OET Writing Handbook

Contents

Test Format

Task: Write a letter using case notes (45 minutes)

Usually referral, discharge, transfer letters for doctors

Suggest:

- 5 minutes to read
- 5 minutes to read and mark the essential information and organise
- 30 minutes to write
- 5 minutes to proofread

Remember: In order to score high in a test, what should we do?

1. What skills are tested > writing, reading, listening, speaking?
2. What do we need to do to improve those skills?

What skills in writing are tested?

Criterion	Purpose	Content	Conciseness & Clarity	Genre & Style	Organisation & Layout	Language	Total
Score/38	3	7	7	7	7	7	38
comments							
Score/500	40	92	92	92	92	92	500

What are the marking criteria?

Purpose

A. early
B. quick and precise
C. expanded on later

Content

a. key information included
b. key information accurately represented
c. audience awareness (we should know who we are writing to)
d. what **the reader** needs to know to provide continued care for this case?

N.B. A good way of deciding what information is essential: put yourself in the reader's shoes and try to decide what you would like to hear first.

Essential information	**Good-to-know information**	Unnecessary information

Conciseness & clarity

a. omit irrelevant information
b. summarise the relevant information efficiently and effectively
c. if irrelevant information included, how distracting is it?

Genre & style

a. Appropriate register and tone > clinical and factual, non-judgemental
b. Professional register and tone
c. Abbreviations and medical jargon used appropriately

Globally accepted abbreviations such as LMP, G5P2Ab2, BP, PR, DM, HTN, IHD, MI, can be used for doctors; if you are unsure, just write the full word.

Organisation & layout

a. Appropriate paragraphing
b. Logical organisation
c. Key information clearly highlighted > discourse markers (please note, it is important, etc) Earlier in a paragraph
d. Appropriate layout

Language (suitable and accurate)

a. Grammar
b. Vocabulary
c. Spelling
d. Punctuation

Accurate, appropriate, not interfering with reading comprehension or speed

Appropriacy more important than range

Approach to writing

A suggested approach to writing:

1. Read the task
   a. Read the end first > who is writing to whom and why?
   b. Read the last entry > that is the trigger for the letter
   c. Read the rest > Look for key information (ESS and GTK)
2. Read the task and mark ESS and GTK
   a. Go back to the beginning of this matter
   b. Decide on the logical organisation (SOAP)
3. Write the letter
   a. Receiver
   b. Date
   c. Dear ….
   d. Re: patient's name and DoB
   e. Purpose
   f. Summarise essential information
   g. Write the GTK information
   h. What you expect + any relevant connection or side matters

(180-200 words) Just a guidance > words are not important, but the information is checked

Example 1: emergency referral

Making a decision on essential information: In a case like this, what would you like to hear first? Suppose you are the emergency cardiology registrar and a GP is calling you for admission:

48-year-old/man/sudden-onset chest pain/ possible MI

Passing by medical centre today, had sudden onset crushing chest pain that did not respond to Anginine

o/e wheezing and crackles, S3+ and SpO2 86% on R/A. ECG shows ST elevation in anterior leads.

With impression of anterior MI possibly in the background of asthma and URTI, he was started on O2…., …

A month ago attended with mild chest pain on exertion, troponin was -ve

Lab tests showed high chol, An exercise test showed IHD, and he was started on …..

Alcohol dependence, smoking, asthma since childhood, Seretide but non-compliance with medications,

Paramedic transfer to emergency department.

You can see the key information above; we tend to start paragraphs with key items so the reader can pay more attention to those. It is similar to writing a paragraph with the 'main idea' at the beginning.

