ENTRI

OET

STUDY MATERIAL

READING

Reading Sub-Test

Part A: Texts

Schizophrenia: Texts

Text A

Assess Symptoms and Establish a Diagnosis.

Establish an accurate diagnosis, considering other psychotic disorders in the differential diagnosis because of the major implications for short- and long-term treatment planning. If a definitive diagnosis cannot be made but the patient appears prodromally symptomatic and at risk for psychosis, evaluate the patient frequently.

Reevaluate the patient's diagnosis and update the treatment plan as new information about the patient and his or her symptoms becomes available.

Identify the targets of each treatment, use outcome measures that gauge the effect of treatment, and have realistic expectations about the degrees of improvement that constitute successful treatment.

Consider the use of objective, quantitative rating scales to monitor clinical status (e.g., Abnormal Involuntary Movement Scale [AIMS], Structured Clinical Interview for DSM-IV Axis I Disorders [SCID], Brief Psychiatric Rating Scale [BPRS], Positive and Negative SyndromeScale [PANSS]).

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Text B

Assistance in Organising Confusing Experiences

ABC model

The ABC model, which was originally developed by Ellis and Harper,12 can be used to give the patient a way of organizing confusing experiences. It involves slowly and thoroughly moving the patient through the various steps using Socratic questioning to clarify the links between the emotional distress the patient is experiencing and the beliefs he holds (Table). It includes the following steps:

- Based on a scale of 0 to 10, the patient rates the intensity of distress.
- The consequence (C) is assessed and divided into emotional and behavioral Cs.
- The patient gives his own explanation as to what activating events (As) seemed to cause C; and the therapist ensures that the factual events are not "contaminated" by judgments and interpretations.
- The therapist provides feedback to the patient to acknowledge the A-C connection.
- The therapist assesses the patient's belief, evaluations, and images and communicates to the patient that a personal meaning is lacking in the A-C model; simple examples can be provided to facilitate understanding.
- The patient's own belief (B), which is actually the cause of C, is then discussed; often, this can be rationalized, and a B such as "nobody will like me if I tell them about my voices" can be disputed and changed to "I can't demand that everyone likes me. Some people will and some won't...Maybe some friends might find it interesting." This may lead to a change in C, ie, less sadness and isolation.

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Text C

Advantages and disadvantages of different routes of administration.

Administration route	Advantages	Disadvantages	Examples	Time to peak plasma concentration
Intramuscular	Rapid systemic entry; patient cooperation not necessary	Invasive; can damage patient–physician relationship	Haloperidol	~20 minutes
			Olanzapine	15–45 minutes
			Aripiprazole	1–3 hours
			Ziprasidone	60 minutes
Inhaled	Less invasive than intramuscular route and can improve patient experience. Enters alveoli for rapid entry into arterial circulation	Requires patient cooperation Bronchospasm/respiratory distress	Loxapine	2 minutes
Oral				
Standard tablets/capsules/solution	Less invasive than intramuscular route and can improve patient experience	Require patient cooperation; slow onset of action; enter systemic circulation via portal system resulting in potential for erratic absorption; can be diverted (“cheeking”)	Haloperidol	2–6 hours
			Olanzapine	5–8 hours
			Risperidone	~1 hour
			Aripiprazole	3–5 hours
			Ziprasidone	6–8 hours
Orally disintegrating tablets	Less invasive than intramuscular route and can improve patient experience. Less potential for diversion (“cheeking”) vs standard tablets/capsules; suitable for patients with dysphagia	Slow onset of action; enter systemic circulation via portal system resulting in potential for erratic absorption	Olanzapine	~6 hours
			Risperidone	1–2 hours
			Aripiprazole	3–5 hours
Buccal/sublingual	Less invasive than intramuscular route and can improve patient experience; rapid absorption; avoids first-pass metabolism	Requires patient cooperation; needs to be taken correctly so that it is not swallowed, mitigated in part by the friability of the tablet	Sublingual asenapine	0.5–1.5 hours
Intranasal	Less invasive than intramuscular route and can improve patient experience; rapid absorption; avoids first-pass metabolism	Requires patient cooperation.	Intranasal midazolam	10 minutes

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Text D

Goals of Treatment

- Minimize stress on the patient and provide support to minimize the likelihood of relapse.
- Enhance the patient's adaptation to life in the community.
- Facilitate continued reduction in symptoms and consolidation of remission, and promote the process of recovery.

