OET Reading practice test 1

42 questions, 60 minutes, with Part A strictly 15 minutes. Practise in the OET format, then check the answer key.

Part A

Text A: Clinical assessment of dehydration

Use this table together with the history. Weigh the child undressed on arrival; where a recent weight is available, percentage weight loss is the most reliable estimate of fluid deficit.

Children at increased risk of dehydration

- infants under 6 months, particularly those of low birth weight
- six or more diarrhoeal stools in the past 24 hours
- three or more vomits in the past 24 hours
- unable to tolerate fluids before presentation, or breastfeeding stopped during the illness
- signs of malnutrition

Sign	Mild (< 5%)	Moderate (5–9%)	Severe (≥ 10%)
Conscious state	Alert and responsive	Lethargic or irritable	Reduced conscious state
Heart rate	Normal	Normal or mildly raised	Tachycardia
Breathing	Normal	Increased rate	Increased rate; deep acidotic breathing
Blood pressure	Normal	Normal	Hypotension
Skin colour and peripheries	Normal; warm	Normal; warm	Pale or mottled; cold; weak pulses
Eyes and fontanelle	Not sunken	Sunken	Deeply sunken
Mucous membranes	Moist	Dry	Dry
Skin turgor	Instant recoil	Mildly decreased	Decreased
Central capillary refill	Normal	Prolonged	Markedly prolonged

Signs in the severe column, particularly markedly prolonged capillary refill, cold mottled peripheries and reduced consciousness, indicate possible hypovolaemic shock. Severe dehydration requires IV fluids (see Text B).

Suspect hypernatraemic dehydration if the child has jittery movements, increased muscle tone, hyperreflexia, seizures or a doughy feel to the skin, and check serum sodium. Bilious (green) vomiting is not consistent with gastroenteritis and needs urgent surgical review.

Text B: Westbrook Children's Hospital – Rehydration protocol

Mild dehydration

Continue breastfeeding (more often than usual) and usual fluids. Give oral rehydration solution (ORS) in small, frequent amounts, aiming for 10 mL/kg/hour, and offer extra after each loose stool or vomit.

Moderate dehydration

- Oral trial: give ORS by syringe or spoon every few minutes, aiming for 10 mL/kg/hour, and reassess after 1 hour.
- If the oral trial fails (refusal or persistent vomiting), insert a nasogastric tube and give ORS at 10–25 mL/kg/hour for 4 hours (rapid NG rehydration). Many infusion pumps cannot exceed 300 mL/hour.
- Use slow NG rehydration for infants under 6 months and children with significant comorbidities or abdominal pain: replace a 5% fluid deficit over the first 6 hours, then clinically reassess. If further hydration support is required, give the daily maintenance volume over the next 18 hours. Any remaining

deficit is reassessed and, if still indicated, replaced in the subsequent 24 hours in addition to maintenance.

• Suspected hypernatraemia is not managed on either NG pathway: check serum sodium and arrange senior paediatric review. Correction must be slower (typically over 48 hours), follow an individualised plan and include serial electrolyte monitoring.

• If vomiting occurs during NG rehydration, slow the fluids temporarily and reassess tolerance. Seek senior clinician review for ongoing vomiting or significant abdominal pain.

Severe dehydration and escalation to IV fluids

• Shock: give a 20 mL/kg bolus of 0.9% sodium chloride IV (or intraosseous) and contact the senior registrar. Repeat the bolus if signs of shock persist.

• Start IV rehydration for all children with severe dehydration, and for those who cannot tolerate NG fluids or whose dehydration worsens despite them.

• For IV rehydration use 0.9% sodium chloride with 5% glucose, and measure electrolytes and blood glucose when the cannula is inserted.

Text C: Medication notes

Ondansetron

A single oral dose (wafer) may be given to children aged 6 months and over who are vomiting and at risk of failing oral rehydration. It is not recommended under 6 months. Give ORS 15–30 minutes after the dose.

Weight	Single oral dose
8 to < 15 kg	2 mg
15 to 30 kg	4 mg
> 30 kg	8 mg

Further doses should be discussed with a senior clinician, as ondansetron can increase stool frequency. Use with caution in children with a known prolonged QT interval or those taking other QT-prolonging medicines.

Antidiarrhoeal agents

Loperamide and other antimotility drugs must not be used in children with acute gastroenteritis. They have little effect on fluid losses and have been associated with paralytic ileus, drowsiness and respiratory depression in young children.

