Answer Key

Part A - Extract 1

1. collarbone
2. scaly and pink
3. spots
4. nosebleed
5. spreading
6. dust mites
7. milk
8. MSG
9. chickenpox
10. left wrist
11. hairline
12. grazing

Part A - Extract 2

13. acid reflux
14. H2 receptor blockers
15. bread
16. burning
17. intense
18. stool sample
19. colitis
20. fatigue
21. barium swallow
22. texture
23. burping
24. surgery

Part B

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

Part C - Extract 1

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

Part C - Extract 2

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

Transcript

Part A: Extract 1

Doctor: So what's troubling you today, John?

John: Have this really weird looking rash thing on my chest. It's kind of below my collarbone, and it's become really itchy over the last day. It's really bad at the moment, actually, and I can't stop scratching it. I mean, like, I'm trying, but it's too hard and it looks all kind of scaly and pink is pretty weird. And then yesterday morning, after my shower, I noticed a lot more of these little spots coming up around it. There's only been a few up until then, it's definitely getting worse. Look.

Doctor: Okay, well, that looks like what we call pityriasis rosea. A fancy name for a rash. Really. It's common for your age group. Have you been ill at all recently?

John: I had a bit of a cold for a few days last week. Just a runny nose, sneezing, that kind of thing. I'm fine now, though. About three weeks back, I had a really bad nosebleed. And my mom took me to emergency and it ended up being nothing.

Doctor: Having a cold right prior to an outbreak is quite common, too. Um,the rash usually clears up by itself after a couple of months and rarely reappears. But you'll need to avoid excessive sun and regularly applied generous amounts of moisturizer.

John: But I have a beach party this weekend at my mate's holiday house. If I can't be out in the sun, then there's no point going. I mean, it's actually his 18th, and he's my best mate. Also, this looks pretty disgusting, and there'll be lots of people there. Isn't there something I can take to help clear it up? Or at least stop it from spreading more. Because if that happens by the weekend, it could cover my whole body.

Doctor: Oh, that won't happen, I can assure you, but you will have to keep your shirt on for the hottest part of the day. Do you have any allergies, John?

John: Yeah, I've been allergic to dust mites since I was about 13, I think, because my mom awas always cleaning. My skin usually just gets really itchy and I sneeze like mad. Um, when I was really young, I was allergic to milk, but I'm over that now. The only other thing I have to keep away from is, uh, that stuff they put in cheap take away food to make it taste nicer. What was it called, um MSG. That's it. That stuff gives me shocking headaches. Makes me so tired that I can't do anything for about a day.

Doctor: How about medical history? Have you ever had any major illnesses or operations?

John: I had chickenpox when I was a toddler. But I've also had to go to hospital four times for things. I've been a skateboarder since I was six, so I've had a few spills. I broke my left wrist when I was about eight years old, skating off a quarter pipe. That was a pretty bad one, but I made it over five of my friends who were all lined up on the ground. Then later, I'm not sure how old I was. Maybe 11 had one of those really small breaks, like a hairline fracture in my elbow. I also broke two of my fingers on my right hand. I had to have them strapped up. That was a pain. And then my last one was last year and was probably the worst because it was so painful. It made the other one seem like a joke. I had to go into emergency because of some pretty serious grazing along my leg. I came off my board, going down a hill on the side of this really rough road. It had dirt all in the wound. They just washed it out and put bandages all up my leg. But I was in agony.

Doctor: Well, hopefully that will be the last of your injuries…[fade]

Part A: Extract 2

Doctor: So, Declan, you've been referred to me because you've been experiencing digestive problems. Before I examine you, perhaps you could tell me, in your own words, the history of the condition.

Declan: Well, it all started about three years ago. I suddenly found I was having issues keeping food and drink down. So I went to the doctor and he said, well, what you're describing sounds like acid reflux.Well, I've heard of that, and I didn't think that's what it was uh, anyway, he prescribed a course of H2 receptor blockers and said “just try.” And if this doesn't work, then we'll schedule some tests.

Doctor: And?

Declan: Well, I was right to be skeptical because they didn't work. So I ended up going for an endoscopy and my GP was surprised. He said you were right. There is something else going on. They'd taken a biopsy of my stomach but there was a problem with the bacteria there, so he put me on a triple antibiotic and I was on that for 21 days.

Doctor: And, did that help?