Example 2: referral for management

Mrs Priya Sharma (Official sample case note from OET website)

Essential	Good to now	Side matters
High sugar *High BP > candesartan* *GFR > 60* *HBA1C 10%* *Chol high* *Metformin 500 >> 750* *Lipitor 20mg* *Glipizide 10mg* *Initial improvement in BP, Sugar and chol* *BUT again FBS 16+ other BS 7-8*	*DMT2 since 1999* *No complications (eye OK, no neuropathy, GFR > 60)* *No smoking, no alcohol, no exercise, BMI 24, Allergic to penicillin*	*Worried? Checks levels often* (This might be relevant, but usually prior connections between the clinician and the patient, or issues such as patient's insisting on referral could be relevant and mentioned in the last paragraph)

Purpose: (instantly identifiable, early in the document, elaborated later in the document)

Please note how the first (purpose) and last (closing) paragraphs are personal, using the word 'I', but other paragraphs are factual and descriptive, with the use of passive voice and statements. See the sample below:

> ***I am*** writing to refer Mrs Priya Sharma, a 60-year-old lady with uncontrolled diabetes mellitus type 2 (DMT2), for further management of her sugar levels.
>
> She initially attended surgery on 29/12/2018 with high BS of 6-18. She was taking metformin 500mg BD and glipizide 5mg 2 mane. Her examinations showed a High BP of 155/100mmHg; she was started on candesartan 4mg mane.
>
> On 12/01/2019, her blood test results showed a GFR > 60, HBA1C 10%, Chol high (6.2) and LDLC of 3.7. Metformin was increased from 500 to 750mg BD and Lipitor 20mg mane was started. Glipizide remained unchanged.
>
> Despite an initial improvement in BP, sugar and cholesterol, Mrs Sharma has presented to today me with high fasting BS of 16+ and random BS of 7-8.
>
> Mrs Sharma has had DM Type 2 since 1999; she had a normal eye check in 2017 and has no peripheral neuropathy. She does not drink alcohol, nor smokes. Her BMI is 24, and she has no regular exercise plan. She is allergic to penicillin.
>
> With regards to the uncontrolled fasting BS despite the initial management, ***I would*** appreciate if you could see Mrs Sharma for further management of her sugar levels.

What to write in purpose?

Candidates often mention a diagnosis or a 'provisional diagnosis' in the purpose paragraph. Is this appropriate in all cases? The answer is 'no'.

Suppose you are writing to a consultant asking for an opinion on diagnosis and management; it is unreasonable to say you have a diagnosis and then ask for a diagnosis! In fact, what you need to do is to explain the case in a systematic fashion and ask for the reader's opinion. You might want to mention your 'suspected' or 'possible' diagnosis as your 'opinion', but this should come later in the document where you are closing the letter.

Example 3: referral for diagnosis and management

Compare these two sentences:

> I am writing to refer Miss Browne, who has possible **seborrheic keratosis and eczema**, for **diagnosis** and **management**.
>
> I am writing to refer Miss Browne, who has presented with a skin lesion on her nipple, for **diagnosis** and **management**.

OR

> I am writing to refer **Miss Jane Brown, an 18-year-old patient of mine who has presented with possible seborrheic keratosis/ a weepy and crusty nipple,** for further assessment and management.
>
> I am writing to refer **Miss Jane Brown, an 18-year-old patient of mine who has presented with an itchy and crusty skin lesion on her nipple,** for further assessment and management.

Later in the document, you can elaborate on the reasons for your referral (your third score from 'purpose') and even mention your opinion; you may even request a 'specific procedure' if the specialist deems appropriate, but note that you cannot tell the specialist what to do!

> With regards to the *persistent nature of this problem* and *lack of response to initial management*, **I suspect** this is eczema or possibly seborrheic keratosis. I would appreciate if you could see Mr Brown and ***give us your expert opinion*** on diagnosis and management.

However, in urgent or emergency cases, we try not to beat around the bush and go straight to the diagnosis and 'reason for referral'.

Example 4: emergency referral

Compare these two sentences:

> I am writing to urgently refer Mr John Talbot, a 65-year-old gentleman with possible **acute myocardial infarction (MI)**, for further management.
>
> I am writing to urgently refer Mr John Talbot, a 65-year-old gentleman with **chest pain and ECG changes**, for further management.

The second sentence is not accurately picturing the situation, and in fact, does not clarify why this situation is an emergency.

How to write a good purpose paragraph?

