E2 LANGUAGE

READING SUB-TEST – QUESTION PAPER: PART C

CANDIDATE NUMBER:

LAST NAME:

FIRST NAME:

OTHER NAMES:

PROFESSION:

VENUE:

TEST DATE:

CANDIDATE SIGNATURE _____

Passport Photo

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 this 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:

Ⓐ
Ⓑ
Ⓒ

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.

Text 1: Difficult-to-treat depression

Depression remains a leading cause of distress and disability worldwide. In one country's survey of health and wellbeing in 2007, 7.2% of people surveyed had experienced a mood (affective) disorder in the previous 12 months. Those affected reported a mean of 11.7 disability days when they were "completely unable to carry out or had to cut down on their usual activities owing to their health" in the previous 4 weeks. There was also evidence of substantial under-treatment: amazingly only 35% of people with a mental health problem had a mental health consultation during the previous 12 months. Three-quarters of those seeking help saw a general practitioner (GP). In the 2015–16 follow-up survey, not much had changed. Again, there was evidence of substantial unmet need, and again GPs were the health professionals most likely to be providing care.

While GPs have many skills in the assessment and treatment of depression, they are often faced with people with depression who simply do not get better, despite the use of proven psychological or pharmacological therapies. GPs are well placed in one regard, as they often have a longitudinal knowledge of the patient, understand his or her circumstances, stressors and supports, and can marshal this knowledge into a coherent and comprehensive management plan. Of course, GPs should not soldier on alone if they feel the patient is not getting better.

In trying to understand what happens when GPs feel "stuck" while treating someone with depression, a qualitative study was undertaken that aimed to gauge the response of GPs to the term "difficult-to-treat depression". It was found that, while there was confusion around the exact meaning of the term, GPs could relate to it as broadly encompassing a range of individuals and presentations. More specific terms such as "treatment-resistant depression" are generally reserved for a subgroup of people with difficult-to-treat depression that has failed to respond to treatment, with particular management implications.

One scenario in which depression can be difficult to treat is in the context of physical illness. Depression is often expressed via physical symptoms, however it is also true is that people with chronic physical ailments are at high risk of depression. Functional pain syndromes where the origin and cause of the pain are unclear, are particularly tricky, as complaints of pain require the clinician to accept them as "legitimate", even if there is no obvious physical

cause. The use of analgesics can create its own problems, including dependence. Patients with comorbid chronic pain and depression require careful and sensitive management and a long-term commitment from the GP to ensure consistency of care and support.

It is often difficult to tackle the topic of depression co-occurring with borderline personality disorder (BPD). People with BPD have, as part of the core disorder, a perturbation of affect associated with marked variability of mood. This can be very difficult for the patient to deal with and can feed self-injurious and other harmful behaviour. Use of mentalisation-based techniques is gaining support, and psychological treatments such as dialectical behaviour therapy **form the cornerstone** of care. Use of medications tends to be secondary, and prescription needs to be judicious and carefully targeted at particular symptoms. GPs can play a very important role in helping people with BPD, but should not “go it alone”, instead ensuring sufficient support for themselves as well as the patient.

Another particularly problematic and well-known form of depression is that which occurs in the context of bipolar disorder. Firm data on how best to manage bipolar depression is surprisingly lacking. It is clear that treatments such as unopposed antidepressants can make matters a lot worse, with the potential for induction of mania and mood cycle acceleration. However, certain medications (notably, some mood stabilisers and atypical antipsychotics) can alleviate much of the suffering associated with bipolar depression. Specialist psychiatric input is often required to achieve the best pharmacological approach. For people with bipolar disorder, psychological techniques and long-term planning can help prevent relapse. Family education and support is also an important consideration.

Text 1: Questions 7-14

7. In the first paragraph, what point does the writer make about the treatment of depression?

- Ⓐ 75% of depression sufferers visit their GP for treatment.
- Ⓑ GPs struggle to meet the needs of patients with depression.
- Ⓒ Treatment for depression takes an average of 11.7 days a month.
- Ⓓ Most people with depression symptoms never receive help.

8. In the second paragraph, the writer suggests that GPs

- Ⓐ are in a good position to conduct long term studies on their patients.
- Ⓑ lack training in the treatment and assessment of depression.
- Ⓒ should seek help when treatment plans are ineffective.
- Ⓓ sometimes struggle to create coherent management plans.

