OCCUPATIONAL ENGLISH TEST

Sample Test 4

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. When disclosing distressing information to patients, staff must avoid

(A) the temptation to use simplistic language.

(B) directing their attention at family members.

(C) any approach which leads to misunderstandings.

Extract from a manual on surgery: disclosure

The delivery of bad news is very difficult. Arrange to talk to the patient in the company of family, preferably away from other patients. In some cultures, it is not common to give difficult news directly to the patient. We must be aware that the norms and customs of our patients may not match our own. Often we try to soften the delivery of bad news by saying too much and confusing the matter, or by saying too little and leaving people with unanswered questions. Don't say neoplasm if what you mean, and what will be understood, is cancer. Be clear, allow people to understand and feel some of the impact of the news, and then allow them to ask questions. It is often necessary to repeat the information to other family members, or to the same people the next day.

2. The purpose of the guidelines for general practitioners is

(A) to remind them to write asthma action plans.

(B) to raise their awareness of the value of asthma action plans.

(C) to direct their discussions with patients about asthma action plans.

Policy guidelines for general practitioners: asthma action plans

An integral part of asthma management is the development of a written asthma action plan by the person with asthma and/or their carer together with their doctor. An asthma action plan helps the person with asthma and/or their carer recognise worsening asthma and gives clear instructions on what to do in response.

The process of developing a written asthma action plan is important, as this should be a discussion of the person's individual asthma and its management. The written plan is a reminder of that discussion. Written asthma action plans are one of the most effective asthma interventions available, and have been shown to reduce hospital admission and emergency visits to general practice.

3. The guidelines on chemical waste disposal stress the need for staff to

(A) take appropriate safety precautions when handling chemicals.

(B) ensure that any chemicals in the hospital are properly documented.

(C) consult service providers before disposing of all hazardous chemicals.

Unknown and empty chemical waste container disposal

Unlabelled chemicals are increasingly difficult and very costly to dispose of and may require special analysis in order to identify them. Furthermore, the hospital's chemical waste contractor will now NOT remove any unknown chemicals due to their risk level. Every effort should therefore be made to ensure that all chemicals in use, in storage or being prepared for disposal are fully labelled and described.
If unidentified waste is discovered, you should immediately notify the hospital's designated waste contractor via the helpdesk and complete an incident form. All empty containers which have previously contained chemicals for licensed disposal must be considered as Hazardous Waste until cleaned.

4. This memo is reminding pharmacists about

(A) the rationale for documenting incidents and errors.

(B) the procedure for investigating incidents and errors.

(C) the method for submitting incident and error reports.

Memo

To: All staff

Re: Pharmacy incidents and errors

Dispensing errors, other significant errors, omissions, incidents, or other non-compliances, including complaints of a non-commercial nature arising both within and external to the pharmacy, may be the subject of investigation. Pharmacists should therefore follow a risk management procedure, including appropriate record keeping. The record is to show when the incident was recorded, when it occurred, who was involved (both actual and alleged), the nature of the incident or complaint, what actions were taken and any conclusions. If contact was made with third parties, such as government departments, prescribers, lawyers or professional indemnity insurance companies, details of the conversation should be recorded. Regardless of how serious the incident may appear, comprehensive detailed records need to be kept. The record should be kept for three years because of the delayed nature of some forms of litigation.

5. What point is being made in this guideline about patients with multi-trauma?

(A) Staff should make it a priority to rule out spinal injuries.

(B) Spinal injuries are missed in a small but growing number of cases.

(C) There is evidence that immobilising a patient with spinal injuries is helpful.

Evaluation of potential spinal injuries
Amongst adult patients suffering high-energy multi-trauma, approximately 5% will suffer a significant (i.e. mechanically unstable) vertebral column injury (VCI) and significantly less than 1% suffer a spinal cord injury (SCI). The main risk from undiagnosed unstable VCI is that further neurological compromise will occur. Balanced against this rare but potentially catastrophic risk is the fact that the majority of trauma patients do not have a VCI, and prolonged application of spinal precautions and immobilisation is associated with multiple complications including pressure sores, raised intracranial pressure or ventilator associated pneumonia. Furthermore, the efficacy of these interventions in reducing secondary neurological compromise is controversial. Therefore, patients in ICU should undergo spinal evaluation by CT imaging and interpretation by a consultant radiologist within 24 hours of injury. If imaging is undertaken out of hours, it is acceptable to continue spinal precautions overnight and review imaging early the next day.

