OET

SAMPLE TEST 1

LISTENING: QUESTION AND ANSWER BOOKLET

CANDIDATE NAME:

D.O.B.: D D M M Y Y Y Y

PROFESSION:

VENUE:

TEST DATE:

Starting at the left, print your Candidate Number and fill in the corresponding circle below each number using a 2B pencil.

Example:

2	5
0	0
1	1
●	2
3	3
4	4
5	●
6	6
7	7
8	8
9	9

CANDIDATE NUMBER

0	0	0	0	0	0	0	0	0
1	1	1	1	1	1	1	1	1
2	2	2	2	2	2	2	2	2
3	3	3	3	3	3	3	3	3
4	4	4	4	4	4	4	4	4
5	5	5	5	5	5	5	5	5
6	6	6	6	6	6	6	6	6
7	7	7	7	7	7	7	7	7
8	8	8	8	8	8	8	8	8
9	9	9	9	9	9	9	9	9

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: APPROXIMATELY **40 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, you will have two minutes to check your answers.

At the end of the test, hand in this **Question and Answer Booklet.**

You must not remove OET material from the test room.

HOW TO ANSWER THE QUESTIONS

Part A: Write your answers on this **Question and Answer Booklet** by filling in the blanks. **Example: Patient:** Ray Sands

Part B & Part C: Mark your answers on this **Question and Answer Booklet** by filling in the circle using a 2B pencil. **Example:** (A) (B) (C)

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: --beep--

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 1-24**, complete the notes with information that you hear.

Now, look at the notes for extract one.

Extract 1: Questions 1-12

You hear a physiotherapist talking to a new patient called Ray Sands. For **questions 1-12**, complete the notes with a word or short phrase that you hear.

You now have thirty seconds to look at the notes.

Patient Ray Sands

18 months ago
- back injury sustained (lifting **(1)**_____)

1 year ago
- sciatica developed

6 months ago
- clear of symptoms

Last month
- recurrence of symptoms

Patient's description of symptoms
- pain located in **(2)**_____
- pain described as **(3)**_____
- loss of mobility
- problems sleeping
- mentions inability to **(4)**_____ as most frustrating aspect
- **(5)**_____ sensation (calves)
- general numbness in affected area

Occupation
- **(6)**_____ (involves travel/some manual work)

Initial treatment
- prescribed NSAIDs
- application of **(7)**_____ (provided some relief)

Referrals
- **(8)**_____ (briefly)
- sports injury specialist for manipulation and exercise programme

Further treatment
- epidural injections
- **(9)**_____
- electrical impulses
- decided not to try **(10)**_____
- patient attributes recovery to **(11)**_____

Previous diagnosis
- sciatica probably related to **(12)**_____
- reports no history of pain in buttocks

Extract 2: Questions 13-24

You hear a consultant dermatologist talking to a patient called Jake Ventor. For **questions 13-24**, complete the notes with a word or short phrase that you hear.

You now have thirty seconds to look at the notes.

Patient Jake Ventor

Reason for referral
- skin lesion

Patient's description of condition
- on the **(13)**_____ of his left hand
- preceded by **(14)**_____
- then **(15)**_____ form and join up
- surrounding erythema
- GP describes appearance of lesion as **(16)**_____
- normally resolves within two weeks

History of condition
- first experienced in 1990s when living in China
- also had a lesion on his **(17)**_____ – never recurred there
- recurs regularly on different parts of his left hand
- not becoming more **(18)**_____
- no apparent link to general state of health, **(19)**_____ or stress

Medical history
- **(20)**_____ on lower back in 2006 – no sign of recurrence
- reports no history of **(21)**_____

Information given
- advised that **(22)**_____ was unlikely to be effective
- told him to take care if the skin is **(23)**_____

Outcome
- says his quality of life isn't affected
- a **(24)**_____ will be arranged

That is the end of Part A. Now look at Part B.

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 25-30**, 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.

Ⓐ
Ⓑ
Fill the circle in completely. Example: Ⓒ

---

25. You hear a nurse briefing her colleague about a patient.

What does she warn her colleague about?

(A) The patient is allergic to some types of antibiotics.

(B) Care must be taken to prevent the patient from falling.

(C) Oxygen may be needed if the patient becomes breathless.

26. You hear the manager of a care home for the elderly talking to the nursing staff.

He says that errors in dispensing medication to patients usually result from

(A) interruptions while calculating dosages.

(B) a failure to check for patients' allergies.

(C) administering drugs late in the day.

27. You hear part of a morning briefing on a hospital ward.

What is the plan for the patient today?

(A) Her emotional state will be carefully observed.

(B) She will be transferred to a more specialised unit.

(C) A social worker will come to see what help she needs.

28. You hear part of an ante-natal consultation at a GP practice.

What does the patient want to know about?

(A) the advisability of a home birth

(B) ways of avoiding post-natal depression

(C) what painkillers might be available during labour

29. You hear a trainee doctor telling his supervisor about a problem he had carrying out a procedure.

The trainee feels the cause of the problem was

(A) treatment administered previously.

(B) the patient's negative reaction.

(C) inappropriate equipment.

30. You hear a doctor talking to a teenage boy who has a painful wrist.

The doctor wants to establish whether

(A) a fracture may be misaligned.

(B) the swelling may be due to a sprain.

(C) there may be more than one bone affected.

That is the end of Part B. Now look at Part C.

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 31-42**, 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.

Ⓐ
Ⓑ
Fill the circle in completely. Example: Ⓒ

Extract 1: Questions 31-36

You hear an interview with a cardiologist called Dr Jack Robson, who's an expert on Chagas disease.

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

31. Why does Dr Robson regard Chagas as a neglected disease?

- (A) because of the social groups it mainly affects
- (B) because patients often don't realise they're infected
- (C) because its impact is severe in a relatively small number of cases

32. Dr Robson says that concerns over Chagas in the USA are the result of

- (A) a rise in the number of people at risk of being infected with the disease.
- (B) a greater awareness of how many people there have the disease.
- (C) an increased prevalence of the insect which carries the disease.

