OCCUPATIONAL ENGLISH TEST

Sample Test 4

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 paediatrician talking to the mother of a six-year-old boy called Daniel. 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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M: Mrs Lemmings? Come in, please. I believe you're here to see me about your son Daniel.

F: Yes. He's six years old now. But I wanted to talk to you without him being here, at first anyway.

M: Yes, of course. So, tell me, what seems to be the problem?

F: Well... it's his hands. They're in really bad shape. It's mainly the skin - the way it looks. It's so cracked and dry. He's reluctant to complain about it, but I've managed to get him to tell me that it does hurt. From what he says, I believe the pain is pretty much constant.

M: Right. Is this accompanied by any other symptoms?

F: Well, yes. Although there's no itching, or anything like that. I mean, I've never seen him scratching them, but the most worrying thing is that there's even bleeding sometimes. I just don't understand how they've got so bad.

M: Right.

F: I just don't understand how they've got so bad.

M: So when did this all begin?

F: Oh, it's been months now. I thought it'd clear up in the spring when the weather got warmer cos I initially put it down to that cold snap we had last winter, I mean cos that's when we first noticed it - but obviously I was wrong. I've tried to pin down what sets it off, and the thing I keep coming back to is all the handwashing. It makes it worse. Now I've tried to stop him, but it just upsets him if he can't do it, so we've kind of given in.

M: Have you tried any treatments?

F: Oh yes. We started with creams for dry skin, you know - just about every remedy you can buy over-the counter. And they all helped a bit, but not much. Once we'd exhausted all those options, we moved onto the home remedies from the internet. I read about things like getting him to wear silk gloves at night - let me tell you they weren't very practical. He was ok with the petroleum jelly treatment though, so that's one of the things that we still use now. But also, his older sister Sarah, has eczema. So, another thing we're doing is using Sarah's aqueous cream. Sarah doesn't mind, but Daniel hates using his sister's stuff. I don't want it to sound like I'm making things out to be worse than they actually are. It isn't always terrible. Some weeks are better than others. Like, for instance, during the school holidays. There's a definite improvement then.

M: Can you tell me a bit more background information about Daniel. How is he, generally?

F: Well, in some ways he's fine. I mean, he's doing well at school. But his teachers have alluded to the fact that he's highly strung. That's definitiely how I'd sum him up too. Take, for example, his tantrums. Last week all hell broke loose because he had to go to the childminder on a different day. He spent the whole three hours there crying his eyes out. And this is a lady who's looked after him since he was five months old, so it's not like he doesn't know who she is.

M: Right. So he finds it hard to cope with change - is that a fair assessment?

F: Yes, but it's not just that. When we go on a family day out, I now have to wrap all of his food in plastic clingfilm or he just won't eat it. He's convinced it'll have germs on it. Honestly, it's just making things impossible.

M: So what are your main concerns?

F: Well, I've done a fair bit of reading up on this and that's why I wanted to come see you by myself at first. I've heard about conditions such as Asperger's, but I don't honestly think it's that. What I am worried about is the possibility that this could be OCD, or at least the start of it. And what I'm worried about is - what's the best way to handle it?

M: So what are your main concerns?

PAUSE: 10 SECONDS

Extract two. Questions 13 to 24.

You hear a consultant gastroenterologist talking to a patient called Vincent Sykes. 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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F: Now, looking at your notes Mr Sykes, I see you've been having a few problems recently. Could you tell me a little about what's been happening erm... your symptoms, that you've noticed

M: Well, there are several things really. I've always been on the large side, but my clothes have felt looser recently 'cos I've lost a bit of weight - I mean, I haven't been trying or anything. I suppose it's not surprising 'cos I'm not eating as much at the moment. And these days, when I am eating, I seem to get full so quickly - before I'm even halfway finished. Actually getting the food down is hard sometimes, too ... I just can't ... well, I often feel like ... I'm choking to be honest.

F: I see. And what about your bowel habits - any change there?

M: Yeah - sometimes I have to rush to the loo. And my poo's a much lighter colour than it used to be ... and it's watery too - d'you know what I mean? And my stomach sometimes feels really ... well, gassy is the only way to describe it.

F: Right, I see. And have you noticed anything else?

M: Well, you'll have noticed the whites of my eyes ... they're looking sort of light yellow and

my skin does a bit too. It's also really itchy these days, too - drives me mad. I'm incredibly tired a lot of the time too - I just feel shattered.

F: I see ... and have you been experiencing any pain anywhere? In your joints, for example?

M: Well, my joints feel OK, but there's definitely a pain here, around my stomach and going round to my back. It usually hurts much more when I'm laying down. It's really hard dropping off to sleep some nights. When I first got it, I'd ake an anti-acid because it felt similar to heartburn, but it didn't seem to help, so I stopped doing that. I should've changed my diet really, I suppose, but till recently I'd always loed my food, especially the high-fat stuff. I was never one for sugary things though - I've not got a sweet tooth.