Zinc

Zinc supplementation is recommended by the WHO for children with diarrhoea in low- and middle-income settings, where zinc deficiency is common. It is not routinely used in Australia.

Text D: Parent information – Gastro in children: going home

Drinks and food

• Give small amounts of fluid often – for example, a mouthful every few minutes – even if your child is still vomiting.

• Keep breastfeeding. If your baby is bottle-fed, make up formula at its usual strength. Do not water it down.

• Oral rehydration solution from the pharmacy is the best drink. Avoid undiluted fruit juice, soft drinks and sports drinks: they contain too much sugar and can make diarrhoea worse.

Stopping the spread

• Wash hands with soap and water for at least 20 seconds after nappy changes and using the toilet, and before preparing food. Alcohol-based hand gels do not kill all gastro viruses.

• Keep your child home from childcare, kindergarten or school until 48 hours after the last episode of vomiting or diarrhoea.

• No swimming pools for 2 weeks after the diarrhoea has stopped.

Come back to hospital straight away if your child:

- is drowsy, floppy or hard to wake
- has fewer than 4 wet nappies in 24 hours, or passes very little urine
- vomits green fluid or has blood in their poo
- has severe tummy pain or cannot keep any fluids down

See your GP if your child has diarrhoea for more than 7 days or vomiting for more than 2 days.

Questions 1-7

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

1. Which text names drugs that should never be given to a child with gastroenteritis? _____

2. Which text lists the factors that make a child more likely to become dehydrated? _____

3. Which text states how long a child should stay away from childcare? _____

4. Which text tells you what to do if a child vomits while receiving fluids through a nasogastric tube? _____

5. Which text describes signs that may indicate an abnormal sodium level? _____

6. Which text explains why certain drinks should not be given? _____

7. Which text refers to a treatment recommended only in certain parts of the world? _____

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. How should a child be dressed when weighed on arrival? _____

9. How is skin turgor described in a child with moderate dehydration? _____

10. What type of vomiting suggests the child's illness is not gastroenteritis? _____

11. What hourly volume of ORS should a child with mild dehydration be aiming to take? _____

12. For how long is rapid NG rehydration given? _____

13. Which fluid is given as a bolus to a child in shock? _____

14. What dose of ondansetron should be given to a child weighing 22 kg? _____

Questions 15-20

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

15. Ondansetron is not recommended for infants younger than ___ .

16. After a dose of ondansetron, ORS should be given ___ later.

17. Ondansetron should be used with caution if a child has a known ___ .

18. Parents of bottle-fed babies should be told not to water down the ___ .

19. Parents should be warned that ___ do not kill all gastro viruses.

20. Parents should take their child to a GP if vomiting continues for more than ___ .

Part B

Extract 1: Email: morning handover

To: All nursing staff, Ward 4B
From: Rachel Fenwick, Nurse Unit Manager
Subject: Morning handover

Hi everyone,
From Monday 10 November, morning handover will start at 07:00 rather than 07:15. This follows our review of the 08:00 medication round, which found that time-critical medicines such as insulin and Parkinson's medications were regularly given late because handover was running past 07:45. Night staff will still finish at 07:30, and the roster office has confirmed that no shifts will need to be extended. Handover will remain at the bedside using the current ISBAR sheet. We'll run the new time for eight weeks, and I'd welcome your comments at the January ward meeting before we decide whether to keep it.
Thanks,
Rachel

21. The email has been written to

A notify staff that the start of handover is being changed.
B explain why some medicines are being given late on the ward.
C ask staff for their views on a proposed change to handover.

Extract 2: Policy 6.3: Blood and blood products – patient identification

Policy 6.3 Blood and blood products – Patient identification
Positive patient identification must be completed at the bedside immediately before each unit is commenced. Ask the patient to state their full name and date of birth; do not ask closed questions such as 'Are you Mr Lee?'. Check these details, together with the medical record number, against the patient's identification band, the compatibility label on the unit and the prescription. Where the electronic bedside scanning system is in use, a single registered nurse or midwife may complete the check; otherwise, two staff members must complete it independently. If the patient is unable to state their details, for example because they are unconscious, rely on the identification band. Checks completed at the nurses' station are not valid.

22. According to the policy, the identity check before a transfusion must

A always be carried out by two members of staff.
B include the patient confirming a name that is read out to them.
C be done beside the patient just before each unit starts.

