E2LANGUAGE
TEST IV- SCRIPT

Practice Test 4: Online Practice Test Part 1

1st attempt (27-Apr-2019 03:57:13) : 0 bonus points
Last attempt (27-Apr-2019 03:59:15) with a score of 0

Your Score is 0/12.
Try again. Your mark is 0%

0:00 / 4:19

Part A

Extract 1: Questions 1 to 12

You hear an otolaryngologist talking to a patient named Terry Butler. For **questions 1–12**, complete the notes with a word or short phrase.

You now have thirty seconds to look at your notes.

Patient Terry Butler

Reason for referral
Possible vasomotor rhinitis

Background

- experiences **(1)** crusty mucus especially in the morning
- noticed some **(2)** bleeding / blood
- reduced **(3)** sense of smell
- has been **(4)** sneezing throughout the day
- Painful blockage at times

Occupation

- **(5)** hire car driver

Treatment history

- **(6)** skin prick test
- blood test

(a) GP investigation

- nil medications
- nil viral infection
- ceased **(7)** nasal decongestant spray

(b) GP advice

- **(8)** humidifier to help loosen the mucus
- **(9)** salt water solution several times per day
- **(10)** antihistamine before sleep

General health

- generally fit and healthy

Close

Practice Test 4: Online Practice Test Part 2

1st attempt (27-Apr-2019 04:03:06) : 0 bonus points
Last attempt (27-Apr-2019 04:03:55) with a score of 0

Your Score is 0/12.
Try again. Your mark is 0%

0:00 / 4:41

Part A

Extract 2: Questions 13 to 24

You hear a general practitioner talking to a patient named Jane Brown. For **questions 13-24**, complete the notes with a word or short phrase.

You now have thirty seconds to look at your notes.

Patient Jane Brown

New patient after moving to the area

Patient's description of symptoms
ulnar-sided pain and numbness

radiates to the **(13)** little finger

intermittent for two weeks

Pain worsens **(14)** at night

feels like a **(15)** guitar string being tightened

Initial treatment

rested the arm **(16)** on a pillow

alternated ice and warm compress

tried **(17)** anti-inflammatories / anti inflammatories / ar medication (one week)

Vocation

student

In her **(18)** final year at university

Daily routine

Sitting 10 hours + per day

(19) forearms and wrists regularly pressed against the desk

arms stationery for extended periods

noticeable **(20)** deep creases in arms

- **University tutorial** - leans agains desk

- **University lectures** - uses **(21)** little flip top tables / flip top tables with correct posture

Physical activity

plays **(22)** netball once per week

swims twice per week

Close

Practice Test 4: Question 1 with Transcript

1st attempt (27-Apr-2019 04:22:49) : 25 bonus points
Last attempt (27-Apr-2019 04:22:49) with a score of 100

Your Score is 1/1.
Well done, your mark is 100%

25. You hear a nurse talking to her colleague about a patient's request to leave the ward. ✔

The nurse is concerned that the patient

- should not be left unaccompanied. ✖
- has overestimated his progress ✔
- is not physically ready to walk ✖

Listen to the audio and read the transcript.

0:00 / 1:05

Show Transcript

F: Mr Jenkins really shouldn't be going anywhere at the moment.
M: Well, it's only to the coffee shop down stairs, and he's mobile, so...
F: He can certainly do minor things like showering and getting back and forth to the toilet by himself, but that doesn't necessarily mean he's up to leaving the ward.
M: He's going a little stir crazy, and he's been on the ward now for weeks. He needs to feel like a normal person again.
F: Of course he does, but we can't jeopardise his safety. I realise he believes he can, but I really think it's beyond his capability right now.
M: I'm happy to go with him with

if it'll ease your mind.
F: I'd really prefer if he just holds off until he gets the tick of approval. We don't want him undoing all the effort for a cup of coffee.

Close

Practice Test 4: Question 2 with Transcript

1st attempt (27-Apr-2019 04:25:13) : 0 bonus points
Last attempt (27-Apr-2019 04:25:28) with a score of 100

Your Score is 1/1.
Well done, your mark is 100%

26. You hear a paramedic briefing a doctor on a recent emergency admission. ✔

The paramedic says it's important to

- try to settle the patient. ✔
- notify the patient's family. ✖
- keep the patient hydrated. ✖

Listen to the audio and read the transcript.