A frequently asked question is how to write a good purpose paragraph. What we are trying to achieve in the letter is clarity and accuracy, so do not try to use overly complex sentences; besides, we need to avoid 'wordiness' which is an indication of poor writing quality. See this example:

Example 5: emergency referral

> I am writing to refer Mr John Talbot, a 65-year-old gentleman with signs and symptoms indicative of **acute myocardial infarction (MI)**, for urgent assessment and management.
>
> I am writing to urgently refer Mr John Talbot, a 65-year-old gentleman with possible **acute myocardial infarction (MI)**, for further management.

You might ask 'what is wordiness?' Wordiness could be considered as the opposite of 'conciseness'; in simple terms, if you can communicate a meaning by fewer number of words, this indicates better quality, but if you use too many words for the same concept, your writing quality would be considered deficient.

Table 1. Department of Health and Social Services – who does what

Setting	
Primary care	Community nurse/district nurse/midwife
Intermediate care	Rehab/nursing facility
Secondary care	Inpatient and outpatient care in hospital
Social services	Carers and social needs
Occupational therapy	home situation and coping issues

How to organise the letter?

A good way of deciding what information is essential and what to emphasise: put yourself in the reader's shoes and try to decide what you would like to hear first. A good letter clearly shows the key information to the reader (key ideas come earlier and at the beginning of paragraphs to catch the eye, sometimes with discourse markers such as 'it is important/relevant/worth mentioning).

Example 6: referral to request management plan

Organising a referral letter when we are asking for management:

> I am writing to refer Mr X, a 44-year-old gentleman with lower back pain and possible discogenic radiculopathy, for further assessment and management.

What are the symptoms and signs? (Remember 'Subjective' first and then 'Objective')

> Severe back pain radicular right side, no walking, loss of sensation + examination, SLR limited, lumbar flexion nearly nil.

How long and what have you done?

> Initially, he presented to me 2 weeks ago with ….. , rest and analgesia, no better, but worse

Anything that might be relevant?

> It is worth mentioning …. Head trauma

What I think and what exactly I am requesting now.

> In view of the progressive neurological signs and significant pain, as well as paraesthesia, I suspect Mr X has developed discopathy; I would appreciate if you could see him for further assessment and management, and possibly an MRI if you deem appropriate.

Example 7: discharge letter

Organising a discharge letter for a patient whose operation has been cancelled:

Who to whom? Why?
Cardiothoracic surgeon to GP
Discharge because of cancellation

Presentation (may not be so important in discharge letters, but it is relevant and important here)
Admitted for elective surgery,
Not fit for operation > reasons:
Smoking, high BP, depression, childcare, aspirin

What was done in hospital?
BP control, adjusted meds, smoking advice, counselling
Medication changes > Bisoprolol, lisinopril, nicotine patches, citalopram and aspirin

Discharge plan: What needs to be done and who does it?
Surgeon > Re-admission date decided
GP to monitor > Smoking + Check U&Es in 1/52
Re-admission > stop aspirin + because she is the only carer > respite care for grandchildren
Patient > to contact if chest pain or SOB

Dear Dr Harvey,

Re: Ms Janet Pristiely (DOB: 19/07/1947)

I am writing to **discharge** your patient Ms Janet Pristiely, whose coronary artery bypass surgery (CABG) was cancelled, back into your care.

Ms Pristiely was admitted for a non-critical CABG yesterday, but her procedure was cancelled because she had been smoking prior to admission. On admission, her BP was 180/100mmHg; with medications optimization, BP decreased to 140/80mmHg. She had counselling and she was diagnosed with moderate depression insufficiently controlled by citalopram. She was also given smoking cessation advice.

Regarding Ms Pristiely's medications, lisinopril 8mg was prescribed for hypertension, and nicotine patches 25mg/24hr were added for smoking cessation; bisoprolol was increased to 10mg OD; citalopram and aspirin were increased to 20mg and 150mg OD, respectively. Atorvastatin 40mg OD and NoVo-mix 50IU OD remained unchanged.

Ms Pristiely will be re-admitted on 19/10/2019. Aspirin must be stopped 3 days before re-admission. It is notable that she is the sole carer for her grandchildren, and respite care should be arranged prior to her re-admission.

I would appreciate if you could monitor Ms Pristiely's BP and electrolytes in one week and follow up her smoking cessation. I have advised her to contact me if she experiences any dyspnoea or chest pain in the meantime.