F: Right. And, err... how's everything affecting your life generally... let me explain... your work as a ...

M: I'm retired now actually. Most of my working life, about thirty years of it, was spent in a paint factory - I was the senior colour technician. It was interesting but a lot was resting on my shoulders really, and well the responsibility got me down - you know, things got pretty stressfull sometimes.

F: I can imagine. And do you smoke - or drink?

M: Well, I used to smoke - quite a lot really, looking back - about twenty a day, but I gave up when I stopped work a couple of years ago. But I still like a drink - not a lot, but I do enjoy a few beers at the weekend, you know.

F: Well, it's good that you've stopped smoking. Were you having health problems when you decided to give up?

M: Well, everything seemed to start going wrong a couple of years ago when I got a hepatitis B infection and I decided the cigarettes weren't helping that... and then not long after, about a year ago, they told me I'd got gallstones. That was pretty awful

F: Yes - it must have been. And how have you been since then?

M: Not brilliant really - I got a blood clot about six months ago, err... in my calf, and they put me on Warfarin, you know, for that. And then, last month, on top of everything, they told me I'd developed diabetes two. That was a bit of a surprise, to tell the truth... I really hadn't seen that one coming!

F: No. Well, I can see that you've been through the mill this last year or so, one way or another. OK, what I'd like to do now is to get a couple of tests ordered... [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 palliative care nurse talking to an elderly patient. Now read the question.

PAUSE: 15 SECONDS

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M So you've had some changes in your diet. Is anything a problem for you there?

F I might be losing a bit of weight cos I don't like eating much.

M Does that trouble you?

F No. I just don't want to eat a lot.

M Any trouble with your bowels? I know that you're taking regular laxatives but is that an issue for you?

F I've had a bit of trouble with constipation over the years. I've taken pills on and off. I've taken something now actually, but I still feel a bit bloated, you know, a bit crampy.

M So it's bothersome?

F Yeah. It's not what you'd call slight.

M Well I think we need to have a look at you - maybe make some adjustments to what you're taking, especially since you're getting that bloating.

F That'd be good.

PAUSE: 5 SECONDS

Question 26. You hear a pharmacist talking to a customer who is in pain. Now read the question.

PAUSE: 15 SECONDS

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M Good morning. Can I help you?

F Yes, I've been in a bit of pain. I've got arthritis you see, but it's not that - it's my jaw.

M Oh? Have you had this problem before?

F Yes, it flares up when I get anxious. I'm a bit stressed at the moment. I usually take some paracetamol, but I don't want to take too much because, you know, I'm already taking arthritis medication.

M Well, paracetamol is usually well-tolerated and can be used with your anti-inflammatories. But, you're right - taking that is not getting to the root of the problem. Have you seen a dentist or a doctor about this?

F Yes. I had a bite splint at one time, but it never really helped.

M Well, I'd recommend seeing someone about it again, because this can become a chronic problem.

F OK, you're probably right. Thanks so much.

PAUSE: 5 SECONDS

Question 27. You hear a dietitian talking to a patient about a new treatment plan for diabetes. Now read the question.

PAUSE: 15 SECONDS

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M So, are you interested in trying a new way of treating your Type 2 diabetes through diet? The diet would involve cutting your calorie intake down to 800 a day.

F Ooh - that's not many.

M Well, it'd mean cutting out fat and sugar and just eating protein and vegetables. But the payoff could be that you'll be completely diabetes-free.

F Well, it does sound like a healthy diet, and I guess I ought to have a go, if there's a chance of beating the condition. I just hope it's worth the effort though. I mean, there's no guarantee I won't still have diabetes at the end of it all, is there?

M Well, this is a new treatment, but we wouldn't undertake it without some prospect of success.

PAUSE: 5 SECONDS

Question 28. You hear a senior nurse advising a trainee about a condition called venous thromboembolism (VTE). Now read the question.

PAUSE: 15 SECONDS

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M You mentioned the risk of patients developing venous thromboembolism. What exactly should I be looking for?

F I think it's very important to be aware of the guidelines, but to remember that in practice, diagnosis is complicated. Swollen legs are a typical sign, but patients may or may not present with that, or the swelling may be difficult to detect if the patient is either obese or very thin. Maybe the patient has calf pain, or is breathless, but doesn't have any other symptoms. If you're at all suspicious of VTE in a patient, refer them urgently for investigation. Actually though, most cases of hospital-associated thrombosis occur after discharge. We should ensure there's a regular clotting profile so that appropriate preventative or therapeutic interventions can be made, and organise any prescriptions they'll need on discharge.

PAUSE: 5 SECONDS

Question 29. You hear an eye specialist talking to her patient. Now read the question.