If the patient has achieved an adequate therapeutic response with minimal side effects, monitor response to the same medication and dose for the next 6 months.

Assess adverse side effects continuing from the acute phase, and adjust pharmacotherapy accordingly to minimize them.

Continue with supportive psychotherapeutic interventions.

Begin education for the patient (and continue education for family members) about the course and outcome of the illness and emphasize the importance of treatment adherence.

To avoid gaps in service delivery, arrange for linkage of services between hospital and community treatment before the patient is discharged from the hospital.

For hospitalized patients, it is frequently beneficial to arrange an appointment with an outpatient psychiatrist and, for patients who will reside in a community residence, to arrange a visit before discharge.

After discharge, help patients adjust to life in the community through realistic goal setting without undue pressure to perform at high levels vocationally and socially.

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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 on the spaces provided in this Question Paper.

Answer all the questions within the 15-minute time limit. Your answers should be correctly spelt.

Schizophrenia: Questions

Questions 1-7

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

In which text can you find information about

1. Facilitating continued deduction in symptoms __________________

2. The various steps using socratic questioning __________________

3. Gauging the effect of treatment to establish diagnosis __________________

4. The rating scales used to monitor clinical status __________________

5. Administration routes for giving drugs __________________

6. Advantages of haloperidol medication for treatment __________________

7. Division into emotional and behavioural Cs __________________

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.

8. What must be arranged for, to avoid gaps between hospital and community

____

9. What was the ABC model developed to assist

____

10. What does the therapist provide to acknowledge the A-C connection?

____

11. What can be used to gauge the effect of treatment?

____

12. What must be done if the patient appears problematically symptomatic?

____

13. How long will a sublingual administration of asenapine take to peak plasma concentration?

____

14. Which drugs are examples of slow acting orally disintegrating tablets?

____

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Questions 15-20

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

15. A disadvantage of inhaled medication is that it requires __________________.

16. __________________ route of administration of midazolam ensures rapid absorption.

17. It is advised to __________________ the patient's diagnosis and update the treatment plan.

18. The ABC Model helps to clarify __________________ from the beliefs the patient holds.

19. Assitance in understanding can be facilitated by providing ______________ .

20. After discharge, patients must be allowed to perform without __________________.

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Part B

In this part of the test, there are four 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.

1. The extract from the circular is intended to

A. give information on compiling private prescriptions

B. remind the staff of particulars to be included

C. instruct the doctors of methods to standardise procedures

Record keeping

A record must be kept of every DCA EPP prescription only medicine (POM) supplied. Record to be kept in a bound book or electronically.

- Particulars to be recorded:
  - — Date of supply
  - — Name, quantity and pharmaceutical form and strength of the medicine
  - — Date on the prescription
  - — Name and address of the prescriber
  - — Name and address of the patient

- Entry must be made on the day of supply, or if that is not reasonably practical, on the next following day.
- The record must be retained for a period of 2 years from the date of last entry in the book/electronic register.
- Prescription token must be referenced accordingly and filed in a chronological order, and retained for a period of 2 years from the date of supply.