Declan: I did feel a bit better, but if I ate certain foods, they'd still get stuck in my throat. Like when I was eating bread, that sort of thing.Then fast forward to this time last year and I had the same episode again. I just couldn't keep the food down. Only this time it wasn't only that. I also had a feeling like my stomach was burning. Uh, it was horrible. Like my insides were on fire or something. I thought it would pass like the other symptoms did. But actually, it just got more and more intense. So I called the hospital and the paramedics came out to get me.

Doctor: Mm. So what happened there?

Declan: Well, they did some tests. They took a stool sample on. They told me they were going to analyze that to see what was going on down there. Anyway, eventually I was told I'd been diagnosed with colitis and again was prescribed antibiotics. So I took them. But within an hour or two, have taken those pills I was throwing up again. (Right.) So I ended up back in hospital because I couldn't keep anything down. And I was really suffering from fatigue. I was having trouble even standing at this point, and basically everything hurt. So they admitted me and put me on an IV for fluids because I was dehydrated and malnourished.

Doctor: And, they did more tests.

Declan: Yes. This time they gave me a barium swallow test and took an X-ray of my chest area. What that showed was that I had a disorder in my esophagus. Basically, the endings of the nerve cells are supposed to move the food down my esophagus to my stomach and so

signal to my LES muscle to relax and allow the food into my stomach. But because these nerves aren't working, there's no signal and the muscle doesn't open.

Doctor: So they diagnosed achalasia.

Declan: That's right. They told me I'd have to manage the condition somehow. I mean, that's okay, because it's not all the time. I have these episodes where I can't keep anything down, then for a while I'm okay as long as I'm careful. I keep to a mostly liquid diet or go for food that's easy to break down. I watch the texture of the solid stuff I eat and keep to small portions. Another thing that's helped is having carbonated drinks at meal times because burping helps to get the LES working.

Doctor: That’s right. Okay. Well, I think I've got the picture now. Next, I'd like to ask what you're hoping I can do for you.

Declan: Well, I was looking on the Internet and I saw that there's a new form of surgery that's been developed. That might make a difference to me. Uh, my GP said you'd be able to tell me about that.

Doctor: Okay, well, let's begin by analyzing…[fade]

Part B

Question 25

Woman: John. There was a written complaint filed from Mr Boeing in Room6. He says that he requested a private room last night, which you promised he would get. Then you ignored his attempts to speak with you. Even when he was in considerable pain. What happened?

John: He asked to be moved because he was uncomfortable and in a lot of pain. Unfortunately, Mrs Stewart's took a turn for the worse and needed closer monitoring. I needed to prioritize the ward accordingly. He received all pain medication at the correct time.

Woman: I see.

John: Normally I'd have discussed it with him, but time just didn't allow for it. I had to be where I was needed most, and that was taking care of Mrs Stewart.

Woman: Your job is to prioritize, and you did just that. I'll go in and talk to him and see if he still wants to pursue it, because it's quite a serious allegation.

John: Okay.

Question 26

Doctor: Well, you've got what's known as a bunion.

Woman: It's just so ugly. I've even stopped wearing open toed shoes. How did this happen? I mean, I'm far too young to have this.

Doctor: That's actually a common misconception. The condition can be inherited or even associated with diseases of the joints like osteoarthritis. But the most common cause is poorly fitting footwear, particularly shoes with narrow toe boxes.

Woman: Most of mine do have rather narrow ends, but surely that can't change the shape of your foot. I mean, my big toe is pointing in the wrong direction.

Doctor: What actually happens is the metatarsal, which is the long bone in the middle of your foot, deviates towards the other foot while the hallux, otherwise known as the big toe, pushes towards the other toes. So we get a very prominent joint protruding outwards such as you have here.

Woman: I see.

Question 27

Doctor: Okay, so when you're dealing with asthma patients, it's quite likely that they'll ask you about exercise. And you're going to have to make a quick assessment of what it's appropriate to say. Basically, by giving their lungs a regular workout, they'll cut the risk of asthma symptoms. But if they've never had a regular exercise routine before, the first thing they need to do is go to the GP for a check up and make sure their asthma action plan is up to date. Most patients can fit some regular exercise into their week and you should stress that little changes will make a huge difference. So simply just walking the kids to school or taking a walk in the lunch break instead of sitting down could make an enormous difference. Also, if they can find somebody, they know who's willing to go with them along that journey, that will help massively as well. But remind them that whatever they do, they'll always need to have their blue reliever inhaler with them.

Question 28

Man: Okay, we need to do our debriefing. Any comments about the case, Jackie?