PAUSE: 15 SECONDS

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F Now, Mr James, looking at the latest images of your eye I'd say there are signs of improvement.

M Well, I'm not completely cured, but there's less distortion in my vision. That's a huge relief - I could barely recognise people in the early stages. I'm still not confident about night driving. And I know I've lost colour perception in the centre of the affected eye - everything's grey. I notice it when I close the other one.

F Well, that's certainly what the images suggest - and what you describe is entirely to be expected. Despite the fact that your eye's recovered up to a point, there will be permanent damage to the retina. Instead of lying smoothly against the eye's inner surface, it'll stay a bit wrinkled, which would explain your symptoms.

M Well, at least my vision's clearer than it was. I'm grateful for that.

PAUSE: 5 SECONDS

Question 30. You hear a cardiologist updating hospital colleagues about trials of urine testing. Now read the question.

PAUSE: 15 SECONDS

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M As you're aware, many of our out-patients struggle to take their prescribed hypertensive medication, so we've looked into the reasons for unintentional lack of compliance. We discovered that one of the key reasons for patients forgetting to take their tablets was because of the number of pills required. Reducing the amount prescribed isn't possible of course, but something as simple as urine testing to monitor patients is proving an effective intervention. The results of our trials show that over fifty per cent of patients undergoing urine testing became completely adherent to their drug regime as a result, which of course leads to better outcomes. This is an important breakthrough, given that

previous studies showed limited benefits for high-risk patients from complex and costly alternatives aimed at reducing rates of stroke and heart disease.

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 micro-biologist called Dr Jane Finn giving a presentation about the overuse of antibiotics.

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

PAUSE: 90 SECONDS

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My name's Dr Jane Finn and I'm a micro-biologist. I'm talking today about the overuse of antibiotics, or anti-microbials as they're often called, and the serious dangers this poses for the future. We're all familiar with the threat of a post-antibiotic era in medicine. But how did we get to this point? Well, in the decade up to 2010, we saw a staggering increase of thirty- six per cent in antibiotic use worldwide. As more and more global citizens were able to access them, usually online, we saw uncontrolled consumption during that period. Although recent media stories suggest the general public has finally got the message that antibiotics should be used sparingly, there's still a hard-core who want them prescribed for everything. Doctors are now better at resisting their demands, however, for example when the problem's viral rather than bacterial.

This has improved things. For instance, there's been a fall recorded in the overall amount of antibiotics prescribed in the UK in a given four-year period. At first sight, that's welcome news. The data shows that this decrease hasn't had a negative impact on patients with common infections like pneumonia, but we simply don't know yet if it's made any impression on rates of antibiotic resistance. Other data shows that GPs have reduced the amount of antibiotics they prescribe by thirteen per cent over this period. Dentists have also reduced their prescriptions - by an impressive twenty per cent, but the figure for hospitals is much lower. So, it's not an equally distributed decrease, so the picture's more complicated than it may at first appear.

Something else complicating the picture is a widely-reported medical research paper published recently. This suggested that short courses of antibiotics work just as well to treat most bugs as the traditional longer courses of a week or so. Those conducting trials suggested that there's insufficient data to prove that short courses encourage antibiotic resistance and argued that it's using antibiotics for longer than necessary which increases this risk. The newspapers ran away with the story, however, and sent out mixed messages, by suggesting it was OK for patients to stop treatment once they started feeling better. So, I'd urge caution. After all, an improvement in symptoms doesn't mean that the underlying problem has been resolved. Also, we can't recommend widespread change on the basis of one article in a medical journal. In any case, as the original authors were careful to stress, the suggestions aren't appropriate for all bacteria-based illnesses, and TB was the example they gave.

Indeed, some bugs have proved especially resistant to antibiotic treatment and the best-known is probably MRSA. This came to light when, as a life-threatening condition for patients hospitalised for other reasons, it became particularly tough to treat. MRSA bacteria is notorious for being able to survive for long periods on surfaces like floors, taps and even fabric. And, of course, the fact that healthcare facilities are visited by huge numbers of people means the bacteria spread easily. But studies show that healthcare-associated MRSA declined by about fifty per cent between 1997 and 2011, thanks to things like new guidelines and targets, as well as ward-based contact control and meticulous disinfection procedures. This shows us that, rather than relying on one single action, introducing various initiatives on several fronts can limit the impact of the infection.

Turning to other areas of concern, let's look at antibiotics in agriculture and livestock rearing. People might be surprised to learn that, worldwide, the overall quantity of

antibiotics used in food production is now higher than the amount consumed by humans. Something which horrifies me, is that antibiotics are consumed by animals as a matter of course simply to prevent problems or, indeed, to speed up their growth. This happens a lot in intensive farming, where animals are kept in confined conditions. We've known for years now that this overuse is directly related to resistance in humans, so there's obviously an urgent need for farmers to cut down.