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2. The report on homeless patients suggests that issues can be addressed by

A. assuring help required from a GP or dentist

B. registering the identity of those uncovered

C. adhering to the laid down structure of identification

The issues of looking after homeless patients in General Practice

In 2014 Homeless Link reported that 90% of the homeless people they surveyed were registered with a GP. However many responded that they were not receiving the help they needed for their health problems, and 7% had been refused access to a GP or dentist in the previous 12 months. In some cases these refusals were due to having missed a previous appointment or because of behaviour. Others reported that they were refused access if they did not have identification or proof of address. The Health and Social Care Act introduced statutory duties on the health department to "have regard to the need to reduce inequalities" in access to and outcomes achieved by services. Many practices request multiple forms of identification and proof of address when registering new patients. This can be useful for them to ensure identity and contact details. The General Medical Services Contracts Regulations state that practices may only refuse an application to go on their list if they have reasonable grounds for doing so which do not relate to the applicant's race, gender, social class, age, religion, sexual orientation, appearance, disability or medical condition.

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3. What does this advisory intend to convey?

A. The requirement for monitor of malnourished patients.

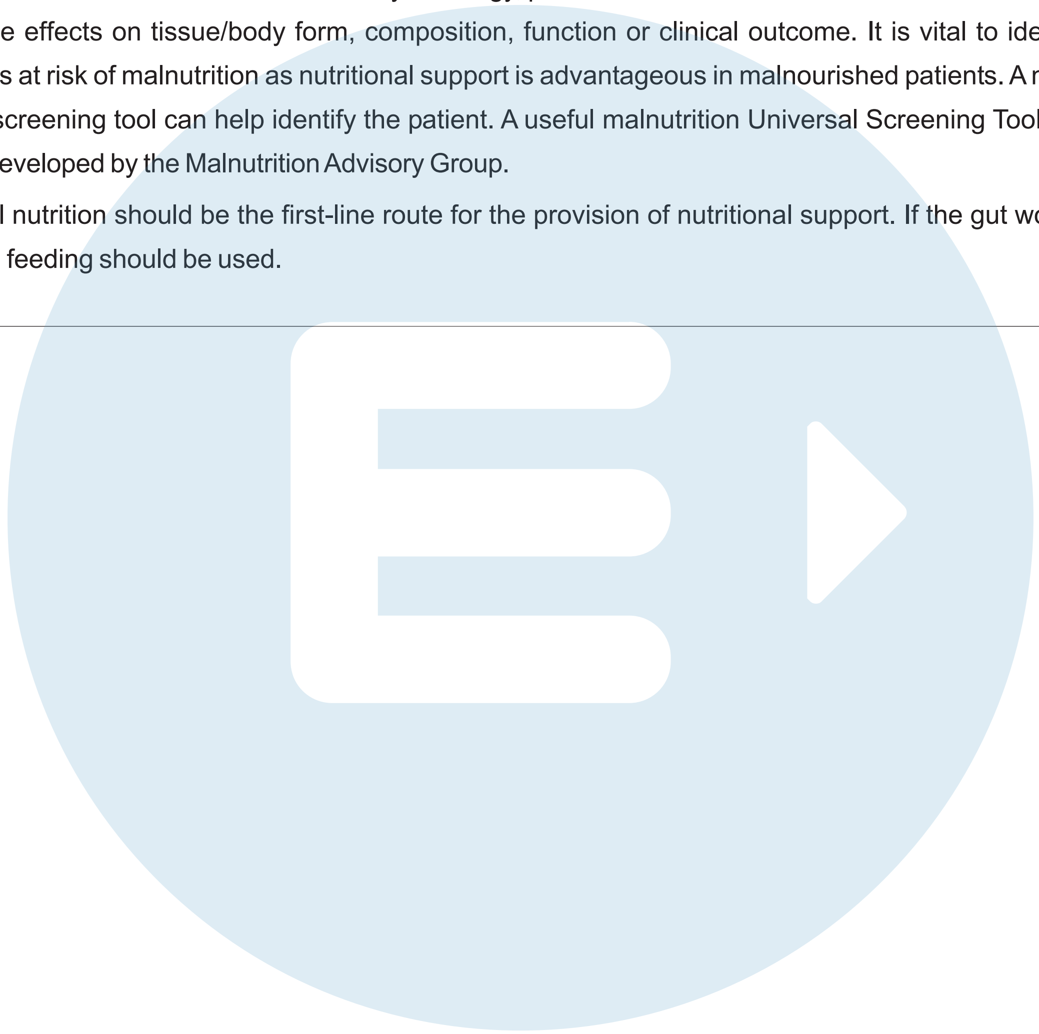
B. Primary route for providing external nutritional support

