GK'S NOTES 2.0

JUNE 2025 EDITION

VOLUME – 3

GK's Notes 2.0 – Volume 3
June 2025 Edition

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Guideline references are based on public domain standards such as NICE, NHS CKS, and GMC Good Medical Practice. Every effort has been made to ensure the accuracy of information at the time of writing. Users are encouraged to consult official NHS and NICE guidelines regularly, as clinical recommendations may evolve over time.

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For updates, revision tools, and additional resources, visit:
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All cases in this book are entirely original and have been created for teaching purposes. They are:

- Based on common UK clinical practice scenarios
- Informed by recurring themes and trends described by candidates
- Fully aligned with NHS, NICE, and GMC guidance
- Written using original phrasing, with no reproduction of official exam content

No actual PLAB 2 exam stations, checklists, scripts, or copyrighted materials have been used, quoted, or reproduced.
This resource does not claim to predict, replicate, or substitute for the real PLAB 2 exam. It is intended to help candidates build confidence in consultation structure, communication skills, clinical reasoning, and management planning in a UK healthcare context.

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GK's Notes 2.0 isn't just a book. It's the core of a smarter, leaner, and fully structured exam prep system—designed to help you pass PLAB 2 without wasting months or thousands on academies, travel and stay.

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  → Covers **all major PLAB 2 case types**
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    - Top differential diagnoses
    - Key red flag symptoms
    - Natural lay explanations
    - Stepwise management
    - Safety netting guidance

- **Case Hotlist**
  → A prioritised list of commonly reported station themes and **AI-generated predictions**
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- **Mock Exam Generator**
  → Randomised mock station lists **simulating full exam rounds** (16 stations)
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  → Balances systems, consultation types, and case difficulty

Ideal for final-month revision, crash review sessions, and structured mock simulations.

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- **Audio Case Library**
  → Realistic 7–8 minute consultations voiced in natural tone
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  → Ideal for passive revision or active speaking drills

- **Exam-Style Question Bank**
  → Structured clinical and scenario-based questions
  → Includes prompts based on patient presentations, concerns, and management decisions

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  → Day-by-day structured prep plan
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  → Join curated practice groups with others preparing for the same exam window
  → Gain access to peer mocks, speaking drills, and community-based accountability

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BONUS: Weekly Live Recall Webinars

Join regular, structured breakdowns of real-world case patterns, updates on recurring themes, and strategy sessions—open to all premium users.
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What Makes This Different?

- Every tool aligns directly with GK's Notes 2.0
- No duplication, no confusion—just clarity
- Practice what you revise, revise what you practise

All of these and more are coming your way very soon.
To access the packs or ask questions, contact me directly.

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Welcome to Volume 3 of GK's Notes 2.0!

This is where the real test begins—not just of your clinical skill, but of your ability to stay human under pressure. Volume 3 tackles some of the most demanding scenarios in PLAB 2: angry patients, medical errors, breaking bad news, ethical dilemmas, safeguarding concerns, counselling, teaching, practical procedures, SimMan emergencies, and prescriptions.

These are stations where no two conversations are ever the same.
There's no single correct sentence. No perfect response.
That's why **this book is not meant to be memorised.**

You don't need to sound like these notes. You need to sound like *you*—calm, confident, and clear-minded.
This volume gives you structure, reasoning, and phrasing you can *understand*, *adapt*, and make your own.

Before You Begin – Some Advice:

Don't Memorise. Understand.
Every line in this book is designed to guide your *thinking*, not your speech. Learn why each question matters. Notice how explanations are built. Then practise responding naturally in your own words.

Simulate the Real Exam.
Speak aloud. Set a timer. Use the 8 minutes wisely. Get used to handling silence, emotion, interruptions, and uncertainty—because the examiners aren't looking for perfect scripts. They're listening for clarity, empathy, and safe decision-making.

Use Structure, Not Scripts.
Frameworks are here to *anchor* you—not cage you. Understand the logic behind them, then use them flexibly. A well-timed pause or a simple "I can see this is really upsetting" often matters more than textbook lines.

Revisit, Reflect, Refine.
Come back to tough cases. Try them again after a week. Reword your explanations. Test how well you can handle variations. Your growth lies in repetition, not perfection.

Connect the Dots.
Link this volume with the earlier ones. The foundation you built in Volumes 1 and 2 is what will carry you through the toughest moments in Volume 3.

This final volume is here to help you rise to the real challenge of PLAB 2—not just passing, but learning to stay steady, kind, and clinically sharp when the consultation gets hard.
No scripts. No shortcuts. Just solid practice, smart structure, and the confidence that you can handle whatever case comes next.

Let's finish what we started.
One honest, human case at a time.
– GK

Staying Up to Date – New Cases & Evolving Stations

PLAB 2 is constantly evolving. While many core stations are repeated frequently, new scenarios continue to appear, and familiar ones are often presented with different angles, emotional tones, or ethical twists.
To reflect this, GK's Notes 2.0 is not a static book—it's a living resource.

- The notes will be updated multiple times each year, incorporating new recalls, evolving phrasing trends, and structural refinements.
- Make sure you're always using the latest version to stay aligned with current exam patterns.
- Join the weekly live webinars where new or modified cases are broken down, explained, and discussed in real time.

PLAB 2 isn't just about having the right notes—it's about staying current, adapting, and practising with the most relevant material available.
To receive updates and webinar links, stay connected through the main study group or contact me directly.

A Note on Accuracy and Errors

This book is the result of a lot of time, care, and effort—put together by one person, with the goal of helping as many PLAB 2 candidates as possible. Every case has been written with maximum attention to accuracy, clinical alignment, and the most up-to-date guidance available at the time of writing.
That said, medicine evolves. Guidelines change. And despite best efforts, mistakes can slip through.
If you ever come across something that seems unclear, outdated, or incorrect—please don't hesitate to double-check it yourself using trusted sources like NICE or NHS CKS. These should always guide your clinical reasoning and management.

And if you do spot an error, I'd be genuinely grateful if you message me directly with the details. I'll make sure it's reviewed and corrected in the next version. Your feedback not only improves the book—it helps everyone who uses it.

Thank you for helping make this resource better for the whole community.

IMPORTANT!!!

These notes are meant to guide your understanding,

NOT TO BE MEMORISED.

Learn the presentation, consultation structure, and management thoroughly.

In the exam, you must adapt naturally — NOT RECITE A SCRIPT.

Chapter 18: Counselling

Counselling Stations in PLAB 2 – And How the CARE Framework Helps You Stay Calm, Clear, and High-Scoring

Counselling stations can feel overwhelming.
You're faced with a patient or a parent who's anxious, angry, or simply unsure—and you're expected to respond with both empathy and authority. Unlike history-taking or diagnosis-focused stations, there's no obvious "endpoint." The danger for candidates is slipping into vague explanations or falling back on memorised scripts that sound unnatural.

The CARE Framework is a practical, repeatable way to structure your consultation so that you sound calm, confident, and natural—even when the topic is difficult.

What is CARE?
CARE stands for:
C – Clarify the Concern
A – Assess the Background
R – Reassure and Explain
E – Engage in a Shared Plan
Use CARE for any consultation where the patient (or a relative) is bringing a **worry, belief, or request** — especially around treatment decisions, ethical concerns, public health questions, refusal of care, parental fears, or misinformation.

Step 1: Clarify the Concern
"What exactly is the patient worried about – and why?"
Before offering advice, slow down and explore the patient's thinking. You need to understand not just *what* they're asking, but *why now?* and *what they believe to be true*.
This step is about active listening and curiosity — without correcting or teaching yet.

Ask:
- "Can I check — what made you want to discuss this today?"
- "Is there something you read, or someone you spoke to, that raised this worry?"
- "What are your thoughts about this so far?"
- "Are you hoping I can offer something specific today?"

Your goals:
- Identify the **trigger** (e.g. article, friend, past experience)
- Understand the **belief** (e.g. fear of side effects, misunderstanding)
- Hear their **expectations** without judgement

Anchor Phrase: *"Let's start with what's on your mind."*

Step 2: Assess the Background

"What clinical and personal context do I need before I can safely advise?"

Once you've understood their concern, now gather focused background — tailored to the issue — so your explanation is safe, relevant, and not generic.

Think of this as your **clinical lens**: Are there risk factors? Red flags? Anything that changes the plan?

Ask focused questions based on the scenario:

- **Pregnancy-related worries**: Gestational age, scan results, complications
- **Medication concerns**: Current dose, compliance, past reactions
- **Vaccine hesitancy**: Past immunisations, allergies, underlying conditions
- **Paediatric concerns**: Age, development, past illnesses or hospital admissions
- **Screening or test requests**: Symptoms, family history, previous tests

Also include:

- "Are you on any regular medications?"
- "Do you have any long-term health conditions?"
- "Is there any relevant family history?"

Your goals:

- Identify **personal risk factors** or safety concerns
- Spot **misunderstandings** based on clinical context
- Get enough information to **tailor your advice safely**

Anchor Phrase: *"Can I ask a few questions so I can guide you properly?"*

Step 3: Reassure and Explain

"Now explain – clearly, calmly, and respectfully."

This is where your teaching begins — but it should *never* sound like a lecture. Instead, break down the concern with empathy, trusted information, and patient-friendly language.

Avoid dismissive phrases like "There's nothing to worry about."

Use balanced, transparent explanations that empower the patient.

Start with empathy:

- "I can see why this might feel confusing."
- "This is a common concern — and I'll talk you through it step by step."
- "There's a lot of information out there. Let's go over what we know from NHS guidance."

Then explain:

- What the issue/test/treatment actually *is*
- Why it's offered or recommended
- How it works, and what to expect
- Benefits vs risks, explained simply
- What *trusted* sources say (NICE, NHS, WHO)

You can use:

- Analogies (e.g. immune system as a memory card)
- Real-world examples (e.g. how most people tolerate the medication)
- Gentle re-framing:

"Rather than thinking of this as dangerous, it might help to think of it as a layer of protection."
"It's not a guarantee, but it's one of the best tools we have."
Your goals:

- Correct **misunderstanding** without confrontation
- Provide **safe, clear information**
- Maintain **emotional balance**

Anchor Phrase: *"Let me break this down in a simple way."*

Step 4: Engage in a Shared Plan
"Let's now decide what to do – together."
Now that the patient is better informed, involve them in the next step. Don't rush decisions. Support autonomy and offer options. The plan must feel safe, sensible, and collaborative.

Say:

- "I'll explain your options, and you can let me know what feels right."
- "You don't have to decide today — we can take this one step at a time."
- "Here's what I'd recommend based on everything we've discussed — but I'll support you either way."

Always include:

- What you recommend and **why**
- Alternatives if they decline
- What happens **next** (e.g. leaflet, referral, follow-up)
- A **safety net**: "If anything changes or you feel unsure later, just get in touch."

Your goals:

- Respect the patient's **pace and preferences**
- Give clear, **actionable next steps**
- Leave them with **reassurance and control**

Anchor Phrase: *"Let's decide this together – you're not alone in this."*

When to Use CARE
This framework works brilliantly for:

- **Medication refusals or hesitations** (e.g. steroids, statins, ACE inhibitors)
- **Vaccine concerns** (flu, MMR, COVID)
- **Ethical dilemmas** (e.g. confidentiality, consent, capacity)
- **Parental concerns** (e.g. autism, febrile seizures, vaccines)
- **Public health education** (e.g. Hepatitis, HIV, STIs, fasting and diabetes)
- **Refusal of tests or procedures** (e.g. colonoscopy, blood transfusion)

Final Words:
CARE is more than a framework — it's a way of thinking that keeps the **patient at the centre** of the conversation.
It's not about perfect phrasing.
It's about curiosity, clarity, calmness — and the confidence to say, *"Let's work through this together."*
Keep practising. Keep adapting.
The more real your consultation feels, the better you'll score.

Requesting Antibiotics for Travel

Category: Counselling
Setting: GP Clinic (You are an FY2 doctor)

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1. Clarify the Concern
Opening:
"Hi, I'm one of the doctors here at the practice. Thanks for coming in today. Could you tell me what brought you in?"
Patient says:
"I'm going on a trip soon and I'm worried I might get a tummy bug again. Last time, I was given ciprofloxacin to carry — I didn't end up needing it, but I'd like to have it just in case this time too."

Explore the motivation gently:
"I see — so it's more for peace of mind this time? Did something happen during your last trip that made you especially concerned?"
Patient explains no major symptoms last time, but feels anxious after reading online or hearing from friends.

Clarify ICE:

- **Ideas:** "What do you think might happen if you don't carry antibiotics?"
- **Concerns:** "Is there something you're especially worried about — like falling ill, missing activities, or something else?"
- **Expectations:** "Are you hoping I'll prescribe you something as a backup just in case?"

→ Patient wants to "be safe" and "avoid hassle abroad."

2. Assess the Relevant Background
A. Travel History & Risk Factors

- "Where are you travelling to?" → *e.g., Thailand*
- "When is the trip?" → *Next week*
- "Who are you travelling with?" → *Wife*
- "Where will you be staying?" → *Five-star resort with included meals*
- "Do you plan to eat street food or local dishes?"
- "Will you be drinking bottled water, or using tap water there?"
- "Any jungle trips, rural village visits, or wildlife experiences planned?"

B. Personal Medical History

- "Do you have any ongoing health conditions like diabetes, recent surgery, or anything that affects your immunity?"
- "Are you taking any regular medications?"
- "Does your wife have any health issues or travel risks?"

→ Healthy middle-aged male, no medical red flags. Wife also well.

C. Past Travel Experience

- "Where did you travel to last time when you were given ciprofloxacin?" → *Brazil, Amazon region*
- "Was it prescribed before travel or after symptoms began?"
- "Did you actually use the antibiotic?" → *No*
- "Did you have any problems with food or water last time?"

→ No prior use, but seeking "cover."

3. Reassure & Explain

Start empathetically:

"I completely understand your concern. Travelling to new environments can increase the risk of stomach upset, and it's good that you're thinking ahead. But I'd like to explain why antibiotics may not be the best option — and what safer alternatives are."

Lay Explanation:

"Tummy bugs" can mean several things:

- **Food poisoning** — due to toxins already formed in food (not treated with antibiotics).
- **Traveller's diarrhoea** — due to bacterial or parasitic infection (e.g., E. coli, Giardia).
- **Typhoid, cholera, dysentery** — more serious, but uncommon with good hygiene.

Antibiotics like ciprofloxacin used to be prescribed before travel, but:

- They **don't protect against food poisoning** (which is toxin-mediated).
- They **can cause side effects** like allergic reactions, gut imbalance, and even tendon damage.
- The **rise in global antibiotic resistance** means many bacteria no longer respond to them.
- **Current UK guidance does NOT recommend antibiotics as a preventive measure** — except in rare, high-risk patients (e.g., those with bowel disease or immunosuppression).

"So even though it may feel like a 'safety net,' it could actually do more harm than good."

4. Educate & Plan Together

A. Safer Preparation Steps:

"Here's what we recommend now to stay healthy while travelling — no antibiotics needed."

1. Food & Water Safety:

- Drink only **bottled water** (make sure it's sealed).
- Avoid **ice cubes** (often made from tap water).
- Stick to **hot, freshly cooked food**.
- Avoid **salads, raw seafood, unpasteurised dairy**, or **street food** unless visibly hygienic.

2. Hygiene:

- Use **hand sanitiser** before meals and after toilet use.
- Keep tissues and disinfectant wipes handy for surfaces.

3. OTC Medications:

- **Loperamide (Imodium)** is useful if you get mild diarrhoea:

  "You can take 1 capsule after your first loose stool, then 1 after each episode, max 8 per day — but don't take it if you have fever, blood in the stool, or bad cramps."

4. When to Seek Help Abroad:

- If you get:
  - High fever
  - Blood in your stool
  - Vomiting that prevents fluid intake
  - Symptoms lasting more than 3 days

  → See a local doctor — don't self-medicate.

B. Vaccinations & Prevention:

- "You might benefit from vaccines like **Hepatitis A**, **Typhoid**, and depending on where you're going, possibly **Yellow Fever**."
- "Have you had these recently?" → If not, offer travel vaccine referral.
- "You might also need **malaria prophylaxis** depending on the region — shall I check that for you now?"

C. Insurance & Resources:
"Please ensure you have **good travel insurance** — it really helps if you fall ill abroad."

Safety Net:
"If you develop severe symptoms abroad, don't try to manage it yourself — please see a local doctor. And if anything changes before you go, feel free to get back in touch with us."

Offer Leaflet or Link:
- NHS Fit for Travel printout or QR code.
- Optional: local travel clinic details if needed for vaccines.

Note to the Student (Diagnostic Thinking)
This is not a refusal station — it's a **redirection** case. The key to scoring high is:
- Understanding **what the patient fears**
- Using **clear, natural language** to explain resistance and antibiotic misuse
- Offering **better options** without sounding dismissive
- Staying up to date with NICE and NHS Fit for Travel advice.

Obesity and Weight Management

Setting: GP Clinic – Telephone Consultation
Role: FY2 GP Doctor
Patient: 40-year-old woman calling to discuss weight concerns

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1. Clarify the Concern
Introduction:
"Hello, you're through to one of the doctors at the practice. I understand you wanted to talk about your weight today—would it be okay if I asked a few questions to better understand what's been happening?"
Clarifying Motivation and ICE:
- "What made you decide to reach out about your weight now?"
- "Have you noticed anything recently that made you more concerned?"
- "What do you think might be contributing to your weight gain?"
- "Is there something specific you're worried this might be affecting—like your health, confidence, or energy levels?"
- "What are you hoping we can help you achieve today?"

Patient responds: Wants to be healthier and lose weight, has struggled since childhood, tried dieting once but didn't work, eats fast food often, no regular exercise, no known medical conditions. She mentions her mother and sister are also overweight.

2. Assess the Relevant Background
A. Weight History:
- "When did you first start noticing your weight becoming a concern?"
- "Have you ever been able to lose weight successfully in the past?"
- "What approaches have you already tried—was it a specific diet, or did you make other changes?"

B. Diet and Lifestyle (DESA):
- "What does a typical day of eating look like for you?"
- "How often do you tend to have takeaway or fast food?"

- "Do you have a regular exercise routine—or are there any barriers preventing physical activity, like joint pain or lack of time?"
- "Do you smoke or drink alcohol?"

C. Possible Underlying or Contributing Factors:

- "Do you feel tired a lot of the time or feel cold easily?" (screening for hypothyroidism)
- "Are your periods regular?" (screening for PCOS)
- "Have you ever noticed mood changes or been eating more during stressful times?"

D. Psychosocial Impact:

- "How is this affecting your confidence, mood, or daily activities?"
- "Do you feel supported by people around you?"

E. Family History:

- "You mentioned your mother and sister are also overweight—has anyone in the family had diabetes, high blood pressure, or heart issues?"

F. Medical History and Medications:

- "Are you currently on any medications?"
- "Do you have any long-term conditions, like diabetes or high blood pressure?"
- "Have you had any blood tests done recently—for example, for cholesterol or thyroid function?"

Patient summary: Long-standing weight concerns since childhood, eats fast food regularly, no structured exercise, no past medical issues, no medication. Family history includes obesity but no known diabetes or heart conditions.

3. Reassure and Explain

Empathetic Reassurance:

"Firstly, thank you for opening up about this—many people struggle silently with their weight, and it's a positive step that you've reached out."

"I want to reassure you that this is not a personal failure or something to be ashamed of. Obesity is a medical condition influenced by many factors—not just diet and exercise, but also genetics, environment, hormones, and even mental health."

Lay Explanation:

- "Carrying excess weight over time increases the risk of developing conditions like diabetes, high blood pressure, joint pain, and heart problems—but the good news is that even small changes can significantly reduce those risks."
- "Your body mass index—or BMI—is one of the ways we classify obesity. If it's above a certain range, we describe it as class 2 or class 3 obesity, but regardless of the number, our approach focuses on healthy change, not judgment."

4. Educate and Plan Together

A. Lifestyle First (Always the First Line):

"Let's talk about how we can support you through manageable steps, starting with lifestyle."

- "We can look at a structured weight loss plan that includes balanced, portion-controlled eating and gradual increases in physical activity."
- "We also work with community-based weight management services that offer expert guidance, support groups, and follow-up. I can refer you to one of these if you're interested."

B. Behavioural Support:

- "Setting small, realistic goals and making gradual changes often works better than extreme diets. Some people benefit from apps or coaching to help with tracking habits and progress."

C. Medication (only if appropriate):

- "We typically consider medications like Orlistat or Semaglutide if BMI is above 30, or above 27 if there are other health conditions—but only after lifestyle measures have been properly tried."

- "If lifestyle changes alone don't lead to enough weight loss, we may consider medication. One of the options is **Orlistat**, which helps reduce fat absorption from the food you eat."
- "It's generally safe, but some people experience side effects — especially if they eat a high-fat meal while on it."

If patient asks about side effects of Orlistat (or preemptively):

- "The most common issues are digestive — things like oily or loose stools, an urgent need to go to the toilet, and sometimes gas or mild tummy pain. These symptoms tend to improve when the diet is lower in fat."
- "Because it can affect absorption of some vitamins — especially fat-soluble ones like vitamin D — we usually check your levels before starting and may suggest a supplement."
- "It's also worth knowing that sometimes the stools can be bulky or float, and some patients say it can affect toilet flushing."
- "We'd only prescribe this after doing your blood tests and confirming it's suitable for you."
-

D. Bariatric Surgery (only if relevant):

- "In very specific situations—like if BMI is above 40 or 35 with complications—we consider surgical options. That's something we'd assess later if needed, through a specialist service."

E. Blood Tests and Check-Up:

- "I'd recommend a basic blood panel including thyroid function, blood sugar, cholesterol, and possibly an ECG. This helps us rule out any hidden medical causes and gives us a baseline."

F. Motivation and Education:

- "Weight loss isn't just about appearance—it improves energy levels, self-confidence, fertility, joint pain, and long-term health. You're more likely to keep it off when it's done gradually and sustainably."

G. NHS Resources and Tools:

- "There are NHS-supported apps and tools we can suggest. I'll text you some links, and we can send you printed leaflets too if you prefer."
- NHS Better Health: Weight Loss Plan
  NHS Fit for Life App
  Offer SMS with links if doing telephone consultation.

Safety Net:
"If you notice any symptoms like fatigue, irregular periods, or mood changes getting worse, or if weight gain becomes rapid or unexplained, please do get in touch earlier."

Follow-Up Plan:
Book blood tests and telephone review in 4 weeks. Offer referral to local NHS weight management programme if available.

Note to the Student:
This case is not about quick solutions, but about showing empathy, explaining the complexity of obesity, and guiding the patient through realistic, non-judgmental options. Always address lifestyle first. Offer structured follow-up and appropriate investigations, and be kind but firm in managing expectations.

Obesity Counselling – BMI 40

Setting: GP Clinic – Face-to-Face Consultation
Role: FY2 GP

1. Introduction
"Hello, I'm one of the doctors here at the practice. Thanks for coming in today. Before we start, could I confirm your full name and age, please?"
"Great, thank you. I understand you've come in today because of concerns about weight gain. Could you tell me more about what's been happening?"

2. Clarify the Concern (Paraphrase + ICE)
"You mentioned you've noticed weight gain recently. Can I ask what's worrying you most about it?"

- She reports steady weight gain.
- No other symptoms, no medical history.
- Recently went through menopause.
- Not on a structured or healthy diet.
- Doesn't smoke or drink alcohol.

"Is there anything specific you were hoping I'd talk to you about today—such as treatment options?"
→ Patient is hoping to hear about medications or surgery options.

3. Assess the Background
"Thanks for sharing that. Would it be okay if I ask a few questions to understand the bigger picture?"
A. ODIPARA for Weight Gain (briefly):

- Onset: "When did you first notice your weight starting to increase?"
- Duration: "Has it been steady or sudden?"
- Interventions: "Have you tried anything so far to manage it?"
- Aggravating: "Any patterns you've noticed—emotional eating, night cravings?"
- Impact: "Is this affecting your daily life, mood, or confidence?"
- Progression: "Has it been getting worse recently?"
- Associated: "Any changes in energy levels, appetite, sleep?"

B. Exclude Organic Causes / Red Flags (DDx Screening):

- Hypothyroidism: "Do you feel colder than others? Any constipation or tiredness?"
- PCOS: "Any irregular periods, acne, or unusual hair growth?"
- OSA: "Any snoring at night or waking up feeling unrefreshed?"
- Diabetes: "Excessive thirst? Frequent urination?"

C. Mood Check:

- "How have you been feeling emotionally?"
- "Do you feel motivated day to day, or have you noticed any drop in mood or energy?"
- "On a scale of 1 to 10, how would you rate your general mood lately?"

D. Menopause (P4 focus):

- "You mentioned menopause — how long ago was that?"
- "Are you taking any hormone therapy or supplements currently?"
- "Any hot flushes, mood swings, or sleep disturbances?"

E. MAFTOSA:

- PMH: "Any long-term conditions or previous operations?"
- Allergies: "Any known medication allergies?"
- FH: "Any family history of obesity, diabetes, or heart conditions?"
- Treatment: "Taking any regular medications or over-the-counter products?"
- Occupation: "What's your usual daily routine like?"
- Social: "Do you live alone or with family? Is meal planning shared?"
- Alcohol/smoking: "You mentioned you don't drink or smoke, which is great."

F. DESA – Current Lifestyle:

- Diet: "What does a usual day of eating look like?"
- Exercise: "Do you get any regular physical activity or is there something that limits it?"
- Sleep: "How are your sleep patterns?"
- Alcohol/smoking: already ruled out.

G. ICE Recap (If not already done):

- Idea: "What do you think might be contributing to the weight gain?"
- Concern: "Are you worried about any specific complications or long-term effects?"
- Expectation: "You mentioned medications and surgery—are you looking to explore those options today?"

4. Examination Findings

- Vitals and general exam: Normal
- BMI: 40
- No stigmata of hypothyroidism or Cushing's
- No signs of OSA or other secondary causes

5. Reassure and Explain (Lay Language, NICE-aligned)

"Thanks for discussing all of that. Based on your history, weight, and examination, your current BMI falls in the range of what we call Class 3 obesity. That means your weight is significantly above the recommended level and carries a higher risk of complications."

"But this is not something to feel blamed or judged for — obesity is a complex medical condition that can run in families, and is influenced by things like hormones, lifestyle, sleep, mood, and even menopause."

"This doesn't mean you're unhealthy right now — but it does mean we need to act to reduce your long-term risk of things like type 2 diabetes, high blood pressure, joint pain, and heart disease."

6. Educate and Plan

"Here's how we can go forward. I'll suggest a multi-step plan, and we'll tailor it to what suits you best."

Step 1 – Investigations:

- "We'll start by checking your blood pressure, blood sugar (HbA1c), cholesterol, thyroid function, and do a simple heart tracing (ECG). This helps us check for any hidden issues."

Step 2 – Lifestyle Support (NICE First-Line):

- "I'll refer you to our local weight management programme. It includes diet plans, activity routines, behavioural coaching, and support groups."
- "These programmes are specially designed to match your preferences, fitness level, and lifestyle."

Step 3 – Medication (after lifestyle trial):

- "If there's no significant improvement with lifestyle support alone, we can consider starting weight loss medication."
- "Options like **Liraglutide** or **Orlistat** are considered if your BMI stays over 30 or over 27 with complications."
- "If lifestyle changes alone don't lead to enough weight loss, we may consider medication. One of the options is **Orlistat**, which helps reduce fat absorption from the food you eat."
- "It's generally safe, but some people experience side effects — especially if they eat a high-fat meal while on it."

If patient asks about side effects of Orlistat (or pre-emptively):

- "The most common issues are digestive — things like oily or loose stools, an urgent need to go to the toilet, and sometimes gas or mild tummy pain. These symptoms tend to improve when the diet is lower in fat."
- "Because it can affect absorption of some vitamins — especially fat-soluble ones like vitamin D — we usually check your levels before starting and may suggest a supplement."

- "It's also worth knowing that sometimes the stools can be bulky or float, and some patients say it can affect toilet flushing."
- "We'd only prescribe this after doing your blood tests and confirming it's suitable for you."
-

Step 4 – Surgery (if appropriate later):

- "Surgical options like **bariatric surgery** are reserved for people with BMI over 40 or over 35 with medical problems. You're in the right BMI range, but surgery is never the first step."
- "If needed, we'd refer you to a Tier 3 or Tier 4 obesity specialist service for that assessment later."

Step 5 – Mental Health and Support:

- "If you feel mood or motivation is an issue, we can offer counselling or CBT-based support alongside."

Optional Leaflet / Resources:

- "I'll print you a leaflet on healthy eating, NHS-calorie counting apps, and information about the Tier 2 weight loss programme."

7. Follow-Up and Safety Netting

"I'll arrange those tests now and refer you to the local service. We'll meet again in around 4–6 weeks to go through the results and review how you're doing."
"If you notice any changes in mood, sleep, energy, or physical symptoms before then, please don't hesitate to contact us sooner."
"Does that sound like a plan you'd be comfortable with?"

Obesity Counselling – Knee Arthroplasty Deferred

Setting: Orthopaedic Outpatient Clinic
Role: FY2 Doctor
Patient: 50-year-old woman with severe left knee osteoarthritis
BMI: 37.5 kg/m²
Structure: CARE – Clarify, Assess, Reassure, Educate & Plan

C – Clarify the Concern
Professional, empathetic start:
"Hello, I'm one of the doctors in the orthopaedic team. I understand you were referred here for your knee pain and discussed a possible operation. Before we go further, may I check your full name and age?"
"Thanks. I can see the consultant has recommended knee replacement but also mentioned the need to reduce your BMI first. Could you tell me what you've understood about that so far?"

Elicit her view naturally:
→ Patient expresses frustration: "I'm in constant pain, I'm ready for the surgery, but now they say I need to lose weight first. I can hardly move — how do they expect me to do that?"
"That sounds very difficult. I want to make sure I understand what's worrying you most — is it the delay, or more the challenge of how to lose weight given the pain?"
"And what are you hoping I can help you with today?"