33. A patient called Marisol recently asked Dr Robson to test her for Chagas because

- (A) she was worried about the health of any children she might give birth to.
- (B) she wanted to know whether it was safe for her to donate blood.
- (C) she thought she had symptoms associated with the disease.

34. What problem does Dr Robson identify in the case of a patient called Jennifer?

(A) an unwillingness to accept that she was ill

(B) an inability to tolerate the prescribed medicine

(C) a delay between the initial infection and treatment

35. What does Dr Robson say about his patient called Juan?

(A) The development of his illness was typical of people with Chagas.

(B) An incorrect initial diagnosis resulted in his condition worsening.

(C) The medication he took was largely ineffective.

36. Dr Robson thinks the short-term priority in the fight against Chagas is to

(A) increase efforts to eliminate the insects which carry the parasite.

(B) produce medication in a form that is suitable for children.

(C) design and manufacture a viable vaccine.

Now look at extract two.

Extract 2: Questions 37-42

You hear an occupational therapist called Anna Matthews giving a presentation to a group of trainee doctors.

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

37. Anna says that the main focus of her work as an occupational therapist is

- (A) designing activities to meet the changing needs of each patient.
- (B) making sure she supports patients in reaching their goals.
- (C) being flexible enough to deal with patients of all ages.

38. When Anna first met the patient called Ted, she was

- (A) unable to identify completely with his attitude.
- (B) optimistic that he would regain full mobility.
- (C) mainly concerned about his state of mind.

39. Because Ted seemed uninterested in treatment, Anna initially decided to focus on

- (A) what he could achieve most easily.
- (B) allowing him to try and help himself.
- (C) making him come to terms with his injuries.

40. Anna feels that, in the long term, her therapy helped Ted because

- (A) it led him to become less emotional.
- (B) it made him appreciate the need for patience.
- (C) it showed him there was something to work towards.

41. Anna describes the day Ted had his plaster casts removed in order to

(A) demonstrate how slow any progress can seem to patients.

(B) illustrate the problems caused by raising a patient's hopes.

(C) give advice on what to do when patients experience setbacks.

42. Anna suggests that when patients like Ted recover enough to go home, they are often

(A) too ambitious in what they try to achieve initially.

(B) able to build on the work of the occupational therapist.

(C) held back by the over-protective attitude of family members.

That is the end of Part C.

You now have two minutes to check your answers.

THAT IS THE END OF THE LISTENING TEST

SAMPLE TEST 1

READING PART A: TEXT BOOKLET

CANDIDATE NAME:

D.O.B.: D D M M Y Y Y Y

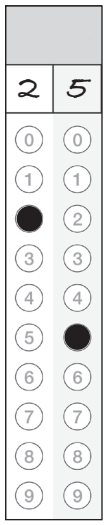
PROFESSION:

VENUE:

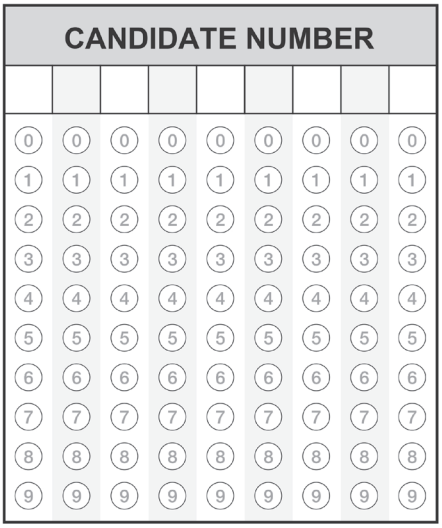
TEST DATE:

Starting at the left, print your Candidate Number and fill in the corresponding circle below each number using a 2B pencil.

Example:



CANDIDATE NUMBER



CANDIDATE DECLARATION

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CANDIDATE SIGNATURE:

INSTRUCTIONS TO CANDIDATES

You must **NOT** remove OET material from the test room.

Text A

Fractures (buckle or break in the bone) often occur following direct or indirect injury, e.g. twisting, violence to bones. Clinically, fractures are either:

- closed, where the skin is intact, or
- compound, where there is a break in the overlying skin

Dislocation is where a bone is completely displaced from the joint. It often results from injuries away from the affected joint, e.g. elbow dislocation after falling on an outstretched hand.

Sprain is a partial disruption of a ligament or capsule of a joint.

Text B

Simple Fracture of Limbs

Immediate management:

- Halt any external haemorrhage by pressure bandage or direct pressure
- Immobilise the affected area
- Provide pain relief

Clinical assessment:

- Obtain complete patient history, including circumstances and method of injury
  - medication history – enquire about anticoagulant use, e.g. warfarin
- Perform standard clinical observations. Examine and record:
  - colour, warmth, movement, and sensation in hands and feet of injured limb(s)
- Perform physical examination

  Examine:
  - all places where it is painful
  - any wounds or swelling
  - colour of the whole limb (especially paleness or blue colour)
  - the skin over the fracture
  - range of movement
  - joint function above and below the injury site

  Check whether:
  - the limb is out of shape – compare one side with the other
  - the limb is warm
  - the limb (if swollen) is throbbing or getting bigger
  - peripheral pulses are palpable

Management:

- Splint the site of the fracture/dislocation using a plaster backslab to reduce pain
- Elevate the limb – a sling for arm injuries, a pillow for leg injuries
- If in doubt over an injury, treat as a fracture
- Administer analgesia to patients in severe pain. If not allergic, give morphine (preferable); if allergic to morphine, use fentanyl
- Consider compartment syndrome where pain is severe and unrelieved by splinting and elevation or two doses of analgesia
- X-ray if available

Text C

Drug Therapy Protocol:
Authorised Indigenous Health Worker (IHW) must consult Medical Officer (MO) or Nurse Practitioner (NP). Scheduled Medicines Rural & Isolated Practice Registered Nurse may proceed.