Extract 3: Memo: recall of VP-300 infusion pumps

MEMO – Biomedical Engineering
Re: Recall of Vireo VP-300 volumetric infusion pumps
The manufacturer has recalled the VP-300 after reports that the downstream occlusion alarm may fail to sound at flow rates below 5 mL/hour. No other model is affected. With immediate effect, do not start any new infusion on a VP-300. Infusions already running at 5 mL/hour or more may continue until the current bag is finished, provided the volume infused is checked against the pump display every hour. Any infusion running below 5 mL/hour must be transferred to an alternative pump now. Once a VP-300 is no longer in use, attach a red 'Do not use' tag and leave it in the ward equipment room for collection. Replacement pumps are being delivered to wards today.

23. What does the memo say about VP-300 pumps that are already running an infusion at 5 mL/hour or more?

A They should be switched to a replacement pump as soon as one arrives on the ward.
B They may finish the current bag if the volume infused is checked against the display hourly.

C They may finish the current bag if the line is checked hourly for kinks and other occlusions.

Extract 4: Guideline 4.7: verbal and telephone medication orders

4.7 Verbal and telephone medication orders

Verbal orders should be accepted only in an emergency, or when the prescriber cannot attend in person and a delay would compromise care. They are not to be used for convenience. The nurse receiving the order must write it down and read it back to the prescriber, including the patient's name, medicine, dose, route and frequency, before it is entered on the medication chart. Where possible, a second nurse should also listen to the order, particularly for high-risk medicines such as anticoagulants and insulin. The order must be recorded as a 'verbal order', with the prescriber's name and the time it was received, and countersigned by the prescriber within 24 hours.

24. According to the guideline, a nurse who receives a verbal order must

A obtain the prescriber's countersignature on the order before the first dose is given.

B repeat the patient's name and the order details to the prescriber before charting it.

C arrange for a second nurse to hear any order for insulin or an anticoagulant.

Extract 5: Notice: hand hygiene audit results

Hand Hygiene Audit – Quarter 3 Results

Thank you to everyone on the Surgical Unit for your efforts this quarter. Overall compliance reached 86%, above the national benchmark of 80% for the third quarter in a row. However, the results are not even across the five moments. Compliance after touching a patient was 93%, but before touching a patient it fell to 72%, and before an aseptic procedure to 75%. Missed opportunities before patient contact were most common when staff helped patients to reposition or mobilise, or took a quick set of observations between other tasks. Please remember that hand hygiene is needed before every contact with a patient, not only before aseptic procedures. The next audit will be carried out by observers from another unit.

25. The main purpose of the notice is to

A congratulate staff on staying above the national benchmark for a third quarter.

B explain that the next audit will focus on the moments before patient contact.

C draw attention to hand hygiene being missed before contact with patients.

Extract 6: Bladder scanner user manual: cleaning the transducer

Section 9: Cleaning the transducer

Clean the transducer after every patient. First remove all ultrasound gel with a soft, dry tissue; disinfectants are less effective if gel remains on the surface. Then wipe the transducer and the first 30 cm of cable with a detergent wipe, followed by a disinfectant wipe from the approved list in Appendix C. Allow the surface to remain wet for the contact time stated on the wipe packaging. Do not immerse the transducer or allow fluid to enter the cable connection, as this may damage the internal components and will void the warranty. Alcohol-based wipes must not be used, because repeated use causes the acoustic lens to crack. Inspect the lens for damage before each use.

26. The extract states that the transducer

A should be inspected for damage to the lens after it has been cleaned.

B may be disinfected with any wipe as long as the contact time is followed.

C must have all the gel removed before a disinfectant wipe is applied.

Part C

Text 1: Social prescribing – remedy or distraction?

When Margaret Ellison's GP suggested she join a community gardening group, the 74-year-old widow assumed she was being politely dismissed. She had come in, for the fourth time in two months, with vague chest discomfort that repeated tests had failed to explain. 'I thought, she's had enough of me,' Ellison recalls. Eighteen months later, she runs the group's seed-swap stall and has not booked an unscheduled appointment since. Her experience is the kind of story that advocates of social prescribing like to tell, and the kind that sceptics say tells us very little.