A – Assess the Relevant Background
1. Weight History & Lifestyle Context:
"When did your weight first start becoming a concern?"
"Has it been a gradual change or sudden increase?"
"Have you tried anything in the past — diets, meal plans, or weight loss programmes?"

2. DESA:

Diet: "Can you walk me through a typical day of eating?"
"How often do you eat takeaways or snack between meals?"
Exercise: "I understand movement is difficult — are you able to do any light activity, like walking short distances or stretching at home?"
Smoking/Alcohol: "Do you smoke or drink?" → She doesn't

3. Menopause & Hormonal History:

"You mentioned menopause — when did that happen?"
"Are you on any hormone treatment like HRT?"

4. Impact on Life and Function:

"How has the weight affected your energy or daily function?"
"You mentioned pain — is it making it hard to do household tasks or work?"
→ She works as a supermarket cashier and struggles to stand for long.
"How has all this been affecting your mood or confidence?"

5. Secondary Causes and Red Flag Screening (targeted):

Hypothyroidism: "Do you feel tired a lot, cold when others aren't, or have constipation?"
Cushing's: "Any recent bruising, stretch marks, or puffiness in the face?"
Obstructive Sleep Apnoea (OSA): "Any snoring at night or daytime sleepiness?"
Diabetes risk: "Any increased thirst or urination?"
→ No red flags identified

6. PMH/Drugs/FH:

"Any other medical problems like diabetes, heart disease, or thyroid issues?"
"Are you taking any regular medications?"
"Anyone in your family with similar weight issues or metabolic conditions?"
→ No comorbidities, no medications, family history of obesity.

R – Reassure

Gentle, confident reassurance with validation:
"Thanks for sharing all of that. I can see you've been managing a lot — pain, work, and now this added delay. I want to reassure you that this isn't about denying you the surgery, and it's definitely not about blaming you."

Explain the medical context clearly:
"At the moment, your **BMI is 37.5**, which falls above the safe threshold for surgery. For knee replacements, NHS guidelines recommend a BMI of **under 35**."
"That's because the **knee is a weight-bearing joint**. With a higher BMI, the new joint is more likely to loosen, wear out early, or become infected. These complications can lead to poor healing or needing a repeat operation."
"We want your surgery to work well the first time — that's why this step is so important."

E – Educate & Plan

1. Pain and Joint Support (Short-Term):

"Let's improve your pain management so you can move a little more comfortably."
Offer regular paracetamol + topical NSAID
Avoid escalation to opioids

"I'll also refer you to **physiotherapy** — not for intense activity, but for gentle, joint-safe exercises that actually help reduce pain and protect the knee."

2. Weight Management Plan:

Diet-first, exercise-supported approach (NICE CG189):

"Most weight loss comes from **dietary changes** — even small reductions in portion size and switching to lower-calorie meals make a big difference."

Refer to **dietitian** for structured plan

Recommend:

NHS Weight Loss App

Free NHS joint-friendly exercise videos

Weekly goals for food tracking and portion control

If lifestyle alone is insufficient after trial period:

Consider **Orlistat**:

"It reduces fat absorption in the gut."

Side effects: oily stools, flatulence, urgency, possible vitamin deficiency

Consider **Semaglutide** if Tier 3 pathway is available and criteria are met

3. Investigations:

"I'd like to check a few things that could be influencing your weight or making it harder to lose weight."

HbA1c (diabetes risk)

TSH (thyroid)

Lipid profile (cardiovascular risk)

ECG (pre-op baseline)

4. Clear Goal and Timeline:

"We're aiming for a **BMI below 35** — that's around a 5–7 kg reduction depending on your height. It's not a huge amount, and with consistent support, it's achievable in a few months."

"We'll reassess your fitness for surgery once we're closer to that target."

5. Addressing the Concern: "How can I lose weight if I can't exercise?"

"That's a very valid question, and many people feel the same way. You don't need to do high-impact exercise. Most weight loss comes from food choices. With some guidance from our team and light, physiotherapy-guided activity, we can help you reach the goal safely."

"And the best part — even a small weight loss can actually reduce your knee pain."

6. Emotional and Practical Support:

Offer Tier 2 weight management referral (if available)

Monitor for signs of low mood or frustration

"If at any point you feel stuck, unmotivated, or emotionally overwhelmed, please let us know — we can offer extra support."

Final Actions, Safety Netting & Follow-Up

Blood tests: HbA1c, TSH, Lipid profile, ECG

Referrals: Dietitian, Physiotherapy

Resources: NHS Weight Loss App, printed BMI chart, joint-friendly videos

Medication: Consider Orlistat if needed after lifestyle trial

Follow-up: Reassess weight and surgical fitness in 6–8 weeks

Safety Net:

"If you notice worsening joint pain, swelling, fever, or symptoms of low mood — or if your function drops significantly — please get in touch sooner."

Sick Note Request – Parent Caring for Child with Chickenpox

Setting: GP Clinic
Role: FY2 GP
Patient: 40-year-old woman requesting time off to care for her child

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C – Clarify the Concern

"Hello, I'm one of the doctors here today. Before we begin, could I just confirm your full name and age, please?"
"How can I help you today?"
Patient: "My child has chickenpox and I'd like a sick note so I can take time off work to care for him."
"Thanks for sharing that. So just to make sure I've understood — your child has recently been diagnosed with chickenpox, and you're asking for a sick note in your name to give to your employer while you stay home to look after him. Is that correct?"
→ "Yes, exactly."

A – Assess the Relevant Background

1. Child's Health Status

- "When did the chickenpox start?"
  → "Three days ago."
- "How's your child doing now?"
  → "He's recovering. No fever now, and the rash is drying up."

2. Mother's Health

- "Have you had any symptoms yourself?"
  → "No, I feel fine."
- "Do you remember having chickenpox as a child?"
  → "I'm not sure."

3. Home Support

- "Is anyone else able to help at home?"
  → "No, my husband's away on a business trip, and our nanny won't come because of the chickenpox."

4. Work Circumstances

- "What do you do for work?"
  → "Marketing executive."
- "Is working from home an option?"
  → "No, my role requires me to be in the office."
- "Have you discussed the situation with your employer?"
  → "No, I was hoping to avoid that — I just wanted a sick note."

5. Alternatives

- "Do you have any family nearby, or anyone else you could ask to help out temporarily?"
  → "No, unfortunately not."

6. Direct Concern

- "Can I check — are you asking for the sick note because your employer requires documentation?"
  → "Yes, they usually want something on paper."

R – Reassure

"I really do understand how difficult this must be — you're clearly trying to do the right thing by staying home to look after your child, especially without any help around."

"You're in a tough situation, and many parents face similar challenges when children become unwell. Wanting to be there for them — especially during something like chickenpox — is completely understandable."

"But I also need to be upfront and honest with you about what I'm legally allowed to do as a doctor. In the UK, **sick notes — or fit notes — can only be issued when the person themselves is medically unfit for work.** Since you are currently well, I cannot issue a sick note in your name."

"This isn't a judgment on your parenting or your priorities — it's simply a boundary around how these documents are regulated. I wish I could offer something official to make this easier, but using a sick note in this context would be considered inappropriate documentation."

E – Educate & Plan

1. What You *Can* Offer

"While I can't issue a sick note, I can write a brief letter that states you've informed us your child is currently unwell with suspected chickenpox, and that you're providing care. This is not a medical certificate — it simply confirms what you've told us today."

"Some employers find that helpful when explaining short-notice absences."

2. Work Discussion

"It may be worth having a conversation with your employer. Many workplaces do have provisions for:

- Short-term unpaid leave
- Annual leave
- Or even shift swaps, depending on the team"

"I completely understand why you hesitated, but they may be more understanding than expected — especially when they realise it's a childcare emergency, not a long-term issue."

3. Reassure About Chickenpox Exposure

"Since you're not showing any symptoms, and your child is improving, there's no concern for your own health at this stage. Even if you're unsure about your childhood infection history, most adults in the UK have natural immunity unless proven otherwise."

4. Childcare Options (Gently Framed)

"If you'd like, I can also point you to local childcare resources or community parent support groups that may be able to help in future emergencies — even short-term assistance can sometimes make a difference."

Safety Net (Naturally Integrated):

"If your child's condition worsens — for example, if the spots become infected, he develops high fever again, or you notice any unusual behaviour — please don't hesitate to get in touch."

"And if you start to feel unwell yourself or develop any symptoms, we'd be happy to review you right away."

Close:

"You're clearly doing your best in a difficult situation. I can print that letter now if you'd like — just something simple to show you've spoken to us. And I'll give you an NHS leaflet on chickenpox too, in case your employer or school asks for information."

"Would that be helpful?"

Sick Note Request – Childcare Issues During School Holidays

Setting: GP Clinic
Role: FY2 GP

Patient: 35-year-old woman requesting a sick note to stay home during school holidays

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C – Clarify the Concern

"Hello, I'm one of the doctors here today. Before we begin, could I confirm your full name and age, please?"
"How can I help you today?"
Patient: "Doctor, I need a sick note so I can stay home and look after my children during the school holidays."
"Thanks for letting me know. Just to clarify — your children are currently off school due to the holidays, and you'd like a sick note so you can take time off work to care for them. Is that right?"
"Yes, exactly."

A – Assess the Relevant Background

1. About the Children

- "Can I ask how many children you have?"
  → "Two."
- "Are they generally well? Do they have any additional needs or require special supervision?"
  → "No, they're fine."

2. Current Childcare Arrangement

- "Who normally looks after them when you're working?"
  → "My husband usually does."
- "Is he not available at the moment?"
  → "He's away on a fishing holiday."

3. Employment Context

- "What do you do for work?"
  → "I'm a palliative care nurse."
- "And is that a permanent role?"
  → "Yes, I work full-time."

4. Leave or Flexibility Already Used

- "Have you already taken annual leave this year?"
  → "Yes, I used it earlier this summer."
- "Have you tried speaking to your employer about your situation?"
  → "No, I thought a sick note would be easier."

5. Other Options Explored

- "Have you looked into other options — like a childminder, local holiday club, or family support?"
  → "No, not yet."

6. Impact

- "What happens if you're unable to attend work this week?"
  → "I'm worried I'll face disciplinary action or lose pay."

7. Prior Requests

- "Have you ever been issued a sick note for a similar reason in the past?"
  → "No, this is the first time I've asked."

R – Reassure

"Thank you for being open about your situation. I completely understand how difficult this must be — especially when your regular childcare isn't available and you want to be there for your children."
"And I want to reassure you that it's not wrong to seek support or ask for time off in situations like this. You're clearly doing your best as a parent and a professional."

"But I do need to be honest with you about what I can and cannot do as a doctor. Sick notes — also known as fit notes — are issued when someone is medically unwell and unable to work because of **their own health condition**."
"In your case, as you're feeling well and there's no medical illness affecting your ability to work, I'm legally not permitted to issue a sick note."
"I know that may be disappointing to hear, and I do want to emphasise — this isn't about minimising your responsibilities or judging your priorities. It's simply a legal and professional boundary we have to follow."

E – Educate & Plan

1. Advice on Next Steps

"The most appropriate step now would be to speak to your line manager or rota coordinator. Many employers, especially in the NHS, understand that school holidays can create sudden challenges."

- "They may be able to:
    - Adjust your shifts
    - Offer unpaid leave
    - Approve short-notice annual leave
    - Or allow some flexibility, depending on the role"

2. Other Support Options

"If that's not possible, you might also explore options like:

- Local holiday childcare schemes (some are council-funded)
- Short-term childminders
- Support from friends or extended family — even for part of the day"

"If cost is a barrier, there are websites and local forums where trusted childminders or shared childcare services are listed for working parents. If you'd like, I can print a list of local options."

3. When Asked "What Would You Do?"

"That's a fair question. I think planning ahead for school holidays is something we all try to do, but life doesn't always go to plan. If I were in your shoes, I'd probably speak to my workplace first to see what flexibility they can offer, and if needed, look at short-term childcare — even just a few hours a day can make a big difference."

Safety Net:

"If anything changes — for example, if your own health is affected, or if your children become unwell — please don't hesitate to contact us again. And if you need a letter confirming that your child is well and the issue is childcare-related, I'd be happy to provide one for your employer."

Close:

"I really hope your employer is supportive. You're clearly trying to manage things responsibly. Please let me know if you'd like any written resources or further help navigating childcare contacts."

Sick Note Request – Whiplash After RTA (No Injury Found)

Setting: GP Clinic
Role: FY2 GP
Patient: 40-year-old woman
Presenting Concern: Requests a sick note for whiplash injury following a road traffic accident

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C – Clarify the Concern

"Hello, I'm one of the doctors here at the practice. Before we begin, could I confirm your full name and age, please?"
"What's brought you in today?"
→ Patient: "I was in a car accident two weeks ago. I need a sick note for whiplash."

"Just to make sure I understand, you were involved in an accident, and you'd like a fit note for work stating that you're currently unwell with a whiplash injury. Is that correct?"
→ "Yes."

A – Assess the Relevant Background

1. Accident Details

- "When did the accident occur?"
- "Can you describe what happened?"
- "Were you alone in the vehicle?"
- "Did you lose consciousness at any point?"
- "Were alcohol or any medications involved at the time?" *(Ask non-judgementally)*

2. Emergency Department Visit

- "Did you go to the hospital afterwards?"
- "What assessments or investigations were done there — did they check your neck or spine?"
- "Were you told there were any injuries?"
- "Did you receive any treatment or follow-up advice?"

3. Current Symptoms

- "Do you currently have any neck pain or stiffness?"
- "Any difficulty moving your neck side to side or up and down?"
- "Have you experienced any numbness, tingling, or weakness in your arms or legs?"
- "Any dizziness, headaches, or balance problems?"
- "Any pain affecting your sleep or daily activities?"

→ Patient denies all symptoms.

4. Functional & Work Impact

- "What is your current occupation?"
- "Have you returned to work since the accident?"
- "Has the DVLA placed any restriction on your licence?"
- "What support do you have at home?"

5. Medical History

- "Do you have any long-term medical conditions?"
- "Any medications or allergies I should know about?"

6. ICE

- "What do you think is going on?"
- "Is there anything you're particularly worried about?"
- "What were you hoping I could do for you today?"

→ Patient says: "I'm not injured, but I'm scared I'll be fired. I want you to give me a sick note so I can delay returning to work. Can't you just write it?"

Examination

Observations: Within normal range
General physical exam: No distress, no signs of discomfort
Neck exam:

- Full active range of motion in all directions
- No tenderness on palpation
- No muscle spasm or swelling

Neurological exam:

- Cranial nerves intact
- Upper and lower limb tone, power, reflexes, coordination all normal

- Gait and balance preserved

R – Reassure

"I really appreciate you being open about everything — it's clear you're feeling overwhelmed and just trying to find a way to protect your job."
"You've been through a stressful event, and it's understandable that you want time to get things sorted — especially with driving restrictions and legal proceedings in the mix."
"And I want to reassure you — I'm not here to make things harder. My job is to support you medically, and to be transparent and fair in what I document."

E – Educate & Plan

1. Clarify Findings and Boundaries

"Based on your hospital records, today's physical examination, and your current symptoms, there is **no evidence of a whiplash injury**."
"Sick notes, also called fit notes, are **legal medical certificates**. I can only issue one if there's a **current health condition** that is making you unfit for work."
"In your case, you are **clinically well** at the moment. So, although I understand the situation, I **cannot write a sick note for whiplash** — because it would be inaccurate and ethically wrong."

2. Medical Ethics and Documentation

"As a doctor, I have a duty to be honest in everything I sign. Writing a note that says you have a medical condition when you don't would:

- Breach medical ethics
- Mislead your employer
- And could have legal implications for both of us"

"I hope you can understand that I have to maintain professional standards — even when the personal circumstances are difficult."

3. Supportive Guidance

"You still have other options, and I'd be happy to help with those. You can:

- Speak to your **employer's HR department** directly and explain that your return to driving is delayed due to **DVLA suspension**, not injury.
- Contact the **Citizens Advice Bureau**, who can offer legal advice on how to handle this with your employer.
- Ask your solicitor or court liaison officer for further support if this is linked to a legal process."

4. Analgesia and Safety Netting

"Since you mentioned some neck tightness earlier, even if mild, I can recommend over-the-counter analgesics like paracetamol or ibuprofen."
"If you do develop new symptoms — neck pain, tingling, stiffness, headaches, or any concerns — please don't hesitate to come back. I'd be happy to reassess you at that point."

Close

"You've done the right thing by coming in today. While I can't issue a sick note, I hope the advice and support I've offered will help you move forward safely and professionally. Would you like me to print a summary of today's consultation for your records?"

Variation (Patient Requests You Fabricate Stress):

Patient: "Okay then… at least you can say I'm stressed out. Just write that I'm too stressed to go to work."

Doctor (natural, professional response):
"Thanks for being honest with me — and I understand you're just trying to protect yourself right now. But I have to be clear: I'm only allowed to document what is **medically true** and **clinically assessed**."
"If you're not experiencing stress, then writing that down would be dishonest — and that's something I can't do, even if it seems harmless. My documentation has to reflect what you actually have — not what might sound helpful on paper."
"I hope you can understand that this isn't about refusing to help — it's about keeping my professional responsibilities clear, and making sure everything I write is accurate."

Optional Follow-up (If She Then Asks: "What if I say I *am* stressed?")

"That's a fair question, and if you were genuinely feeling mentally unwell, I'd absolutely want to explore it and support you properly. But based on everything you've shared — and what you've said just now — you're not currently experiencing stress symptoms that affect your ability to work."
"If that changes, I'd be more than happy to see you again and assess things properly — but I can't write a fit note for a condition you've just told me you don't have."

Request to Change Injury Record After Normal Ankle X-ray

Setting: A&E Department
Role: FY2 Doctor
Patient: 35-year-old woman
Presenting Concern: Follow-up after ankle X-ray; later requests documentation be changed to support workplace compensation

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1. Introduction

"Hello again, Ms. Johnson. I'm Dr [Name], one of the junior doctors in A&E. I saw you earlier when you came in with ankle pain."
"I now have your X-ray results with me, and we'll go through them together. But before I do that, I just want to check — could you please confirm your full name and age again?"

2. Focused History (Follow-Up)

- "Are you still experiencing pain in the ankle?"
- "Has it improved, worsened, or stayed the same since we last saw you?"
- "Any swelling or difficulty moving the joint?"
- "Have you been able to walk or bear weight at all?"
- "Do you have any other long-term medical conditions?"
- "Are you taking any regular medications?"
- "Any allergies to medications?"

→ Patient reports ongoing mild pain. No worsening. No systemic symptoms. No comorbidities.

3. Examination (Previously Done)

- **Observations:** Stable
- **Ankle exam:** Mild lateral tenderness, no deformity, no instability
- **Neurovascular exam:** Normal
- **Gait:** Able to weight-bear with discomfort
- **X-ray:** No fracture or dislocation → Diagnosis: Ankle sprain (soft tissue injury)

4. Explain Diagnosis and Plan

"I've reviewed your X-ray, and I'm pleased to say there's no fracture or dislocation. Let me show you — these long bones here are your tibia and fibula, and the joint and heel bones are all intact."
"So this appears to be a **soft tissue sprain** — likely some overstretching of the ankle ligaments. These injuries are common and usually settle with conservative care."
Management Advice:

- Recommend the **PRICE** method: Protect, Rest, Ice, Compression, Elevation
- Offer over-the-counter analgesia (paracetamol or ibuprofen)
- Expected recovery: 5–7 days for mild sprains; up to 2 weeks for full resolution

5. Ethical Request Raised – "Can You Change My Notes?"

Patient: "Doctor, can you change the notes to say this happened at work? My lawyer said I could get compensation if it's recorded as a workplace injury."

6. Reassure and Ethical Explanation

"I understand you're facing a lot right now — you've had an injury, and you're trying to manage the financial pressures that come with time off work. It's natural to explore every option available."
"But I need to be completely honest with you. When you first presented today, you clearly told us the injury happened at home. That was recorded in your medical notes at the time, and we documented everything based on what was said and observed."
"As a doctor, I am legally and ethically required to record information truthfully. I **cannot change your records** to say something that didn't happen — even if it might help you with compensation. Doing so would breach **medical ethics**, **NHS policy**, and **GMC guidance**."
"It's not about me being unwilling to help — it's about **maintaining the honesty of your medical records**, which is something the entire system depends on."

7. If Patient Insists – "Can I Speak to a Senior Doctor?"

Patient: "You're a junior doctor — can I speak to your senior instead? Maybe they can help."
Response:
"That's a fair question. I've been trained to manage these situations, and I've also discussed this type of case with senior colleagues in the past."
"But just to be absolutely transparent with you — **no doctor**, whether junior or senior, is permitted to change clinical notes to include something that didn't actually happen. That's a clear boundary for all of us working in the NHS."
"You're welcome to speak to a senior if you'd like a second explanation, but I want to be upfront — the outcome would be the same."

8. Offer Alternative Support

"I still want to support you in other ways. If you're struggling with time off or finances, you could consider speaking with:

- Your **employer's HR** or occupational health team
- The **Citizens Advice Bureau** — they provide free guidance on benefits and compensation claims
- The **local council or JobCentre Plus**, especially if you're a single parent — they might be able to help with support grants or income-based assistance"

"I'd be happy to write a brief summary of today's findings if you need documentation for your employer."

9. Safety Netting

"If the pain worsens, swelling increases, or you have trouble bearing weight — or if anything new develops — please come back. We'll be happy to reassess, and if needed, we can refer you to physiotherapy or follow-up care."

10. Close

"I'm really sorry I couldn't provide the note you were hoping for, but I hope the explanation was clear. You've done the right thing by coming in, and I wish you a speedy recovery. Let me know if you'd like any further advice or information printed for your records."

Note to Candidate: Why This Is Not a CARE Structure Case

This is **not a traditional counselling station** because:

- The **ethical concern only arises after clinical discussion** (X-ray, diagnosis, management)
- The **primary task** is managing an **ethically inappropriate request** following routine A&E care
- Using the **standard consultation flow** (history → exam → diagnosis → ethical handling) mirrors natural NHS practice and scores higher

Using CARE here may feel artificial or premature, since the **patient's agenda is only revealed late** in the consultation.

Request to Change Notes – Wrist Pain

Setting: A&E
Role: FY2 Doctor
Patient: 19-year-old woman
Presenting Complaint: Wrist pain after minor injury
X-ray Result: Normal – No fracture or dislocation
Diagnosis: Soft tissue injury (wrist sprain)

Key Ethical Issue

After being told that her wrist is fine, patient asks:
Patient: "Doctor, can you change my notes, please?"
When asked why and how, she initially avoids giving a clear reason, then eventually says:
"My grandma is very sick. I can't go to work. If you say this happened at work, I'll get paid. I need a sick note."

Structured Response

1. Acknowledge the Request Gently:
"I understand you're under pressure and trying to look after your family — especially when caring for someone unwell."
2. Explore Reason Without Judging:
"Can I just ask — how exactly would you like the notes to be changed? And what would that help you with?"
3. Ethical Refusal (Warm but Clear):
"Thank you for being honest. But I need to explain that I can't change the medical records. Everything I write must reflect what you told us during the assessment."
"It would be wrong for me to document something that didn't happen, even if it's for a good reason. As doctors, we must record facts honestly — not because we're afraid of consequences, but because it's the **right** thing to do."
4. Maintain Integrity Without Escalating:
"This isn't about me being junior. No doctor in this department, senior or junior, would change medical records in this way. It's simply something we don't do."
5. Optional Supportive Suggestions (Brief):

"If you're facing difficulties with work or finances, it might help to speak to your employer or the Citizens Advice Bureau. They're very good at guiding people through these types of situations."

Confidentiality – Parent Calls About Daughter with Depression

Setting: FY2 GP
Mode: Phone Call
Caller: 55-year-old mother/father
Patient: 22-year-old daughter who recently visited GP
Structure: CARE – Clarify, Assess, Reassure, Educate & Plan

C – Clarify the Concern

"Hello, I'm one of the doctors at the practice. May I confirm your name, please? And just to check, what is your relationship to the patient?"
→ "I'm her mother. She came in recently and saw someone — I want to know what's going on with her."
"Thank you. And how can I help you today?"
→ "We're just really worried. We don't know why she went in. We wanted to know whether she's okay, and whether she's on any medication."
"Okay, thank you for sharing that. I can hear how concerned you are. I understand you're trying to support your daughter, and that not knowing what's going on makes it more difficult."

A – Assess the Relevant Background

"If it's okay, I'd just like to understand the situation a little better so I can help in the best way I can."

- "Have you been able to speak to your daughter directly?"
  → "No, we've been calling. She's not picking up."
- "Have you tried contacting anyone else — a mutual friend, or someone nearby who knows her?"
  → "No."
- "Have you tried visiting her?"
  → "She lives far away, and we're both quite old. We can't go."

"Thank you for letting me know. I know that must feel very helpless."
"May I ask — is there anything in particular that's making you more worried than usual?"
→ "She's had problems in the past. When she was a teenager, after a breakup, she took paracetamol — she tried to harm herself. That's why we're worried she might do something again."
"Thank you for being so open with me. I can hear how serious your concern is, and you're absolutely right to take it seriously. Can I ask a few quick questions just to help us understand the background?"
Explore Risk Profile (Briefly but sensitively):

- "Has that ever happened again since then?"
- "Do you know if she received any counselling or support after that time?"
- "Do you know if she's had any other mental health or medical issues?"
- "Do you know where she lives now, and whether she lives alone?"
- "Any idea if she's under any financial stress, job issues, or recent emotional strain?"

→ Caller gives limited answers but continues to express concern.

R – Reassure (and Set Boundaries)

"First of all, thank you so much for sharing all of that. You're clearly doing everything you can to support her, and I want to reassure you that your call is not being dismissed or ignored."
"That said, I do need to be honest with you: I'm really sorry, but I can't share any specific information about your daughter or her care — even with close family — unless she has explicitly given us permission to do so."

"This is due to our **strict confidentiality policy**, which applies to all patients over the age of 16. It's one of the core pillars of medical practice — and it helps ensure that patients feel safe to seek help and speak openly."
"If patients feel that their private health information might be shared without their knowledge, they may stop trusting doctors — or worse, avoid seeking care altogether. That could put them in more danger long-term."
"So while I completely understand your position as a parent, I hope you can also understand why we're not allowed to give details. It's not because we don't care — it's because we're trying to do the right thing by both safety and ethics."

E – Educate & Plan (Without Breaching Confidentiality)
"Now, although I can't go into detail about your daughter's specific care, I can explain what we generally do for someone in this situation — especially if we're concerned about their mental health or risk of harm."
"When someone comes to us with signs of depression or emotional distress, we take it very seriously. We assess the risk, we offer support, and we put safeguards in place — like regular follow-up, counselling referrals, and something called a **crisis card**, which includes emergency contacts if they ever feel unsafe."
"In your case, I will be raising your concern internally. We'll review her record to make sure she has appropriate support in place. If there's anything that needs to be done, we'll take action — but I won't be able to update you on what we've done, and I hope you understand why."
"If you do manage to speak to her, I'd encourage you to gently let her know you're worried, and that you've reached out because you care."

Close
"Thank you again for sharing this with me. I can't tell you how valuable it is that you flagged it. You've done the right thing."
"If anything changes or you have further concerns, you're always welcome to call us again. We'll continue to do our part — even if we can't always share that with you directly."

Confidentiality – Consultant Surgeon Requests Mother's CT Scan Result

Setting: FY2 in Surgical Ward
Mode: In-person discussion
Patient: Margaret Williams, 70 years old
Requestor: Mr. Harris, consultant surgeon from another trust (patient's son)
Structure: CARE – Clarify, Assess, Reassure, Educate & Plan

C – Clarify the Concern
"Good afternoon, I'm Dr [Your Name], one of the junior doctors in the surgical team. May I know your name and how you're related to the patient?"
→ "I'm Mr. Harris, consultant surgeon at [X] Trust. Margaret Williams is my mother. I understand she's had a CT scan — I'm concerned this could be colonic cancer. Could you tell me what the scan showed?"
"Thank you for letting me know. Would you like to take a seat before we continue?"
→ If he declines, remain standing.
"Before we go any further, may I confirm your mother's full name and age just so I have the correct record in front of me?"

A – Assess the Background
"Can I ask — is your mother aware that you're here today and hoping to discuss her scan?"
→ "No, she doesn't know I'm asking." *(or)* "She's not really aware of what's going on."

"And how much have you been told so far by our team, or by your mother herself?"
→ "She's said very little. I only know she had a CT."
"Have you spoken to any of the doctors or nurses about her condition before today?"
→ "No, not yet."
"You mentioned you're worried about cancer — is there something in particular that made you think that?"
→ "She's had weight loss and blood in stool."
"May I also ask — are you her next of kin? Has she appointed anyone as lasting power of attorney for health decisions?"
→ "I'm the next of kin. No official LPA."
"And just for context — do you know who usually discusses her medical issues with her? Does she prefer that to be you or someone else?"

R – Reassure & Hold Boundaries

"Thank you for being open. I completely understand why you're concerned — both as her son and as a doctor. And I know it must be frustrating not having all the information when you're worried about your mother's health."
"That said, I'm really sorry, but I'm not in a position to share any information about your mother's scan or condition right now."
"The main reason is that I haven't yet confirmed whether your mother has given permission to discuss her medical details with anyone, including family — and I wouldn't want to make any assumptions."
"I also want to avoid making any mistakes or breaching her expectations of privacy — especially at a time when trust and clarity are important."
"I hope you understand — it's not about your position, it's simply that I don't yet have enough context to safely proceed."

E – Educate & Offer a Plan

"What I can do, though, is this: if you give me a little time, I'll speak to the senior team and confirm whether your mother has given consent for any family discussions."
"If she has, we'd be very happy to discuss things with you — either here or by phone, whichever is easier for you. If she hasn't, then we'll first speak to her and ask."
"In general, when patients are admitted, we take care to clarify who they want involved in these conversations. I just don't want to get this wrong."
"In the meantime, I'll make a note of your concerns so that when we do speak to her, we're aware of your observations — especially the concern about malignancy."