So, is there any progress to report? Well, though there's still serious work to be done in places, for example for manufacturers of antibiotics to stop discharging untreated waste products into water courses and so on, it's not all doom and gloom. We're finding now that when doctors prescribe antibiotics, they're choosing narrow-spectrum ones. These are active only against specific bacteria and so cause less general resistance. And something which is being talked about excitedly in the pharmaceutical industry just now is a therapy which uses bacterial viruses called phages to treat infections – something which was first practised about a century ago. Antibacterial therapies, whether phage- or antibiotic-based, have advantages and disadvantages, and there's still a lot to be learned about the interactions between phage, bacteria and human host, but maybe the time to take phage therapy seriously is rapidly approaching.

Now, before I go on to … [fade]

PAUSE: 10 SECONDS

Now look at extract two.

Extract two. Questions 37 to 42. You hear a rheumatologist called Michael Evans talking about osteoarthritis.

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

PAUSE: 90 SECONDS

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Hello. I'm Michael Evans. I want tell you about the work we're doing on a condition that affects one in ten people in this country, and that's osteoarthritis. Osteoarthritis typically

affects the knees, hips or hands when the cartilage that lines the joints starts to wear away.

So how can we help patients with osteoarthritis? When I was at medical school, and that’s a long time ago now, the theory was that it was due to wear-and-tear - an inevitable part of getting old. You still sometimes hear this, but it’s one of the many myths about the condition. After all, we have teenagers who develop it! And every joint has the capacity for repair. So we should think of osteoarthritis as a situation where processes for tissue repair are overwhelmed by destructive processes that often relate to injury, weight and mechanical load factors. But there are also other risk factors; genetics may play an important role, and occupation makes a difference too of course.

Let’s look at some more of the myths surrounding osteoarthritis. Osteoarthritis of the hands is an interesting case, because this is one time you might think you can’t put the blame on mechanical load factors. But you’d be wrong. There are actually circulating molecules that come from fat – and these influence the development of inflammation in joints. In fact, you’re thirty per cent more likely to get hand osteoarthritis if you’re obese. And there are a couple of studies going on right now to test the theory that losing weight can have a positive effect on osteoarthritis in the hands.

So, what about knees? A lot of people say there are very high knee-joint replacement rates in Australia, for example, because people do a lot of running in an attempt to keep fit. But this is another myth. In fact, studies show that for the majority of people, running’s helpful in terms of stopping the onset of osteoarthritis, though if you’re a marathon runner you do potentially place yourself at some risk. Now if you've already got osteoarthritis and you want to take up running, the data’s a bit conflicting. There are studies suggesting it can lead to exacerbations of the condition, but others suggest that patients who keep up their running do better at managing the condition than those who give it up.

In fact, the sport that’s often referred to as the ‘knee surgeon's friend’ is netball. This is because it involves a lot of jumping, which puts pressure on the knee, which can cause a tear in the cruciate ligament - one of the main stabilising ligaments in the knee. This often leads to the development of knee osteoarthritis within ten to fifteen years. In the hope of preventing this, players may be encouraged to have surgery to repair the cruciate ligament. But, in most cases, this is probably unnecessary, and it doesn't appear to change their long- term risk of developing osteoarthritis. The best way to prevent the problem arising is actually to teach players to jump and land in the right

way. Unfortunately, whilst professional players get taught this neuro-muscular technique, most ordinary players don't know about it.

Now let’s move on to diagnosis. We have various imaging techniques, such as X-ray, and we have MRIs. For osteoarthritis of the knee, if an X-ray’s going to show us anything at all, it must be a standing weight-bearing X-ray. But in most cases, it doesn't change what the doctor might do to the patient. We can diagnose by taking the history, assessing the symptoms, and examining the joint. And if someone of over fifty has an MRI scan, the likelihood is that it’ll reveal a meniscal tear. That just happens as part and parcel of growing older, and it’s not something that normally causes pain because a torn meniscus doesn't contain nerve fibres at that age. So it’s just going to lead to unnecessary worry, and in most cases intervention will do more harm than good.

The next thing the patient wants to know is, is there a cure? Well, not yet, but recently there have been exciting developments in osteoarthritis treatment. People ask about stem cells, but at present they’re unlikely to be any more helpful than a salt-water injection into the knee because stem-cell technology hasn’t got far enough yet. But we’re currently in the process of testing what we call ‘disease-modifying osteoarthritis drugs’ that appear to be effective at regenerating joint tissues and reducing pain and these will be injections a person gets into a joint, maybe once every twelve months. But our main hope is that, instead of turning to hip or knee replacements, patients can learn to control their condition through things like weight management and appropriate exercise.

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.