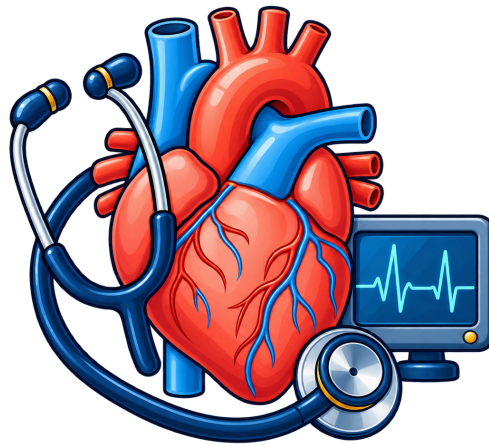


ENGLISH FOR WORK / ENGLISH FOR CARDIOLOGISTS

Cardiology English

Explain the finding. Clarify the decision.



Phil Stilwell

© 2026 Phil Stilwell. All rights reserved.

No part of this publication may be reproduced, stored in a retrieval system, or transmitted in any form or by any means without prior written permission from the author, except as permitted by law.

Eight practical lessons. Eleven extended conversations.
Vocabulary, phrase banks, guided speaking, and explained answers.

Revised 2026 edition / Upper-intermediate to advanced

Your route through the book

[01 Giving an urgent cardiovascular handoff, page 4](#)

Communicate a time-critical concern without assigning an unconfirmed diagnosis or delaying emergency care.

[02 Explaining ambulatory rhythm monitoring, page 14](#)

Explain what a rhythm recording can show and obtain a usable symptom account without promising detection.

[03 Explaining an echocardiogram, page 26](#)

Translate an imaging measurement into plain English without reducing the whole assessment to one number.

[04 Discussing atrial-fibrillation treatment goals, page 36](#)

Separate symptom control from stroke prevention while explaining a benefit-and-bleeding discussion.

[05 Discussing coronary angiography consent, page 48](#)

Explain a proposed procedure and clarify what has and has not been agreed.

[06 Checking a heart-failure home plan, page 58](#)

Check understanding of an individualized plan without treating a printed sheet as proof of comprehension.

[07 Explaining absolute and relative risk, page 71](#)

Translate a relative change into comparable absolute frequencies without turning group data into a personal guarantee.

[08 Coordinating rehabilitation and return to activity, page 81](#)

Explain a rehabilitation referral and negotiate practical follow-up without giving an unsupplied exercise prescription.

[Professional communication notes, page 3](#)

[Three additional workplace cases, page 94](#)

[Answers and explanations, page 106](#)

[Phrase finder, page 160](#)

[Vocabulary index, page 162](#)

[References and publication notes, page 166](#)

Suggested study range: B2-C1. This is an editorial study range, not a certified proficiency assessment.

A precise finding is not the whole decision.

Cardiology moves between symptoms, electrical recordings, imaging, and probabilities. Clear language identifies the evidence source, explains what a number measures, and connects the next action to a responsible professional.

Lead urgent handoffs with the concern

Give the current concern and action already taken before background detail. Preserve unknowns and confirm acceptance without delaying the actual emergency response.

"The emergency pathway is active; I am confirming the receiving team."

Name the measurement

A percentage, rhythm label, or imaging estimate answers a particular question. Do not let patients mistake a measurement for a percentage of life remaining or a complete diagnosis.

"Ejection fraction describes a pumping measurement, not how much of your heart is alive."

Make comparisons comparable

Risk numbers need the same outcome, denominator, and time period. Explain absolute change as well as relative change using the supplied figures.

"That is one fewer event per hundred over the stated period, not a personal guarantee."

Keep the plan connected

A referral, device transmission, or discharge summary is not proof that follow-up occurred. Name the receiving clinician, outstanding question, and communication route.

"The rehabilitation referral is sent; the first appointment is not yet confirmed."

Professional boundaries

All people, records, figures, and encounters are fictional. This is professional English practice, not medical advice, clinical training, a treatment protocol, or certification. Use current evidence, authorized supervision where required, local law, and your actual clinical and emergency procedures. Do not use an exercise to decide that symptoms can safely wait, select treatment, or calculate a dose. Communication about privacy, consent, and professional duties depends on jurisdiction and setting. Use qualified language support and protect real patient information.

A Read the situation

LESSON 01 / GIVING AN URGENT CARDIOVASCULAR HANDOFF

Communicate a time-critical concern without assigning an unconfirmed diagnosis or delaying emergency care.

Concern first, uncertainty intact

Dr Vale hands over Chris, who reports chest pressure with breathlessness. The emergency response is already active. The cause, initial test results, and current measurements are not supplied in this exercise. Dr Chen is accepting the clinical handoff. The task is concise communication of reported symptoms, known actions, and unresolved information, not deciding whether chest discomfort is safe to wait.

People: Dr Vale, Referring physician; Dr Chen, Receiving cardiologist.

Read the record

Choose one answer per question using the facts above.

1. What symptoms are reported?

- A.** A normal examination
- B.** No current concern
- C.** Chest pressure with breathlessness
- D.** A confirmed infarction

2. What is already active?

- A.** A routine appointment next month
- B.** A completed discharge
- C.** A prescribed medicine from this exercise
- D.** The emergency response

3. Who accepts the handoff?

- A.** An unnamed waiting-list clerk
- B.** Nobody
- C.** Dr Chen
- D.** Chris's employer

[Answers and explanations, page 106](#)

B Vocabulary in use

CORE TERMS

acute coronary syndrome

Group of urgent conditions involving reduced coronary blood flow.

evaluate suspected acute coronary syndrome

myocardial infarction

Heart-muscle injury and death caused by ischemia under diagnostic criteria.

confirm myocardial infarction

exertional symptom

Symptom associated with physical effort.

clarify exertional symptoms

diaphoresis

Marked sweating, described in clinical context.

report associated diaphoresis

troponin

Cardiac-injury biomarker interpreted with timing and clinical context.

interpret a troponin result

hemodynamic status

State of circulation assessed through relevant clinical information.

communicate hemodynamic status

myocardial ischemia

Inadequate blood supply to heart muscle relative to its needs.

assess myocardial ischemia

retrosternal

Located behind the breastbone.

describe retrosternal discomfort

rest symptom

Symptom occurring without physical exertion.

report symptoms at rest

dyspnea

Subjective sensation of difficult or uncomfortable breathing.

describe reported dyspnea

serial testing

Repeated testing over a defined clinical sequence.

explain serial testing

initial assessment

First clinical evaluation in the relevant encounter.

report the initial assessment

Say it in context

Stress the highlighted expression. Keep the surrounding words connected; pause at the end of the phrase.

acute coronary syndrome ACUTE CORONARY SYNDROME

evaluate suspected acute coronary syndrome

Keep the meaning precise: Group of urgent conditions involving reduced coronary blood flow.

rest symptom REST SYMPTOM

report symptoms at rest

Keep the meaning precise: Symptom occurring without physical exertion.

B Precision and professional shorthand

EXTEND YOUR RANGE

prehospital report

Clinical information collected before arrival at the receiving hospital.

relay the prehospital report

symptom trajectory

Pattern of symptom change over time.

describe the symptom trajectory

time-critical concern

Concern requiring prompt action within the relevant clinical process.

communicate a time-critical concern

qualified interpreter

Trained language professional supporting accurate communication between speakers.

request a qualified interpreter

patient preference

A person's stated wishes about care or communication.

elicit the patient preference

documented plan

Agreed next steps recorded for the people involved.

review the documented plan

emergency activation

Initiation of the relevant emergency-response process.

confirm emergency activation

receiving team

Professionals accepting the next stage of care.

identify the receiving team

closed-loop escalation

Urgent communication that includes confirmation of receipt and responsibility.

complete closed-loop escalation

teach-back

Checking an explanation by inviting the listener to restate its meaning.

use teach-back without blame

clinical handoff

Transfer of relevant care information and responsibility between professionals.

confirm the clinical handoff

source attribution

Identification of who reported, observed, or established a fact.

preserve source attribution

Say it in context

Stress the highlighted expression. Keep the surrounding words connected; pause at the end of the phrase.

initial assessment INITIAL ASSESSMENT

report the initial assessment

Keep the meaning precise: First clinical evaluation in the relevant encounter.

time-critical concern TIME-CRITICAL CONCERN

communicate a time-critical concern

Keep the meaning precise: Concern requiring prompt action within the relevant clinical process.

Phrases that move the work forward

Lead with the concern

I am handing over chest pressure with breathlessness.

Avoid invention

I do not have a verified measurement to report.

Request acceptance

Please confirm that your team is receiving the patient and report.

Correct immediately

That detail needs correction before it is repeated.

Invite correction

Please stop me if I have misunderstood.

Separate uncertainty

That remains uncertain; it is not a confirmed finding.

Make space

We can pause before moving to the next point.

Keep a record accurate

I will distinguish what was reported from what was observed.

State the action

The emergency response is already active.

Separate diagnosis

The cause is not established in this handoff.

Preserve timing

I will distinguish reported onset from the time of our assessment.

Close the loop

I have your acknowledgment and the receiving contact.

Explain a term

In everyday language, that means the following.

Check your explanation

Let me explain that another way.

Name responsibility

Let us confirm who will follow up.

Confirm an agreement

We have agreed on the next step, not on an outcome.

Precision in real exchanges

Purpose: Separate diagnosis

Useful wording: The cause is not established in this handoff.

Purpose: Request acceptance

Useful wording: Please confirm that your team is receiving the patient and report.

D Choose the response that fits

Choose one response for each situation. Preserve the facts, the decision boundary, and the purpose of the exchange.

1. Which opening is strongest?

- A.** Chest pressure with breathlessness; the emergency response is active.
- B.** A small issue may need discussion eventually.
- C.** A confirmed infarction with invented results.
- D.** No concern because no results are shown.

2. Which result must not be invented?

- A.** The active emergency response
- B.** A normal troponin
- C.** The reported chest pressure
- D.** The accepted handoff

3. A colleague needs the term for this meaning: Located behind the breastbone. Which term fits?

- A.** retrosternal
- B.** symptom trajectory
- C.** patient preference
- D.** troponin

D Choose the response that fits / continued

4. Rebuild the exchange from "Concern first, uncertainty intact". Dr Vale: "I do not yet have verified current measurements to pass on. I will update you as they become available." Dr Chen: [missing response] Dr Vale: "I also need to distinguish the patient's reported onset from the time someone first contacted the service." Which response belongs in the gap?

- A.** Exactly. We are still awaiting the troponin result. Please include the sampling time when you pass it on.
- B.** Please do. The receiving team needs to know which facts are new and who is responsible for them.
- C.** I am receiving the report. Keep this time-critical concern with the clinical team while we clarify the verified information.
- D.** Then do not describe the hemodynamic status as normal. Missing information must stay visible while the real assessment continues.

[Answers and explanations, page 106](#)

One useful distinction

Chest pressure and breathlessness are reported symptoms, not a confirmed infarction. Missing measurements must remain missing; the exercise cannot classify urgency or establish a diagnosis.

E Conversation

Concern first, uncertainty intact

Concern first, uncertainty intact

Complete the numbered gaps. Use each bank entry once; some entries contain several words.

WORD AND PHRASE BANK

time-critical concern / Myocardial infarction / symptom trajectory / troponin /
closed-loop escalation / dyspnea / receiving team / prehospital report /
hemodynamic status / Emergency activation

- 01 **Dr Vale:** I am handing over Chris, who reports chest pressure with breathlessness. The emergency response is already active.
- 02 **Dr Chen:** I am receiving the report. Keep this ¹ _____ with the clinical team while we clarify the verified information.
- 03 **Dr Vale:** I will separate what Chris reports from what our team has actually observed or measured.
- 04 **Dr Chen:** Good. Report ² _____ as a symptom, and do not convert it into a diagnosis without the evidence.
- 05 **Dr Vale:** I do not yet have verified current measurements to pass on. I will update you as they become available.
- 06 **Dr Chen:** Then do not describe the ³ _____ as normal. Missing information must stay visible while the real assessment continues.
- 07 **Dr Vale:** I also need to distinguish the patient's reported onset from the time someone first contacted the service.
- 08 **Dr Chen:** Yes. The ⁴ _____ should retain its source and timing rather than be blended with later observations.
- 09 **Dr Vale:** I have not labeled this a confirmed infarction. The symptoms justify concern, but the cause is unestablished here.
- 10 **Dr Chen:** Correct. ⁵ _____ is not a substitute label for every chest-pressure report.

Conversation continues on the next page.

Concern first, uncertainty intact

CONVERSATION / CONTINUED

- 11 **Dr Vale:** Nor should an absent test result be treated as a negative test that rules out the concern.
- 12 **Dr Chen:** Exactly. We are still awaiting the ⁶ _____ result. Please include the sampling time when you pass it on.
- 13 **Dr Vale:** I will send any verified update through the active pathway rather than leave a separate routine message.
- 14 **Dr Chen:** Please do. The ⁷ _____ needs to know which facts are new and who is responsible for them.
- 15 **Dr Vale:** Shall I wait until every field is complete before confirming transfer of the report?
- 16 **Dr Chen:** No. ⁸ _____ is already underway; do not interrupt necessary care to perfect the wording.
- 17 **Dr Vale:** I will identify the unfinished information explicitly and confirm the contact for further clinical updates.
- 18 **Dr Chen:** That supports ⁹ _____. I acknowledge the concern and am accepting this handoff through our clinical process.
- 19 **Dr Vale:** Understood. Reported symptoms, active response, unresolved cause, and no invented measurements or results.
- 20 **Dr Chen:** Correct. Continue communicating the ¹⁰ _____ as verified information becomes available, alongside the real clinical response.

CHECK THE GAPS

1. time-critical concern / 2. dyspnea / 3. hemodynamic status / 4. prehospital report / 5. Myocardial infarction / 6. troponin / 7. receiving team / 8. Emergency activation / 9. closed-loop escalation / 10. symptom trajectory

[Why these answers fit, page 107](#)

F Check accuracy and scope

Concern first, uncertainty intact

Return to the case

Dr Vale hands over Chris, who reports chest pressure with breathlessness. The emergency response is already active. The cause, initial test results, and current measurements are not supplied in this exercise. Dr Chen is accepting the clinical handoff. The task is concise communication of reported symptoms, known actions, and unresolved information, not deciding whether chest discomfort is safe to wait.

Choose one answer per question. Use the case facts and keep any uncertainty or limits intact.

1. What completes the communication loop?

- A. An unanswered voicemail alone
- B. A guessed diagnosis
- C. A promise that nothing can change
- D. Confirmation of the receiving team and responsibility

2. What should not delay emergency care?

- A. The receiving clinician's assessment
- B. Necessary clinical action
- C. Completing every detail of this language exercise
- D. The actual local emergency pathway

[Answers and explanations, page 109](#)

Listen for the distinction

Swap roles. Repeat the acceptance and missing-information statements without inserting measurements or a diagnosis.

Urgent does not mean speculative

Use a clear opening and closed confirmation. Do not increase certainty to sound decisive, and do not postpone an active emergency response until a report sounds polished.

F Say it / transfer to a new case

A corrected onset time

During an active emergency handoff, the patient clarifies that symptoms began at 09:10, not 09:40. The receiving clinician acknowledges the correction. No cause is established.

Complete the four gaps. With a partner, read alternate roles, then switch. Studying alone, read both roles and pause before each response.

WORD AND PHRASE BANK

active / 09:10 / 09:40 / unestablished

- 01 **Referrer:** The corrected reported onset is ¹ _____.
- 02 **Receiver:** The previously reported onset time of ² _____ has been superseded.
- 03 **Referrer:** The emergency response remains ³ _____.
- 04 **Receiver:** The cause remains ⁴ _____.

CHECK THE GAPS

1. 09:10 / 2. 09:40 / 3. active / 4. unestablished

[Why these answers fit, page 109](#)

Rebuild the exchange

Choose the missing response. Read the completed three-turn exchange aloud, changing roles on the second reading.

1. Rebuild the exchange from "Concern first, uncertainty intact". Dr Vale: "I will send any verified update through the active pathway rather than leave a separate routine message." Dr Chen: [missing response] Dr Vale: "Shall I wait until every field is complete before confirming transfer of the report?" Which response belongs in the gap?

- A.** Please do. The receiving team needs to know which facts are new and who is responsible for them.
- B.** Exactly. We are still awaiting the troponin result. Please include the sampling time when you pass it on.
- C.** I am receiving the report. Keep this time-critical concern with the clinical team while we clarify the verified information.
- D.** Good. Report dyspnea as a symptom, and do not convert it into a diagnosis without the evidence.

[Answers and explanations, page 110](#)

A Read the situation

LESSON 02 / EXPLAINING AMBULATORY RHYTHM MONITORING

Explain what a rhythm recording can show and obtain a usable symptom account without promising detection.

A symptom marker is not a diagnosis

Ellis describes intermittent palpitations. Dr Mora proposes an ambulatory recording to compare symptoms with heart rhythm. No arrhythmia has been established in this case. Ellis will receive device-specific instructions from the service. A symptom diary and event marker may help interpretation; they do not themselves diagnose the sensation or guarantee that every episode will be captured.

People: Ellis, Patient; Dr Mora, Cardiologist.

Read the record

Choose one answer per question using the facts above.

1. What is the proposed purpose?

- A.** Prove an arrhythmia already exists
- B.** Replace all urgent assessment
- C.** Compare symptoms with recorded rhythm
- D.** Guarantee every episode is captured

2. What is not established?

- A.** An arrhythmia
- B.** Ellis's symptom report
- C.** A proposed recording
- D.** The need for instructions

3. Who provides equipment instructions?

- A.** The service using the actual device
- B.** A guessed universal script
- C.** Another patient
- D.** The learner inventing settings

[Answers and explanations, page 111](#)

B Vocabulary in use

CORE TERMS

palpitations

Awareness of the heartbeat as unusual, forceful, fast, or irregular.

describe palpitations

arrhythmia

Abnormality of heart rhythm.

investigate a suspected arrhythmia

ectopic beat

Beat arising outside the usual initiating site.

describe an ectopic beat

event marker

Device feature marking a time for later review.

use the event marker

recording period

Time during which the device collects data.

confirm the recording period

paroxysmal

Occurring in episodes with onset and offset.

describe paroxysmal symptoms

electrocardiogram

Recording of the heart's electrical activity.

interpret an electrocardiogram

sinus rhythm

Rhythm originating from the heart's usual sinus-node pacemaker.

identify sinus rhythm

ambulatory monitor

Device recording heart rhythm during everyday activity.

fit an ambulatory monitor

symptom diary

Record of symptoms, times, and relevant activity.

keep a symptom diary

symptom-rhythm correlation

Relationship between reported symptoms and rhythm at the relevant time.

assess symptom-rhythm correlation

bradycardia

Heart rate slower than expected in the relevant context.

assess bradycardia

Say it in context

Stress the highlighted expression. Keep the surrounding words connected; pause at the end of the phrase.

palpitations **PALPITATIONS**

describe palpitations

Keep the meaning precise: Awareness of the heartbeat as unusual, forceful, fast, or irregular.

ambulatory monitor **AMBULATORY MONITOR**

fit an ambulatory monitor

Keep the meaning precise: Device recording heart rhythm during everyday activity.

B Precision and professional shorthand

EXTEND YOUR RANGE

tachycardia

Heart rate faster than expected in the relevant context.

assess tachycardia

electrode lead

Electrical recording connection used in acquiring a trace.

check an electrode lead

signal quality

Adequacy of the recorded signal for interpretation.

assess signal quality

qualified interpreter

Trained language professional supporting accurate communication between speakers.

request a qualified interpreter

patient preference

A person's stated wishes about care or communication.

elicit the patient preference

documented plan

Agreed next steps recorded for the people involved.

review the documented plan

conduction

Transmission of electrical impulses through the heart.

evaluate cardiac conduction

signal artifact

Distortion in a recording not representing the true underlying signal.

identify signal artifact

monitor return

Process of returning equipment or transmitting its recorded data.

confirm monitor return

teach-back

Checking an explanation by inviting the listener to restate its meaning.

use teach-back without blame

clinical handoff

Transfer of relevant care information and responsibility between professionals.

confirm the clinical handoff

source attribution

Identification of who reported, observed, or established a fact.

preserve source attribution

Say it in context

Stress the highlighted expression. Keep the surrounding words connected; pause at the end of the phrase.

bradycardia **BRADYCARDIA**

assess bradycardia

Keep the meaning precise: Heart rate slower than expected in the relevant context.

signal quality **SIGNAL QUALITY**

assess signal quality

Keep the meaning precise: Adequacy of the recorded signal for interpretation.

Phrases that move the work forward

Explain the purpose

We want to compare what you feel with the rhythm at that time.

Limit the promise

The recording may not capture every episode.

Clarify the marker

The marker identifies a time for review, not a diagnosis.

Separate urgent care

Follow the urgent-care instructions rather than waiting for the monitor report.

Ellis / in the conversation

My heart sometimes feels as though it skips and then thumps.

Dr Mora / in the conversation

We need appropriate evidence before naming a particular rhythm.

Dr Mora / in the conversation

An ambulatory monitor can record during ordinary activity, helping us look for a relationship with the episodes.

Dr Mora / in the conversation

An arrhythmia has not been established in this case.

Separate symptom and finding

Palpitations do not name a specific rhythm by themselves.

Make the diary useful

Include the time, what you felt, and what you were doing.

Use the actual instructions

The service will explain this device's controls and restrictions.

Close the process

Let us confirm how the recording reaches the reviewing team.

Ellis / in the conversation

Is that enough to name the rhythm problem?

Ellis / in the conversation

They never seem to happen at the exact moment someone checks me.

Ellis / in the conversation

Does agreeing to the monitor mean you have already diagnosed an arrhythmia from my account?

Dr Mora / in the conversation

The recording is part of investigating the question.

Precision in real exchanges

Purpose: Make the diary useful

Useful wording: Include the time, what you felt, and what you were doing.

Purpose: Clarify the marker

Useful wording: The marker identifies a time for review, not a diagnosis.

D Choose the response that fits

Choose one response for each situation. Preserve the facts, the decision boundary, and the purpose of the exchange.

1. Which distinction is correct?

- A.** Palpitations are a symptom; an arrhythmia is a rhythm abnormality.
- B.** Every palpitation proves an arrhythmia.
- C.** A diary is a diagnosis.
- D.** A marker guarantees a dangerous rhythm.

2. What makes a diary entry useful?

- A.** Time, sensation, and activity
- B.** Only the patient's opinion of the device color
- C.** A diagnosis invented at home
- D.** An unrelated appointment number

3. A colleague needs the term for this meaning: Rhythm originating from the heart's usual sinus-node pacemaker. Which term fits?

- A.** sinus rhythm
- B.** patient preference
- C.** electrode lead
- D.** recording period

D Choose the response that fits / continued

4. Rebuild the exchange from "A symptom marker is not a diagnosis". Ellis: "Does agreeing to the monitor mean you have already diagnosed an arrhythmia from my account?" Dr Mora: [missing response] Ellis: "What should I record when I notice the feeling, besides pressing whatever button the device has?" Which response belongs in the gap?

- A.** Exactly. Follow the actual urgent-care instructions; the recording period is not permission to delay needed clinical assessment.
- B.** Yes. Those instructions help protect signal quality and explain the controls, restrictions, and reporting process for this device.
- C.** No. An arrhythmia has not been established in this case. The recording is part of investigating the question.
- D.** An ambulatory monitor can record during ordinary activity, helping us look for a relationship with the episodes.

[Answers and explanations, page 111](#)

One useful distinction

Palpitations are a symptom; arrhythmia is a rhythm finding. A marked event helps locate information but does not itself diagnose it.

E Conversation

A symptom marker is not a diagnosis

A symptom marker is not a diagnosis

Complete the numbered gaps. Use each bank entry once; some entries contain several words.

WORD AND PHRASE BANK

Signal artifact / palpitations / arrhythmia / symptom-rhythm correlation / event marker / symptom diary / signal quality / recording period / ambulatory monitor / monitor return

- 01 **Ellis:** My heart sometimes feels as though it skips and then thumps. Is that enough to name the rhythm problem?
- 02 **Dr Mora:** Those are ¹ _____, a symptom description. We need appropriate evidence before naming a particular rhythm.
- 03 **Ellis:** The episodes come and go. They never seem to happen at the exact moment someone checks me.
- 04 **Dr Mora:** An ² _____ can record during ordinary activity, helping us look for a relationship with the episodes.
- 05 **Ellis:** Does agreeing to the monitor mean you have already diagnosed an arrhythmia from my account?
- 06 **Dr Mora:** No. An ³ _____ has not been established in this case. The recording is part of investigating the question.
- 07 **Ellis:** What should I record when I notice the feeling, besides pressing whatever button the device has?
- 08 **Dr Mora:** The service will explain the device. A ⁴ _____ should include the time, what you feel, and what you are doing.
- 09 **Ellis:** And pressing a marker does not mean the device has instantly told me what caused the sensation?
- 10 **Dr Mora:** Correct. The ⁵ _____ identifies a time to review; it is not itself a diagnosis or a promise of real-time assessment.

Conversation continues on the next page.

A symptom marker is not a diagnosis

CONVERSATION / CONTINUED

- 11 **Ellis:** I am worried I will wear it and nothing will happen during the recording period.
- 12 **Dr Mora:** That is a possible limitation. We are seeking ⁶ _____, and the available recording may not capture every intermittent event.
- 13 **Ellis:** If the trace looks strange while I move, will every unusual line be treated as a heart problem?
- 14 **Dr Mora:** No. ⁷ _____ can affect recordings, so quality and context matter to the interpretation.
- 15 **Ellis:** Then I should follow the actual device instructions rather than borrow instructions from a friend's different monitor.
- 16 **Dr Mora:** Yes. Those instructions help protect ⁸ _____ and explain the controls, restrictions, and reporting process for this device.
- 17 **Ellis:** If I develop a concerning new symptom, I should not assume pressing the marker replaces asking for help.
- 18 **Dr Mora:** Exactly. Follow the actual urgent-care instructions; the ⁹ _____ is not permission to delay needed clinical assessment.
- 19 **Ellis:** I also want to know how you receive the recording and when the team explains its findings.
- 20 **Dr Mora:** We will confirm the ¹⁰ _____ process and the service's review arrangements, without promising a result the data may not establish.

CHECK THE GAPS

1. palpitations / 2. ambulatory monitor / 3. arrhythmia / 4. symptom diary / 5. event marker / 6. symptom-rhythm correlation / 7. Signal artifact / 8. signal quality / 9. recording period / 10. monitor return

[Why these answers fit, page 112](#)

F Check accuracy and scope

A symptom marker is not a diagnosis

Return to the case

Ellis describes intermittent palpitations. Dr Mora proposes an ambulatory recording to compare symptoms with heart rhythm. No arrhythmia has been established in this case. Ellis will receive device-specific instructions from the service. A symptom diary and event marker may help interpretation; they do not themselves diagnose the sensation or guarantee that every episode will be captured.

