	A	benefits to patients of using bedrails can outweigh the dangers.
6	A	They may be useful for patients who are not fully responsive.

PART C: QUESTIONS 7-14

7	A	It was entirely preventable.
8	C	Staff focus their attention on a limited number of issues.
9	A	understands why healthcare employees have to make certain choices.
10	D	The information recorded on them does not always reflect reality.
11	D	lack of consistency
12	B	It isn't clear who ought to be tackling the situation.
13	B	illustrate a fundamental obstacle.
14	D	the approach they take to deal with challenges

PART C: QUESTIONS 15-22

15	C	to illustrate the strange nature of migraine aura
16	B	did not result in a definitive conclusion.
17	C	the simultaneous occurrence of CSD and aura
18	A	migraine could cause a structural change.
19	D	the suggestion that infant colic may be linked to migraine
20	A	It fails to filter out irrelevant details.
21	B	a more positive aspect of the research.
22	B	They are unlikely to be permanent.

RADSAMPLE02

Occupational English Test

WRITING SUB-TEST: RADIOGRAPHY
SAMPLE RESPONSE: LETTER

Dr Ian Page
Director
Intensive Care

10 February 2019

Dear Dr Page,

Re: Delays in response to ICU request

As Chief Radiographer, I have been asked by Dr Quirk to investigate the circumstances surrounding the delay in responding to an ICU request for Mr Rouse on Saturday, 01 February.

Responding to ICU requests is a top priority and we always attempt to respond to such requests as quickly as possible. On the day in question, one of our radiographers called in sick, so we were operating at half our normal staff level. Further complicating this was the fact that just prior to receiving notification for the request for a CXR in ICU, we received notice that a theatre case would be ready for us in five minutes, which needed top priority. Calling in the on-call radiographer was not considered as our policy states they must be provided 45 minutes notice prior to their arrival at the hospital. Unfortunately, the theatre case was delayed until 2.30 and the radiographer was not able to leave the theatre to attend to the ICU case until 2.40.

It would appear that on this occasion circumstances were not favourable. Normally, prompt, reliable service is provided, and we anticipate that this will continue in the future. Fortunately, it is rare that situations such as this arise.

I hope this has been of help.

Yours sincerely,

Chief Radiographer