C. Identification and management of malnourished patients.

Step to contain malnourishment

Malnutrition is a state in which a deficiency of energy, protein and/or other nutrients causes measurable adverse effects on tissue/body form, composition, function or clinical outcome. It is vital to identify patients at risk of malnutrition as nutritional support is advantageous in malnourished patients. A nutritional screening tool can help identify the patient. A useful malnutrition Universal Screening Tool has been developed by the Malnutrition Advisory Group.

Enteral nutrition should be the first-line route for the provision of nutritional support. If the gut works, enteral feeding should be used.



4. The directive on discharge plan outlines the

A. Approach to be considered on the length of the stay

B. Need for the patients choice in the duration of stay

C. Use of systems to estimate the course of admission

Discharge or transfer protocols update

Most patients want to know how long they are likely to stay in hospital, and to be provided with information about their treatment and when they are likely to be discharged. This helps them achieve their goals and plan for their own transfer. The exceptions to this are intensive care and high-dependency units, where setting an expected date should be delayed until the patient is transferred to the ward. Predicting a patient's length of stay can be undertaken in two ways. It can be based on actual performance in the ward or unit, or on benchmarking information. It is essential that the ward or unit understands and uses the adopted system to give a valid and sustainable approach. The Department of Health's discharge guidance states that: "Estimated date of discharge is based on the expected time required for tests and interventions to be completed, the integrated care pathway and the time it is likely to take for the patient to be clinically stable and fit for discharge."

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5. In the prospectus for infection prevention, what are control professionals required to do?

A. Prepare an exhaustive analysis and control an outbreak

B. Chart a course to apply policies that cuts an infection

C. Implement practices that are best suited for individuals

Infection prevention and control professional

A person whose primary training is in either nursing, medical technology, microbiology, or epidemiology and who has acquired specialized training in infection control. Responsibilities may include collection, analysis, and feedback of infection data and trends to healthcare providers; consultation on infection risk assessment, prevention and control strategies; performance of education and training activities; implementation of evidence-based infection control practices or those mandated by regulatory and licensing agencies; application of epidemiologic principles to improve patient outcomes; participa-tion in planning renovation and construction projects (e.g., to ensure appropriate containment of con-struction dust); evaluation of new products or procedures on patient outcomes; oversight of employee health services related to infection prevention; implementation of preparedness plans; communication within the healthcare setting, with local and state health departments, and with the community at large concerning infection control issues; and participation in research.

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6. In view of the circular published, what is the hospital trying to address

A. services required by the midwives for intensive care

B. support required for full term pregnant mothers

C. objectives that are vital for quality maternal care

Commitment and Support by Governing Body

In view of the necessity for Zamboanga City Medical Center

- to continuously control maternal death;
- to continuously provide quality and safe maternal care service; and
- to collaborate with the Department of Health on the control of maternal deaths to meet the Millenium Development Goal,

the undersigned representing the governing body and top management of Zamboanga City Medical Center hereby wholeheartedly commit to lead and to provide support in establishing and developing a Maternal Death Control Management System in Zamboanga City Medical Center starting October 13, 2018. We also hereby authorize the Zamboanga City Medical Center Maternal Death Control Management System Team to administer the program. This Manifestation of Commitment and Support by the governing and top management by the Zamboanga City Medical Center shall be renewed every three years.

