OET WRITING CORRECTION REPORT

Report #190 • **Sub-Test: MEDICINE**

STUDENT INFORMATION

Student	Not provided
Task	Urgent referral letter — suspected acute coronary syndrome (Medicine)
Patient	Mr Daniel Okoye, 58 years, long-haul truck driver
Recipient	Dr Helen Marsh, Consultant Cardiologist, Westmead Cardiology Unit, Darcy Road, Westmead NSW 2145
Word count	Approximately 190 words (target: 180–200) — on target for length, but under-informative for the content it carries
Source notes	Verified

SCORE COMPARISON

CURRENT SCORE	PROJECTED SCORE
211 /500	**355** /500
Grade C	**Grade B**

INDIVIDUAL CRITERIA SCORES

Purpose	Content	Conciseness & Clarity
2/3	**2**/7	**4**/7
Band 2	*Band 2*	*Band 4*
Genre & Style	**Organisation & Layout**	**Language**
3/7	**3**/7	**2**/7
Band 3	*Band 3*	*Band 2*

Scoring scale: Purpose is marked out of 3; all other criteria out of 7. Total = (sum of raw scores ÷ 38) × 500. Raw total here = 16 → 211/500 (Grade C).

ASSESSMENT SUMMARY

There is a workable referral underneath this letter, and several things in it are done correctly. You opened in the first line with the reason for writing — "I am writing to refer Mr Okoye … for further assessment and management" — so Dr Marsh knows within seconds what is being asked of her, and you closed with a courteous offer of further contact. The decision to separate the six-week exertional history from "Today he presented …" is genuinely sound clinical writing: it lets the cardiologist watch the picture escalate rather than presenting a single undifferentiated blur of symptoms, which is exactly how a crescendo pattern should be communicated. Several figures are reproduced faithfully from the notes — blood pressure 164/96, pulse 94, HbA1c 8.1% — and you correctly reported that the point-of-care troponin was "mildly elevated" rather than inflating it, which matters, because a mildly raised troponin with rest pain is precisely what defines this as a non-ST-elevation presentation. You named the working assessment the notes give, crescendo angina, and you included both interventions delivered today: aspirin 300 mg and a glyceryl trinitrate spray. You also flagged the family history of myocardial infarction. The salutation and the named recipient are correctly paired, the Re: line carries the patient's identity and age, and the body sits inside the 180–200 word target, so you are not being penalised for length. These are real foundations.

What holds the score down is accuracy, and in a cardiology referral inaccuracy is not cosmetic. The most serious fault is the ECG: you wrote "elevated ST segment in leads V1 to V4" where the notes record T-wave inversion in leads V4–V6. That single sentence changes both the diagnosis and the territory — it converts a non-ST-elevation syndrome into an anterior ST-elevation infarct and moves the abnormality from the lateral to the anteroseptal leads. A cardiologist reading it would activate a primary PCI pathway on false grounds, and if the true tracing were then seen, the referral's credibility collapses. Compounding this, your opening announces "acute myocardial infarction" while your sixth paragraph says "crescendo angina"; the reader cannot tell which you mean, so the purpose is stated but not stably held. The social history is also wrong in a way that misdirects risk assessment: "20 packs of alcohol daily" for 20 standard drinks per week is a gross overstatement, and 25 cigarettes daily became 20. You also transplanted the left-arm radiation back into the six-week history, when the notes are explicit that there was no radiation on 4 March — losing exactly the escalation you had otherwise captured. Four items of safety-critical content are absent altogether: the nil-known allergy status, the three current medications, the aspirin 100 mg started on 4 March, and — most importantly — that Mr Okoye is a long-haul truck driver who continues to drive interstate and has been advised to stop pending your review. Finally, "Her last HBA1C", "vitalwere", "hab", "Aspiri", "donot", "Your sincerely" and the truncated "Docto" force the reader to work, and "acute coronary artery is chemical changes" is unreadable.