Close

"Thank you for your understanding, Mr. Harris. I really appreciate you taking the time to come in — and I can assure you that we'll act on your concerns and ensure your mother gets the appropriate care and follow-up."
"Once I've clarified the consent status, I'll make sure we get back in touch with you. Is there a best contact number I can take from you?"
"Please let me know if there's anything else we can do to support you in the meantime."

Confidentiality - Minor Requesting Contraception

Setting

- FY2 in GP practice.
- Mother presents alone, concerned after finding contraceptive pills in her 15-year-old daughter's room.
- Seeks information about daughter's consultations.

1. Clarify the Concern (Precise)
Aim:

- Define **exactly** what the parent is worried about.
- Understand if it's **only** about the pills or **wider** concerns.

What to Say/Do:
Acknowledge concern warmly.
Elicit full background on the situation:
➔ *"Can you please tell me exactly what you found and what made you concerned?"*
Confirm **daughter's age** and relationship to parent:
➔ *"Just to clarify, how old is your daughter?"*
Check whether the parent has discussed it with the daughter already:
➔ *"Have you had an opportunity to speak with your daughter about this?"*
Explore what **specific information** the parent is seeking:
➔ *"Are you asking for information about whether your daughter has been seen here recently, or something else in particular?"*

Key Points to Cover:

- What was found
- Daughter's exact age
- Whether daughter was confronted
- What outcome the parent expects from the consultation

2. Assess the Relevant Background (Natural, Professional)
Overall Aim:

- Understand the full situation gently **without forcing concerns**.
- **Respond** to what the parent says, not **assume** hidden worries.
- Keep it **natural**, **empathetic**, and **structured**.

What to Do in the Assess Phase
1. **Listen carefully to the parent's initial concern.**

- Focus on understanding exactly **why they are worried**.
- Don't interrupt. Allow them to speak.

2. **Clarify gently if needed:**

- *"Can you tell me a little more about what specifically is worrying you?"*
  (→ Lets them guide what matters most to them.)

3. **If the parent only talks about the pills, do not probe** further.

- Just acknowledge concern.
- Move naturally to explaining confidentiality.

4. **If the parent hints at deeper worries** (e.g., safety, older partner, STIs, religion, law), **then explore carefully** – using natural, empathetic questions.

How to Explore if Concerns are Raised

If Parent Mentions...	*Gently Explore By Saying...*
Safety or "wrong crowd"	*"Are you worried about her general safety or wellbeing?"*
Partner being older or inappropriate	*"Would you like to share if you have any concerns about the person she might be seeing?"*
STIs or unsafe sex	*"Would you like me to explain how we advise young people about protecting themselves against infections?"*
Religious conflict	*"I completely respect that. Would you like me to understand any particular family values that are important to you?"*
Legal concerns ("this must be illegal")	*"Would you like me to clarify how the law works for young people in these situations?"*
Struggling emotionally ("I don't know how to talk to her")	*"Would it help if we talked a little about ways to approach sensitive conversations with teenagers?"*

3. Reassure and Explain (Sharp and Logical)

Aim:

- Acknowledge the parental worry kindly.
- Set clear professional boundaries regarding confidentiality.
- Offer neutral support without breaching confidentiality.

What to Say/Do:

Acknowledge the concern empathetically:

➔ *"I completely understand why you are concerned. It's natural to worry as a parent in this situation."*

State confidentiality rule clearly and professionally:

➔ *"However, I must explain that every patient's medical information, including that of young people, is confidential. We are not allowed to share any information without the patient's consent."*

Emphasize fairness and patient safety:

➔ *"This applies to all patients equally, to protect trust and ensure they feel safe accessing care."*

Provide a relatable example to illustrate fairness:

➔ *"For example, even if another family member asked for your information, we would not disclose it without your consent. It's the same principle."*

Apologize while standing firm:

➔ *"I am really sorry that I cannot give you the information you have asked for, but my hands are tied by these confidentiality rules."*

Offer an alternative to help within ethical limits:

➔ *"However, if you would like, I can explain how we support young people in situations like this in general terms."*

4. Educate and Engage in Shared Plan

Aim:

- Explain Fraser Guidelines and how care is structured for young patients.
- Address any secondary concerns systematically.

What to Say/Do:

Explain normal process when minors request contraception:

➔ *"When a young person under 16 comes to request contraception, we first encourage them to involve a parent or a trusted*

adult."

➔ *"If they decline, we perform a structured assessment to check whether they understand their decision fully."*

List assessment areas under Fraser Guidelines:

- Do they understand the nature and purpose of contraception?
- Are they mature enough to make this decision?
- What risks are involved if contraception is not provided?
- Would their health suffer if contraception is refused?
- Is there any concern about coercion or safeguarding?

Explain goal of the assessment:

➔ *"If the young person is found to be competent and it is judged to be in their best interest, contraception may be offered. This protects their health and reduces risks like unwanted pregnancy or STIs."*

Address Specific Additional Concerns (Professionally)

Parental Concern	*Professional Response*
Older Partner Concern	*"As part of the assessment, we always check who their partner is, the age difference, and whether there is any risk of abuse or exploitation. If there is concern, we escalate to safeguarding authorities."*
STI Concern	*"We advise on safe sex practices and encourage regular screening for sexually transmitted infections."*
Religious Objections	*"We respect every patient's religious background. However, our medical advice is based on health needs. We do not offer religious guidance."*
Legal Concern about Underage Sex	*"Sexual activity under the age of 16 is technically illegal, but the law focuses on protecting young people. If both parties are close in age and maturity, it is not treated as criminal unless safeguarding concerns exist."*
Request for Parenting Advice	*"The best approach is to focus on building trust and communication. Spending time together, listening without judgment, and creating a supportive environment can encourage young people to open up about sensitive issues."*

Summarise your supportive stance:

"Although I cannot share specific information today, I am very happy to guide you further if you need any advice on how to support your daughter during this time."

Offer additional support:

"If you like, I can also give you written information or suggest support services aimed at parents and teenagers."

Don't Tell My Mum She Has Cancer

Setting: GP or ward (telephone or in-person)
Role: FY2 doctor
Patient: 82-year-old woman, recently diagnosed with bowel cancer
Context: Initially presented with confusion (temporary delirium), now fully recovered with capacity
Caller: Son (next of kin), no legal power of attorney
Task: He contacts you with vague concerns, and eventually requests that you *do not disclose the diagnosis to the patient*

C – Clarify the Concern

Step 1: Confirm identity and relationship

- "May I confirm your full name, please?"
- "And just to be sure — you're [patient]'s son, correct?"
- "Thank you. I'm one of the doctors currently looking after your mother."

Step 2: Define your role and open the conversation

- "I understand you had some concerns and wanted to speak with someone — I'm happy to help however I can."
- "Can I ask what specifically prompted your call today?"

Step 3: Let the relative voice their request

- Son may say: "Please don't tell her she has cancer. She won't be able to handle it. She's very fragile."

Step 4: Explore emotions and reasoning

- "I can hear that you're really worried. Can I ask — what exactly are you most concerned about if she finds out?"
- "Has she ever shared how she feels about knowing serious or life-changing diagnoses?"
- "Has she said in the past whether she would or wouldn't want to know something like this?"

A – Assess the Relevant Background

1. Clarify what he already knows

- "What have you been told so far about her diagnosis or condition?"
- "Were you present when the doctors first discussed her investigations or scan results?"

2. Explore the basis for his worry

- "You mentioned she's fragile — what makes you say that?"
- "How has she been coping emotionally since the confusion improved?"
- "Has she shown signs of distress, fear, or depression since she came back to baseline?"
- "Does she seem to suspect anything about her condition?"

3. Explore his view on the previous confusion

- "When she was first admitted, she was a little confused — but she's now fully alert, orientated, and engaging in decisions."
- "From your side, has she seemed clear-headed at home since discharge or during visits?"

4. Explore deeper emotional context

- "How are you coping with all of this?"
- "It must be hard supporting her while carrying these concerns."
- "Is there anything else adding to the stress — for example, other family disagreements, care planning, or past traumas?"

Purpose: Establish if the son is grieving in advance, afraid of death discussions, or projecting his fear onto her.

R – Reassure & Reframe the Concern

1. Validate his emotions

- "I really appreciate that you're trying to protect her. It's very clear that you care deeply and don't want her to suffer emotionally."
- "This is a heartbreaking situation, and I'm glad you felt comfortable speaking to us about it."

2. Reframe with legal and ethical principles

- "Your mother has now regained full mental capacity. We've assessed this carefully — she is alert, understands her surroundings, can retain information, and make decisions."
- "As per medical ethics and legal standards, patients with capacity have the right to be told about their own health — even if the news is serious."

3. Clarify what *cannot* be done

- "Without her specific request not to be informed, we cannot ethically withhold the diagnosis."
- "It would go against both GMC guidance and our professional responsibilities to exclude her from conversations about her own body and care."

4. Address the 'Why was my sister told first?' concern

- "That happened while she was confused and didn't have decision-making capacity."

- "In those situations, we are allowed to update the next of kin to ensure decisions are made in the patient's best interest."
- "Now that she has recovered, we must return responsibility for decisions back to her directly."

E – Educate, Offer a Plan, and Empower the Relative

1. Describe how disclosure will be handled with care

- "Please let me reassure you — she will not be told abruptly or without emotional support."
- "We will first ask her gently: 'Would you like to know more about what's going on with your health?'"
- "If she says no, we will stop there — and respect that fully."
- "If she says yes, we will explain everything gradually, kindly, and never in isolation."
- "We always involve a member of the team trained in these discussions — whether a palliative nurse, psychologist, or chaplain."

2. Offer a role for the son

- "If she wants, she can ask to have you present — or even request that information is relayed through you."
- "But we can't make that decision for her."

3. Clarify why this protects her dignity

- "Respecting her autonomy and involving her directly is the most dignified, supportive thing we can do."
- "You've done the right thing by raising these concerns — it gives us the chance to tailor how we approach her and prepare the right support."

4. Offer a compromise and ongoing support

- "I can speak to her first, assess how she's feeling, and offer her the choice."
- "If she consents, we can update you together after the discussion."
- "And if at any point you'd like to speak to one of our senior team members or support services, I can arrange that too."

Final Safety Net and Summary

- **Document clearly**: Son is next of kin but **not legal proxy**, and has requested nondisclosure due to emotional concerns
- **Patient has capacity**: Therefore, full disclosure is clinically and ethically appropriate
- **Plan made**:
    - Speak to patient gently, assess readiness to know
    - Proceed only if she requests information
    - Offer her option of support services and family involvement
    - Keep son informed with her permission

Worried about Vascular Dementia

Setting: GP Clinic, FY2
Patient: 40-year-old woman
Trigger: Concern after sister's recent diagnosis with vascular dementia
Structure: CARE – Clarify, Assess, Reassure, Educate & Plan

C – Clarify the Concern

"Hello, I'm one of the doctors here at the practice. Thank you for coming in today. Could I confirm your full name and age before we begin?"

→ "Thank you. How can I help you today?"

"You're worried about vascular dementia? I'm really sorry to hear about your sister's diagnosis. How is she doing at the moment?"

→ "She's struggling a bit and I'm just scared I might get it too."
"I completely understand. It's natural to worry, especially when it involves someone close to you. I'll do my best to explain what we know about vascular dementia and how we might approach this together."

A – Assess the Relevant Background

"Before I explain anything further, would you mind if I ask a few questions about your health and lifestyle, so I can give advice that's relevant to you?"

1. Understanding and Expectations

- "What do you understand about vascular dementia so far?"
- "Have you done any reading or research about what causes it?"
- "Is there anything specific you were hoping to find out today?"

→ Patient says she knows it's related to strokes, unsure what her own risks are.

2. Medical History

- "Do you have any long-term medical conditions apart from the psoriasis?"
  → "No diabetes or high blood pressure, just psoriasis."
- "Are you on any regular treatment for psoriasis?"
  → "Steroid creams."
- "Any previous strokes, TIAs, or heart issues?"
  → "No."
- "Any medications apart from creams?"
  → "No."

3. Family History

- "Just to confirm — your sister has been diagnosed with vascular dementia?"
  → "Yes."
- "Any other relatives with dementia or memory problems?"
  → "No."

4. Lifestyle Factors (DESA)

- **Diet:** "Would you say you mostly cook at home or eat out?" → "Often eat out."
- "How's your fruit and vegetable intake?" → "Not great."
- "Do you eat a lot of red meat or fried food?" → "Yes, quite a bit."
- **Exercise:** "Do you do any regular physical activity?" → "Not really."
- **Smoking/Alcohol:** "Do you smoke or drink alcohol?" → "No smoking, occasional wine."
- **BMI:** Measured in clinic: **Obese range**
- **BP:** Slightly elevated on today's reading

R – Reassure

"Thank you for sharing all that — and I want to reassure you first of all that just because your sister has vascular dementia, it doesn't mean you will get it too."
"It's true that having a family member affected can slightly raise your risk — but there's a lot you can do to reduce that risk."
"The fact that you've come in early to talk about this tells me that you're proactive — and that already puts you in a better position than most."

E – Educate & Plan

1. Explain Dementia (Lay Terms)

"Dementia is a condition where the brain gradually starts to lose some of its function — usually memory at first, and later other abilities like communication or coordination."

2. Explain Vascular Dementia

"Vascular dementia specifically is caused by problems with the blood supply to the brain — often due to small, repeated strokes or sometimes a single large one."

"It's different from Alzheimer's disease in that it's more connected to cardiovascular health — things like blood pressure, diabetes, cholesterol, or even psoriasis, which is linked to inflammation in blood vessels."

3. Discuss Risk Categories

"When we talk about dementia risk, we break it into two categories:"

A. Non-Modifiable Risks (we can't change):

- Family history — like your sister
- Age — dementia is more common after 65
- Past stroke or heart attack (not present here)

B. Modifiable Risks (we can change):

- High blood pressure
- Obesity
- Lack of exercise
- Poor diet
- Smoking, alcohol
- Inflammatory conditions like psoriasis if poorly controlled

4. Patient-Specific Advice

"Based on what you've told me, you do have a few **modifiable risk factors** we can work on — particularly your diet, activity level, and BMI."

"There are also things **we** can help with:"

- We can **monitor your blood pressure** regularly and offer support with weight management.
- If psoriasis worsens, we may consider specialist input — because chronic inflammation affects blood vessels.
- If we find your cholesterol or sugars are high on future tests, we'll act on that early.

"And there are things **you** can work on too:"

- Cook more meals at home
- Reduce oily foods and red meat
- Aim for **30 minutes of exercise five times a week** — even brisk walking counts
- Continue avoiding smoking and keep alcohol to safe levels

Safety Netting & Follow-Up

"If at any point you notice things like persistent high blood pressure readings, memory changes, or if you feel low or anxious about this, please don't hesitate to book in."

"Would you be open to doing a blood pressure check and blood tests to look at cholesterol and blood sugar?"

Close

"So to summarise — while you do have some risk, there's a lot we can do to reduce it. You've made a great start just by coming in today."

"Let's take it step-by-step. I'll arrange a follow-up in a few weeks to check your bloods, blood pressure, and support any lifestyle goals."

"Would it be helpful if I sent you a patient leaflet or link with tips on vascular dementia prevention?"

Diabetic Retinopathy

Setting: GP Clinic
Role: FY2 Doctor
Patient: 56-year-old man, referred by optician

C – Clarify the Concern

"Hello, I'm Dr [Name], one of the junior doctors here at the GP practice. Could I confirm your full name and age, please?"
"Thanks for confirming. I understand you've been referred here by your optician — could you tell me what made you go in for an eye test?"
→ Patient describes blurred vision and recent optician referral.
"I see — you noticed your vision getting a bit blurry, and the optician referred you here after checking your eyes."
Ideas – "What do you think might be causing your vision problems?"
Concerns – "Can I ask what's worrying you the most about this right now?
Expectations – "Is there anything specific you were hoping I could do for you today?"
→ "I'm scared I might go blind."
"That's completely understandable. Let's work through this together — I'll ask you a few questions to understand things better, and we'll talk about what we can do to help."

A – Assess the Relevant Background

"Let me start with a few questions about your vision."

Presenting Complaint (ODIPARA)

- "When did the blurred vision start?"
- "Is it in one eye or both?"
- "Is it getting worse or staying the same?"
- "Any floaters, flashes, pain, redness, or double vision?"

→ Patient has mild, progressive bilateral blurred vision.

Diabetic Complication Screening

- "Do you have any numbness or tingling in your hands or feet?"
- "Any ulcers, skin colour changes, or foot problems?"
- "Any chest pain or breathlessness?"
- "Any symptoms like fatigue, increased thirst, or frequent urination recently?"

→ No other complications reported. Vision is the main issue.

Diabetes-Specific History

- "You mentioned you've had diabetes — was it type 1 or 2?" → Type 2
- "How long have you had it?" → 3 years
- "How is it currently managed?" → Diet only
- "Have you been attending your diabetes reviews?" → No, missed follow-ups due to caring for mum
- "Have you had diabetic eye checks before?" → Yes, but missed last one
- "Were you ever given a diet sheet or referred to a dietician?" → Yes, but didn't follow it
- "Have you had your feet checked in the last year?" → No

MAFTOSA + Lifestyle

- **Medications:** None currently
- **Allergies:** No
- **Family history:** Sister has diabetes
- **Trauma/Surgery:** No
- **Occupation:** Self-employed

- **Smoking:** 20 cigarettes/day for 10 years
- **Alcohol:** 30 units/week
- **Activities:** Doesn't exercise; eats takeaway most days; struggles to cook due to caregiving responsibilities

"Has the vision problem affected your daily life or work?"
→ "Yes, I'm worried I won't be able to work if this gets worse."

R – Reassure

"Thank you for sharing all that. From what you've told me, it sounds like this is likely related to a condition called **diabetic retinopathy** — and I know that can sound worrying, but you're not alone in this."
"You're right — it happens when blood sugar levels affect the small blood vessels at the back of the eye. It doesn't usually cause pain, and in early stages it may not affect vision at all — but it can slowly get worse if not treated."
"The important thing is that you've come in now. While we **can't reverse** damage that's already happened, we **can stop it from getting worse**, and sometimes even stabilise your sight."

E – Educate & Plan

1. Diagnosis and Explanation

"Based on your history and the optician's report, this looks like **background diabetic retinopathy** — that means early damage, but not yet severe."
"It happens when high sugar damages small vessels in the retina, causing tiny leaks or bleeds. Over time, if not controlled, it can affect vision more seriously."

2. Plan of Action

Referral to Ophthalmology

- "I'll refer you to the eye specialist. They'll do a detailed scan and may offer treatment like eye injections or laser therapy depending on the findings."

Start Medication – Metformin

- "As you've developed a complication, diet alone is no longer enough. We'll start you on **Metformin**, a tablet that helps lower your blood sugar and protect your eyes and other organs."

Blood Tests

- "We'll check your **HbA1c**, which tells us how your sugars have been over the past 3 months."
- "We'll also check your **kidney function**, and screen for cholesterol and other risk factors."

Lifestyle Changes

- "We'll support you in reducing **smoking** and **alcohol** — both increase the risk of further complications."
- "Would you be open to seeing a **dietician**, or joining a local diabetes support group?"
- "We can also explore carer support options for your mum so you can prioritise your health too."

DVLA Notification

- "Because your vision is affected, you must **temporarily stop driving** and **inform the DVLA**. Once the eye team clears you, you may be able to resume — but it's important for your safety and others'."

SAFETY NETTING

"If your vision suddenly worsens, or you notice new floaters, flashes, or eye pain — please go to A&E or call us urgently."
"And if you ever feel overwhelmed managing all of this, we're here to support you. This isn't just about prescriptions — it's about building a long-term plan that works for you."

CLOSE

"You've done the right thing coming in today, Mr. Jones. We'll take it one step at a time — starting with stabilising your sugar and getting the eye team involved."
"Would you like me to send you a leaflet about diabetic eye complications and local support services?"

Down Syndrome

Patient: X, 46 years old
Setting: GP Surgery
Role: FY2 Doctor
Concern: Worried about risk of Down syndrome in current pregnancy

Clarify the Concern

- Explore the reason for visit:
  "Can I ask what made you bring this up today?"
  → Patient explains she's newly pregnant and concerned due to her age and a friend's experience.

- Explore ICE:
  "What do you know about Down syndrome?"
  "Are you worried about the risk, or more about the testing process?"
  "What were you hoping I could help you with today?"

Assess the Relevant Background

A. Pregnancy Profile

- "How many weeks along are you?"
- "Was the pregnancy planned?"
- "Have you had any bleeding, pain, or concerning symptoms?"
- "Have you had your booking appointment or any early scans yet?"

B. Obstetric History

- "How many pregnancies have you had?"
- "Any miscarriages or complications in past pregnancies?"
- "How old are your other children? Were they healthy?"

C. Medical & Medication History

- "Do you have any long-term health conditions (e.g., diabetes, thyroid problems, high BP)?"
- "Any surgeries, especially related to the uterus or ovaries?"
- "Are you taking any supplements or medications?"

D. Family & Genetic History

- "Is there any history of Down syndrome or other inherited conditions in your family?"
- "Is the baby's father related to you by blood (consanguinity)?"

E. Lifestyle & Psychosocial

- "Do you smoke, drink alcohol, or use any other substances?"
- "How's your diet and daily activity level?"
- "Who's supporting you through this pregnancy — partner, family?"

Reassure & Explain

"I completely understand your concern — and I want to reassure you that it's very common for women in their 40s to have similar worries. You've done the right thing by coming in early to discuss it."

What is Down syndrome?
"It's a genetic condition caused by an extra copy of chromosome 21. It happens randomly at conception — not due to anything you've done. It can affect learning and development, and may be associated with certain physical health issues. However, every child is different, and with the right support, many lead fulfilling lives."

Age & Risk
"It's true that the risk of Down syndrome increases with age. At 46, the approximate chance is about 1 in 30. But it's important to remember: this is still a probability — not a certainty. Many women your age have healthy babies."

Engage in Shared Plan + Specific Management

1. First-Line Screening

- **Combined Test** (11–14 weeks):
  - **Blood test** (hCG and PAPP-A)
  - **Ultrasound** for nuchal translucency
  - Gives a *risk estimate* for Down syndrome, Edward's and Patau's syndromes
  - Safe, non-invasive, and optional

- **Quadruple Test** (14–20 weeks):
  - Offered if Combined Test missed
  - Blood-only test (AFP, hCG, Estriol, Inhibin A)

2. If Screening Suggests Higher Risk (>1 in 150)

- **Diagnostic Testing Options**:
  - **Chorionic Villus Sampling (CVS)** → 11–14 weeks
  - **Amniocentesis** → After 15 weeks
  - Both provide >99% accuracy but carry a small **miscarriage risk** (~0.5%)

- **These tests are 100% optional** — patient can choose based on preference and emotional readiness.

3. Supportive Measures & Referrals

- **Referral to:**
  - Antenatal care for routine pregnancy support
  - Specialist midwife or genetic counsellor (if requested)
  - Early Pregnancy Unit if complications arise

- **Emotional Support**:
  "Whatever the outcome, we'll be here to support you fully — and your care won't be affected by the results. We can take this step-by-step and revisit decisions later if you need more time."

4. Safety Netting & Leaflet

- **Give NHS Down Syndrome Screening leaflet**
- "Call us if you experience any bleeding, pain, or feel emotionally overwhelmed."
- "You're not alone in this — help is always available."

5. Follow-Up Plan

- Book Combined Test if gestation appropriate
- If >14 weeks, arrange Quad Test
- Schedule early antenatal review

Maternal Age & Down Syndrome Risk (For Reference)

Age	*Risk (approx.)*	*Memory Tip*
20	1 in 1,500	Very low risk
30	1 in 900	Still low
35	1 in 350	Starting to rise
40	1 in 100	×3 risk vs 35
45	1 in 30	Very high risk

Huntington's Disease – Genetic Risk

Category: Counselling → Genetic Conditions
Setting: GP Surgery
Role: FY2 Doctor
Patient: 40-year-old man
Trigger: Concerned he may have inherited Huntington's disease from mother and passed it to his two children (aged 10 and 8)
Structure: CARE – Clarify, Assess, Reassure, Educate & Plan
Tools Available: Pen and paper (visual aid)

C – Clarify the Concern

"Hello, I'm one of the doctors here at the practice. Could I confirm your full name and age before we begin?"
"Thank you. I understand you've come in today because you're worried about Huntington's disease — could you tell me a bit more about what's been on your mind?"
→ Patient shares: His mother was diagnosed at 62, deteriorating quickly. He's worried he may have the gene and may have passed it to his children.
"That sounds like a really heavy situation. You're doing the right thing by coming in to talk about this. Would it be alright if I ask a few more questions to understand what you're thinking and how we can support you today?"
"What do you already know about Huntington's — how it develops or how it's passed down?"
"What are your biggest concerns right now — is it about your own future health, or your children's risk, or both?"
"Is there anything specific you were hoping we could do for you today?"

A – Assess the Relevant Background

1. Family History

- "How long ago was your mum diagnosed?" → "Recently, she's 62."
- "What kind of symptoms is she experiencing?" → "Movement problems and memory issues — it's progressing fast."
- "Any other relatives in the family with something similar?" → "No, just my mum."
- "Do you have siblings?" → "No."

2. Personal Symptoms

- "Have you noticed anything unusual yourself — like balance issues, twitching, mood changes, or memory problems?"
  → "No, I feel completely fine so far."

3. Children and Impact

- "You mentioned your kids — how old are they?" → "10 and 8."
- "Have you shared your concern with your partner or thought about how this might affect them emotionally or practically?"
- "Has your mother's illness affected you or your family's routine or emotional wellbeing?"

→ "It's been hard on everyone. I'm scared the same thing will happen to me. I just want to know if I've passed it on to my children."

R – Reassure

"Thank you for speaking so honestly. It's absolutely natural to feel overwhelmed when something like this happens to a close family member."

"Let me reassure you — **having a parent with Huntington's does not automatically mean you have it**. There's a 50% chance that you might carry the gene — and a 50% chance that you didn't inherit it at all."

"And right now, the fact that you're not showing any symptoms is reassuring. The average age of symptom onset is typically between 30 and 50, but even then, some people remain well for many years."

"There are clear steps we can take to give you more certainty, and help you feel more in control."

E – Educate & Plan

1. What Is Huntington's Disease?

"Huntington's is a condition that gradually affects the brain. It causes **three main types of symptoms**:

- **Movement:** Involuntary movements, balance issues (called chorea)
- **Cognitive:** Difficulty with memory, focus, or decision-making
- **Emotional:** Mood swings, irritability, or low mood"

"It's a progressive condition, and while it isn't curable yet, there are ways to manage symptoms and plan ahead."

2. Genetics – 50% Inheritance Risk

"Huntington's is passed down through something called **autosomal dominant inheritance**. That means if one parent carries the gene, each child has a 1 in 2 — or 50% — chance of inheriting it."

(Use pen and paper to draw a Punnett square or simple diagram to show the 50/50 chance for each child.)

"If you carry the gene, each of your children also has a 50% chance of inheriting it. But — and this is important — **if you don't have the gene, your children cannot get it either**."

3. Genetic Testing and Next Steps

"There is a test available that can tell you whether you carry the gene. It's a **blood or saliva test**, and it's free on the NHS. But this is a very personal choice — some people want to know early, others prefer not to unless symptoms appear."

"Before testing, we'd refer you to a **specialist genetic counselling team**. They'll help you understand the emotional, practical, and family implications of knowing your result — and support you through every step of the process."

4. Support and Mental Health

"It's common to feel fear, guilt, or sadness in these situations — especially when you have children. If you're feeling overwhelmed, I can link you with **mental health support** and **local peer support groups** for families affected by Huntington's."

PLAN

Referral to Genetic Counselling

"We'll start by referring you to a genetic counsellor. You can take your time and decide if and when you'd like to proceed with testing."

Offer Resources

"I'll give you an NHS information leaflet about Huntington's disease, and a trusted website you can read at your own pace."

Mental Health Support (if needed)

"If this is affecting your sleep, appetite, or mood — please don't hesitate to ask. We can help."

Safety Netting

"If you notice anything new — like mood changes, clumsiness, or memory issues — or if your emotional wellbeing gets worse, please book in. You don't need to go through this alone."

Close

"You've taken an important step today. You're thinking ahead — not just for yourself, but for your children. That takes real courage."

"You'll hear from the genetics clinic soon. And if more questions come up after this chat — even weeks from now — please get in touch."

"Before we finish, is there anything else you were hoping I'd cover today?"

Variation– 25-Year-Old Woman Without Children

This version shares the same structure and explanation as the main case but must be adapted for:

- **Younger age**
- **Absence of symptoms**
- **No children**
- **Focus on future planning and emotional uncertainty**

Adjustments to the CARE Structure:

C – Clarify the Concern

- Patient is worried about inheriting Huntington's after her mother's diagnosis.
- Explore ICE with a future-focused tone:
  - "What do you understand about Huntington's so far?"
  - "Are you worried about your health now, or more about planning your future?"
  - "Is there anything specific you were hoping we could do today — like testing or information?"

A – Assess

- Screen gently for symptoms (unlikely at this age, but important for reassurance).
- Ask about emotional wellbeing: "Has this been affecting your mood or daily life?"
- Ask if she's in a relationship or planning for children in future.

R – Reassure

- Emphasize that no symptoms and young age are positive signs.
- Acknowledge that it's normal to feel conflicted about testing.
- "Some people choose not to find out, and that's okay — it's a very personal decision."

E – Educate & Plan

- Explanation of inheritance, Punnett square optional (no children yet).
- Focus on **genetic counselling as the first step**.
- Highlight **reproductive options** like **PGD** (Preimplantation Genetic Diagnosis) if she's planning children in future.
- Offer emotional support and written information.

Post-MI Medication Adherence Counselling

Consultation Type: Telephone consultation

Role: FY2 in GP

Patient: 55-year-old man, 4 weeks post-STEMI + PCI + stent
Issue: Missing medications due to forgetfulness and fear of overdose

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INTRODUCTION (Telephone Protocol)

- "Good morning, am I speaking to Mr [Name]?"
- "I'm Dr [Your Name], one of the junior doctors here at the surgery. I'm calling for your follow-up after your recent hospital admission. Is this still a good time to talk?"
- "To ensure I have the right records, could you please confirm your full name and age?"
- "And just to check — are you in a safe and private space to talk?"