Choose one answer per question. Use the case facts and keep any uncertainty or limits intact.

1. Which promise is unsupported?

- A. A marker identifies an event time.
- B. Every episode will definitely be captured.
- C. The device has specific instructions.
- D. The recording needs interpretation.

2. What must remain separate?

- A. Urgent-care instructions and routine monitor review
- B. Symptom time and the corresponding trace
- C. A device and its actual instructions
- D. The report and its reviewing team

[Answers and explanations, page 114](#)

Listen for the distinction

Swap roles. Repeat the device-instruction and urgent-care distinctions without inventing equipment settings.

Explain the purpose before the equipment

A patient needs to know what question the monitor addresses, not just how long it is worn. Keep emergency instructions separate from routine recording instructions.

F Say it / transfer to a new case

A diary time needs clarification

A diary says an episode occurred at 7, without morning or evening. The reviewing team asks Ellis to clarify before matching it to the trace. No rhythm conclusion is supplied.

Complete the four gaps. With a partner, read alternate roles, then switch. Studying alone, read both roles and pause before each response.

WORD AND PHRASE BANK

evening / trace / supplied / clarify

- 01 **Reviewer:** The entry gives seven but not morning or ¹ _____.
- 02 **Ellis:** I need to ² _____ that detail.
- 03 **Reviewer:** Then we can match it to the ³ _____.
- 04 **Ellis:** No rhythm conclusion has been ⁴ _____.

CHECK THE GAPS

1. evening / 2. clarify / 3. trace / 4. supplied

[Why these answers fit, page 114](#)

Rebuild the exchange

Choose the missing response. Read the completed three-turn exchange aloud, changing roles on the second reading.

1. Rebuild the exchange from "A symptom marker is not a diagnosis". Ellis: "If the trace looks strange while I move, will every unusual line be treated as a heart problem?" Dr Mora: [missing response] Ellis: "Then I should follow the actual device instructions rather than borrow instructions from a friend's different monitor." Which response belongs in the gap?

- A.** Exactly. Follow the actual urgent-care instructions; the recording period is not permission to delay needed clinical assessment.
- B.** No. Signal artifact can affect recordings, so quality and context matter to the interpretation.
- C.** Those are palpitations, a symptom description. We need appropriate evidence before naming a particular rhythm.
- D.** An ambulatory monitor can record during ordinary activity, helping us look for a relationship with the episodes.

[Answers and explanations, page 115](#)

Review 1 / Meaning and context

Use language from the lessons you have completed. Choose one answer per question.

Case file

Revisit "Giving an urgent cardiovascular handoff" and "Explaining ambulatory rhythm monitoring". Choose precise terminology, then reconstruct the missing responses using both neighboring turns. The final two questions also revisit earlier conversations.

1. A colleague needs the term for this meaning: Heart-muscle injury and death caused by ischemia under diagnostic criteria. Which term fits?

- A. myocardial infarction
- B. dyspnea
- C. teach-back
- D. emergency activation

2. A colleague needs the term for this meaning: Record of symptoms, times, and relevant activity. Which term fits?

- A. palpitations
- B. qualified interpreter
- C. tachycardia
- D. symptom diary

3. Rebuild the exchange from "Concern first, uncertainty intact". Dr Vale: "I have not labeled this a confirmed infarction. The symptoms justify concern, but the cause is unestablished here." Dr Chen: [missing response] Dr Vale: "Nor should an absent test result be treated as a negative test that rules out the concern." Which response belongs in the gap?

- A. Correct. Continue communicating the symptom trajectory as verified information becomes available, alongside the real clinical response.
- B. Correct. Myocardial infarction is not a substitute label for every chest-pressure report.
- C. No. Emergency activation is already underway; do not interrupt necessary care to perfect the wording.
- D. Good. Report dyspnea as a symptom, and do not convert it into a diagnosis without the evidence.

Review 1 / Meaning and context / continued

4. Rebuild the exchange from "A symptom marker is not a diagnosis". Ellis: "If I develop a concerning new symptom, I should not assume pressing the marker replaces asking for help." Dr Mora: [missing response] Ellis: "I also want to know how you receive the recording and when the team explains its findings." Which response belongs in the gap?

- A.** An ambulatory monitor can record during ordinary activity, helping us look for a relationship with the episodes.
- B.** Exactly. Follow the actual urgent-care instructions; the recording period is not permission to delay needed clinical assessment.
- C.** No. An arrhythmia has not been established in this case. The recording is part of investigating the question.
- D.** Yes. Those instructions help protect signal quality and explain the controls, restrictions, and reporting process for this device.

[Answers and explanations, page 146](#)

A Read the situation

LESSON 03 / EXPLAINING AN ECHOCARDIOGRAM

Translate an imaging measurement into plain English without reducing the whole assessment to one number.

A percentage is not the amount of heart left

Ren reads an echocardiogram report containing a left-ventricular ejection-fraction measurement. No numerical value or heart-failure diagnosis is supplied. Ren thinks the percentage describes how much heart muscle is still alive. Dr Kim explains what the measurement represents and why symptoms, structure, filling, valves, and other findings also matter.

People: Ren, Patient; Dr Kim, Cardiologist.

Read the record

Choose one answer per question using the facts above.

1. What does Ren misunderstand?

- A.** The appointment date
- B.** A prescribed dose
- C.** A confirmed valve procedure
- D.** The meaning of the ejection-fraction percentage

2. What is not supplied?

- A.** An echocardiogram report
- B.** Ren's question
- C.** A clinician explanation
- D.** A numerical value or heart-failure diagnosis

3. What else belongs in interpretation?

- A.** The report's font size
- B.** A guessed comparison
- C.** Symptoms and other cardiac findings
- D.** Only the percentage

[Answers and explanations, page 116](#)

B Vocabulary in use

CORE TERMS

echocardiogram

Ultrasound examination of heart structure and function.

explain an echocardiogram

systole

Phase of the cardiac cycle involving ventricular contraction and ejection.

describe systolic function

left ventricle

Heart chamber pumping blood into the systemic circulation.

assess the left ventricle

stroke volume

Amount of blood ejected by a ventricle in one beat.

distinguish stroke volume

reduced ejection fraction

Ejection fraction below the relevant category threshold in context.

explain reduced ejection fraction

valvular stenosis

Narrowing that restricts flow through a heart valve.

explain valvular stenosis

ejection fraction

Proportion of ventricular blood volume expelled with a contraction.

explain left-ventricular ejection fraction

diastole

Phase involving ventricular relaxation and filling.

describe diastolic filling

right ventricle

Heart chamber pumping blood toward the lungs.

assess the right ventricle

preserved ejection fraction

Ejection fraction within the relevant preserved category despite possible other dysfunction.

discuss preserved ejection fraction

valvular regurgitation

Backward flow through a valve that does not close adequately.

assess valvular regurgitation

wall motion

Movement of heart-muscle segments during the cardiac cycle.

assess regional wall motion

Say it in context

Stress the highlighted expression. Keep the surrounding words connected; pause at the end of the phrase.

echocardiogram ECHOCARDIOGRAM

explain an echocardiogram

Keep the meaning precise: Ultrasound examination of heart structure and function.

right ventricle RIGHT VENTRICLE

assess the right ventricle

Keep the meaning precise: Heart chamber pumping blood toward the lungs.

B Precision and professional shorthand

EXTEND YOUR RANGE

diastolic function

Ventricular relaxation and filling characteristics.
assess diastolic function

ventricular volume

Amount of blood within a ventricle at a specified phase.
measure ventricular volume

image quality

Adequacy of images for the intended interpretation.
describe image quality

qualified interpreter

Trained language professional supporting accurate communication between speakers.
request a qualified interpreter

patient preference

A person's stated wishes about care or communication.
elicit the patient preference

documented plan

Agreed next steps recorded for the people involved.
review the documented plan

structural heart disease

Abnormality of heart anatomy or associated structures.
investigate structural heart disease

pressure estimate

Indirect approximation of pressure from available measurements.
qualify a pressure estimate

comparison study

Earlier examination used to evaluate change.
review a comparison study

teach-back

Checking an explanation by inviting the listener to restate its meaning.
use teach-back without blame

clinical handoff

Transfer of relevant care information and responsibility between professionals.
confirm the clinical handoff

source attribution

Identification of who reported, observed, or established a fact.
preserve source attribution

Say it in context

Stress the highlighted expression. Keep the surrounding words connected; pause at the end of the phrase.

wall motion **WALL MOTION**

assess regional wall motion

Keep the meaning precise: Movement of heart-muscle segments during the cardiac cycle.

image quality **IMAGE QUALITY**

describe image quality

Keep the meaning precise: Adequacy of images for the intended interpretation.

Phrases that move the work forward

Check the interpretation

What did that percentage suggest to you?

Correct gently

It is not the percentage of your heart that is still alive.

Broaden the picture

Filling, valves, symptoms, and other findings also matter.

Avoid a single-number diagnosis

We cannot interpret the whole situation from one number alone.

Ren / in the conversation

I thought it meant that only that much of my heart is still alive.

Dr Kim / in the conversation

Let me explain what the number represents.

Dr Kim / in the conversation

This measurement concerns the left ventricle, the chamber that pumps blood toward the body.

Dr Kim / in the conversation

It relates the blood expelled to the ventricular volume before that contraction.

Define the measurement

It describes the proportion of blood pushed out with a contraction.

Name the chamber

This report refers to the left ventricle.

Qualify the image

The report should state any important image-quality limitation.

Separate a comparison

A change needs a comparable earlier study and clinical context.

Dr Kim / in the conversation

Ejection fraction does not measure how much heart tissue remains alive.

Ren / in the conversation

I have been thinking of it as a percentage score for the whole heart.

Ren / in the conversation

What is the percentage actually a percentage of, if it is not the amount of working muscle?

Ren / in the conversation

Then a report using an amount of blood per beat would be describing something related but different?

Precision in real exchanges

Purpose: Name the chamber

Useful wording: This report refers to the left ventricle.

Purpose: Broaden the picture

Useful wording: Filling, valves, symptoms, and other findings also matter.

D Choose the response that fits

Choose one response for each situation. Preserve the facts, the decision boundary, and the purpose of the exchange.

1. What does ejection fraction measure?

- A.** Life expectancy in percent
- B.** The percentage of arteries without narrowing
- C.** A proportion of ventricular blood expelled with contraction
- D.** The percentage of living heart tissue

2. Which statement is accurate?

- A.** Preserved ejection fraction alone does not exclude heart failure.
- B.** A preserved value proves every cardiac function is normal.
- C.** The percentage is a prognosis timetable.
- D.** A low value identifies every cause.

3. A colleague needs the term for this meaning: Phase involving ventricular relaxation and filling. Which term fits?

- A.** patient preference
- B.** reduced ejection fraction
- C.** diastole
- D.** ventricular volume

D Choose the response that fits / continued

4. Rebuild the exchange from "A percentage is not the amount of heart left". Ren: "What is the percentage actually a percentage of, if it is not the amount of working muscle?" Dr Kim: [missing response] Ren: "Then a report using an amount of blood per beat would be describing something related but different?" Which response belongs in the gap?

- A.** It relates the blood expelled to the ventricular volume before that contraction. It describes a pumping proportion.
- B.** Correct. Diastolic function is part of the assessment, along with structure, valves, symptoms, and other findings.
- C.** Systole involves contraction and ejection. Diastole involves relaxation and filling; both are relevant to function.
- D.** Ejection fraction does not measure how much heart tissue remains alive. Let me explain what the number represents.

[Answers and explanations, page 116](#)

One useful distinction

Ejection fraction is a pumping proportion, not a percentage of living heart tissue or life expectancy. It is not the whole assessment of cardiac function.

Conversation

A percentage is not the amount of heart left

A percentage is not the amount of heart left

Complete the numbered gaps. Use each bank entry once; some entries contain several words.

WORD AND PHRASE BANK

Ejection fraction / Diastolic function / comparison study / Stroke volume / left ventricle / image quality / valvular regurgitation / Systole / Preserved ejection fraction / ventricular volume

- 01 **Ren:** The report gives a percentage. I thought it meant that only that much of my heart is still alive.
- 02 **Dr Kim:** ¹ _____ does not measure how much heart tissue remains alive. Let me explain what the number represents.
- 03 **Ren:** Please do. I have been thinking of it as a percentage score for the whole heart.
- 04 **Dr Kim:** This measurement concerns the ² _____, the chamber that pumps blood toward the body.
- 05 **Ren:** What is the percentage actually a percentage of, if it is not the amount of working muscle?
- 06 **Dr Kim:** It relates the blood expelled to the ³ _____ before that contraction. It describes a pumping proportion.
- 07 **Ren:** Then a report using an amount of blood per beat would be describing something related but different?
- 08 **Dr Kim:** Yes. ⁴ _____ is an amount per beat, while ejection fraction expresses a proportion.
- 09 **Ren:** I also saw systolic and diastolic in the report. Are those two different parts of the heartbeat?
- 10 **Dr Kim:** ⁵ _____ involves contraction and ejection. Diastole involves relaxation and filling; both are relevant to function.

Conversation continues on the next page.

A percentage is not the amount of heart left

CONVERSATION / CONTINUED

- 11 **Ren:** So the part about filling is not just an extra technical detail that can be ignored?
- 12 **Dr Kim:** Correct. ⁶ _____ is part of the assessment, along with structure, valves, symptoms, and other findings.
- 13 **Ren:** If someone has a preserved percentage, does that prove they cannot have heart failure?
- 14 **Dr Kim:** No. ⁷ _____ alone does not exclude it. We need the complete clinical picture, not just that label.
- 15 **Ren:** I understand. The report also discusses a valve, which I assumed the percentage already covered.
- 16 **Dr Kim:** Valve findings are assessed separately. For example, ⁸ _____ describes backward flow through a valve, not the ejection fraction itself.
- 17 **Ren:** What if part of the scan was hard to see clearly? Should that limitation be explained too?
- 18 **Dr Kim:** Yes. Important ⁹ _____ limitations should be stated rather than hidden behind a precise-looking number.
- 19 **Ren:** Then I should ask how this fits the rest of the assessment, not treat it as an isolated score.
- 20 **Dr Kim:** Exactly. Any ¹⁰ _____ also needs context. We will explain the actual findings without inventing a diagnosis from one measurement.

CHECK THE GAPS

1. Ejection fraction / **2.** left ventricle / **3.** ventricular volume / **4.** Stroke volume / **5.** Systole / **6.** Diastolic function / **7.** Preserved ejection fraction / **8.** valvular regurgitation / **9.** image quality / **10.** comparison study

[Why these answers fit, page 117](#)

F Check accuracy and scope

A percentage is not the amount of heart left

Return to the case

Ren reads an echocardiogram report containing a left-ventricular ejection-fraction measurement. No numerical value or heart-failure diagnosis is supplied. Ren thinks the percentage describes how much heart muscle is still alive. Dr Kim explains what the measurement represents and why symptoms, structure, filling, valves, and other findings also matter.

Choose one answer per question. Use the case facts and keep any uncertainty or limits intact.

1. Which distinction is useful?

- A. Both mean the number of heartbeats.
- B. Both measure the patient's age.
- C. Neither refers to pumping.
- D. Stroke volume is an amount; ejection fraction is a proportion.

2. Which conclusion exceeds this case?

- A. The terminology needs explanation.
- B. No numerical value is supplied.
- C. Ren has a specific heart-failure category.
- D. Ren has a report.

[Answers and explanations, page 119](#)

Listen for the distinction

Swap roles. Repeat the preserved-ejection-fraction explanation without assigning Ren a diagnosis.

Ask what the number means to the listener

A percentage can sound intuitive while being misunderstood. Establish the patient's interpretation before adding ranges or categories that may create a second misunderstanding.

F Say it / transfer to a new case

A comparison needs context

A report cites an earlier scan, but the cardiologist has not yet reviewed whether the studies are comparable. No meaningful change has been established.

Complete the four gaps. With a partner, read alternate roles, then switch. Studying alone, read both roles and pause before each response.

WORD AND PHRASE BANK

context / established / scan / comparable

- 01 **Patient:** The report refers to an earlier ¹ _____.
- 02 **Clinician:** I still need to review whether they are ² _____.
- 03 **Patient:** A meaningful change is not ³ _____.
- 04 **Clinician:** We will interpret the findings in ⁴ _____.

CHECK THE GAPS

1. scan / 2. comparable / 3. established / 4. context

[Why these answers fit, page 119](#)

Rebuild the exchange

Choose the missing response. Read the completed three-turn exchange aloud, changing roles on the second reading.

1. Rebuild the exchange from "A percentage is not the amount of heart left". Ren: "If someone has a preserved percentage, does that prove they cannot have heart failure?" Dr Kim: [missing response] Ren: "I understand. The report also discusses a valve, which I assumed the percentage already covered." Which response belongs in the gap?

- A.** Exactly. Any comparison study also needs context. We will explain the actual findings without inventing a diagnosis from one measurement.
- B.** Ejection fraction does not measure how much heart tissue remains alive. Let me explain what the number represents.
- C.** No. Preserved ejection fraction alone does not exclude it. We need the complete clinical picture, not just that label.
- D.** Valve findings are assessed separately. For example, valvular regurgitation describes backward flow through a valve, not the ejection fraction itself.

[Answers and explanations, page 120](#)

A Read the situation

LESSON 04 / DISCUSSING ATRIAL-FIBRILLATION TREATMENT GOALS

Separate symptom control from stroke prevention while explaining a benefit-and-bleeding discussion.

The rhythm question and the stroke question

Avery has an established atrial-fibrillation diagnosis and asks why stroke prevention is discussed when the heartbeat feels calmer. Dr Patel will explain that symptom or rhythm management and stroke prevention address related but different questions. No risk score, medicine selection, dose, or instruction to stop treatment is supplied. Avery is worried about bleeding and wants that concern included.

People: Avery, Patient; Dr Patel, Cardiologist.

Read the record

Choose one answer per question using the facts above.

1. What diagnosis is established?

- A. No rhythm diagnosis
- B. Atrial fibrillation
- C. A new stroke in this case
- D. A bleeding disorder diagnosed here

2. What does Avery ask about?

- A. A dose already supplied
- B. A confirmed procedure date
- C. A guaranteed risk-free medicine
- D. Why stroke prevention matters when symptoms feel calmer

3. What is absent from the case?

- A. A consultation
- B. A medicine selection or risk score
- C. Avery's bleeding concern
- D. The diagnosis

[Answers and explanations, page 121](#)

B Vocabulary in use

CORE TERMS

atrial fibrillation

Irregular atrial electrical activity producing an irregular heart rhythm.

explain atrial fibrillation

rate control

Strategy aimed at controlling heart rate.

discuss rate control

anticoagulation

Treatment reducing blood's ability to form clots through coagulation pathways.

review anticoagulation

stroke risk

Likelihood of stroke in a defined clinical context and period.

assess stroke risk

thromboembolism

Obstruction caused by a clot traveling from another site.

discuss thromboembolism

catheter ablation

Procedure targeting tissue involved in an abnormal rhythm.

discuss catheter ablation

atrial flutter

Organized rapid atrial rhythm distinct from atrial fibrillation.

distinguish atrial flutter

rhythm control

Strategy aimed at restoring or maintaining an appropriate rhythm.

discuss rhythm control

antiplatelet therapy

Treatment reducing platelet activity in clot formation.

distinguish antiplatelet therapy

bleeding risk

Likelihood of bleeding under relevant clinical circumstances.

assess bleeding risk

cardioversion

Intervention intended to restore an appropriate heart rhythm.

explain cardioversion

left atrial appendage

Pouch-like structure attached to the left atrium.

explain the left atrial appendage

Say it in context

Stress the highlighted expression. Keep the surrounding words connected; pause at the end of the phrase.

atrial fibrillation **ATRIAL FIBRILLATION**

explain atrial fibrillation

Keep the meaning precise: Irregular atrial electrical activity producing an irregular heart rhythm.

antiplatelet therapy **ANTIPLATELET THERAPY**

distinguish antiplatelet therapy

Keep the meaning precise: Treatment reducing platelet activity in clot formation.

B Precision and professional shorthand

EXTEND YOUR RANGE

renal function

How effectively the kidneys perform their relevant functions.

review renal function

shared treatment decision

Care choice informed by evidence and the person's priorities.

reach a shared treatment decision

individual risk estimate

Context-dependent estimate for a person's likelihood of an outcome.

explain an individual risk estimate

qualified interpreter

Trained language professional supporting accurate communication between speakers.

request a qualified interpreter

patient preference

A person's stated wishes about care or communication.

elicit the patient preference

documented plan

Agreed next steps recorded for the people involved.

review the documented plan

drug interaction

Effect of one medicine or substance on another's action.

check for a drug interaction

bleeding history

Account of previous bleeding events and related circumstances.

clarify the bleeding history

anticoagulation review

Clinical reassessment of anticoagulant use and relevant risks.

arrange an anticoagulation review

teach-back

Checking an explanation by inviting the listener to restate its meaning.

use teach-back without blame

clinical handoff

Transfer of relevant care information and responsibility between professionals.

confirm the clinical handoff

source attribution

Identification of who reported, observed, or established a fact.

preserve source attribution

Say it in context

Stress the highlighted expression. Keep the surrounding words connected; pause at the end of the phrase.

left atrial appendage LEFT ATRIAL APPENDAGE

explain the left atrial appendage

Keep the meaning precise: Pouch-like structure attached to the left atrium.

individual risk estimate INDIVIDUAL RISK ESTIMATE

explain an individual risk estimate

Keep the meaning precise: Context-dependent estimate for a person's likelihood of an outcome.

Phrases that move the work forward

Separate the goals

Calming symptoms and preventing stroke are related but different goals.

Keep assessment individual

We need to assess your stroke and bleeding risks in context.

Clarify a colloquial term

Blood thinner can refer to medicines with different actions.

Explore the history

Tell me about any previous bleeding and the circumstances.

Avery / in the conversation

Why are we still discussing stroke prevention as though nothing has changed?

Avery / in the conversation

I assumed that if I felt fewer episodes, the risk question would disappear with the symptoms.

Avery / in the conversation

Please explain the terms rate control and rhythm control.

Dr Patel / in the conversation

Rate control concerns the heart rate; rhythm control concerns the rhythm itself.

Acknowledge improvement

It is useful to hear that the heartbeat feels calmer.

Invite the concern

What worries you most about bleeding?

Avoid an instruction

This explanation is not a direction to stop your medicine.

Agree on review

Let us review the relevant information before settling the plan.

Dr Patel / in the conversation

With atrial fibrillation, symptom improvement and stroke prevention are related but different parts of care.

Dr Patel / in the conversation

Feeling better is valuable, but stroke risk cannot be judged from how noticeable the heartbeat feels alone.

Avery / in the conversation

They sound as though they mean exactly the same thing.

Dr Patel / in the conversation

Neither phrase alone settles the prevention decision.

Precision in real exchanges

Purpose: Invite the concern

Useful wording: What worries you most about bleeding?

Purpose: Clarify a colloquial term

Useful wording: Blood thinner can refer to medicines with different actions.

D Choose the response that fits

Choose one response for each situation. Preserve the facts, the decision boundary, and the purpose of the exchange.

1. Which distinction is correct?

- A.** Rhythm or symptom control does not replace the stroke-prevention assessment.
- B.** Calmer symptoms prove stroke risk is zero.
- C.** Every medicine has the same action.
- D.** A procedure automatically settles all future risk decisions.

2. Which question includes Avery's concern?

- A.** What previous bleeding have you experienced, and what worries you?
- B.** Why are you being difficult about risk?
- C.** Can we ignore bleeding?
- D.** You agree there can be no harm?

3. A colleague needs the term for this meaning: Strategy aimed at restoring or maintaining an appropriate rhythm. Which term fits?

- A.** rhythm control
- B.** thromboembolism
- C.** shared treatment decision
- D.** patient preference

D Choose the response that fits / continued

4. Rebuild the exchange from "The rhythm question and the stroke question". Avery: "Please explain the terms rate control and rhythm control. They sound as though they mean exactly the same thing." Dr Patel: [missing response] Avery: "I would like the bleeding concern discussed as carefully as the benefit, not treated as a reason to stop asking." Which response belongs in the gap?

- A.** Yes. Anticoagulation and antiplatelet treatment have different actions. We should use the actual medicine name and purpose.
- B.** Feeling better is valuable, but stroke risk cannot be judged from how noticeable the heartbeat feels alone.
- C.** Rate control concerns the heart rate; rhythm control concerns the rhythm itself. Neither phrase alone settles the prevention decision.
- D.** Tell me what happened and when. Your bleeding history deserves a careful account rather than an unexplained yes-or-no label.

[Answers and explanations, page 121](#)

One useful distinction

Feeling fewer palpitations does not, by itself, settle the stroke-prevention decision. Do not derive an instruction to start or stop a medicine from this language exercise.

E Conversation

The rhythm question and the stroke question

The rhythm question and the stroke question

Complete the numbered gaps. Use each bank entry once; some entries contain several words.

WORD AND PHRASE BANK

bleeding risk / individual risk estimate / drug interaction / Rate control /
anticoagulation review / bleeding history / stroke risk / shared treatment decision /
Anticoagulation / atrial fibrillation

- 01 **Avery:** My heartbeat feels calmer now. Why are we still discussing stroke prevention as though nothing has changed?
- 02 **Dr Patel:** With ¹ _____, symptom improvement and stroke prevention are related but different parts of care.
- 03 **Avery:** I assumed that if I felt fewer episodes, the risk question would disappear with the symptoms.
- 04 **Dr Patel:** Feeling better is valuable, but ² _____ cannot be judged from how noticeable the heartbeat feels alone.
- 05 **Avery:** Please explain the terms rate control and rhythm control. They sound as though they mean exactly the same thing.
- 06 **Dr Patel:** ³ _____ concerns the heart rate; rhythm control concerns the rhythm itself. Neither phrase alone settles the prevention decision.
- 07 **Avery:** I would like the bleeding concern discussed as carefully as the benefit, not treated as a reason to stop asking.
- 08 **Dr Patel:** We should assess ⁴ _____ and your concerns alongside the possible benefit of a proposed option.
- 09 **Avery:** I have called all these medicines blood thinners, but perhaps that hides an important difference.
- 10 **Dr Patel:** Yes. ⁵ _____ and antiplatelet treatment have different actions. We should use the actual medicine name and purpose.

Conversation continues on the next page.

The rhythm question and the stroke question

CONVERSATION / CONTINUED

- 11 **Avery:** I had bleeding in the past, but I am not sure which details are relevant for this discussion.
- 12 **Dr Patel:** Tell me what happened and when. Your ⁶ _____ deserves a careful account rather than an unexplained yes-or-no label.
- 13 **Avery:** Will other medicines and health conditions also affect how you judge the options for me?
- 14 **Dr Patel:** Yes. A ⁷ _____, kidney function, and other relevant factors may need review in the actual assessment.
- 15 **Avery:** Then a general chart online cannot tell me precisely which treatment I should take or at what dose.
- 16 **Dr Patel:** Correct. An ⁸ _____ needs your full history. We will review that together before discussing what the result means for you.
- 17 **Avery:** I also want to understand what matters most to me in choosing among appropriate options.
- 18 **Dr Patel:** That belongs in a ⁹ _____, with accurate information about benefits, harms, and practical demands.
- 19 **Avery:** I understand this explanation does not mean I should stop a medicine because I feel better.
- 20 **Dr Patel:** Exactly. Any change requires the appropriate ¹⁰ _____ and an individualized plan from your treating team.