6. What does this update tell medical professionals about bovine insulin?

(A) It is being withdrawn due to the risks associated with its long-term use.

(B) Users may experience difficulties when switching to alternatives.

(C) Any side effects are more difficult to identify in older patients.

Memo

To: All staff

Re: Withdrawal of bovine insulin

Bovine insulin preparations will shortly be withdrawn due to limited availability of the active ingredient.

As people with insulin-treated diabetes who currently use bovine insulin preparations will continue to require insulin treatment, they will need to be changed to alternative, acceptable preparations.

People using bovine insulins are likely to be older patients with long-standing diabetes. They may therefore have absolute insulin deficiency. These individuals will be at risk of impaired awareness of hypoglycaemia, predisposing them to severe hypoglycaemia.

Use of bovine insulin has been associated with the presence of insulin autoantibodies, which may impair the action of insulin. Porcine, human or analogue insulins are likely to lower the glucose more than the same dose of bovine insulins, and insulin dose titration may be difficult and unpredictable. People with bovine insulin-treated diabetes are therefore a high-risk group.

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.

Ⓐ
Ⓑ
Ⓒ
Ⓓ

Fill the circle in completely. Example: Ⓑ

Text 1: Conjunctive group therapy: a case study of an adult type I diabetes mellitus patient

Diabetes mellitus (DM) is a chronic condition and a significant public health problem; complications are responsible for high morbidity and in many cases premature mortality. Type 1 diabetes (DM1) has an early onset and insulin injection is an integral part of the medical therapy of this condition. The onset of DM1 generates various biological and psychological changes and may force patients to face complicated challenges, such as maintaining optimal physical health, managing their condition, and dealing with possible comorbidities and unpredictable symptoms. As a chronic condition, DM1 demands radical changes in lifestyle, in order for the patient to achieve effective adjustment.

While patients' individual differences play a significant role in the course of the condition, they will also share several common psychological reactions to DM1, such as denial and stress over the diagnosis, prognosis, and treatment of the condition, as well as depression. Consequently, DM1 treatment requires what has been termed a biopsychosocial approach, combining medical monitoring and regimen compliance on the one hand, and psychological intervention on the other. Group therapy for patients with physical illnesses is based on this model and has been widely used in applied clinical research and practice. It has been used both for its effectiveness as a therapeutic approach, and also because as a process it enables simultaneous treatment of a large number of patients. Numerous studies have found group therapy to be an effective treatment for chronic conditions in general, and more specifically for DM1.

Ella was a 30-year-old DM1 patient who participated in a 2-year Conjunctive Group Therapy (CGT) programme, while receiving parallel medical treatment for DM1. Therapy was based on the principles of CGT, which involved eight members including the patient and used non-guided topics of discussion as its basis. The rules and regulations of the sessions were based on discretion, confidence and open expression. Each session lasted two hours, and the group met twice per month. Ella's participation in the group was based both on a referral from her endocrinologist and her personal request for a psychotherapeutic intervention.

Although Ella's participation in the group was voluntary, she initially displayed strong resistance to the process. Nevertheless, as therapy progressed, Ella became actively involved by initiating group discussions and interacting assertively with group members. She identified the role of DM1 in her life in relation to herself and her social environment, and also managed to reflect on the group processes effectively. Combined with Ella's natural ability to express herself clearly, **all this** put her in a very strong position to focus on the issues that had previously impeded her self-care. In time, therefore, she was able to modify her actions and so start to make progress regarding DM1 regulation.

Ella's expectations of CGT treatment had been very low, as she thought that the group's function would merely be to soothe everyday distress caused by her condition. Moreover, she perceived diabetes as an external factor that affected herself and her life, by compromising her health, dreams, actions and potential in general. In terms of emotional state, Ella's core feelings were a continuous and generalized stress and anxiety that developed from a constant sense of threat. Ella had great difficulty in achieving a pattern of stable self-care and tended to attribute this inconsistency to external factors, such as the physician or the regimen. Additionally, over the years, she had dropped out of a variety of activities such as meeting friends, travelling and fulfilling academic obligations. Before the intervention, she lived with her parents and felt dependent on them. She had also given up the choice of creating a family of her own, attributing this decision to the unpredictability of DM1.