C – Clarify the Concern

"I understand that you had a heart attack about four weeks ago and had a stent put in. I believe you were started on some heart medications. How have things been since then?"
→ Patient says: "I forget if I've taken my meds. If I'm unsure, I skip it because I don't want to accidentally overdose. Also, I forget which tablet is for what."
"Thank you for being honest about that. It's quite common to feel overwhelmed after such a major event. I'm really glad you've booked this call so we can work through this together and make things easier and safer for you."

A – Assess the Background

1. Brief Medical History & Recovery

- "Just to go back a bit, can I ask — how was your experience in hospital? Did they explain what happened clearly?"
- "Do you remember what kind of heart attack you had?" → STEMI
- "Any chest pain, breathlessness, or fatigue recently?" → "No"
- "How's your general energy and sleep since then?"

2. Current Medications

- "Are you taking any of your heart medications at the moment — like aspirin, clopidogrel, ramipril, statin, or beta-blocker?"
- "Have you had any side effects like dizziness, nausea, dry cough, or fatigue?"
- "Do you remember being told why you were started on these tablets?"

3. Compliance & Challenges

- "Is the main problem remembering to take them, or are there other things that make it difficult?"
- "Do you have a routine? Do you usually take tablets with meals or at a fixed time?"
- "Have you accidentally taken the same dose twice before?"

4. Mental Health & Psychosocial

- "How has your mood been since your discharge?"
- "Do you live alone, or is there someone at home with you?" → Lives alone
- "Are you working currently or taking some time off?"
- "Have you had any follow-up from the hospital, such as rehab or nurse visits?"

5. Smoking, Alcohol, Lifestyle

- "Just to confirm — you've stopped smoking since the heart attack?" → "Yes"
- "Do you drink any alcohol these days?"
- "How is your diet and physical activity at the moment?"

6. ICE

- **Ideas:** "What do you think is causing this difficulty with your tablets?"
- **Concerns:** "Are you mostly worried about taking too much or doing it wrong?"
- **Expectations:** "Is there something specific you'd like help with today — like a simpler routine or reminders?"

R – Reassure and Normalize

"First of all, I want to say you're doing the right thing by following up. This is actually very common — a lot of patients feel uncertain or even scared about new medications after something as serious as a heart attack."
"It's important to remember that these tablets are prescribed in safe doses. So even if you accidentally took one late or repeated a dose once, it's unlikely to cause harm — but taking them regularly is key to preventing another heart event."
"Missing or skipping doses over time can reduce the protection these medications offer, so our goal today is to find a way that helps you take them consistently without stress."

E – Educate and Plan

1. Explain Purpose of Each Medication

Use simple, non-technical phrasing:

- **Aspirin and Clopidogrel** – "Keep the stent open by preventing blood clots."
- **Ramipril** – "Protects the heart muscle and lowers blood pressure."
- **Bisoprolol** – "Slows the heart slightly to reduce strain."
- **Atorvastatin** – "Lowers cholesterol and prevents further artery damage."

"These 5 work together to reduce the risk of another heart attack. You may not feel the benefits immediately, but they're working behind the scenes every day."

2. Collaborative Problem-Solving

"Let's find something that works for your routine — here are a few options:"

- **Pill organiser (dosette box)**: One-week supply arranged in daily sections
- **Smartphone alarm or medication reminder app**
- **Printed medication chart** with morning/evening boxes
- **Pharmacy blister packs** if you'd prefer it done for you

"Would one of those feel easier to stick to?"

3. Supportive Services

- **Cardiac rehabilitation**: "I'll refer you — they offer supervised exercises, education, and peer support. It makes a big difference."
- **Leaflets and visual charts**: "I'll post you a printed summary of what each tablet does."
- **Mental health support** (if low mood): "We can connect you with a health coach or CBT service to support you emotionally through recovery."

4. DVLA / Safety Info

- "Since it's been over 4 weeks, and you've had no symptoms, you may be fit to drive again — but you should confirm with your cardiologist first."

Safety Netting and Follow-Up

"If you experience chest pain, shortness of breath, dizziness, or swelling in your legs — please call 111 or 999 depending on severity."
"I'll book you in for a follow-up in **1 month** to check how you're doing with the tablets and to update the care plan if needed."
"In the meantime, if you're ever unsure about a dose or side effect, call the pharmacist or our practice nurse. Don't wait."

Summary to Patient

"So, to sum up — your heart medications are vital for preventing another heart attack, and missing doses reduces that protection. You're not alone in this, and together we'll find a routine that works for you."
"I'll arrange a leaflet, refer you to cardiac rehab, and we'll speak again in a month."

"Is there anything else you were hoping to ask before we finish the call?"

Post-MI Medication Explanation

Setting: GP Clinic
Role: FY2
Patient: 65-year-old woman, discharged yesterday after STEMI + PCI
Medications: Aspirin, Clopidogrel, Ramipril, Bisoprolol, Atorvastatin
Main Concerns:

1. "Could you please explain what all these medications are for?"
2. "Why do I need another appointment next week?"

C – Clarify the Concern

"Hello, my name is Dr [Your Name], one of the junior doctors here in the surgery. Could I confirm your full name and age, please?"
"Thanks for confirming. I understand you were recently discharged from hospital after your heart procedure, and you've come today with some questions about the tablets — is that right?"
→ Patient shows a paper with medications and dosages.
"That's completely understandable. Starting new medications after a heart attack can feel overwhelming — let's go through them one by one. I'll also explain the importance of next week's review."
"Before that, have you been feeling okay since coming home — any chest pain, breathing trouble, tiredness, dizziness, or low mood?"
→ "No issues."

A – Assess Background

1. Event Review

- "Do you recall what led up to the heart attack?"
- "Did they explain what was done in hospital?" → PCI + stent

2. Red Flag Review (MI Complications)

- "Any palpitations, leg swelling, breathlessness?"
- "How has your mood been since discharge — sleep, appetite, motivation?"
- "Any headaches, bleeding, or visual problems?"

3. Medical History + MMA

- "Any known long-term conditions like diabetes, kidney issues, or asthma?"
- "Are you taking any other regular medications?"
- "Any allergies to medication in the past?"

4. Lifestyle (DESA)

- "Have you ever smoked, or do you smoke now?"
- "Do you drink alcohol at all?"
- "How is your current diet — home-cooked, processed, oily?"
- "Do you manage to stay active or go for walks?"

5. ICE

- **Ideas:** "Do you already have an idea what each tablet might be for?"
- **Concerns:** "Any worries about taking this many tablets or side effects?"
- **Expectations:** "Were you hoping I'd explain each one or give a summary?"

R – Reassure

"It's completely natural to have questions after a big event like this. You're on the right medications, and we're going to support you with understanding and managing them step-by-step."
"Not everyone gets side effects, and most people do well — but even if issues do come up, we can adjust things easily."

E – Educate & Plan

Medication Explanation – Clear & Layperson-Friendly

1. **Aspirin 75 mg – once daily, morning, lifelong**

"This is a blood thinner — it keeps the blood flowing smoothly and prevents future clots or blockages."
Side effects: Upset stomach, risk of bleeding (e.g., nosebleeds, black stool, blood in vomit)

2. **Clopidogrel 75 mg (or Ticagrelor 90 mg) – once daily**

"Also a blood thinner — it works alongside aspirin to keep your stent open."
Side effects: Easy bruising, gum bleeding, heavier periods

3. **Ramipril – start with 2.5 mg once daily**

"This lowers your blood pressure and helps your heart heal. It also protects your kidneys long-term."
Side effects: Dry cough (common), dizziness, rarely swelling or kidney issues

4. **Bisoprolol – 2.5 mg in the morning**

"Slows your heart slightly to reduce its workload and lowers your blood pressure."
Side effects: Tiredness, cold hands/feet, dizziness, rarely erectile dysfunction

5. **Atorvastatin – 40 or 80 mg at night**

"Lowers cholesterol and helps stabilise artery walls. It prevents future heart problems."
Side effects: Muscle aches, joint pain, liver enzyme changes (we'll monitor these)
"All of these are proven to reduce the risk of having another heart attack — they work together as a team. They're long-term medications, but we can adjust doses over time if needed."

Why Follow-Up in 1 Week?

"The Ramipril can affect your kidneys and salt levels early on, so we'll be doing a blood test to check your **kidney function and potassium**. We'll also check your blood pressure and how your body is responding to everything."

Lifestyle Advice (DESA)

"In addition to the tablets, changing a few habits can help your recovery and prevent future problems:"

- **Diet**: "Go for fresh, home-cooked meals. Reduce salt, red meat, and processed food. Add more vegetables, whole grains, and oily fish."
- **Exercise**: "Start gently — short daily walks are ideal. We'll refer you to a cardiac rehabilitation program that supports this."
- **Smoking**: "If you're still smoking — stopping now is one of the best things you can do."
- **Alcohol**: "Try to keep under 14 units a week, with alcohol-free days."

"Cardiac rehab is a great way to get personalised support — would you like me to refer you?"

Support

- "Would you like me to send you a simple leaflet explaining what each medication is for?"
- "We can also help set up a **pill organiser** or reminder system if you find it hard to keep track."
- "If you feel low or anxious at any point, just let us know — we're here for both physical and emotional support."

Safety Netting

"If you develop chest pain, shortness of breath, fainting, palpitations, or unusual bleeding — seek urgent help via 111 or 999."
"If you feel dizzy, develop a persistent dry cough, or notice muscle pain — book in with us urgently so we can review your medication."

Follow-Up Plan

"We'll see you again in 1 week for blood tests and a quick review of how you're adjusting. After that, you'll have regular follow-ups with our nurse or GP."
"You're already doing a lot just by showing up and asking questions — that's the most important step."
"Is there anything else you'd like me to go over again?"

Osteoporosis Medication Counselling

Setting: Orthopaedic ward – inpatient counselling before discharge
Role: FY2
Patient: 70-year-old lady admitted for pelvic fracture due to a fall
Background:

- Osteoporosis confirmed after admission
- **New medications**: Alendronate, Vitamin D, Paracetamol
- **Existing meds**: Lisinopril (dose reduced), Aspirin
- Lives alone, **home not single-level**, kitchen not on same floor
- Concerned about **side effects and instructions** for new meds

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CARE Structure

C – Clarify the Concern

"Hello, my name is Dr [Name], one of the doctors here on the ward. Could I confirm your full name and age, please?"
"Thanks for confirming. I understand you were admitted following a fall, and we now know that your bones are weaker than expected — which led to the fracture. You've started some new medications and I'm here to go through those with you."
"Before we begin, can I ask — what do you already know about osteoporosis?"
(Patient unsure or says "weak bones")
"And what would you like me to explain today? Are you mainly concerned about side effects, or how and when to take them?"
"Any other worries, such as taking them alone at home, or managing things around the house?"
→ Patient says she's concerned about side effects and how she'll manage them alone after discharge.

A – Assess Relevant Background

1. Explore Fall History + Risk Factors

- "Could you tell me what happened with the fall — was it indoors or outside?"
- "Did you feel dizzy beforehand?"
- "Have you had any previous falls, even small ones?"
- "Do you have any family history of fractures or osteoporosis?"

2. Comorbidities + Medications

- Past MI → Taking aspirin, lisinopril
- "Any other medical conditions — diabetes, kidney problems, or reflux?"

- "Any recent blood pressure issues or blackouts?"
  → *Lisinopril was reduced due to orthostatic hypotension*

3. MAFTOSA

- **M**: Aspirin, lisinopril, new bone meds
- **A**: No known allergies
- **F**: Family history of osteoporosis in mother
- **T/S**: No recent surgeries except pelvic fracture fixation
- **O**: Retired
- **S**: Lives alone
- **A**: Active indoors but has difficulty with stairs

4. DESA

- Diet: Irregular, limited dairy
- Exercise: Minimal after fall
- Smoking/Alcohol: None
  → Highlight importance of reviewing home layout and mobility risk

5. ICE

- **I**: "I think these tablets are for my bones but I don't really know how they help"
- **C**: "I'm afraid of side effects, especially stomach problems"
- **E**: "Just want to know how long I need to be on them and how to take them properly"

R – Reassure & Explain

"Thanks for sharing that. You've brought up exactly the right questions, and I'll go through each medication, why you need it, and how to take it safely."

1. Osteoporosis Diagnosis (Lay Explanation)

"Osteoporosis means your bones have become thinner and less dense — almost like the structure inside is more fragile. That's why a small fall caused a big fracture."
"It happens more in women after menopause, and other risk factors include age, family history, low calcium or vitamin D, and some medications like steroids — though that doesn't apply to you."
"The goal now is to reduce the risk of any future fractures — and we're tackling it from all angles."

2. Medication Explanations (All Meds)

Alendronate (Alendronic acid)

- "This is the main medication to strengthen bones and reduce your fracture risk."
- "It slows the cells that break down bone, helping your bones rebuild."
- **How to take it:**
  - Once weekly (usually 70mg) or daily (10mg)
  - **Take on an empty stomach** in the morning with a full glass of water
  - **Stay upright for 30 minutes** — no food, drinks, or lying down during that time
- **Side effects:**
  - Heartburn or stomach pain if not taken correctly
  - Rare: Jaw pain (osteonecrosis), unusual thigh pain
  - "Tell your dentist you're on this — they may adapt how they treat you."

Vitamin D (± Calcium if co-formulated)

- "This works alongside alendronate, helping your body absorb calcium to build bone."
- Taken once daily with food — usually after breakfast
- **Side effects:**

- Rare: High calcium — which can cause nausea, thirst, or kidney stones
- We'll monitor your blood calcium if needed

Paracetamol

- "This is for pain relief, especially as you recover from your pelvic fracture."
- "Take one or two tablets every 4 to 6 hours if needed — maximum 8 tablets a day."
- **Side effects:**
  - Rare if taken correctly
  - Overdose can harm your liver, so please avoid doubling doses

Lisinopril (Reduced from 20mg to 5mg)

- "This helps protect your heart and kidneys and also lowers blood pressure."
- "We reduced your dose from 20 to 5mg to avoid further drops in pressure, especially after your fall — sometimes standing up too quickly can make people dizzy on this medication."
- **Side effects:**
  - Dizziness (especially early in treatment)
  - Dry cough
  - Rare: Excessive drop in BP, kidney changes

Aspirin

- "This keeps your blood thinner, to reduce the risk of clots and further heart attacks."
- "Take once daily with food."
- **Side effects:**
  - Stomach upset
  - Rare: Bleeding in stools, urine, or bruises — call us if this occurs

E – Educate & Plan Together

Lifestyle Modifications

"Along with medications, we can take a few steps to make your bones stronger and prevent falls."

- **D**iet: "Try adding more dairy, leafy greens, fish, and eggs — we can also connect you to a dietician if helpful."
- **E**xercise: "Start with light walking or chair-based physiotherapy after recovery — your physio team will guide you."
- **S**moking: None
- **A**lcohol: Avoid heavy use, as it weakens bones

Home Safety Plan

"Since your kitchen isn't on the same floor and you live alone, we'll arrange a **physiotherapy and occupational therapy** home assessment. They'll check if any support rails, mobility aids, or adjustments are needed before you return home safely."

Safety Netting

"Please call us or the ward if you experience:

- Trouble swallowing,
- Jaw pain,
- Unusual bleeding,
- Severe dizziness, or
- New bone pain"

Follow-Up Plan

- GP review in 4–6 weeks to:
  - Check blood pressure and kidney function (on lisinopril)
  - Reassess medication tolerance
- Bone health will be reviewed annually with possible repeat DEXA after 2–3 years
- Dentist notification required for anyone on bisphosphonates

Final Check

"Does this all sound clear to you? Would you like me to write any of this down or send a leaflet home with you?"

Meningitis Prophylaxis

C – Clarify the Concern

Opening Statement:
"Hello, I'm one of the doctors here at the practice. Could I confirm your full name and age, please? Thank you."
Paraphrase & Explore:
"I understand you've come in today because your mother-in-law has recently been diagnosed with meningitis, and you're concerned about whether you may have been exposed. Is that right?"
Explore Contact Exposure:

- "When exactly was your mother-in-law diagnosed?"
- "Do you know what type of meningitis she was diagnosed with — was it meningococcal, viral, or something else?"
- "When did you last have contact with her?"
- "Were you living in the same house, visiting regularly, or was it just a brief contact?"
- "Did you share utensils or have close physical contact — like hugging, kissing, or helping her when unwell?"
- "Did she have a rash or need ICU admission?"

ICE:

- *Ideas*: "What do you think might happen because of the exposure?"
- *Concerns*: "Are you worried about developing the same illness?"
- *Expectations*: "Were you hoping we could prescribe antibiotics today?"

A – Assess Background & Risk

Medical History & Risk:

- "Do you have any existing health conditions or problems with your immune system?"
- "Have you ever had meningitis before?"
- "Are you taking any regular medications or have any allergies, especially to antibiotics?"

Vaccination:

- "Have you had any meningitis vaccines in the past — like Meningitis B, ACWY, Hib, or pneumococcal?"

Social History:

- "Do you live with your mother-in-law or was it a one-time visit?"
- "Has anyone else in the household or family been unwell?"
- "Do you work around children or in a healthcare setting?"

Symptom Screening:

- "Have you experienced any fever, headache, vomiting, sensitivity to light, stiff neck, or rash in the past week?"

R – Reassure & Educate

Acknowledge and Empathise:
"I completely understand your concern, especially when someone close to you has a serious illness. You're absolutely right to ask about protecting yourself and others."

Explanation – Lay Language:

- "Meningitis is an infection of the lining around the brain and spinal cord. It can be caused by viruses, bacteria, or rarely fungi."
- "Some types of meningitis — particularly *meningococcal* — are contagious and can spread through close or prolonged contact, like living in the same house or kissing."
- "Other forms like viral meningitis or pneumococcal meningitis are not considered highly contagious, so we generally don't offer antibiotics for contacts in those cases."

Why Diagnosis Matters:

- "Before giving any antibiotics, it's important for us to confirm what kind of meningitis your mother-in-law had."
- "If it's confirmed as *meningococcal meningitis*, and your contact qualifies as close household contact, then yes — we would give a one-time antibiotic to protect you."
- "But if it was viral or pneumococcal, we would not need to give anything."

E – Engage in a Shared Plan

Step 1: Confirm the Diagnosis

- "The first thing I'll do is contact the hospital team or check their letter to confirm the diagnosis. We'll act quickly once we know the type."

Step 2: If Meningococcal Confirmed

- "If confirmed, we will prescribe a single dose of **ciprofloxacin 500 mg orally** — the first-line treatment for adults and children over 12."
- Alternatives: "If you're allergic to ciprofloxacin, we can consider **rifampicin** (twice daily for 2 days) or **ceftriaxone** as an injection."

Step 3: Vaccination Discussion

- "Even if you've had a vaccine in the past, sometimes immunity can wane. We may recommend a booster vaccine like **MenACWY** or **MenB** in the next few weeks for longer-term protection."

What If It's Viral or Pneumococcal?

- "Then no antibiotic is needed — and since you haven't developed any symptoms after a full week, that's also a reassuring sign."

Safety Netting:

- "If you develop any symptoms — such as a fever, stiff neck, severe headache, light sensitivity, or a purplish rash — seek urgent medical help or call 999."

Written Support:

- "I'll give you a leaflet on meningitis and how we decide about preventive treatment."

Follow-Up:

- "Once I confirm the type of meningitis with the hospital, I'll call you back this afternoon or by tomorrow morning to let you know if we're giving antibiotics."

Riluzole Counselling

Setting: GP clinic
Patient: 55-year-old man with ALS (a form of MND), diagnosed 8 months ago

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C – Clarify the Concern

Doctor:
"Hi, my name is Dr [Name], one of the doctors here at the practice. Could I confirm your full name and age please? Thanks."
Explore the reason for visit: "What would you like to discuss today?" *Let the patient bring up Riluzole or the medication request naturally.*
If Riluzole is mentioned: "Thank you for bringing that up. What have you heard about Riluzole?" "Was there anything specific you were hoping to understand or explore today about the medication?"
"Could I ask, what prompted this concern? Have you heard about it recently or discussed it with someone?"
Patient may respond: "I read that Riluzole helps slow MND. I want to start it if possible."
Ask ICE:

- *Ideas*: "What have you heard about what Riluzole does?"
- *Concerns*: "Is there something specific you're worried might happen without it?"
- *Expectations*: "Were you hoping I could start the medication today?"

A – Assess the Background

Assess diagnosis and context:

- "When were you first diagnosed with ALS?"
- "What symptoms led to the diagnosis — was it difficulty with walking, speaking, or something else?"
- "Since then, have your symptoms progressed much?"
- "Are you under care from a neurologist or a specialist MND clinic?"

Assess current treatment/support:

- "Have you been receiving physiotherapy, occupational therapy, or speech and language support?"
- "Do you remember if Riluzole was mentioned during your last specialist appointment?"

Medical History:

- "Do you have any other medical conditions, particularly liver or kidney issues?"
- "Are you currently on any medications or supplements?"
- "Have you had any previous adverse reactions to medications?"

Functional impact:

- "How are you managing at home — has the condition started affecting your daily activities, like preparing food, getting dressed, or mobility?"
- "Are you still driving or working?"

R – Reassure & Explain

Acknowledge the concern empathetically:
"I can completely understand wanting to explore every option that could help. It's completely reasonable to want to make sure you're doing everything possible."
Explain what Riluzole is:
"Riluzole is the only currently licensed oral medication in the UK that may help slow the progression of ALS, the type of MND you've been diagnosed with."
"It works by reducing the release of a brain chemical called glutamate, which is thought to damage nerves in MND. It's **not a cure**, but it may slow progression slightly — typically by **2 to 3 months** on average."
Specialist role:
"This medication can only be **initiated by a specialist neurologist**. That's because it requires specific monitoring — particularly for the **liver and blood counts** — and not all patients with MND benefit from it."
"If your specialist hasn't started it yet, it could be because they're assessing the best timing for you based on your symptoms, risks, and likely benefit."

Address cost worry (if raised):
"Please don't worry — this is **not about cost**. If it's right for you, the NHS will provide it. It's about making sure the benefit outweighs the potential side effects."

E – Educate and Plan Together

Side effects to be aware of:

- "The main risk is **liver damage**, so we need regular blood tests to check your liver function."
- "Other side effects may include **tiredness, dizziness, nausea**, or **reduced white blood cells**, which could increase your risk of infections."
- "Less commonly, it may affect sleep or cause stomach upset."

Next Steps:

- "At this stage, I would recommend **discussing Riluzole directly with your neurologist** at your next review — they can assess if it's time to begin."
- "Once it's started by them, GPs like me can often help with **repeat prescriptions and monitoring**."

Ongoing support:

- "In the meantime, please continue with your support therapies — like physio, OT, or speech therapy — they play a key role in maintaining independence and quality of life."
- "If anything changes — like new symptoms or worsening of your condition — do let us or your specialist team know."

Safety Netting:
"If you experience any symptoms like yellowing of the skin or eyes (jaundice), increased fatigue, or signs of infection — please call us immediately."
Resources & Leaflet:
"I'll give you a leaflet about Riluzole and also the link to the MND Association website, which explains it very clearly in patient-friendly language."
Follow-Up:
"I'll document today's discussion in your notes. If you don't have a specialist appointment soon, I can help chase one up — but otherwise, bring this up with them at your next scheduled review."

Smoking Cessation Counselling – COPD Discharge

Setting: F2 in acute medicine ward
Patient: 70-year-old man, admitted for COPD exacerbation, being discharged today

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C – Clarify the Concern

Greeting & Framing
"Hello, I'm Dr [Name], one of the doctors on the ward. I understand you're being discharged today after being treated for your chest condition. Could I confirm your full name and age before we begin?"
"I also wanted to have a quick conversation before you go — about something very important to your long-term lung health."
Clarifying Event & Insight

- "Can you tell me what you understand about why you were admitted?"
- "What did the doctors say about the cause of your breathing problems?"
- "Have you been told how smoking affects COPD?"

Current Smoking Habit

- "Do you currently smoke?"
- "How many cigarettes do you usually smoke a day?"
- "How long have you been smoking?"

- "Have you ever tried to quit before?"

Explore Motivation

- "What do you think about the idea of stopping smoking now?"
- "What's stopping you from quitting at the moment?"

A – Assess the Relevant Background

Triggers & Dependence

- "What do you enjoy about smoking?"
- "Have you noticed any symptoms if you don't smoke for a day or two?"
- "What situations make you want to smoke more?"

Previous Quit Attempts

- "You mentioned you tried before — how did you go about it?"
- "What made it difficult that time?"

Mood & Coping

- "How have you been feeling emotionally since this admission?"
- "Any stress, anxiety, or low mood recently?"
- "Do you think smoking helps you cope with anything in particular?"

Insight & Support

- "Do you feel you need help to stop?"
- "Is there anyone supporting you at home — family or friends?"

R – Reassure & Educate

Acknowledge Difficulty

"I completely understand — you've likely been smoking for decades, and it becomes part of daily life. It's normal to feel unsure about quitting."

"I'm not here to judge you — just to help you see what's possible and support you if you want to try."

Explain Impact of Smoking on COPD

"The main reason your lungs are in this condition is long-term damage from cigarette smoke. If you continue smoking, the damage gets worse — and unfortunately, the lungs can't heal."

"You'll be at risk of:

- Frequent flare-ups
- Needing home oxygen
- Breathlessness even at rest
- Repeated hospital admissions
- And even long-term disability or early death"

Give Hope

"But the good news is — stopping smoking **right now** can make a huge difference:

- It reduces your chances of another flare-up
- Slows lung damage
- Improves your breathing and quality of life
- And even reduces your cancer risk"

E – Engage in Shared Plan

Negotiate – Not Force

"I'm not asking you to quit today. But would you be open to learning how we could support you if you decide to give it a go?"

Offer Options

Nicotine Replacement Therapy (NRT)

- Gums, patches, lozenges, inhalators, sprays
- "These reduce cravings and help ease you off gradually."
- "You can buy many of these over the counter, or we can arrange NHS support."

Medications

- **Varenicline** or **Bupropion** (non-nicotine tablets)
- "They help reduce cravings and withdrawal. Usually started 1–2 weeks before quit date."

Counselling & Apps

- One-to-one or group support via NHS Stop Smoking Services
- NHS Quit Smoking App
- Referral to local support groups or helpline

Set a Goal

"If you're considering it, we usually suggest picking a quit date about two weeks from now and preparing with support."

Safety Net & Offer Leaflet

"If you feel shaky or anxious about stopping, don't worry — we're here to help. I'll give you a leaflet with info about services and a quit plan."

"If you get cravings, feel low, or want to talk, your GP and the smoking cessation team are just a phone call away."

Follow-Up

"Would it be okay if I arrange a follow-up call or referral to the smoking support team in your area after discharge?"

Summary to Patient

"To summarise — I know stopping smoking is not easy, but it's the most important step to protect your lungs and stay out of hospital. You don't need to decide right now, but you do have options, and we're here to help when you're ready."

Smoking Cessation – Breastfeeding Mother

Setting: FY2 GP Consultation
Patient: 30-year-old woman, 1 month postnatal, breastfeeding, restarted smoking

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C – Clarify the Concern

Greeting & Framing the Consultation

"Hello, I'm Dr [Name], one of the doctors here at the practice. Can I confirm your full name and age?"

"Thanks. I understand you've recently had your baby—congratulations! And you've come in today because you'd like support to stop smoking again — is that right?"

Explore Insight and Motivation

- "What made you want to stop smoking now?"
  → Expected: "Because of my child."
- "How are you finding things with your baby so far?"
- "Are you breastfeeding at the moment?"

Smoking Background

- "When did you first start smoking again?"
- "Roughly how many cigarettes a day are you smoking now?"
- "Have you tried to stop again since then?"

Explore Expectations

- "Is there anything in particular you were hoping I could help you with today — like nicotine therapy or advice?"

A – Assess the Relevant Background

Modified FAMISH History

- **F** – Family: "Anyone else at home who smokes?"
- **A** – Alcohol: "Do you drink alcohol?"
- **M** – Medical History/Medications: "Any other health issues or medications?"
- **I** – Insight: "Do you feel you need support to quit?"
- **S** – Social: "Who's helping you with the baby? Are you getting enough rest?"
- **H** – History of Mental Health: "Have you felt low, anxious, or overwhelmed recently?"

Child's Health

- "How was the delivery?"
- "Is your baby feeding well and gaining weight?"

Withdrawal Patterns

- "What happens if you don't smoke for a few hours?"
- "Have you noticed any cravings or mood changes?"

R – Reassure & Explain

Reinforce Positive Decision

"Well done for stopping during your pregnancy — and I really appreciate that you're trying again now. That's such a positive step."

Benefits of Quitting

- "Stopping now will improve your own health — your breathing will get better, and you reduce your risk of heart disease, stroke, and cancers."
- "It also hugely helps your baby's health — they'll have fewer chest infections, fewer ear infections, and lower risk of asthma."

Address Guilt or Fear

- "Don't feel bad about restarting — this is about what you do from now on. It's never too late to try again, and we'll support you."

E – Educate and Engage in Shared Plan

Offer Options Tailored for Breastfeeding

1. Nicotine Replacement Therapy (NRT)

Recommended First-Line in Breastfeeding Mothers

- "This includes patches, gums, lozenges, and sprays."
- "Sprays or gums are great for quick cravings, especially if you breastfeed just before using them — then wait 3–4 hours before feeding again."
- "The amount of nicotine passed in breastmilk is small, and much less harmful than smoking itself."

2. Medications (if asked)

- "Some medications like varenicline or bupropion are not routinely recommended while breastfeeding. But if needed, we can discuss it with your specialist."
  → Document if declined or deferred

3. E-Cigarettes

- "They're less harmful than cigarettes because they don't contain tar or carbon monoxide."
- "If used under guidance from NHS stop smoking services, they can help reduce cravings."
- "But they're not completely risk-free and should ideally be a bridge toward full quitting."

Set Quit Plan

- "Would you like to set a quit date — maybe within the next 2 weeks?"
- "We can work together on a plan that fits around feeding times."