9. What do the results of the study described in the third paragraph suggest?

- Ⓐ GPs prefer the term “treatment resistant depression” to “difficult-to-treat depression”.
- Ⓑ Patients with “difficult-to-treat depression” sometimes get “stuck” in treatment.
- Ⓒ The term “difficult-to-treat depression” lacks a precise definition.
- Ⓓ There is an identifiable sub-group of patients with “difficult-to-treat depression”.

10. Paragraph 4 suggests that

- Ⓐ prescribing analgesics is unadvisable when treating patients with depression.
- Ⓑ the co-occurrence of depression with chronic conditions makes it harder to treat.
- Ⓒ patients with depression may have undiagnosed chronic physical ailments.
- Ⓓ doctors should be more careful when accepting pain complaints as legitimate.

11. According to paragraph 5, people with BPD have

Ⓐ depression occurring as a result of the disorder

Ⓑ noticeable mood changes which are central to their disorder.

Ⓒ a tendency to have accidents and injure themselves.

Ⓓ problems tackling the topic of their depression.

12. In paragraph 5, what does the phrase ***'form the cornerstone'*** mean regarding BPD treatment?

Ⓐ Psychological therapies are generally the basis of treatment.

Ⓑ There is more evidence for using mentalisation than dialectical behaviour therapy.

Ⓒ Dialectical behaviour therapy is the optimum treatment for depression.

Ⓓ In some unusual cases prescribing medication is the preferred therapy.

13. In paragraph 6, what does the writer suggest about research into bipolar depression management?

Ⓐ There is enough data to establish the best way to manage bipolar depression.

Ⓑ Research hasn't provided the evidence for an ideal management plan yet.

Ⓒ A lack of patients with the condition makes it difficult to collect data on its management.

Ⓓ Too few studies have investigated the most effective ways to manage this condition.

14. In paragraph 6, what does the writer suggest about the use of medications when treating bipolar depression?

Ⓐ There is evidence for the positive and negative results of different medications.

Ⓑ Medications typically make matters worse rather than better.

Ⓒ Medication can help prevent long term relapse when combined with family education.

Ⓓ Specialist psychiatrists should prescribe medication for bipolar disorder rather than GPs.

Text 2: Are the best hospitals managed by doctors?

Doctors were once viewed as ill-prepared for leadership roles because their selection and training led them to become "heroic lone healers." However, the emphasis on patient-centered care and efficiency in the delivery of clinical outcomes means that physicians are now being prepared for leadership. The Mayo Clinic is America's best hospital, according to the 2016 US News and World Report (USNWR) ranking. Cleveland Clinic comes in second. The CEOs of both — John Noseworthy and Delos "Toby" Cosgrove — are highly skilled physicians. In fact, both institutions have been physician-led since their inception around a century ago. Might there be a general message here?

A study published in 2011 examined CEOs in the top-100 hospitals in USNWR in three key medical specialties: cancer, digestive disorders, and cardiovascular care. A simple question was asked: are hospitals ranked more highly when they are led by medically trained doctors or non-MD professional managers? The analysis showed that hospital quality scores are approximately 25% higher in physician-run hospitals than in manager-run hospitals. Of course, this does not prove that doctors make better leaders, though the results are surely consistent with that claim.

Other studies find a similar correlation. Research by Bloom, Sadun, and Van Reenen revealed how important good management practices are to hospital performance. However, they also found that it is the proportion of managers with a clinical degree that had the largest positive effect; in other words, the separation of clinical and managerial knowledge inside hospitals was associated with more negative management outcomes. Finally, support for the idea that physician-leaders are advantaged in healthcare is consistent with observations from many other sectors. Domain experts – "expert leaders" (like physicians in hospitals) — have been linked with better organizational performance in settings as diverse as universities, where scholar-leaders enhance the research output of their organizations, to basketball teams, where former All-Star players turned coaches are ***disproportionately linked*** to NBA success.

What are the attributes of physician-leaders that might account for this association with enhanced organizational performance? When asked this question, Dr. Toby Cosgrove, CEO of Cleveland Clinic, responded without hesitation, "credibility … peer-to-peer credibility." In other words, when an outstanding physician heads a major hospital, it signals that they have *"**walked the walk**".* The Mayo website notes that it is physician-led because, "This helps ensure a continued focus on our primary value, the needs of the patient come first." Having spent their careers looking through a patient-focused lens, physicians moving into executive positions might be expected to bring a patient-focused strategy.