0:00 / 1:10

Show Transcript

F: Mr Teagan has suffered suspected second-degree burns from boiling oil to the back of both hands and forearms. He works as an apprentice chef and was lifting a pot of oil when he slipped, inadvertently scalding himself. Apparently he panicked and his co-workers were forced to hold his arms under cool running water until we arrived at the scene. They also managed to contact his wife who's on her way. You may appreciate her assistance as he's very distressed and obviously frightened. My colleague has managed to administer oxygen and gave 2.5 milligrams of Morphine, but that was as far as

he got as Mr Teagan continued to put up quite a struggle on route, which is something you'll need to consider before any further treatment. Pain is well controlled at present.

Close

Practice Test 4: Question 3 with Transcript

1st attempt (27-Apr-2019 04:26:29) : 25 bonus points
Last attempt (27-Apr-2019 04:26:29) with a score of 100

Your Score is 1/1.
Well done, your mark is 100%

27. You hear an anaesthetist talking with a patient prior to her surgery. ✔

What does the patient want to know?

- ○ Potential risks while anaesthetised ✖
- ◉ Post-operative pain management ✔
- ○ The length of sedation involved ✖

Listen to the audio and read the transcript.

0:00 / 1:05

Show Transcript

M: So Mrs Simpson, do you have any questions before we go into the theatre.
F: Oh I'm sorry I think I'm just a little nervous, everything you told me earlier has gone in one ear and out the other.
M: It's perfectly normal to be anxious before major surgery.
F: Well, if I'm going to be under for such a long time, it just worries me that anything could happen. I know there are dangers involved with it... and I think I'm prepared for that, but how will leave me feeling...? I mean... well, I'm really not looking forward to it. It's going to be a lot of rehab and really training myself to walk again. I'm just not sure if I'm up to the challenge.

How can I possibly go through all of that when I'm in such agony? It just doesn't seem possible; it's just such a long process.

Close

Practice Test 4: Question 4 with Transcript

1st attempt (27-Apr-2019 04:26:49) : 25 bonus points
Last attempt (27-Apr-2019 04:26:49) with a score of 100

Your Score is 1/1.
Well done, your mark is 100%

28. You hear a trainee doctor telling her supervisor about an uncomfortable situation she recently encountered with an end of life patient. ✔

The trainee found it difficult to

- ○ connect with the family member. ✖
- ◉ maintain control of her emotions. ✔
- ○ provide advice on the best course of action. ✖

Listen to the audio and read the transcript.

0:00 / 1:05

Show Transcript

F: Would you mind if we talk about Mr Harris in bed six?
M: Sure, is there a problem?
F: No, nothing like that. The ICU nurse asked me to talk with the patient's family about his situation. I mean, basically explain to them that there's nothing else we can really do for him and that he likely won't survive.
M: How did it go?
F: Horribly, they were asking what they should do next, what steps to take. I could barely keep myself together. It was just so hard to talk with them just staring at me like that with such blank expressions. It was the hardest thing I've ever encountered. I honestly don't

think I'm cut out for situations like that.
M: I assure you, it's perfectly normal in such a predicament.

Close

Practice Test 4: Question 5 with Transcript

1st attempt (27-Apr-2019 04:27:11) : 25 bonus points
Last attempt (27-Apr-2019 04:27:11) with a score of 100

Your Score is 1/1.
Well done, your mark is 100%

29. You hear a nurse briefing a colleague at the end of his shift. ✔

What does he instruct his colleague to do?

- Monitor the patients pain level ✖
- Ensure the patient remains lying down ✖
- Keep the patient's wife up to date ✔

Listen to the audio and read the transcript.