Social prescribing, in its simplest form, means referring patients to non-medical sources of support: walking groups, debt advice, art classes, volunteering. The key figure in most models is the link worker, a non-clinical staff member who meets the patient, often several times, to find out what matters to them and to connect them with local services. The idea itself is not new. GPs have long scribbled the number of a bereavement group on the back of a prescription. What has changed over the past decade is that it has been formalised, most visibly in England, where link workers have been funded within primary care networks since 2019. Australia has been slower, relying largely on short-term pilots.

For Dr Priya Raman, a GP in suburban Melbourne who helped design one of those pilots, the case is straightforward. 'Around a fifth of the consultations I see are driven mainly by social problems – isolation, housing, money,' she says. 'I can't fix those with a fifteen-minute appointment and a script. Somebody needs the time to sit with the patient, and that somebody doesn't need a medical degree.' In her practice's two-year pilot, patients who saw a link worker made, on average, 27 per cent fewer GP visits in the following year than in the year before.

Figures like these are precisely what worry Professor Alan Whitcombe, a health services researcher who has reviewed much of the published literature. 'Almost all of the evaluations are before-and-after studies without a comparison group,' he says. 'People tend to see their GP when they are at their worst, and over time many of them would improve anyway. That alone can produce an impressive-looking fall in attendance.' This phenomenon, known as regression to the mean, is a familiar trap in health research, and Whitcombe argues that enthusiasts have largely ignored it. The handful of controlled trials that do exist, he notes, have found modest effects on wellbeing and little consistent change in the use of health services.

Whitcombe is careful not to dismiss the idea altogether. 'I'm not saying it doesn't work. I'm saying we don't yet know who it works for, and that matters when money is tight.' Raman accepts the criticism up to a point, but believes it holds social prescribing to an unfair standard. 'Nobody demands a randomised trial before we refer someone to a physiotherapist,' she says. 'And some of the outcomes that matter most, like whether a person feels part of their community again, are hard to capture in the measures researchers favour.'

Among GPs themselves, opinion is divided less on the principle than on the practicalities. Dr Tom Hadley, who practises in a regional town in New South Wales, supports the concept but questions whether it can work where he lives. 'You can only prescribe what exists,' he says. 'In a city there might be twenty groups to choose from. Here, a link worker would spend most of her time discovering there's nothing to link people to.' Others worry that referral could become a way of moving patients on without addressing underlying medical problems, a risk Raman acknowledges. 'A link worker is an addition to good clinical care,' she says, 'never a substitute for it.'

Funding remains the sticking point. Most Australian schemes depend on grants of two or three years, and several have closed just as they were becoming established. Link workers on short contracts leave, and the relationships with community groups that took years to build disappear with them. Meanwhile, the voluntary organisations that receive the referrals are rarely paid for the extra demand. 'There's an assumption that the community sector will simply absorb it,' says Linda Moretti, who coordinates a network of neighbourhood houses in Adelaide. 'We had a walking

group that went from eight people to forty in a year. That's wonderful, but someone had to train the extra volunteers, and it wasn't the health system.'

What seems clear is that the future of social prescribing will not be settled by stories like Margaret Ellison's, however compelling. Whitcombe would like to see a large trial with a proper control group and longer follow-up; Raman would settle for funding that outlasts a single electoral cycle. Both, perhaps, are asking for the same thing: the chance to find out properly. Ellison, for her part, is untroubled by the debate. 'All I know,' she says, 'is that I stopped thinking about my chest once I had something else to think about.'

27. The writer refers to Margaret Ellison's experience in the first paragraph in order to

A illustrate how a link worker can find out what really matters to a patient.
B show how social prescribing can reduce visits by patients who attend frequently.
C suggest that unexplained physical symptoms often reflect social isolation.
D introduce a kind of evidence whose value is itself disputed in the debate.

28. What does the writer say about social prescribing in the second paragraph?

A It has been introduced in England and Australia at a broadly similar pace.
B It has shifted from an informal GP habit to a formal service, especially in England.
C It differs from earlier practice mainly in the kinds of activity patients are offered.
D It relies on link workers who hold a clinical qualification to assess patients.

29. What point does Dr Raman make about link workers?

A They need enough clinical knowledge to recognise underlying medical problems.
B They cut GP visits by about a fifth among the patients they work with.
C They can spend time with patients that a brief consultation does not allow.
D They allow GPs to fit more patients into their usual appointment times.

30. In the fourth paragraph, 'This phenomenon' refers to

A the failure of evaluators to include a comparison group in their studies.
B the reduced attendance that follows once patients' social needs are met.
C the improvement many patients would show over time without any referral.
D the selection of patients for referral at the point their needs are greatest.