CHECK THE GAPS

1. atrial fibrillation / 2. stroke risk / 3. Rate control / 4. bleeding risk / 5. Anticoagulation / 6. bleeding history / 7. drug interaction / 8. individual risk estimate / 9. shared treatment decision / 10. anticoagulation review

[Why these answers fit, page 122](#)

F Check accuracy and scope

The rhythm question and the stroke question

Return to the case

Avery has an established atrial-fibrillation diagnosis and asks why stroke prevention is discussed when the heartbeat feels calmer. Dr Patel will explain that symptom or rhythm management and stroke prevention address related but different questions. No risk score, medicine selection, dose, or instruction to stop treatment is supplied. Avery is worried about bleeding and wants that concern included.

Choose one answer per question. Use the case facts and keep any uncertainty or limits intact.

1. Which instruction cannot be supplied here?

- A. Stop anticoagulation because the heartbeat feels calmer.
- B. Discuss the goals separately.
- C. Clarify the medicine name.
- D. Review the bleeding history.

2. Why clarify blood thinner?

- A. It always identifies one exact product.
- B. It proves the dose.
- C. It means the blood becomes water.
- D. The informal phrase can hide different medicine actions.

[Answers and explanations, page 124](#)

Listen for the distinction

Swap roles. Repeat the bleeding-history question and the explicit boundary against inferring a medicine change.

Explain why two goals remain on the agenda

Feeling better can be mistaken for proof that every risk has disappeared. Acknowledge the improvement while explaining the separate question and taking bleeding concerns seriously.

F Say it / transfer to a new case

Clarify which medicine is meant

Nico says blood thinner but cannot recall the product. The clinician will verify its name and purpose before discussing a change. No stop instruction has been given.

Complete the four gaps. With a partner, read alternate roles, then switch. Studying alone, read both roles and pause before each response.

WORD AND PHRASE BANK

given / purpose / review / name

- 01 **Nico:** I do not recall the product ¹ _____.
- 02 **Clinician:** We will verify its name and ² _____.
- 03 **Nico:** No stop instruction has been ³ _____.
- 04 **Clinician:** A change needs individual ⁴ _____.

CHECK THE GAPS

1. name / 2. purpose / 3. given / 4. review

[Why these answers fit, page 124](#)

Rebuild the exchange

Choose the missing response. Read the completed three-turn exchange aloud, changing roles on the second reading.

1. Rebuild the exchange from "The rhythm question and the stroke question". Avery: "Will other medicines and health conditions also affect how you judge the options for me?" Dr Patel: [missing response] Avery: "Then a general chart online cannot tell me precisely which treatment I should take or at what dose." Which response belongs in the gap?

- A.** Feeling better is valuable, but stroke risk cannot be judged from how noticeable the heartbeat feels alone.
- B.** Yes. Anticoagulation and antiplatelet treatment have different actions. We should use the actual medicine name and purpose.
- C.** We should assess bleeding risk and your concerns alongside the possible benefit of a proposed option.
- D.** Yes. A drug interaction, kidney function, and other relevant factors may need review in the actual assessment.

[Answers and explanations, page 125](#)

Review 2 / Meaning and context

Use language from the lessons you have completed. Choose one answer per question.

Case file

Revisit "Explaining an echocardiogram" and "Discussing atrial-fibrillation treatment goals". Choose precise terminology, then reconstruct the missing responses using both neighboring turns. The final two questions also revisit earlier conversations.

1. A colleague needs the term for this meaning: Phase of the cardiac cycle involving ventricular contraction and ejection. Which term fits?

- A. preserved ejection fraction
- B. structural heart disease
- C. teach-back
- D. systole

2. A colleague needs the term for this meaning: Likelihood of bleeding under relevant clinical circumstances. Which term fits?

- A. atrial fibrillation
- B. bleeding risk
- C. qualified interpreter
- D. renal function

3. Rebuild the exchange from "A symptom marker is not a diagnosis". Ellis: "And pressing a marker does not mean the device has instantly told me what caused the sensation?" Dr Mora: [missing response] Ellis: "I am worried I will wear it and nothing will happen during the recording period." Which response belongs in the gap?

- A. That is a possible limitation. We are seeking symptom-rhythm correlation, and the available recording may not capture every intermittent event.
- B. The service will explain the device. A symptom diary should include the time, what you feel, and what you are doing.
- C. We will confirm the monitor return process and the service's review arrangements, without promising a result the data may not establish.
- D. Correct. The event marker identifies a time to review; it is not itself a diagnosis or a promise of real-time assessment.

Review 2 / Meaning and context / continued

4. Rebuild the exchange from "The rhythm question and the stroke question". Avery: "I also want to understand what matters most to me in choosing among appropriate options." Dr Patel: [missing response] Avery: "I understand this explanation does not mean I should stop a medicine because I feel better." Which response belongs in the gap?

- A.** With atrial fibrillation, symptom improvement and stroke prevention are related but different parts of care.
- B.** Exactly. Any change requires the appropriate anticoagulation review and an individualized plan from your treating team.
- C.** We should assess bleeding risk and your concerns alongside the possible benefit of a proposed option.
- D.** That belongs in a shared treatment decision, with accurate information about benefits, harms, and practical demands.

[Answers and explanations, page 148](#)

A Read the situation

LESSON 05 / DISCUSSING CORONARY ANGIOGRAPHY CONSENT

Explain a proposed procedure and clarify what has and has not been agreed.

A diagnostic test is not automatic treatment

Dr Lewis discusses proposed diagnostic coronary angiography with Blair. Blair assumes a stent will definitely be inserted during the same visit. The exercise supplies no coronary anatomy, intervention decision, risk percentage, or preparation instructions. Dr Lewis must explain the diagnostic purpose, address questions, and clarify the actual consent arrangements for any possible intervention rather than treat attendance as agreement.

People: Blair, Patient; Dr Lewis, Cardiologist.

Read the record

Choose one answer per question using the facts above.

1. What is proposed?

- A.** A guaranteed normal result
- B.** Diagnostic coronary angiography
- C.** A stent already selected
- D.** Surgery already completed

2. What does Blair assume?

- A.** A result already exists
- B.** The appointment is a rehabilitation session
- C.** A stent will definitely be inserted
- D.** No procedure is proposed

3. What is not supplied?

- A.** A patient question
- B.** A consent discussion
- C.** The diagnostic purpose
- D.** Coronary anatomy or an intervention decision

[Answers and explanations, page 126](#)

B Vocabulary in use

CORE TERMS

coronary angiography

Imaging of coronary arteries using an appropriate angiographic technique.

explain coronary angiography

catheter laboratory

Specialist environment for catheter-based cardiac procedures.

attend the catheter laboratory

radial access

Vessel access through the radial artery.

discuss radial access

contrast medium

Substance used to improve visibility of structures on imaging.

explain contrast medium

coronary narrowing

Reduction in the internal opening of a coronary artery.

evaluate coronary narrowing

stent

Device placed to help maintain an opening in a vessel or structure.

explain a coronary stent

cardiac catheterization

Procedure using a catheter to investigate or treat cardiac conditions.

discuss cardiac catheterization

vascular access

Route of entry into a blood vessel for a procedure.

explain vascular access

femoral access

Vessel access through the femoral artery.

discuss femoral access

coronary anatomy

Arrangement and features of the coronary arteries.

assess coronary anatomy

percutaneous coronary intervention

Catheter-based procedure used to treat appropriate coronary artery disease.

discuss percutaneous coronary intervention

diagnostic procedure

Procedure intended to obtain information about a condition.

distinguish a diagnostic procedure

Say it in context

Stress the highlighted expression. Keep the surrounding words connected; pause at the end of the phrase.

coronary angiography CORONARY ANGIOGRAPHY

explain coronary angiography

Keep the meaning precise: Imaging of coronary arteries using an appropriate angiographic technique.

femoral access FEMORAL ACCESS

discuss femoral access

Keep the meaning precise: Vessel access through the femoral artery.

B Precision and professional shorthand

EXTEND YOUR RANGE

procedural risk

Possible harm associated with a procedure.

discuss procedural risk

procedure consent

Agreement to a specified procedure after appropriate discussion.

confirm procedure consent

postprocedure observation

Monitoring after a procedure under the actual care plan.

explain postprocedure observation

qualified interpreter

Trained language professional supporting accurate communication between speakers.

request a qualified interpreter

patient preference

A person's stated wishes about care or communication.

elicit the patient preference

documented plan

Agreed next steps recorded for the people involved.

review the documented plan

sedation

Medicines used to reduce awareness, anxiety, or discomfort to an intended degree.

explain the sedation plan

access-site complication

Problem occurring at the vessel-entry location.

explain access-site complications

preparation instruction

Direction needed before a procedure for the individual plan.

verify preparation instructions

teach-back

Checking an explanation by inviting the listener to restate its meaning.

use teach-back without blame

clinical handoff

Transfer of relevant care information and responsibility between professionals.

confirm the clinical handoff

source attribution

Identification of who reported, observed, or established a fact.

preserve source attribution

Say it in context

Stress the highlighted expression. Keep the surrounding words connected; pause at the end of the phrase.

diagnostic procedure DIAGNOSTIC PROCEDURE

distinguish a diagnostic procedure

Keep the meaning precise: Procedure intended to obtain information about a condition.

postprocedure observation POSTPROCEDURE OBSERVATION

explain postprocedure observation

Keep the meaning precise: Monitoring after a procedure under the actual care plan.

Phrases that move the work forward

Check expectations

What have you understood will happen during the visit?

Separate treatment

A diagnostic test is not an automatic decision to insert a stent.

Discuss risk accurately

We will explain the risks relevant to the actual procedure and your situation.

Verify preparation

Use the instructions from the team doing your procedure.

Blair / in the conversation

I told my family I am coming in to have a stent.

Dr Lewis / in the conversation

We are discussing coronary angiography, a diagnostic investigation.

Blair / in the conversation

I thought the test and the treatment were simply two names for what always happens together.

Blair / in the conversation

Then the purpose is to understand the arteries, rather than promise that a particular device will be inserted?

State the diagnostic aim

The proposed test is intended to show the coronary arteries.

Clarify the agreement

We need to discuss exactly what you are consenting to.

Invite alternatives

Please ask about reasonable alternatives and what they would establish.

Keep the decision open

No intervention decision is supplied by this conversation alone.

Blair / in the conversation

Is that the right description of the appointment?

Dr Lewis / in the conversation

Let us clarify the difference before you make arrangements around an assumption.

Dr Lewis / in the conversation

Treatment may be discussed in relation to findings, but it is not automatic.

Dr Lewis / in the conversation

We need to explain how any findings would affect the options before you agree to proceed.

Precision in real exchanges

Purpose: Clarify the agreement

Useful wording: We need to discuss exactly what you are consenting to.

Purpose: Discuss risk accurately

Useful wording: We will explain the risks relevant to the actual procedure and your situation.

D Choose the response that fits

Choose one response for each situation. Preserve the facts, the decision boundary, and the purpose of the exchange.

1. Which distinction is essential?

- A.** Every angiogram includes a stent.
- B.** Attendance is consent to any procedure.
- C.** The anatomy is known before investigation.
- D.** Diagnostic angiography does not automatically mean stent insertion.

2. Which instruction would be inappropriate to invent?

- A.** An explanation that anatomy is not supplied
- B.** A medication-holding schedule
- C.** A request to clarify consent
- D.** A question about expectations

3. A colleague needs the term for this meaning: Route of entry into a blood vessel for a procedure. Which term fits?

- A.** coronary narrowing
- B.** patient preference
- C.** vascular access
- D.** procedure consent

D Choose the response that fits / continued

4. Rebuild the exchange from "A diagnostic test is not automatic treatment". Blair: "Then the purpose is to understand the arteries, rather than promise that a particular device will be inserted?" Dr Lewis: [missing response] Blair: "Please explain the phrase PCI if it comes up. I hear abbreviations and lose track of which action is meant." Which response belongs in the gap?

- A.** Good. We will also explain postprocedure observation and practical arrangements, without promising an outcome or discharge time we have not established.
- B.** Yes. It helps assess coronary anatomy. We need to explain how any findings would affect the options before you agree to proceed.
- C.** That is why we clarify scope. A stent is not something we should describe as already decided when it has not been.
- D.** The team will discuss the actual vascular access plan and its implications with you. Do not infer your plan from another person's experience.

[Answers and explanations, page 126](#)

One useful distinction

Diagnostic angiography and coronary intervention are different actions. Possible same-session treatment must be explained within the actual plan and consent process; it is not automatic.

Conversation

A diagnostic test is not automatic treatment

A diagnostic test is not automatic treatment

Complete the numbered gaps. Use each bank entry once; some entries contain several words.

WORD AND PHRASE BANK

coronary angiography / procedure consent / preparation instructions / coronary anatomy /
Percutaneous coronary intervention / diagnostic procedure / stent / vascular access /
postprocedure observation / contrast medium

- 01 **Blair:** I told my family I am coming in to have a stent. Is that the right description of the appointment?
- 02 **Dr Lewis:** We are discussing ¹ _____, a diagnostic investigation. Let us clarify the difference before you make arrangements around an assumption.
- 03 **Blair:** I thought the test and the treatment were simply two names for what always happens together.
- 04 **Dr Lewis:** A ² _____ gathers information. Treatment may be discussed in relation to findings, but it is not automatic.
- 05 **Blair:** Then the purpose is to understand the arteries, rather than promise that a particular device will be inserted?
- 06 **Dr Lewis:** Yes. It helps assess ³ _____. We need to explain how any findings would affect the options before you agree to proceed.
- 07 **Blair:** Please explain the phrase PCI if it comes up. I hear abbreviations and lose track of which action is meant.
- 08 **Dr Lewis:** ⁴ _____ is a catheter-based treatment approach. We should explain the actual proposal rather than hide it behind initials.
- 09 **Blair:** What would the consent discussion need to cover if treatment during the same visit were a possibility?
- 10 **Dr Lewis:** The ⁵ _____ must be clear about the proposed actions, alternatives, relevant risks, and your questions.

Conversation continues on the next page.

A diagnostic test is not automatic treatment

CONVERSATION / CONTINUED

- 11 **Blair:** I do not want signing for a test to be treated as agreement to something nobody has explained.
- 12 **Dr Lewis:** That is why we clarify scope. A ⁶ _____ is not something we should describe as already decided when it has not been.
- 13 **Blair:** I have read different stories about the wrist and groin. Should I choose from those accounts myself?
- 14 **Dr Lewis:** The team will discuss the actual ⁷ _____ plan and its implications with you. Do not infer your plan from another person's experience.
- 15 **Blair:** I also want to ask about the dye and any concerns in my own medical history.
- 16 **Dr Lewis:** We should review those concerns when explaining the ⁸ _____ and the procedure's risks in your individual circumstances.
- 17 **Blair:** Should I follow preparation advice I found online while I wait for the written instructions?
- 18 **Dr Lewis:** Follow the team's ⁹ _____. If another source gives different fasting or medicine advice, please contact us to clarify it before making a change.
- 19 **Blair:** I can explain the visit more accurately now: a diagnostic discussion, with any intervention requiring clarity.
- 20 **Dr Lewis:** Good. We will also explain ¹⁰ _____ and practical arrangements, without promising an outcome or discharge time we have not established.

CHECK THE GAPS

1. coronary angiography / 2. diagnostic procedure / 3. coronary anatomy / 4. Percutaneous coronary intervention / 5. procedure consent / 6. stent / 7. vascular access / 8. contrast medium / 9. preparation instructions / 10. postprocedure observation

[Why these answers fit, page 127](#)

F Check accuracy and scope

A diagnostic test is not automatic treatment

Return to the case

Dr Lewis discusses proposed diagnostic coronary angiography with Blair. Blair assumes a stent will definitely be inserted during the same visit. The exercise supplies no coronary anatomy, intervention decision, risk percentage, or preparation instructions. Dr Lewis must explain the diagnostic purpose, address questions, and clarify the actual consent arrangements for any possible intervention rather than treat attendance as agreement.

Choose one answer per question. Use the case facts and keep any uncertainty or limits intact.

1. What does informed agreement require here?

- A. A promise of zero risk
- B. A clear discussion of the specified procedure and relevant options
- C. A signature without explanation
- D. An assumption based on appointment attendance

2. Which statement preserves the facts?

- A. No intervention decision is established in this case.
- B. A stent is definitely needed.
- C. Every artery is normal.
- D. A risk percentage has been supplied.

[Answers and explanations, page 129](#)

Listen for the distinction

Swap roles. Repeat the consent-scope question and the instruction to use the actual team's preparation advice.

Explain before asking for agreement

A familiar procedure name may hide different expectations. Ask what the patient thinks will happen, then clarify the intended test and any separately discussed intervention.

F Say it / transfer to a new case

A preparation sheet needs clarification

Morgan receives two different preparation sheets. The procedural team will verify which applies. Morgan has not been told to alter medicines in this scenario.

Complete the four gaps. With a partner, read alternate roles, then switch. Studying alone, read both roles and pause before each response.

WORD AND PHRASE BANK

instructions / authorized / verify / clarified

- 01 **Morgan:** The two sheets give different ¹ _____.
- 02 **Clinician:** The procedural team will ² _____ which applies.
- 03 **Morgan:** No medicine change is ³ _____ here.
- 04 **Clinician:** The correct plan is not yet ⁴ _____.

CHECK THE GAPS

1. instructions / 2. verify / 3. authorized / 4. clarified

[Why these answers fit, page 129](#)

Rebuild the exchange

Choose the missing response. Read the completed three-turn exchange aloud, changing roles on the second reading.

1. Rebuild the exchange from "A diagnostic test is not automatic treatment". Blair: "I have read different stories about the wrist and groin. Should I choose from those accounts myself?" Dr Lewis: [missing response] Blair: "I also want to ask about the dye and any concerns in my own medical history." Which response belongs in the gap?

- A.** Follow the team's preparation instructions. If another source gives different fasting or medicine advice, please contact us to clarify it before making a change.
- B.** That is why we clarify scope. A stent is not something we should describe as already decided when it has not been.
- C.** Yes. It helps assess coronary anatomy. We need to explain how any findings would affect the options before you agree to proceed.
- D.** The team will discuss the actual vascular access plan and its implications with you. Do not infer your plan from another person's experience.

[Answers and explanations, page 130](#)

A Read the situation

LESSON 06 / CHECKING A HEART-FAILURE HOME PLAN

Check understanding of an individualized plan without treating a printed sheet as proof of comprehension.

Teach-back checks the explanation

Dr Evans reviews an individualized heart-failure plan with Lee. The actual plan includes symptom monitoring, a verified medicine list, contact routes, and follow-up. No weight threshold, fluid limit, or dose adjustment is supplied here. Lee has received the sheet but is unclear which number is for routine questions and which route is for urgent concerns. The clinician must clarify the distinction and use teach-back without blame.

People: Dr Evans, Cardiologist; Lee, Patient.

Read the record

Choose one answer per question using the facts above.

1. What has Lee received?

- A. A supplied dose-adjustment rule
- B. A universal fluid limit
- C. A completed follow-up visit
- D. A written individualized plan

2. What is unclear?

- A. Whether Dr Evans is reviewing it
- B. Whether follow-up exists
- C. Routine versus urgent contact routes
- D. Whether Lee has a plan

3. What does teach-back check?

- A. A diagnosis without assessment
- B. The clarity of the explanation received
- C. The patient's moral character
- D. Whether questions should be prohibited

[Answers and explanations, page 131](#)

B Vocabulary in use

CORE TERMS

heart failure

Clinical syndrome in which cardiac dysfunction causes symptoms and signs in context.

explain heart failure

edema

Swelling caused by fluid in tissues.

describe peripheral edema

paroxysmal nocturnal dyspnea

Episodes of breathlessness waking a person from sleep.

clarify nocturnal dyspnea

daily weight record

Log of body-weight measurements under an agreed monitoring plan.

review a daily weight record

fluid restriction

Individual instruction limiting fluid intake when clinically indicated.

clarify a prescribed fluid restriction

diuretic

Medicine increasing urine production.

explain a prescribed diuretic

congestion

Fluid accumulation associated with relevant circulatory dysfunction.

assess congestion

orthopnea

Breathlessness occurring when lying flat.

ask about orthopnea

exercise tolerance

Ability to perform physical activity without limiting symptoms.

describe exercise tolerance

fluid balance

Relationship between fluid intake, output, and retention.

assess fluid balance

sodium intake

Amount of sodium consumed through food and drink.

discuss sodium intake

guideline-directed therapy

Treatment consistent with applicable evidence-based recommendations and individual circumstances.

review guideline-directed therapy

Say it in context

Stress the highlighted expression. Keep the surrounding words connected; pause at the end of the phrase.

heart failure **HEART FAILURE**

explain heart failure

Keep the meaning precise: Clinical syndrome in which cardiac dysfunction causes symptoms and signs in context.

exercise tolerance **EXERCISE TOLERANCE**

describe exercise tolerance

Keep the meaning precise: Ability to perform physical activity without limiting symptoms.

B Precision and professional shorthand

EXTEND YOUR RANGE

decompensation

Worsening of a condition beyond its compensated state.

assess suspected decompensation

contact pathway

Defined route for reaching the appropriate care service.

distinguish contact pathways

follow-up interval

Planned time between reviews in the individual's care.

confirm the follow-up interval

qualified interpreter

Trained language professional supporting accurate communication between speakers.

request a qualified interpreter

patient preference

A person's stated wishes about care or communication.

elicit the patient preference

action plan

Individualized instructions about monitoring and responding to changes.

review the action plan

self-monitoring

Person's observation or recording of agreed health information.

explain self-monitoring

care-plan discrepancy

Difference between versions or understandings of the intended care plan.

resolve a care-plan discrepancy

teach-back

Checking an explanation by inviting the listener to restate its meaning.

use teach-back without blame

clinical handoff

Transfer of relevant care information and responsibility between professionals.

confirm the clinical handoff

B Precision and professional shorthand / continued

documented plan

Agreed next steps recorded for the people involved.

review the documented plan

source attribution

Identification of who reported, observed, or established a fact.

preserve source attribution

Say it in context

Stress the highlighted expression. Keep the surrounding words connected; pause at the end of the phrase.

guideline-directed therapy **GUIDELINE-DIRECTED THERAPY**

review guideline-directed therapy

Keep the meaning precise: Treatment consistent with applicable evidence-based recommendations and individual circumstances.

follow-up interval **FOLLOW-UP INTERVAL**

confirm the follow-up interval

Keep the meaning precise: Planned time between reviews in the individual's care.

Phrases that move the work forward

Check the explanation

I want to check that I explained the two routes clearly.

Remove blame

That tells me I need to explain the distinction differently.

Separate routes

A routine message is not the same as urgent clinical contact.

Resolve a mismatch

These two versions need checking before you rely on them.

Dr Evans / in the conversation

Before you leave, let us check how clearly I explained its different parts.

Dr Evans / in the conversation

Tell me which part is unclear, and we can work through that distinction.

Dr Evans / in the conversation

We need to make that explicit using your actual instructions.

Lee / in the conversation

I also want to understand what I am observing, not just copy numbers into a daily weight record.

Invite teach-back

Using your plan, tell me which route you would use for each listed situation.

Keep it individual

The thresholds and instructions must be the ones agreed for you.

Verify the list

Let us confirm which medicine list is current.

Close with clarity

Please show me where the next review and contact details are recorded.

Lee / in the conversation

I have read the action plan, but the contact numbers still confuse me.

Lee / in the conversation

I cannot tell which contact pathway is for ordinary questions and which is for something requiring urgent help.

Dr Evans / in the conversation

A routine message is not the urgent-care route.

Dr Evans / in the conversation

We will explain the monitoring purpose and the instructions agreed for you.

Precision in real exchanges

Purpose: Keep it individual

Useful wording: The thresholds and instructions must be the ones agreed for you.

Purpose: Separate routes

Useful wording: A routine message is not the same as urgent clinical contact.

D Choose the response that fits

Choose one response for each situation. Preserve the facts, the decision boundary, and the purpose of the exchange.

1. Which teach-back request is best?

- A.** Stop asking because it is printed.
- B.** Using your plan, explain which contact route applies to each listed situation.
- C.** You understand everything, yes?
- D.** Prove you memorized the whole sheet.

2. Which response avoids blame?

- A.** The sheet cannot be unclear.
- B.** Your question proves you do not care.
- C.** I need to explain that distinction differently.
- D.** You are bad at following instructions.

3. A colleague needs the term for this meaning: Breathlessness occurring when lying flat. Which term fits?

- A.** orthopnea
- B.** patient preference
- C.** fluid restriction
- D.** contact pathway

D Choose the response that fits / continued

4. Rebuild the exchange from "Teach-back checks the explanation". Dr Evans: "We need to make that explicit using your actual instructions. A routine message is not the urgent-care route." Lee: [missing response] Dr Evans: "We will explain the monitoring purpose and the instructions agreed for you. This discussion does not supply a universal threshold." Which response belongs in the gap?

- A.** I appreciate that. Some symptoms, such as breathlessness when lying flat, are hard to describe with the usual shorthand.
- B.** The medicine sheet also needs checking. I do not want to assume an old diuretic instruction remains current.
- C.** I cannot tell which contact pathway is for ordinary questions and which is for something requiring urgent help.
- D.** I also want to understand what I am observing, not just copy numbers into a daily weight record.

[Answers and explanations, page 131](#)

One useful distinction

A written action plan does not prove understanding. Clarify the actual instructions; the lesson must not become a universal weight, fluid, or medicine-adjustment protocol.

Conversation

Teach-back checks the explanation

Teach-back checks the explanation

Complete the numbered gaps. Use each bank entry once; some entries contain several words.

WORD AND PHRASE BANK

daily weight record / follow-up interval / fluid restriction / self-monitoring / Orthopnea /
teach-back / diuretic / contact pathway / care-plan discrepancy / action plan

- 01 **Dr Evans:** You have the written plan. Before you leave, let us check how clearly I explained its different parts.
- 02 **Lee:** I have read the ¹ _____, but the contact numbers still confuse me.
- 03 **Dr Evans:** Thank you for saying so. Tell me which part is unclear, and we can work through that distinction.
- 04 **Lee:** I cannot tell which ² _____ is for ordinary questions and which is for something requiring urgent help.
- 05 **Dr Evans:** We need to make that explicit using your actual instructions. A routine message is not the urgent-care route.
- 06 **Lee:** I also want to understand what I am observing, not just copy numbers into a ³ _____.
- 07 **Dr Evans:** We will explain the monitoring purpose and the instructions agreed for you. This discussion does not supply a universal threshold.
- 08 **Lee:** Good. I have seen different advice about a ⁴ _____, and I did not know whether it applied to everyone.
- 09 **Dr Evans:** It does not automatically apply in the same way to everyone. Use the individualized instructions from your treating team.
- 10 **Lee:** The medicine sheet also needs checking. I do not want to assume an old ⁵ _____ instruction remains current.