0:00 / 1:19

Show Transcript

M: So in bed 5 is Mr Benjamin Higgins, 75 years of age under Dr Monroe. He had elective angioplasty and insertion of stent via the left femoral artery this morning at 9am. He has a history of hypertension, hypocholesteremia and angina. His medications are metoprolol twice a day, simvastatin and glyceryl trinitrate single spray. He has no known allergies. With regards to the operation, there were no complications and he returned to the ward today at 1130am.
F: Did he have any pain at all?
M: He did, just 3 out of 10, mild discomfort. I tried to call Dr Monroe, but he was in theatre, but his secretary said she'll pass

it on. He has to remain supine until 5PM today, and his wife will have to be informed of his progress. When I received him he was alert and orientated, and his vitals were within normal range. ECG is normal sinus rhythm and that was at 1145.

Close

Practice Test 4: Question 6 with Transcript

1st attempt (27-Apr-2019 04:27:30) : 25 bonus points
Last attempt (27-Apr-2019 04:27:30) with a score of 100

Your Score is 1/1.
Well done, your mark is 100%

30. You hear a veterinarian and the owner of a cat discussing how to give insulin to her pet. ✔

What does the veterinarian say is most important?

- (●) Giving more than the recommended dose ✔
- ( ) Keeping the insulin refrigerated ✖
- ( ) Avoiding shaking the bottle ✖

Listen to the audio and read the transcript.

0:00 / 1:10

Show Transcript

M: So I'll just explain a little on the initial steps of administering the insulin.
F: OK.
M: It's really very simple. So the first thing is the insulin needs to stay in the refrigerator. Now Felix is getting 2 units, twice per day, so what I suggest is marking it on a calendar for each day, so divide the day in half with a line. I'd recommend drawing a little box in each section so you can give it a big tick for both morning and evening doses. The one thing you don't want to do is double dose the insulin. So you turn the bottle upside down and roll it gently, don't shake it, and then take out a syringe.
F: What happens if you shake it?

M: I could potentially destroy it, so you want to try to avoid that.
F: OK, sure.

Close

Test 4 Part 1 + Transcript

1st attempt (27-Apr-2019 04:37:24) : 10 bonus points
Last attempt (27-Apr-2019 04:37:51) with a score of 100

Your Score is 6/6.
Well done, your mark is 100%

0:00 / 7:07

You hear an interview with an optometrist called Henry Chapman, who's talking about the impact of macular degeneration.

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

31. What began Henry?s special interest in macular degeneration? ✔

- ○ seeing the impact it had on his own family ✖
- ◉ treating many patients over a 30-year career ✔
- ○ observing the isolation that comes from the disease ✖

32. In Henry?s opinion, what is the most troubling aspect of the disease? ✔

- ○ the inability to recognise the faces of loved ones ✖
- ○ the psychological impact it can often generate ✖
- ◉ the changes it causes to a person's daily existence ✔

Interviewer: We're talking today with Henry Chapman, an optometrist with a special interest in macular degeneration. Mr Chapman, firstly what is macular degeneration and how did your particular interest in the disease come about?

Henry Chapman: Macular degeneration is actually the name given to a group of chronic, degenerative retinal eye diseases that cause a distortion... or progressive loss of a person's central vision, but leaves the peripheral, or side vision, intact. Say, if someone with macular degeneration were facing me now, they'd see my arms and legs, the area around me, but my face would likely be obscured by a dark or empty space. They experience a dreadful sense of being disconnected or cut off from everyday life. As an optometrist for 30 years, I've had my share of cases, and every new patient is like a spark because the impact of each accumulates over time to a kind of...oh, almost what you'd call a

33. Henry thinks that the traumas associated with loss of vision are ✔

- ◉ sometimes overlooked within the optometry community. ✔
- ○ commonly misconceived as part of the aging process. ✖
- ○ less understood than with many other diseases. ✖

34. Henry believes macular degeneration patients initially keep their fears to themselves because they ✔

- ○ are scared to admit they have a serious condition. ✖
- ○ do not feel completely comfortable discussing their disease. ✖
- ◉ consider their disease minor in comparison to total blindness. ✔

35. Why did Henry choose his patient called Jennifer to test his new method? ✔

- ○ because she had a special kind of macular degeneration ✖
- ◉ because of her negative reaction to her condition ✔

fixation I guess. Even after all these years, however, I was still shocked to hear my sister has been recently diagnosed with macular degeneration, and because of that, I've now also seen first-hand what this terrible disease does to the entire family.

