# Answer Key

## PART A: QUESTIONS 1-12

1. dry
2. (very) gradual
3. swollen/ bulging (out)
4. soft
5. farm labourer
6. (night) security guard
7. beta blockers
8. crackling (accept: cracking)/ crep/ crepitation
9. (bad) eczema
10. echocardiogram/ cardiac echo/ echo
11. arterial blood gas/ ABG
12. corticosteroids

## PART A: QUESTIONS 13-24

13. myopic/ short(-)sighted/ near(-)sighted
14. nystagmus/ (a) flicker(ing)
15. pigment (in eye)
16. driving
17. focus
18. distance
19. (hotel) receptionist
20. cataract (developed)
21. opacity/ clouding
22. detached retina/ retina(l) detachment
23. (eye) floaters
24. glare/ bright lights

## PART B: QUESTIONS 25-30

25. A
26. C
27. C
28. B
29. B
30. C

## PART C: QUESTIONS 31-36

31. B
32. A
33. B
34. C
35. A
36. B

## PART C: QUESTIONS 37-42

37. B
38. A
39. C
40. A
41. B
42. A

# Transcript

## Part A Extract1

F Good morning, Mr Miller. Now, looking at your notes, I see you've been having a few problems recently. Could you tell me a little about what's been happening, in your own words?

M Well, yeah – it's a combination of things really. To kick-off, I feel pretty tired most of the time – just haven't got the energy I used to have. And I've got this cough – it's there all the time and it feels dry – I mean, I'm not coughing up phlegm or blood or anything like that. But the worst thing, which really bothers me, is that I'm so short of breath – even if I'm just getting dressed in the morning or going up a few steps, I have to stop 'cos I get breathless so quickly. And I've lost quite a bit of weight, too – I mean, I didn't notice at first cos it was very gradual. But all in all, I'm about ten kilos lighter than I was six months ago. I've not been dieting or anything – I, I love my food!

F OK. And, well have you noticed anything else?

M Yeah – just take a look at my fingers. The tips look swollen, don't they – and it's the same with my toes, which are bulging out at the end too. It's weird. And my nails – I don't understand it – they've become soft. They're not hard like they used to be. Look….

F Erm, OK … I see what you mean. And tell me a little about yourself…. Umm what do you do for a living?

M Well, till recently, I worked as a farm labourer. Did it for about twenty years in total. It was hard physical graft, and it finally got to the stage where I just couldn't cope with it any more. It really took it out of me. So, this last couple of years, I've been a security guard, working nights at a local DIY warehouse. It's a bit boring, and the late shifts took a bit of getting used to, but it's OK.

F And, erm, are you finding it less physically demanding?

M That's right. I just haven't got the stamina now for anything else – in fact, I've even had to give up my golf. Can't manage it any more. Any spare time now goes on looking after my pigeons – I've done that since I was a teenager.

F Oh very nice. And, erm, what about your medical history. Now, I see you were diagnosed with hypertension last year, and you're taking beta blockers at the moment for that.

M That's right. My GP said it'd help. Something the GP also said, when I saw him about my breathing problems, was that he heard what he called 'crackling' noises in my chest. I can't hear them, but he could - through the stethoscope.

F OK. And is there any family history of breathing or lung problems, or any serious illnesses that you know of?

M I don't think so. My mother was always healthy, but my dad developed bad eczema as an adult. I remember the red patches on his hands and face. But he didn't have any lung problems as far as I know.

F Right, and… well looking at your previous tests, you were diagnosed with hypertension about 6 months ago, you had…

M Oh yeah, erm… an echocardiogram, you know, to check my heart… and a chest x-ray about four weeks ago after I saw my GP. That came back OK as far as I know.

F I see.

M I'm not keen on hospitals, to be honest. Am I going to need to have lots more tests?

F Well, I'm going to suggest you have what's called an arterial blood gas test. This will let us check how well your lungs are working – how they move oxygen into your blood and remove carbon dioxide from it.

M OK.

F And, I'm also going to order a CT scan. Now, this'll be more revealing than the chest x-ray you had. And I may then prescribe a course of corticosteroids. This will depend on what the tests show up. Now, I'd start you on a relatively low dose and then we'll … [fade]

## Part A Extract2

M: I've got your notes here Mrs Burton, but as we're meeting for the first time, could you begin by telling me a little about your eyesight and the treatment you've had over the years. Erm, did you wear glasses as a child, for example?