CRITICAL ERRORS / AREAS FOR IMPROVEMENT

#	ERROR	IMPACT
1	ECG findings reversed and wrong lead territory — ~~his ECG revealed acute coronary artery is chemical changes with elevated ST segment in leads V1 to V4~~ → **his ECG revealed ischaemic changes with T-wave inversion in leads V4–V6**	This is the single most dangerous line in the letter. ST elevation in V1–V4 describes an anteroseptal STEMI requiring immediate reperfusion; T-wave inversion in V4–V6 describes lateral ischaemia consistent with the non-ST-elevation syndrome the notes actually record. You have changed both the diagnosis and the territory, and the receiving unit would triage Mr Okoye down an entirely wrong pathway.
2	Diagnosis stated wrongly, then contradicted — ~~sign and symptoms of chest pain with acute myocardial infarction … Therefore, Okoye has been diagnosed as crescendo angina.~~ → **suspected non-ST-elevation acute coronary syndrome on a background of crescendo angina**	The notes give one assessment: crescendo angina, suspected NSTE-ACS. Announcing a completed myocardial infarction in the opening and then a different diagnosis six paragraphs later leaves Dr Marsh unable to determine what you believe is happening, which undermines the urgency you are trying to convey and weakens the Purpose

#	ERROR	IMPACT
		criterion at both ends of the letter.
3	Alcohol and smoking quantities grossly misreported — ~~He smokes 20 cigarettes per day and consumes 20 packs of alcohol daily.~~ → **He has smoked 25 cigarettes daily for 30 years and drinks 20 standard drinks per week.**	"Twenty packs of alcohol daily" describes a life-threatening dependence that this patient does not have, and would divert attention towards withdrawal risk and hepatic assessment during an acute coronary admission. Understating the cigarettes and omitting the 30-year duration also understates the pack-year burden on which cardiovascular risk stratification depends.
4	Occupation and driving cessation omitted — **Mr Okoye is a long-haul truck driver who continues to drive interstate; he has been advised to cease driving pending your review, and is anxious about his licence.**	This is a public-safety matter as much as a clinical one. A commercial driver with rest angina and a raised troponin must not be at the wheel, and the cardiologist needs to know the advice has already been given so that it can be reinforced and the fitness-to-drive assessment planned. Its absence also removes the patient's stated concern from the referral.
5	Allergy status and current medications omitted — **He has no known allergies. Current medications are perindopril 5 mg daily, atorvastatin 20 mg nocte and metformin 1 g twice daily; aspirin 100 mg daily was commenced on 4 March.**	Before angiography with iodinated contrast and before any antiplatelet or anticoagulant loading, an explicit nil-known-allergy statement is what the receiving unit needs on paper. The metformin is separately important, as it is customarily withheld around contrast administration, and the existing statin and ACE inhibitor doses determine what optimisation is still available.

KEY AREAS FOR IMPROVEMENT

AREA	PRIORITY	RECOMMENDATION
Accuracy of investigation reporting	**HIGH**	Copy ECG findings word for word from the notes before you write anything around them: the abnormality (T-wave inversion), and the leads (V4–V6). Never paraphrase an ECG. Read your sentence back and ask whether it still describes the same tracing; if the word 'elevation' appears where the notes said 'inversion', you have changed the diagnosis.
Diagnostic consistency across the letter	**HIGH**	Decide the working diagnosis once, take it directly from the ASSESSMENT line of the notes, and use the same wording in the opening and the closing. Here that phrase is 'suspected non-ST-elevation acute coronary syndrome'. If you also mention crescendo angina, present it as the pattern leading to that suspicion, not as a competing conclusion.
Numerical fidelity in social history	**HIGH**	Alcohol units are almost always given per week and cigarettes per day; transposing the two changes the clinical picture entirely. Before submitting, run a figures-only pass: circle every number you have written

AREA	PRIORITY	RECOMMENDATION
		and match it against the notes, checking the unit and the time period attached to each.
Safety-critical omissions	MEDIUM	Build a fixed checklist for every referral: allergies, current medications with dose and frequency, occupation where it bears on risk, and any advice already given to the patient. Here all four were available and all four were left out, yet you were still inside the word count — the space existed.
Proofreading and language control	MEDIUM	'Her last HBA1C', 'vitalwere', 'hab', 'Aspiri', 'donot' and the unfinished 'Docto' are all catchable in one slow read-aloud. Reserve two minutes at the end for a pronoun pass and a drug-name pass alone: every pronoun must be masculine here, and every drug must be spelt in full.
Chronological separation of the two consultations	MAINTAIN	Your decision to give the 4 March exertional history its own paragraph and then open a new one with 'Today he presented …' is exactly right for a crescendo presentation. Protect this habit. Simply keep each consultation's findings inside its own paragraph so that features new today — rest pain, jaw radiation, sweating — are visibly new.