Gradually, as the intervention progressed still further, numerous changes were observed. First of all, diabetes treatment became a more tangible target as Ella realized that the group had taught her new behaviours regarding her condition and had helped her address critical questions related to it. The group also offered her a clear picture of her dysfunctional behaviors, such as binge eating, which used to have a negative impact on her diabetes. The previous generalized sense of worry was eliminated and she engaged in stress management, which also decreased her sense of vulnerability. She gradually recognized her obligations concerning self-care and the amount of control she could have over **that**; therefore, she managed to stabilize her behaviour in this regard. Furthermore, she regained contact with lost friends and engaged in new relationships. She began travelling again and continued her studies, which boosted her sense of self-worth. Overall, CGT helped Ella to redefine the role of diabetes in her life, achieve reconciliation with it and so, finally, to integrate it into her everyday existence.

Text 1: Questions 7-14

7. In the first paragraph, what aspect of DM1 is highlighted?

(A) the demanding treatment regime it entails
(B) the extent of the problems it causes society
(C) the degree of disruption it brings to patients' lives
(D) the severity of medical complications it can lead to

8. The writer sees one benefit of a biopsychosocial approach as

(A) allowing medical professionals to conduct valuable research.
(B) focusing on the person as an individual rather than on the condition.
(C) addressing issues shared by many patients with persistent conditions.
(D) producing the most rapid improvements in patients with mental health issues.

9. In the third paragraph, we learn that the patient called Ella joined the CGT programme partly because

(A) her physician was disappointed with her response to medication.
(B) she had expressed an interest in having treatment of this kind.
(C) she felt the timings of the sessions were convenient for her.
(D) her treatment was not addressing her personal needs.

10. In the fourth paragraph, the writer says that Ella benefitted from CGT by learning to

(A) take charge of situations effectively.
(B) articulate her feelings in front of others.
(C) alter her approach to managing her condition.
(D) suppress her negative thoughts about diabetes.

11. The phrase '**all this**' in the fourth paragraph refers to changes in

(A) Ella's own personality.

(B) Ella's behaviour in the group.

(C) Ella's acceptance of her diabetes.

(D) Ella's belief in the aims of programme.

12. In the fifth paragraph, what does the writer say about Ella's attitude before she started CGT?

(A) She felt she had been repeatedly let down by family and friends.

(B) She was worried that she was developing psychological problems.

(C) She was upset by the prospect of being unable to have any children.

(D) She blamed others for her inability to look after herself on a daily basis.

13. In the final paragraph, the writer says that Ella ultimately benefitted from CGT by

(A) coming to accept that she could live with her condition.

(B) gaining insights into other behaviours typical of her condition.

(C) learning to focus on the day-to-day treatment of the condition.

(D) becoming aware of the way her condition had impacted on others.

14. What does the word '**that**' in the final paragraph refer to?

(A) Ella's obligations to the group

(B) the stability of Ella's behaviour

(C) a recognition that Ella was vulnerable

(D) Ella's ability to manage her own condition

Text 2: Alzheimer’s from a new angle

As chairman of the department of neurology and neurological sciences at Stanford University School of Medicine, Dr Frank Longo knows how destructive Alzheimer's can be. The disease was discovered in 1906, but despite more than a century of research, including the testing of over 200 new drugs in the past two decades, there are still no real treatments. As Longo says, ‘We've cured Alzheimer's in mice many times, why can't we move that success to people?’. He’s referring to numerous promising compounds that have eliminated the amyloid plaques associated with Alzheimer's in animals. However, if ongoing trials continue to go the way he hopes, his new drug, called LM11A-31, could be a critical part of finally making that happen.

For decades, scientists have focused on trying to get rid of the hallmark feature of Alzheimer's: the sticky protein plaques of amyloid that they have dealt with so well in mice. If they could get rid of that in humans too, the thinking went, they could eliminate the disease, or at least lessen its severity. LM11A-31, however, doesn't directly attack amyloid. ‘We're sceptical about what is actually causing Alzheimer's,’ Longo says, referring to those protein plaques. ‘Most people are **working at the edges of the problem**, but we're going right after the core of it.’ LM11A-31 isn't designed to eliminate every clump of amyloid, but rather to keep brain cells strong, safeguarded against neurological onslaughts, whether they're the effects of amyloid or other factors involved in Alzheimer's. It's a less orthodox approach, but if it works, it could be a turning point.

Under a microscope, Longo displays before-and-after slides of some brain neurons from mice. On the before slide, the normally orderly and uniform cells are in disarray. They're dying, slowly being choked off from their supply of nutrients by amyloid plaques that start to accumulate in the Alzheimer's-afflicted brain. In the after slide, the cells look normal. The difference, Longo says, is LM11A-31. For brain cells, their molecular connections to other neurons are their lifeline. It's like their version of a social networking site, as they continually bombard other neurons with status updates. But when the cells are assaulted by something like amyloid, these communications are threatened, ultimately leading to the death of the cells.