F: Ahh yes, since I was about seven. My parents were concerned by the way I held a book when I was reading so they took me to an optometrist. He told them I had some kind of astigmatism.

M: Am I right in assuming that's myopic rather than hyperopic?

F: Well yes, I'm near-sighted…if that's what you mean.

M: That's right. Some people actually have mixed astigmatism - they're far-sighted in one eye and near in the other.

F: Oh well, that's not me. And, as well as my astigmatism, as you've probably noticed, my eyes flicker. I'm not aware of it myself but other people comment on it sometimes. I think you call it…nystagmus. It meant that, when I had my eye surgery, they preferred to use a general rather than a local anaesthetic.

M: OK, so did anyone ever tell you what they thought might have caused the condition?

F: Well, I was once told that my generally poor eyesight is most probably down to the fact that I don't have enough pigment in the eye. On the whole, my eyes have never really caused me any significant difficulties, however. I've always had to wear glasses, so that's a part of life now. I suppose…the only thing is that driving's always been out of the question. I'd never have passed the sight part of the test. That's probably a good thing because it takes me some time to focus, which could make me pretty dangerous if I was ever behind the wheel of a car.

M: Yes, indeed.

F: Also I'm useless at sports like tennis - I think that's because I'm…I'm poor at judging the distance between myself and the ball. That was a pain as a teenager, but I've never particularly wanted to play since then. And I've hardly had any issues at work because of my sight. I'm a receptionist in a hotel and I've never had any difficulty reading computer screens or anything fortunately.

M: You've…You've had your eyes regularly checked throughout your life presumably?

F: Yeah that's right. Every couple of years. My prescription's changed a little over time - but not that much. Though I certainly couldn't manage without reading glasses these days. About three years ago, I was told a

cataract was developing in my right eye. It was a few years before they decided to remove it – that was this February – and it all went very smoothly.

M: Good, and you… you were pleased with the result?

F: Yeah I was, yeah, thrilled. If only all our failing parts could be replaced so easily! However, when I had the routine check-up a couple of weeks after the operation, I was told there was some clouding…err opacity, I think was the word they used - in the capsule containing the new lens. It's a bit disappointing. They could clear it with a laser if it gets to be a real problem…erm, but my flicker makes that rather a risky option. I knew that there's a greater chance of developing a detached retina after a cataract op…but I'm glad to say they found there wasn't any evidence of that in my case. All they did was make an appointment for me to be checked out again in six months-time. But they said I should get in touch if I felt concerned about my eyes.

M: And is that what brings you here today?

F: Yeah, because I am bothered about a couple of things. So, firstly I've noticed more floaters than usual. I don't know if that's something to worry about or not. Erm, more annoying is the fact that I'm much more troubled by glare than I used to be. So I wanted to ask your opinion on that.

M: OK, well let's start by having …..[fade]

# Part B

## Question 25

F OK, so the next thing is about Suzie Williams in bed three.

M Right.

F She's been admitted for chest pain to rule out MI. So far she had an EKG which was OK, and the first set of cardiac enzymes and troponins are negative. When she came in, her blood pressure was elevated a little, like one eighty two over ninety five, but she was given losartan and at six o'clock it was one forty two over eighty two. She was also dehydrated so we started her on IV fluids, D5 half-normal saline running at a hundred and twenty five millilitres. That can go until midnight and then it can be disconnected. She's scheduled for a stress test tomorrow and some more enzyme tests. OK?

M OK.

## Question 26

M Now I'll hand over to Jenny, who has a few words to say about staffing. Jenny?

F Thanks. Now, if we compare ourselves to other hospitals of the same size, in other regions, we're actually recording lower rates of staff turnover. That's just as well given the challenges filling vacant positions across the sector. Where we do compare unfavourably is in the number of days lost to sick leave. That's making it hard to maintain full cover on the wards, and we all know the costs of that. As a matter of urgency then, HR are looking into the worst affected areas to understand the reasons behind it and to see if there's anything we can do to help and support the staff involved.

## Question 27

M It's coming up to that time of year when we have to start preparing for the flu vaccination programme.

F Yes, we usually do it at the start of next month, don't we?

M That's right. If you remember last year we hired a local hall and did as many people as we could in one afternoon.

F Yes, I'd just started working here then. It was a hectic couple of hours but it worked pretty well, don't you think?