Jackie: Well, we were late getting started due to a delay in getting the surgical consent to come in, but I've talked to the junior resident and I think we just had a few crossed wires there. So it is sorted.

Man: Yeah, we were busy in the clinic this morning, but we were also delayed getting into this room because the case before us went over their time, which pushed us back. That's becoming a regular occurrence with that particular team. I'm going to ask our nurse manager to adjust their time slots based on the recent history of their cases.

Jackie: We were also slow to get the portable films from radiology. There were several rooms requesting films and radiology seemed short staffed. That's unusual for them, but let's keep an eye on that. And if it happens again, raise it is a concern.

Question 29

Doctor: So, Mr Clark, you'll need to keep the cast dry, which means covering it with a plastic bag when taking a shower. I'm sure you'll manage.

Mr Clark: If the cast does get wet, I can use a hair dryer, can I?

Doctor: Yes, put it on a cool setting, though. One other thing, it's easy to forget to exercise the shoulder and the elbow. Don't sit all day like a statue.

Mr Clark: Right. And It's not normal to feel any tingling or numbness.

Doctor: It's unlikely to happen, but inform us as soon as possible if it does. After a day or two, some people can start to feel the cast is too tight or too loose. Again, if that's an issue, you should let us know.

Mr Clark: Okay, so you can adjust it.

Doctor: Actually, we can replace the cast if there's any discomfort.

Question 30

Woman: Before changing the dressing if there are any particular instructions regarding how to deal with Mrs Harris or the ulcer, you'll be given them at the start of the shift. You won't ever have to access her records yourself and scroll through everything. There's an equipment checklist here with the type of cleaning solution and forceps you need, so you'll know that off by heart. Uh, you will see that a face mask isn't essential, though some nurses prefer to have one. As you know very well, you should chat to Mrs Harris very briefly about what you'll be doing, even when she gets familiar with the routine. Now, please take great care in recording the condition of the skin surrounding the wound, plus the presence of any sort of inflammation, discoloration or odor. This assessment has got to be thorough. Then get her in a position that's comfortable for her, and you can begin.

Man: Okay.

Part C: Extract 1

John Booker: As a physiotherapist for 22 years, I've been asked all sorts of questions, but the one I hear most often is: can physiotherapy help my condition?

Physiotherapy assesses, diagnoses, treats and prevents a wide range of health conditions and movement disorders. It helps reduce pain and repair damage while increasing mobility and improving quality of life. In some instances, it could be an effective replacement for surgical intervention. Obviously, not all conditions can be cured by physiotherapy alone, but help it can certainly do. So today I'd like to focus on a condition that still creates controversy when mentioned alongside physiotherapy on that is scoliosis. Can physiotherapy make an impact on someone suffering from this condition, in particular mild to moderate scoliosis? Let's find out.

Scoliosis isn't always easy to treat, but understanding this condition and its related issues will help a physiotherapist determine the best possible options. Scoliotic spine has one or more curves to either side exceeding 10 degrees. It can resemble a C or an S shape. What makes it difficult to treat is that the majority of cases have no known cause so specific types are easier to deal with: however, structural scoliosis, which results from the development of the musculoskeletal system. And functional scoliosis, which occurs from muscle imbalances, leg length discrepancies and inflammation of the tissues. These both have definite causes, allowing us to create an individualized and comprehensive treatment plan.

Physiotherapy is but one part of the multidisciplinary network of healthcare professions employed in the treatment of scoliosis. A confirmed diagnosis comes firstly from a thorough physical examination for any abnormalities and a symmetry. If scoliosis is suspected, then an X-ray will be taken to confirm what's known as the patient's curve angle or severity of the scoliosis. From here, physiotherapists work closely with doctors, including orthopedic spine specialists, in determining the best options going forward.

I believe a good, multifaceted approach to this is ideally broken down into four distinct phases. The first of these in my program is pain relief. Although not all scoliosis sufferers will experience pain or even discomfort, many do and for these patients the provision of pain relief, assists with compliance and also with corrective or prevention exercises. Physiotherapists have a variety of techniques for achieving this, such as the releasing of tight muscles through gentle massage, acupuncture, and the use of supportive postural taping and various electrotherapy modalities such as ultrasound.

Phase two is a particularly important step for several reasons. It's for rectifying any imbalances through stretching and strengthening exercises. This often still includes taping techniques until strength and flexibility of increased physiotherapy here focuses on both sides of the spine as well as adjacent areas like the hip or shoulder depending on what's

impacting spinal alignment. The aim is to restore the range of motion of the spine, muscle length and strength as well as endurance and cost ability.