CORRECTED LETTER WITH ANNOTATIONS

Dr ~~Helem~~**Helen** Marsh *[CRITICAL — the recipient's name is given in the task instruction. Misspelling a consultant's name on an urgent referral is the first thing they see and it costs you credibility immediately.]*

Consultant Cardiologist✓ *[Title and unit correctly reproduced — good attention to the address block.]*

Westmead Cardiology Unit

Darcy ~~road Westmead NSW 2145~~**Road,**

Westmead NSW 2145 *[Street type takes a capital, and the suburb, state and postcode belong on their own line.]*

~~18th March, 2025~~**18 March 2025**

Dear Dr Marsh,✓ *[Correct named salutation for a named recipient — this correctly pairs with 'Yours sincerely' at the close.]*

~~RE:~~**Re:** Mr ~~Danial~~**Daniel** Okoye~~ Age: 58 Years~~**, aged 58** *[CRITICAL — the patient's given name is misspelt. Identity errors on a referral risk the wrong record being opened at the receiving unit.]*

I am writing to **urgently** refer Mr Okoye, ~~and 58 years old~~**a 58-year-old** man who presented with ~~sign~~**signs** and symptoms of chest pain with ~~acute myocardial infarction~~**suspected non-ST-elevation acute coronary syndrome** for further assessment and management. *[CRITICAL — the notes give crescendo angina with suspected NSTE-ACS, not a completed infarct. The word 'urgently' is also needed here: this is an urgent referral and the opening must say so.]*

Mr Okoye has on and off chest ~~pain~~**tightness** on exertion ~~which radiates to left arm~~ for the last six weeks. *[CRITICAL — the notes state there was no radiation on 4 March. Radiation to the left arm and jaw is new today, and moving it backwards erases the escalation that makes this referral urgent. The relief by rest within five minutes belongs here — see Critical Errors #2.]*

Today he presented with severe central chest pain and shortness of breath which ~~aggravates on climbing stairs~~**is aggravated by climbing one flight of stairs**.✓ *[Opening a new paragraph with 'Today' is a good decision — it lets the reader see the change of pattern at a glance. However, the three rest episodes lasting up to 20 minutes, the jaw radiation, the sweating and nausea, and last night's waking with chest heaviness all belong in this paragraph — see Critical Errors.]*

His ~~vitalwere normal but showed~~**observations showed a** blood pressure of 164/96 **mmHg**, pulse 94**/min and regular**, although his ECG revealed acute coronary ~~artery is chemical~~**ischaemic** changes with ~~elevated ST segment in leads V1 to V4~~**T-wave inversion in leads V4–V6**. *[CRITICAL — two separate faults. First, observations described as 'normal' cannot then include 164/96 mmHg; the contradiction makes the reader stop and re-read. Second, and far more serious, you have reported ST elevation in V1–V4 where the notes record T-wave inversion in V4–V6. This changes both the diagnosis and the territory and would send the patient down a primary PCI pathway on false evidence — see Critical Errors #1.]*

His ~~Troponin~~**point-of-care troponin** was also mildly elevated.✓ *[Well judged — you reported the troponin exactly as the notes give it, 'mildly elevated', without inflating it. That restraint is precisely what supports a non-ST-elevation picture.]*

Therefore, **Mr** Okoye has been diagnosed ~~as~~**with** crescendo angina. *[This contradicts the 'acute myocardial infarction' you announced in the opening. Use one diagnostic statement throughout. Retain the patient's title on every mention.]*

He has **a** significant history of hypertension, ~~hypercholestrolemia~~**hypercholesterolaemia** and diabetes ~~mellitis~~**mellitus**. *[CRITICAL — the nil-known allergy status and the three current medications (perindopril 5 mg daily, atorvastatin 20 mg nocte, metformin 1 g twice daily) belong here, together with the aspirin 100 mg started on 4 March — see Critical Errors #5. No text has been inserted for you.]*

~~Her~~**His** last ~~HBA1C~~**HbA1c** was 8.1%. *[CRITICAL — the pronoun reverses the patient's sex. Run a separate pronoun pass before submitting. The value itself is accurate; the total cholesterol of 6.4 mmol/L should sit alongside it.]*

He smokes ~~20~~**25** cigarettes per day and consumes 20 ~~packs of alcohol daily~~**standard drinks of alcohol per week**. *[CRITICAL — '20 packs daily' describes severe dependence this patient does not have. The 30-year smoking duration and his two refusals of nicotine replacement also belong here — see Critical Errors #3.]*

There is **a** family history of myocardial infarction too. *[Right instinct, but unspecific. The notes give a father who died of myocardial infarction at 54 and a brother stented at 50 — premature disease in two first-degree relatives is a strong risk marker and should be stated.]*