M Sure, but there's been so much publicity recently about how sensible it is to get the jab that I suspect we'll have a lot more people coming along this year.

F So we better think about taking on an agency nurse perhaps to lend an extra hand. M: OK. Let's run that by the practice manager. And she might have some other suggestions too.

## Question 28

M The bed manager just rang. He wants us to clear three spaces in the ward. Today.

F Oh it's never-ending! Let's see what we can do. There's no one ready to be discharged. But we could try chasing referrals for Mr Davison to the community hospital for rehab. Where are his notes?

M Yes, but has he had his assessment yet?

F They were all away at that conference yesterday and the day before. I think he'll have slipped through the net.

M But Doctor Ammat's already got him medically stable and signed off. So he should be the next one to move on.

F Well I'd get him there as quickly as possible before they give the place to somebody else.

M I'll phone them straight away.

## Question 29

F This is session number four, which is going to include, again, impression-taking. We've created the crown impression of tooth number 30, we also took care of an inlay preparation. So today we're going to stay on that side with our impression-taking. We're going to make a duplicate of what we've already done. And our attention to detail is now going up another notch. When I take an impression of a tooth that I've created in the mouth, I naturally have to take care of the saliva, the blood, the gum tissue… We're not going to cover all that today. You'll hit that next semester. What we are going to cover are the dynamics of your impression, the margins, the proximal contacts, the bite and the occlusion. We're going to capture all that in one impression.

## Question 30

M I can’t see the results of Mr Roberts’ last blood test to check creatinine levels. Did you do the last one?

F No, not me. Let’s see. Ah, here it is. The last test was four hours ago and results show a level of thirty eight, so it’s still well below normal. We’d better do one when he wakes up, as it might have changed. The patient’s not keen on needles though. I had a real job last night trying to convince him it was necessary. Not the easiest of patients, if you’re happy to have a go.

M OK. My turn, I reckon.

## Part C Extract1

F: My name's Dr Clare Cox. I'm a geriatrician specialising in palliative care. My topic today is an increasingly important issue: end-of-life care for dementia patients. The care of dementia patients presents certain problems. Dementia is a terminal illness and is the third highest cause of death in Australia. But dementia is different from other such conditions. It has an unpredictable trajectory and there can be difficult issues around patients' mental capacity, decision-making and communication. But, in spite of an equal need for palliative care services, dementia patients don't always fit the traditional model of such care. Families often suffer distress because they feel unable to ensure that their loved one's wishes are being respected, or just don't know what that person wanted because the discussion wasn't held early enough. There is, therefore, a clear need for well-funded, patient-centred palliative dementia care that's available when and where it's needed.

I do a lot of work with Dementia Australia – an organisation which represents the needs of Australians living with all types of dementia, and of their families and carers. It also campaigns on dementia issues and funds research.

Dementia Australia decided it was the right time to examine the issue of end-of-life dementia care, from the perspective of the consumer as well as from that of the healthcare professional. It's a timely initiative. We have plenty of anecdotal evidence, but not enough hard facts about what's going wrong and why the system's failing. But the current situation isn't all bad. Despite the issues I've mentioned, I've heard some wonderful examples of how palliative care has made a big difference to people's lives. Things can obviously go badly wrong if this isn't handled well, but in the right circumstances people with dementia can reach the end of their lives peacefully and with dignity.

Dementia Australia commissioned researchers to conduct a survey on the end-of-life issues affecting dementia patients. The survey covered both care professionals, that's doctors, nurses and others working with dementia patients, as well as family-member carers. The interest was overwhelming with more than a thousand responses from around Australia. But what do the results tell us? Well, the initial results confirmed what we've heard about access to appropriate end-of-life care. It was obvious immediately that there was a striking gap between the perceptions of care professionals, and family-member carers about end-of-life dementia care. For instance, while fifty-eight per cent of family-member carers said that they didn't have access to palliative care specialists, and sixty-eight per cent didn't have access to hospices, three-quarters of care professionals indicated that people with dementia in their area do in fact have access to palliative care. This begs the question of whether consumers – that is patients and family-member carers – might not be aware of services that are available.

Another notable finding of the survey was that care professionals often lack knowledge of the legal issues surrounding end-of-life care. Some reports indicate that care professionals are at times reluctant to use pain medications such as morphine because of concerns about hastening a patient's death. However, access to

appropriate pain relief is considered to be a fundamental human right, even if death is earlier as a secondary effect of medication. Our survey found that twenty-seven per cent of care professionals were unsure about this, or didn't believe that patients are legally entitled to adequate pain control, if it might hasten death. So perhaps it isn't surprising then, that a quarter of former family-member carers felt that pain wasn't adequately managed in end-of-life care.