Interviewer: What's the most challenging part for those living with macular degeneration?

Henry Chapman: Take a recent patient of mine called Robert, he was 55 when he first noticed the symptoms - blurred vision, distortion of straight lines. The effect on his life was profound, and that's the tragedy of this disease. He was working as a driving instructor, then suddenly had to resign, but still with the financial burdens of daily life. His passion for carpentry, or even basic reading fell by the wayside. Worst of all for Robert was no longer being able to see his grandchildren's faces clearly, which was obviously very upsetting. Unfortunately he also experienced depression for a time. This may not happen to everyone, but it's certainly more common than people realise.

Interviewer: What can be done for patients such as Robert?

Henry Chapman: This is a disease that's typically related to aging, which is the commonest risk factor, but it's certainly not a normal or inevitable consequence of getting old. So although older people are generally more accepting of the

extra baggage that comes with aging, it's still difficult for many to accept and discuss the changes associated with macular degeneration. There's a tragedy attached to any disease or illness, but vision loss also carries some major disruptions to a person's lifestyle as well as mental hurdles like few other diseases do. I feel that's something that can at times be neglected. There are support groups, but I'm talking on an optometrist level. My job is to help diagnose and treat a patient, but what of their additional struggles? That's where I'd like to place myself a little better, and allow patient's like Robert the freedom and availability to open up.

Interviewer: And do patients ever volunteer to express their fears or frustrations to you directly?

Henry Chapman: They do, but in the beginning what I see is their brave face. They often say "there's always someone worse off." And that's an admirable trait, but reality soon rears its ugly head. Because macular degeneration doesn't result in total blindness, sufferers are left with partial vision, and I suspect that many patients may genuinely interpret this as being somehow less significant than total blindness, like they don't have the right to speak out. The reality is of course that sufferers of macular degeneration have many of the same fears and impediments as those who've completely lost their sight. And yet

they're worried about voicing this. So it's imperative that we not only actively listen, but also encourage and support them to openly share their stories.

Interviewer: Can you give us an example of how you've changed the way you treat your own patients?

Henry Chapman: Sure. I have a patient called Jennifer, she's 62 and has late stage neovascular, or wet macular degeneration. This is caused by the formation of very fragile blood vessels which leak fluid and blood within and under the retina. It also leads to a rapid loss of central vision as opposed to the dry kind, which is a far slower decline. Therefore it came as a great shock for Jennifer, in turn making her a perfect prototype, if you will, in trying something new. I allocated just an additional ten minutes to each of her appointments and explained it was for an open discussion. This extra time gave me the opportunity to delve a little deeper into how she was coping with the rapid changes she was experiencing, and gave her more freedom to discuss her concerns. The positive change in communication was extraordinary, so I adopted this for all my patients thereafter.

Interviewer: So what, if anything, can be done to help prevent macular degeneration?

Henry Chapman: Research is ongoing and advancements in treatment are being made daily,

and this needs to continue. But you can't leave it up to researchers. I'm believe in what the individual can do. This means that any difficulty with vision should never be dismissed as a part of aging. In its early stages macular degeneration may not result in noticeable visual symptoms, but it can be detected with an eye test. If people want to save their sight, I can't stress enough how crucial the early detection of any form of macular degeneration is. The sooner that this disease is detected, the earlier that steps can be undertaken to help slow its progression and save sight through treatment and necessary lifestyle modifications.

Interviewer: Thank you for sharing your experience with us today.

Close

Test 4 Part 2 + Transcript

1st attempt (27-Apr-2019 04:43:37) : 10 bonus points
Last attempt (27-Apr-2019 04:43:48) with a score of 100

Your Score is 6/6.
Well done, your mark is 100%

0:00 / 6:24

You hear a clinical dietician called Rebecca Hudson giving a presentation to a group of healthcare providers.

