

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

CANDIDATE NUMBER:

LAST NAME:

FIRST NAME:

MIDDLE NAMES:

PROFESSION:

VENUE:

TEST DATE:

Candidate details and photo will be printed here.

Passport Photo

CANDIDATE DECLARATION

By signing this, you agree not to disclose or use in any way (other than to take the test) or assist any other person to disclose or use any OET test or sub-test content. If you cheat or assist in any cheating, use any unfair practice, break any of the rules or regulations, or ignore any advice or information, you may be disqualified and your results may not be issued at the sole discretion of CBLA. CBLA also reserves its right to take further disciplinary action against you and to pursue any other remedies permitted by law. If a candidate is suspected of and investigated for malpractice, their personal details and details of the investigation may be passed to a third party where required.

CANDIDATE SIGNATURE: _____

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)



Part B

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:   

1. According to the notice, the course is only available to nurses who
- (A) wish to apply for a hospital internship.
 - (B) are prepared to pay for the course themselves.
 - (C) are already employed in a related field.

NOTICE

Emergency Nurse Practitioner (ENP) Minor Injury Course

We are pleased to announce that the hospital's ENP service will be running a Minor Injury Course.

The aim of the course is to prepare experienced registered nurses working within emergency, primary care and walk-in environments to provide a high level of autonomous care for patients presenting with minor trauma.

The ENP Minor Injury Course structure has recently been changed. There will no longer be an additional clinical placement, and course applicants will therefore be required to complete all their clinical competencies in their own clinical setting with a designated mentor, with whom we will correspond in advance of the course. Therefore, only applications from registered nurses working in a nursing role on a permanent basis in a relevant area such as the emergency department or minor injuries unit within their organisation can be considered and their place will need to be funded by their organisation, rather than self-funded.



2. The guideline about breast pumps

- (A) restricts their removal from the ward.
- (B) provides operating instructions.
- (C) indicates times of unavailability.

Maternity Ward Guideline 4.3.7: Electric breast pumps

- All inpatient areas that care for infants of expressing or breastfeeding mothers have been allocated electric breast pumps. These should stay on their allocated ward except for when they are being cleaned. They are exclusively for use in the infants' ward area and should not be given to parents to take to their own accommodation.
- In addition to the ward-based pumps, there are expressing rooms containing electric breast pumps around the hospital. All the expressing rooms can be used by mothers of patients in any ward area as well as by mothers visiting outpatients.
- Breast pumps are now all tagged to enable pumps to be tracked and found quickly.
- A breast pump can be shared between mothers on a ward but should be wiped down by the mother after each use. Breast pumps are cleaned by the Hospital Sterilisation and Decontamination Unit weekly.



3. According to the policy, what must the Registered Nurse do when a patient is discharged?

- (A) check the clarity of aftercare instructions
- (B) liaise with other health professionals
- (C) ensure easy accessibility to patient data

Hospital Discharge Policy 4.1.5 Registered Nurse

Registered Nurses will have the responsibility for ensuring advice on discharge is provided to patients and, if required, relevant onward referrals are made including the booking of future outpatient appointments. The Registered Nurse must ensure that all relevant documentation is complete and accurate.

Registered Nurses will ensure effective handover (both verbal and written) of patients' assessment and on-going care needs. They will also be responsible (with the support of the discharge coordinator, where appropriate) for day-to-day co-ordination of discharge and act as a point of contact and conduit for effective communication for all members of the multi-disciplinary team. They must ensure that all requirements to facilitate a safe discharge are in place: this may include dressings, medication, and any equipment.



4. This notice provides information about

- (A) the potential dangers that NGTs pose to patients.
- (B) the precautions to be followed during the procedure.
- (C) the correct technique for inserting a nasogastric tube.

NOTICE

Nasogastric tube (NGT)

By inserting a nasogastric tube, you are gaining access to the stomach and its contents. This enables you to drain gastric contents, decompress the stomach, obtain a specimen of the gastric contents, or introduce a passage into the GI tract. This will allow you to treat gastric immobility and bowel obstruction, and permit drainage in drug overdosage or poisoning. NG tubes can be used to aid in the prevention of vomiting and aspiration and for assessment of GI bleeding. They can also be used for enteral feeding initially.

The potential for contact with a patient's blood/body fluids while starting an NG is present and increases with the inexperience of the operator. Gloves must be worn while starting an NG; and if the risk of vomiting is high, the operator should consider face and eye protection as well as a gown.