In a recent study that matched random samples of U.S. and UK employees with employers, we found that having a boss who is an expert in the core business is associated with high levels of employee job satisfaction and low intentions of quitting. Similarly, physician-leaders may know how to raise the job satisfaction of other clinicians, thereby contributing to enhanced organizational performance. If a manager understands, through their own experience, what is needed to complete a job to the highest standard, then they may be more likely to create the right work environment, set appropriate goals and accurately evaluate others' contributions.

Finally, we might expect a highly talented physician to know what "good" looks like when hiring other physicians. Cosgrove suggests that physician-leaders are also more likely to tolerate innovative ideas like the first coronary artery bypass, performed by René Favaloro at the Cleveland Clinic in the late '60s. Cosgrove believes that the Cleveland Clinic unlocks talent by giving safe space to people with extraordinary ideas and importantly, that leadership tolerates appropriate failure, which is a natural part of scientific endeavour and progress.

The Cleveland Clinic has also been training physicians to lead for many years. For example, a cohort-based annual course, "Leading in Health Care," began in the early 1990s and has invited nominated, high-potential physicians (and more recently nurses and administrators) to engage in 10 days of offsite training in leadership competencies which fall outside the domain of traditional medical training. Core to the curriculum is emotional intelligence (with 360-degree feedback and executive coaching), teambuilding, conflict resolution, and situational leadership. The course culminates in a team-based innovation project presented to hospital leadership. 61% of the proposed innovation projects have had a positive institutional impact. Moreover, in ten years of follow-up after the initial course, 48% of the physician participants have been promoted to leadership positions at Cleveland Clinic.

Text 2: Questions 15-22

15. In paragraph 1, why does the writer mention the Mayo and Cleveland Clinics?

Ⓐ To highlight that they are the two highest ranked hospitals on the USNWR

Ⓑ To introduce research into hospital management based in these clinics

Ⓒ To provide examples to support the idea that doctors make good leaders

Ⓓ To reinforce the idea that doctors should become hospital CEOs

16. What is the writer's opinion about the findings of the study mentioned in paragraph 2?

Ⓐ They show quite clearly that doctors make better hospital managers.

Ⓑ They show a loose connection between doctor-leaders and better management.

Ⓒ They confirm that the top-100 hospitals on the USNWR ought to be physician-run.

Ⓓ They are inconclusive because the data is insufficient.

17. Why does the writer mention the research study in paragraph 3?

Ⓐ To contrast the findings with the study mentioned in paragraph 2

Ⓑ To provide the opposite point of view to his own position

Ⓒ To support his main argument with further evidence

Ⓓ To show that other researchers support him

18. In paragraph 3, the phrase ***'disproportionately linked'*** suggests

Ⓐ all-star coaches have a superior understanding of the game.

Ⓑ former star players become comparatively better coaches.

Ⓒ teams coached by former all-stars consistently outperform other teams.

Ⓓ to be a successful basketball coach you need to have played at a high level.

19. In the fourth paragraph, what does the phrase ***"walked the walk,"*** imply about physician-leaders?

Ⓐ They have earned credibility through experience.

Ⓑ They have ascended the ranks of their workplace.

Ⓒ They appropriately incentivise employees.

Ⓓ They share the same concerns as other doctors.

20. In paragraph 6, the writer suggests that leaders promote employee satisfaction because

Ⓐ they are often cooperative.

Ⓑ they tend to give employees positive evaluations.

Ⓒ they encourage their employees not to leave their jobs.

Ⓓ they understand their employees' jobs deeply.

21. In the seventh paragraph, why is the first coronary artery bypass operation mentioned?

Ⓐ To demonstrate the achievements of the Cleveland clinic

Ⓑ To present René Favaloro as an exemplar of a 'good' doctor

Ⓒ To provide an example of an encouraging medical innovation

Ⓓ To show how failure naturally contributes to scientific progress

22. In paragraph 8, what was the outcome of the course "Leading in Health Care"?

Ⓐ The Cleveland Clinic promoted almost half of the participants.

Ⓑ 61% of innovation projects lead to participants being promoted.

Ⓒ Some participants took up leadership roles outside the medical domain.

Ⓓ A culmination of more team-based innovations.