He ~~hab~~**has** been commenced on ~~tab Aspiri 300mg~~**aspirin 300 mg** and ~~glycering~~**glyceryl** trinitrate spray.✓ *[Both interventions given today are correctly included — good. But 'tab' is note-form shorthand, drug names must be spelt in full, and a space is required between figure and unit.]*

In view of **the** above condition your expertise in further **urgent** assessment, management -and ongoing rehabilitation would be highly appreciated. *[The closing should expand the purpose into a specific request. The consideration of coronary angiography, the advice to cease driving pending your review, and the referrals for cardiac rehabilitation and smoking cessation are the plan items the reader must act on — see Critical Errors #4.]*

If you require further information please ~~donot~~**do not** hesitate to contact me.✓ *[A conventional and appropriate closing courtesy — keep this line.]*

~~Your~~**Yours** sincerely

~~Docto~~**General Practitioner** *[The sign-off is unfinished. Sign with the role only — 'General Practitioner', or 'Dr [Name], General Practitioner' is not used, as OET requires anonymity.]*

Key: ~~red strikethrough~~ = error to remove / ✓ = strength to keep | **green bold** = correction | *blue superscript* = examiner note | corrected line-by-line in the student's own order

DETAILED ERROR ANALYSIS

ORIGINAL	CORRECTED	ERROR TYPE	SEVERITY
elevated ST segment in leads V1 to V4	**T-wave inversion in leads V4–V6**	Investigation reported wrongly — abnormality reversed and lead territory changed	**Critical**
acute coronary artery is chemical changes	**ischaemic changes**	Meaning-bearing word swap / garbled technical phrase	**Critical**
chest pain with acute myocardial infarction	**suspected non-ST-elevation acute coronary syndrome**	Wrong diagnosis in opening, contradicted later	**Critical**
consumes 20 packs of alcohol daily	**drinks 20 standard drinks per week**	Quantity and time period both wrong	**Critical**
He smokes 20 cigarettes per day	**He has smoked 25 cigarettes daily for 30 years**	Understated quantity; duration omitted	**Critical**
chest pain on exertion which radiates to left arm for the last six weeks	**chest tightness on exertion for the last six weeks, relieved by rest within five minutes**	Symptom transplanted into the wrong time frame	**Critical**
Her last HBA1C was 8.1%	**His last HbA1c was 8.1%**	Pronoun reverses patient sex; abbreviation miscapitalised	**Critical**
[no mention of occupation or driving]	**long-haul truck driver, still driving interstate; advised to cease driving pending review**	Safety-critical omission	**Critical**
[no allergy line, no current medications]	**No known allergies; perindopril 5 mg daily, atorvastatin 20 mg nocte, metformin 1 g twice daily**	Omission of allergy status and regular medications	**Critical**
His vitalwere normal but showed blood pressure of 164/96	**His observations showed a blood pressure of 164/96 mmHg**	Internal contradiction; missing space; missing units	**Minor**
tab Aspiri 300mg and glycerin trinitrate spray	**aspirin 300 mg and glyceryl trinitrate spray**	Note-form abbreviation and two drug-name misspellings	**Minor**
Dr Helem Marsh / Mr Danial Okoye / Your sincerely / Docto	**Dr Helen Marsh / Mr Daniel Okoye / Yours sincerely / General Practitioner**	Identity and layout errors in address block and sign-off	**Minor**
His Troponin was also mildly elevated.	**Retained**	Accurate reporting of a borderline result without exaggeration	**Positive**
Today he presented with … [new paragraph]	**Retained**	Chronological separation of the two consultations	**Positive**
blood pressure of 164/96, pulse 94 … HBA1C was 8.1%	**Retained (units added)**	Accurate transcription of key numerical values	**Positive**
He hab been commenced on … Aspiri 300mg and glycerin trinitrate spray	**Retained (spelling corrected)**	Both interventions given today correctly included	**Positive**
Dear Dr Marsh … Your sincerely	**Retained (spelling corrected)**	Correct named-salutation and complimentary-close pairing	**Positive**

ORIGINAL	CORRECTED	ERROR TYPE	SEVERITY
If you require further information please donot hesitate to contact me.	**Retained (spelling corrected)**	Appropriate professional closing courtesy	**Positive**

MODEL LETTER — BAND A

Dr Helen Marsh

Consultant Cardiologist

Westmead Cardiology Unit

Darcy Road

Westmead NSW 2145

18 March 2025

Dear Dr Marsh,

Re: Mr Daniel Okoye, aged 58

I am referring Mr Okoye, a long-haul truck driver, for urgent assessment of suspected non-ST-elevation acute coronary syndrome; coronary angiography may be required.