5. In this policy extract, what point is made about clinical guidelines?

- (A) Their content must be approved by all relevant staff.
- (B) They are a set of recommendations rather than regulations.
- (C) Ignoring them for no reason is likely to result in disciplinary action.

Clinical Guidelines

The development, introduction and use of guidelines is intended to ensure consistent care to all patients and reduce risks of errors and incidents through ensuring the whole clinical team is working in an informed, consistent, and clearly understood way. The policy aims to ensure that clinical guidelines are developed and agreed, keeping all key staff involved and informed as well as reflecting best practice. It is important to recognise that Clinical Guidelines are not mandatory and are not a substitute for clinical judgement. However, where guidelines are not followed, clinicians should be able to account for why a decision not to adhere to them has been taken. In these situations, it is good practice to record this in the patient notes. Clinicians also have a responsibility to report these instances to those responsible for producing the guidelines in order that such instances can be reflected more accurately within them.



6. The protocol instructs maternity staff administering Ferinject to

- A temporarily discontinue prescribing iron tablets.
- B avoid giving it to breastfeeding women.
- C be alert for any negative reactions.

Protocol for the use of Ferinject during pregnancy

Ferinject (Iron III carboxymaltose) has 50 mg/ml of elemental iron. It is administered by slow IV injection or infusion with no need for a test dose. It should be avoided in the first trimester, and it should be administered with caution during the second and third trimesters in cases of severe anemia where iron supplements are ineffective.

Less than 1% passes into breast milk, which is unlikely to be significant. While the rate of anaphylaxis with this preparation is low, it does carry a risk of anaphylactoid reaction. It does not require any monitoring except for a set of observations prior to administration.

Oral iron should be avoided for 5 days after the administration of Ferinject. A follow up full blood count should be performed at 2-3 weeks (adapt to clinical scenario if necessary) and the GP notified of the treatment and need for continuation of iron.



Part C

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: Planning for the future

The esteemed clinician-scientist Professor Robert Winston sparked debate recently. He avoids hiring graduates who have achieved high first-class degrees to work in his laboratories, he said, because experience has taught him that they are less likely to be well-rounded and good team players. Many hard-working and gifted students may feel aggrieved by his approach, but it is refreshing to see public acknowledgement that recruitment strategies must assess more than just academic ability. A similar debate has also resurfaced about medical school admissions, with senior clinicians and medical educators reiterating the need for a holistic application system to identify the most promising future doctors.

A prevailing problem is how to decide on a uniform description of the traits that should be sought in the doctors of tomorrow. After all, graduates from medical school are expected to go on to pursue careers in specialties as diverse as neurosurgery, dermatology, and microbiology. Clearly, these require different skills and personality types. So, can one single recruitment strategy identify a generic set of desirable traits for all future doctors?

Boston University Medical School is confident that this is possible. Using applicants' interviews, essays and letters of reference to identify evidence of service engagement, cultural sensitivity and emotional resilience, they attempt to match universally important traits with elements of applicant data that reveal or predict **them**.

The medical workforce, meanwhile, continues to evolve in response to the changing demographics and health needs of the population. The Centre for Workforce Intelligence is the UK authority on workforce planning and development and has recommended that reductions are needed in specialties such as general surgery, obstetrics and gynaecology, and anaesthesia, and that increases in training posts for general practice should continue.

According to its analysis, an overall decrease of 167 entry-level training posts for specialties based at hospitals, and an increase of 450 in general-practice training posts, would correct current imbalances. The UK Department of Health has also **vowed to tackle** this specialty mismatch and has promised to make the two specialties currently under most pressure, general practice and emergency medicine, more attractive to new doctors.



With increasing superspecialisation, practitioners in secondary-care disciplines tend to be world experts in narrow clinical areas. They may be enticed by the glamour of academia, but they often interact with relatively few patients during their careers. Generalists, meanwhile, have a far greater volume of clinical interactions and form relationships with countless patients. This has a different type of glamour, related to the unique opportunity to share everyday patient experiences. Indeed, the best general practitioners are invariably those who have mastered their unit of clinical interaction, the consultation. The very human skills of dealing with uncertainty, discussing patients' rational and irrational concerns, and developing trust, are vital to maintaining high-quality care in general practice.