Conversation continues on the next page.

Teach-back checks the explanation

CONVERSATION / CONTINUED

- 11 **Dr Evans:** Exactly. We will verify the current list rather than let two different versions sit beside each other unexplained.
- 12 **Lee:** That sounds like a ⁶ _____ we should resolve before I use the sheet at home.
- 13 **Dr Evans:** Yes. Now, using the corrected plan, explain how you would choose the contact route for each situation it lists.
- 14 **Lee:** I can use the written information for that ⁷ _____ plan rather than guessing which changes matter.
- 15 **Dr Evans:** Correct. This ⁸ _____ checks my explanation. A misunderstanding tells me to explain differently, not to blame you.
- 16 **Lee:** I appreciate that. Some symptoms, such as breathlessness when lying flat, are hard to describe with the usual shorthand.
- 17 **Dr Evans:** We can use plain words. ⁹ _____ is the clinical term for that symptom, but your own description remains important.
- 18 **Lee:** I also need to know when the next review is and who answers questions before it.
- 19 **Dr Evans:** We will confirm the ¹⁰ _____ and the relevant contact details in the actual plan.
- 20 **Lee:** Then I can describe the monitoring, medicines, and contact routes separately instead of treating the page as one long instruction.

CHECK THE GAPS

1. action plan / 2. contact pathway / 3. daily weight record / 4. fluid restriction / 5. diuretic / 6. care-plan discrepancy / 7. self-monitoring / 8. teach-back / 9. Orthopnea / 10. follow-up interval

[Why these answers fit, page 132](#)

F Check accuracy and scope

Teach-back checks the explanation

Return to the case

Dr Evans reviews an individualized heart-failure plan with Lee. The actual plan includes symptom monitoring, a verified medicine list, contact routes, and follow-up. No weight threshold, fluid limit, or dose adjustment is supplied here. Lee has received the sheet but is unclear which number is for routine questions and which route is for urgent concerns. The clinician must clarify the distinction and use teach-back without blame.

Choose one answer per question. Use the case facts and keep any uncertainty or limits intact.

1. What must not be invented?

- A.** A universal dose-adjustment threshold
- B.** A request to verify the plan
- C.** A distinction between contact routes
- D.** A next review question

2. What does receipt of the sheet establish?

- A.** Completed follow-up
- B.** An unchanged condition forever
- C.** That Lee has the sheet, not that every instruction is understood
- D.** Complete comprehension

[Answers and explanations, page 134](#)

Listen for the distinction

Swap roles. Repeat the teach-back request and the non-blaming clarification without adding clinical thresholds.

Ask the patient to explain the plan, not perform obedience

Teach-back evaluates the clarity of the explanation. A misunderstanding is an opportunity to explain differently, not evidence of poor intelligence or unwillingness.

F Say it / transfer to a new case

Two versions of a plan

Kai has an old medicine list and a newly printed plan. Their instructions differ. Nurse Jo will obtain clinician verification. No adjustment is authorized by this exercise.

Complete the four gaps. With a partner, read alternate roles, then switch. Studying alone, read both roles and pause before each response.

WORD AND PHRASE BANK

differ / adjustment / clarified / verification

- 01 **Kai:** The instructions on the two versions ¹ _____.
- 02 **Jo:** We need clinician ² _____.
- 03 **Kai:** This exercise authorizes no medicine ³ _____.
- 04 **Jo:** The current plan remains to be ⁴ _____.

CHECK THE GAPS

1. differ / 2. verification / 3. adjustment / 4. clarified

[Why these answers fit, page 134](#)

Rebuild the exchange

Choose the missing response. Read the completed three-turn exchange aloud, changing roles on the second reading.

1. Rebuild the exchange from "Teach-back checks the explanation". Dr Evans: "Yes. Now, using the corrected plan, explain how you would choose the contact route for each situation it lists." Lee: [missing response] Dr Evans: "Correct. This teach-back checks my explanation. A misunderstanding tells me to explain differently, not to blame you." Which response belongs in the gap?

- A.** I cannot tell which contact pathway is for ordinary questions and which is for something requiring urgent help.
- B.** I can use the written information for that self-monitoring plan rather than guessing which changes matter.
- C.** I also need to know when the next review is and who answers questions before it.
- D.** That sounds like a care-plan discrepancy we should resolve before I use the sheet at home.

[Answers and explanations, page 135](#)

Review 3 / Meaning and context

Use language from the lessons you have completed. Choose one answer per question.

Case file

Revisit "Discussing coronary angiography consent" and "Checking a heart-failure home plan". Choose precise terminology, then reconstruct the missing responses using both neighboring turns. The final two questions also revisit earlier conversations.

1. A colleague needs the term for this meaning: Specialist environment for catheter-based cardiac procedures. Which term fits?

- A. catheter laboratory
- B. sedation
- C. teach-back
- D. coronary anatomy

2. A colleague needs the term for this meaning: Relationship between fluid intake, output, and retention. Which term fits?

- A. fluid balance
- B. decompensation
- C. heart failure
- D. qualified interpreter

3. Rebuild the exchange from "The rhythm question and the stroke question". Avery: "I have called all these medicines blood thinners, but perhaps that hides an important difference." Dr Patel: [missing response] Avery: "I had bleeding in the past, but I am not sure which details are relevant for this discussion." Which response belongs in the gap?

- A. Yes. Anticoagulation and antiplatelet treatment have different actions. We should use the actual medicine name and purpose.
- B. Yes. A drug interaction, kidney function, and other relevant factors may need review in the actual assessment.
- C. We should assess bleeding risk and your concerns alongside the possible benefit of a proposed option.
- D. Feeling better is valuable, but stroke risk cannot be judged from how noticeable the heartbeat feels alone.

Review 3 / Meaning and context / continued

4. Rebuild the exchange from "Teach-back checks the explanation". Lee: "I appreciate that. Some symptoms, such as breathlessness when lying flat, are hard to describe with the usual shorthand." Dr Evans: [missing response] Lee: "I also need to know when the next review is and who answers questions before it." Which response belongs in the gap?

- A.** Yes. Now, using the corrected plan, explain how you would choose the contact route for each situation it lists.
- B.** It does not automatically apply in the same way to everyone. Use the individualized instructions from your treating team.
- C.** We can use plain words. Orthopnea is the clinical term for that symptom, but your own description remains important.
- D.** Thank you for saying so. Tell me which part is unclear, and we can work through that distinction.

[Answers and explanations, page 150](#)

A Read the situation

LESSON 07 / EXPLAINING ABSOLUTE AND RELATIVE RISK

Translate a relative change into comparable absolute frequencies without turning group data into a personal guarantee.

Twenty-five percent of what?

For arithmetic practice only, a fictional comparison describes 40 events among 1,000 people without an intervention and 30 among 1,000 with it over the same five-year period. These are not real treatment estimates or a recommendation. Dr Ali explains the ten-event difference, the one-percentage-point absolute reduction, and the 25 percent relative reduction to Robin. No individual risk estimate is supplied.

People: Robin, Patient in a fictional numerical exercise; Dr Ali, Cardiologist.

Read the record

Choose one answer per question using the facts above.

1. How many events occur in the fictional comparison group?

- A. 10 per 10
- B. 40 per 1,000
- C. 30 per 100
- D. 25 per 100

2. How many events occur in the intervention group?

- A. 40 per 100
- B. 1 per 1,000
- C. 25 per 1,000
- D. 30 per 1,000

3. What is the common time period?

- A. An unspecified lifetime
- B. Five years
- C. One day
- D. Ten years

[Answers and explanations, page 136](#)

B Vocabulary in use

CORE TERMS

absolute risk

Probability of a defined outcome over a stated time in a specified group.

communicate absolute risk

absolute risk reduction

Difference between comparison and intervention risks.

explain absolute risk reduction

percentage point

Unit for the arithmetic difference between two percentages.

distinguish percentage points

natural frequency

Count expressed out of a stated group size.

use natural frequencies

comparison group

Group providing a reference for evaluating another group.

identify the comparison group

event rate

Frequency of specified events in a defined group or observation period.

compare event rates

relative risk

Ratio of risk in one group to risk in a comparison group.

calculate relative risk

relative risk reduction

Absolute reduction divided by the comparison risk.

explain relative risk reduction

denominator

Total number underlying a proportion or rate.

state the denominator

time horizon

Period over which an outcome probability is described.

specify the time horizon

intervention group

Group receiving the approach being evaluated.

describe the intervention group

baseline risk

Risk before or without the evaluated change in the relevant comparison.

explain baseline risk

Say it in context

Stress the highlighted expression. Keep the surrounding words connected; pause at the end of the phrase.

absolute risk **ABSOLUTE RISK**

communicate absolute risk

Keep the meaning precise: Probability of a defined outcome over a stated time in a specified group.

denominator **DENOMINATOR**

state the denominator

Keep the meaning precise: Total number underlying a proportion or rate.

B Precision and professional shorthand

EXTEND YOUR RANGE

confidence interval

Range expressing statistical uncertainty around an estimate under its assumptions.

interpret a confidence interval

population estimate

Estimate describing a defined group rather than a guaranteed individual outcome.

interpret a population estimate

benefit framing

Way of presenting a possible favorable outcome or reduction in harm.

balance benefit framing

qualified interpreter

Trained language professional supporting accurate communication between speakers.

request a qualified interpreter

patient preference

A person's stated wishes about care or communication.

elicit the patient preference

documented plan

Agreed next steps recorded for the people involved.

review the documented plan

number needed to treat

Reciprocal of absolute risk reduction for a defined outcome and period.

qualify number needed to treat

risk communication

Explanation of probabilities, uncertainty, and possible consequences.

improve risk communication

uncertainty range

Range communicating limits of an estimate's precision or applicability.

explain the uncertainty range

teach-back

Checking an explanation by inviting the listener to restate its meaning.

use teach-back without blame

clinical handoff

Transfer of relevant care information and responsibility between professionals.

confirm the clinical handoff

source attribution

Identification of who reported, observed, or established a fact.

preserve source attribution

Say it in context

Stress the highlighted expression. Keep the surrounding words connected; pause at the end of the phrase.

baseline risk BASELINE RISK

explain baseline risk

Keep the meaning precise: Risk before or without the evaluated change in the relevant comparison.

benefit framing BENEFIT FRAMING

balance benefit framing

Keep the meaning precise: Way of presenting a possible favorable outcome or reduction in harm.

Phrases that move the work forward

State the denominator

Both figures are out of one thousand people.

Use natural frequencies

The comparison is forty events versus thirty.

Name the absolute change

The absolute reduction is one percentage point.

Limit the meaning

These fictional group figures do not predict your individual outcome.

Robin / in the conversation

Does it mean twenty-five fewer people out of every hundred?

Robin / in the conversation

I follow those more easily than a headline percentage on its own.

Robin / in the conversation

Are those counted over the same period, or is one an annual number and the other a lifetime number?

Dr Ali / in the conversation

We must keep that period attached to the comparison.

Keep time consistent

Both cover the same five-year period.

Explain the difference

That is ten fewer events per thousand.

Name the relative change

Ten is one quarter of forty, so the relative reduction is twenty-five percent.

Keep uncertainty honest

No confidence interval has been supplied.

Dr Ali / in the conversation

We need the denominator and the original risk before interpreting a relative percentage.

Dr Ali / in the conversation

The natural frequencies are forty events per thousand without the intervention and thirty per thousand with it.

Dr Ali / in the conversation

The time horizon is five years for both.

Robin / in the conversation

Then the difference is ten events per thousand, rather than two hundred and fifty per thousand.

Precision in real exchanges

Purpose: Explain the difference

Useful wording: That is ten fewer events per thousand.

Purpose: Name the absolute change

Useful wording: The absolute reduction is one percentage point.

D Choose the response that fits

Choose one response for each situation. Preserve the facts, the decision boundary, and the purpose of the exchange.

1. What is the absolute difference?

- A.** 25 percentage points
- B.** 40 fewer events per 100
- C.** 10 fewer events per 1,000
- D.** 250 fewer events per 1,000

2. What is the absolute percentage-point reduction?

- A.** Seventy-five percentage points
- B.** One percentage point
- C.** Twenty-five percentage points
- D.** Ten percentage points

3. A colleague needs the term for this meaning: Absolute reduction divided by the comparison risk. Which term fits?

- A.** comparison group
- B.** relative risk reduction
- C.** patient preference
- D.** population estimate

D Choose the response that fits / continued

4. Rebuild the exchange from "Twenty-five percent of what?". Robin: "Are those counted over the same period, or is one an annual number and the other a lifetime number?" Dr Ali: [missing response] Robin: "Then the difference is ten events per thousand, rather than two hundred and fifty per thousand." Which response belongs in the gap?

- A.** The time horizon is five years for both. We must keep that period attached to the comparison.
- B.** Exactly. No confidence interval is supplied here. We should keep that limitation explicit rather than manufacture certainty.
- C.** Not in this example. We need the denominator and the original risk before interpreting a relative percentage.
- D.** The natural frequencies are forty events per thousand without the intervention and thirty per thousand with it.

[Answers and explanations, page 136](#)

One useful distinction

Forty per 1,000 is 4 percent; thirty per 1,000 is 3 percent. The difference is one percentage point, equivalent to a 25 percent relative reduction from 4 percent.

E Conversation

Twenty-five percent of what?

Twenty-five percent of what?

Complete the numbered gaps. Use each bank entry once; some entries contain several words.

WORD AND PHRASE BANK

relative risk reduction / Relative risk / absolute risk reduction / percentage point / confidence interval / time horizon / population estimate / benefit framing / denominator / natural frequencies

- 01 **Robin:** A twenty-five percent reduction sounds large. Does it mean twenty-five fewer people out of every hundred?
- 02 **Dr Ali:** Not in this example. We need the ¹ _____ and the original risk before interpreting a relative percentage.
- 03 **Robin:** Please use the counts first. I follow those more easily than a headline percentage on its own.
- 04 **Dr Ali:** The ² _____ are forty events per thousand without the intervention and thirty per thousand with it.
- 05 **Robin:** Are those counted over the same period, or is one an annual number and the other a lifetime number?
- 06 **Dr Ali:** The ³ _____ is five years for both. We must keep that period attached to the comparison.
- 07 **Robin:** Then the difference is ten events per thousand, rather than two hundred and fifty per thousand.
- 08 **Dr Ali:** Correct. The ⁴ _____ is ten per thousand, which is one percentage point.
- 09 **Robin:** I want to get the wording right: four percent compared with three percent is one percentage point apart.
- 10 **Dr Ali:** Exactly. A ⁵ _____ is the unit for subtracting percentages, not the same as a relative percent change.

Conversation continues on the next page.

Twenty-five percent of what?

CONVERSATION / CONTINUED

- 11 **Robin:** Where does twenty-five percent come from if the absolute difference is only one percentage point?
- 12 **Dr Ali:** The ⁶ _____ is ten divided by forty. The reduction is one quarter of the comparison count.
- 13 **Robin:** So the relative risk itself is thirty divided by forty, or three quarters of the comparison risk?
- 14 **Dr Ali:** Yes. ⁷ _____ is 0.75 in this illustration. The relative reduction is 0.25, or twenty-five percent. Those are different ways of describing the same comparison.
- 15 **Robin:** Could someone use only the larger-sounding relative reduction to make the option appear more impressive?
- 16 **Dr Ali:** That is why ⁸ _____ matters. Presenting the absolute figures too helps keep the size of the comparison clear.
- 17 **Robin:** I also understand that these made-up numbers cannot tell me what will happen to me personally.
- 18 **Dr Ali:** Correct. A ⁹ _____ would still need careful interpretation. These made-up figures only illustrate the arithmetic; they are not a prediction for you.
- 19 **Robin:** And we should not add a precision range unless the source actually supplies one and explains it.
- 20 **Dr Ali:** Exactly. No ¹⁰ _____ is supplied here. We should keep that limitation explicit rather than manufacture certainty.

CHECK THE GAPS

1. denominator / 2. natural frequencies / 3. time horizon / 4. absolute risk reduction / 5. percentage point / 6. relative risk reduction / 7. Relative risk / 8. benefit framing / 9. population estimate / 10. confidence interval

[Why these answers fit, page 137](#)

F Check accuracy and scope

Twenty-five percent of what?

Return to the case

For arithmetic practice only, a fictional comparison describes 40 events among 1,000 people without an intervention and 30 among 1,000 with it over the same five-year period. These are not real treatment estimates or a recommendation. Dr Ali explains the ten-event difference, the one-percentage-point absolute reduction, and the 25 percent relative reduction to Robin. No individual risk estimate is supplied.

Choose one answer per question. Use the case facts and keep any uncertainty or limits intact.

1. What is the relative reduction?

- A. 25 percent
- B. 1 percent
- C. 75 percent
- D. 10 percent

2. Which conclusion must be avoided?

- A. These figures guarantee Robin's personal outcome.
- B. The denominators match.
- C. The time periods match.
- D. The figures are fictional.

[Answers and explanations, page 139](#)

Listen for the distinction

Swap roles. Say the absolute and relative differences using only the fictional figures supplied.

Keep the denominator visible

A large relative percentage can be heard as a large personal probability change. Use the same group size and time period when comparing figures, then explain the limits of individual prediction.

F Say it / transfer to a new case

A second fictional comparison

For arithmetic practice only, fictional five-year event counts are 20 per 1,000 in one group and 15 per 1,000 in another. No treatment recommendation is implied.

Complete the four gaps. With a partner, read alternate roles, then switch. Studying alone, read both roles and pause before each response.

WORD AND PHRASE BANK

fictional / twenty-five / five / 0.5

- 01 **Clinician:** The absolute difference is ¹ _____ per thousand.
- 02 **Patient:** That is ² _____ percentage points.
- 03 **Clinician:** The relative reduction is ³ _____ percent.
- 04 **Patient:** These numbers remain ⁴ _____.

CHECK THE GAPS

1. five / 2. 0.5 / 3. twenty-five / 4. fictional

[Why these answers fit, page 139](#)

Rebuild the exchange

Choose the missing response. Read the completed three-turn exchange aloud, changing roles on the second reading.

1. Rebuild the exchange from "Twenty-five percent of what?". Robin: "So the relative risk itself is thirty divided by forty, or three quarters of the comparison risk?" Dr Ali: [missing response] Robin: "Could someone use only the larger-sounding relative reduction to make the option appear more impressive?" Which response belongs in the gap?

- A.** Correct. A population estimate would still need careful interpretation. These made-up figures only illustrate the arithmetic; they are not a prediction for you.
- B.** That is why benefit framing matters. Presenting the absolute figures too helps keep the size of the comparison clear.
- C.** Exactly. A percentage point is the unit for subtracting percentages, not the same as a relative percent change.
- D.** Yes. Relative risk is 0.75 in this illustration. The relative reduction is 0.25, or twenty-five percent. Those are different ways of describing the same comparison.

[Answers and explanations, page 140](#)

A Read the situation

LESSON 08 / COORDINATING REHABILITATION AND RETURN TO ACTIVITY

Explain a rehabilitation referral and negotiate practical follow-up without giving an unsupplied exercise prescription.

Referred is not yet enrolled

Dr Reed has referred Sam to cardiac rehabilitation after an assessed cardiac event. The rehabilitation team has received the referral, but no intake appointment is confirmed. Sam wants to return to a physically demanding job and has a transport barrier. Exercise clearance, work restrictions, and an individual program require the actual clinical assessment; none is supplied in this exercise. Coordinator Inez will help clarify access arrangements.

People: Sam, Patient; Dr Reed, Cardiologist.

Read the record

Choose one answer per question using the facts above.

1. What is confirmed?

- A. Receipt of the rehabilitation referral
- B. A completed intake
- C. Full work clearance
- D. A prescribed exercise intensity

2. What barrier does Sam report?

- A. Transport
- B. A refusal of all rehabilitation
- C. A completed exercise test
- D. A supplied work restriction

3. What requires individual assessment?

- A. Sam's expressed wish
- B. Exercise and work guidance
- C. Whether a referral was sent
- D. Inez's name

[Answers and explanations, page 141](#)

B Vocabulary in use

CORE TERMS

cardiac rehabilitation

Supervised program supporting recovery, risk reduction, and functioning after eligible cardiac conditions.

explain cardiac rehabilitation

exercise prescription

Individualized specification of appropriate exercise under clinical assessment.

review an exercise prescription

graded activity

Activity progressed in steps under an appropriate plan.

discuss graded activity

return-to-work assessment

Evaluation of readiness and requirements for resuming work.

request a return-to-work assessment

occupational demand

Physical or other requirement of a person's job.

describe occupational demands

risk-factor modification

Changes directed at relevant disease risk factors.

support risk-factor modification

rehabilitation intake

Initial assessment and planning encounter for a rehabilitation program.

arrange rehabilitation intake

functional capacity

Ability to perform physical tasks under relevant conditions.

assess functional capacity

supervised exercise

Exercise performed with the relevant professional oversight.

arrange supervised exercise

work restriction

Specified limitation on work activity under an appropriate assessment.

clarify work restrictions

secondary prevention

Measures reducing recurrence or complications after established disease.

discuss secondary prevention

rehabilitation goal

Individual objective for recovery or functioning.

set a rehabilitation goal

Say it in context

Stress the highlighted expression. Keep the surrounding words connected; pause at the end of the phrase.

cardiac rehabilitation CARDIAC REHABILITATION

explain cardiac rehabilitation

Keep the meaning precise: Supervised program supporting recovery, risk reduction, and functioning after eligible cardiac conditions.

supervised exercise SUPERVISED EXERCISE

arrange supervised exercise

Keep the meaning precise: Exercise performed with the relevant professional oversight.

B Precision and professional shorthand

EXTEND YOUR RANGE

attendance barrier

Obstacle to taking part in scheduled care.

identify an attendance barrier

program eligibility

Whether a person meets requirements for a particular service.

verify program eligibility

intake confirmation

Verification that an initial program appointment is booked.

obtain intake confirmation

qualified interpreter

Trained language professional supporting accurate communication between speakers.

request a qualified interpreter

patient preference

A person's stated wishes about care or communication.

elicit the patient preference

documented plan

Agreed next steps recorded for the people involved.

review the documented plan

transport arrangement

Plan for travel to and from a service.

confirm transport arrangements

coverage verification

Checking the applicable financial or insurance arrangements.

obtain coverage verification

care coordinator

Professional organizing connected services and practical arrangements.

contact the care coordinator

teach-back

Checking an explanation by inviting the listener to restate its meaning.

use teach-back without blame

clinical handoff

Transfer of relevant care information and responsibility between professionals.

confirm the clinical handoff

source attribution

Identification of who reported, observed, or established a fact.

preserve source attribution

Say it in context

Stress the highlighted expression. Keep the surrounding words connected; pause at the end of the phrase.

rehabilitation goal **REHABILITATION GOAL**

set a rehabilitation goal

Keep the meaning precise: Individual objective for recovery or functioning.

intake confirmation **INTAKE CONFIRMATION**

obtain intake confirmation

Keep the meaning precise: Verification that an initial program appointment is booked.

C Phrases that move the work forward

Explain the service

Rehabilitation combines assessed activity, education, and support.

Ask about access

What would make getting to the sessions difficult?

Avoid clearance by implication

This referral is not a statement that every work task is safe for you.

Separate coverage

We need to verify the applicable coverage rather than promise it.

Sam / in the conversation

I want to return to work, but the job involves lifting and long periods on my feet.

Sam / in the conversation

Does the rehabilitation referral mean I have already been cleared to do every part of the job?

Sam / in the conversation

Then what is rehabilitation intended to add beyond another appointment about the event itself?

Sam / in the conversation

I received a letter saying the referral arrived.

State the stage

The team has received the referral; intake is not yet confirmed.

Describe the job

Tell us what the work requires physically.

Name the coordinator

Inez can help clarify the access arrangements.

Confirm the next step

Let us identify who will confirm the intake and contact you.

Dr Reed / in the conversation

Those occupational demands need to be described for the assessment rather than inferred from your job title.

Dr Reed / in the conversation

A return-to-work assessment is a separate clinical question.

Dr Reed / in the conversation

Cardiac rehabilitation can combine assessed activity, education, and support, with a program suited to the relevant clinical circumstances.

Sam / in the conversation

I assumed that meant I had a first session booked.

Precision in real exchanges

Purpose: Describe the job

Useful wording: Tell us what the work requires physically.

Purpose: Avoid clearance by implication

Useful wording: This referral is not a statement that every work task is safe for you.

D Choose the response that fits

Choose one response for each situation. Preserve the facts, the decision boundary, and the purpose of the exchange.

1. Which statement preserves the referral stage?

- A.** Received, but intake not yet confirmed.
- B.** Sam is already enrolled.
- C.** Full work clearance has been issued.
- D.** The exercise program is finalized.

2. Which question addresses access respectfully?

- A.** Why do you refuse all care?
- B.** What makes travel to the sessions difficult?
- C.** Why are you unmotivated?
- D.** Can we ignore transport?

3. A colleague needs the term for this meaning: Ability to perform physical tasks under relevant conditions. Which term fits?

- A.** patient preference
- B.** program eligibility
- C.** occupational demand
- D.** functional capacity

D Choose the response that fits / continued

4. Rebuild the exchange from "Referred is not yet enrolled". Sam: "Then what is rehabilitation intended to add beyond another appointment about the event itself?" Dr Reed: [missing response] Sam: "I received a letter saying the referral arrived. I assumed that meant I had a first session booked." Which response belongs in the gap?

- A.** That is a useful rehabilitation goal to discuss with the team as they assess your circumstances.
- B.** Yes. Any graded activity must follow the agreed clinical plan, with the relevant review and support.
- C.** Cardiac rehabilitation can combine assessed activity, education, and support, with a program suited to the relevant clinical circumstances.
- D.** Those occupational demands need to be described for the assessment rather than inferred from your job title.

[Answers and explanations, page 141](#)

One useful distinction

A rehabilitation referral is not an exercise prescription or work-clearance certificate. Keep acceptance, intake, assessment, and participation distinct.

E Conversation

Referred is not yet enrolled

Referred is not yet enrolled

Complete the numbered gaps. Use each bank entry once; some entries contain several words.