Practical Tips

- Avoid smoking indoors or in the car — even second-hand smoke lingers on clothes.
- Change clothes after smoking if possible.
- Breastfeed before smoking or using NRT for minimal exposure.

Support Services

- Referral to local stop smoking service
- NHS Smokefree app and Quitline
- Postnatal mental health or parenting support if needed

Safety Net & Summary

Summarise

"So just to summarise — quitting now will benefit both you and your baby, and we've discussed several safe ways to help you quit, especially with nicotine replacement. You're not alone — we'll support you through it."

Leaflet & Resources

"I'll give you a leaflet with these options, and contact details for the smoking support service."

Follow-up

"Let's check in again in a week or two to see how you're getting on — how does that sound?"

Smoking Cessation Counselling – Cardiology Clinic

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1. Clarify the Concern

"Hi, I'm one of the doctors here in the cardiology clinic. Thank you for coming in today. How can I help you?" → [Patient says she is attending a follow-up and has some questions about her procedure and treatment.]

Explore Understanding and Trigger for Concern:

- "Can you tell me what happened with your heart last month?"
- "What were you told about your diagnosis of unstable angina?"
- "How have you been feeling since then?"
- "Was there anything you were hoping to clarify or talk about today?"

Ask Specifically About Smoking if Not Brought Up:

- "I can see in your records that you've been smoking for quite some time. Can I ask — has anyone spoken with you about the link between smoking and your heart condition?"
- "Do you currently still smoke?"

2. Assess the Relevant Background

Smoking History:

- 20 cigarettes/day for 35 years
- "Have you tried to quit before? What happened then?"
- "What do you feel makes it difficult to stop?"
- "What do you like about smoking?"
- "What happened when you cut down previously?"

Explore Concerns About Quitting:

- "Any worries about weight gain, stress, cravings, or mood changes if you stop?"

Psychosocial / FAMISH Overview:

- Family support?
- Alcohol?
- Mental health: Low mood, anxiety?
- Insight: "Do you believe smoking may be affecting your heart?"

- Social stressors: "How has life been since the diagnosis?"

Medical History:

- Diagnosed with unstable angina 1 month ago
- Scheduled for coronary angioplasty
- On aspirin and statin
- No diabetes or hypertension

3. Reassure & Explain (Lay Explanation)

Angina + Angioplasty Explanation: "Your chest pain happened because the heart muscle wasn't getting enough oxygen — usually due to narrowing in the arteries. Angioplasty is done to widen these arteries using a small balloon and a stent, restoring blood flow."

Impact of Smoking (Patient-Specific):

"We know you've been smoking for 35 years, and it's a habit that brings comfort. But I want to be honest — smoking is one of the biggest risks for narrowing the arteries again, even after a successful procedure."

4. Engage in Shared Plan + Specific Management

Affirm and Respect Autonomy:

- "It's completely your choice. But I'd like to help you understand your options so that when you're ready, the path is clear."

Negotiation:

- "If stopping feels too hard right now — would you consider cutting down first?"
- "Would you be open to speaking to a specialist about it, even just to explore?"

Options for Support:

- **NHS Smoking Cessation Clinic:** 1:1 or group support
- **Nicotine Replacement Therapy (NRT):**
  - Patches, lozenges, gum, nasal spray
  - Used to manage cravings
- **Prescription Medication:**
  - Bupropion or Varenicline (based on tolerance and risk)
- **NHS Smokefree App**

Address Concerns:

- **Weight gain:** "Manageable with dietician input and activity."
- **Cravings/stress:** "Short-lived — we can give tips, tools, and counselling support."
- **Mood:** "If you feel low or anxious, we can offer counselling referrals too."

"My grandfather smoked and lived till 90."

"I hear you — and I'm genuinely glad your grandfather lived a long and healthy life. Some people do. But smoking affects everyone differently. In your case, we already know your heart has been damaged. That makes the risks much more immediate and personal."

"Are you cancelling my procedure if I don't quit?"

"Absolutely not. The angioplasty is a vital and life-saving procedure — it's going ahead. But the truth is, if smoking continues after the procedure, it increases the risk that the stent fails or another heart attack happens. And I'd hate for that to undo everything we're trying to fix."

"I'm afraid I'll gain weight."

"That's a very valid concern — many people do experience some weight change. But it's usually because their taste and appetite improve, and they may start to snack more. We can help with that by arranging a dietitian or giving some tips to manage it early on."

"I'll crave cigarettes or feel stressed/depressed."
"That's a really common fear. The cravings are real — but they pass. And you won't be alone in it. We have options to help with the cravings — nicotine gum, sprays, or patches. If you're feeling low or overwhelmed, we can offer mental health support alongside quitting."

Negotiate & Offer Flexible Options:
- "This doesn't have to be a cold-turkey decision today. Even cutting down gradually can help."
- "Would you be open to trying nicotine replacement for just a week, to see how it feels?"
- "There's a whole team — smoking cessation specialists, nurses, dietitians — who can guide you."

Available Resources:
- Local smoking cessation clinic (referral offered)
- NHS Smokefree app
- Leaflet explaining smoking & angioplasty risks
- Offer to review again at follow-up after the procedure

Safety Net and Follow-Up:
- "This isn't something you have to decide today. Take time, speak with loved ones."
- "If you ever want to quit, we'll support you fully — that's our job."

Actions Today:
- Leaflet on smoking cessation given
- Referred to local smoking cessation service
- Noted for discussion again after angioplasty follow-up

Abdominal Aortic Aneurysm (AAA) Screening Result – Counselling

Station Type: GP Surgery / Telephone
Patient: Mr. John Smith, 67-year-old man
Letter: NHS AAA Screening result: Aneurysm size 5.2 cm – follow-up needed

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Clarify the Concern

"Hello, I'm Dr [Name], one of the doctors here at the surgery. Could I just confirm your full name and age, please?"
"I understand you recently received a letter following your AAA screening—could you tell me a bit about what the letter said and how you felt when you read it?"
(Patient say he didn't understand it and is confused)
"Thanks for sharing that. So just to clarify, the letter mentioned an AAA measuring 5.2 cm and invited you for a follow-up appointment. Is that right?"
Check understanding:
- "Have you heard of AAA before?"
- "Did you understand the leaflet that came with the letter?"
- "Is there anything in particular you're worried about?"

Assess the Background

Focused History & Screening Context:
- "Can I check—was this the first time you had this type of scan?"
- "Do you recall whether it was part of the NHS screening program or requested by a hospital doctor?"

Symptoms Screening:
- "Have you had any abdominal pain or back pain recently?"
- "Any pain radiating to the groin or leg?"

- "Any change in appetite or weight?"
- "Any dizziness or feeling faint?"

PMH & Risk Factors:

- "Do you have any other medical conditions such as high blood pressure or cholesterol?"
- "Do you smoke or have you smoked in the past?"
- "Is there any history of heart disease or aneurysms in your family?"

MMA + Social:

- "Are you on any regular medications?"
- "Any allergies?"
- "Are you still working or retired?"
- "Do you live alone or with someone?"

ICE:

- *Ideas*: "What did you think the scan result meant?"
- *Concerns*: "Is there anything in particular you're worried about?"
- *Expectations*: "Were you hoping I could explain the result or what happens next?"

Reassure & Explain

Layman Explanation of AAA:

"Thank you for being so open. Let me explain clearly what's going on."

"The aorta is the main blood vessel that carries blood from your heart to the rest of your body. In some people, a part of it in the tummy area can start to bulge or balloon out. This is called an abdominal aortic aneurysm—or AAA for short."

"We do routine screening for men over 65 because this can grow silently and may not cause any symptoms at all."

Size-Based Risk Explanation:

- "We consider anything over 3.0 cm to be an aneurysm."
- "The scan you had recently showed that the size of your aorta is 5.2 cm. That's larger than normal, but we categorise that as a **medium-sized aneurysm** — which means it isn't at the immediate danger stage, but we do need to monitor it more closely."
- "You don't need any treatment or surgery right now, and you don't need to stay in hospital. This is a condition that often grows slowly, and we'll keep a very close eye on it."
- "The main concern with aneurysms is that they could burst, but most don't. The risk of bursting increases as it grows bigger."

Why Follow-up is Needed:

- "At 5.2 cm, it needs regular monitoring to keep you safe. We check the size every 3 months and make sure it's not growing too fast."
- "You'll be seen by a vascular specialist to discuss things further."
- "Sometimes surgery is considered when the size gets close to 5.5 cm or if it grows quickly."

Engage in Shared Plan

What Happens Next:

- "We'll **routinely refer you to the vascular team**. They are specialists in blood vessels and are part of the NHS screening programme for aneurysms. Their role is to **keep track of the size, monitor the risk, and help decide when — if ever — any treatment is needed.**"
- "You'll have scans every 3 months to track the size."
- "If it gets to a point where surgery is safer than watching, they'll explain the operation and help you decide."

Lifestyle Advice:
- "Stopping smoking, controlling blood pressure, keeping cholesterol down, and regular walking can all slow the growth."
- "Are you currently on medication for blood pressure or cholesterol? If not, we might want to start you on some."

Reassurance:
- "I want to reassure you—this isn't an emergency. You don't need to panic. But it's important we keep monitoring it."

Leaflet + Safety Netting:
- "I'll send you an easy-to-read leaflet that explains AAA in simple terms."
- "If you develop sudden, severe tummy or back pain, or feel faint or collapse, call 999 immediately. It's rare, but we want you to be safe."

Final Check:
- "Does that explanation help clear things up?"
- "Do you have any questions or is there anything else you'd like me to go over?"

Abdominal Aortic Aneurysm (AAA) – Size Categories and Management

Aneurysm Size (cm)	*Classification*	*Monitoring*	*Action / Management*
< 3.0 cm	**Normal**	No follow-up needed	Reassure. No aneurysm. Return to usual screening (if age-eligible).
3.0 – 4.4 cm	**Small AAA**	**Yearly ultrasound**	Lifestyle advice, smoking cessation, blood pressure control.
4.5 – 5.4 cm	**Medium AAA**	**3-monthly ultrasound**	Refer to vascular specialist. Continue monitoring. Evaluate surgical risk.
≥ 5.5 cm	**Large AAA**	**Surgical referral**	Consider elective repair (open or EVAR) if fit for surgery.
Rapid growth	Growth >1 cm/year	**Urgent referral**	Refer to vascular team urgently. May need surgery even if <5.5 cm.

Additional Points

- **Emergency surgery** is required if aneurysm **ruptures**: sudden abdominal/back pain + collapse → **999**
- **Surgery type**:
  - **EVAR** (Endovascular repair): Minimally invasive, preferred in high-risk patients
  - **Open repair**: For younger or anatomically unsuitable for EVAR
- **Medical management** includes:
  - Blood pressure control (ACE inhibitors like ramipril)
  - Statins for cardiovascular protection
  - Smoking cessation (most important modifiable factor)

Valve Replacement Counselling

Setting: GP Clinic
Patient: 68-year-old man
Background: Previously evaluated in cardiology for breathlessness. Echo showed AS. Consultant advised valve replacement. Now presents to GP with some concerns.

Introduction

"Hello, I'm one of the doctors here at the practice. It's good to meet you. Could I confirm your full name and age please?
I understand you recently saw the cardiologist and they mentioned something about a valve replacement. What would you like to go through today?"

Clarify the Concern

"What's been on your mind since that consultation?"
Patient says no one clearly explained the diagnosis.

- *"What's the problem?"*
- *"What is valve replacement?"*
- *"How many days will I be in hospital?"*
- *"What happens afterwards?"*
- *"I'm worried because I have to take care of my wife – she has Parkinson's."*

"What exactly did the specialist say to you — were they clear about why this procedure is needed?"
"Do you feel like you were given enough information at the time?"
"You mentioned earlier you weren't told what the diagnosis was. Would it be alright if I go through what this likely means and why the procedure was advised?"

Assess the Relevant Background

This section ensures you understand both clinical and social context before explaining anything.

Symptoms and Functional Status

"Can you tell me more about your breathlessness — how long it's been going on, and what sort of activities make you feel breathless now?"
"Do you ever feel dizzy, lightheaded, or get chest pain?"
"Have these symptoms been getting worse over time?"

Medical Background

"Do you have any other medical conditions — such as diabetes, kidney problems, or previous heart issues?"
"Are you on medications for blood pressure or anything else regularly?"

Caring Responsibilities

"You mentioned your wife has Parkinson's — do you support her with mobility, medications, or daily tasks?"
"Has any professional carer ever been involved?"
"Is there anyone else in the family who could help out if needed?"

Reassure and Explain

Acknowledge First

"Thank you for sharing all of that — it sounds like you've been trying to manage a lot without a clear explanation. Let me walk you through what this condition usually means and what the surgery involves — in simple terms — and we can go from there."

Explanation of the Diagnosis

"Inside the heart, there are valves that open and close to make sure blood flows in the right direction. One of those valves — called the **aortic valve** — can sometimes become **narrow and stiff** with age.

This condition is called **aortic stenosis**. When that happens, your heart has to work much harder to push blood out to the rest of the body.
That extra strain can make you feel **breathless**, **tired**, or even dizzy — especially when moving around. If untreated, this can lead to **heart failure** or serious complications. That's why the specialist likely advised valve replacement."

Explanation of Valve Replacement

"Valve replacement means removing the stiff, narrowed valve and putting in a new one — either mechanical or made from biological tissue.
In many cases, the surgery is done through the chest using open-heart surgery. In some people — depending on age and general health — there's a less invasive option called **TAVI**, done through a blood vessel in the leg."

Benefits and Outcomes

"This procedure can significantly improve symptoms — most patients find they can breathe better, walk further, and feel less tired. It also reduces the long-term risk to your heart."

Educate and Engage in a Shared Plan

Address His Questions

Q: "How many days do I need to stay in hospital?"
"If it's open-heart surgery, most people stay in hospital for about **5 to 7 days** — including a short time in intensive care. If it's done by the less invasive method (TAVI), the stay is usually **2 to 3 days**."

Q: "What happens after that?"
"You'll be seen by the cardiology team, and they may recommend **cardiac rehab** to help you regain strength. You'll also be given advice on medications, activity, and follow-up appointments."

Addressing His Concern About His Wife

"Thank you for mentioning that you care for your wife — that's a huge responsibility, and I completely understand your hesitation.
If you decide to go ahead with the procedure, we can involve **adult social care** and **carer support services** to arrange temporary help for your wife while you recover.
You won't have to manage this on your own — and I can help coordinate that support for you."

Offer Options & Empowerment

"You don't need to make any decisions today — but I'm happy to explain anything again or help you speak to the cardiology team. I can also refer you to a **cardiac nurse** if you'd like someone to go through it in more depth."

Safety Netting

"If you feel more breathless at rest, develop chest pain, or have dizzy spells or blackouts — please don't wait. Call 111 or attend A&E. These can be signs the valve is worsening."

Follow-Up Plan

- GP review in 1 week to check decision and arrange support
- Contact cardiac team if further clarification is needed
- **Refer to adult social services** for carer support planning
- Consider referral to cardiac rehab services early if patient agrees

Leaflet

"I'll give you an NHS leaflet that explains aortic stenosis and valve replacement in simple terms — including diagrams and what to expect before, during, and after surgery. It also has contact details if you have questions later."

Heart Murmur in 6 Week Old Baby

Your Role: FY2 in GP
Patient: 6-week-old girl – Telephone Call
Caller: Father, anxious — wants to know if murmur is serious and whether to go to A&E
Background: Murmur heard 2 days ago by GP, referred to paediatrics. Baby is otherwise well and developing normally. Mother blames herself and is very anxious.

Telephone Introduction
"Hello, this is one of the doctors calling from the GP surgery. I understand you contacted us earlier about your baby.
Is now a good time to talk?
Before we begin, could I quickly confirm — may I know your full name?
And could you tell me your baby's name and age?"

Clarify the Concern – Use ICE Questions Naturally
"Thanks again for picking up the call. Before we go any further, would you mind sharing what the GP mentioned when they saw your daughter the other day?"
(Listen first – this helps you understand what the parent knows or misunderstood)
"And since then, how have things been at home?"
(Pause – let them open up)
If they mention the mother being upset or anxious:
— "Is your wife doing okay with all of this?"
— "What's been worrying her the most, if you don't mind me asking?"
— "Some parents do blame themselves when they hear something like this — is she feeling that way too?"
If they sound unsure or overwhelmed:
— "It's completely understandable to feel a bit unsure — especially when something involving your baby's heart is mentioned. Was the idea today just to check whether everything is okay for now, or to talk things through a bit more?"
Purpose: Elicit emotional and clinical concerns early, including guilt, anxiety, and expectations.

Assess Relevant Background
"Before I advise you, would it be okay if I ask a few questions about how your baby's been doing generally?"
Basic History

- **Birth**
  "Was she born full term? Any complications during or after birth?"
- **Red Book**
  "Has the health visitor noted anything in her red book — weight, development, or heart sounds?"
- **Development**
  "Does she seem alert, follow your voice, and make little sounds or smiles yet?"
- **Family History**
  "Any history of heart problems in the family — especially in other children or close relatives?"

Red Flag Screening for congenital heart disease:

- "Any episodes where her lips or fingers have turned blue?"
- "Do you notice she breathes fast or seems to struggle while feeding?"
- "Any sweating during feeds?"
- "Has she ever seemed unusually sleepy or floppy?"
- "Is she gaining weight normally?"

If all responses are reassuring: This supports the likelihood of a benign or innocent murmur.

Reassure & Explain

"Thank you for answering all that — it sounds like she's doing really well overall, which is very reassuring."

What is a murmur?

"A murmur is just a sound the doctor hears when blood flows through the heart. In babies, it's often due to the way blood rushes through a very normal heart — this is called an **innocent or flow murmur**, and it's quite common."

"Most babies with innocent murmurs are completely healthy, and these sounds often go away on their own as the baby grows — usually by 6 months to a year."

Addressing the mother's guilt:

"I'd also like to say clearly — **this is not something your wife caused**. It's not due to anything she did or didn't do during pregnancy or after birth. These murmurs happen naturally, and the important thing is she's well now and being followed up."

Educate & Plan

Next Steps:

"Your GP has already done the right thing by referring her to a paediatrician. They may re-examine her or do a heart scan if needed — but again, this is **routine** in well babies like yours."

A&E Indications (Safety Netting):

"Right now, based on what you've told me, there's no need to go to A&E.
But if she becomes breathless, feeds poorly, turns blue around the lips, sweats during feeding, or seems more sleepy than usual — please take her to the nearest emergency department immediately or call us again."

Offer Information:

"Would it be helpful if I sent you a leaflet that explains innocent murmurs in babies, just so both you and your wife can have something to read through together?"

Offer emotional support:

"If your wife is still feeling overwhelmed or blaming herself, I'd be very happy to speak to her too — please let her know she's welcome to call us any time. You're both doing the right thing by asking questions and caring so much."

6. Wrap-Up & Final Reassurance

"I hope I've been able to offer some reassurance today. From what we've discussed, your baby is well, and this murmur is very likely to be innocent.
Keep your scheduled appointment with the specialist — and if anything changes before then, we're here to help."

Varicose Veins Counselling

1. Clarify the Concern

"Hi, I'm one of the doctors here. How can I help you today?"
→ [Patient says she's had some swelling in her legs and wants to understand what's going on.]

Explore why the patient presented:

- "Can you tell me what made you book this appointment now?"
- "What have you noticed recently about your legs that's been bothering you?"
- "Has anything changed or gotten worse in the last few weeks?"

Explore subjective symptom impact and ICE:

- "How is it affecting your work or routine at the salon?"
- "Do your legs feel heavy, tired, or uncomfortable?"
- "Any particular worries about what this might be?"
- "Were you hoping we'd do anything specific today — like tests or a referral?"

2. Assess the Relevant Background

Structured Swelling History – ODPARA:

- **Onset:** "When did the swelling first start?"
- **Duration:** "Is it there all day or does it come and go?"
- **Progression:** "Has it gradually worsened or stayed about the same?"
- **Precipitating Factors:** "Is it worse after a long shift or at night?"
- **Alleviating Factors:** "Does anything help — like raising your legs or resting?"
- **Associated Symptoms:** "Any itching, skin colour changes, or visible veins? Any pain or bleeding?"

Risk Factors and Relevant Medical Background:

- Family History: "You mentioned your mother had varicose veins — did she have complications like ulcers or surgery?"
- Thrombosis History: "Have you ever had a blood clot or deep vein thrombosis?"
- Obstetric History: "Were there any complications with your last pregnancy or delivery?"
- Hormonal/Medical History: "Do you have any conditions like thyroid issues, or are you on hormonal contraception?"
- Smoking/Comorbidities: "Do you smoke? Any other long-term medical conditions?"

Occupational and Lifestyle Context:

- "Can you tell me more about your daily routine as a hairdresser — how long are you typically on your feet?"
- "Do you wear any kind of support stockings during work hours?"

Functional Impact:

- "Do your legs ever feel too heavy or tired to continue working?"
- "Have you had to reduce any activities because of this?"

3. Reassure & Explain

Diagnosis Explanation:

"Based on your symptoms and from examining your legs, you have a condition called **varicose veins**. These are swollen, twisted veins just under the skin caused by weakened valves. These valves normally keep blood flowing upwards toward the heart, but if they become faulty, blood can pool in the legs — causing swelling and heaviness."

Why This Happens:

"It's not something you've done wrong — it often runs in families, and it's more common in women, especially after pregnancy. Jobs that involve prolonged standing, like yours, can also make it worse."

Severity Reassurance:

"Your veins aren't showing signs of complications like ulcers, bleeding, or skin changes — which is a good sign. So at this point, it's considered a **mild** form."

4. Engage in a Shared Plan + Specific Management

Conservative Management Plan:

1. **Compression Stockings:**
    - "Wearing medical-grade compression stockings during the day helps support the veins and improve blood flow."
    - "They should be worn first thing in the morning and taken off before bed."
    - "They must be properly fitted — we can arrange help with sizing."
2. **Lifestyle Modifications:**
    - "Try to shift your weight while standing and use a footrest or stool intermittently."
    - "When you're home, elevate your legs when resting."
    - "Daily walking or light exercise helps with blood flow."
    - "Maintaining a healthy weight also reduces the pressure on your leg veins."

Why Surgery Isn't Advised Right Now:

- "I understand your mother had surgery — she probably had complications that made it necessary."
- "For milder cases, surgery is not the first step because it involves physically removing or sealing off veins, which carries its own risks like leg swelling or nerve injury."
- "The NHS follows clear guidelines — and conservative management is both effective and safer initially."

When We Would Refer:

- "If you develop pain that doesn't improve, skin discolouration, bleeding, or an ulcer, we'll definitely refer you to a vascular specialist."

Resources and Reassurance:

- "I'll give you a leaflet today that explains what varicose veins are, tips for managing them, and when to seek help."

Safety Netting:

- "If anything changes — like you develop pain, a sore that doesn't heal, bleeding from a vein, or colour changes in the skin — please book an appointment immediately."

Follow-Up:

- "Let's try these measures over the next few months. If you don't notice improvement or it worsens, we'll discuss referral options."

Jehovah's Witness – Post-Surgical Anaemia

Setting: Surgical Ward (Orthopaedics)
Role: FY2 Doctor
Patient: Adult, post-hip arthroplasty (2 days ago)
Presenting Complaint: Severe tiredness
Key Finding: Hb = 6 g/dL (critically low)
Background: Jehovah's Witness, refuses blood transfusions

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1. Introduction

- Greet the patient warmly and professionally:
  "Hello, I'm one of the doctors looking after you following your hip surgery. I understand you've been feeling quite tired since the procedure, so I'd like to check on how you're doing and go through your blood results. Would that be okay?"
- Confirm name and age, and gain consent to proceed with the discussion.

2. Presenting Complaint – Tiredness

Explore the symptom gently:

- "Could you describe how the tiredness has been affecting you?"
- "When did it start — was it straight after surgery, or did it come on gradually?"

- "Are you able to sit up or walk without feeling lightheaded?"
- "Have you had to lie down most of the day?"

Explanation to patient: "Tiredness like this after surgery isn't uncommon, but in your case, we've also found that your red blood levels — what we call haemoglobin — are quite low, which likely explains why you're feeling so exhausted."

3. Symptom Screening (for Anaemia)

Ask clearly and gently:

- "Have you felt dizzy when sitting or standing up?"
- "Have you noticed any shortness of breath, even when you're resting?"
- "Do you ever feel your heart racing or beating irregularly?"
- "Any chest discomfort or pressure?"

Lay explanation: "When haemoglobin is low, your body doesn't get enough oxygen, so you may feel out of breath or your heart may beat faster to compensate. This can also lead to dizziness or tiredness."

4. Background and Surgical Risk Assessment

- "Before your surgery, did you have any blood tests done?"
- "Did anyone mention low blood levels before the operation?"
- "Do you know if there were any complications during surgery — especially bleeding?"
- "Were you given any treatments right after the operation to address blood loss?"

Check for other causes:

- "Do you have any known medical conditions like kidney problems, stomach ulcers, or bleeding issues?"

Explanation: "Often after major surgeries like hip replacement, patients can lose more blood than expected. This may not always be visible, but it can lower your haemoglobin significantly."

5. PMAFTOSA History (Focused)

- **Past medical history:** Anaemia, kidney/liver/bleeding issues?
- **Medications:** Especially anticoagulants (aspirin, warfarin)?
- **Allergies:** Any known allergies?
- **Family history:** Any genetic blood conditions?
- **Tobacco/Alcohol/Recreational drugs:** Smoking or heavy alcohol use?
- **Occupation:** Relevant if job requires physical exertion
- **Support at home:** Anyone available to help recovery?

6. ICE (Ideas, Concerns, Expectations)

- "Do you have any idea why you might be feeling this way?"
- "Is there anything in particular you're worried about?"
- "What were you hoping we could do for you today?"

Listen carefully. Patient may express religious refusal of blood or concerns about dying.

7. Examination (Verbalised)

- "I'd now like to examine you briefly — I'll check your heart rate, breathing, and surgical site."
- Perform general exam, vitals, inspect wound
- Note pallor, delayed cap refill, signs of bleeding, and cardiac strain

Findings: Likely stable obs, pale appearance, but fatigued with exertion.

8. Provisional Diagnosis

"Based on your symptoms and the blood test results, you have something called post-operative anaemia. Your haemoglobin — the part of the blood that carries oxygen — is at 6, which is quite a bit lower than the normal level of around 12. This explains your tiredness and breathlessness."

9. Explanation of Standard Treatment

"In most patients, we'd correct this by giving a blood transfusion — essentially, healthy blood from a donor to bring your levels up and restore your energy. It's usually quick and effective, especially when haemoglobin is this low."

10. Patient Refuses Transfusion

When patient refuses:

- "Thank you for letting me know. Can I ask — are you a Jehovah's Witness?"
- "Did you discuss this with the team before surgery?"
- "Have you signed an advance directive or written document refusing transfusion?"

Be respectful: "I fully respect your beliefs and values. As your doctor, I want to make sure we can still support your recovery safely in a way that aligns with your wishes."

11. Management Plan (Alternative Path)

A. Supportive Alternatives (with clear explanation):

1. **IV Iron infusion**:
   "Iron helps the body make new red blood cells. Giving it directly into your vein helps your levels recover more quickly."
2. **Erythropoietin (EPO) injections**:
   "This is a hormone that tells your bone marrow to produce more red blood cells. It's not blood — it helps your own body produce it."
3. **High-dose folic acid and vitamin B12**
   "These are essential nutrients your body needs to make blood cells."
4. **Strict monitoring & fluid balance**
   "We'll check your haemoglobin daily and make sure your heart isn't under strain."
5. **Minimising blood draws**
   "We'll limit how much blood is taken for tests so we don't worsen the anaemia."
6. **Oxygen therapy** (if breathless)
   "Giving extra oxygen can help your body cope better while your blood levels improve."

B. Liaison & Safeguards

- "We have a liaison service for Jehovah's Witnesses — they're trained to help with these situations and can guide us on acceptable treatments."
- "Would you be comfortable if we involved them?"

12. Safety Netting and Follow-Up

- "We'll monitor you very closely for any signs of worsening — like chest pain, fainting, or increased breathlessness. Please let us know immediately if anything changes."
- "You may take longer to recover than usual, but we'll support you with everything that's acceptable to you."
- "I'll speak with my senior team and keep a full record of this discussion so everyone is on the same page."
- "We'll review your blood results and symptoms each day and adjust the plan as needed."

DKA Admission Refusal

Setting: A&E (Acute Medicine)
Patient: 30-year-old female
Presentation: Abdominal pain and vomiting
Findings: Confirmed Diabetic Ketoacidosis (DKA), UTI on dipstick, patient reluctant to stay

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C – Clarify the Concern

Begin by establishing rapport and exploring why the patient wants to leave:

- "I understand you've been feeling very unwell with vomiting and tummy pain and were admitted for further care."
- "I've also been told that you're thinking about going home. Could I ask what's making you feel that way?"
- Explore underlying reasons gently:
    - "Do you have someone to care for?"
    - "Are you worried about something outside of hospital?"
    - "Is it that you don't feel comfortable here, or do you think you're getting better?"

Purpose: Understand their reason for refusal and open the door for a supportive, non-confrontational discussion.

A – Assess the Medical Situation

1. Explore Current Symptoms (DKA-focused)

- "When did the tummy pain and vomiting begin?"
- "Have you felt very thirsty, dry-mouthed, or had trouble passing urine?"
- "Any dizziness, headaches, or breathing changes?"
- "Have you noticed a fruity smell on your breath or felt more confused lately?"

2. Explore DKA Triggers

- "Have you been ill recently—any fevers, sore throat, chest pain, or urinary symptoms?"
- "Any diarrhoea or recent infections?"
- "Has anything stressful happened recently?"

3. Diabetes and Medication History

- "What type of diabetes do you have and how long have you had it?"
- "Do you take insulin? How many units per day?"
- "Have you missed any insulin doses recently?"
- "Have you had DKA before?"