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

37. Rebecca says that a challenge many healthcare providers face with overweight patients is ✔

- ○ establishing a strong relationship. ✖
- ◉ balancing aspects of communication. ✔
- ○ timing their discussions effectively. ✖

38. Rebecca believes that demonstrating sensitivity when discussing weight is ✔

- ◉ established from the outset of the consultation. ✔
- ○ sometimes misunderstood by healthcare providers. ✖
- ○ directing language away from the term obesity. ✖

Rebecca Hudson:

My name's Rebecca Hudson, and I'm a clinical dietician working here in the hospital. Today I'll be presenting what some consider a very challenging topic — raising the issue of weight loss and obesity with patients.

A person's weight is a complex and sensitive issue. Many factors are at play, like concerns about being judged, feelings of embarrassment or even failure. As a dietician, I see this on a daily basis, yet beginning discussions about weight can still be unsettling for both myself and the patient, who often knows it's coming. This is because as healthcare providers, we're sometimes uncertain of how to discuss weight related issues while still providing support to our patients in ways that are empowering and nonjudgmental. During the consultation we strive to get our message across, but if we lack the initial training to do so, chances are we'll lose trust and irrevocably

39. Rebecca suggests that asking open-ended questions ✔

- helps eliminate any personal prejudice. ✖
- covers many barriers with a single sentence. ✔
- is the ideal way to begin the consultation. ✖

40. When consultations prove difficult, Rebecca suggests ✔

- focussing on the patient's general health rather than obesity. ✖
- convincing the patient that support is never out of reach. ✖
- changing the way the patient views their weight problem. ✔

41. Rebecca thinks that a patient's continuing education ✔

- should include of a small number of obtainable objectives. ✔
- can present new demands for the healthcare provider. ✖
- must include the family in order to be successful. ✖

damage the provider-patient relationship that's so vital. We risk stigmatising, or even shaming our patients to the detriment of treatment goals and inevitably patient outcomes.

So how is effective communication achieved for sensitive matters? Often a healthcare provider's comments as they open the channels of dialogue with the patient are the most important. A patient's level of comfort in discussing their weight needs to be established. Asking directly if they're OK talking about their general health and weight is the most efficient way to do this. Once the conversation is moving, I've personally found that tactfully choosing terms like "excess body weight" or "above ideal body weight" far easier on the ear than "excess fat" or "obese." This practice is very important in establishing trust. One method I've found very useful during this time is not referring to them as the condition. It's common these days to hear that a patient "has diabetes" rather than "is diabetic." This crosses over to "has obesity" rather than "is obese."

The next step in maintaining dialogue with the patient is by way of open ended questions, and ensuring we articulate them the way they're intended. This is achieved by first eradicating all implicit assumptions and bias about obesity to ensure that we don't give patients a feeling of being judged. Let me give you an example. The basic

questions used by dieticians are based upon three of the main factors that influence a person's weight; their eating, drinking and exercise patterns, as well as their previous, attempts at weight loss. If I say "I think you need to lose weight," this is my opinion, a judgement. Now consider an alternative like, "Are you interested in losing some weight?" This suggests that you're likely sympathetic to any past attempts, that you're willing to provide them with support across the board, and it allows the patient to begin the conversation without feeling judged or criticised.

There are of course occasions when consultations don't go as planned, even after your support has been well established. I'm a strong believer, as are many of my colleagues, in relating a patient's weight to their current medical condition, whether it's diabetes, heart disease, osteoarthritis of the knee, or a disease of the eye. Regardless of the condition, the general health of the patient is paramount. This is a technique, that when employed with tact, will prove a very persuasive one as often obesity is considered a separate issue. So when it's seen as a contributing factor, and therefore one that if brought under control may reduce symptoms such as chronic pain, the effort needed to make the change soon appears less significant.

Education and ongoing support for

the patient will reinforce a healthcare provider's advice and recommendations. This can be as simple as providing patient fact sheets and brochures about their current condition as well as the benefits of weight management. My personal recommendation is to carefully select two or three measurable, achievable goals and discuss the steps necessary to reach them. This is also a valuable time for the healthcare provider to evaluate the patent's readiness to make the necessary lifestyle changes to lose weight, as well as the extent of familial support; the latter often being a key element of success.

All that I've mentioned here today are examples of what dieticians refer to as 'motivational interviewing.' This is an open-ended way of interacting built around helping patients go from being disinterested in or against a behaviour change, to taking steps toward being willing to make some

Close