WORD AND PHRASE BANK

care coordinator / exercise prescription / attendance barrier / graded activity /
occupational demands / Cardiac rehabilitation / return-to-work assessment /
rehabilitation goal / coverage verification / intake confirmation

- 01 **Sam:** I want to return to work, but the job involves lifting and long periods on my feet.
- 02 **Dr Reed:** Those ¹ _____ need to be described for the assessment rather than inferred from your job title.
- 03 **Sam:** Does the rehabilitation referral mean I have already been cleared to do every part of the job?
- 04 **Dr Reed:** No. A ² _____ is a separate clinical question. The referral is not unrestricted clearance.
- 05 **Sam:** Then what is rehabilitation intended to add beyond another appointment about the event itself?
- 06 **Dr Reed:** ³ _____ can combine assessed activity, education, and support, with a program suited to the relevant clinical circumstances.
- 07 **Sam:** I received a letter saying the referral arrived. I assumed that meant I had a first session booked.
- 08 **Dr Reed:** The team has received it, but ⁴ _____ has not yet been provided. We need to make that next step clear.
- 09 **Sam:** Getting there may be difficult. I do not have a reliable lift during the hours the service usually operates.
- 10 **Dr Reed:** That ⁵ _____ matters. Inez can help clarify transport and access arrangements rather than assume you do not want to attend.

Conversation continues on the next page.

Referred is not yet enrolled

CONVERSATION / CONTINUED

- 11 **Sam:** I also need to know whether the sessions are covered before I commit to costs I cannot manage.
- 12 **Dr Reed:** We need ⁶ _____. I cannot promise a financial outcome without checking the applicable arrangements.
- 13 **Sam:** A friend suggested copying their exercise schedule while I wait. Is that the same as the program I will receive?
- 14 **Dr Reed:** No. An ⁷ _____ needs your own assessment. Ask the rehabilitation team what is appropriate for you rather than copying your friend's schedule.
- 15 **Sam:** I would like the program to help me with the tasks that actually matter at home and work.
- 16 **Dr Reed:** That is a useful ⁸ _____ to discuss with the team as they assess your circumstances.
- 17 **Sam:** I understand that progress may involve different steps rather than an immediate return to everything.
- 18 **Dr Reed:** Yes. Any ⁹ _____ must follow the agreed clinical plan, with the relevant review and support.
- 19 **Sam:** For now I need the intake date, transport information, and a clear route for my work questions.
- 20 **Dr Reed:** We will identify the ¹⁰ _____ and responsible clinicians for those questions, without treating the referral as a completed assessment.

CHECK THE GAPS

1. occupational demands / 2. return-to-work assessment / 3. Cardiac rehabilitation / 4. intake confirmation / 5. attendance barrier / 6. coverage verification / 7. exercise prescription / 8. rehabilitation goal / 9. graded activity / 10. care coordinator

[Why these answers fit, page 142](#)

F Check accuracy and scope

Referred is not yet enrolled

Return to the case

Dr Reed has referred Sam to cardiac rehabilitation after an assessed cardiac event. The rehabilitation team has received the referral, but no intake appointment is confirmed. Sam wants to return to a physically demanding job and has a transport barrier. Exercise clearance, work restrictions, and an individual program require the actual clinical assessment; none is supplied in this exercise. Coordinator Inez will help clarify access arrangements.

Choose one answer per question. Use the case facts and keep any uncertainty or limits intact.

1. What must not be inferred from the referral?

- A.** A safe exercise intensity or unrestricted work clearance
- B.** A need to clarify intake
- C.** A transport question
- D.** A coordinator's role

2. Which promise is unsupported?

- A.** Coverage needs verification.
- B.** Every cost and journey will definitely be covered.
- C.** Inez can help clarify arrangements.
- D.** Intake is not confirmed.

[Answers and explanations, page 144](#)

Listen for the distinction

Swap roles. Repeat the transport-barrier question without implying poor motivation or promising coverage.

Practical barriers are part of the clinical conversation

Attendance can be difficult even when the patient wants support. Ask about transport and work demands before labeling missed access as a lack of motivation.

F Say it / transfer to a new case

A job title hides the task

Rory works in a warehouse and asks about returning to lifting. The clinical team requests the actual task demands before assessing restrictions. No lifting limit is supplied.

Complete the four gaps. With a partner, read alternate roles, then switch. Studying alone, read both roles and pause before each response.

WORD AND PHRASE BANK

supplied / demands / lifting / assessment

- 01 **Rory:** My job includes ¹ _____.
- 02 **Clinician:** We need the task ² _____ before assessing restrictions.
- 03 **Rory:** No lifting limit has been ³ _____.
- 04 **Clinician:** The work guidance needs individual ⁴ _____.

CHECK THE GAPS

1. lifting / 2. demands / 3. supplied / 4. assessment

[Why these answers fit, page 144](#)

Rebuild the exchange

Choose the missing response. Read the completed three-turn exchange aloud, changing roles on the second reading.

1. Rebuild the exchange from "Referred is not yet enrolled". Sam: "A friend suggested copying their exercise schedule while I wait. Is that the same as the program I will receive?" Dr Reed: [missing response] Sam: "I would like the program to help me with the tasks that actually matter at home and work." Which response belongs in the gap?

- A.** That attendance barrier matters. Inez can help clarify transport and access arrangements rather than assume you do not want to attend.
- B.** No. An exercise prescription needs your own assessment. Ask the rehabilitation team what is appropriate for you rather than copying your friend's schedule.
- C.** We will identify the care coordinator and responsible clinicians for those questions, without treating the referral as a completed assessment.
- D.** The team has received it, but intake confirmation has not yet been provided. We need to make that next step clear.

[Answers and explanations, page 145](#)

Review 4 / Meaning and context

Use language from the lessons you have completed. Choose one answer per question.

Case file

Revisit "Explaining absolute and relative risk" and "Coordinating rehabilitation and return to activity". Choose precise terminology, then reconstruct the missing responses using both neighboring turns. The final two questions also revisit earlier conversations.

1. A colleague needs the term for this meaning: Difference between comparison and intervention risks. Which term fits?

- A. absolute risk reduction
- B. teach-back
- C. time horizon
- D. number needed to treat

2. A colleague needs the term for this meaning: Specified limitation on work activity under an appropriate assessment. Which term fits?

- A. attendance barrier
- B. cardiac rehabilitation
- C. qualified interpreter
- D. work restriction

3. Rebuild the exchange from "Teach-back checks the explanation". Dr Evans: "It does not automatically apply in the same way to everyone. Use the individualized instructions from your treating team." Lee: [missing response] Dr Evans: "Exactly. We will verify the current list rather than let two different versions sit beside each other unexplained." Which response belongs in the gap?

- A. I cannot tell which contact pathway is for ordinary questions and which is for something requiring urgent help.
- B. I also want to understand what I am observing, not just copy numbers into a daily weight record.
- C. The medicine sheet also needs checking. I do not want to assume an old diuretic instruction remains current.
- D. I appreciate that. Some symptoms, such as breathlessness when lying flat, are hard to describe with the usual shorthand.

Review 4 / Meaning and context / continued

4. Rebuild the exchange from "Referred is not yet enrolled". Sam: "I understand that progress may involve different steps rather than an immediate return to everything." Dr Reed: [missing response] Sam: "For now I need the intake date, transport information, and a clear route for my work questions." Which response belongs in the gap?

- A.** No. A return-to-work assessment is a separate clinical question. The referral is not unrestricted clearance.
- B.** Yes. Any graded activity must follow the agreed clinical plan, with the relevant review and support.
- C.** Those occupational demands need to be described for the assessment rather than inferred from your job title.
- D.** That is a useful rehabilitation goal to discuss with the team as they assess your circumstances.

[Answers and explanations, page 152](#)

Language for the next case

An alert from a cardiac device

device transmission

A device transmission is information sent from the monitoring system and is not automatically a reviewed clinical finding.

Dr Kim: A device transmission and a reviewed finding are separate stages.

review workflow

The review workflow describes how the service receives, assesses, and communicates device information rather than assuming every notification has already been interpreted.

Dr Kim: We should clarify the real review workflow and who communicates the outcome, without promising a finding before review.

Data availability

Data availability concerns whether usable information reached the service and cannot itself establish the underlying clinical state when data are missing.

Dr Kim: Correct. Data availability is a separate question from what the information means clinically.

alert

An alert flags information for attention under the actual system and requires context rather than automatically establishing a diagnosis.

Dr Kim: An alert needs the actual system context and review; the word alone does not establish a diagnosis.

urgent-care instructions

Urgent-care instructions identify the appropriate clinical response to concerning symptoms and are not replaced by sending a routine device transmission.

Dr Kim: Follow the actual urgent-care instructions rather than treating a routine transmission as a substitute for assessment.

review status

Review status identifies whether information is awaiting assessment or has been reviewed and should not be inferred solely from a receipt notification.

Dr Kim: A clear review status prevents exactly that confusion while keeping the appropriate clinical contact route visible.

Read the phrases aloud. Then complete the conversation on the following pages using the word bank.

Conversation

An alert from a cardiac device

Patient Ellis sees a message that a device transmission was received and asks whether it proves a new problem. Dr Kim explains the actual review process. No alert type, device setting, symptom assessment, or diagnosis is supplied. Device messaging is not a substitute for the actual urgent-care route if concerning symptoms occur.

Complete the numbered gaps. Use each bank entry once; some entries contain several words.

WORD AND PHRASE BANK

device transmission / urgent-care instructions / review workflow / Data availability /
review status / alert

- 01 **Ellis:** My device account says a transmission was received. Does that mean the team has found a new heart problem?
- 02 **Dr Kim:** Receipt confirms that information arrived. It does not, by itself, tell us the clinical interpretation.
- 03 **Ellis:** I thought every notification meant a clinician had already reviewed the recording and reached a conclusion.
- 04 **Dr Kim:** A ¹ _____ and a reviewed finding are separate stages.
- 05 **Ellis:** What about the word alert? Is that always a diagnosis rather than a signal for someone to check?
- 06 **Dr Kim:** An ² _____ needs the actual system context and review; the word alone does not establish a diagnosis.
- 07 **Ellis:** I do not want to ignore something important, but I also do not want to invent a conclusion.
- 08 **Dr Kim:** We should clarify the real ³ _____ and who communicates the outcome, without promising a finding before review.
- 09 **Ellis:** Does this kind of system always mean someone is watching every heartbeat in real time?
- 10 **Dr Kim:** Do not assume that. The service must explain the actual monitoring arrangements and their limitations for your device.

Conversation continues on the next page.

An alert from a cardiac device

CONVERSATION / CONTINUED

- 11 **Ellis:** If I have a concerning new symptom, should I just send data and wait for the next message?
- 12 **Dr Kim:** Follow the actual ⁴ _____ rather than treating a routine transmission as a substitute for assessment.
- 13 **Ellis:** I also want to know how to report a problem with the connection itself.
- 14 **Dr Kim:** The team can explain the appropriate technical contact and distinguish a connection problem from a clinical finding.
- 15 **Ellis:** So a missing signal would not automatically prove that my heart rhythm is normal or abnormal?
- 16 **Dr Kim:** Correct. ⁵ _____ is a separate question from what the information means clinically.
- 17 **Ellis:** Could we confirm who explains the reviewed result and how I can check the status?
- 18 **Dr Kim:** Yes. We will identify the actual contact route and distinguish a pending review from a completed discussion.
- 19 **Ellis:** That helps me understand the message without mistaking an administrative confirmation for a diagnosis.
- 20 **Dr Kim:** A clear ⁶ _____ prevents exactly that confusion while keeping the appropriate clinical contact route visible.

CHECK THE GAPS

1. device transmission / 2. alert / 3. review workflow / 4. urgent-care instructions / 5. Data availability / 6. review status

[Why these answers fit, page 154](#)

The data arrived but review is pending

The service confirms receipt of a transmission. Clinical review is pending. The patient has not reported a symptom in this update.

Complete the exchange using each phrase once. Read both roles, then switch roles and repeat with the bank covered.

WORD AND PHRASE BANK

received / pending / diagnosis / status

- 01 **Patient:** The transmission was ¹ _____.
- 02 **Clinician:** Clinical review remains ² _____.
- 03 **Patient:** That is not a confirmed ³ _____.
- 04 **Clinician:** We should clarify the review ⁴ _____.

CHECK THE GAPS

1. received / 2. pending / 3. diagnosis / 4. status

[Why these answers fit, page 154](#)

Keep the distinction audible

Distinguish a device transmission, an alert, and a reviewed clinical finding.

Language for the next case

Reconciling a cross-specialty medicine plan

document version

The document version identifies which dated instruction is being discussed and helps distinguish a superseded copy from a current plan.

Dr Reed: The document version matters. We should establish which copies are current and what authority each instruction has.

responsible prescriber

The responsible prescriber is the clinician accountable for the relevant medicine decision and should be identified explicitly when instructions conflict.

Dr Reed: Let us confirm the responsible prescriber and the necessary cross-specialty discussion.

communication ownership

Communication ownership assigns responsibility for explaining the verified plan and correcting the earlier conflicting message to the patient.

Dr Reed: That is communication ownership, which must not disappear after the clinicians agree among themselves.

procedural context

Procedural context includes the actual planned intervention and relevant circumstances, which must be known before medicine instructions are reconciled.

Dr Reed: Agreed. The procedural context must be verified before a medicine plan is treated as appropriate.

reconciled instruction

A reconciled instruction is the verified direction after conflicting information has been resolved by the appropriate clinicians.

Dr Reed: A reconciled instruction should identify the relevant medicine details, timing, and contact route in the real clinical plan.

closed-loop reconciliation

Closed-loop reconciliation resolves the conflicting instructions and verifies that the appropriate recipients have the updated plan rather than merely documenting internal agreement.

Dr Reed: Then closed-loop reconciliation includes both a clinical decision and accurate communication to the people who need it.

Read the phrases aloud. Then complete the conversation on the following pages using the word bank.

Conversation

Reconciling a cross-specialty medicine plan

Dr Reed, a cardiologist, and Dr Hall, a procedural clinician, find conflicting medicine instructions in two appointment documents. The actual medicines, procedure, and doses are not supplied. They agree to verify the current plan, responsible prescriber, and patient communication before presenting an instruction as settled.

Complete the numbered gaps. Use each bank entry once; some entries contain several words.

WORD AND PHRASE BANK

procedural context / communication ownership / reconciled instruction /
responsible prescriber / closed-loop reconciliation / document version

- 01 **Dr Hall:** Our appointment document contains a medicine instruction that conflicts with the cardiology letter. The patient has noticed the difference.
- 02 **Dr Reed:** We need to resolve that through the responsible clinicians, not ask the patient to guess which document to follow.
- 03 **Dr Hall:** I will identify the exact instruction and date rather than summarize it as a general disagreement.
- 04 **Dr Reed:** The ¹ _____ matters. We should establish which copies are current and what authority each instruction has.
- 05 **Dr Hall:** The procedure team needs the actual clinical context, not an assumption that all procedures use identical instructions.
- 06 **Dr Reed:** Agreed. The ² _____ must be verified before a medicine plan is treated as appropriate.

Conversation / continued

- 07 **Dr Hall:** We should also identify the clinician responsible for the prescription rather than assume the appointment office owns the decision.
- 08 **Dr Reed:** Let us confirm the ³ _____ and the necessary cross-specialty discussion.
- 09 **Dr Hall:** Until then, I will not describe a stop or restart instruction as agreed merely because it appears in one letter.
- 10 **Dr Reed:** Correct. We are reconciling conflicting information, not issuing a new medicine instruction in this conversation.

Conversation continues on the next page.

Reconciling a cross-specialty medicine plan

CONVERSATION / CONTINUED

- 11 **Dr Hall:** The patient needs a single clear explanation once the actual decision has been verified.
- 12 **Dr Reed:** A ⁴ _____ should identify the relevant medicine details, timing, and contact route in the real clinical plan.
- 13 **Dr Hall:** If one document is superseded, should we retain the correction history rather than silently erase the old wording?
- 14 **Dr Reed:** Yes. Follow the actual record-correction process so the change and its authority remain traceable.
- 15 **Dr Hall:** I will confirm who contacts the patient and how we verify that the conflicting message has been corrected.
- 16 **Dr Reed:** That is ⁵ _____, which must not disappear after the clinicians agree among themselves.
- 17 **Dr Hall:** We should also update the relevant teams so the old instruction is not repeated at the next appointment.
- 18 **Dr Reed:** Exactly. A resolved discussion is incomplete if the outdated message remains the one everyone keeps using.
- 19 **Dr Hall:** I will record the verified plan, the responsible clinicians, and the communication outcome under our actual process.
- 20 **Dr Reed:** Then ⁶ _____ includes both a clinical decision and accurate communication to the people who need it.

CHECK THE GAPS

1. document version / 2. procedural context / 3. responsible prescriber / 4. reconciled instruction / 5. communication ownership / 6. closed-loop reconciliation

[Why these answers fit, page 156](#)

The old letter is still being used

The clinicians have verified the current plan, but an appointment office is still sending the older letter. The team requests an authorized correction and patient communication.

Complete the exchange using each phrase once. Read both roles, then switch roles and repeat with the bank covered.

WORD AND PHRASE BANK

older / correction / verified / communication

- 01 **Clinician:** The current plan is ¹ _____.
- 02 **Office:** We are still sending the ² _____ letter.
- 03 **Clinician:** We need an authorized ³ _____.
- 04 **Office:** The patient also needs clear ⁴ _____.

CHECK THE GAPS

1. verified / 2. older / 3. correction / 4. communication

[Why these answers fit, page 156](#)

Keep the distinction audible

Resolve conflicting instructions through the responsible clinicians without independently changing treatment.

Language for the next case

Discussing priorities in advanced heart disease

symptom burden

Symptom burden describes the impact of symptoms on daily life and helps connect clinical information with what matters to the patient.

Dr Shah: We can discuss your symptom burden and how it affects the activities and time that matter to you.

care goals

Care goals describe the outcomes and experiences important to the patient and are not automatically a specific resuscitation or treatment-withdrawal decision.

Dr Shah: A discussion of care goals is not itself a resuscitation decision. Any specific decision needs its own appropriate discussion.

advance care discussion

An advance care discussion explores preferences for future care and requires accurate documentation without claiming that every later circumstance or decision is already settled.

Dr Shah: An advance care discussion can help, with the actual documentation and legal arrangements explained where relevant.

Palliative care

Palliative care addresses symptoms, support, and quality of life and can be discussed alongside disease-directed care rather than automatically replacing it.

Dr Shah: Palliative care can be discussed alongside other treatment. It does not automatically mean that every treatment stops.

treatment burden

Treatment burden includes the practical and personal demands of care and should be considered with expected benefits and the patient's priorities.

Dr Shah: We should discuss treatment burden alongside expected benefits, using the actual clinical options rather than an invented choice.

care coordinator

A care coordinator helps connect services and responsibilities, but the actual role and contact route must be confirmed rather than assumed.

Dr Shah: We can identify the appropriate care coordinator and confirm the next discussion without converting today's priorities into an unmade treatment decision.

Read the phrases aloud. Then complete the conversation on the following pages using the word bank.

Conversation

Discussing priorities in advanced heart disease

Patient Avery, living with advanced heart disease, wants less breathlessness and more time at home. Dr Shah explores those priorities and explains that supportive or palliative care can be discussed alongside disease-directed care. No prognosis estimate, treatment withdrawal, or resuscitation decision is supplied.

Complete the numbered gaps. Use each bank entry once; some entries contain several words.

WORD AND PHRASE BANK

advance care discussion / Palliative care / treatment burden / symptom burden /
care goals / care coordinator

- 01 **Avery:** I want less breathlessness and more time at home. I am worried that saying that sounds like giving up.
- 02 **Dr Shah:** Those priorities deserve a direct discussion. Telling us what matters does not automatically mean stopping disease-directed care.
- 03 **Avery:** I would like the team to hear the practical things I am finding hardest, not only the test results.
- 04 **Dr Shah:** We can discuss your ¹ _____ and how it affects the activities and time that matter to you.
- 05 **Avery:** Someone mentioned palliative care, and I thought that meant all other treatment would end immediately.
- 06 **Dr Shah:** ² _____ can be discussed alongside other treatment. It does not automatically mean that every treatment stops.
- 07 **Avery:** I also worry that a conversation about priorities will be recorded as a decision about resuscitation.
- 08 **Dr Shah:** A discussion of ³ _____ is not itself a resuscitation decision. Any specific decision needs its own appropriate discussion.
- 09 **Avery:** I would like my daughter involved, but I still want to speak for myself while I can.
- 10 **Dr Shah:** We can include her with your permission while keeping you central to the conversation and clarifying the relevant roles.

Conversation continues on the next page.

Discussing priorities in advanced heart disease

CONVERSATION / CONTINUED

- 11 **Avery:** If there are options with different burdens, I want those explained in terms I can compare.
- 12 **Dr Shah:** We should discuss ⁴ _____ alongside expected benefits, using the actual clinical options rather than an invented choice.
- 13 **Avery:** Can you guarantee that choosing a particular plan will keep me out of hospital?
- 14 **Dr Shah:** No. We can explain the aims and uncertainties, but we should not promise an outcome that cannot be guaranteed.
- 15 **Avery:** Then I would like a plan that records my priorities without pretending the future is settled.
- 16 **Dr Shah:** An ⁵ _____ can help, with the actual documentation and legal arrangements explained where relevant.
- 17 **Avery:** What happens if my priorities change as my symptoms or circumstances change?
- 18 **Dr Shah:** We should revisit them. A record should support your care, not freeze a preference that no longer represents you.
- 19 **Avery:** I would appreciate a clear contact who can help coordinate the clinical and practical support.
- 20 **Dr Shah:** We can identify the appropriate ⁶ _____ and confirm the next discussion without converting today's priorities into an unmade treatment decision.

CHECK THE GAPS

1. symptom burden / 2. Palliative care / 3. care goals / 4. treatment burden / 5. advance care discussion / 6. care coordinator

[Why these answers fit, page 158](#)

A preference has changed

A patient previously prioritized clinic-based treatment but now asks to discuss more care at home. No treatment change has yet been agreed.

Complete the exchange using each phrase once. Read both roles, then switch roles and repeat with the bank covered.

WORD AND PHRASE BANK

agreed / options / priorities / heard

- 01 **Patient:** I want to revisit my ¹ _____.
- 02 **Clinician:** A treatment change is not yet ² _____.
- 03 **Patient:** My current wishes should be ³ _____.
- 04 **Clinician:** We will explain the actual ⁴ _____.

CHECK THE GAPS

1. priorities / 2. agreed / 3. heard / 4. options

[Why these answers fit, page 158](#)

Keep the distinction audible

Elicit care goals without equating supportive care with abandonment or a predetermined resuscitation decision.

01 / Answers and explanations

A / Read the situation

A1. What symptoms are reported?

C. Chest pressure with breathlessness

The case supplies the symptom report without establishing its cause.

[Return to the exercise, page 4](#)

A2. What is already active?

D. The emergency response

The emergency response begins before the communication exercise.

[Return to the exercise, page 4](#)

A3. Who accepts the handoff?

C. Dr Chen

Dr Chen is the receiving cardiologist explicitly accepting the report.

[Return to the exercise, page 4](#)

D / Response choices

D1. Which opening is strongest?

A. Chest pressure with breathlessness; the emergency response is active.

Naming the symptoms and active response communicates the actual concern and action without adding unsupported findings.

[Return to the exercise, page 8](#)

D2. Which result must not be invented?

B. A normal troponin

No troponin result is supplied, so normal cannot be inserted as reassurance.

[Return to the exercise, page 8](#)

01 / Answers and explanations / continued

D3. A colleague needs the term for this meaning: Located behind the breastbone. Which term fits?

A. retrosternal

A Correct. retrosternal: Located behind the breastbone. The usual combination is "describe retrosternal discomfort".

B Not here. symptom trajectory: Pattern of symptom change over time. The usual combination is "describe the symptom trajectory".

C Not here. patient preference: A person's stated wishes about care or communication. The usual combination is "elicit the patient preference".

D Not here. troponin: Cardiac-injury biomarker interpreted with timing and clinical context. The usual combination is "interpret a troponin result".

[Return to the exercise, page 8](#)

D4. Rebuild the exchange from "Concern first, uncertainty intact". Dr Vale: "I do not yet have verified current measurements to pass on. I will update you as they become available." Dr Chen: [missing response] Dr Vale: "I also need to distinguish the patient's reported onset from the time someone first contacted the service." Which response belongs in the gap?

D. Then do not describe the hemodynamic status as normal. Missing information must stay visible while the real assessment continues.

A Not here. This line belongs to turn 12, after Dr Vale says: "Nor should an absent test result be treated as a negative test that rules out the concern." It addresses that point, not the missing turn in the supplied exchange.

B Not here. This line belongs to turn 14, after Dr Vale says: "I will send any verified update through the active pathway rather than leave a separate routine message." It addresses that point, not the missing turn in the supplied exchange.

C Not here. This line belongs to turn 2, after Dr Vale says: "I am handing over Chris, who reports chest pressure with breathlessness. The emergency response is already active." It addresses that point, not the missing turn in the supplied exchange.

D Correct. This is Dr Chen's response in turn 6. It connects Dr Vale's preceding point with Dr Vale's follow-up. Hemodynamic status requires relevant circulatory assessment and cannot be called normal from missing measurements.

[Return to the exercise, page 8](#)

E / Conversation

1. time-critical concern

Turn 2. A time-critical concern requires the active clinical response while the handoff conveys known facts and unresolved information.

01 / Answers and explanations / continued

2. dyspnea

Turn 4. Dyspnea is the reported breathing difficulty; the term does not by itself establish a cause or measurement.

3. hemodynamic status

Turn 6. Hemodynamic status requires relevant circulatory assessment and cannot be called normal from missing measurements.

4. prehospital report

Turn 8. The prehospital report contains information collected before hospital arrival and needs accurate source and timing attribution.

5. Myocardial infarction

Turn 10. Myocardial infarction is a diagnosis requiring appropriate evidence and is not established by the supplied symptom report alone.

6. troponin

Turn 12. Troponin is interpreted as a cardiac-injury biomarker with timing and context; no value is supplied in this case.

7. receiving team

Turn 14. The receiving team accepts the next stage of care and needs updates through the active clinical channel.

8. Emergency activation

Turn 16. Emergency activation initiates the relevant urgent response and must not be delayed while a language report is perfected.

9. closed-loop escalation

Turn 18. Closed-loop escalation includes acknowledgment and accepted responsibility, not simply sending information without confirmation.

10. symptom trajectory

Turn 20. Symptom trajectory describes how symptoms change over time and should be reported accurately as new information becomes available.

[Return to the conversation, page 10](#)

01 / Answers and explanations / continued

F / Accuracy and scope

F1. What completes the communication loop?

D. Confirmation of the receiving team and responsibility

Closed-loop communication requires acknowledgment rather than merely attempted contact.

[Return to the exercise, page 12](#)

F2. What should not delay emergency care?

C. Completing every detail of this language exercise

The exercise is for language practice and must never replace or delay the real response.

[Return to the exercise, page 12](#)

F / Guided speaking

1. 09:10

Referrer: The corrected reported onset is 09:10.

Turn 1. 09:10 is the corrected onset time; it replaces the original report of 09:40.

2. 09:40

Receiver: The previously reported onset time of 09:40 has been superseded.