4. PMAFTOSA + Social Red Flags

- Past Medical History: heart, kidney, previous DKA
- Medications: insulin, others
- Allergies: known drug allergies
- Family History: diabetes, heart disease
- Tobacco/Alcohol: alcohol misuse?
- Social: who at home? any support? child/dependent care?
- Access: ability to self-manage or check blood sugar?

5. Verbalised Physical Examination

"I'd now like to check a few things to assess how unwell you are."

- **General appearance**: tired, dehydrated, laboured breathing (Kussmaul)
- **Vitals**: BP, HR, RR, O2 sats, temp
- **Neurological**: alertness, orientation
- **Abdomen**: tenderness, signs of infection
- **Urine dipstick**: nitrates, leukocytes suggest UTI

- **Breath**: fruity (acetone) smell may indicate ketones
- **Capillary glucose and ketones** (already done in A&E)

R – Reassure & Explain (with Management)

1. Explain the Diagnosis in Lay Terms

"You've developed a serious condition called diabetic ketoacidosis — or DKA. It happens when your body doesn't get enough insulin, so it starts breaking down fat for energy. That creates harmful chemicals called ketones, which make your blood acidic."

"This is likely why you've been vomiting and feeling so tired. It also causes dehydration and can affect your kidneys and heart."

"We've also found signs of a urinary tract infection, which may have triggered this episode."

2. Explain the Urgency

"At the moment, your blood tests show you're in a state where your body is under a lot of stress. Without urgent treatment, things can deteriorate rapidly. It's not something that can wait."

"If left untreated, DKA can lead to coma, organ failure, and even death. That's why we need to act quickly and keep you under supervision."

3. Explain the Treatment Plan (Management)

- **Fluids**: "We'll start by giving you fluid through a drip to treat the dehydration."
- **Insulin**: "We'll give you insulin into your vein to bring down your blood sugar and stop the ketone production."
- **Infection treatment**: "You'll also need antibiotics for the urine infection — again, through a drip."
- **Monitoring**: "Your blood sugar, ketones, potassium and acid levels will be checked every hour. These changes need real-time adjustments, which can only be done here in the hospital."

"These treatments can't be done safely at home — they require hospital care and trained staff monitoring you closely."

E – Engage in Shared Plan

This is where you address practical concerns and offer realistic support options while respectfully encouraging hospital stay.

Acknowledge concerns:

- "I understand you need to pick up your child. That's incredibly important."
- "You mentioned having a wedding tomorrow — I can imagine how much this means to you."

Offer practical solutions:

- "We can contact the hospital safeguarding or social services team to arrange temporary support for your child or speak to the school if needed."
- "Would it help if we helped you contact a family member who can manage things while you're here?"
- "You're not alone — we'll try to support you with both your health and your home situation."

Reinforce the need for admission:

"We're not trying to keep you here unnecessarily — but DKA is not something we can safely treat at home."

"If you were to go home, there's a serious risk of worsening — and you might end up back here in a worse condition, which would be more dangerous and harder to treat."

Address home-treatment requests:

- "Injecting insulin at home won't be enough. In DKA, the body needs constant IV insulin and fluid, with blood tests every hour to keep you safe."
- "We also need to treat the infection with antibiotics through a drip, not just tablets."

Confirm mutual understanding:

"Does all of this make sense? Do you feel more comfortable now about why we're recommending you stay?"

Safety Netting

- "We'll keep monitoring you very closely while you're here. If you feel worse at any time, we can adjust your treatment immediately."
- "Please don't hesitate to press the call bell or ask if anything feels off — we're here to help."

Diagnostic Justification

The patient presents with vomiting, abdominal pain, ketonuria, and dehydration, with confirmed acidosis and hyperglycaemia. These are classic features of DKA. UTI on dipstick (nitrates/leukocytes) likely triggered the episode. Diagnosis is already established, and the task is to convince the patient to stay for life-saving care.

Paediatric DKA – Parental Request for Discharge

Setting: Paediatric ward, FY2 doctor
Patient: 9-year-old child
Presenting Situation: First episode of DKA; admitted yesterday and currently receiving treatment. Mother asks about discharge due to a pre-booked family holiday.

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1. Clarify the Concern

- Begin warmly and professionally:
  "I understand you wanted to speak to one of the doctors. How can I help today?"
- Prompt the mother to express her concern:
  - "Could you share with me what's on your mind?"
  - "Is there something in particular you're worried about?"
- Likely concern raised: "We have a family holiday planned and I want to discharge my child today."
- Gently explore further:
  - "Could I ask when and where you're planning to travel?"
  - "Was it a long-planned trip?"
  - "Are you flying out soon or is it within the country?"
- Acknowledge and validate:
  - "That sounds like a really special plan, and I completely understand how disappointing this must be for you."
  - "Let me explain clearly what's going on medically so we can make the safest plan for your child."

2. Assess Relevant Background

A. History of Presenting Symptoms

- "What made you bring him to hospital yesterday?"
- "Was there any vomiting, tummy pain, or excessive thirst?"
- "Did you notice him passing urine more often?"
- "Did he seem more tired than usual or lose weight recently?"

B. Triggers and Recent Illness

- "Has he had any infections recently? Cough, fever, urinary symptoms?"
- "Any episodes of diarrhoea or vomiting before this one?"

C. Medical History

- "Has he ever had any medical conditions before this?"
- "Is this the first time he's been told he has diabetes?"
- "Has he ever been admitted to hospital before?"

D. Family and Development

- "Is he up to date on all immunisations?"

- "Any developmental concerns in the past?"
- "How has his growth and general health been?"

E. Parental Insight and Understanding

- "What have the doctors told you about your child's condition so far?"
- "Do you know what DKA is or what it means?"
- "Have they explained why your child is being treated the way he is?"

Verbalise Examination Plan:

  - "I'd also like to quickly review his vital signs and general condition now."
  - "I'll check his hydration, pulse, respiratory rate, and review his fluid balance chart."
  - "We'll go through his most recent blood results together."
- **Confirm parameters from task (if given):**
  - pH, bicarbonate, blood ketones, blood glucose, sodium/potassium
  - Urine ketones and infection markers (if UTI suspected as trigger)

3. Reassure & Explain

A. Lay Explanation of Diagnosis

- "Your child has a condition called **diabetic ketoacidosis**, or **DKA**."
- "It happens when the body doesn't have enough insulin to use sugar for energy."
- "So instead, the body starts breaking down fat—and that creates toxic substances called **ketones**."
- "These ketones build up in the blood and can make the blood very acidic, which is dangerous."

B. Treatment and Why Hospital Admission is Necessary

- "We are treating this with **IV fluids** to rehydrate him and **IV insulin** to bring his sugar and ketone levels under control."
- "We're also checking his blood sugar, salt levels (like sodium and potassium), and urine frequently to make sure he's improving."
- "These treatments are only safe to give under **hospital supervision** because the condition can change very quickly."

C. Why Discharge is Unsafe Right Now

- "At the moment, your child's condition is **not yet stable**—his sugars and ketones are still being corrected."
- "If you were to leave now, there is a **serious risk** his blood could become more acidic again."
- "One of the worst complications of DKA, particularly in children, is **brain swelling (cerebral oedema)**, which can happen if not monitored properly."

D. Clear Explanation of Consequences if Untreated

- "DKA, if left untreated or incompletely treated, can lead to:
  - Severe dehydration
  - Shock
  - Brain swelling
  - Even death in the worst-case scenario."
- "These risks increase **exponentially** if he leaves without completing treatment."

4. Engage in Shared Plan

A. Address Holiday Concern with Practical Solutions

- "I can see how much this holiday means to your family. I completely understand that you've been looking forward to it."
- "But right now, your child's **life and long-term health** must come first."
- "Perhaps you could check with the travel agency if they allow rescheduling or cancellation for medical emergencies."

- "If you have **travel insurance**, this would usually be covered."

B. Reassure and Reframe

- "I promise we're not keeping him here any longer than necessary."
- "The team reviews his blood results closely and we'll discharge him as soon as he's safe to go."

C. Reiterate the Medical Need Firmly But Kindly

- "It's **not possible** to monitor or treat DKA at home or abroad—even with oral medication or insulin injections."
- "These treatments need **continuous monitoring**, which is only available in the hospital."
- "If something were to go wrong on holiday—especially if you're abroad—it could take **too long** to get emergency care."

D. Offer Review, Leaflet and Safety Net

- "Would it help if I brought in one of our diabetes nurses to explain the plan?"
- "I can also give you a **written summary** of your child's condition and treatment so far."
- "We will review him twice daily to ensure he's on the right track for discharge."

Hypoglycaemia with Recurrent Seizures – Refusal to Stay

Setting: Acute Medicine Ward
Role: FY2 Doctor
Patient: 28-year-old man with Type 1 Diabetes
Presentation: Recurrent fits due to hypoglycaemia (BSL 2.1 twice)
Context: Patient wants to leave hospital due to work obligations

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1. Clarify the Concern

- Start with rapport and let the patient speak:
  "Thanks for taking the time to speak with me. I understand you're feeling better now and would prefer to leave the hospital. Before we talk about that, could you tell me how you're feeling and what's been going on?"
- Let the patient express their reason:
  Likely to say they feel fine now and need to return to work.
- Acknowledge and show understanding:
  "That makes sense — work can be demanding, and it's completely understandable that you'd want to get back to your routine."
- Explore emotional cues:
  "Aside from work, is there anything else on your mind? Any worries about staying here?"

2. Assess the Relevant Background

- **Clarify recent episode**:
  "Do you remember what happened earlier today?"
  "What were you doing before the seizure happened?"
  (Patient may not recall — common in post-ictal state.)
- **Explore hypoglycaemia triggers**:
  - "Have you been managing your diabetes with insulin?"
  - "Did you take insulin today or last night?"
  - "Did you eat after taking insulin?"
  - "Have you been under stress, doing more physical activity than usual, or drinking alcohol recently?"
- **Medical history**:

  - "Have you had similar episodes in the past?"
  - "Any other long-term conditions besides diabetes?"
  - "Any recent infections or changes in your diabetes care plan?"
- **Verbalise Examination**:
  "I'd now like to check a few things to understand your current condition better — I'll assess your general appearance, check your vitals, and perform a focused neurological exam to ensure there's no ongoing post-ictal effects or signs of head injury."
  (Findings will be normal at this point.)
- **Ask about social support**:
  - "Who do you live with?"
  - "Who usually helps you if you're unwell?"
  - "Is your workplace aware of your condition?"
  - "Does anyone check on you regularly at home?"
- **Assess understanding**:
  - "Has anyone explained what happened during your stay so far?"
  - "Do you know what caused the seizures?"

3. Reassure and Explain

- **Layman Explanation of Diagnosis**:
  "The cause of your seizures was a very low blood sugar level — we call this hypoglycaemia. Your blood sugar dropped to 2.1 mmol/L, which is dangerously low and can trigger a fit. This happened twice while you were here."
- **Explain what went wrong**:
  "You mentioned taking your usual insulin but not eating. Insulin works by lowering your sugar, so if you skip meals, it can drop too low — this can cause seizures, confusion, or even coma."
- **Why hospital stay is essential**:
  "Right now, your condition is not stable. We've already had to treat you urgently twice. If this happens again — and you're at home or alone — it could be extremely dangerous, even life-threatening."
- **Investigations needed**:
  "We'd like to do a brain scan to rule out other causes for seizures. Also, the diabetes team needs to review your insulin dose to adjust your treatment and help prevent this from happening again."
- **Risks of leaving**:
  "Leaving now puts you at risk of having another seizure, possibly without anyone around. It could cause a head injury, or even lead to a coma if not treated in time."
- **Treatment**:
  - Monitor BSL hourly and correct as needed
  - Review and adjust insulin dosing
  - Referral to diabetes specialist nurse
  - Blood tests: HbA1c, U&E, infection screen
  - Neuroimaging if seizures unexplained

4. Engage in a Shared Plan + Specific Management

- **Address work concern**:
  "I can see work is important to you — if it helps, we can provide a medical certificate for absence, and you might even be able to work from your hospital bed if you feel up to it. Would that be helpful?"
- **Explore realistic discharge planning**:
  "We don't want to keep you longer than necessary. Our aim is to stabilise your blood sugar, monitor you

for at least another 24 hours, and involve the diabetes team. Once that's done, we'll discuss discharge together."

- **Offer support and next steps**:
  "Let's agree to monitor your sugars closely today and tomorrow, and if everything stays stable, we'll make a discharge plan that works for both your health and your work."
- **Safety net**:
  "If you ever feel unwell again — dizzy, shaky, confused — please let someone know immediately or come back. Hypoglycaemia can be subtle at first but escalate quickly."
- **Follow-up**:
  "After discharge, we'll arrange for you to see the diabetes team and possibly a dietitian to help avoid future drops. We'll also ensure your GP is updated."

Colonoscopy Refusal After Sigmoidoscopy

Setting: GP Practice
Patient: 65-year-old woman
Background: Recent sigmoidoscopy revealed polyps with dysplastic changes (removed). Now referred for full colonoscopy. Patient requests GP consultation, expressing reluctance to proceed.

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1. Clarify the Concern

- Start by gently opening the consultation:
  "I understand you recently had a camera test and now they've asked for another one. Could you tell me what's been worrying you about this next step?"
- Key questions to elicit the real concern:
  - "What was your experience like with the previous procedure?"
  - "What was explained to you at the time?"
  - "What are your thoughts about the new test they're recommending?"
  - "Do you feel something wasn't made clear?"
  - "Is it more the procedure itself that's bothering you—or the reason they want to do it?"
- Likely concerns raised:
  - Previous sigmoidoscopy was uncomfortable, painful, or poorly explained.
  - The patient believes the findings were benign and another test is unnecessary.
  - She's worried about pain, embarrassment, sedation, or unnecessary tests.

2. Assess Relevant Background

A. Clarify Initial Procedure and Current Symptoms

- "What symptoms led to the first test—was it bleeding or something else?"
- "Are those symptoms still present?"
- "Have you had polyps or similar tests in the past?"

B. Risk and Family History

- "Has anyone in your family had bowel polyps or bowel cancer?"
- "Have you had any previous colonoscopies or issues with your bowel?"

C. Lifestyle Context

- "How is your diet—would you say you eat enough fibre?"
- "Do you smoke or drink?"
- "Do you stay fairly active?"

D. Full MAFTOSA Check

- Medications (especially anticoagulants), Allergies, PMH (e.g., cardiac disease, bowel issues), FHx, TOBACCO, Alcohol.

3. Reassure & Explain

A. Why the Colonoscopy is Needed

- "Let me explain clearly what happened and why they want this second test."
- "The sigmoidoscopy looked only at the lower part of your bowel—just the last few inches."
- "They found polyps there—these are small growths, not cancer—but in your case, they showed early abnormal changes, called dysplasia."
- "When polyps have dysplastic changes, we want to check the entire bowel to make sure there aren't any more."
- "Polyps can develop silently in other areas. If left untreated, some of them can eventually turn into cancer."

B. Why Colonoscopy Wasn't Done First

- "Sigmoidoscopy is usually done first if someone presents with rectal bleeding because it's quicker and easier to perform."
- "It checks the most common area where bleeding comes from and doesn't require full bowel preparation."
- "If something concerning is found—like polyps—we follow it up with a colonoscopy."

C. What the Colonoscopy Involves

- "It's a more complete camera test that allows us to check the entire large bowel."
- "It gives us the chance to find and remove any other polyps early—before they cause any harm."
- "The test is done under sedation if you'd like—so you'll be comfortable and won't feel much."
- "We can also use local anaesthetic jelly and pain relief if you prefer not to be fully sedated."

D. Addressing Her Previous Experience

- "I'm sorry the previous test was uncomfortable—this one can be done differently."
- "You'll have a chance to speak with the endoscopy team in advance and let them know your preferences."

4. Engage in Shared Plan

A. Check Understanding and Offer a Reframe

- "Does that explanation help a little bit with why the test is needed?"
- "Would it help if the team used stronger sedation or if you had a female endoscopist?"

B. Confirm Patient Autonomy and Preferences

- "Of course, the decision is always yours—we can never force you to have a test you're not comfortable with."
- "But I would strongly encourage it because finding and removing polyps early is one of the most effective ways we prevent bowel cancer."

C. Offer Solutions and Next Steps

- "Would you like me to write to the hospital and ask them to speak with you first, before booking the test?"
- "We can request that sedation be used from the start this time."
- "Would you like some written information or a leaflet to read at home?"

D. Final Reassurance

- "You've done the right thing by coming to ask. It's normal to feel nervous after a difficult experience."
- "We just want to give you the best chance of staying healthy—and this test is an important part of that."

TIA Counselling – Driving Restriction in Taxi Driver

Role: FY2 doctor in GP surgery
Patient: 40-year-old male taxi driver
Scenario: Patient had a confirmed TIA two weeks ago. He was advised not to drive for 3 months but has been seen driving. You must address this concern and ensure patient safety.

C – Clarify the Concern
"Hello, I'm one of the doctors here at the practice. Thanks for taking the time to speak with me today. Could I confirm your name and age, please?"
Confirms details
"Thanks. I understand you were recently seen at the TIA clinic, and I've also noted that you were advised not to drive for three months. However, I noticed you've been driving — I wanted to check in with you and see how you've been doing. Could you take me through what's been happening?"
Patient: "Yes, I've been driving. I feel fine and have no symptoms."
"I see. Can I ask — did the team at the clinic explain to you what a TIA is and why you were advised to stop driving?"
Patient unsure or dismisses advice

A – Assess the Background
1. Review of Previous Event
- "Let's go back to what happened two weeks ago — what symptoms did you have?"

Right-sided facial droop, arm weakness – lasted 1 hour
- "What tests were done?"

Bloods and CT scan – normal
- "What treatment did they start?"

Clopidogrel, statin, BP medication
2. Drug Compliance
- "Are you taking your medications every day?"

"Yes, regularly."
3. Advice Given
- "Apart from the medications, what instructions were you given?"
- "Did anyone explain about driving restrictions?"

4. Medical Background (P2, MMA, FMAM)
- "Have you had anything like this before?"

Yes – similar event 6 months ago
- "Any other medical conditions?"

No
- "Any family history of stroke or heart problems?"

None
5. Lifestyle History (DESA & MAFTOSA)
- "Do you smoke?" – *10+ cigarettes/day for 20+ years*
- "How much alcohol do you drink?" – *5–6 beers daily*
- "What's your diet like?" – *Mostly fast food*
- "Do you exercise?" – *"No time."*
- "How's your stress level, sleep, and support system?" – *High stress, limited support*

6. Employment & Financial Status

- "Are you self-employed or work for a company?"

Self-employed

- "Is taxi driving your only source of income?"

Yes

- "How are you managing financially at the moment?"

Struggling, has children to support

R – Reassure & Explain

"Thank you for being honest — I really appreciate that. I know this must be incredibly stressful, especially when your livelihood depends on driving. I do want to explain a few things so we're on the same page."

What is a TIA?

"You were diagnosed with a **Transient Ischaemic Attack**, or **mini-stroke**. That means there was a brief blockage in the blood supply to part of your brain, which caused your symptoms. Even though your tests came back normal and the symptoms went away, a TIA is **a major red flag** — it means you're at **high risk of having a full stroke**, especially in the first few weeks."

Why the driving ban?

"I know you feel well now, and I'm very glad to hear that. But **feeling fine doesn't guarantee you're safe to drive**. The brain can be unpredictable during this recovery period. You could develop sudden weakness, blurry vision, or confusion — even without warning. If that happens while you're driving, the outcome could be devastating — for you and for others."

(Let the patient reflect)

"I'm not saying this to scare you — it's just that as a taxi driver, you're responsible not only for yourself but also for your passengers and others on the road."

Legal and Safety Obligations

"According to **DVLA rules**, anyone who's had a TIA must **stop driving for 1 month**. For **Group 2 licences** (like taxi or HGV drivers), the restriction is usually **3 months** or longer, and you must be cleared by a medical professional before driving again."

"If you drive during this period and something happens, it could lead to **legal action**, loss of licence, or worse — and that's not something we want for you."

DVLA Reporting

"It's your legal responsibility to inform the DVLA. We don't want to escalate this — and we're only having this conversation because we genuinely care about your safety and want to support you."

E – Engage in Shared Plan

1. Driving Ban Re-emphasized

"So for now, you must **stop driving immediately**. You can restart only when you've been **reviewed medically** and confirmed to be fit."

2. Financial Options

"I understand your financial concerns. Could I ask — apart from driving, have you ever done any other jobs, like desk work, deliveries, or customer support?"

"No, but I'm willing to try anything."

"We can refer you to the **Job Centre** or the **Citizens Advice Bureau** — they often help people find **temporary roles or income support** while they recover."

3. Supportive Measures

"During this time, we can also:

- Arrange **support for smoking cessation**

- Help reduce alcohol intake
- Refer to a **dietician or lifestyle coach**
- Book a **review in 1 month** to monitor your blood pressure and TIA recovery"

4. Safety Net
"If you develop **any new symptoms** — facial drooping, weakness, confusion, or slurred speech — you must call **999 immediately**."

Closure
"Do you have any other concerns or worries you'd like to talk about today?"
(Answer questions empathetically)
Summarise:
"To summarise —

- You had a mini-stroke, which puts you at risk of a major stroke
- You're not safe to drive for now, and must inform DVLA
- This is **not permanent** — we'll reassess you after the 3-month period
- We'll help you with financial support options and health advice"

"Thank you again for taking the time to speak honestly with me. Everything we've discussed is to **keep you safe and protect your future** — we're here to help."

Student Diagnostic Note

- Confirmed TIA 2 weeks ago (R-sided weakness, resolved in 1 hour)
- High-risk occupation (Group 2 licence – taxi driver)
- Non-compliance with DVLA restriction (driving after TIA)
- Risk factors: smoking, alcohol, poor diet, no exercise
- Counselling must emphasize **medical risk**, **legal obligation**, **public safety**, and **available support**

→ Use CARE structure to ensure understanding, empathy, and compliance. Driving ban for **3 months minimum**, DVLA must be notified, reviewed before clearance.

Worried about prostate cancer

Setting: GP surgery
Patient: 40-year-old male
Trigger: Father recently diagnosed with prostate cancer
Task: Address concern, assess risk factors, provide education and guidance

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C – Clarify the Concern
Doctor: Hello, I'm one of the doctors here today. Thanks for coming in.
Could I confirm your full name and age, please?
And how can I help you today?
(*Patient: "I'm worried I might get prostate cancer. My dad was just diagnosed."*)
"I'm really sorry to hear about that. How is your dad doing now?"
(*Acknowledge empathetically, but don't dwell too long.*)
"Could you tell me more about what's been worrying you? Did something happen recently that made you think about this more?"
(*Patient says he read online about family risk and wants to know his own chances.*)
"I completely understand why this is playing on your mind. Let's talk through everything clearly — what it is, what your risk is, and what steps you can take."

A – Assess the Background

1. Assess current understanding:

"What have you heard or read so far about prostate cancer?"
"Do you know what the prostate does, or where it is in the body?"
"Are you aware of what the early symptoms might be?"

(*Patient says he's heard it can affect urination and spread to the bones.*)

2. Ask about his father's case:

"At what age was your father diagnosed?"
"Did he have symptoms, or was it picked up during a check-up?"
"Do you know how far along it was when caught?"
"Any other family members ever diagnosed with prostate cancer?"

(*Father diagnosed at 68 with urinary symptoms. No other relatives affected.*)

3. Risk and lifestyle history:

"Do you have any Afro-Caribbean background?"
"Do you smoke?"
"How often do you eat red meat like beef or lamb?"
"Would you say you have a balanced diet — with fruits, vegetables, and fibre?"
"Do you exercise regularly?"

(*Patient smokes, eats red meat most days, sedentary job. No Afro-Caribbean background.*)

4. General health check:

"Do you have any ongoing health issues?"
"Are you taking any medications regularly?"

(*No medical conditions or regular medications.*)

R – Reassure and Educate

"Thank you for explaining all that — it really helps me understand your situation."
"Let me start by explaining a bit about the prostate itself."

Explanation in lay terms:

"The prostate is a small gland that sits below the bladder. Its main role is to help produce semen."
"Prostate cancer is a condition where cells in this gland grow abnormally. It's quite common in older men, especially after age 60."
"Some men develop symptoms like needing to pee more often, especially at night, or a weak stream. But in the early stages, there may be no symptoms at all."
"Late-stage symptoms can include back pain, weight loss, or blood in urine — but these are not usually how it starts."

Reassurance with clarity:

"Now, the good news is that you're 40, and prostate cancer in men under 50 is *very rare*.
While having a father diagnosed does increase your long-term risk slightly, it does *not* mean you'll definitely develop it."
"There's no need for any tests or scans right now. But it's really good that you've come in — because we *can* reduce your risk with some small lifestyle changes."

E – Engage in a Shared Plan + Management

1. Lifestyle advice (modification = risk reduction):

"Here are some things that can reduce your long-term risk of prostate cancer and also benefit your overall health:"

Try to reduce red meat intake — aim for no more than 1–2 times per week
Include more fruits, vegetables, and fibre in your diet
Exercise regularly — even 20–30 mins brisk walking 4–5 times a week helps
If you smoke, consider cutting down or joining a stop-smoking programme

2. PSA Screening Advice (NICE and NHS-aligned):

"We don't usually start screening with PSA blood tests unless you're over 50.
However, because your father had prostate cancer, we can consider starting annual PSA checks from around age 45 if you'd like — we can discuss this again in a few years."

3. Monitoring symptoms:

"There's no need to worry right now, but if you ever do notice symptoms like increased urination, back pain, or unexplained weight loss in future, come see us right away."

4. Check understanding and offer leaflet:

"Does all this make sense so far?"
"Would you like a leaflet or some trusted websites where you can read more?"
(*Give Macmillan or NHS prostate cancer links if asked*)

Safety Netting and Closure

"You've done the right thing by coming in — it's always better to ask than to worry. You're not at risk right now, and we're here if anything changes."
"Is there anything else I can help you with before we finish today?"

Student Note: Why No Tests or Exam Were Done

Patient is **only 40 years old** → routine screening not indicated
No urinary symptoms → no need for PSA, PR, or imaging
Focus is on **counselling, risk assessment, and reassurance**
NICE advises **PSA screening only ≥50**, or ≥45 **if high risk**
High-risk = family history + Afro-Caribbean background → **not both present here**
Lifestyle counselling and follow-up planning is **gold standard management**

Requesting PSA Test

Setting: GP surgery
Patient: 52–55-year-old man with **no urinary symptoms**, requesting a PSA test
Task: Assess concerns, explain PSA testing, and engage in shared decision-making

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C – Clarify the Concern

Doctor: Hello, I'm one of the doctors here today. Thanks for coming in.
Can I confirm your full name and age, please?
Great — how can I help you today?
(*Patient: "I'd like to get a PSA test done."*)

"Sure — could I ask what's made you think about doing this test now?"
(*Patient: "My friend was recently diagnosed with prostate cancer after doing a PSA. We used to play golf together, and now he's not doing well."*)
"I'm sorry to hear about your friend — that must have been quite difficult. How's he doing now?"
(*Acknowledge gently, then transition.*)
"It's completely understandable to feel concerned. Let's talk through what the PSA test is, how it works, and what options are available for you. Does that sound okay?"

A – Assess the Relevant Background
First, can I ask if you've ever had this test done before?
(*Patient: "No, first time."*)
1. Understanding and Expectations:
"Have you read or heard anything about what PSA is or why we use it?"
"What do you think this test might show you?"
"What were you hoping we could do today?"

2. Symptom Check:
"Have you had any symptoms like:
Going to the toilet more often than usual?
Needing to rush to the toilet?
Difficulty starting your stream or weak stream?
Dribbling afterward or feeling like you don't fully empty?"
"Any back pain or weight loss recently?"
(*No symptoms reported.*)

3. Risk Factor History:
"Has your father or any brothers had prostate cancer?"
"What's your ethnic background?" (*Afro-Caribbean background increases risk*)
"Do you smoke?"
"Do you eat red meat often?"
"How much exercise do you get?"
"Would you say your diet is high or low in fibre?"

4. General Health:
"Any ongoing medical conditions or medications?"
(*No PMH, lifestyle moderately active, diet not very high in fibre, red meat 3–4 times/week.*)

R – Reassure and Explain Clearly
"Thanks for being open about your concern — it's completely reasonable to feel unsure when someone close to you has gone through something like prostate cancer.
What's really good is that you've come in early, you're asking the right questions, and we can talk through the facts together."
"The important thing to remember is — you're not currently having any symptoms, and you're not in the very high-risk group. That means we're not worried about anything right now, but we can still take your concern seriously and make a plan that feels right for you."

E – Educate and Engage in Shared Decision

What PSA Is:

"PSA stands for Prostate Specific Antigen — it's a protein made by the prostate gland. A small amount is always present in the blood, and it can go up due to several reasons."

"PSA levels can be high in:

Normal enlargement of the prostate (which happens as men age)

Inflammation or infection (even without symptoms)

And yes, sometimes prostate cancer."

"So while it can **help detect** prostate cancer early, it's not perfect."

Benefits of PSA Testing:

"It may help pick up cancer before symptoms appear"

"It can help start treatment early, which can improve outcomes"

"In some cases, it can give peace of mind if the level is normal"

Limitations / Risks of PSA Testing:

"**False positives**: In about **3 out of 4 cases** where PSA is raised, the person **does not** have cancer. This can lead to unnecessary worry, scans, or even biopsies."

"**False negatives**: About **1 in 7 men** with prostate cancer have a normal PSA — so a normal result doesn't guarantee nothing's wrong."

"Some cancers found through PSA are very slow-growing and might never cause problems, but men may still go through treatment with side effects."

Decision-Making:

"So it's not a test we do for everyone routinely — we offer it after an informed discussion like this.
You're 52, which is an appropriate age to start thinking about it. There's **no medical indication** for a test right now since you have no symptoms, but if you decide to go ahead, we're happy to arrange it."

"Would you like to go ahead with the test now that we've gone through this?"

Next Steps if PSA Test Is Done:

"If the result comes back **raised**, we'll discuss it together. In that case, we'd refer you to a urologist within 2 weeks. They would likely start with an **MRI scan**, and if needed, go ahead with a **biopsy** to confirm whether it's cancer."