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Text 1: The Chemistry and Physics Behind the Perfect Cup of Coffee

We humans seem to like drinks that contain coffee constituents (organic acids, Maillard products, esters and heterocycles, to name a few) at 1.2 to 1.5 percent by mass (as in filter coffee), and also favor drinks containing 8 to 10 percent by mass (as in espresso). Concentrations outside of these ranges are challenging to execute. There are a limited number of technologies that achieve 8 to 10 percent concentrations, the espresso machine being the most familiar.

There are many ways, though, to achieve a drink containing 1.2 to 1.5 percent coffee. A pour-over, Turkish, Arabic, Aeropress, French press, siphon or batch brew (that is, regular drip) apparatus – each produces coffee that tastes good around these concentrations. These brew methods also boast an advantage over their espresso counterpart: They are cheap. An espresso machine can produce a beverage of this concentration: the Americano, which is just an espresso shot diluted with water to the concentration of filter coffee. There are two families of brewing device within the low-concentration methods – those that fully immerse the coffee in the brew water and those that flow the water through the coffee bed.

From a physical perspective, the major difference is that the temperature of the coffee particulates is higher in the full immersion system. The slowest part of coffee extraction is not the rate at which compounds dissolve from the particulate surface. Rather, it's the speed at which coffee flavor moves through the solid particle to the water-coffee interface, and this speed is increased with temperature.

A higher particulate temperature means that more of the tasty compounds trapped within the coffee particulates will be extracted. But higher temperature also lets more of the unwanted compounds dissolve in the water, too. The Specialty Coffee Association presents a flavor wheel to help us talk about these flavors – from green/vegetative or papery/musty through to brown sugar or dried fruit.

The water-to-coffee ratio matters, too, in the brew time. Simply grinding more fine to increase extraction invariably changes the brew time, as the water seeps more slowly through finer grounds. One can increase the water-to-coffee ratio by using less coffee, but as the mass of coffee is reduced, the brew time also decreases. Optimization of filter coffee brewing is hence multidimensional and trickier than full immersion methods.

Every coffee enthusiast will rightly tell you that blade grinders are disfavored because they produce a seemingly random particle size distribution; there can be both powder and essentially whole coffee beans coexisting. The alternative, a burr grinder, features two pieces of metal with teeth that cut the coffee into progressively smaller pieces. They allow ground particulates through an aperture only once they are small enough.

There is contention over how to optimize grind settings when using a burr grinder, though. One school of thought supports grinding the coffee as fine as possible to maximize the surface area, which lets you extract the most delicious flavors in higher concentrations. The rival school advocates grinding as coarse as possible to minimize the production of fine particles that impart negative flavors. Perhaps the most useful advice here is to determine what you like best based on your taste preference.

Finally, the freshness of the coffee itself is crucial. Roasted coffee contains a significant amount of CO_2 and other volatiles trapped within the solid coffee matrix: Over time these gaseous organic molecules will escape the bean. Fewer volatiles mean a less flavorful cup of coffee. Most cafes will not serve coffee more than four weeks out from the roast date, emphasizing the importance of using freshly roasted beans.

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Text 1: Questions 7 - 14

7. The favorable concentration of drinks by mass in espresso include

- (A) 3 percent by mass
- (B) 8 percent by mass
- (C) 12 percent by mass
- (D) 1.3 percent by mass

8. What can be the advantage of other brew methods over espresso

- (A) They produce a favorable concentration
- (B) The methods are cheaper
- (C) The other brew methods produce tastier coffee
- (D) The other methods are advantageous

9. What can be the meaning of "counterpart"

- (A) Neighbor
- (B) Enemy
- (C) Coequal
- (D) Sibling

10. Higher temperature can help easy extraction even though

- (A) More tastier compounds get trapped
- (B) Unwanted compounds gets dissolved in the water
- (C) The brewing gets trickier
- (D) The speed gets increased with temperature

11. What can be true with respect to optimization of filter coffee brewing

- (A) Water-coffee ration can be less of importance
- (B) Full immersion methods gets less trickier and multidimensional
- (C) Simple grinding does not changes brew time
- (D) The relevance of optimization is null