Drug	Form	Strength	Route of administration	Recommended dosage	Duration
Morphine	Ampoule	10 mg/mL	IM/SC	**Adult only:** 0.1-0.2 mg/kg to a max. of 10 mg	Stat
			IV (IHW may not administer IV)	**Adult only:** Initial dose of 2 mg then 0.5-1 mg increments slowly, repeated every 3-5 minutes if required to a max. of 10 mg	Further doses on MO/NP order

Use the lower end of dose range in patients ≥70 years.
Provide Consumer Medicine Information: advise can cause nausea and vomiting, drowsiness.
Respiratory depression is rare – if it should occur, give naloxone.

Text D

Technique for plaster backslab for arm fractures – use same principle for leg fractures

1. Measure a length of non-compression cotton stockinette from half way up the middle finger to just below the elbow. Width should be 2–3 cm more than the width of the distal forearm.
2. Wrap cotton padding over top for the full length of the stockinette — 2 layers, 50% overlap.
3. Measure a length of plaster of Paris 1 cm shorter than the padding/stockinette at each end. Fold the roll in about ten layers to the same length.
4. Immerse the layered plaster in a bowl of room temperature water, holding on to each end. Gently squeeze out the excess water.
5. Ensure any jewellery is removed from the injured limb.
6. Lightly mould the slab to the contours of the arm and hand in a neutral position.
7. Do not apply pressure over bony prominences. Extra padding can be placed over bony prominences if applicable.
8. Wrap crepe bandage firmly around plaster backslab.

END OF PART A
THIS TEXT BOOKLET WILL BE COLLECTED

SAMPLE TEST 1

READING PART A: QUESTION AND ANSWER BOOKLET

CANDIDATE NAME:

D.O.B.: D D M M Y Y Y Y

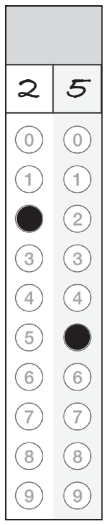
PROFESSION:

VENUE:

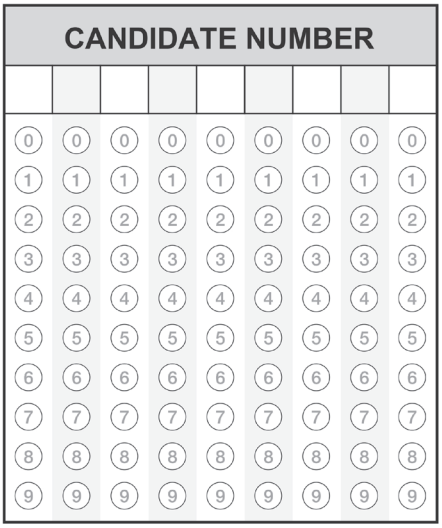
TEST DATE:

Starting at the left, print your Candidate Number and fill in the corresponding circle below each number using a 2B pencil.

Example:



CANDIDATE NUMBER



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CANDIDATE SIGNATURE:

TIME: 15 MINUTES

INSTRUCTIONS TO CANDIDATES

DO NOT open this **Question and Answer Booklet** or the **Text Booklet** until you are told to do so.

Write your answers in the spaces provided in this **Question and Answer Booklet**.

You must answer the questions within the 15-minute time limit.

One mark will be granted for each correct answer.

Answer **ALL** questions. Marks are **NOT** deducted for incorrect answers.

At the end of the 15 minutes, hand in this **Question and Answer Booklet** and the **Text Booklet**.

DO NOT remove OET material from the test room.

www.oet.com

Part A

TIME: 15 minutes

• Look at the four texts, **A-D**, in the separate **Text Booklet.**

• For each question, **1-20**, look through the texts, **A-D**, to find the relevant information.

• Write your answers in the spaces provided in this **Question Paper**.

• Answer all the questions within the 15-minute time limit.

• Your answers should **only** be taken from texts **A-D** and must be correctly spelt.

Fractures, dislocations and sprains: Questions

Questions 1-7

For each question, **1-7**, decide which text (**A**, **B**, **C** or **D**) the information comes from. Write the letter **A**, **B**, **C** or **D** in the space provided. You may use any letter more than once.

In which text can you find information about

1 procedures for delivering pain relief? _____

2 the procedure to follow when splinting a fractured limb? _____

3 what to record when assessing a patient? _____

4 the terms used to describe different types of fractures? _____

5 the practitioners who administer analgesia? _____

6 what to look for when checking an injury? _____

7 how fractures can be caused? _____

Questions 8-14

Answer each of the questions, **8-14**, with a word or short phrase from one of the texts. Each answer may include words, numbers or both. You should **not** write full sentences.

8 What should be used to elevate a patient's fractured leg?

_____

9 What is the maximum dose of morphine per kilo of a patient's weight that can be given using the intra-muscular (IM) route?

_____

10 Which parts of a limb may need extra padding?

_____

11 What should be used to treat a patient who suffers respiratory depression?

_____

12 What should be used to cover a freshly applied plaster backslab?

_____

13 What analgesic should be given to a patient who is allergic to morphine?

_____

14 What condition might a patient have if severe pain persists after splinting, elevation and repeated analgesia?

_____

Questions 15-20

Complete each of the sentences, **15**-**20**, with a word or short phrase from one of the texts. Each answer may include words, numbers or both.

15 Falling on an outstretched hand is a typical cause of a _____ of the elbow.

16 Upper limb fractures should be elevated by means of a _____ .

17 Make sure the patient isn't wearing any _____ on the part of the body where the plaster backslab is going to be placed.

18 Check to see whether swollen limbs are _____ or increasing in size.

19 In a plaster backslab, there is a layer of _____ closest to the skin.

20 Patients aged _____ and over shouldn't be given the higher dosages of pain relief.

END OF PART A
THIS QUESTION PAPER WILL BE COLLECTED

Any answers recorded here will not be marked.