"And if it comes back **normal**, we'll repeat it in future only if needed."

Safety Netting and Closure

"If you do notice any changes in your urination, develop back pain, or have any new concerns, please come back to us anytime."

"Would you like a leaflet or link to some information about PSA testing and prostate health?"

(*Offer NHS or Cancer Research UK material*)

"Any other questions before we wrap up today?"

Student Note:

Don't treat this like a BPH or prostatitis case — **this is a risk discussion, not a symptom consultation**

NICE says PSA may be offered after **informed discussion** with men aged 50+

No need for PR exam unless symptoms or requested (but explain its purpose if mannequin is present)

Focus on **balanced explanation** of benefits and risks, then **shared decision-making**

This station tests **communication**, **education**, **clarity**, and **patient autonomy**

Worried About Testicular Cancer

Setting: GP Clinic
Patient: 19-year-old male
Task: Counselling and reassurance regarding testicular cancer concern (no lump)

C – Clarify the Concern

Doctor: Hello, I'm one of the doctors here today. Thanks for coming in.
Before we begin, could I please confirm your full name and age?
Great. How can I help you today?
(*Patient: "I think I have cancer."*)
"I'm sorry to hear you're worried about that. Can I ask what made you feel that way?"
(*Patient says: "Some of my friends were talking about testicular cancer in young men. I checked myself and now I'm not sure what I'm feeling."*)
"Thank you for being open about that. It's a really good habit to check yourself, and I'm glad you came in so we can talk through it properly."

A – Assess the Relevant Background

"To understand this better, can I ask a few questions about what you noticed when you examined yourself?"

1. MEDS Lump Assessment (if patient thinks he found something)

Which side did you feel something on? Left or right?
Was it the whole testicle or a small part?
How big did it feel? What did it feel like?
Is it hard, soft, or fluid-like?
Is it painful?
Has it changed in size?
When did you first notice it?

(*Patient unsure what he felt. Says it didn't feel like a lump exactly*)

2. Cancer Symptom Screening

Any back pain or loin pain?
Any breast swelling or tenderness?
Any weight loss or night sweats?

(*All negative*)

3. Risk Factor Assessment

Any family history of testicular cancer?
Were there any issues with your testicles when you were born? (e.g. undescended testis?)

(*No risk factors*)

4. Social and Medical History

Any recent trauma or infections?
Are you sexually active? Any STI symptoms?

(*None reported*)

5. Fertility or Body Concerns (if patient appears anxious or asks)

Do you have any concerns about fertility or changes in your body?

Examination

"To reassure you properly, I'd like to examine your testicles. I will ensure privacy, use a chaperone, and talk you through it gently. Is that okay with you?"

Inspection:

No visible swelling, redness, or asymmetry

Palpation:

Both testicles normal in size and consistency
Normal epididymis palpable posteriorly
No masses, tenderness, or abnormalities

Transillumination (optional):

No suspicious findings; normal tissue characteristics

Findings:

Examination entirely normal — no lump, swelling, or abnormalities

R – Reassure Confidently

"I've examined you thoroughly, and I can confidently say there's **no lump** and **nothing concerning** on the examination today."
"What you're likely feeling is the **epididymis** — a normal part of the testicle at the back where sperm is stored. It can sometimes feel like a small ridge or soft tube. That's completely normal."
"You also don't have any risk factors for testicular cancer like family history or undescended testicles, and no symptoms that suggest anything serious."

E – Educate and Shared Plan

"It's great that you're checking yourself — we actually recommend that all young men examine themselves once a month, ideally after a warm shower."
"What you're feeling is part of your normal anatomy, and you don't need any tests or scans. But if you ever do notice a **firm, painless lump inside the testicle itself**, or symptoms like **back pain** or **breast changes**, please come back straight away."
"You've done exactly the right thing by asking when you weren't sure."
"Would you like me to show you a diagram or leaflet that explains how to do a proper testicular self-exam?"

Safety Netting and Closure

"If anything changes — you feel a new lump, have pain, or develop any of the symptoms we talked about — don't hesitate to come back in. But for now, everything looks completely normal."
"Is there anything else you'd like to talk about or ask before we finish?"

Student Note: Diagnostic Reasoning Summary

19-year-old male with **no symptoms**, **no risk factors**, and **normal examination**
No further testing or referral required
Primary aim: **confident reassurance**, not over-investigation
Patient education on **normal anatomy** and **monthly self-examination** reinforced
Examiner looking for: confidence, safety netting, and avoidance of unnecessary escalation

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Vasectomy Request

Setting: GP Clinic
Patient: 26-year-old male
Task: Counselling regarding vasectomy request using CARE framework

C – Clarify the Concern

"Thanks for coming in today. How can I help you?"
(*Patient: "I'd like to discuss getting a vasectomy."*)
"Alright, thank you for sharing that. Before we go further, could you help me understand what led you to this decision?"
Ask:

- "Is this something you've been thinking about for a while, or did something trigger it recently?"
- "Have you done any reading or spoken to anyone about vasectomy?"
- "What do you currently understand about the procedure — how it's done and what it involves?"
- "Have you come across any information about its effectiveness and possible long-term impact?"
- "Do you know whether vasectomy is reversible — and what the chances are of success if someone changes their mind later on?"

Gauge expectations:

- "What are you hoping will come out of today's discussion?"

A – Assess Relevant Background

"To give you the best advice, I'd like to ask a few questions about your personal and relationship situation — is that alright with you?"

2.1 – About Him

- "Do you currently have any children?"
- "Do you think you might ever want children in the future — even in a different phase of life?"
- "Are you currently in a relationship? How long has it been?"
- "Is this a shared decision between you and your partner, or are you considering this independently?"
- "Have you and your partner discussed alternative contraception methods?"
- "Is there anything that makes you prefer vasectomy over other long-term or reversible options?"

2.2 – About the Partner (with consent to discuss)

- "If I may ask, how old is your partner?"
- "Has your partner expressed a desire to have children in the future?"
- "Is she currently using any contraception — such as the pill, implant, or IUD?"
- "Does she agree with the idea of you undergoing a vasectomy?"

R – Reassure and Advise Thoughtfully

"Vasectomy is a **minor surgical procedure** done under local anaesthetic. It involves cutting and sealing the tubes that carry sperm, making you permanently sterile. The actual ejaculation stays the same, but it will no longer contain sperm."
"It's one of the most effective forms of contraception available. That said, it's not immediately effective — sperm can remain in the tubes for a few months, so you'd need to continue using protection until a follow-up test confirms it's worked."
"One very important point is that **vasectomy is intended to be permanent**. Reversal procedures do exist, but they are expensive, not routinely available on the NHS, and success rates are **not guaranteed** — particularly as more time passes."
"You're still quite young, and statistically, people under 30 — especially those with no children — have a higher rate of regret, often due to changes in relationships or life circumstances later on."
"So before making a permanent choice, it's important to take a step back, reflect, and ensure it's absolutely the right decision for your future."

E – Educate and Shared Plan

"What I'd suggest for now is to take a short pause. Let's arrange a **follow-up in a month** after you've had some time to reflect. We can also refer you to **specialist counselling services**, which give you a chance to speak in detail — either alone or with your partner — to make sure this is the right step for you."

"You're entitled to make this decision for yourself. My role is simply to help you make it with as much information and confidence as possible."

If patient insists (e.g., "My body, my choice"):

"I completely respect that, and it's not about denying you your right. It's about ensuring you make a **well-informed** choice with full clarity about what this could mean for you in the future."

If patient is concerned about confidentiality:

"Just to reassure you — everything we discuss here is **fully confidential**. I won't involve your partner or anyone else unless you explicitly ask me to."

Student Note: Key Reasoning Summary

Patient is **under 30 with no children**, requesting a **permanent contraception method**
Explored **motivations**, **relationship factors**, and **partner's perspective**
Explained vasectomy clearly, including **procedure**, **irreversibility**, **regret risk**, and **alternative options**
Recommended a **cooling-off period + optional counselling** before formal referral
Management: Follow-up in 1 month, offer of counselling, supportive and non-judgemental approach throughout

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Refused Tonsillectomy Referral

Setting: FY2 in GP Surgery
Patient: 50-year-old mother
Concern: Tonsillectomy request refused for her 15-year-old (or possibly 8-year-old) son
Task: Address the parent's frustration and explain the tonsillectomy criteria per NHS guidance

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C – Clarify the Concern

"Thank you for coming in today. I understand your son was referred for a tonsillectomy and the referral was declined, and you've come in to discuss what happened."

"Before we go further, would it be okay if I asked a few questions to understand more about your son's condition and how this is affecting you both?"

→ Expect emotionally charged questions from the parent:

"Why did they refuse the surgery?"
"How can they let him suffer like this?"
"Is it just to save NHS money?"

Goal: Allow full emotional expression first, with non-verbal empathy:

Maintain eye contact
Nod and show engaged facial expressions. Don't interrupt
Use verbal empathy:

"I can see how upsetting this is."
"Anyone in your position would feel the same."
"I'm really sorry this wasn't explained clearly earlier."

A – Assess the Background

"Let's go through your son's symptoms in more detail to get a full picture. Can I confirm a few things?"

History Taking – Focused and Detailed

Duration & Onset:

"How long has your son been having problems with tonsillitis?"

"Did it begin just last year, or has this been going on for longer?"

Frequency & Pattern:

"Roughly how many episodes has he had?"

"How many per year?"

"How long does each episode typically last?"

Symptoms per Episode:

"Does he get a sore throat, visible pus, fever, or difficulty swallowing?"

"Any breathing issues, or coughing with phlegm?"

"Does he seem very tired or unwell during these attacks?"

Medical Management:

"Have you taken him to A&E or needed a hospital admission for any of the episodes?"

"Was he prescribed antibiotics — and how often?"

"Have any throat swabs or investigations been done?"

"Did you see an ENT specialist previously?"

Impact on Daily Life:

"Has this affected his attendance at school or performance in exams?"

"Has he had to miss important events or sports?"

"Have you noticed any changes in his behaviour or mood?"

"How has this affected the family's daily routine?"

R – Reassure & Explain Carefully

"From everything you've told me, I can completely understand why you're frustrated. I'd like to explain the decision and the criteria that specialists use."

What Are Tonsils and Why the Delay?

"Tonsils are part of the immune system. They help children fight infections when they're young. As children grow older, their immune system matures, and many children start to get fewer throat infections even without surgery. Tonsillectomy is permanent — once removed, tonsils don't grow back. So, we only offer it when the **impact is severe and persistent**, and the benefits clearly outweigh the risks of surgery."

Tonsillectomy Criteria

"To be considered for tonsil removal, your child must meet one of these sets of criteria based on how long this has been going on:

If it's been going on for 1 year:

→ There must be **at least 7 well-documented episodes** of tonsillitis in the past year.

If the problem has lasted for 2 years:

→ There must be **at least 5 episodes per year**, for both years.

If it's lasted 3 or more years:

→ Then at least **3 episodes per year** in **each year** are needed.

"Each episode must be clear and documented — meaning a proper sore throat, fever, pus on the tonsils, or difficulty eating."

Why Was the Referral Rejected?
"Based on the information that was provided, it seems your son doesn't yet meet the referral criteria. That's not a reflection of how you or your son feel — it's just how the guidelines are applied by the specialist team."
"I want to reassure you — this is not about saving money. The decision is made to **ensure surgery is used when clearly beneficial** and that other children with more severe or frequent illness are prioritised appropriately."
"Also, in many children, the frequency of infections naturally reduces with age, which is why delaying surgery may actually prevent it from being needed altogether."

E – Educate & Share a Plan
What You Can Do Now:
"I'd like us to keep a **record of any future episodes** — noting date, symptoms, treatment, and whether antibiotics were prescribed. That way, if things worsen, we can send a stronger re-referral."
"In the meantime, we'll continue supporting symptom management and can give advice during each episode."

Leaflet & Information:
"I'll give you a leaflet that explains tonsillectomy criteria and what signs to monitor."
"If you'd like, I can also show you the paper the ENT team used to assess the referral — it shows the same criteria we've discussed."

Follow-Up:
"If your son's symptoms increase or the impact on his life worsens, please come back — we can re-audit the situation and consider another referral."
"And of course, if you're ever worried during a tonsillitis episode — like fever not settling, severe pain, or breathing trouble — you can contact us or call 111."

Recurrent Infections in a Child

Setting: GP Surgery
Patient: 3-year-old child
Accompanied by: Father
Presenting Concern: Father is worried about repeated infections and potential immune system problems

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Clarify the Concern
"Thank you for bringing your child in today. I understand you're concerned that he may have some underlying immune problem because he's been getting sick often. I'd like to talk through what's been going on and explore your concerns in detail, if that's okay."
"Can I ask—what makes you specifically worried about his immune system? Is it the frequency of illness, the severity, or something else?"

Assess the Background
Illness Pattern and Frequency:
"When did these episodes start?"
"Roughly how many infections has he had over the past year?"
"How often is he falling ill—monthly, every few weeks?"
"What kind of symptoms does he get in each episode—cough, fever, ear pain, diarrhoea?"

Severity and Medical Response:
"Has he needed antibiotics for these infections?"

"Has he been admitted to hospital at any point?"
"Has he ever needed emergency care for breathing difficulties or severe illness?"
"Has he been seen by anyone else—like the school nurse or A&E—for these infections?"

Pattern and Triggers:
"Does it tend to happen more when the weather changes or when he returns to nursery after a break?"
"Has anyone else in the household been unwell at the same time?"

General and Medical History:
"Was he born full term, and has he been developing normally for his age?"
"Is he up to date with all his vaccinations?"
"Any known medical conditions, regular medications, or allergies?"

Social History:
"Does he go to nursery regularly?"
"Who looks after him at home?"
"Any family history of immune-related illnesses?"

Reassure and Explain

"I've had a look at him and from the examination today, everything appears completely normal. He looks active, well, and not showing signs of serious illness or chronic infection."
"In young children, especially around nursery-going age, it's completely normal to experience frequent viral infections. Children this age can catch around six or seven infections in a year, especially as their immune system is still developing."
"Mixing with other children at nursery is how they build natural immunity. The infections may seem frequent, but this is part of how their immune system learns to respond."
"There's no indication right now that there's anything wrong with his immune system. The infections he's getting sound like common childhood illnesses."

Educate and Plan

"Based on what you've described, I don't think a referral to a specialist is necessary at this point."
"However, I understand your concern, and to be thorough, we can arrange some basic blood tests to look at his overall health and immune markers. If anything unusual shows up, we can consider a referral then."
"I wouldn't recommend any scans or X-rays right now, as they're not needed and wouldn't help in this situation."
"In the meantime, continue encouraging a healthy routine—balanced meals, good hydration, regular sleep, and hand hygiene. It may help reduce the number of infections he picks up."

Safety Netting

"If you notice any worrying signs like failure to thrive, repeated hospital admissions, very severe infections, or if he starts getting infections that don't settle with usual treatments, please come back to see us."
"If his symptoms change or become more severe, or if you're ever unsure, feel free to contact the practice or call 111."

Follow-Up Plan

"Let's go ahead with the blood tests and we'll be in touch with the results. If everything is normal, we'll continue monitoring over the next few months. You can always come back if new concerns arise."

8-Week Vaccination Counselling

Setting: GP practice, telephone or face-to-face consultation
Doctor Role: FY2 in GP
Patient: Mother of a 5-week-old baby, seeking information on upcoming 8-week vaccinations (Vaccination chart available in the room)

C – Clarify the Concern

"Thank you for coming in today. I understand you've booked this appointment to discuss your baby's upcoming 8-week vaccinations. Before we go into details, could I ask — is there anything specific you were hoping to understand or discuss about them?"
Wait for response — if parent says "I just want to know what they are and if they're safe," proceed:
"Absolutely, I'll explain everything clearly. But first, would it be alright if I ask a few questions to understand what you already know and if you have any particular worries?"

Explore Parental Knowledge & Beliefs

"Could you tell me what you know about vaccines in general?"
"Do you know what a vaccine consists of?"
"Why do you think we give vaccines to babies?"

Understand Beliefs Around Benefits & Risks

"What do you think are the benefits of giving vaccines?"
"And what do you feel might happen if a child doesn't receive them?"

Explore Understanding of Mechanism

"Can you share how you think vaccines work in the body?"

Explore Concerns or Hesitancy

"Do you have any worries or concerns about vaccines in general?"
"Has anything about vaccines made you hesitant — either personally or from things you've heard?"
"Have you or your partner heard anything online or from friends that caused confusion?"

Explore Personal Vaccine History

"Were you vaccinated as a child?"
"Have you completed your own vaccine schedule?"

Take notes if misinformation arises — address this gently in the education step.

A – Assess the Background

(Use modified paediatric structure: **BIRD-MAF)**

B – Birth History

"Were there any complications during pregnancy or birth?"

I – Immunisation History

"Have any vaccinations been given yet?"

(Note: none given before 8 weeks in UK, so just confirm schedule is followed.)

R – Red Book

"Have you been using the red book to track your baby's weight and growth?"

D – Development

"Is your baby making eye contact and responding when spoken to or touched?"
"Are they moving their arms and legs well?"
"Do they feed well and seem to be growing steadily?"

M – Medications

"Is your baby on any regular medication?"

A – Allergies

"Are there any known allergies so far?"

F – Fever or Illness

"Has your baby had any fevers or illnesses recently?"

E – Educate First (Explain Before Reassuring)

Transition clearly to structured vaccine explanation.

"Thanks for sharing all that. Let me now explain what the 8-week vaccines are, how they work, and why they're important."

What is a vaccine?

"A vaccine contains very tiny amounts of inactive or weakened particles from viruses or bacteria. These particles are completely harmless, but they help the immune system recognise and build defence mechanisms — so if your baby ever encounters the actual infection, their body is ready to fight it off quickly."

How do they work?

"When these vaccine particles are introduced, the immune system responds by making antibodies. These antibodies stay in the system and help your baby stay protected if they ever come across that infection in real life. So the vaccine doesn't cause illness — it prepares the body to protect itself."

Vaccines Given at 8 Weeks

"At 8 weeks, your baby will receive 3 vaccines — 2 injections and 1 oral liquid. Let me explain each:"

1. 6-in-1 Injection (Diphtheria, Tetanus, Pertussis, Polio, Hib, Hepatitis B)

Diphtheria: Bacterial throat infection that can block airways and be life-threatening.
Tetanus: Caused by bacteria in soil, affects nerves and muscles.
Pertussis (Whooping cough): Severe cough in babies, can cause breathlessness and feeding difficulty.
Polio: A virus that affects the nervous system and can cause paralysis. No cure.
Hib (Haemophilus influenzae type b): Causes chest infections, ear infections, and meningitis.
Hepatitis B: Virus affecting the liver. Chronic infections can cause long-term liver damage.

2. Meningococcal B Vaccine

Protects against **meningitis B**, which is inflammation of the brain lining. It can lead to serious illness or death if not prevented.

3. Rotavirus (Oral liquid)

Protects against **rotavirus**, a virus that causes severe diarrhoea and vomiting in infants, sometimes requiring hospital treatment for dehydration.

Common Side Effects

"These vaccines are very safe. But your baby may:
Feel a bit irritable or drowsy for a day or two
Develop a mild fever
Have a sore leg at the injection site
These usually settle within 48 hours. If needed, you can give paracetamol at home — we'll advise the dose depending on your baby's weight."

R – Reassure & Address Concerns

Use this section to normalise concerns and address common myths and hesitancy.

"It's completely normal to want to understand exactly what's going into your child's body. I appreciate how seriously you're taking this."

"Vaccines are extremely safe. Before they're approved, they undergo rigorous safety checks. Millions of babies across the UK and worldwide receive these vaccines safely every year."

"I know some people worry about vaccines causing autism or overloading a baby's immune system. I want to reassure you that there is no link between vaccines and autism — this has been studied in detail by experts around the world. The original study that suggested a link was found to be flawed and was retracted."

"Your baby's immune system is incredibly capable — even more than we realise. The amount of material in these vaccines is tiny compared to what your baby naturally deals with every day."

Addressing Other Common Questions

"Isn't it too much for one visit?"

"It may seem like a lot, but your baby's immune system handles far more every day. Giving them all together reduces appointments and provides early protection."

"Are these mandatory?"

"They're not legally mandatory, but they're strongly recommended. These infections can cause serious complications, and vaccination is the most effective way to protect your child."

Partner's Concerns?

"I'd be happy to talk to your partner if they have any specific worries. We also have NHS information leaflets you can take home."

Final Check & Safety Netting

"Do you have any other questions or concerns I can help with today?"

[Address any remaining worries.]

"If you notice any unexpected symptoms after the vaccine — like a persistent high fever, an unusual rash, or if you're just worried — don't hesitate to contact us or call 111. Serious reactions are very rare, but we always want to keep your baby safe."

"We'll see you at the 8-week appointment. If your baby is unwell that day — like a fever or cold — just give us a call and we'll advise whether to reschedule."

How to Say It Naturally

"Think of vaccines like a training session for your baby's immune system. They help build the body's army to recognise and fight off serious infections — without actually causing the illness itself."

Flu Vaccine Counselling

Setting: GP Practice – Telephone Consultation
You are: FY2 Doctor
Patient: Mother of 2-year-old boy
Task: Counsel the parent regarding flu vaccination, address concerns, and provide clear, evidence-based advice to help her make an informed decision.

Clarify:

Understanding the Parent's Concerns

Greet and confirm identity:

Confirm relationship:

Paraphrase the issue and explore concerns:

"I understand this is his first flu vaccine and you've heard some worrying stories. Could you tell me what's making you unsure about the vaccine?"

Explore knowledge and source:

"Have you read or heard anything specific about the flu vaccine that's made you concerned?"

Acknowledge and reassure:

"It's completely understandable to want to know more before making any decisions about your child's health. Let's go through everything so you feel confident either way."

Assess:

Assessing Eligibility and Safety

Ask key screening questions to **rule out contraindications**:

"Before we discuss the vaccine itself, I'd like to ask a few questions about X's health to make sure it's safe for him to receive it."

Health Status

Any **flu-like symptoms** at present?

Any history of **asthma**, **severe wheezing**, or hospital admissions?

Is he taking any regular medications?

Allergies

Any **known allergies** — especially to **eggs** or previous vaccines?

Has he had **any reaction** to past jabs?

Immune Status

Is X **immunocompromised** or on any immune-suppressing medication?

Background Health

Ask BIRDDD (briefly):

Birth: Any birth-related complications?

Immunisation: Is he up to date?

Reactions: Has he reacted to other vaccines?

Development: Any developmental concerns?

Diet/Diseases: Any chronic illnesses?

Social

"Is he in nursery or daycare?" *(relevant for exposure risk and spread)*

"I'm glad to hear there are no medical reasons preventing him from having the vaccine. That's reassuring."

Reassure:

Explaining the Vaccine and Its Benefits

"Let me explain a few important things about the flu and the vaccine, so you have all the facts."

What is the flu?

"Flu is not just a bad cold. It can cause **fever, tiredness, cough, body aches, vomiting**, and can sometimes lead to **serious complications like pneumonia, meningitis, or heart inflammation**."

How the vaccine works

"The vaccine contains a **weakened version of the flu virus** that cannot cause illness but helps your child's immune system build protection."

"It takes about **2 weeks** to become effective and protects against the most common strains expected that season."

Vaccine schedule

"From the age of **2**, all children in the UK are offered the flu vaccine **every year** on the NHS — usually in autumn or early winter."

"For children aged **2–17**, we use a **nasal spray** rather than an injection. It's painless and very quick."

"Because flu viruses change every year, the vaccine is also updated yearly — so it's important to have it every year."

Effectiveness

"It doesn't guarantee that he won't catch the flu, but if he does, it's likely to be **milder and much shorter**, and he'll be **less likely to need hospital treatment**."

Educate:

Addressing Her Specific Concerns

"Can my child get flu from the vaccine?"

"No — the nasal spray contains a **weakened** virus that cannot cause full-blown flu. He might get a mild runny nose or low-grade fever, but not actual flu."

"Is it safe?"

"Yes. The flu vaccine is **very safe**, and millions of children receive it every year in the UK. The side effects are usually very mild and short-lived."

"My neighbour's child had a fit after the vaccine — will that happen to X?"

"It's rare, but some children may develop a fever after vaccination. In very rare cases, a high fever might lead to a **febrile convulsion** — but this is more commonly caused by **flu itself** than the vaccine."

"We advise giving **paracetamol** if he feels feverish and monitoring him closely. If he has any history of fits, we'll take extra care."

"What are the side effects?"

"Common side effects include:

Runny or blocked nose
Slight fever
Headache or tiredness
Mild loss of appetite These last a day or two and go away without treatment."

"Serious side effects like allergic reactions are **extremely rare**, and vaccination teams are trained to handle them if they occur."

"What happens if I don't get him vaccinated?"

"There's a higher risk he could catch the flu, pass it on to others, and develop complications — especially since flu spreads easily in nurseries."

"Even healthy children can become very unwell with the flu, and the vaccine helps reduce that risk."

"Is it compulsory?"

"It's **not compulsory**, but it is **strongly recommended** by the NHS because of the potential risks from flu."

Safety Netting

"If X gets a high fever after the vaccine, you can give him **paracetamol**. If anything unusual happens, like trouble breathing or a rash, please seek medical advice right away."

Leaflet

"I'll send you a leaflet about the flu vaccine, and you can also read more on the **NHS website**."

Check Understanding

"Can I check — does that all make sense so far? Would you feel comfortable summarising what we discussed? How are you feeling about going ahead with the vaccine now?"

MMR Vaccine Counselling

Setting: GP Surgery
Role: FY2 Doctor
Patient: mother of 11-month-old girl
Task: Counselling about MMR vaccination due next week

C – Clarify the Concern

Goal: Understand what the parent is worried about, what they've heard, and what they are hoping to discuss — without making assumptions.

Begin with warmth and openness:
"Thank you for coming in today. I understand your little one is due for her vaccinations next week. Before we go into details, could you tell me what's been on your mind or what led you to book this appointment?"

Invite the parent to express in their own words:
"Is there anything specific you've heard or read that raised questions for you?"
"Have you had a chance to talk to anyone else about this — like friends, family, or other parents?"
"Has something in particular made you feel uncertain or concerned about this vaccine?"

Explore her understanding and past experience:
"How have things been with the previous vaccinations?"
"Has your daughter ever had any side effects or issues after other vaccines?"
"Is she otherwise doing well — eating, sleeping, and playing normally?"
"Are her vaccinations up to date so far?"

Clarify her expectations from the visit:
"What would you find helpful to discuss today?"
"Would it be okay if I share some information with you, and we can decide together what feels right for your family?"

A – Assess the Relevant Background

Goal: Gather medical, developmental, and psychosocial information relevant to vaccine safety.

Child's health check (MAF):
Medical history: "Any medical problems in the past?"
Allergies: "Any allergies, particularly to vaccines or medications like neomycin?"
Feeding/Sleeping/Development: "Is she eating, drinking, sleeping well?" "Any concerns about how she's growing or learning?"

Immunisation & Birth History (BIRD):
"Was she born full-term with a smooth delivery?"
"Are her development and milestones appropriate for her age?"
"Is she up to date with the rest of her vaccinations so far?"

Impact:
"Has this worry affected you emotionally or made you anxious about medical visits?"
"Has it led to any disagreements or stress at home?"

R – Reassure & Explain Clearly

Goal: Provide simple, evidence-based answers to *every* concern. Build trust. Normalize fear but provide clarity.

What is MMR and Why Give It?

"MMR stands for Measles, Mumps, and Rubella — three serious infections that can cause long-term complications like brain inflammation, hearing loss, or miscarriage in pregnancy."

"The vaccine is given in two doses — one at 12-13 months and one around 4-5 years."

"It protects your child and also others around who can't be vaccinated, like newborns or people with weakened immunity."

Is There a Link Between MMR and Autism?

"I completely understand your worry. There was a study years ago that claimed a link — but that study was later discredited and withdrawn because it was flawed."

"Since then, over 20 large studies across millions of children have shown no connection between the MMR vaccine and autism."

"The signs of autism typically appear around the same time as the vaccine is given — which causes confusion — but it is coincidental, not caused by the vaccine."

Is There a Link with Bowel Conditions?

"No — that was part of the same discredited study. There is no proven link between MMR and any bowel condition."

Can I Get the Vaccines Separately?

"Unfortunately, no. The MMR vaccine is only offered as a combined dose — three in one — because this gives the best protection and reduces the number of injections."

Why Is Rubella Still Found in the UK?

"Some people travel without being vaccinated, and not everyone in the population is fully vaccinated. That's why it's important to keep high coverage to protect everyone."

Are These Infections Still Seen in the UK?

"Yes — we still see occasional outbreaks, especially in communities with lower vaccine uptake."

E – Educate & Engage in Shared Plan

Goal: Provide options, check understanding, and create a supportive plan.

Side Effects & Safety

"The MMR vaccine is very safe. The side effects are usually mild — things like a slight fever, a sore arm, or some swelling of the glands in the neck."

"Serious side effects are very rare, and the benefits of the vaccine far outweigh the risks."

"You don't need to worry about egg allergy — the vaccine is still safe in those cases."

Importance of Vaccination

"Vaccines protect not just Rachel, but also others who can't get vaccinated. With enough uptake, we can reduce or even eliminate diseases."

"It's your choice, and I want you to feel confident and informed. Even if you're not sure today, we can give you more time to think."

Leaflet, Follow-Up and Final Check

"Would it help if I gave you an NHS leaflet that summarises all of this?"

"You don't have to decide right now. Would you like to go home, read the leaflet, and we can speak again in a few days?"

"If you have any more questions or change your mind, you can always call or come in."

Worried About Miscarriage

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1. Clarify the Concern (Why now? What's worrying her?)

"Hi, I'm Dr [Name], one of the doctors in the Obstetrics and Gynaecology department. I understand this is your first antenatal visit—first of all, congratulations. Before we begin with the routine checks, would it be alright if I ask—how are you feeling about the pregnancy?"

(Actor will likely share sadness/anxiety about past miscarriages and whether this pregnancy will be different)

"Thank you for sharing that, and I'm really sorry to hear about what you went through before. You're not alone in feeling anxious—many women who've had miscarriages in the past feel this way. I'd like to understand a bit more so I can support you properly."