31. How does Dr Raman respond to Professor Whitcombe's criticism?

A She argues that other referrals are not judged by the same standard.
B She rejects it as based on a misunderstanding of the research.
C She agrees that randomised trials should come before further funding.
D She claims that a sense of belonging can easily be measured.

32. What is Dr Hadley's main concern about social prescribing?

A Short-term contracts make it hard to keep link workers in regional areas.
B Referral may lead GPs to overlook medical causes of patients' symptoms.
C Community groups in his area would struggle to cope with extra referrals.
D Its benefits depend on activities that his town may be unable to offer.

33. Linda Moretti's example of the walking group illustrates

A the way community relationships are lost when short-term grants end.
B the difficulty voluntary groups face in recruiting enough volunteers.
C the workload that referrals create for groups that receive no extra funding.
D the need for GPs to be more selective about which patients they refer.

34. What does the writer suggest in the final paragraph?

A Ellison's indifference shows that the debate has little relevance for patients.
B A large controlled trial should come before any longer-term funding is given.
C Whitcombe and Raman each want the means to evaluate the approach properly.

D Raman's request for funding is more realistic than Whitcombe's call for a trial.

Text 2: Thinking about thinking in the emergency department

The man in cubicle 6 had been labelled before he arrived. The ambulance handover described a 52-year-old 'known to the department', smelling of alcohol, who had fallen at a bus stop. Over the next four hours he was reviewed twice, given intravenous fluids and left to sleep it off. It was only when a nurse starting the night shift noticed that one of his pupils was larger than the other that a CT scan was ordered. It showed an acute subdural haematoma. He survived after emergency surgery, but the case, described here with identifying details changed, has become a teaching example in the hospital where it happened.

Diagnostic error, broadly defined as a missed, wrong or delayed diagnosis, is now recognised as one of the largest and least visible sources of harm in healthcare. Estimates vary widely depending on how errors are counted, but studies of emergency departments commonly suggest that a small percentage of patients leave with a diagnosis that later proves to be wrong, and that a fraction of those are seriously harmed. Spread across millions of attendances a year, even low rates translate into substantial numbers of people. Unlike a medication error, however, a missed diagnosis rarely produces an incident report; often nobody, including the clinician, ever learns that it happened.

Much of the recent attention has focused on the way clinicians think. Dr Helen Adeyemi, an emergency physician who teaches clinical reasoning, points out that experienced doctors rely heavily on rapid pattern recognition. 'Most of the time that's exactly what you want. It's how an expert spots sepsis from across the room,' she says. 'The trouble is that the same shortcut that makes us fast also makes us vulnerable.' The man in cubicle 6, she argues, is a textbook example of anchoring: once the first impression of intoxication had formed, each later finding was interpreted to fit it rather than to test it. Closely related is premature closure, accepting a diagnosis before it has been fully verified, which in her view is 'the most expensive habit in emergency medicine'.

One proposed remedy is the diagnostic checklist. Some departments now prompt clinicians, before discharge or when a plan changes, to ask a short set of questions: What else could this be? Does anything not fit? What is the worst thing it could be, and have I excluded it? Adeyemi's own department introduced such a prompt two years ago for patients presenting with falls, headache or reduced consciousness. 'It takes thirty seconds,' she says, 'and it gives people permission to doubt.' An internal review found that requests for senior review rose after the change, although she concedes that the department has not been able to show a fall in missed diagnoses.

Not everyone is convinced that correcting clinicians' thinking is the answer. Professor Mark Bergstrom, who researches patient safety, regards much of the literature on bias as 'intellectually attractive but practically thin'. Experimental studies, he notes, have struggled to show that teaching clinicians about biases makes them less susceptible to them. 'Knowing the name of a bias doesn't stop you having it, any more than knowing about optical illusions stops you seeing them,' he says. In his view, many errors blamed on faulty thinking are better explained by gaps in knowledge, missing information or simple overload: a doctor responsible for too many patients at once may close a case early not because of a bias, but because she has no choice.

Bergstrom would rather see effort directed at the system around the clinician, such as staffing levels, access to previous records and reliable follow-up of test results, than at the clinician's mind. Adeyemi does not see the two approaches as competing. 'Of course workload matters. An exhausted doctor is a biased doctor,' she says. 'But you will never staff an emergency department so well that nobody ever takes a shortcut.'

