OET Writing:

1 Format & **Planning**
2 Discuss in Groups
3 Create a plan

Format:
5 mins – Reading (no pens)
40 mins – Writing

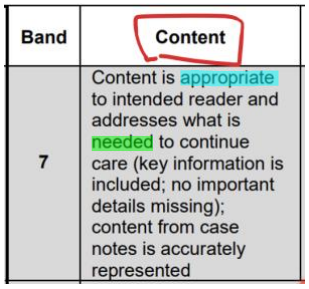
Planning: 10 mins (approx.)

Writing: 30 mins

Check: 5 mins [You will mis simple errors]

3 Stages....

How to plan a letter...

Understand	Choosing Notes	Organise
Critical questions: 1. Reader? Task? 2. Reader knows patient? 3. Writer? Task before? 4. Urgent? 5. Why are we writing today? 6. Where is everyone? Where is Pt going?	Select relevant case notes from information: 1. **Appropriate** (not direct): suitable, useful, handy, *might* be a good SOME 2. **Needed** (direct connection): essential, vital, paramount, etc. ALL 	Paragraphing: Introduction Requests: Tell the reader what to do

Band	Content
7	Content is appropriate to intended reader and addresses what is needed to continue care (key information is included; no important details missing); content from case notes is accurately represented

OET Writing Criteria: scoring system

SET English

Band	Purpose	Band	Content	Conciseness & Clarity	Genre & Style	Organisation & Layout	Language
3	Purpose of document is immediately apparent and sufficiently expanded as required	7	Content is appropriate to intended reader and addresses what is needed to continue care (key information is included; no important details missing); content from case notes is accurately represented	Length of document is appropriate to case and reader (no irrelevant information included); information is summarised effectively and presented clearly	Writing is clinical/factual and appropriate to genre and reader (discipline and knowledge); technical language, abbreviations and polite language are used appropriately for document and recipient	Organisation and paragraphing are appropriate, logical and clear; key information is highlighted and sub-sections are well organised; document is well laid out	Language features (spelling/punctuation/vocabulary/ grammar/sentence structure) are accurate and do not interfere with meaning
		6	Performance shares features of bands 5 and 7				
2	Purpose of document is apparent but not sufficiently highlighted or expanded	5	Content is appropriate to intended reader and mostly addresses what is needed to continue care; content from case notes is generally accurately represented	Length of document is mostly appropriate to case and reader; information is mostly summarised effectively and presented clearly	Writing is clinical/factual and appropriate to genre and reader with occasional, minor inappropriacies; technical language, abbreviations and polite language are used appropriately with minor inconsistencies	Organisation and paragraphing are generally appropriate, logical and clear; occasional lapses of organisation in sub-sections and/or highlighting of key information; layout is generally good	Minor slips in language generally do not interfere with meaning
		4	Performance shares features of bands 3 and 5				
1	Purpose of document is not immediately apparent and may show very limited expansion	3	Content is mostly appropriate to intended reader; some key information (about case or to continue care) may be missing; there may be some inaccuracies in content	Inclusion of some irrelevant information distracts from overall clarity of document; attempt to summarise only partially successful	Writing is at times inappropriate to the document or target reader; over-reliance on technical language and abbreviations may distract reader	Organisation and paragraphing are not always logical, creating strain for the reader; key information may not be highlighted; layout is mostly appropriate with some lapses	Inaccuracies in language, in particular in complex structures, cause minor strain for the reader but do not interfere with meaning
		2	Performance shares features of bands 1 and 3				
0	Purpose of document is partially obscured/unclear and/or misunderstood	1	Content does not provide intended reader sufficient information about the case and what is needed to continue care; key information is missing or inaccurate	Clarity of document is obscured by the inclusion of many unnecessary details; attempt to summarise not successful	The writing shows inadequate understanding of the genre and target reader; mis- or over-use of technical language and abbreviations cause strain for the reader	Organisation not logical, putting strain on the reader; or heavy reliance on case note structure; key information is not well highlighted and the layout may not be appropriate	Inaccuracies in language cause considerable strain for the reader and may interfere with meaning
		0	Performance below Band 1				

SET English

WRITING SUB-TEST: **MEDICINE**
TIME ALLOWED: **READING TIME: 5 MINUTES**
WRITING TIME: 40 MINUTES

Read the case notes and complete the writing task which follows.