On 4 March, Mr Okoye reported six weeks of central chest tightness on exertion, relieved within five minutes by rest, without radiation or dyspnoea. His ECG was unremarkable and aspirin 100 mg daily was commenced.

Today he describes three episodes at rest in the past week, lasting up to twenty minutes, radiating to the left arm and jaw with sweating and nausea. He is breathless climbing one flight of stairs and woke last night with chest heaviness. Blood pressure was 164/96 mmHg and pulse 94/min regular. ECG showed T-wave inversion in leads V4–V6 and point-of-care troponin was mildly elevated.

His background includes hypertension, hypercholesterolaemia (total cholesterol 6.4 mmol/L) and type 2 diabetes (HbA1c 8.1%). He smokes 25 cigarettes daily and his father died of myocardial infarction aged 54. Medications are perindopril 5 mg daily, atorvastatin 20 mg nocte and metformin 1 g twice daily; he has no known allergies.

Aspirin 300 mg was given today and glyceryl trinitrate spray prescribed. He has been advised to cease driving pending your review; I would be grateful for your urgent assessment.

Yours sincerely,

General Practitioner

SCORE IMPROVEMENT GUIDE

TIP 1: Protect your two-consultation structure

Your strongest decision was separating the six-week exertional history from 'Today he presented …'. That layout lets a cardiologist see a crescendo pattern in one glance, and it is exactly what the notes are structured to invite. Keep doing this in every referral where symptoms have escalated: one paragraph per consultation, with nothing from today leaking backwards into the earlier account.

TIP 2: Never paraphrase an ECG

Transcribe ECG findings literally: the abnormality and the leads, in the notes' own words. You wrote 'elevated ST segment in leads V1 to V4' where the notes give T-wave inversion in V4–V6 — a change of diagnosis and of territory in one clause. Before submitting, place your finger on the ECG line in the notes and read your sentence against it. If a single word differs, correct it.

TIP 3: State one diagnosis and hold it

Take the working diagnosis directly from the ASSESSMENT line and use identical wording in your opening and your closing. Here that is 'suspected non-ST-elevation acute coronary syndrome'. You opened with acute myocardial infarction and closed with crescendo angina; the reader cannot act confidently on two different answers. One phrase, used twice, is what earns Purpose band 3.

TIP 4: Run a figures-and-units pass

Circle every number before you submit and check both the value and the time period. Twenty standard drinks per week became '20 packs of alcohol daily', and 25 cigarettes became 20. Add units as you go — mmHg, /min, mg, mmol/L. Two minutes on this pass would have removed three of your five critical errors and lifted Content substantially.

TIP 5: Keep a fixed pre-submission checklist

Allergies, current medications with dose and frequency, occupation where it bears on risk, and any advice already given. You omitted all four, including that Mr Okoye is a truck driver still driving interstate who has been told to stop. That is the single most important sentence for both the cardiologist and public safety, and you had the word count available to include it.

TIP 6: The gains here are within reach

The clinical reasoning underneath this letter is sound: you identified the escalation, reported the troponin honestly and included both acute treatments. Correct the ECG line, settle on one diagnosis, fix the alcohol and smoking figures, add the allergy, medication and driving content, and give yourself a slow proofread — and this letter moves from 211 to roughly 355, Grade B.

EXAMINER COMMENT

EXAMINER COMMENT

There is real clinical instinct in this letter. You recognised that the story is one of escalation and you built the

structure to show it, giving the six-week exertional history its own paragraph before opening a new one with 'Today he presented …'. You reported the point-of-care troponin as 'mildly elevated' rather than inflating it, you named crescendo angina, and you included both interventions delivered in surgery. The blood pressure, pulse and HbA1c are accurately transcribed, the salutation is correctly paired with the recipient's title, and the body sits inside the target length. What holds the letter at Grade C is accuracy. Reporting ST elevation in leads V1–V4, where the notes record T-wave inversion in V4–V6, reverses both the diagnosis and the territory and would send Mr Okoye down a primary PCI pathway on false evidence — no other single fault in an OET letter costs more. Announcing acute myocardial infarction in the opening and crescendo angina six paragraphs later leaves the reader unsure what you believe. '20 packs of alcohol daily' overstates a weekly figure many times over, and the omission of the nil-known allergy status, the three regular medications and the fact that this man is a truck driver still driving interstate removes precisely what the receiving unit needs. Your next task: write out the ECG line and the social history line word for word from the notes before drafting anything around them. Fix accuracy and this becomes a strong letter. — Dr Nasir Academy Assessment Team

— Dr Nasir Academy Assessment Team