Turn 2. 09:40 was reported first but is now replaced by 09:10. "Previously reported" refers to the order of the reports, not which clock time is earlier.

3. active

Referrer: The emergency response remains active.

Turn 3. Correcting the history does not interrupt the active emergency response.

4. unestablished

Receiver: The cause remains unestablished.

Turn 4. The timing correction does not itself establish a diagnosis.

[Return to the conversation, page 13](#)

01 / Answers and explanations / continued

F / Rebuild the exchange

1. Rebuild the exchange from "Concern first, uncertainty intact". Dr Vale: "I will send any verified update through the active pathway rather than leave a separate routine message." Dr Chen: [missing response] Dr Vale: "Shall I wait until every field is complete before confirming transfer of the report?" Which response belongs in the gap?

A. Please do. The receiving team needs to know which facts are new and who is responsible for them.

A Correct. This is Dr Chen's response in turn 14. It connects Dr Vale's preceding point with Dr Vale's follow-up. The receiving team accepts the next stage of care and needs updates through the active clinical channel.

B Not here. This line belongs to turn 12, after Dr Vale says: "Nor should an absent test result be treated as a negative test that rules out the concern." It addresses that point, not the missing turn in the supplied exchange.

C Not here. This line belongs to turn 2, after Dr Vale says: "I am handing over Chris, who reports chest pressure with breathlessness. The emergency response is already active." It addresses that point, not the missing turn in the supplied exchange.

D Not here. This line belongs to turn 4, after Dr Vale says: "I will separate what Chris reports from what our team has actually observed or measured." It addresses that point, not the missing turn in the supplied exchange.

[Return to the exercise, page 13](#)

02 / Answers and explanations

A / Read the situation

A1. What is the proposed purpose?

C. Compare symptoms with recorded rhythm

The proposed recording explores symptom-rhythm relationships without a guaranteed diagnosis.

[Return to the exercise, page 14](#)

A2. What is not established?

A. An arrhythmia

The case supplies palpitations but no confirmed rhythm diagnosis.

[Return to the exercise, page 14](#)

A3. Who provides equipment instructions?

A. The service using the actual device

Instructions must match the actual device and service, not assumptions in the exercise.

[Return to the exercise, page 14](#)

D / Response choices

D1. Which distinction is correct?

A. Palpitations are a symptom; an arrhythmia is a rhythm abnormality.

The symptom and the electrical finding require correlation rather than automatic equivalence.

[Return to the exercise, page 18](#)

D2. What makes a diary entry useful?

A. Time, sensation, and activity

The relevant details help connect a reported event with the corresponding recorded interval.

[Return to the exercise, page 18](#)

02 / Answers and explanations / continued

D3. A colleague needs the term for this meaning: Rhythm originating from the heart's usual sinus-node pacemaker. Which term fits?

A. sinus rhythm

A Correct. sinus rhythm: Rhythm originating from the heart's usual sinus-node pacemaker. The usual combination is "identify sinus rhythm".

B Not here. patient preference: A person's stated wishes about care or communication. The usual combination is "elicit the patient preference".

C Not here. electrode lead: Electrical recording connection used in acquiring a trace. The usual combination is "check an electrode lead".

D Not here. recording period: Time during which the device collects data. The usual combination is "confirm the recording period".

[Return to the exercise, page 18](#)

D4. Rebuild the exchange from "A symptom marker is not a diagnosis". Ellis: "Does agreeing to the monitor mean you have already diagnosed an arrhythmia from my account?" Dr Mora: [missing response] Ellis: "What should I record when I notice the feeling, besides pressing whatever button the device has?" Which response belongs in the gap?

C. No. An arrhythmia has not been established in this case. The recording is part of investigating the question.

A Not here. This line belongs to turn 18, after Ellis says: "If I develop a concerning new symptom, I should not assume pressing the marker replaces asking for help." It addresses that point, not the missing turn in the supplied exchange.

B Not here. This line belongs to turn 16, after Ellis says: "Then I should follow the actual device instructions rather than borrow instructions from a friend's different monitor." It addresses that point, not the missing turn in the supplied exchange.

C Correct. This is Dr Mora's response in turn 6. It connects Ellis's preceding point with Ellis's follow-up. An arrhythmia is an abnormal heart rhythm, which has not been established by this symptom account.

D Not here. This line belongs to turn 4, after Ellis says: "The episodes come and go. They never seem to happen at the exact moment someone checks me." It addresses that point, not the missing turn in the supplied exchange.

[Return to the exercise, page 18](#)

E / Conversation

1. palpitations

Turn 2. Palpitations describe the awareness of an unusual heartbeat and do not by themselves identify a specific rhythm abnormality.

02 / Answers and explanations / continued

2. ambulatory monitor

Turn 4. An ambulatory monitor records rhythm during everyday activity and may help investigate symptoms that are intermittent.

3. arrhythmia

Turn 6. An arrhythmia is an abnormal heart rhythm, which has not been established by this symptom account.

4. symptom diary

Turn 8. A symptom diary records the sensation, timing, and activity so the reviewing clinician can interpret events in context.

5. event marker

Turn 10. An event marker identifies a time for subsequent review and does not itself diagnose the event.

6. symptom-rhythm correlation

Turn 12. Symptom-rhythm correlation compares the reported experience with the recorded rhythm at the relevant time.

7. Signal artifact

Turn 14. Signal artifact is distortion that may arise during recording and must be distinguished from the underlying cardiac signal.

8. signal quality

Turn 16. Signal quality concerns whether the recording is adequate for interpretation and depends on the actual equipment and circumstances.

9. recording period

Turn 18. The recording period is the data-collection interval and is not a reason to defer necessary urgent clinical assessment.

10. monitor return

Turn 20. Monitor return is the equipment or data-return process needed for review and should not be left as an assumed final step.

[Return to the conversation, page 20](#)

02 / Answers and explanations / continued

F / Accuracy and scope

F1. Which promise is unsupported?

B. Every episode will definitely be captured.

A finite recording may not capture every intermittent symptom or produce a definitive explanation.

[Return to the exercise, page 22](#)

F2. What must remain separate?

A. Urgent-care instructions and routine monitor review

Routine recording does not replace appropriate urgent assessment of concerning clinical changes.

[Return to the exercise, page 22](#)

F / Guided speaking

1. evening

Reviewer: The entry gives seven but not morning or evening.

Turn 1. The time is incomplete because its morning-or-evening context is missing.

2. clarify

Ellis: I need to clarify that detail.

Turn 2. Clarification is required before assigning the diary entry to a recording interval.

3. trace

Reviewer: Then we can match it to the trace.

Turn 3. The purpose is to compare the clarified symptom time with the rhythm recording.

4. supplied

Ellis: No rhythm conclusion has been supplied.

Turn 4. The scenario provides a data clarification, not a diagnosed rhythm.

[Return to the conversation, page 23](#)

02 / Answers and explanations / continued

F / Rebuild the exchange

1. Rebuild the exchange from "A symptom marker is not a diagnosis". Ellis: "If the trace looks strange while I move, will every unusual line be treated as a heart problem?" Dr Mora: [missing response] Ellis: "Then I should follow the actual device instructions rather than borrow instructions from a friend's different monitor." Which response belongs in the gap?

B. No. Signal artifact can affect recordings, so quality and context matter to the interpretation.

A Not here. This line belongs to turn 18, after Ellis says: "If I develop a concerning new symptom, I should not assume pressing the marker replaces asking for help." It addresses that point, not the missing turn in the supplied exchange.

B Correct. This is Dr Mora's response in turn 14. It connects Ellis's preceding point with Ellis's follow-up. Signal artifact is distortion that may arise during recording and must be distinguished from the underlying cardiac signal.

C Not here. This line belongs to turn 2, after Ellis says: "My heart sometimes feels as though it skips and then thumps. Is that enough to name the rhythm problem?" It addresses that point, not the missing turn in the supplied exchange.

D Not here. This line belongs to turn 4, after Ellis says: "The episodes come and go. They never seem to happen at the exact moment someone checks me." It addresses that point, not the missing turn in the supplied exchange.

[Return to the exercise, page 23](#)

03 / Answers and explanations

A / Read the situation

A1. What does Ren misunderstand?

D. The meaning of the ejection-fraction percentage

Ren thinks the percentage measures remaining living heart muscle, which is not what it describes.

[Return to the exercise, page 26](#)

A2. What is not supplied?

D. A numerical value or heart-failure diagnosis

The exercise provides a terminology discussion without an individual value or diagnosis.

[Return to the exercise, page 26](#)

A3. What else belongs in interpretation?

C. Symptoms and other cardiac findings

The brief explicitly places the measurement within a broader clinical and imaging assessment.

[Return to the exercise, page 26](#)

D / Response choices

D1. What does ejection fraction measure?

C. A proportion of ventricular blood expelled with contraction

The measurement concerns pumping from a ventricle, not tissue survival or a global health percentage.

[Return to the exercise, page 30](#)

D2. Which statement is accurate?

A. Preserved ejection fraction alone does not exclude heart failure.

Heart failure and cardiac function require the full clinical and imaging context.

[Return to the exercise, page 30](#)

03 / Answers and explanations / continued

D3. A colleague needs the term for this meaning: Phase involving ventricular relaxation and filling. Which term fits?

C. diastole

A Not here. patient preference: A person's stated wishes about care or communication. The usual combination is "elicit the patient preference".

B Not here. reduced ejection fraction: Ejection fraction below the relevant category threshold in context. The usual combination is "explain reduced ejection fraction".

C Correct. diastole: Phase involving ventricular relaxation and filling. The usual combination is "describe diastolic filling".

D Not here. ventricular volume: Amount of blood within a ventricle at a specified phase. The usual combination is "measure ventricular volume".

[Return to the exercise, page 30](#)

D4. Rebuild the exchange from "A percentage is not the amount of heart left". Ren: "What is the percentage actually a percentage of, if it is not the amount of working muscle?" Dr Kim: [missing response] Ren: "Then a report using an amount of blood per beat would be describing something related but different?" Which response belongs in the gap?

A. It relates the blood expelled to the ventricular volume before that contraction. It describes a pumping proportion.

A Correct. This is Dr Kim's response in turn 6. It connects Ren's preceding point with Ren's follow-up. Ventricular volume is the blood in the chamber at a specified phase and provides the relevant basis for the pumping proportion.

B Not here. This line belongs to turn 12, after Ren says: "So the part about filling is not just an extra technical detail that can be ignored?" It addresses that point, not the missing turn in the supplied exchange.

C Not here. This line belongs to turn 10, after Ren says: "I also saw systolic and diastolic in the report. Are those two different parts of the heartbeat?" It addresses that point, not the missing turn in the supplied exchange.

D Not here. This line belongs to turn 2, after Ren says: "The report gives a percentage. I thought it meant that only that much of my heart is still alive." It addresses that point, not the missing turn in the supplied exchange.

[Return to the exercise, page 30](#)

E / Conversation

1. Ejection fraction

Turn 2. Ejection fraction is the proportion of ventricular blood expelled with a contraction, not the proportion of living heart tissue.

03 / Answers and explanations / continued

2. left ventricle

Turn 4. The left ventricle is the chamber pumping blood into the body's systemic circulation and is the chamber named in this report.

3. ventricular volume

Turn 6. Ventricular volume is the blood in the chamber at a specified phase and provides the relevant basis for the pumping proportion.

4. Stroke volume

Turn 8. Stroke volume is the amount ejected in one beat, which differs from expressing that ejection as a proportion.

5. Systole

Turn 10. Systole includes ventricular contraction and ejection and is distinct from the relaxation and filling phase.

6. Diastolic function

Turn 12. Diastolic function concerns relaxation and filling and can matter even when a pumping proportion appears preserved.

7. Preserved ejection fraction

Turn 14. Preserved ejection fraction describes a measurement category and does not by itself exclude heart failure or other dysfunction.

8. valvular regurgitation

Turn 16. Valvular regurgitation means backward flow through a valve and is not synonymous with an ejection-fraction measurement.

9. image quality

Turn 18. Image quality affects what an examination can establish and relevant limitations should remain visible in the interpretation.

10. comparison study

Turn 20. A comparison study is an earlier examination used to assess change and must be interpreted for comparability and context.

[Return to the conversation, page 32](#)

03 / Answers and explanations / continued

F / Accuracy and scope

F1. Which distinction is useful?

D. Stroke volume is an amount; ejection fraction is a proportion.

The terms describe related but different ways of expressing ventricular ejection.

[Return to the exercise, page 34](#)

F2. Which conclusion exceeds this case?

C. Ren has a specific heart-failure category.

The scenario intentionally supplies neither an individual measurement nor a diagnosis.

[Return to the exercise, page 34](#)

F / Guided speaking

1. scan

Patient: The report refers to an earlier scan.

Turn 1. An earlier examination is mentioned as a potential comparison.

2. comparable

Clinician: I still need to review whether they are comparable.

Turn 2. Comparability is unresolved and cannot be assumed from the existence of two reports.

3. established

Patient: A meaningful change is not established.

Turn 3. The case supplies no completed interpretation of a change.

4. context

Clinician: We will interpret the findings in context.

Turn 4. The relevant clinical and examination context must accompany the comparison.

[Return to the conversation, page 35](#)

03 / Answers and explanations / continued

F / Rebuild the exchange

1. Rebuild the exchange from "A percentage is not the amount of heart left". Ren: "If someone has a preserved percentage, does that prove they cannot have heart failure?" Dr Kim: [missing response] Ren: "I understand. The report also discusses a valve, which I assumed the percentage already covered." Which response belongs in the gap?

C. No. Preserved ejection fraction alone does not exclude it. We need the complete clinical picture, not just that label.

A Not here. This line belongs to turn 20, after Ren says: "Then I should ask how this fits the rest of the assessment, not treat it as an isolated score." It addresses that point, not the missing turn in the supplied exchange.

B Not here. This line belongs to turn 2, after Ren says: "The report gives a percentage. I thought it meant that only that much of my heart is still alive." It addresses that point, not the missing turn in the supplied exchange.

C Correct. This is Dr Kim's response in turn 14. It connects Ren's preceding point with Ren's follow-up. Preserved ejection fraction describes a measurement category and does not by itself exclude heart failure or other dysfunction.

D Not here. This line belongs to turn 16, after Ren says: "I understand. The report also discusses a valve, which I assumed the percentage already covered." It addresses that point, not the missing turn in the supplied exchange.

[Return to the exercise, page 35](#)

04 / Answers and explanations

A / Read the situation

A1. What diagnosis is established?

B. Atrial fibrillation

The brief explicitly identifies atrial fibrillation as an established diagnosis.

[Return to the exercise, page 36](#)

A2. What does Avery ask about?

D. Why stroke prevention matters when symptoms feel calmer

Avery links improved sensations with a question about continuing risk discussion.

[Return to the exercise, page 36](#)

A3. What is absent from the case?

B. A medicine selection or risk score

No individual score, prescription, dose, or stopping instruction may be invented.

[Return to the exercise, page 36](#)

D / Response choices

D1. Which distinction is correct?

A. Rhythm or symptom control does not replace the stroke-prevention assessment.

Treatment goals overlap but require their own relevant clinical assessment.

[Return to the exercise, page 40](#)

D2. Which question includes Avery's concern?

A. What previous bleeding have you experienced, and what worries you?

Asking about previous bleeding and worries elicits relevant history without minimizing the concern.

[Return to the exercise, page 40](#)

04 / Answers and explanations / continued

D3. A colleague needs the term for this meaning: Strategy aimed at restoring or maintaining an appropriate rhythm. Which term fits?

A. rhythm control

A Correct. rhythm control: Strategy aimed at restoring or maintaining an appropriate rhythm. The usual combination is "discuss rhythm control".

B Not here. thromboembolism: Obstruction caused by a clot traveling from another site. The usual combination is "discuss thromboembolism".

C Not here. shared treatment decision: Care choice informed by evidence and the person's priorities. The usual combination is "reach a shared treatment decision".

D Not here. patient preference: A person's stated wishes about care or communication. The usual combination is "elicit the patient preference".

[Return to the exercise, page 40](#)

D4. Rebuild the exchange from "The rhythm question and the stroke question".

Avery: "Please explain the terms rate control and rhythm control. They sound as though they mean exactly the same thing." Dr Patel: [missing response] Avery: "I would like the bleeding concern discussed as carefully as the benefit, not treated as a reason to stop asking." Which response belongs in the gap?

C. Rate control concerns the heart rate; rhythm control concerns the rhythm itself. Neither phrase alone settles the prevention decision.

A Not here. This line belongs to turn 10, after Avery says: "I have called all these medicines blood thinners, but perhaps that hides an important difference." It addresses that point, not the missing turn in the supplied exchange.

B Not here. This line belongs to turn 4, after Avery says: "I assumed that if I felt fewer episodes, the risk question would disappear with the symptoms." It addresses that point, not the missing turn in the supplied exchange.

C Correct. This is Dr Patel's response in turn 6. It connects Avery's preceding point with Avery's follow-up. Rate control aims at controlling heart rate and is distinct from a strategy focused on restoring or maintaining rhythm.

D Not here. This line belongs to turn 12, after Avery says: "I had bleeding in the past, but I am not sure which details are relevant for this discussion." It addresses that point, not the missing turn in the supplied exchange.

[Return to the exercise, page 40](#)

E / Conversation

1. atrial fibrillation

Turn 2. Atrial fibrillation is the established rhythm diagnosis here, and its care includes distinct symptom and stroke-risk questions.

04 / Answers and explanations / continued

2. stroke risk

Turn 4. Stroke risk requires individual assessment and cannot be assumed absent merely because palpitations feel less noticeable.

3. Rate control

Turn 6. Rate control aims at controlling heart rate and is distinct from a strategy focused on restoring or maintaining rhythm.

4. bleeding risk

Turn 8. Bleeding risk is a relevant part of the individualized benefit-and-harm discussion and should not be dismissed.

5. Anticoagulation

Turn 10. Anticoagulation acts on coagulation pathways and is not simply another name for every medicine informally called a blood thinner.

6. bleeding history

Turn 12. Bleeding history records previous events and their circumstances and is relevant to an individualized clinical review.

7. drug interaction

Turn 14. A drug interaction can change a medicine's effects and belongs in review of the actual medicines and clinical context.

8. individual risk estimate

Turn 16. An individual risk estimate depends on the relevant person, outcome, period, and clinical information, not a generic online chart alone.

9. shared treatment decision

Turn 18. A shared treatment decision combines clinical evidence with the person's informed priorities rather than ignoring either.

10. anticoagulation review

Turn 20. An anticoagulation review reassesses the actual treatment and risks; the language exercise supplies no authorization to change a medicine.

[Return to the conversation, page 42](#)

04 / Answers and explanations / continued

F / Accuracy and scope

F1. Which instruction cannot be supplied here?

A. Stop anticoagulation because the heartbeat feels calmer.

The case gives no medication-change instruction or evidence for making one.

[Return to the exercise, page 44](#)

F2. Why clarify blood thinner?

D. The informal phrase can hide different medicine actions.

The phrase is colloquial and does not distinguish anticoagulants from other therapies.

[Return to the exercise, page 44](#)

F / Guided speaking

1. name

Nico: I do not recall the product name.

Turn 1. The medicine's identity remains unresolved despite the informal label.

2. purpose

Clinician: We will verify its name and purpose.

Turn 2. Verification must establish what the actual medicine is intended to do.

3. given

Nico: No stop instruction has been given.

Turn 3. The case provides no instruction to discontinue the medicine.

4. review

Clinician: A change needs individual review.

Turn 4. An individual clinical review is required before deciding on a change.

[Return to the conversation, page 45](#)

04 / Answers and explanations / continued

F / Rebuild the exchange

1. Rebuild the exchange from "The rhythm question and the stroke question". Avery: "Will other medicines and health conditions also affect how you judge the options for me?" Dr Patel: [missing response] Avery: "Then a general chart online cannot tell me precisely which treatment I should take or at what dose." Which response belongs in the gap?

D. Yes. A drug interaction, kidney function, and other relevant factors may need review in the actual assessment.

A Not here. This line belongs to turn 4, after Avery says: "I assumed that if I felt fewer episodes, the risk question would disappear with the symptoms." It addresses that point, not the missing turn in the supplied exchange.

B Not here. This line belongs to turn 10, after Avery says: "I have called all these medicines blood thinners, but perhaps that hides an important difference." It addresses that point, not the missing turn in the supplied exchange.

C Not here. This line belongs to turn 8, after Avery says: "I would like the bleeding concern discussed as carefully as the benefit, not treated as a reason to stop asking." It addresses that point, not the missing turn in the supplied exchange.

D Correct. This is Dr Patel's response in turn 14. It connects Avery's preceding point with Avery's follow-up. A drug interaction can change a medicine's effects and belongs in review of the actual medicines and clinical context.

[Return to the exercise, page 45](#)

05 / Answers and explanations

A / Read the situation

A1. What is proposed?

B. Diagnostic coronary angiography

The case proposes a diagnostic investigation, not a settled intervention.

[Return to the exercise, page 48](#)

A2. What does Blair assume?

C. A stent will definitely be inserted

Blair confuses the proposed diagnostic procedure with an automatic treatment decision.

[Return to the exercise, page 48](#)

A3. What is not supplied?

D. Coronary anatomy or an intervention decision

The clinician cannot invent anatomical findings or a final intervention plan.

[Return to the exercise, page 48](#)

D / Response choices

D1. Which distinction is essential?

D. Diagnostic angiography does not automatically mean stent insertion.

The proposed diagnostic purpose and any intervention agreement must be distinguished.

[Return to the exercise, page 52](#)

D2. Which instruction would be inappropriate to invent?

B. A medication-holding schedule

Preparation and medicine instructions must come from the actual clinical team.

[Return to the exercise, page 52](#)

05 / Answers and explanations / continued

D3. A colleague needs the term for this meaning: Route of entry into a blood vessel for a procedure. Which term fits?

C. vascular access

A Not here. coronary narrowing: Reduction in the internal opening of a coronary artery. The usual combination is "evaluate coronary narrowing".

B Not here. patient preference: A person's stated wishes about care or communication. The usual combination is "elicit the patient preference".

C Correct. vascular access: Route of entry into a blood vessel for a procedure. The usual combination is "explain vascular access".

D Not here. procedure consent: Agreement to a specified procedure after appropriate discussion. The usual combination is "confirm procedure consent".

[Return to the exercise, page 52](#)

D4. Rebuild the exchange from "A diagnostic test is not automatic treatment". Blair: "Then the purpose is to understand the arteries, rather than promise that a particular device will be inserted?" Dr Lewis: [missing response] Blair: "Please explain the phrase PCI if it comes up. I hear abbreviations and lose track of which action is meant." Which response belongs in the gap?

B. Yes. It helps assess coronary anatomy. We need to explain how any findings would affect the options before you agree to proceed.

A Not here. This line belongs to turn 20, after Blair says: "I can explain the visit more accurately now: a diagnostic discussion, with any intervention requiring clarity." It addresses that point, not the missing turn in the supplied exchange.

B Correct. This is Dr Lewis's response in turn 6. It connects Blair's preceding point with Blair's follow-up. Coronary anatomy describes the arteries; this case supplies no anatomical findings.

C Not here. This line belongs to turn 12, after Blair says: "I do not want signing for a test to be treated as agreement to something nobody has explained." It addresses that point, not the missing turn in the supplied exchange.

D Not here. This line belongs to turn 14, after Blair says: "I have read different stories about the wrist and groin. Should I choose from those accounts myself?" It addresses that point, not the missing turn in the supplied exchange.

[Return to the exercise, page 52](#)

E / Conversation

1. coronary angiography

Turn 2. Coronary angiography examines coronary arteries; it does not automatically include stent treatment.

05 / Answers and explanations / continued

2. diagnostic procedure

Turn 4. A diagnostic procedure obtains information and must be distinguished from a separate treatment action or decision.

3. coronary anatomy

Turn 6. Coronary anatomy describes the arteries; this case supplies no anatomical findings.

4. Percutaneous coronary intervention

Turn 8. Percutaneous coronary intervention is catheter-based treatment, distinct from diagnostic imaging alone.

5. procedure consent

Turn 10. Procedure consent concerns the specified actions agreed after discussion, including any possible intervention in the actual plan.

6. stent

Turn 12. A stent is a device used in some interventions and is not automatically inserted merely because angiography is discussed.

7. vascular access

Turn 14. Vascular access identifies the actual vessel-entry route, not a plan borrowed from another patient.

8. contrast medium

Turn 16. Contrast medium improves imaging visibility and its relevant risks and preparation need individual clinical review.

9. preparation instructions

Turn 18. Preparation instructions must match the real procedure and medicines; the language exercise does not supply a safe substitute.

10. postprocedure observation

Turn 20. Postprocedure observation means planned monitoring; it does not establish a guaranteed discharge time.

[Return to the conversation, page 54](#)

05 / Answers and explanations / continued

F / Accuracy and scope

F1. What does informed agreement require here?

B. A clear discussion of the specified procedure and relevant options

Consent concerns an understood, specified proposal and cannot be replaced by attendance alone.

[Return to the exercise, page 56](#)

F2. Which statement preserves the facts?

A. No intervention decision is established in this case.

The scenario does not provide findings or a decision authorizing intervention.

[Return to the exercise, page 56](#)

F / Guided speaking

1. instructions

Morgan: The two sheets give different instructions.

Turn 1. The problem is conflicting preparation information rather than a completed clinical decision.

2. verify

Clinician: The procedural team will verify which applies.

Turn 2. Verification by the responsible team is the supplied next step.

3. authorized

Morgan: No medicine change is authorized here.

Turn 3. The scenario supplies no authorization to alter a medicine.

4. clarified

Clinician: The correct plan is not yet clarified.

Turn 4. Conflicting documents leave the relevant instruction unresolved until verification.

[Return to the conversation, page 57](#)

05 / Answers and explanations / continued

F / Rebuild the exchange

1. Rebuild the exchange from "A diagnostic test is not automatic treatment". Blair: "I have read different stories about the wrist and groin. Should I choose from those accounts myself?" Dr Lewis: [missing response] Blair: "I also want to ask about the dye and any concerns in my own medical history." Which response belongs in the gap?

D. The team will discuss the actual vascular access plan and its implications with you. Do not infer your plan from another person's experience.

A Not here. This line belongs to turn 18, after Blair says: "Should I follow preparation advice I found online while I wait for the written instructions?" It addresses that point, not the missing turn in the supplied exchange.

B Not here. This line belongs to turn 12, after Blair says: "I do not want signing for a test to be treated as agreement to something nobody has explained." It addresses that point, not the missing turn in the supplied exchange.

C Not here. This line belongs to turn 6, after Blair says: "Then the purpose is to understand the arteries, rather than promise that a particular device will be inserted?" It addresses that point, not the missing turn in the supplied exchange.

D Correct. This is Dr Lewis's response in turn 14. It connects Blair's preceding point with Blair's follow-up. Vascular access identifies the actual vessel-entry route, not a plan borrowed from another patient.