Longo has a diagram of the signals passed among brain nerves that are triggered by amyloid proteins. These can ultimately lead neurons to deteriorate. There are 14 in total, and so far he's found that LM11A-31 can halt at least ten. There are even signs that LM11A-31 might help people whose brains are already damaged by amyloid. ‘The general assumption was that the damage to brain neurons was irreversible,’ says Longo. ‘What our studies show is that in mice, there is a significant amount of damage that is reversible,’ he says. ‘If approved [for human use], these could be the first drugs that will change the course of the disease rather than just treat its symptoms’, says James Hendrix of the Alzheimer's Association. But the reality is that it's not clear yet whether the changes seen from LM11A-31 restored any lost memory. Brain experts are eagerly awaiting Longo's next series of studies for the answer to that question. So far, not everyone is convinced. ‘To bring back neurons that have been destroyed by plaques and tangles – to me that still seems almost like science fiction,’ says Hendrix.

Still, there's no denying the potential of compounds like LM11A-31 and the need to think about new ways to attack the disease. Some experts are convinced that if people live long enough, some form of dementia, most likely Alzheimer's, is inevitable, although figuring out which patients can benefit from which types of treatments, and when, is still an open question. Although this hypothesis is unpalatable to many medical professionals, it's a proposition that even the US government is starting to appreciate. In 2011, Congress created a National Alzheimer's Plan to coordinate and accelerate the development, testing and approval of new drugs to treat the disease. And the Alzheimer's Association will soon issue a consensus statement on how to move promising drug candidates to human testing as quickly as possible.

If and when viable treatments become available, part of the puzzle will include figuring out who they should be given to, and when. The idea of applying amyloid PET scans to everyone on their 65th birthday isn’t going to run, given that they currently cost several thousand dollars each. But some type of risk score, as we now have for heart disease, isn’t far off. There’s no doubt that we need to think beyond amyloid and encourage patients to participate in trials testing non-amyloid strategies as well. In an ideal world, you'd want to design a therapeutic regimen based on the different components contributing to each patient’s dementia issues. LM11A-31 may well become the first drug in that cocktail.

Text 2: Questions 15-22

15. In the first paragraph, it's suggested that Dr Longo feels

A annoyed that certain Alzheimer's treatments are not approved for human use.

B concerned that the Alzheimer's drug LM11A-31 may prove ineffective.

C surprised that so little is still known about what causes Alzheimer's.

D frustrated by the lack of progress towards treating Alzheimer's.

16. Longo's phrase '**working at the edges of the problem**' reveals his feeling that other researchers

A are distracted by their success with animals.

B are refusing to recognise a key feature of Alzheimer's.

C are afraid to admit the problems they have encountered.

D are focusing on some of the less relevant aspects of Alzheimer's.

17. In the second paragraph, what point does the writer make about the drug LM11A-31?

A It is effective even in the most severe cases.

B It is a product of previous research into amyloids.

C It works regardless of the actual cause of the disease.

D It provides little protection against other neurological conditions.

18. With the reference to social-networking sites, the writer is illustrating

A how important it is that neurons in the brain are in constant contact.

B how quickly disease can spread from one brain cell to another.

C how easy it is to disrupt communication in the brain.

D how complex the connections in the brain are.

19. In the fourth paragraph, we learn that according to Longo, LM11A-31 blocks certain

(A) signals.

(B) neurons.

(C) brain nerves.

(D) amyloid proteins.

20. What reservation about the drug LM11A-31 is expressed in the fourth paragraph?

(A) Restoration of neurons may only be short-term.

(B) Research by Longo's team may have been biased.

(C) Results from trials on mice may not be replicated in humans.

(D) Reversal of damage may not have any effect on the patient's memory.

21. According to the writer, which group is reluctant to accept that dementia is inevitable?

(A) patients

(B) the US government

(C) medical professionals

(D) the Alzheimer's Association

22. In the final paragraph, what does the writer think will start to happen soon?

(A) Other non-amyloid-focused treatments for Alzheimer's will emerge.

(B) Drug regimens for Alzheimer's will be targeted to individuals.

(C) A prediction tool for Alzheimer's will be developed.

(D) All over 65s will be tested for Alzheimer's.

END OF READING TEST
THIS BOOKLET WILL BE COLLECTED

BLANK