Where the two agree is on feedback. Emergency clinicians are unusual in that they rarely find out what happened to their patients after they leave the department. A patient discharged with musculoskeletal chest pain who is admitted to another hospital with a heart attack two days later may never come to the original doctor's attention. Without that information, says Bergstrom,

'confidence and accuracy drift apart, and nobody notices'. A few hospitals have begun sending clinicians automatic summaries of unplanned re-attendances and changes in diagnosis, presented as learning rather than blame. Early reports suggest that staff value them, though some find the first few messages uncomfortable reading.

That discomfort may be the real obstacle. In a profession that prizes decisiveness, admitting uncertainty can feel like weakness, and junior staff may hesitate to question a senior colleague's working diagnosis. In the case of the man in cubicle 6, it was a nurse who saw that something did not fit and, crucially, felt able to say so. 'The checklist didn't save him,' Adeyemi says. 'A culture in which someone was willing to speak up did. Our job is to make that the normal thing to do, not the brave thing.'

35. According to the first paragraph, what was the consequence of the early impression that the man was intoxicated?

A He was reviewed by a doctor only once before the night shift began.
B Imaging of his head was delayed until a change in his pupils was noticed.
C His intravenous fluids were withheld until the cause of his fall was known.
D His surgery was postponed while staff waited for him to become sober.

36. According to the second paragraph, how does diagnostic error differ from medication error?

A It is usually picked up later by the clinician who made it.
B It is seldom documented through the incident reporting system.
C It harms a greater proportion of the patients it affects.
D It occurs at lower rates but affects more patients overall.

37. What is Dr Adeyemi's view of rapid pattern recognition?

A It serves experts well, but should give way to a checklist in patients who have fallen.
B It works best for conditions such as sepsis and less well for injuries hidden by alcohol.
C It is usually what is needed, yet the feature that makes it quick is also a risk.
D It is valuable in experts, but becomes unsafe mainly when clinicians are exhausted.

38. What does the department's experience show about the checklist?

A It was followed by more requests for senior review, but its effect on missed diagnoses is unclear.
B It led to more requests for senior review and an early, measurable fall in missed diagnoses.
C It reduced requests for senior review, as junior staff felt more able to make decisions alone.
D Its effect could not be judged, since no review was carried out after it was introduced.

39. Professor Bergstrom mentions optical illusions in order to

A illustrate how fatigue and overload can distort what clinicians perceive.
B explain why studies of bias in clinicians often produce unreliable results.
C suggest that many missed diagnoses arise from misreading physical signs.
D show that learning to recognise a bias does not protect clinicians from it.

40. How does Dr Adeyemi respond to Professor Bergstrom's focus on the system?

A She accepts that workload matters, but sees bias as a separate problem from fatigue.
B She accepts that workload matters, and thinks better staffing would make reasoning tools unnecessary.
C She accepts that workload matters, but thinks better staffing alone could never remove shortcuts.
D She accepts that workload matters, but believes reasoning should be tackled before staffing.

41. What does Bergstrom mean when he says 'confidence and accuracy drift apart'?

A Clinicians become less accurate under heavy workload without feeling any less certain.
B Clinicians' self-assurance goes unchecked because they rarely learn how patients fared.
C Clinicians' certainty falls as they discover how often their diagnoses are later changed.
D Clinicians lose confidence in discharge decisions when test results are not followed up.

42. In the final paragraph, Dr Adeyemi makes the point that

A the nurse's action shows that the checklist works best when used by nursing staff.
B the case was resolved by one person's courage rather than by the department's culture.
C decisive leadership by senior doctors is what makes it safe for juniors to speak up.
D speaking up about a concern should be routine rather than something that takes courage.

Answer key

Check after you finish. For the evidence and an explanation of each answer, submit the same test free online.

1. C
2. A
3. D
4. B
5. A
6. D
7. C
8. undressed
9. mildly decreased
10. bilious
11. 10 mL/kg/hour
12. 4 hours
13. 0.9% sodium chloride
14. 4 mg
15. 6 months
16. 15–30 minutes
17. prolonged QT interval
18. formula
19. alcohol-based hand gels
20. 2 days
21. A
22. C
23. B
24. B
25. C
26. C
27. D
28. B
29. C
30. C
31. A
32. D
33. C
34. C
35. B
36. B
37. C
38. A
39. D
40. C
41. B
42. D