SAMPLE TEST 1

READING PARTS B&C: QUESTION AND ANSWER BOOKLET

CANDIDATE NAME:

D.O.B.: D D M M Y Y Y Y

PROFESSION:

VENUE:

TEST DATE:

Starting at the left, print your Candidate Number and fill in the corresponding circle below each number using a 2B pencil.

Example:

2	5
0	0
1	1
●	2
3	3
4	4
5	●
6	6
7	7
8	8
9	9

CANDIDATE NUMBER

0	0	0	0	0	0	0	0	0
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2	2	2	2	2	2	2	2	2
3	3	3	3	3	3	3	3	3
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7	7	7	7	7	7	7	7	7
8	8	8	8	8	8	8	8	8
9	9	9	9	9	9	9	9	9

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CANDIDATE SIGNATURE:

TIME: 45 MINUTES

INSTRUCTIONS TO CANDIDATES

DO NOT open this **Question and Answer Booklet** 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 and Answer Booklet**.

DO NOT remove OET material from the test room.

HOW TO ANSWER THE QUESTIONS

Mark your answers on this **Question and Answer Booklet** by filling in the circle using a 2B pencil. **Example:** Ⓐ Ⓑ Ⓒ

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: Ⓒ

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1. The manual informs us that the Blood Pressure Monitor

(A) is likely to interfere with the operation of other medical equipment.

(B) may not work correctly in close proximity to some other devices.

(C) should be considered safe to use in all hospital environments.

Instruction Manual: Digital Automatic Blood Pressure Monitor

Electromagnetic Compatibility (EMC)

With the increased use of portable electronic devices, medical equipment may be susceptible to electromagnetic interference. This may result in incorrect operation of the medical device and create a potentially unsafe situation. In order to regulate the requirements for EMC, with the aim of preventing unsafe product situations, the EN60601-1-2 standard defines the levels of immunity to electromagnetic interferences as well as maximum levels of electromagnetic emissions for medical devices. This medical device conforms to EN60601-1-2:2001 for both immunity and emissions. Nevertheless, care should be taken to avoid the use of the monitor within 7 metres of cellphones or other devices generating strong electrical or electromagnetic fields.

2. The notice is giving information about

A ways of checking that an NG tube has been placed correctly.

B how the use of NG feeding tubes is authorised.

C which staff should perform NG tube placement.

NG feeding tubes

Displacement of nasogastric (NG) feeding tubes can have serious implications if undetected. Incorrectly positioned tubes leave patients vulnerable to the risks of regurgitation and respiratory aspiration. It is crucial to differentiate between gastric and respiratory placement on initial insertion to prevent potentially fatal pulmonary complications. Insertion and care of an NG tube should therefore only be carried out by a registered doctor or nurse who has undergone theoretical and practical training and is deemed competent or is supervised by someone competent. Assistant practitioners and other unregistered staff must never insert NG tubes or be involved in the initial confirmation of safe NG tube position.

3. What must all staff involved in the transfusion process do?

A check that their existing training is still valid

B attend a course to learn about new procedures

C read a document that explains changes in policy

'Right Patient, Right Blood' Assessments

The administration of blood can have significant morbidity and mortality. Following the introduction of the 'Right Patient, Right Blood' safety policy, all staff involved in the transfusion process must be competency assessed. To ensure the safe administration of blood components to the intended patient, all staff must be aware of their responsibilities in line with professional standards.

Staff must ensure that if they take any part in the transfusion process, their competency assessment is updated every three years. All staff are responsible for ensuring that they attend the mandatory training identified for their roles. Relevant training courses are clearly identified in Appendix 1 of the Mandatory Training Matrix.

4. The guidelines establish that the healthcare professional should

(A) aim to make patients fully aware of their right to a chaperone.

(B) evaluate the need for a chaperone on a case-by-case basis.

(C) respect the wishes of the patient above all else.

Extract from 'Chaperones: Guidelines for Good Practice'
A patient may specifically request a chaperone or in certain circumstances may nominate one, but it will not always be the case that a chaperone is required. It is often a question of using professional judgement to assess an individual situation. If a chaperone is offered and declined, this must be clearly documented in the patient's record, along with any relevant discussion. The chaperone should only be present for the physical examination and should be in a position to see what the healthcare professional undertaking the examination/investigation is doing. The healthcare professional should wait until the chaperone has left the room/cubicle before discussion takes place on any aspect of the patient's care, unless the patient specifically requests the chaperone to remain.

5. The guidelines require those undertaking a clinical medication review to

A involve the patient in their decisions.

B consider the cost of any change in treatments.

C recommend other services as an alternative to medication.

Annual medication review

To give all patients an annual medication review is an ideal to strive for. In the meantime there is an argument for targeting all clinical medication reviews to those patients likely to benefit most.

Our guidelines state that 'at least a level 2 medication review will occur', i.e. the minimum standard is a treatment review of medicines with the full notes but not necessarily with the patient present. However, the guidelines go on to say that 'all patients should have the chance to raise questions and highlight problems about their medicines' and that 'any changes resulting from the review are agreed with the patient'.

It also states that GP practices are expected to

- minimise waste in prescribing and avoid ineffective treatments.
- engage effectively in the prevention of ill health.
- avoid the need for costly treatments by proactively managing patients to recovery through the whole care pathway.

6. The purpose of this email is to

(A) report on a rise in post-surgical complications.

(B) explain the background to a change in patient care.

(C) remind staff about procedures for administrating drugs.

To:	All Staff
Subject:	Advisory Email: Safe use of opioids

In August, an alert was issued on the safe use of opioids in hospitals. This reported the incidence of respiratory depression among post-surgical patients to an average 0.5% – thus for every 5,000 surgical patients, 25 will experience respiratory depression. Failure to recognise respiratory depression and institute timely intervention can lead to cardiopulmonary arrest, resulting in brain injury or death. A retrospective multi-centre study of 14,720 cardiopulmonary arrest cases showed that 44% were respiratory related and more than 35% occurred on the general care floor. It is therefore recommended that post-operative patients now have continuous monitoring, instead of spot checks, of both oxygenation and ventilation.