Perhaps the best way to attract doctors to this discipline is therefore to encourage the selection of future clinicians who are likely to have these traits in the first place. Although Boston University Medical School's admissions system may not be perfect, its innovation shows that, with more time and thought, medical school recruitment can be improved and made more holistic. It seems obvious that medical school admissions systems should be guided by workforce requirements. Naturally, intellectual achievements will always be important, and the pace of modern evidence-based medicine certainly demands bright and inquisitive minds. However, the problems of multimorbidity and an ageing population are very real, and there can be little doubt that future health systems will require well-rounded generalists who have the skills to deal with presentations across the biopsychosocial spectrum.

A holistic admissions process is likely to facilitate the recruitment of suitably skilled people, who will appreciate the satisfaction of a lifetime building human relationships. So perhaps instead of coercing existing doctors towards facing the generalist challenges, the UK Department of Health would be better advised to invest in the medical school admissions process and re-evaluate recruitment to the profession altogether.



Text 1: Questions 7-14

7. What is the writer's reaction to Professor Winston's strategy?
- (A) He approves of the idea behind it.
 - (B) He is surprised by the theory it is based on.
 - (C) He worries about the implications it may have.
 - (D) He is disappointed by the narrowness of its focus.
8. The writer's purpose in the second paragraph is to highlight
- (A) the personal qualities needed for a career in medicine.
 - (B) the difficulty of knowing which specialty fits each personality best.
 - (C) the extensive choice of career options open to medical graduates.
 - (D) the challenge of assessing candidates' suitability for a medical career.
9. What does the word 'them' in the third paragraph refer to?
- (A) people applying for places at medical school
 - (B) aspects of medical school applicants' personalities
 - (C) documents relating to applications for medical school
 - (D) grades which applicants are likely to achieve at medical school
10. The fourth paragraph focuses on the
- (A) predicted lack of qualified medical professionals in the UK.
 - (B) reasons why fewer doctors are choosing to go into general practice.
 - (C) ways to ensure the demand for certain medical professionals is met.
 - (D) need to maintain a broad range of specialties in the medical workforce.



11. The expression 'vowed to tackle' is used to stress
- (A) a commitment to a certain objective.
 - (B) an unwillingness to change direction.
 - (C) a reaction to some unexpected criticism.
 - (D) an acknowledgement of a miscalculation.
12. What point does the writer make about superspecialisation?
- (A) Clinicians have little opportunity to develop certain valuable skills.
 - (B) Generalist practitioners are having to deal with an increasing workload.
 - (C) Specialists may be unaware of work carried out in other branches of medicine.
 - (D) Some specialties attract clinicians with less interest in direct contact with patients.
13. In the sixth paragraph, the writer says that medical schools should
- (A) ensure that academic standards remain a priority.
 - (B) encourage graduates to become general practitioners.
 - (C) teach students how to build relationships with patients.
 - (D) favour applicants who possess good interpersonal skills.
14. What does the writer suggest about the UK Department of Health in the final paragraph?
- (A) It underestimates the scale of the challenge.
 - (B) Its approach to solving the problem is misguided.
 - (C) Its grasp of the population's healthcare needs is limited.
 - (D) It has misunderstood the underlying causes of the situation.



Text 2: Open patient records

In the US, the expansion of patient access to electronic medical records has been accompanied by numerous studies investigating the experiences of patients and clinicians. Starting from about 2000, the use of patient portals to display test results spread rapidly, and in 2010, 100 primary care doctors volunteered to open their free text entries to 10,000 of their patients. By 2019, more than 50 million patients in the US had access to what their clinicians wrote about their medical care. In 2021, the US federal government mandated that patients should have easy electronic access at no charge to all information held in their electronic health records. Today, patients can use readily available patient portals to access all the information a clinician might use to make decisions about their care in both inpatient and outpatient settings, including primary care and specialist notes, laboratory test results, and imaging reports. So, what might doctors in other countries whose governments are in the process of implementing transparent medical records learn from the US experience?

US clinicians anticipated increased workloads as, from about 2000, patients gained access to test results and, a decade later, to visit notes. Primary care doctors worried about upset and confused patients contacting them or asking time-consuming questions during visits, and requesting changes to what had been written. These concerns were largely unrealised, and at the end of the year-long 2010 pilot, none of the participating doctors chose to turn off access to notes. In fact, their healthcare organisations chose instead to expand access to notes written by all clinicians. These results have been replicated in hundreds of provider organisations across the country, and follow-up studies indicate that clinicians' views of open notes become more positive over time.

Some studies suggest clinicians are changing the way they document in the wake of open medical records. In one, around 37% of doctors reported spending at least 'some' more time writing notes, but preliminary inquiries using the timestamps from electronic health records suggest that any increase in time spent in documentation is miniscule (fractions of a second). It is likely that doctors learn to think differently about how to document, particularly when new to the practice of open medical records. Such additional cognitive burden may make it feel as if they are spending more time writing, even though direct measurements indicate no change. As doctors become accustomed to writing in this way, such strain may well ease.