Table 2, Objective language – Action vs Statement

Action	**Statement**
She had a pulse rate of 112/min.	**Her pulse rate was 112/min.** **The pulse rate was 112/min.**
On examination, she was breathing fast, with high PR and temperature. She used the intercostal muscles for breathing.	**On examination, respiratory rate was raised** at 25/min**, PR was** 112/min**, and temperature was** 37.7C**. There was** obvious respiratory distress with intercostal retraction**.**

Example 8: referral to occupational therapy

Who to whom and why?
GP > OT for assessment of workplace

Presentation > less important (not relevant to OT)
What is important is when it started and the diagnosis
Duration and progress + treatment > Less important (not relevant to OT)

Present condition + work nature (requirements) > **Significant and relevant**
~~Risk factors~~ (good-to-know)? (not relevant to OT)

What is requested?
Workplace assessment and modification.

Dear Ms Graham,

Re: Mr Barry Jones DoB 11.06.1973

I am writing to request a workplace assessment for Mr Barry Jones, a 46-year-old regular patient of mine, who is returning to work after a prolonged period of lower back strain.

Mr Jones attended the surgery on 31/05/2019 complaining of severe lower back pain for 4 days after lifting a heavy box. X-ray excluded disc pathology. With an impression of severe lower back strain, he was prescribed *naproxen and carisoprodol* and was referred to physiotherapy. He was signed off work for 30 days.

Mr Jones was compliant with physiotherapy and exercise plan, but his recovery was slow. His pain is worse after 20-30 minutes of sitting or lying down, but he has an improved range of movement despite moving stiffly. He walks 30 minutes per day but finds this tiring.

Mr Jones works as a forklift driver in a warehouse. His job requires prolonged sitting and occasional heavy lifting.

With regards to Mr Jones' present condition and his desire to return to work, I think he can return to work return to work with modifications of his work pattern. I would appreciate if you could make an assessment of his workplace and advise on duties he can take and modifications if required.

Discharge Letters

In discharge letters, the focus is more on future plans; how the patient has been admitted is only relevant when the reader is not aware of the admission (eg urgent admission/non-elective admissions).

The past medical history is already known by GPs and this does not need to be re-iterated, except for cases where the writer would like to emphasise risk factors or mention something that might particularly be relevant to pay attention to.

Example 9: discharge from secondary care to primary care psychiatrist

Discharge letter from secondary care psychiatrist to primary care psychiatrist:

Presentation > self-admission, signs and sx, after non-compliance and substance abuse
Hospital stay > improvement, focus of treatment
GTK > Risk factors, unemployed, lives alone, alcohol, smoking, drug use, last use, other comorbidities
Plan > Risks identified > ensure compliance, monitor drug use, follow up mental health clinic

Essential	**GTK**	**Side info**
Admission and discharge date Dx Drug use Self-admission (voluntary admission) Non-compliance Auditory command hallucinations telling her to harm herself Visual hallucinations Delusion Admission signs Commenced on risperidone Improvement details Focus of treatment Ready to discharge Follow up in community mental health clinic	Drug use Other illnesses	Lives alone Non-compliant Unemployed Drug abuse

I am writing to discharge your patient Ms Bethany Tailor, who was admitted with relapse schizophrenia 18 days ago, back into your care.

Ms Tailor admitted herself to our care on 1st March 2018, as she was aggressive and agitated, responding to internal stimuli, with thought blocking and latency. On the same day, she started taking risperidone, and within 10 days she reported cessation of any visual or auditory hallucinations, better thought organisation, and better ability to minimise delusions as well as improved focus on her daily activities. Her insight is now good, but her judgement is fair.

As you are aware, Ms Tailor has a history of polysubstance abuse, mainly alcohol and cocaine, and the last cocaine use on 28/02/2018 could be the trigger to her symptoms; besides, she is not compliant with her medications. She is returning to her apartment where she lives alone.

Her final assessment showed good progress considering the chronic nature of her condition. She was discharged with risperidone 4mg PO nocte and extra risperidone 1mg BID PRN for psychosis and agitation. Ms Tailor needs to be encouraged to continue treatment at Proudhurst Practice and to avoid substance abuse; a follow up appointment has been arranged for her.