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: Sleep deprivation

Millions of people who suffer sleep problems also suffer myriad health burdens. In addition to emotional distress and cognitive impairments, these can include high blood pressure, obesity, and metabolic syndrome. ‘In the studies we’ve done, almost every variable we measured was affected. There’s not a system in the body that’s not affected by sleep,’ says University of Chicago sleep researcher Eve Van Cauter. ‘Every time we sleep-deprive ourselves, things go wrong.’

A common refrain among sleep scientists about two decades ago was that sleep was performed by the brain in the interest of the brain. That wasn’t a fully elaborated theory, but it wasn’t wrong. Numerous recent studies have hinted at the purpose of sleep by confirming that neurological function and cognition are messed up during sleep loss, with the patient’s reaction time, mood, and judgement all suffering if they are kept awake too long.

In 1997, Bob McCarley and colleagues at Harvard Medical School found that when they kept cats awake by playing with them, a compound known as adenosine increased in the basal forebrain as the sleepy felines stayed up longer, and slowly returned to normal levels when they were later allowed to sleep. McCarley’s team also found that administering adenosine to the basal forebrain acted as a sedative, putting animals to sleep. It should come as no surprise then that caffeine, which blocks adenosine’s receptor, keeps us awake. Teaming up with Basheer and others, McCarley later discovered that, as adenosine levels rise during sleep deprivation, so do concentrations of adenosine receptors, magnifying the molecule’s sleep-inducing effect. ‘The brain has cleverly designed a two-stage defence against the consequences of sleep loss,’ McCarley says. Adenosine may underlie some of the cognitive deficits that result from sleep loss. McCarley and colleagues found that infusing adenosine into rats’ basal forebrain impaired their performance on an attention test, similar to that seen in sleep-deprived humans. But adenosine levels are **by no means the be-all and end-all** of sleep deprivation’s effects on the brain or the body.

Over a century of sleep research has revealed numerous undesirable outcomes from staying awake too long. In 1999, Van Cauter and colleagues had eleven men sleep in the university lab. For three nights, they spent eight hours in bed, then for six nights they were allowed only four hours (accruing what Van Cauter calls a sleep debt), and then for six nights they could sleep for up to twelve hours (sleep recovery). During sleep debt and recovery, researchers gave the participants a glucose tolerance test and found striking differences. While sleep deprived, the men’s glucose metabolism resembled a pre-diabetic state. ‘We knew it would be affected,’ says Van Cauter. ‘The big surprise was the effect being much greater than we thought.’

Subsequent studies also found insulin resistance increased during bouts of sleep restriction, and in 2012, Van Cauter's team observed impairments in insulin signalling in subjects' fat cells. Another recent study showed that sleep-restricted people will add 300 calories to their daily diet. Echoing Van Cauter's results, Basheer has found evidence that enforced lack of sleep sends the brain into a catabolic, or energy-consuming, state. This is because **it** degrades the energy molecule adenosine triphosphate (ATP) to produce adenosine monophosphate and this results in the activation of AMP kinase, an enzyme that boosts fatty acid synthesis and glucose utilization. 'The system sends a message that there's a need for more energy,' Basheer says. Whether this is indeed the mechanism underlying late-night binge-eating is still speculative.

Within the brain, scientists have glimpsed signs of physical damage from sleep loss, and the time-line for recovery, if any occurs, is unknown. Chiara Cirelli's team at the Madison School of Medicine in the USA found structural changes in the cortical neurons of mice when the animals are kept awake for long periods. Specifically, Cirelli and colleagues saw signs of mitochondrial activation – which makes sense, as 'neurons need more energy to stay awake,' she says – as well as unexpected changes, such as undigested cellular debris, signs of cellular aging that are unusual in the neurons of young, healthy mice. 'The number [of debris granules] was small, but it's worrisome because it's only four to five days' of sleep deprivation,' says Cirelli. After thirty-six hours of sleep recovery, a period during which she expected normalcy to resume, those changes remained.

Further insights could be drawn from the study of shift workers and insomniacs, who serve as natural experiments on how the human body reacts to losing out on such a basic life need for chronic periods. But with so much of our physiology affected, an effective therapy − other than sleep itself – is hard to imagine. 'People like to define a clear pathway of action for health conditions,' says Van Cauter. 'With sleep deprivation, everything you measure is affected and interacts synergistically to produce the effect.'

Text 1: Questions 7-14

7. In the first paragraph, the writer uses Eve Van Cauter's words to

A explain the main causes of sleep deprivation.

B reinforce a view about the impact of sleep deprivation.

C question some research findings about sleep deprivation.

D describe the challenges involved in sleep deprivation research.

8. What do we learn about sleep in the second paragraph?

A Scientific opinion about its function has changed in recent years.

B There is now more controversy about it than there was in the past.

C Researchers have tended to confirm earlier ideas about its purpose.

D Studies undertaken in the past have formed the basis of current research.

9. What particularly impressed Bob McCarley of Harvard Medical School?

A the effectiveness of adenosine as a sedative

B the influence of caffeine on adenosine receptors

C the simultaneous production of adenosine and adenosine receptors

D the extent to which adenosine levels fall when subjects are allowed to sleep

10. In the third paragraph, what idea is emphasised by the phrase '**by no means the be-all and end-all**'?

A Sleep deprivation has consequences beyond its impact on adenosine levels.

B Adenosine levels are a significant factor in situations other than sleep deprivation.

C The role of adenosine as a response to sleep deprivation is not yet fully understood.

D The importance of the link between sleep deprivation and adenosine should not be underestimated.