[Return to the exercise, page 57](#)

06 / Answers and explanations

A / Read the situation

A1. What has Lee received?

D. A written individualized plan

The sheet exists, but this exercise supplies no clinical thresholds or dosing rules.

[Return to the exercise, page 58](#)

A2. What is unclear?

C. Routine versus urgent contact routes

Lee needs the two communication routes distinguished explicitly.

[Return to the exercise, page 58](#)

A3. What does teach-back check?

B. The clarity of the explanation received

Teach-back reveals how the explanation was understood and supports clarification.

[Return to the exercise, page 58](#)

D / Response choices

D1. Which teach-back request is best?

B. Using your plan, explain which contact route applies to each listed situation.

Explaining the appropriate contacts reveals understanding of the plan instead of merely obtaining a yes-or-no answer.

[Return to the exercise, page 63](#)

D2. Which response avoids blame?

C. I need to explain that distinction differently.

Teach-back should prompt clearer explanation rather than criticism of the patient.

[Return to the exercise, page 63](#)

06 / Answers and explanations / continued

D3. A colleague needs the term for this meaning: Breathlessness occurring when lying flat. Which term fits?

A. orthopnea

A Correct. orthopnea: Breathlessness occurring when lying flat. The usual combination is "ask about orthopnea".

B Not here. patient preference: A person's stated wishes about care or communication. The usual combination is "elicit the patient preference".

C Not here. fluid restriction: Individual instruction limiting fluid intake when clinically indicated. The usual combination is "clarify a prescribed fluid restriction".

D Not here. contact pathway: Defined route for reaching the appropriate care service. The usual combination is "distinguish contact pathways".

[Return to the exercise, page 63](#)

D4. Rebuild the exchange from "Teach-back checks the explanation". Dr Evans: "We need to make that explicit using your actual instructions. A routine message is not the urgent-care route." Lee: [missing response] Dr Evans: "We will explain the monitoring purpose and the instructions agreed for you. This discussion does not supply a universal threshold." Which response belongs in the gap?

D. I also want to understand what I am observing, not just copy numbers into a daily weight record.

A Not here. This line belongs to turn 16, after Dr Evans says: "Correct. This teach-back checks my explanation. A misunderstanding tells me to explain differently, not to blame you." It addresses that point, not the missing turn in the supplied exchange.

B Not here. This line belongs to turn 10, after Dr Evans says: "It does not automatically apply in the same way to everyone. Use the individualized instructions from your treating team." It addresses that point, not the missing turn in the supplied exchange.

C Not here. This line belongs to turn 4, after Dr Evans says: "Thank you for saying so. Tell me which part is unclear, and we can work through that distinction." It addresses that point, not the missing turn in the supplied exchange.

D Correct. This is Lee's response in turn 6. It connects Dr Evans's preceding point with Dr Evans's follow-up. A daily weight record is an agreed monitoring log and does not itself supply a universal threshold for action.

[Return to the exercise, page 63](#)

E / Conversation

1. action plan

Turn 2. An action plan provides individualized monitoring and response instructions, but receiving it does not prove complete understanding.

06 / Answers and explanations / continued

2. contact pathway

Turn 4. A contact pathway identifies the appropriate route to a service; routine questions and urgent concerns use different actual arrangements.

3. daily weight record

Turn 6. A daily weight record is an agreed monitoring log and does not itself supply a universal threshold for action.

4. fluid restriction

Turn 8. A fluid restriction is an individual clinical instruction when indicated, not a rule that can be borrowed from another person's plan.

5. diuretic

Turn 10. A diuretic is a medicine that increases urine production; its actual instructions need verification rather than guesswork.

6. care-plan discrepancy

Turn 12. A care-plan discrepancy is a difference between versions or understandings that requires verification before reliance.

7. self-monitoring

Turn 14. Self-monitoring means observing or recording agreed information and should be linked to the actual individualized response plan.

8. teach-back

Turn 15. Teach-back checks how clearly the explanation was understood and should prompt clarification rather than blame.

9. Orthopnea

Turn 17. Orthopnea is breathlessness when lying flat; explaining the term does not replace assessment of the person's actual symptoms.

10. follow-up interval

Turn 19. The follow-up interval is the individually planned time between reviews and must not be guessed from a generic worksheet.

[Return to the conversation, page 65](#)

06 / Answers and explanations / continued

F / Accuracy and scope

F1. What must not be invented?

A. A universal dose-adjustment threshold

The exercise supplies no numerical or medicine-change instructions to generalize.

[Return to the exercise, page 67](#)

F2. What does receipt of the sheet establish?

C. That Lee has the sheet, not that every instruction is understood

Possession of a document is different from understanding or completion of care.

[Return to the exercise, page 67](#)

F / Guided speaking

1. differ

Kai: The instructions on the two versions differ.

Turn 1. The discrepancy concerns conflicting instructions rather than a confirmed current plan.

2. verification

Jo: We need clinician verification.

Turn 2. The responsible clinical review must establish which instructions apply.

3. adjustment

Kai: This exercise authorizes no medicine adjustment.

Turn 3. No medicine change may be inferred from the language-practice scenario.

4. clarified

Jo: The current plan remains to be clarified.

Turn 4. The supplied next step is resolving the discrepancy before relying on a version.

[Return to the conversation, page 68](#)

06 / Answers and explanations / continued

F / Rebuild the exchange

1. Rebuild the exchange from "Teach-back checks the explanation". Dr Evans: "Yes. Now, using the corrected plan, explain how you would choose the contact route for each situation it lists." Lee: [missing response] Dr Evans: "Correct. This teach-back checks my explanation. A misunderstanding tells me to explain differently, not to blame you." Which response belongs in the gap?

B. I can use the written information for that self-monitoring plan rather than guessing which changes matter.

A Not here. This line belongs to turn 4, after Dr Evans says: "Thank you for saying so. Tell me which part is unclear, and we can work through that distinction." It addresses that point, not the missing turn in the supplied exchange.

B Correct. This is Lee's response in turn 14. It connects Dr Evans's preceding point with Dr Evans's follow-up. Self-monitoring means observing or recording agreed information and should be linked to the actual individualized response plan.

C Not here. This line belongs to turn 18, after Dr Evans says: "We can use plain words. Orthopnea is the clinical term for that symptom, but your own description remains important." It addresses that point, not the missing turn in the supplied exchange.

D Not here. This line belongs to turn 12, after Dr Evans says: "Exactly. We will verify the current list rather than let two different versions sit beside each other unexplained." It addresses that point, not the missing turn in the supplied exchange.

[Return to the exercise, page 68](#)

07 / Answers and explanations

A / Read the situation

A1. How many events occur in the fictional comparison group?

B. 40 per 1,000

The supplied comparison group has forty events among one thousand people over five years.

[Return to the exercise, page 71](#)

A2. How many events occur in the intervention group?

D. 30 per 1,000

The intervention group has thirty events among the same denominator of one thousand.

[Return to the exercise, page 71](#)

A3. What is the common time period?

B. Five years

Both fictional figures refer to the same five-year period for a valid comparison.

[Return to the exercise, page 71](#)

D / Response choices

D1. What is the absolute difference?

C. 10 fewer events per 1,000

Subtracting thirty from forty gives ten fewer events among one thousand people.

[Return to the exercise, page 75](#)

D2. What is the absolute percentage-point reduction?

B. One percentage point

Four percent minus three percent equals one percentage point.

[Return to the exercise, page 75](#)

07 / Answers and explanations / continued

D3. A colleague needs the term for this meaning: Absolute reduction divided by the comparison risk. Which term fits?

B. relative risk reduction

A Not here. comparison group: Group providing a reference for evaluating another group. The usual combination is "identify the comparison group".

B Correct. relative risk reduction: Absolute reduction divided by the comparison risk. The usual combination is "explain relative risk reduction".

C Not here. patient preference: A person's stated wishes about care or communication. The usual combination is "elicit the patient preference".

D Not here. population estimate: Estimate describing a defined group rather than a guaranteed individual outcome. The usual combination is "interpret a population estimate".

[Return to the exercise, page 75](#)

D4. Rebuild the exchange from "Twenty-five percent of what?". Robin: "Are those counted over the same period, or is one an annual number and the other a lifetime number?" Dr Ali: [missing response] Robin: "Then the difference is ten events per thousand, rather than two hundred and fifty per thousand." Which response belongs in the gap?

A. The time horizon is five years for both. We must keep that period attached to the comparison.

A Correct. This is Dr Ali's response in turn 6. It connects Robin's preceding point with Robin's follow-up. The time horizon is the period over which the event figures apply; both use the same five years.

B Not here. This line belongs to turn 20, after Robin says: "And we should not add a precision range unless the source actually supplies one and explains it." It addresses that point, not the missing turn in the supplied exchange.

C Not here. This line belongs to turn 2, after Robin says: "A twenty-five percent reduction sounds large. Does it mean twenty-five fewer people out of every hundred?" It addresses that point, not the missing turn in the supplied exchange.

D Not here. This line belongs to turn 4, after Robin says: "Please use the counts first. I follow those more easily than a headline percentage on its own." It addresses that point, not the missing turn in the supplied exchange.

[Return to the exercise, page 75](#)

E / Conversation

1. denominator

Turn 2. The denominator is the group size underlying each figure; both fictional groups contain one thousand people.

07 / Answers and explanations / continued

2. natural frequencies

Turn 4. Natural frequencies express the counts out of a common group size, here forty versus thirty events per thousand.

3. time horizon

Turn 6. The time horizon is the period over which the event figures apply; both use the same five years.

4. absolute risk reduction

Turn 8. Absolute risk reduction is the difference between the two group risks, here ten per thousand or one percentage point.

5. percentage point

Turn 10. A percentage point measures the difference between percentage values; four percent minus three percent equals one point.

6. relative risk reduction

Turn 12. Relative risk reduction compares the decrease with the original comparison risk; ten divided by forty equals twenty-five percent.

7. Relative risk

Turn 14. Relative risk is the intervention risk divided by the comparison risk, here thirty over forty or 0.75.

8. benefit framing

Turn 16. Benefit framing is how a favorable effect is presented; balanced explanation includes absolute as well as relative figures.

9. population estimate

Turn 18. A population estimate describes a group and does not guarantee the outcome for an individual person.

10. confidence interval

Turn 20. A confidence interval expresses statistical uncertainty under defined assumptions and cannot be invented when no interval is supplied.

[Return to the conversation, page 77](#)

07 / Answers and explanations / continued

F / Accuracy and scope

F1. What is the relative reduction?

A. 25 percent

The reduction of ten divided by the comparison count of forty is one quarter, or twenty-five percent.

[Return to the exercise, page 79](#)

F2. Which conclusion must be avoided?

A. These figures guarantee Robin's personal outcome.

Fictional group data cannot establish a personal risk or guarantee an individual result.

[Return to the exercise, page 79](#)

F / Guided speaking

1. five

Clinician: The absolute difference is five per thousand.

Turn 1. Twenty minus fifteen gives five events per thousand in this fictional comparison.

2. 0.5

Patient: That is 0.5 percentage points.

Turn 2. Five divided by one thousand is half of one percent, or 0.5 percentage points.

3. twenty-five

Clinician: The relative reduction is twenty-five percent.

Turn 3. Five divided by the comparison count of twenty equals twenty-five percent.

4. fictional

Patient: These numbers remain fictional.

Turn 4. The figures are invented for practice and do not support a clinical recommendation.

[Return to the conversation, page 80](#)

07 / Answers and explanations / continued

F / Rebuild the exchange

1. Rebuild the exchange from "Twenty-five percent of what?". Robin: "So the relative risk itself is thirty divided by forty, or three quarters of the comparison risk?" Dr Ali: [missing response] Robin: "Could someone use only the larger-sounding relative reduction to make the option appear more impressive?" Which response belongs in the gap?

D. Yes. Relative risk is 0.75 in this illustration. The relative reduction is 0.25, or twenty-five percent. Those are different ways of describing the same comparison.

A Not here. This line belongs to turn 18, after Robin says: "I also understand that these made-up numbers cannot tell me what will happen to me personally." It addresses that point, not the missing turn in the supplied exchange.

B Not here. This line belongs to turn 16, after Robin says: "Could someone use only the larger-sounding relative reduction to make the option appear more impressive?" It addresses that point, not the missing turn in the supplied exchange.

C Not here. This line belongs to turn 10, after Robin says: "I want to get the wording right: four percent compared with three percent is one percentage point apart." It addresses that point, not the missing turn in the supplied exchange.

D Correct. This is Dr Ali's response in turn 14. It connects Robin's preceding point with Robin's follow-up. Relative risk is the intervention risk divided by the comparison risk, here thirty over forty or 0.75.

[Return to the exercise, page 80](#)

08 / Answers and explanations

A / Read the situation

A1. What is confirmed?

A. Receipt of the rehabilitation referral

The receiving team has the referral, but later assessment and booking stages remain unresolved.

[Return to the exercise, page 81](#)

A2. What barrier does Sam report?

A. Transport

Transport is the stated practical obstacle, not a lack of interest.

[Return to the exercise, page 81](#)

A3. What requires individual assessment?

B. Exercise and work guidance

The exercise supplies no clearance or program from which to give activity instructions.

[Return to the exercise, page 81](#)

D / Response choices

D1. Which statement preserves the referral stage?

A. Received, but intake not yet confirmed.

The brief confirms receipt only and leaves intake and individual assessment unfinished.

[Return to the exercise, page 85](#)

D2. Which question addresses access respectfully?

B. What makes travel to the sessions difficult?

Asking what makes travel difficult explores the stated barrier without inventing a negative attitude.

[Return to the exercise, page 85](#)

08 / Answers and explanations / continued

D3. A colleague needs the term for this meaning: Ability to perform physical tasks under relevant conditions. Which term fits?

D. functional capacity

A Not here. patient preference: A person's stated wishes about care or communication. The usual combination is "elicit the patient preference".

B Not here. program eligibility: Whether a person meets requirements for a particular service. The usual combination is "verify program eligibility".

C Not here. occupational demand: Physical or other requirement of a person's job. The usual combination is "describe occupational demands".

D Correct. functional capacity: Ability to perform physical tasks under relevant conditions. The usual combination is "assess functional capacity".

[Return to the exercise, page 85](#)

D4. Rebuild the exchange from "Referred is not yet enrolled". Sam: "Then what is rehabilitation intended to add beyond another appointment about the event itself?" Dr Reed: [missing response] Sam: "I received a letter saying the referral arrived. I assumed that meant I had a first session booked." Which response belongs in the gap?

C. Cardiac rehabilitation can combine assessed activity, education, and support, with a program suited to the relevant clinical circumstances.

A Not here. This line belongs to turn 16, after Sam says: "I would like the program to help me with the tasks that actually matter at home and work." It addresses that point, not the missing turn in the supplied exchange.

B Not here. This line belongs to turn 18, after Sam says: "I understand that progress may involve different steps rather than an immediate return to everything." It addresses that point, not the missing turn in the supplied exchange.

C Correct. This is Dr Reed's response in turn 6. It connects Sam's preceding point with Sam's follow-up. Cardiac rehabilitation is supervised care, not automatic authorization for unrestricted activity.

D Not here. This line belongs to turn 2, after Sam says: "I want to return to work, but the job involves lifting and long periods on my feet." It addresses that point, not the missing turn in the supplied exchange.

[Return to the exercise, page 85](#)

E / Conversation

1. occupational demands

Turn 2. Occupational demands are the actual job tasks relevant to the work assessment.

08 / Answers and explanations / continued

2. return-to-work assessment

Turn 4. A return-to-work assessment evaluates actual readiness; rehabilitation attendance alone does not establish it.

3. Cardiac rehabilitation

Turn 6. Cardiac rehabilitation is supervised care, not automatic authorization for unrestricted activity.

4. intake confirmation

Turn 8. Intake confirmation establishes the receiving program's actual appointment, not merely referral receipt.

5. attendance barrier

Turn 10. An attendance barrier is a practical obstacle, not necessarily refusal of rehabilitation.

6. coverage verification

Turn 12. Coverage verification checks the actual financial arrangements and prevents an unsupported promise that every cost is covered.

7. exercise prescription

Turn 14. An exercise prescription specifies activity for an individual after appropriate assessment and should not be copied from another person's program.

8. rehabilitation goal

Turn 16. A rehabilitation goal is an individualized recovery or functioning objective that connects the program with the person's needs.

9. graded activity

Turn 18. Graded activity progresses in planned steps under an appropriate individual plan rather than an unsupplied universal schedule.

10. care coordinator

Turn 20. A care coordinator connects services and practical arrangements while clinical decisions remain with the appropriately responsible professionals.

[Return to the conversation, page 87](#)

08 / Answers and explanations / continued

F / Accuracy and scope

F1. What must not be inferred from the referral?

A. A safe exercise intensity or unrestricted work clearance

Actual exercise and work guidance requires the appropriate individual clinical assessment.

[Return to the exercise, page 89](#)

F2. Which promise is unsupported?

B. Every cost and journey will definitely be covered.

The case supplies no verified financial or transport entitlement to guarantee.

[Return to the exercise, page 89](#)

F / Guided speaking

1. lifting

Rory: My job includes lifting.

Turn 1. Lifting is the actual work activity raised in the scenario.

2. demands

Clinician: We need the task demands before assessing restrictions.

Turn 2. A job title alone does not specify the relevant physical requirements.

3. supplied

Rory: No lifting limit has been supplied.

Turn 3. The exercise provides no numerical or clinical restriction to infer.

4. assessment

Clinician: The work guidance needs individual assessment.

Turn 4. The appropriate clinical assessment must precede individualized work guidance.

[Return to the conversation, page 90](#)

08 / Answers and explanations / continued

F / Rebuild the exchange

1. Rebuild the exchange from "Referred is not yet enrolled". Sam: "A friend suggested copying their exercise schedule while I wait. Is that the same as the program I will receive?" Dr Reed: [missing response] Sam: "I would like the program to help me with the tasks that actually matter at home and work." Which response belongs in the gap?

B. No. An exercise prescription needs your own assessment. Ask the rehabilitation team what is appropriate for you rather than copying your friend's schedule.

A Not here. This line belongs to turn 10, after Sam says: "Getting there may be difficult. I do not have a reliable lift during the hours the service usually operates." It addresses that point, not the missing turn in the supplied exchange.

B Correct. This is Dr Reed's response in turn 14. It connects Sam's preceding point with Sam's follow-up. An exercise prescription specifies activity for an individual after appropriate assessment and should not be copied from another person's program.

C Not here. This line belongs to turn 20, after Sam says: "For now I need the intake date, transport information, and a clear route for my work questions." It addresses that point, not the missing turn in the supplied exchange.

D Not here. This line belongs to turn 8, after Sam says: "I received a letter saying the referral arrived. I assumed that meant I had a first session booked." It addresses that point, not the missing turn in the supplied exchange.

[Return to the exercise, page 90](#)

Review 1 / Explanations

Cumulative review

1. A colleague needs the term for this meaning: Heart-muscle injury and death caused by ischemia under diagnostic criteria. Which term fits?

A. myocardial infarction

A Correct. myocardial infarction: Heart-muscle injury and death caused by ischemia under diagnostic criteria. The usual combination is "confirm myocardial infarction".

B Not here. dyspnea: Subjective sensation of difficult or uncomfortable breathing. The usual combination is "describe reported dyspnea".

C Not here. teach-back: Checking an explanation by inviting the listener to restate its meaning. The usual combination is "use teach-back without blame".

D Not here. emergency activation: Initiation of the relevant emergency-response process. The usual combination is "confirm emergency activation".

[Return to the exercise, page 24](#)

2. A colleague needs the term for this meaning: Record of symptoms, times, and relevant activity. Which term fits?

D. symptom diary

A Not here. palpitations: Awareness of the heartbeat as unusual, forceful, fast, or irregular. The usual combination is "describe palpitations".

B Not here. qualified interpreter: Trained language professional supporting accurate communication between speakers. The usual combination is "request a qualified interpreter".

C Not here. tachycardia: Heart rate faster than expected in the relevant context. The usual combination is "assess tachycardia".

D Correct. symptom diary: Record of symptoms, times, and relevant activity. The usual combination is "keep a symptom diary".

[Return to the exercise, page 24](#)

Review 1 / Explanations / continued

3. Rebuild the exchange from "Concern first, uncertainty intact". Dr Vale: "I have not labeled this a confirmed infarction. The symptoms justify concern, but the cause is unestablished here." Dr Chen: [missing response] Dr Vale: "Nor should an absent test result be treated as a negative test that rules out the concern." Which response belongs in the gap?

B. Correct. Myocardial infarction is not a substitute label for every chest-pressure report.

A Not here. This line belongs to turn 20, after Dr Vale says: "Understood. Reported symptoms, active response, unresolved cause, and no invented measurements or results." It addresses that point, not the missing turn in the supplied exchange.

B Correct. This is Dr Chen's response in turn 10. It connects Dr Vale's preceding point with Dr Vale's follow-up. Myocardial infarction is a diagnosis requiring appropriate evidence and is not established by the supplied symptom report alone.

C Not here. This line belongs to turn 16, after Dr Vale says: "Shall I wait until every field is complete before confirming transfer of the report?" It addresses that point, not the missing turn in the supplied exchange.

D Not here. This line belongs to turn 4, after Dr Vale says: "I will separate what Chris reports from what our team has actually observed or measured." It addresses that point, not the missing turn in the supplied exchange.

[Return to the exercise, page 24](#)

4. Rebuild the exchange from "A symptom marker is not a diagnosis". Ellis: "If I develop a concerning new symptom, I should not assume pressing the marker replaces asking for help." Dr Mora: [missing response] Ellis: "I also want to know how you receive the recording and when the team explains its findings." Which response belongs in the gap?

B. Exactly. Follow the actual urgent-care instructions; the recording period is not permission to delay needed clinical assessment.

A Not here. This line belongs to turn 4, after Ellis says: "The episodes come and go. They never seem to happen at the exact moment someone checks me." It addresses that point, not the missing turn in the supplied exchange.

B Correct. This is Dr Mora's response in turn 18. It connects Ellis's preceding point with Ellis's follow-up. The recording period is the data-collection interval and is not a reason to defer necessary urgent clinical assessment.

C Not here. This line belongs to turn 6, after Ellis says: "Does agreeing to the monitor mean you have already diagnosed an arrhythmia from my account?" It addresses that point, not the missing turn in the supplied exchange.

D Not here. This line belongs to turn 16, after Ellis says: "Then I should follow the actual device instructions rather than borrow instructions from a friend's different monitor." It addresses that point, not the missing turn in the supplied exchange.

[Return to the exercise, page 24](#)

Review 2 / Explanations

Cumulative review

1. A colleague needs the term for this meaning: Phase of the cardiac cycle involving ventricular contraction and ejection. Which term fits?

D. systole

A Not here. preserved ejection fraction: Ejection fraction within the relevant preserved category despite possible other dysfunction. The usual combination is "discuss preserved ejection fraction".

B Not here. structural heart disease: Abnormality of heart anatomy or associated structures. The usual combination is "investigate structural heart disease".

C Not here. teach-back: Checking an explanation by inviting the listener to restate its meaning. The usual combination is "use teach-back without blame".

D Correct. systole: Phase of the cardiac cycle involving ventricular contraction and ejection. The usual combination is "describe systolic function".

[Return to the exercise, page 46](#)

2. A colleague needs the term for this meaning: Likelihood of bleeding under relevant clinical circumstances. Which term fits?

B. bleeding risk

A Not here. atrial fibrillation: Irregular atrial electrical activity producing an irregular heart rhythm. The usual combination is "explain atrial fibrillation".

B Correct. bleeding risk: Likelihood of bleeding under relevant clinical circumstances. The usual combination is "assess bleeding risk".

C Not here. qualified interpreter: Trained language professional supporting accurate communication between speakers. The usual combination is "request a qualified interpreter".

D Not here. renal function: How effectively the kidneys perform their relevant functions. The usual combination is "review renal function".

[Return to the exercise, page 46](#)

Review 2 / Explanations / continued

3. Rebuild the exchange from "A symptom marker is not a diagnosis". Ellis: "And pressing a marker does not mean the device has instantly told me what caused the sensation?" Dr Mora: [missing response] Ellis: "I am worried I will wear it and nothing will happen during the recording period." Which response belongs in the gap?

D. Correct. The event marker identifies a time to review; it is not itself a diagnosis or a promise of real-time assessment.

A Not here. This line belongs to turn 12, after Ellis says: "I am worried I will wear it and nothing will happen during the recording period." It addresses that point, not the missing turn in the supplied exchange.

B Not here. This line belongs to turn 8, after Ellis says: "What should I record when I notice the feeling, besides pressing whatever button the device has?" It addresses that point, not the missing turn in the supplied exchange.

C Not here. This line belongs to turn 20, after Ellis says: "I also want to know how you receive the recording and when the team explains its findings." It addresses that point, not the missing turn in the supplied exchange.

D Correct. This is Dr Mora's response in turn 10. It connects Ellis's preceding point with Ellis's follow-up. An event marker identifies a time for subsequent review and does not itself diagnose the event.

[Return to the exercise, page 46](#)

4. Rebuild the exchange from "The rhythm question and the stroke question". Avery: "I also want to understand what matters most to me in choosing among appropriate options." Dr Patel: [missing response] Avery: "I understand this explanation does not mean I should stop a medicine because I feel better." Which response belongs in the gap?

D. That belongs in a shared treatment decision, with accurate information about benefits, harms, and practical demands.

A Not here. This line belongs to turn 2, after Avery says: "My heartbeat feels calmer now. Why are we still discussing stroke prevention as though nothing has changed?" It addresses that point, not the missing turn in the supplied exchange.

B Not here. This line belongs to turn 20, after Avery says: "I understand this explanation does not mean I should stop a medicine because I feel better." It addresses that point, not the missing turn in the supplied exchange.

C Not here. This line belongs to turn 8, after Avery says: "I would like the bleeding concern discussed as carefully as the benefit, not treated as a reason to stop asking." It addresses that point, not the missing turn in the supplied exchange.

D Correct. This is Dr Patel's response in turn 18. It connects Avery's preceding point with Avery's follow-up. A shared treatment decision combines clinical evidence with the person's informed priorities rather than ignoring either.

[Return to the exercise, page 46](#)

Review 3 / Explanations

Cumulative review

1. A colleague needs the term for this meaning: Specialist environment for catheter-based cardiac procedures. Which term fits?

A. catheter laboratory

A Correct. catheter laboratory: Specialist environment for catheter-based cardiac procedures. The usual combination is "attend the catheter laboratory".

B Not here. sedation: Medicines used to reduce awareness, anxiety, or discomfort to an intended degree. The usual combination is "explain the sedation plan".

C Not here. teach-back: Checking an explanation by inviting the listener to restate its meaning. The usual combination is "use teach-back without blame".

D Not here. coronary anatomy: Arrangement and features of the coronary arteries. The usual combination is "assess coronary anatomy".