This lack of awareness extends beyond pain management. The statistics on refusing treatment were particularly shocking. Almost a third of care professionals were unaware that people have the right to refuse food and hydration, and one in ten also thought refusal of antibiotics wasn't an option for patients in end-of-life care. How can we ever achieve consumer empowerment and consumer-directed care if the professionals are so ill informed? There's a clear need for greater information and training on patient rights, yet over a third of care professionals said they hadn't received any such training at all.

It's obvious that end-of-life care planning is desirable. Discussing and documenting preferences is clearly the best way of minimising the burden of decision-making on carers, and ensuring patients' wishes are respected. Advance care planning is essentially an insurance policy that helps to protect our patients in case they lose their decision-making capacity. Even though a patient might believe that loved ones will have their best interests at heart, the evidence shows that such people aren't that good at knowing what decisions those they love would make on complex matters such as infection control and hydration.

So, before I go on to …..[fade]

## Part C Extract2

M: Good morning. My name's Dr Keith Gardiner, and I'd like to talk to you today about some research I've been involved in, concerning something that affects all health professionals – staff-patient communication.

Now, firstly, let me reassure you that in feedback, patients seem positive about the way information is communicated to them. But I recently decided to explore the issue in more detail when I was in a hospital with a patient and witnessed for myself what can result when a health care professional assumes they've made themselves clear to a patient, when in fact they've been anything but. Luckily, I've had very few complaints made against members of my team, but the potential is certainly there.

So first, let's start by looking at a typical hospital admission for an in-patient, and the first communication they have about any procedures they are to undergo. On arrival, a patient will complete necessary paperwork. Various staff will talk to them about their treatment during their stay, which is designed to reduce patient anxiety. However, from some patients' point of view, this interaction can seem very complex and difficult to take in, especially at a time when they're not at their best physically or mentally. So it's doubly important to check that any communication has been understood.

Now, to illustrate what I'm talking about, let's take a hypothetical situation. I often use this because it highlights the potential consequences of poor communication. A man in his eighties is admitted to hospital, despite his protestations, with ongoing severe back pain. On investigation, it's found his cancer has spread. The outlook is poor - and further compounded by his becoming depressed and refusing to eat while in hospital. A feeding tube is inserted, a procedure which the patient complies with, but which his family members query. The doctor on duty updates them, assuming they're aware of the severity of the patient's condition – when in fact no such prognosis has been shared with them. An extreme case, but a plausible one, nevertheless.

In order to find out exactly what in-patients felt about the service they were receiving in this hospital, we conducted a patient survey. The questions were carefully targeted to capture patients' opinions about the effectiveness of the communication they'd been involved in during their stay. The survey questioned patients on both what they had expected prior to admission, and what their stay was really like. These two scores were then used to calculate what's called a 'gap' score. The survey also included questions to measure the patients' behavioural intention – that is, how willing they would be to return to the hospital for treatment. Patients completed the survey themselves, and results were then processed with the help of medical students.

Now, the survey produced some interesting data about communication, including both praise and complaints. Clearly in a hospital situation, staff are dealing with confidential and sensitive information, which must be communicated in private – a situation which can be difficult to achieve in a large and busy hospital. However, we scored highly on that point. And we were also pleased to note that staff did manage to communicate in a manner that treated patients with dignity and respect. Of course, staff also have to ensure patients fully

understand what's been said to them. And this last point's where we received the most negative feedback. Both patients and relatives noted a tendency for professionals to resort to the use of jargon, and complex terms when explaining both diagnoses and procedures, which left some patients confused. However, patients were generally satisfied with the information about any follow-up treatment provided after discharge.

Also, once we'd sifted through all the results, a clear pattern began to emerge regarding the care given by nurses, which I found particularly interesting. I'd assumed that having a number of different nurses attending to a patient during their stay was a good thing, because you need enough staff to cover the various shifts, and attend to patients' needs. What I certainly hadn't expected, though, was for patients to say they felt their recovery was faster when they had to communicate with only a small number of nurses - in other words when they were surrounded by familiar faces. The findings aren't conclusive, and more investigative work needs to be done on a bigger sample – but it's certainly food for thought.