11. What was significant about the findings in Van Cauter's experiment?

(A) the rate at which the sleep-deprived men entered a pre-diabetic state

(B) the fact that sleep deprivation had an influence on the men's glucose levels

(C) the differences between individual men with regard to their glucose tolerance

(D) the extent of the contrast in the men's metabolic states between sleep debt and recovery

12. In the fifth paragraph, what does the word '**it**' refer to?

(A) an enzyme

(B) new evidence

(C) a catabolic state

(D) enforced lack of sleep

13. What aspect of her findings surprised Chiara Cirelli?

(A) There was no reversal of a certain effect of sleep deprivation.

(B) The cortical neurons of the mice underwent structural changes.

(C) There was evidence of an increased need for energy in the brains of the mice.

(D) The neurological response to sleep deprivation only took a few hours to become apparent.

14. In the final paragraph, the quote from Van Cauter is used to suggest that

(A) the goals of sleep deprivation research are sometimes unclear.

(B) it could be difficult to develop any treatment for sleep deprivation.

(C) opinions about the best way to deal with sleep deprivation are divided.

(D) there is still a great deal to be learnt about the effects of sleep deprivation.

Text 2: ADHD

The American Psychiatric Association (APA) recognised Attention Deficit Hyperactivity Disorder (ADHD) as a childhood disorder in the 1960s, but it wasn't until 1978 that the condition was formally recognised as afflicting adults. In recent years, the USA has seen a 40% rise in diagnoses of ADHD in children. It could be that the disorder is becoming more prevalent, or, as seems more plausible, doctors are making the diagnosis more frequently. The issue is complicated by the lack of any recognised neurological markers for ADHD. The APA relies instead on a set of behavioural patterns for diagnosis. It specifies that patients under 17 must display at least six symptoms of inattention and/or hyperactivity; adults need only display five.

ADHD can be a controversial condition. Dr Russell Barkley, Professor of Psychiatry at the University of Massachusetts insists; 'the science is overwhelming: it's a real disorder, which can be managed, in many cases, by using stimulant medication in combination with other treatments'. Dr Richard Saul, a behavioural neurologist with five decades of experience, disagrees; 'Many of us have difficulty with organization or details, a tendency to lose things, or to be forgetful or distracted. Under such subjective criteria, the entire population could potentially qualify. Although some patients might need stimulants to function well in daily life, the lumping together of many vague and subjective symptoms could be causing a national phenomenon of misdiagnosis and over-prescription of stimulants.'

A recent study found children in foster care three times more likely than others to be diagnosed with ADHD. Researchers also found that children with ADHD in foster care were more likely to have another disorder, such as depression or anxiety. This finding certainly reveals the need for medical and behavioural services for these children, but it could also prove the non-specific nature of the symptoms of ADHD: anxiety and depression, or an altered state, can easily be mistaken for manifestations of ADHD.

ADHD, the thinking goes, begins in childhood. In fact, in order to be diagnosed with it as an adult, a patient must demonstrate that they had traits of the condition in childhood. However, studies from the UK and Brazil, published in JAMA Psychiatry, are fuelling questions about the origins and trajectory of ADHD, suggesting not only that it can begin in adulthood, but that there may be two distinct syndromes: adult-onset ADHD and childhood ADHD. **They** echo earlier research from New Zealand. However, an editorial by Dr Stephen Faraone in JAMA Psychiatry highlights potential flaws in the findings. Among them, underestimating the persistence of ADHD into adulthood and overestimating the prevalence of adult-onset ADHD. In Dr Faraone's words, 'the researchers found a group of people who had sub-threshold ADHD in their youth. There may have been signs that things weren't right, but not enough to go to a doctor. Perhaps these were smart kids with particularly supportive parents or teachers who helped them cope with attention problems. Such intellectual and social scaffolding would help in early life, but when the scaffolding is removed, full ADHD could develop'.

Until this century, adult ADHD was a seldom-diagnosed disorder. Nowadays however, it's common in mainstream medicine in the USA, a paradigm shift apparently driven by two factors: reworked – many say less stringent – diagnostic criteria, introduced by the APA in 2013, and marketing by manufacturers of ADHD medications. Some have suggested that this new, broader definition of ADHD was fuelled, at least in part, to broaden the market for medication. In many instances, the evidence proffered to expand the definitions came from studies funded in whole or part by manufacturers. And as the criteria for the condition loosened, reports emerged about clinicians involved in diagnosing ADHD receiving money from drug-makers.

This brings us to the issue of the addictive nature of ADHD medication. As Dr Saul asserts, 'addiction to stimulant medication isn't rare; it's common. Just observe the many patients periodically seeking an increased dosage as their powers of concentration diminish. This is because the body stops producing the appropriate levels of neurotransmitters that ADHD drugs replace − **a trademark** of addictive substances.' Much has been written about the staggering increase in opioid overdoses and abuse of prescription painkillers in the USA, but the abuse of drugs used to treat ADHD is no less a threat. While opioids are more lethal than prescription stimulants, there are parallels between the opioid epidemic and the increase in problems tied to stimulants. In the former, users switch from prescription narcotics to heroin and illicit fentanyl. With ADHD drugs, patients are switching from legally prescribed stimulants to illicit ones such as methamphetamine and cocaine. The medication is particularly prone to abuse because people feel it improves their lives. These drugs are antidepressants, aid weight-loss and improve confidence, and can be abused by students seeking to improve their focus or academic performance. So, more work needs to be done before we can settle the questions surrounding the diagnosis and treatment of ADHD.

Text 2: Questions 15-22

15. In the first paragraph, the writer questions whether

(A) adult ADHD should have been recognised as a disorder at an earlier date.

(B) ADHD should be diagnosed in the same way for children and adults.

(C) ADHD can actually be indicated by neurological markers.

(D) cases of ADHD have genuinely increased in the USA.