Example 10: referral for diagnosis and management

Who to whom? Why? GP => Cardiologist => unstable angina

Purpose:
Referring for further assessment and management > unstable angina (angina on mild exertion)

Presentation:
First:
Angina + SOB + orthopnoea + postural hypotension
BP drop + Crepitations + oedema + JVP

- Lasix increased

Second:
Symptoms of SOB improved > BP drop + Crepitations + oedema + JVP > improved
BUT angina on mild exertion
ECG changes => anterolateral ischaemia => unstable angina

Good to know:
PMHx

My opinion and What I expect:
Opinion > Unstable angina
Despite improvement in CCF symptoms, he is worse with ischaemia > **What should I do?**

I am writing Mr Zu, a 72-year-old gentleman with new anterolateral ischemic changes, for your urgent assessment and management.

Two weeks ago, Mr Zu attended our clinic with angina while gardening that improved with anginine, requiring more pillows at night, and mild postural dizziness. Upon examination he had some postural drop from 160/90 to 140/80mmHg. He had a raised JVP, bibasal crepitations and mild ankle edema.

We agreed on watchful monitoring, but he came back 4 days ago with worsening of the symptoms; we agreed to increase Lasix from 40mg to 80mg. In his ECG today, signs of anterolateral ischemia are notable, though his symptoms have improved; he had a 10-minute angina on mild exertion yesterday.

Mr Zu's PMHx includes HTN, IHD, CCF, and acute MI 7 years ago. His medications are Lasix 40mg (80mg) PO mane, Enalapril 10mg PO OD, Nifedipine 10mg PO TDS, Slow-K BD, and Anginine T S.L. PRN.

In view of the above, I would appreciate if you could see Mr Zu as an urgent case, for diagnosis of the cause and for management of his decompensated CCF and anterolateral ischemia. Should you require further information, please do not hesitate to contact.

Transfer Letters

Transfer letters are actually an amalgamate of referral and discharge at the same time; the focus is more on what needs to be done (more like discharge letters).

In transfer letters, past history and risk factors might be relevant. It is good practice to mention why the patient is being transferred (eg unsuitable home situation/inability to manage own chores).

Example 11: transfer to rehabilitation centre

Jacob McCarthy
82 Male > under knee amputation >
Hospital Doctor > Admission officer of **nursing facility**

Why?
ongoing care and physiotherapy
Patient with amputation + cannot go home > needs physio and rehab + home situation not safe

What was done in hospital? How is he now?

Risk factors and good to know info >
diabetes, dementia,

What needs?
What has been arranged > follow up
What needs to be arranged > occupational therapy home assessment

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26 April 2018

Dear Dr Meccam

Re: Mr. Jacob McCarthy

I am writing to discharge Mr McCarthy, who has undergone a right below-knee (RBK) amputation following a complicated diabetic ulcer, for rehabilitation and physiotherapy.

Mr McCarthy was admitted with a gangrenous diabetic ulcer which he had not been aware of; this was due to diabetic neuropathy. As initial attempts to manage infection failed, he had to undergo a RBK amputation. He showed good recovery from the operation, and he is now stable on oral antibiotics.

Mr McCarthy has a history of DM type 2, which is insufficiently controlled due to non-compliance, hypertension, dementia, and peripheral vascular disease.

He also requires assistance with daily activities and mobilisation; it might be relevant that he lives with his 76-year-old wife who is his main carer. Based on the physiotherapy and occupational therapy assessments, it would not be safe for him to be discharged home (despite his wife's insistence).

The discharge plan includes daily dressing, mobilisation and encouraging his regular medications, as well as oral antibiotics and analgesics as required. A follow-up appointment has been arranged with the vascular surgery department in 2 weeks' time where Mr McCarthy's situation will be re-assessed. Thank you for your attention; should you have any further queries, please do not hesitate to contact our direct phone line.

Prepared by Dr Robert Babak Shokouhi

Note: The samples may not be the best example for the actual OET exam, but just a guide for improving the required skills.