This stage is Paramount's for allowing ongoing treatments in phase three to occur. This is because it's there that the patient requires the strength and flexibility gained in phase two in order to resume normal activities. These include sports and recreation, which is the objective most patients have in mind during the treatment process; is where we aim to restore full function? This is where we, as physiotherapists, need to tailor rehabilitation to the specific patients so they can safely achieve their functional goals. This, of course, includes trained athletes who placed great stress upon their bodies, so caution must be taken when giving advice and strong encouragement is needed for keeping too realistic recovery times.

The final phase is undoubtedly the most important in terms of full recovery and this is the prevention of a recurrence. This relies heavily on the partnership between physiotherapists and patients. By this, I mean we identify the optimal exercises for the patient to continue and it is then up to them to maintain these exercises throughout the course of their life. Here too, other professions may be utilized. For example, in a case of an unequal leg length, a podiatrist could address this with a heel rise, shoe rise or built-up foot orthotic.

What patients expect to achieve on what is achieved varies greatly. However, those with mild to moderate scoliosis who have a commitment to maintaining their newfound strength and flexibility can expect a full recovery, especially if diagnosed and treated early. Physiotherapy is a vital part of this recovery and prevention and should never be underestimated. So the next time you're asked, can physiotherapy help my condition? I'd be inclined to give a firm nod and respond by saying, with your commitment, physiotherapy is invaluable.

Part C: Extract 2

Interviewer: My guest today is Gary Princelet, who's a speech and language therapist. First of all, Gary, I think there's a bit of uncertainty out there about what the work of an SLT actually involves, and it can vary. So tell us exactly what you do.

Gary: I'm a speech and language therapist working with adults in an acute hospital. I carry out communication and swallowing assessments. Recommend safe consistencies for people with conditions like disfasia and I make referrals for people who need ongoing help once they're discharged.

Ah, a lot of people don't realize that we assess a range of things as well as language, but esophageal assessments actually account for the vast majority of patients on an acute case load.

Interviewer: How did you get into this type of work?

Gary: My mom had a stroke when she was in her twenties, so I grew up with someone who had a communication disorder. She was really inspirational because she was working as a dentist before the stroke, but had to retrain to use her left hand when she was left with right sided weakness. Um, my son's learning disabled too. And, our struggle to get a speech therapist was the final push I needed to look into training as one myself. It wasn't the career path had originally planned for myself.

Interviewer: So what type of training did you have?

Gary: It's a degree level job, so I went back to university as a mature student. I could have done a two year MSC cause I'd already got a degree. But I chose the three year BSC so that I could still have a life. Um, the two year Masters is very full on. In the UK the best way to get a job afterwards is to sign up for NHS jobs and apply for everything. It's been a lean few years for SLT jobs in the UK, but it's quite cyclical, so I expect the situation to improve. There are some private jobs going to, which can be good as long as there's mentoring in place.

Interviewer: Describe a typical day in your job.

Gary: I get in at 8:30 and we go through what we call the list, which is our daily caseload and when they need to be seen. As well as current patients, there are new referrals every day, so they get divided up. Then I spend a few minutes plotting my route through the day, prioritizing who I need to see and when they're going to be free to see me.

Then I go onto the wards and do my assessments and reviews. I stop for the wards, protected lunchtime between 11:30 and 1:00, catch up with my admin, then see more

patients in the afternoon. I'm still doing my disfasia training, so I have to report back to my supervisor quite regularly.

Interviewer: And what skills do you need for this type of work?

Gary: I think you need to be a good communicator and listener and being observant helps, but above all, in a hospital setting, there's no room for lone wolves. We work with other therapists like physios and occupational therapists, for example, as well as nurses and doctors. And we have to work together to find ways to fit all the pieces together so that the outcome for the patient and their family is the best possible. But you do get bad outcomes in an acute hospital because your patients are sick and sometimes they don't make it. Despite the best efforts of everyone involved in their care. So you've got to be prepared to take that, too. Uh

Interviewer: What advice would you give someone wanting to break into this career?

Gary: If you want to pursue a career as a speech therapist, you need to get some experience under your belt. Some therapists will let prospective students shadow them for a day or two. Though hospital departments generally won't allow that unless you have a firm offer of a place at university. But there are opportunities to volunteer with support groups and charities. So that's probably your best route. Um, the local stroke support group took me in and were really welcoming. Um, it's also a useful way to see if it's the right fit for you before you invest too much time in it.