Clinicians worried initially about how transparent medical records may engender adversarial patient-clinician relationships and increase doctors' liability. Trusting relationships are known to diminish the risk of litigation, even when errors occur, and the US's overall experience suggests that open and transparent communication increases trust among patients, families, and clinicians. The movement to encourage disclosure and apology when problems arise, which has spread across US states in recent years, provides **further reassurance**. Studies indicate that increased transparency, disclosure, and apology may decrease the chance that patients and families will file lawsuits. Furthermore, insurers state that open medical records do not seem to increase the risk that patients will allege malpractice.



Further challenges accompanying the rollout of open medical records remain. Clinicians have concerns about the wellbeing of their most vulnerable patients, such as those experiencing domestic violence. US regulations allow clinicians to withhold information from the patient portal if they believe it might harm an individual patient or another person. Yet it is unlikely that all doctors and patients are aware of this exception. Healthcare organisations could help ensure the safety of such vulnerable patients by providing training to clinicians and patients. Electronic health record vendors could also design provider functions that facilitate trauma informed care, including options to create confidential notes and enhanced privacy settings that allow patients greater control over what information is available on the portal.

Another issue currently under debate in the US is when test results should be released to patients. In the past, with the common-sense expectation that clinicians would first communicate with patients, most health systems chose to delay the release of some findings, such as pathology examinations, medical imaging reports, or cardiac monitoring. In contrast, the new US rules mandate instantaneous release of virtually all results, regardless of whether they suggest bad tidings.

Challenges such as these are not insolvable, but they will take a **creative combination** of cultural and technical adaptations to resolve. All new medicines are accompanied by side effects that affect some patients adversely, and for some patients, fully transparent records may be contraindicated. But in the US, the benefits of open medical records for all involved seem to well outweigh the risks. Patients consistently report clinically meaningful effects, and any potentially negative effects on practitioners have been limited and manageable.



Text 2: Questions 15-22

15. In the first paragraph we learn that, in the USA, allowing patients access to their own medical records
- (A) has been driven by doctors.
 - (B) was prompted by targeted research.
 - (C) was made possible by advances in technology.
 - (D) happened over a relatively short period of time.
16. What point does the writer make about open access medical records in the second paragraph?
- (A) Healthcare organisations decided to implement them more quickly than required.
 - (B) Doctors made incorrect assumptions about the effects they would have.
 - (C) Their implementation has affected doctors more than patients.
 - (D) Pilot studies on them didn't go as expected.
17. What is the writer doing in the third paragraph?
- (A) disputing the results of research into writing notes
 - (B) making suggestions about the best way to write notes
 - (C) offering a theory about doctors' perceptions of writing notes
 - (D) exploring the role that experience plays in writing effective notes
18. In the writer's opinion, the policy of open records has not led to an increase in lawsuits because
- (A) knowing that patients can access their records means doctors feel compelled to apologise for errors.
 - (B) having access to information leads people to have greater confidence in their doctors.
 - (C) other changes in the US have made legal battles less attractive for patients.
 - (D) sharing knowledge means doctors can learn from the mistakes of others.



19. In the fourth paragraph, the writer believes that '**further assurance**' is being given to
- (A) patients.
 - (B) families.
 - (C) clinicians.
 - (D) US states.
20. What point does the writer make about vulnerable patients?
- (A) Current legislation is not robust enough to protect them.
 - (B) Keeping their data safe is not just the responsibility of doctors.
 - (C) They are insufficiently informed about the way open records may endanger them.
 - (D) Keeping information from them puts them more at risk than including it in their electronic records.
21. In the sixth paragraph, the writer suggests that
- (A) there is some news which is best given by a doctor.
 - (B) some US health systems are trying to bypass a new rule.
 - (C) test results should be checked by a doctor before patients get access to them.
 - (D) new rules on access to results fail to distinguish between different types of test.
22. In the final paragraph, the phrase '**creative combination**' is used to suggest that making open records work
- (A) is the responsibility of both patients and doctors.
 - (B) may require people and organisations to think in new ways.
 - (C) means accepting that different groups of patients will use them differently.
 - (D) will depend on people accepting that there are both risks and benefits to using them.

**END OF READING TEST
THIS BOOKLET WILL BE COLLECTED**



BLANK