Notes:

Assume that today's date is 11 February 2019.

You are a doctor in the Emergency Department of Newtown Hospital. You have been responsible for the care of M John Aloisius, recently admitted with breathing problems.

PATIENT DETAILS:

Name: John Aloisius
Marital status: Single
Residence: 39 Long Street, Bridgeford
DOB: 04 Sep 1985 (33 y.o.)
Next of kin: Brother (age 39)

Social background:
Occupation: archaeologist (recently returned from year-long visit to remote region of Latin America)

Past medical history:
No PMHx
No surgeries
No medication
NSAIDs allergy
Non smoker

Family history: Mother: asthma (since childhood)
Father: dec. 1999 (lung cancer)

01 Feb 2019: **Admission to Emergency Department**
Presenting problem:
Night sweats & fevers, cough & sputum with some hemoptysis (over several weeks)
VS: BP: 114/72 mmHg, P: 90 beats/minute, T: 38.5°C,
RR: 18 breaths/minute, Oximeter: 92% saturation room air

Physical examination:
Notable for cachexia, chest with scattered rales, no consolidation

Diagnosis: Pulmonary tuberculosis

Treatment & test results:
Chest x-ray: apical infiltrate

01 Feb 2019 Pt. placed on respiratory isolation
03 Feb 2019: Sputum acid-fast stain & mycobacterial culture positive for tuberculosis
Liver function (AST & ALT): normal
TB medications started: Isoniazid 5 mg/kg PO/IM qDay, Rifampin 10 mg/kg/day PO, Pyrazinamide 15-30 mg/kg
PO, qDay, Ethambutol 2.8g PO twice weekly
HIV serology: negative
Vitamin B-6 50mg PO once daily
11 Feb 2019 Sputum acid-fast stain: negative

Medical progress:
Good
Pt: 'lonely & depressed' (isolation)

Nursing management:
Respiratory isolation (private room) with negative pressure
Normal diet
Follow anti-tuberculosis medication schedule: monitor side-effects
Weekly sputum analysis
Medical staff to wear high-efficiency disposable masks (for bacillus filtration)

Discharge date: 11 Feb 2019

Discharge plan: Continue 4-drug regimen (for 2 months)
Cease pyrazinamide & ethambutol after 2 months
Continue isoniazid + rifampin (daily or intermittent) for 4 mths
Monitor medication compliance: directly observed therapy
(DOT) by nurse recommended (→poss. reduction of above regimen to 2 / 3x wk after 2 wks at initial dose)
Monitor for toxicity (CBC, serum creatinine, baseline & periodic liver enzymes)
Baseline & periodic serum uric acid assessments
Periodic visual acuity & red-green color perception (Ishihara test)
Continue vitamin B-6 supplements

Writing Task:

Using the above information, write a letter of discharge to Dr Hodges, the patient's regular doctor, informing her of the treatment Mr Aloisus has received and advising on further management. Address the letter to Dr Christine Hodges, 2 Hill Forest Road, Newtown.

In your answer:

- **Expand the relevant notes into complete sentences**
- **Do not use note form**
- **Use letter format**

Plan

Introduction	• **Further management**
Timeline	• 1st February: symptoms suggestive of • Diagnosis: PT • Test + Treatment details? – you can put some in if you want • Medication **+ Isolated for 4 months** • Condition: good Try as much as possible to summarise
Medication	TB medications started: Isoniazid 5 mg/kg PO/IM qDay, Rifampin 10 mg/kg/day PO, Pyrazinamide 15-30 mg/kg PO, qDay, Ethambutol 2.8g PO twice weekly
Requests	Discharge plan: Continue 4-drug regimen (for 2 months) Cease pyrazinamide & ethambutol after 2 months Continue isoniazid + rifampin (daily or intermittent) for 4 mths Monitor medication compliance: directly observed therapy (DOT) by nurse recommended (→poss. reduction of above regimen to 2 / 3x wk after 2 wks at initial dose) Monitor for toxicity (CBC, serum creatinine, baseline & periodic liver enzymes) Baseline & periodic serum uric acid assessments Periodic visual acuity & red-green color perception (Ishihara test) Continue vitamin B-6 supplements

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