[Return to the exercise, page 69](#)

2. A colleague needs the term for this meaning: Relationship between fluid intake, output, and retention. Which term fits?

A. fluid balance

A Correct. fluid balance: Relationship between fluid intake, output, and retention. The usual combination is "assess fluid balance".

B Not here. decompensation: Worsening of a condition beyond its compensated state. The usual combination is "assess suspected decompensation".

C Not here. heart failure: Clinical syndrome in which cardiac dysfunction causes symptoms and signs in context. The usual combination is "explain heart failure".

D Not here. qualified interpreter: Trained language professional supporting accurate communication between speakers. The usual combination is "request a qualified interpreter".

[Return to the exercise, page 69](#)

Review 3 / Explanations / continued

3. Rebuild the exchange from "The rhythm question and the stroke question". Avery: "I have called all these medicines blood thinners, but perhaps that hides an important difference." Dr Patel: [missing response] Avery: "I had bleeding in the past, but I am not sure which details are relevant for this discussion." Which response belongs in the gap?

A. Yes. Anticoagulation and antiplatelet treatment have different actions. We should use the actual medicine name and purpose.

A Correct. This is Dr Patel's response in turn 10. It connects Avery's preceding point with Avery's follow-up. Anticoagulation acts on coagulation pathways and is not simply another name for every medicine informally called a blood thinner.

B Not here. This line belongs to turn 14, after Avery says: "Will other medicines and health conditions also affect how you judge the options for me?" It addresses that point, not the missing turn in the supplied exchange.

C Not here. This line belongs to turn 8, after Avery says: "I would like the bleeding concern discussed as carefully as the benefit, not treated as a reason to stop asking." It addresses that point, not the missing turn in the supplied exchange.

D Not here. This line belongs to turn 4, after Avery says: "I assumed that if I felt fewer episodes, the risk question would disappear with the symptoms." It addresses that point, not the missing turn in the supplied exchange.

[Return to the exercise, page 69](#)

4. Rebuild the exchange from "Teach-back checks the explanation". Lee: "I appreciate that. Some symptoms, such as breathlessness when lying flat, are hard to describe with the usual shorthand." Dr Evans: [missing response] Lee: "I also need to know when the next review is and who answers questions before it." Which response belongs in the gap?

C. We can use plain words. Orthopnea is the clinical term for that symptom, but your own description remains important.

A Not here. This line belongs to turn 13, after Lee says: "That sounds like a care-plan discrepancy we should resolve before I use the sheet at home." It addresses that point, not the missing turn in the supplied exchange.

B Not here. This line belongs to turn 9, after Lee says: "Good. I have seen different advice about a fluid restriction, and I did not know whether it applied to everyone." It addresses that point, not the missing turn in the supplied exchange.

C Correct. This is Dr Evans's response in turn 17. It connects Lee's preceding point with Lee's follow-up. Orthopnea is breathlessness when lying flat; explaining the term does not replace assessment of the person's actual symptoms.

D Not here. This line belongs to turn 3, after Lee says: "I have read the action plan, but the contact numbers still confuse me." It addresses that point, not the missing turn in the supplied exchange.

[Return to the exercise, page 69](#)

Review 4 / Explanations

Cumulative review

1. A colleague needs the term for this meaning: Difference between comparison and intervention risks. Which term fits?

A. absolute risk reduction

A Correct. absolute risk reduction: Difference between comparison and intervention risks. The usual combination is "explain absolute risk reduction".

B Not here. teach-back: Checking an explanation by inviting the listener to restate its meaning. The usual combination is "use teach-back without blame".

C Not here. time horizon: Period over which an outcome probability is described. The usual combination is "specify the time horizon".

D Not here. number needed to treat: Reciprocal of absolute risk reduction for a defined outcome and period. The usual combination is "qualify number needed to treat".

[Return to the exercise, page 91](#)

2. A colleague needs the term for this meaning: Specified limitation on work activity under an appropriate assessment. Which term fits?

D. work restriction

A Not here. attendance barrier: Obstacle to taking part in scheduled care. The usual combination is "identify an attendance barrier".

B Not here. cardiac rehabilitation: Supervised program supporting recovery, risk reduction, and functioning after eligible cardiac conditions. The usual combination is "explain cardiac rehabilitation".

C Not here. qualified interpreter: Trained language professional supporting accurate communication between speakers. The usual combination is "request a qualified interpreter".

D Correct. work restriction: Specified limitation on work activity under an appropriate assessment. The usual combination is "clarify work restrictions".

[Return to the exercise, page 91](#)

Review 4 / Explanations / continued

3. Rebuild the exchange from "Teach-back checks the explanation". Dr Evans: "It does not automatically apply in the same way to everyone. Use the individualized instructions from your treating team." Lee: [missing response] Dr Evans: "Exactly. We will verify the current list rather than let two different versions sit beside each other unexplained." Which response belongs in the gap?

C. The medicine sheet also needs checking. I do not want to assume an old diuretic instruction remains current.

A Not here. This line belongs to turn 4, after Dr Evans says: "Thank you for saying so. Tell me which part is unclear, and we can work through that distinction." It addresses that point, not the missing turn in the supplied exchange.

B Not here. This line belongs to turn 6, after Dr Evans says: "We need to make that explicit using your actual instructions. A routine message is not the urgent-care route." It addresses that point, not the missing turn in the supplied exchange.

C Correct. This is Lee's response in turn 10. It connects Dr Evans's preceding point with Dr Evans's follow-up. A diuretic is a medicine that increases urine production; its actual instructions need verification rather than guesswork.

D Not here. This line belongs to turn 16, after Dr Evans says: "Correct. This teach-back checks my explanation. A misunderstanding tells me to explain differently, not to blame you." It addresses that point, not the missing turn in the supplied exchange.

[Return to the exercise, page 91](#)

4. Rebuild the exchange from "Referred is not yet enrolled". Sam: "I understand that progress may involve different steps rather than an immediate return to everything." Dr Reed: [missing response] Sam: "For now I need the intake date, transport information, and a clear route for my work questions." Which response belongs in the gap?

B. Yes. Any graded activity must follow the agreed clinical plan, with the relevant review and support.

A Not here. This line belongs to turn 4, after Sam says: "Does the rehabilitation referral mean I have already been cleared to do every part of the job?" It addresses that point, not the missing turn in the supplied exchange.

B Correct. This is Dr Reed's response in turn 18. It connects Sam's preceding point with Sam's follow-up. Graded activity progresses in planned steps under an appropriate individual plan rather than an unsupplied universal schedule.

C Not here. This line belongs to turn 2, after Sam says: "I want to return to work, but the job involves lifting and long periods on my feet." It addresses that point, not the missing turn in the supplied exchange.

D Not here. This line belongs to turn 16, after Sam says: "I would like the program to help me with the tasks that actually matter at home and work." It addresses that point, not the missing turn in the supplied exchange.

[Return to the exercise, page 91](#)

Additional case 1 / Explanations

Extended conversation

1. device transmission

Turn 4. A device transmission is information sent from the monitoring system and is not automatically a reviewed clinical finding.

2. alert

Turn 6. An alert flags information for attention under the actual system and requires context rather than automatically establishing a diagnosis.

3. review workflow

Turn 8. The review workflow describes how the service receives, assesses, and communicates device information rather than assuming every notification has already been interpreted.

4. urgent-care instructions

Turn 12. Urgent-care instructions identify the appropriate clinical response to concerning symptoms and are not replaced by sending a routine device transmission.

5. Data availability

Turn 16. Data availability concerns whether usable information reached the service and cannot itself establish the underlying clinical state when data are missing.

6. review status

Turn 20. Review status identifies whether information is awaiting assessment or has been reviewed and should not be inferred solely from a receipt notification.

[Return to the conversation, page 94](#)

Transfer exchange

1. received

Patient: The transmission was received.

Turn 1. The service confirms that the device information arrived.

Additional case 1 / Explanations / continued

2. pending

Clinician: Clinical review remains pending.

Turn 2. Receipt does not mean the clinical interpretation is complete.

3. diagnosis

Patient: That is not a confirmed diagnosis.

Turn 3. A received transmission alone does not establish a clinical diagnosis.

4. status

Clinician: We should clarify the review status.

Turn 4. The relevant question is the actual stage of review and communication.

[Return to the conversation, page 96](#)

Additional case 2 / Explanations

Extended conversation

1. document version

Turn 4. The document version identifies which dated instruction is being discussed and helps distinguish a superseded copy from a current plan.

2. procedural context

Turn 6. Procedural context includes the actual planned intervention and relevant circumstances, which must be known before medicine instructions are reconciled.

3. responsible prescriber

Turn 8. The responsible prescriber is the clinician accountable for the relevant medicine decision and should be identified explicitly when instructions conflict.

4. reconciled instruction

Turn 12. A reconciled instruction is the verified direction after conflicting information has been resolved by the appropriate clinicians.

5. communication ownership

Turn 16. Communication ownership assigns responsibility for explaining the verified plan and correcting the earlier conflicting message to the patient.

6. closed-loop reconciliation

Turn 20. Closed-loop reconciliation resolves the conflicting instructions and verifies that the appropriate recipients have the updated plan rather than merely documenting internal agreement.

[Return to the conversation, page 98](#)

Transfer exchange

1. verified

Clinician: The current plan is verified.

Turn 1. The clinical plan has been checked and agreed by the relevant clinicians.

Additional case 2 / Explanations / continued

2. older

Office: We are still sending the older letter.

Turn 2. The remaining problem is distribution of the superseded document.

3. correction

Clinician: We need an authorized correction.

Turn 3. The outdated communication must be corrected through the proper record and document process.

4. communication

Office: The patient also needs clear communication.

Turn 4. An internal correction alone does not ensure the patient receives the accurate plan.

[Return to the conversation, page 101](#)

Additional case 3 / Explanations

Extended conversation

1. symptom burden

Turn 4. Symptom burden describes the impact of symptoms on daily life and helps connect clinical information with what matters to the patient.

2. Palliative care

Turn 6. Palliative care addresses symptoms, support, and quality of life and can be discussed alongside disease-directed care rather than automatically replacing it.

3. care goals

Turn 8. Care goals describe the outcomes and experiences important to the patient and are not automatically a specific resuscitation or treatment-withdrawal decision.

4. treatment burden

Turn 12. Treatment burden includes the practical and personal demands of care and should be considered with expected benefits and the patient's priorities.

5. advance care discussion

Turn 16. An advance care discussion explores preferences for future care and requires accurate documentation without claiming that every later circumstance or decision is already settled.

6. care coordinator

Turn 20. A care coordinator helps connect services and responsibilities, but the actual role and contact route must be confirmed rather than assumed.

[Return to the conversation, page 103](#)

Transfer exchange

1. priorities

Patient: I want to revisit my priorities.

Turn 1. The patient asks to discuss a changed preference about the setting of care.

Additional case 3 / Explanations / continued

2. agreed

Clinician: A treatment change is not yet agreed.

Turn 2. The scenario contains a request for discussion, not a completed decision.

3. heard

Patient: My current wishes should be heard.

Turn 3. The patient's updated preferences need to inform the next discussion.

4. options

Clinician: We will explain the actual options.

Turn 4. Available options require an appropriate clinical discussion rather than an assumed change.

[Return to the conversation, page 105](#)

Find a phrase by purpose

Giving an urgent cardiovascular handoff

Lead with the concern: I am handing over chest pressure with breathlessness.

State the action: The emergency response is already active.

Avoid invention: I do not have a verified measurement to report.

[Full phrase bank, page 7](#)

Explaining ambulatory rhythm monitoring

Explain the purpose: We want to compare what you feel with the rhythm at that time.

Separate symptom and finding: Palpitations do not name a specific rhythm by themselves.

Limit the promise: The recording may not capture every episode.

[Full phrase bank, page 17](#)

Explaining an echocardiogram

Check the interpretation: What did that percentage suggest to you?

Define the measurement: It describes the proportion of blood pushed out with a contraction.

Correct gently: It is not the percentage of your heart that is still alive.

[Full phrase bank, page 29](#)

Discussing atrial-fibrillation treatment goals

Separate the goals: Calming symptoms and preventing stroke are related but different goals.

Acknowledge improvement: It is useful to hear that the heartbeat feels calmer.

Keep assessment individual: We need to assess your stroke and bleeding risks in context.

[Full phrase bank, page 39](#)

Find a phrase by purpose / continued

Discussing coronary angiography consent

Check expectations: What have you understood will happen during the visit?

State the diagnostic aim: The proposed test is intended to show the coronary arteries.

Separate treatment: A diagnostic test is not an automatic decision to insert a stent.

[Full phrase bank, page 51](#)

Checking a heart-failure home plan

Check the explanation: I want to check that I explained the two routes clearly.

Invite teach-back: Using your plan, tell me which route you would use for each listed situation.

Remove blame: That tells me I need to explain the distinction differently.

[Full phrase bank, page 62](#)

Explaining absolute and relative risk

State the denominator: Both figures are out of one thousand people.

Keep time consistent: Both cover the same five-year period.

Use natural frequencies: The comparison is forty events versus thirty.

[Full phrase bank, page 74](#)

Coordinating rehabilitation and return to activity

Explain the service: Rehabilitation combines assessed activity, education, and support.

State the stage: The team has received the referral; intake is not yet confirmed.

Ask about access: What would make getting to the sessions difficult?

[Full phrase bank, page 84](#)

Vocabulary index

absolute risk[Lesson 07, p. 72](#)**access-site complication**[Lesson 05, p. 50](#)**acute coronary syndrome**[Lesson 01, p. 5](#)**alert**[Case 1, p. 93](#)**anticoagulation**[Lesson 04, p. 37](#)**antiplatelet therapy**[Lesson 04, p. 37](#)**atrial fibrillation**[Lesson 04, p. 37](#)**attendance barrier**[Lesson 08, p. 83](#)**benefit framing**[Lesson 07, p. 73](#)**bleeding risk**[Lesson 04, p. 37](#)**cardiac catheterization**[Lesson 05, p. 49](#)**cardioversion**[Lesson 04, p. 37](#)**care goals**[Case 3, p. 102](#)**catheter ablation**[Lesson 04, p. 37](#)**clinical handoff**[Lesson 01, p. 6](#), [Lesson 02, p. 16](#), [Lesson 03, p. 28](#),
[Lesson 04, p. 38](#), [Lesson 05, p. 50](#), [Lesson 06, p. 60](#),
[Lesson 07, p. 73](#), [Lesson 08, p. 83](#)**closed-loop reconciliation**[Case 2, p. 97](#)**comparison group**[Lesson 07, p. 72](#)**conduction**[Lesson 02, p. 16](#)**congestion**[Lesson 06, p. 59](#)**contrast medium**[Lesson 05, p. 49](#)**coronary angiography**[Lesson 05, p. 49](#)**coverage verification**[Lesson 08, p. 83](#)**absolute risk reduction**[Lesson 07, p. 72](#)**action plan**[Lesson 06, p. 60](#)**advance care discussion**[Case 3, p. 102](#)**ambulatory monitor**[Lesson 02, p. 15](#)**anticoagulation review**[Lesson 04, p. 38](#)**arrhythmia**[Lesson 02, p. 15](#)**atrial flutter**[Lesson 04, p. 37](#)**baseline risk**[Lesson 07, p. 72](#)**bleeding history**[Lesson 04, p. 38](#)**bradycardia**[Lesson 02, p. 15](#)**cardiac rehabilitation**[Lesson 08, p. 82](#)**care coordinator**[Lesson 08, p. 83](#), [Case 3, p. 102](#)**care-plan discrepancy**[Lesson 06, p. 60](#)**catheter laboratory**[Lesson 05, p. 49](#)**closed-loop escalation**[Lesson 01, p. 6](#)**communication ownership**[Case 2, p. 97](#)**comparison study**[Lesson 03, p. 28](#)**confidence interval**[Lesson 07, p. 73](#)**contact pathway**[Lesson 06, p. 60](#)**coronary anatomy**[Lesson 05, p. 49](#)**coronary narrowing**[Lesson 05, p. 49](#)**daily weight record**[Lesson 06, p. 59](#)

Vocabulary index / continued

Data availability[Case 1, p. 93](#)**denominator**[Lesson 07, p. 72](#)**diagnostic procedure**[Lesson 05, p. 49](#)**diastole**[Lesson 03, p. 27](#)**diuretic**[Lesson 06, p. 59](#)**documented plan**[Lesson 01, p. 6](#), [Lesson 02, p. 16](#), [Lesson 03, p. 28](#),
[Lesson 04, p. 38](#), [Lesson 05, p. 50](#), [Lesson 06, p. 61](#),
[Lesson 07, p. 73](#), [Lesson 08, p. 83](#)**dyspnea**[Lesson 01, p. 5](#)**ectopic beat**[Lesson 02, p. 15](#)**ejection fraction**[Lesson 03, p. 27](#)**electrode lead**[Lesson 02, p. 16](#)**event marker**[Lesson 02, p. 15](#)**exercise prescription**[Lesson 08, p. 82](#)**exertional symptom**[Lesson 01, p. 5](#)**fluid balance**[Lesson 06, p. 59](#)**follow-up interval**[Lesson 06, p. 60](#)**graded activity**[Lesson 08, p. 82](#)**heart failure**[Lesson 06, p. 59](#)**image quality**[Lesson 03, p. 28](#)**initial assessment**[Lesson 01, p. 5](#)**intervention group**[Lesson 07, p. 72](#)**left ventricle**[Lesson 03, p. 27](#)**myocardial infarction**[Lesson 01, p. 5](#)**decompensation**[Lesson 06, p. 60](#)**device transmission**[Case 1, p. 93](#)**diaphoresis**[Lesson 01, p. 5](#)**diastolic function**[Lesson 03, p. 28](#)**document version**[Case 2, p. 97](#)**drug interaction**[Lesson 04, p. 38](#)**echocardiogram**[Lesson 03, p. 27](#)**edema**[Lesson 06, p. 59](#)**electrocardiogram**[Lesson 02, p. 15](#)**emergency activation**[Lesson 01, p. 6](#)**event rate**[Lesson 07, p. 72](#)**exercise tolerance**[Lesson 06, p. 59](#)**femoral access**[Lesson 05, p. 49](#)**fluid restriction**[Lesson 06, p. 59](#)**functional capacity**[Lesson 08, p. 82](#)**guideline-directed therapy**[Lesson 06, p. 59](#)**hemodynamic status**[Lesson 01, p. 5](#)**individual risk estimate**[Lesson 04, p. 38](#)**intake confirmation**[Lesson 08, p. 83](#)**left atrial appendage**[Lesson 04, p. 37](#)**monitor return**[Lesson 02, p. 16](#)**myocardial ischemia**[Lesson 01, p. 5](#)

Vocabulary index / continued

natural frequency[Lesson 07, p. 72](#)**occupational demand**[Lesson 08, p. 82](#)**Palliative care**[Case 3, p. 102](#)**paroxysmal**[Lesson 02, p. 15](#)**patient preference**[Lesson 01, p. 6](#), [Lesson 02, p. 16](#), [Lesson 03, p. 28](#),
[Lesson 04, p. 38](#), [Lesson 05, p. 50](#), [Lesson 06, p. 60](#),
[Lesson 07, p. 73](#), [Lesson 08, p. 83](#)**percutaneous coronary intervention**[Lesson 05, p. 49](#)**postprocedure observation**[Lesson 05, p. 50](#)**preparation instruction**[Lesson 05, p. 50](#)**pressure estimate**[Lesson 03, p. 28](#)**procedural risk**[Lesson 05, p. 50](#)**program eligibility**[Lesson 08, p. 83](#)**radial access**[Lesson 05, p. 49](#)**receiving team**[Lesson 01, p. 6](#)**recording period**[Lesson 02, p. 15](#)**rehabilitation goal**[Lesson 08, p. 82](#)**relative risk**[Lesson 07, p. 72](#)**renal function**[Lesson 04, p. 38](#)**rest symptom**[Lesson 01, p. 5](#)**return-to-work assessment**[Lesson 08, p. 82](#)**review workflow**[Case 1, p. 93](#)**right ventricle**[Lesson 03, p. 27](#)**number needed to treat**[Lesson 07, p. 73](#)**orthopnea**[Lesson 06, p. 59](#)**palpitations**[Lesson 02, p. 15](#)**paroxysmal nocturnal dyspnea**[Lesson 06, p. 59](#)**percentage point**[Lesson 07, p. 72](#)**population estimate**[Lesson 07, p. 73](#)**prehospital report**[Lesson 01, p. 6](#)**preserved ejection fraction**[Lesson 03, p. 27](#)**procedural context**[Case 2, p. 97](#)**procedure consent**[Lesson 05, p. 50](#)**qualified interpreter**[Lesson 01, p. 6](#), [Lesson 02, p. 16](#), [Lesson 03, p. 28](#),
[Lesson 04, p. 38](#), [Lesson 05, p. 50](#), [Lesson 06, p. 60](#),
[Lesson 07, p. 73](#), [Lesson 08, p. 83](#)**rate control**[Lesson 04, p. 37](#)**reconciled instruction**[Case 2, p. 97](#)**reduced ejection fraction**[Lesson 03, p. 27](#)**rehabilitation intake**[Lesson 08, p. 82](#)**relative risk reduction**[Lesson 07, p. 72](#)**responsible prescriber**[Case 2, p. 97](#)**retrosternal**[Lesson 01, p. 5](#)**review status**[Case 1, p. 93](#)**rhythm control**[Lesson 04, p. 37](#)**risk communication**[Lesson 07, p. 73](#)

Vocabulary index / continued

risk-factor modification[Lesson 08, p. 82](#)**sedation**[Lesson 05, p. 50](#)**serial testing**[Lesson 01, p. 5](#)**signal artifact**[Lesson 02, p. 16](#)**sinus rhythm**[Lesson 02, p. 15](#)**source attribution**[Lesson 01, p. 6](#), [Lesson 02, p. 16](#), [Lesson 03, p. 28](#),
[Lesson 04, p. 38](#), [Lesson 05, p. 50](#), [Lesson 06, p. 61](#),
[Lesson 07, p. 73](#), [Lesson 08, p. 83](#)**stroke risk**[Lesson 04, p. 37](#)**structural heart disease**[Lesson 03, p. 28](#)**symptom burden**[Case 3, p. 102](#)**symptom trajectory**[Lesson 01, p. 6](#)**systole**[Lesson 03, p. 27](#)**teach-back**[Lesson 01, p. 6](#), [Lesson 02, p. 16](#), [Lesson 03, p. 28](#),
[Lesson 04, p. 38](#), [Lesson 05, p. 50](#), [Lesson 06, p. 60](#),
[Lesson 07, p. 73](#), [Lesson 08, p. 83](#)**time horizon**[Lesson 07, p. 72](#)**transport arrangement**[Lesson 08, p. 83](#)**troponin**[Lesson 01, p. 5](#)**urgent-care instructions**[Case 1, p. 93](#)**valvular stenosis**[Lesson 03, p. 27](#)**ventricular volume**[Lesson 03, p. 28](#)**work restriction**[Lesson 08, p. 82](#)**secondary prevention**[Lesson 08, p. 82](#)**self-monitoring**[Lesson 06, p. 60](#)**shared treatment decision**[Lesson 04, p. 38](#)**signal quality**[Lesson 02, p. 16](#)**sodium intake**[Lesson 06, p. 59](#)**stent**[Lesson 05, p. 49](#)**stroke volume**[Lesson 03, p. 27](#)**supervised exercise**[Lesson 08, p. 82](#)**symptom diary**[Lesson 02, p. 15](#)**symptom-rhythm correlation**[Lesson 02, p. 15](#)**tachycardia**[Lesson 02, p. 16](#)**thromboembolism**[Lesson 04, p. 37](#)**time-critical concern**[Lesson 01, p. 6](#)**treatment burden**[Case 3, p. 102](#)**uncertainty range**[Lesson 07, p. 73](#)**valvular regurgitation**[Lesson 03, p. 27](#)**vascular access**[Lesson 05, p. 49](#)**wall motion**[Lesson 03, p. 27](#)

References and publication notes

All cases, organizations, figures, and conversations are fictional teaching material, not transcripts. Communication practice does not replace qualified advice or current workplace procedures.

[1] American Heart Association. Ejection Fraction Heart Failure Measurement.

Background for explaining the measurement and why it is only part of a clinical assessment. Source checked 10 October 2026.

<https://www.heart.org/en/health-topics/heart-failure/diagnosing-heart-failure/ejection-fraction-heart-failure-measurement>

[2] American Heart Association. Atrial Fibrillation Medications.

Context for distinct treatment goals and stroke/bleeding discussions, not a prescribing guide. Source checked 10 October 2026.

<https://www.heart.org/en/health-topics/atrial-fibrillation/treatment-and-prevention-of-atrial-fibrillation/atrial-fibrillation-medications>

[3] American Heart Association. Coronary Angiogram.

Background for explaining diagnostic coronary angiography and related terminology. Source checked 10 October 2026.

<https://www.heart.org/en/health-topics/heart-attack/diagnosing-a-heart-attack/coronary-angiogram>

[4] American Heart Association. Cardiac Rehabilitation for Heart Failure.

Context for medically supervised rehabilitation and practical access questions. Source checked 10 October 2026.

<https://www.heart.org/en/health-topics/heart-failure/treatment-options-for-heart-failure/cardiac-rehab-for-heart-failure>

Companion course

The website offers the eight-lesson course and related practice. This book can be used independently. No audio access or external account is needed for its exercises.

<https://englishladder.com/efsp-cardiologists.html>

Explain the finding. Clarify the decision.

Eight cardiovascular encounters practice urgency, rhythm evidence, imaging explanations, stroke and bleeding tradeoffs, procedure discussions, care plans, risk numbers, and rehabilitation handoffs.

Giving an urgent cardiovascular handoff

Chest pressure and breathlessness are reported symptoms, not a confirmed infarction. Missing measurements must remain missing; the exercise cannot classify urgency or establish a diagnosis.

Explaining ambulatory rhythm monitoring

Palpitations are a symptom; arrhythmia is a rhythm finding. A marked event helps locate information but does not itself diagnose it.

Explaining an echocardiogram

Ejection fraction is a pumping proportion, not a percentage of living heart tissue or life expectancy. It is not the whole assessment of cardiac function.

Discussing atrial-fibrillation treatment goals

Feeling fewer palpitations does not, by itself, settle the stroke-prevention decision. Do not derive an instruction to start or stop a medicine from this language exercise.

Phil Stilwell

© 2026 Phil Stilwell. All rights reserved.

No part of this publication may be reproduced, stored in a retrieval system, or transmitted in any form or by any means without prior written permission from the author, except as permitted by law.

English Ladder / English for Work / Revised 2026 edition

This publication includes AI-generated text and cover illustration, revised and checked during production. Brand artwork remains the English Ladder mark. This edition makes no claim of independent professional certification.

Typeface: Bitstream Vera, embedded under its accompanying license. Illustration created with OpenAI's native image generator for this edition. The copyright notice is not a claim to ownership of third-party frameworks or references.