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12. A burr grinder features

Ⓐ Seemingly random particle size distribution
Ⓑ Coexistence of powder and whole coffee beans
Ⓒ A progressive grinding of coffee into smaller pieces
Ⓓ Blade grinders are completely disfavored

13. What can be “contention”

Ⓐ Approval
Ⓑ Disagreement
Ⓒ Harmony
Ⓓ Plea

14. Less flavorful cup of coffee can be due to

Ⓐ The gaseous organic molecules that escape the bean over time
Ⓑ The volatiles that get trapped into the beans over time
Ⓒ The freshly roasted beans have significant amount of CO_2
Ⓓ Cafes serve coffee that can be containing more volatiles

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Text 2: Difficult-to-treat depression

Depression remains a leading cause of distress and disability worldwide. In one country's survey of health and wellbeing in 1997, 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 35% of people with a mental health problem had a mental health consultation during the previous 12 months. Of those with a mental health problem, 27% (i.e., three-quarters of those seeking help) saw a general practitioner (GP). In the 2007–08 follow-up survey, not much had changed: 12-month prevalence rates were 4.1% for depression, 1.3% for dysthymia and 1.8% for bipolar disorder. These disorders were associated with significant disability, role impairment, and mental health and substance use co-morbidity. Again, there was evidence of substantial unmet need, and again GPs were the health professionals most likely to be providing care.

While general practitioners (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 therapies, be they psychological or pharmacological. This supplement aims to address some of the issues that GPs face in this context. 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. Thus, the term has face validity, if not specificity. 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, but the obverse is that people with chronic physical ailments are at high risk of depression. Pain syndromes 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.

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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 2: Questions 15 - 22

15. Paragraph one aims to convey that

- (A) each surveyed participant in 1997 reported 11.7 disability days.
- (B) those with an affective disorder performed their typical duties as normal.
- (C) a large proportion of mental health consultations were provided by a GP.
- (D) 35% having a mental health consultation is a great improvement.

16. What is signified from the statistics of 2007-2008?

- (A) Comparable findings for the several mental illnesses mentioned.
- (B) The rate of depression had fallen considerably.
- (C) Disability days had declined from the 1997 statistics.
- (D) The level of treatment provided had improved somewhat.

17. What information is expressed in paragraph two?

- (A) GPs are in an advantageous position
- (B) GPs should not force a pointless plan
- (C) GPs must address the issues when faced
- (D) GPs are likely to have required skills

18. According to paragraph 3, the term '**difficult-to-treat depression**' has

- (A) relatability to its broader meaning
- (B) an unidentifiable and misunderstood meaning
- (C) full value and is specific in its meaning
- (D) full value but is not specific in its meaning

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19. Paragraph 4 implies that physical ailments are a difficult area because

- (A) clinicians do not generally believe all apparent physical symptoms
- (B) clinicians must decipher what is valid and what is improbable
- (C) clinicians observe the patient for any legitimacy of mental problems
- (D) clinicians only recognise legitimate complaints of comorbid chronic pain

20. According to paragraph 5, people with BPD s

- (A) have a stable mood making it difficult to diagnose.
- (B) have mood fluctuations which are key to the disorder.
- (C) have rapid mood swings which are clearly identifiable.
- (D) have limited support from the health service.

21. In paragraph 6, the author's use of '**surprisingly lacking**' is

- (A) to portray a tone of doubt that it is truly lacking.
- (B) because of the scarcity of bipolar disorder in modern times.
- (C) due to the established prevalence of bipolar disorder.
- (D) to enable readers to understand and feel the author's skepticism.

22. Reducing symptoms associated with BPD is achieved by

- (A) psychological techniques and long term planning
- (B) treatments requiring unopposed antidepressant use
- (C) medications including use of atypical antipsychotics
- (D) therapies like family education and support groups

END OF READING TEST

THIS BOOKLET WILL BE COLLECTED

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