16. What does Dr Saul object to?

(A) the suggestion that people need stimulants to cope with everyday life

(B) the implication that everyone has some symptoms of ADHD

(C) the grouping of imprecise symptoms into a mental disorder

(D) the treatment for ADHD suggested by Dr Barkley

17. The writer regards the study of children in foster care as significant because it

(A) highlights the difficulty of distinguishing ADHD from other conditions.

(B) focuses on children known to have complex mental disorders.

(C) suggests a link between ADHD and a child's upbringing.

(D) draws attention to the poor care given to such children.

18. In the fourth paragraph, the word '**They**' refers to

(A) syndromes.

(B) questions.

(C) studies.

(D) origins.

19. Dr Faraone suggests that the group of patients diagnosed with adult-onset ADHD

(A) had teachers or parents who recognised the symptoms of ADHD.

(B) should have consulted a doctor at a younger age.

(C) had mild undiagnosed ADHD in childhood.

(D) were specially chosen by the researchers.

20. In the fifth paragraph, it is suggested that drug companies have

(A) been overly aggressive in their marketing of ADHD medication.

(B) influenced research that led to the reworking of ADHD diagnostic criteria.

(C) attempted to change the rules about incentives for doctors who diagnose ADHD.

(D) encouraged the APA to rush through changes to the criteria for diagnosing ADHD.

21. In the final paragraph, the word '**trademark**' refers to

(A) a physiological reaction.

(B) a substitute medication.

(C) a need for research.

(D) a common request.

22. In the final paragraph, what does the writer imply about addiction to ADHD medication?

(A) It is unlikely to turn into a problem on the scale of that caused by opioid abuse.

(B) The effects are more marked in certain sectors of the population.

(C) Insufficient attention seems to have been paid to it.

(D) The reasons for it are not yet fully understood.

END OF READING TEST
THIS BOOKLET WILL BE COLLECTED

MEDSAMPLE01

WRITING: QUESTION BOOKLET

CANDIDATE NAME:

D.O.B.: D D M M Y Y Y Y

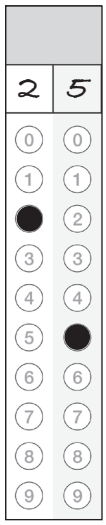
PROFESSION:

VENUE:

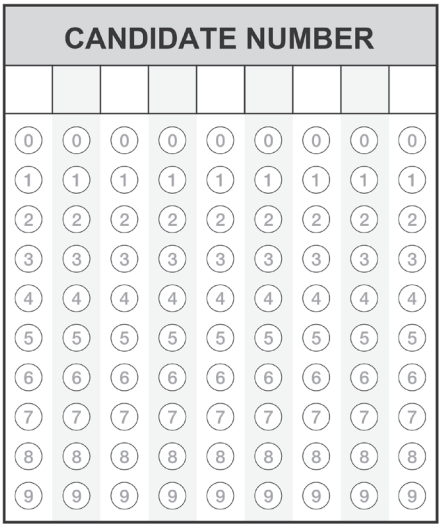
TEST DATE:

Starting at the left, print your Candidate Number and fill in the corresponding circle below each number using a 2B pencil.

Example:



CANDIDATE NUMBER



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:

INSTRUCTIONS TO CANDIDATES

You must write your answer for the Writing sub-test in the **Writing Answer Booklet.**

You must **NOT** remove OET material from the test room.

Occupational English Test

WRITING SUB-TEST: MEDICINE
TIME ALLOWED: READING TIME: 5 MINUTES
WRITING TIME: 40 MINUTES

Read the case notes and complete the writing task which follows.

Notes:

Assume that today's date is 18 June 2018
You are a practitioner examining a 45-year old female patient, Ms Anne Hall.

PATIENT DETAILS:

Name: Anne Hall (Ms)
DOB: 19 Sep 1972
Height: 163cm Weight: 75kg BMI: 28.2 (overweight 18/6/18)

Social History: Teacher (Secondary – History, English)
Divorced, 2 children at home (born 2002, 2004)
Non-smoker (since children born)
Social drinker – mainly spirits

Substance Intake:
Nil

Allergies: Codeine; dust mites; sulphur dioxide

Family history: Mother – hypertension; asthmatic; Father – peptic ulcer
Maternal grandmother – died heart attack, aged 80
Maternal grandfather – died asthma attack
Paternal grandmother – unknown
Paternal grandfather – died 'old age' 94

Previous medical history:

Childhood asthma; chickenpox; measles
1983 tonsillectomy
1990 hepatitis A (whole family infected) 1992 sebaceous cyst removed
1995 whiplash injury
2006 depression (separation from husband); SSRI – fluoxetine 11 mths
2008 overweight – sought weight reduction
2010 URTI (Upper Respiratory Tract Infection)
2012 dyspepsia
2014 dermatitis; prescribed oral & topical corticosteroids

18 Jun 2018	Presenting complaint: dysphagia (solids), onset 2 weeks ago post-viral (?) URTI URTI self-medicated with OTC (over-the-counter) Chinese herbal product - contents unknown No relapse/remittent course No sensation of lump No obvious anxiety Concomitant epigastric pain radiating to back, level T12 Weight loss: 1-2kg Recent increase in coffee consumption Takes aspirin occasionally (2-3 times/month); no other NSAIDs Provisional diagnosis: gastro-oesophageal reflux +/- stricture
Plan:	Refer gastroenterologist for opinion and endoscopy if required ↓coffee/alcohol intake Cease OTC product Pantoprazole 40mg daily

Writing Task:

Using the information in the case notes, write a letter of referral for further investigation and definitive diagnosis to the gastroenterologist, Dr Jason Roberts, at Newtown Hospital, 111 High Street, Newtown.

In your answer:

- **Expand the relevant notes into complete sentences**
- **Do not use note form**
- **Use letter format**

The body of the letter should be approximately 180–200 words.

Any answers recorded here will not be marked.

OET

WANS000000

WRITING: ANSWER BOOKLET

CANDIDATE NAME:

D.O.B.: D D M M Y Y Y Y

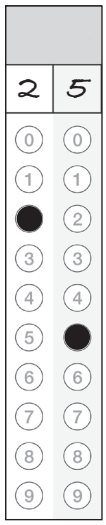
PROFESSION:

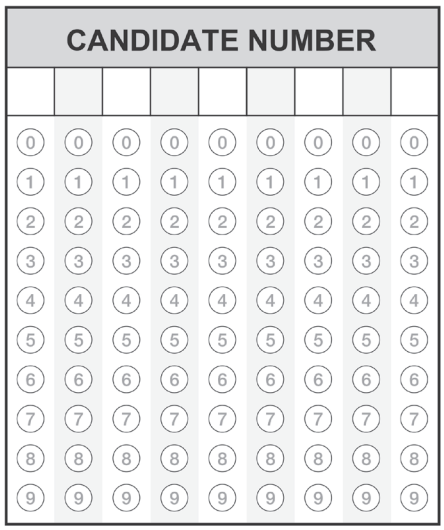
VENUE:

TEST DATE:

Starting at the left, print your Candidate Number and fill in the corresponding circle below each number using a 2B pencil.

Example:





CANDIDATE DECLARATION

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CANDIDATE SIGNATURE:

TIME ALLOWED
READING TIME: 5 MINUTES
WRITING TIME: 40 MINUTES

INSTRUCTIONS TO CANDIDATES

1. **Reading time: 5 minutes**
   During this time you may study the writing task and notes. You **MUST NOT** write, highlight, underline or make any notes.
2. **Writing time: 40 minutes**
3. Use the back page for notes and rough draft only. Notes and rough draft will **NOT** be marked.

   Please write your answer clearly on page 1 and page 2.

   Cross out anything you **DO NOT** want the examiner to consider.
4. You must write your answer for the Writing sub-test in this **Answer Booklet** using **pen or pencil**.
5. You must **NOT** remove OET material from the test room.

Please record your answer on this page within the lines provided.

(Only answers on Page 2 and Page 3 within the lines provided will be marked.)

Please record your answer on this page within the lines provided.

(Only answers on Page 2 and Page 3 within the lines provided will be marked.)

Space for notes and rough draft. Only your answers on Page 2 and Page 3 will be marked.

MEDSample01

Roleplay No. 1/2

SPEAKING: ROLE-PLAY BOOKLET

CANDIDATE NAME:

D.O.B.: D D M M Y Y Y Y

PROFESSION:

VENUE:

TEST DATE:

Starting at the left, print your Candidate Number and fill in the corresponding circle below each number using a 2B pencil.

Example:

2	5
0	0
1	1
●	2
3	3
4	4
5	●
6	6
7	7
8	8
9	9

CANDIDATE NUMBER

0	0	0	0	0	0	0	0	0
1	1	1	1	1	1	1	1	1
2	2	2	2	2	2	2	2	2
3	3	3	3	3	3	3	3	3
4	4	4	4	4	4	4	4	4
5	5	5	5	5	5	5	5	5
6	6	6	6	6	6	6	6	6
7	7	7	7	7	7	7	7	7
8	8	8	8	8	8	8	8	8
9	9	9	9	9	9	9	9	9

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:

INSTRUCTION TO CANDIDATES

Please confirm with the Interlocutor that your roleplay card number and colour match the Interlocutor card before you begin.

Interlocutor to complete only

ID No: _____ Passport: ☐ National ID: ☐ Alternative ID approved: ☐

Speaking sub-test:

ID document sighted? ☐ Photo match? ☐ Signature match? ☐ Did not attend? ☐

Interlocutor name: _____

Interlocutor signature: _____

OET SAMPLE TEST

ROLEPLAYER CARD NO. 1 — MEDICINE

SETTING: Local Medical Clinic

PATIENT

You are 45 years old and recovering from a mild heart attack which you had two weeks ago. You were discharged from hospital four days ago. You are seeing the doctor because you are unsure how much physical activity is appropriate; you're concerned it might bring on another heart attack.

TASK

- When asked, say you've felt much weaker and very tired since the heart attack; you're worried that any physical activity, such as walking, gardening or swimming, might bring on another heart attack.
- Say you'd like to know how much physical activity is advisable.
- When asked, say you're an office worker. You sit at a desk all day; you don't get much exercise at work.
- When asked, say you're worried about having another heart attack so you'd like to know what you can do to reduce the risk of further attacks.
- Say that information has been very helpful. You'll try to gradually do more exercise and you'll look into the rehabilitation programme.

OET SAMPLE TEST

CANDIDATE CARD NO. 1 — MEDICINE

SETTING: Local Medical Clinic

DOCTOR

You see a 45-year-old patient who suffered a mild anterior acute myocardial infarction two weeks ago. Recovery was uncomplicated and the patient was discharged from hospital four days ago. He/she is now concerned about how much physical activity is appropriate during recovery.

TASK

- Find out reason for visit.
- Reassure patient about fatigue (e.g., expected: 4–6 weeks for return of full energy levels, etc.). Remind patient about heart attack recovery (e.g., gradual, lifestyle changes and medication to help, etc.). Emphasise importance of exercise (e.g., heart health: strengthening heart; overall health: lowering cholesterol; etc.).
- Give recommendations for exercise (moderate physical activity: patient's recovery uncomplicated, already two weeks since hospital admission, etc.). Advise importance of joining cardiac rehabilitation programme (e.g., increasing exercise tolerance under supervision, etc.). Explore patient's job (type of work, etc.).
- Give timescale for return to work (e.g., 4–6 weeks for desk job, etc.). Explain need to be physically and emotionally ready (e.g., not rushing back, planning return to work: assistance/support from employer, etc.). Explore any concerns.
- Provide recommendations for prevention of future attacks (diet: vegetables, whole grains; lifestyle: physically active; etc.). Reassure patient about his/her concerns (e.g., normal, appropriate, etc.).