2. Assess the Background (Focused, structured antenatal history)

A. Obstetric History

"Can I confirm how many times you've been pregnant, including this one?"

"How many weeks were you when you had the miscarriages?"

"Did the miscarriages happen naturally, or did you need any medical or surgical treatment?"

"Have you had any tests or follow-up after those miscarriages?"

B. Current Pregnancy

"How many weeks along are you now?"

(LMP was 6 weeks ago → estimate gestation)

"Have you had any bleeding, spotting, or pain so far?"

"Are you taking any supplements, like folic acid or vitamin D?"

"How has your general health been recently?"

C. Medical & Gynae History

Any history of high blood pressure, diabetes, thyroid issues, clotting disorders?

Any past surgeries through the front passage (e.g., D&C, hysteroscopy)?

Last cervical smear and result?

D. Social History

"Do you smoke or drink alcohol currently?"

(Note: She quit smoking last year)

"Any recreational drug use?"

"Are you in a stable relationship currently? Do you live with your partner?"

E. Family History

"Any family history of miscarriage, or clotting issues like DVT or PE?"

F. ICE

Ideas: "Do you have any thoughts on what might have caused the miscarriages before?"
Concerns: "Is there anything in particular you're worried about happening again?"
Expectations: "What would you like to get from today's visit?"

3. Reassure & Explain

"You've had two miscarriages in the past, and it's completely natural to worry, but I want to reassure you. The vast majority of women who have had two early miscarriages still go on to have healthy pregnancies."
"We usually start investigating further causes only after three consecutive miscarriages. Since you've had two, we still treat this pregnancy like any other, unless any specific symptoms or medical issues come up."
"There's no strong evidence that anything you did caused those miscarriages. Most early miscarriages happen due to issues with the chromosomes during fertilisation—and they're usually not preventable."

4. Educate & Plan (Management + Prevention + Safety Net)

Routine Investigations

"We'll arrange baseline antenatal blood tests including:
FBC, blood group, Rhesus status, U&E, LFT, clotting screen, blood sugar"
"We'll also screen for infections: HIV, hepatitis B, syphilis, rubella immunity"
"We'll check your urine for infection or protein"

Dating Scan

"We'll arrange a 12-week scan to confirm dates and check early development. This is also used to screen for Down's syndrome."

Lifestyle Advice

Folic acid – "It's great you're already taking it. Keep going till 12 weeks."
Vitamin D – "It's also recommended daily during pregnancy."
Smoking – "It's amazing you quit. That's one of the best things you could do for your baby."
Alcohol – "Best to avoid alcohol altogether during pregnancy."
Exercise – "Stay active as much as you feel comfortable. It's safe, and actually helps reduce pregnancy complications."

When to Seek Help

"Please come back if you have any spotting, bleeding, or tummy pain, even if it's mild. We'd always rather check and reassure you than miss anything."

Follow-Up

Arrange 12-week scan
Book for midwife review
Refer to early pregnancy unit if any symptoms develop
Provide contact details and emergency numbers

Offer Leaflet & Final Check

"I'll give you a copy of the NHS pregnancy book today—it covers everything we've discussed and more. Would it help if I go through anything again?"
"Is there anything else you'd like me to explain before we finish?"

Pregnancy Planning on Captopril

Setting: GP Clinic
Role: FY2 Doctor
Patient: 42-year-old woman with hypertension on Captopril

C – Clarify the Concern

"Doctor, I want to get pregnant. What advice do you have for me?"

"Thanks for sharing that with me—just to understand you better, is there something in particular that's made you want to start trying now?"

"Is this something you've been thinking about for a while, or is it a recent decision?"

"Has anything or anyone been influencing this decision—like recent changes in your relationship, or other personal reasons?"

(Be sensitive—she may be recently married, facing age pressure, or fulfilling a promise to a partner)

A – Assess the Background

A. Pregnancy & Menstrual History

"Do you have any children already?"

"Have you ever been pregnant in the past? Any miscarriages or terminations?"

"Have you ever seen a doctor or had tests done related to fertility?"

"Have you had any surgeries in your abdomen—such as fibroids, ovarian issues, or anything gynaecological?"

"Are your periods regular?"

B. Contraception

"Are you currently using any contraception?"

"Have you stopped already, or are you still on it?"

C. Medical History

"I understand you have high blood pressure—how long have you had it?"

"Is it well controlled at the moment?"

"Are you on any medications for it?" *(Expected: Captopril)*

"How long have you been on Captopril?"

"Have you used any other medications before this for your blood pressure?"

D. Complete PMAFTOSA

Past medical history (diabetes, thyroid, kidney issues)
Medications (other than Captopril)
Allergies
Family history of pregnancy or cardiovascular complications
Tobacco / Alcohol
Support at home

E. Physical Examination (verbalised)

"I'd like to check your **blood pressure**, and measure your **height and weight** so we can calculate your BMI. These will help us understand your risk better before moving forward."

R – Reassure

"I completely understand why you're asking—and it's great that you're thinking ahead."

"At 42, trying for a baby can carry some challenges, but many women your age do have successful pregnancies. What matters is that you're planning early and seeking the right support—that's a strong first step."
"You have high blood pressure, which adds a bit more complexity, but with the right preparation, we can still support a safe pregnancy."

E – Educate & Plan Safely
A. Risk of Current Medication (Captopril)
"Captopril is an ACE inhibitor. While it works well for blood pressure, unfortunately, it's **not safe during pregnancy**.
It can cause **serious harm to the baby**, including kidney problems, low fluid in the womb, or even developmental abnormalities—especially if taken in later stages of pregnancy."

B. Immediate Advice
"For now, I would **strongly advise continuing your current contraception** until we've reviewed things with a specialist and switched your medication to something safer.
That way, you can plan your pregnancy in the safest possible way—for both you and your baby."

C. Referral to Specialist
"I'll refer you to a **pre-conception hypertension specialist or maternal medicine clinic**. They'll help us answer two important questions:
Is it medically safe for you to proceed with pregnancy?
What's the safest way to control your blood pressure while trying?"

D. Future Medication Plan
"If the specialist gives the green light to start trying, we'll switch you from Captopril to a safer option—like **Labetalol**, which is commonly used and safe in pregnancy."

E. If Pregnant Before Review
"If you become pregnant before we've changed your medication—or if you decide to stop contraception sooner—please come back to us **immediately**.
In that case, we'll need to **stop Captopril straight away** and start a pregnancy-safe medicine like Labetalol to protect the baby."

F. Lifestyle Optimisation
"While waiting for review, a few things can support a healthy pregnancy:
Keep your blood pressure well-controlled
Eat a heart-healthy, low-salt diet
Stay physically active, as you're able
Start taking **Folic Acid** (400 mcg daily) before trying
Maintain a healthy weight (BMI below 25 if possible)"

Safety Netting
"If you start to feel unwell—headaches, dizziness, severe blood pressure readings—or if you become pregnant unexpectedly, please let us know urgently.
The earlier we act, the safer it is for both of you."

Final Reassurance & Closing
"You're doing the right thing by planning ahead. This gives us time to make changes that will protect your baby from the very beginning.
We'll refer you today, and you'll be fully supported throughout.
Would you like me to go over anything again, or is there anything you're worried about right now?"

Surgical Abortion Counselling

Setting: GP Surgery
Role: FY2 Doctor
Patient: 32-year-old woman
Gestation: 8 weeks pregnant
Request: Wants to understand surgical abortion, booked for procedure next week

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C – Clarify the Concern

"Hi, I'm Dr [Name], one of the doctors here today. How can I help you?"
Patient: "I want to know more about surgical abortion."
Gently confirm:
"Have you already decided to go ahead with the abortion?"
"Have you been booked at a clinic?"
"Would it be okay if I ask a few questions first, and then walk you through what to expect?"
Check understanding and goals:
"Have you had a chance to read or hear anything about how the procedure is done?"
"Would you like me to explain everything from the start, or are there any parts you're unsure about?"
"Are there any specific things you're worried about?"
"And just to confirm — you're booked next week at a clinic, and today you'd like to understand what to expect — is that right?"

A – Assess the Relevant Background

1. Pregnancy and Reproductive History

"How many weeks pregnant are you now?"
"Have you had any scans or tests yet?"
"Have you been pregnant before — any children, miscarriages, or previous abortions?"
"Any gynaecological or abdominal surgeries?"
"Have you ever had fertility testing or tried to conceive before?"

2. Menstrual and Contraceptive History

"Are your periods usually regular?"
"What contraception were you using before the pregnancy?"

3. Medical and Psychosocial History

"Do you have any medical conditions like diabetes, asthma, epilepsy, or high blood pressure?"
"Any allergies?"
"Are you taking any regular medications?"
"What kind of work do you do?"
"Do you feel emotionally supported at home or in your relationship?"
"Have you had any recent stress — financial or otherwise?"
"Do you smoke, drink alcohol, or use recreational substances?"

4. "If you're comfortable sharing, can I ask a few more questions to help me better understand your situation?"
   "What's led you to consider an abortion at this time?" *(open-ended, non-judgmental)*
   "Have there been any other stresses in your life recently?"
   "Are there any financial pressures that are influencing your decision?"
   "Are you currently in a relationship?"
   "How long have you been with your partner?"
   "Is your partner aware of the pregnancy — and are they generally supportive?"
   "Have you spoken to anyone else — friends, family, or support groups — about this decision?"

"You don't need to answer anything you're not comfortable with — I'm only asking to make sure we give you the right support."

R – Respond with Clear Explanation

"Thanks for sharing all of that. I'll now explain what the procedure involves — from preparation to recovery. Please stop me any time if you'd like me to clarify something."

1. Preparation

"Because you're 8 weeks pregnant, this is usually a straightforward day procedure."
"You won't need to fast. Before the procedure, you'll be given medicine to soften the cervix."
"That's either:
Misoprostol: taken under the tongue, usually 1 hour before, or
Mifepristone: taken 24 hours earlier — the clinic will guide you."

2. Anaesthetic and Pain Relief

"You'll usually be awake but will be given local anaesthesia."
"This involves applying numbing gel and a small injection to numb the cervix."
"You might feel some pressure or cramping, but it's generally well tolerated. Stronger pain relief is available if needed."

3. The Procedure

"The procedure is called **manual vacuum aspiration**. A small suction device is passed through the cervix to remove the pregnancy tissue."
"It typically takes around 10 to 15 minutes."
"If anything is left behind, a second procedure called **dilatation and curettage** may be done to gently remove the remaining tissue."

4. Aftercare

"You'll stay in the clinic for observation for around 4 hours and then go home the same day."
"We advise resting for 24 hours, but you can return to normal activities when you feel able."
"You may have bleeding like a period for up to 2 weeks."
"If you plan to resume sexual activity, you'll need to use contraception immediately."

E – Empower with Support, Safety Netting, and Reassurance

1. Future Fertility

"If everything goes smoothly — which is usually the case — this won't affect your ability to have children in the future."

2. Emotional and Practical Support

"Emotionally, many women feel fine afterwards. Some may feel sad or unsure — that's completely normal."

"There are services like **NUPAS (National Unplanned Pregnancy Advisory Service)** that offer confidential support before and after the procedure."

3. Signs to Watch For

"If you develop:
Heavy bleeding (e.g., soaking 2 pads per hour)
Fever or chills
Foul-smelling discharge
Severe pain that doesn't settle with painkillers
please contact the clinic or your GP immediately."

4. Contraception and Follow-Up

"Most clinics will help you arrange contraception. You'll also be advised to take a pregnancy test 3 weeks later to confirm everything is complete."

Closing

"Have I explained everything clearly so far?"
"Would you like me to go over any part again?"
"You've done the right thing by asking these questions — and you'll have full support throughout the process."

Gender Preference Counselling

Setting: GP Clinic
Role: FY2 Doctor
Patient: 36 years old, mother of 3 girls, requesting guidance to conceive a boy

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C – Clarify the Concern

"Hi, how can I help you today?"

Patient expresses a desire for a male child, asking about timing, positions, and abortion if it's a girl

Key follow-up questions:

"Can I ask — is there any specific reason you're hoping for a boy this time?"
"Is this something you and your partner both want, or are you feeling pressure from someone?"
"Are there any beliefs or information you've come across that I can help clarify?"

A – Assess Background & Risk

Obstetric History

"How many pregnancies have you had before?"
"Were all your previous deliveries normal?"
"Any miscarriages or abortions?"
"Do you recall how far along you were when you had the termination?"

Contraception & Cycle

"Are you currently taking the combined pill?"
"When was your last period?"
"Do you have regular cycles?"
"Are you planning to stop contraception now?"

Fertility & Relationship

"How often do you and your husband have intercourse?"
"Do you know when your fertile window is?"
"Are there any concerns about your relationship or partner's support?"

Myths & Cultural Beliefs

"Have you tried anything before to increase the chance of having a boy?"
"Where did you hear about things like positions or gender prediction?"

ICE – Ideas, Concerns, Expectations

"What do you understand about how gender is determined in pregnancy?"
"Are you worried about what will happen if it's another girl?"
"What are you hoping we can do today — is it for help planning the pregnancy or something else?"

R – Reassure with Facts & Empathy

"I can see how important this is for you, and I want to give you clear, honest information. In the UK, there is no medical or legal method to choose the baby's gender. Gender is determined at the time of conception and cannot be influenced by things like positions or timing."
"Abortion is not permitted for gender selection — it's only allowed if specific legal grounds are met, such as risks to your health or severe abnormalities in the baby."
"You should be mentally prepared that the next child may be a girl again, and I'd encourage you to have that conversation with your husband too."

E – Educate & Engage in a Plan

General Pregnancy Planning Advice:

"You can stop the pill when ready, and try to have intercourse 2–3 times per week."
"Take folic acid 400 mcg daily, starting now and continuing for the first 12 weeks once pregnant."
"Have a pre-conception blood test: HIV, Hep B/C, Rubella, Syphilis."
"Make sure your smear test is up to date before conceiving."
"We'll also check your weight/BMI, as this can affect fertility and pregnancy health."

Lifestyle Guidance:

No alcohol or smoking
Avoid raw/undercooked meats, soft cheeses, liver
Avoid recreational drugs or unprescribed medication
Continue regular light exercise
Review medications for pregnancy safety

Emotional Support & Ethics:

"It's normal to want a certain outcome, but parenthood is unpredictable. Every child is equally valuable."
"If you ever feel under pressure from anyone, or unsupported, please speak to us — your wellbeing matters."

Addressing a Specific Concern (ICE Follow-Up)

My sister has breast cancer. If I get pregnant and it's another girl, can I terminate the pregnancy because of that?

"I'm sorry to hear that — how is your sister doing now?"

"Having a family member with breast cancer can understandably make you concerned. Some forms of breast cancer can be inherited, but the risk depends on the specific gene and family pattern. If you're worried, we can refer you to a genetics counsellor for advice before you conceive. But to clarify, having a sister with breast cancer is not a valid reason on its own to terminate a pregnancy. These situations are assessed carefully if and when you're pregnant, and usually only apply when there's a very high risk of serious inherited conditions."

Closing, Safety Net & Leaflet

"I'll give you a leaflet on planning a healthy pregnancy."
"If you develop any symptoms like tummy pain or miss a period, let us know."
"You're welcome to come back with any further concerns — we're here to support you."

Lesbian Fertility Counselling

Setting: FY2 in GP surgery
Patient: 32-year-old woman in a same-sex relationship
Task: Address fertility concerns and plan next steps.

Opening

Doctor:
"Good morning, I'm Dr [Name], one of the doctors here today. Could I confirm your full name and age, please?"
"How can I help you today?"
" I want to know about my options for getting pregnant."
Doctor:
"Thank you for sharing that. Just to confirm, you'd like to explore fertility options for starting a family — is that right?"

C – Clarify the Concern

"Have you looked into fertility options before, or would you like me to explain everything from the start?"
"Are there any particular aspects you're hoping we can cover today?"
"Is there anything specific you're worried about at this stage?"
Understand the patient's starting point and emotional needs.

A – Assess the Background

1. Relationship and Living Situation:

"Are you currently in a relationship?"
"Would you be comfortable telling me a little about your partner?
"How long have you been together?"
"Are you living together?"
NHS requires a **stable relationship (usually >2 years)**.

2. Reproductive History:

"Have you or your partner ever been pregnant before?"
"Have you undergone any fertility treatments previously (like IVF or IUI)?"
"Any history of miscarriages or living children?"
No living children and no previous fertility-funded treatments preferred.

3. General Health and Lifestyle:

"Do you have any long-term health conditions, like diabetes, thyroid issues, or anything else?"
"Are you taking any medications?"
"Do you smoke or drink alcohol?"
"Do you use any recreational drugs?"
"May I check your height and weight?" **(BMI should ideally be 19–30 kg/m²)**
NICE guidance recommends healthy lifestyle before starting fertility treatment.

4. Screening and Readiness for Pregnancy:
"Have you had any blood tests or scans related to fertility recently?"
"Are you up to date with cervical smears and STI screening?"
"Have you had immunity checks, like rubella status?"
Basic antenatal bloods and STI screens are part of the pre-fertility workup.

5. ICE:
"Do you have any thoughts about what might be involved?"
"Anything particularly worrying you?"
"What are you hoping will happen after today?"
Always explore Ideas, Concerns, and Expectations fully.

R – Reassure and Explain

Diagnosis / Situation:
"Based on what you've told me, you're in a good position to be referred for NHS-funded fertility services."

Explain the NHS Fertility Pathway:
"For same-sex female couples, NHS guidance says you can access fertility support once eligibility criteria are met."
"Typically, you'll first be offered **up to 6 cycles of intrauterine insemination (IUI)** using donor sperm."
"If you are unsuccessful after these cycles, you may then be eligible for **NHS-funded IVF**."
Explain stepwise — **IUI first**, then IVF if needed.

Eligibility Requirements Summary:

Requirement	*Details*
Relationship	Stable same-sex relationship (usually 2+ years)
Prior Children	No living children from either partner
BMI	19–30 kg/m²
Smoking Status	Must be non-smoker
STI Screening	Must be done before referral
Age Consideration	Best outcomes under 35–37

E – Educate and Empower

1. Immediate Next Steps:
"I'll refer you to the local NHS fertility clinic today."
"They will arrange tests including hormonal blood work (e.g., AMH levels), ultrasound scan of ovaries, and partner STI screening."

2. Lifestyle Optimisation:

"Maintaining a healthy BMI between 19–30 is really important for fertility success."

"Avoiding smoking and limiting alcohol improves outcomes significantly."

"Start taking **folic acid 400 mcg daily** for at least 3 months before conception."

Folic acid pre-conception is NICE recommended.

3. Donor Sperm Options:

"You can use sperm from an anonymous donor through NHS pathways or select your own donor through regulated sperm banks."

"The fertility clinic will guide you fully through these options."

Regulated sperm banks are safer and preferred.

4. Emotional Support:

"It's completely normal to feel excited and a bit overwhelmed. Support groups, counselling, and resources like the NUPAS service are available if you'd like to speak to someone."

Always offer emotional support proactively.

5. Safety Netting:

"If anything changes, or if you have more questions after today, please don't hesitate to contact us again. We'll be with you through each step of the journey."

Summary and Wrap-Up

"Today we've discussed your fertility options.
You meet the basic eligibility for referral to the fertility clinic.
I'll send the referral today, and you'll be contacted for further tests soon.
Please continue a healthy lifestyle, start folic acid if you haven't already, and reach out if you need any emotional support.
Before we finish — is there anything else on your mind or anything you'd like me to explain again?"

Contraception Counselling

Setting: GP Clinic, FY2
Mode: Telephone or in-person
Patient: 28-year-old woman
Trigger: Request for short-term contraception; had DVT 2 years ago; not using protection; no prior STI screen; wants advice

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C – Clarify the Concern

"Hi, I'm one of the doctors here at the clinic. Could I confirm your full name and age before we begin?"
→ "Thanks — so how can I help today?"
"I see — you're looking for advice about contraception. Could I ask, what's prompted this now?"
→ "I've recently started seeing someone new. We've had unprotected sex a few times, and I want something short-term for now."
"Thanks for sharing that — I appreciate you being open. Just so I understand clearly: you're looking for a **safe and short-term method** of contraception while starting a new relationship — is that right?"

A – Assess the Relevant Background

"Let me just ask a few more questions to make sure I can advise you safely."

1. Past Contraceptive Use

"Have you used contraception in the past?"
→ "I used to be on the combined pill."
"Have you had any problems with it before?"
→ "No, but I was told to stop it after I had a clot."

2. Medical History & Contraindications

"You mentioned a clot — was that a DVT or something else?"
→ "Yes, DVT in the leg, two years ago."
"Any other medical conditions I should know about?"
→ "No."
"Any regular medications, allergies, or recent surgeries?"
→ "No."

3. Sexual & STI Risk History

"Have you ever had an STI screen before?"
→ "No."
"Have you had unprotected sex with this new partner?"
→ "Yes."
"Any symptoms like discharge, pain during sex, or bleeding after sex?"
→ "No."

4. Lifestyle & Other Risks

"Do you smoke or use alcohol or recreational drugs?" → "No."
"Are your periods regular? Any recent changes?" → "Regular."
"Are you currently pregnant or could you be?"
→ "No."

5. ICE

"What were you hoping I could help you with today?"
→ "I just want a short-term method — not ready to commit to anything long-term."
"Any concerns about side effects or safety?"
→ "Just don't want anything that increases clot risk."

R – Reassure

"Thanks again for being so open — you've made the right decision by asking before starting anything."
"I completely understand your concern about the blood clot — and you're right to avoid anything that contains **oestrogen**, like the combined pill. That's because oestrogen increases the risk of clotting — especially after a history of DVT."
"But don't worry — there are **safe and effective short-term options** that work really well and won't increase your clot risk."

E – Educate & Plan

"We'll go through your options, and then I can help you choose what suits you best."

Options that are safe for you include:

1. Progestogen-Only Pill (POP) – You said you'd prefer this
One pill a day, same time every day
Does **not contain oestrogen** — so safe after DVT
Newer versions (like **Desogestrel 75 mcg**) have a **12-hour window** if you miss a pill
Older POPs (like Norethisterone) have a **3-hour window**
Effectiveness: >99% if taken correctly

Side effects:
- May change bleeding pattern (lighter, irregular, or no periods)
- May cause acne, mood changes, slight weight change
- Rarely causes benign ovarian cysts (which usually resolve on their own)

Missed pill? → May need to use condoms or emergency contraception depending on brand and time missed. Pharmacist can advise in real-time.

2. Barrier Methods (Condoms)
- Work immediately, no hormones
- **Only method that protects against STIs**
- May be used alone or alongside POP

3. Injectable (Depo-Provera)
- Given every 12 weeks
- Does not contain oestrogen — so safe after DVT
- May delay return to fertility after stopping
- Can cause irregular bleeding, weight changes, mood swings

→ Might not be first-line if unsure about long-term commitment

4. Emergency Contraception (if unprotected sex occurred recently)
- If within 5 days: **Copper IUD** (most effective) or **Levonorgestrel** or **Ulipristal** pill
- Safe and can be discussed with pharmacy or GP

→ Ask: "Do you need anything for recent unprotected sex?"

STI Screening

"Because this is a new relationship and there's been unprotected sex, I'd strongly recommend a full **sexual health screen**, even if you have no symptoms."
- Includes: Chlamydia, Gonorrhoea, HIV, Syphilis
- Simple urine or swab test + blood
- Available via GP, GUM clinic or home testing kits
- Important because some STIs are silent but can affect fertility later

Action Plan
- Start on **POP** today — I'll issue a prescription
- Arrange STI screening
- Use **condoms** alongside POP for STI protection
- Book review in 3 months to check tolerability and decide if you want to continue or switch
- Discuss long-term methods later if interested

Safety Netting

"Please seek medical attention urgently if you develop:
- Sudden leg swelling or pain
- Chest pain or breathlessness
- Or if you miss pills and aren't sure what to do — a pharmacist or GP can guide you"

Close

"You've done the right thing today. I'll arrange the POP prescription now, and if you'd like, I can also book you in for a sexual health screen."

"If you change your mind or want to explore other options later — like coils or implants — we can always revisit that."
"Would you like me to send a leaflet or SMS link about the pill and STI testing?"

Mammogram Request

Setting

FY2 doctor in GP surgery
Patient comes with a **concern**
Upon exploration, **requests a mammogram**

C – Clarify the Concern

Greet and confirm identity:
"Hello, I'm Dr. __. *Could I confirm your full name and age, please?"*
Open concern exploration:
"I understand you've come in with some concerns today. Would you mind telling me a little more about what's been worrying you?"
Patient says: *"I want to get a mammogram."*
Explore reason naturally:
"Of course. Could you tell me a little more about what led you to ask for a mammogram today?"
Further exploration:

"Have you noticed any breast changes yourself, like a lump, pain, or skin changes?"
"Or is it more because of family history or general worry?"

A – Assess the Relevant Background

Symptom history (if any breast complaint):

"Have you felt any lump yourself?"
"Which breast, and which area exactly?"
"Any pain over the lump?"
"Any changes in the skin like dimpling or redness?"
"Any nipple changes like pulling in or discharge?"
"Any new lumps in the underarm?"

Family history:

"You mentioned cancer in your family – may I ask who was affected?"
"What type of cancer was it?"
"Was it a close relative like a mother or sister, or more distant like a cousin or aunt?"
"At what age were they diagnosed?"
"Was it in one breast or both?"

Medical history:

"Have you had any previous breast problems or surgeries?"
"Have you had any mammograms in the past?" (important for 50-year-old)

Social history:

"Do you smoke or drink alcohol?"
"Any recent weight loss or changes in health?"

Breast Examination

Before Examination:

Thank the patient:

"Thank you for sharing all that information with me so far."

Explain examination purpose:

"I would like to examine your breasts to check for any findings that might need further tests."

Explain nature of exam:

"It shouldn't be painful, but it may feel a little uncomfortable. Please let me know if you want to pause at any time."

Explain what examination involves:

"I'll be looking at and feeling both breasts and your underarm areas."

Position and exposure:

"You'll need to undress from the waist up. I'll make sure your privacy is fully respected."

Chaperone:

"A female chaperone from the staff will also be present during the examination."

Consent:

"Would that be alright with you?"

Examination Technique

1. Inspection:
   - Hands relaxed on lap (look for symmetry, skin, nipple changes)
   - Hands on hips (tightens chest muscles)
   - Hands behind head (reveals tethering)
   - Lean forward (reveals fixation)
   - Lift breasts (look at undersurface)
   - Gently squeeze each nipple (look for discharge)
2. Palpation:
   - Patient lying at 45°
   - Superficial palpation: check temperature and tenderness
   - Deep palpation: check for masses in all quadrants and axillary tail
   - Areolar palpation: (avoid squeezing nipple)
3. Axillary lymph node examination:
   - Standing
   - Check anterior, posterior, medial, lateral, and apical nodes bilaterally

Findings (given):

- No palpable breast lump
- No palpable axillary lymphadenopathy

Thank the patient, allow to dress.

R – Reassure the Patient

Reassure gently and naturally:

"I have examined you carefully today, and I'm pleased to say there are no lumps or any worrying signs."

Acknowledge feelings:

"It's very natural to feel worried about breast health, especially if there's a family history. You've absolutely done the right thing by coming in."

E – Educate and Plan Management (based on age)

1. 50-Year-Old Patient

About mammogram request:

"I understand you would like another mammogram. You mentioned you had one just six months ago?"
"In that case, repeating a mammogram so soon would not be helpful because breast tissue doesn't change significantly over such a short time. A repeat would just expose you to unnecessary radiation without giving us any new useful information."

Offer genetic counselling:
"Given your family history, the next best step would be referring you to a genetic clinic. They will review your family and personal history carefully and assess your risk properly."

Explain about genetic testing:
"If appropriate, they may offer you testing for genes like BRCA1 and BRCA2, which are linked to breast cancer. However, these tests are expensive and are only offered after specialist assessment."

Leaflet:
- Genetic counselling and BRCA testing leaflet
- Breast awareness leaflet

Safety net:
"If you notice any new lump, skin changes, or nipple changes, please come back immediately."

2. 32-Year-Old Patient

About mammogram request:
"I understand you're requesting a mammogram, but at the moment, based on national guidelines, we don't routinely offer mammograms to women under 40 unless there are multiple family members with breast cancer, or early-age diagnoses, or cancer involving both breasts."

Why not:
"Breast tissue is generally denser under 40, which makes mammograms less reliable, and could cause unnecessary worry without providing clear answers."
Current advice:
- No immediate mammogram
- Encourage **breast awareness** (monthly self-checks)

Explain breast self-awareness:
"Check your breasts once a month, ideally after your period if applicable, looking for any new lumps, changes in shape, or skin or nipple changes."

Screening:
"Routine mammograms through the NHS screening program start at age 50. If any symptoms appear before then, you should return immediately."
Leaflet:
- Breast self-examination and breast awareness leaflet

Safety net:
"If you notice any new lump, discharge, skin changes, or feel generally unwell, please come back immediately."

Cervical Screening Concern in a Lesbian Patient

1. Clarify the Concern

Introduction:

"Good morning, I'm Dr. [Name], one of the doctors working today.
Could you please confirm your full name and age for me?"
"Lovely to meet you. How can I help you today?"

Patient opens:

"Doctor, I think you've sent me the wrong letter! I'm a lesbian — why would I need a smear test?"

Clarify and Explore:

Thank patient for sharing and acknowledge frustration:

"Thank you for bringing this up. I can see you're upset, and that's completely understandable.
Could you tell me a little more about your concerns regarding the letter?"

Ask about expectations:

"When you received the letter, what were your thoughts or concerns about the smear test invitation?"

2. Assess Background and Risk Factors

Medical and Sexual Health Assessment:

Apologize sensitively before sexual history questions:

"I'll need to ask some personal questions to guide my advice better. Is that alright?"

General Health Questions:

Any ongoing health issues?
Medications?
Family history of cancer?

Sexual History (sensitively asked):

Are you currently sexually active?
Are you in a relationship? (Gender-neutral)
Do you use any protection (condoms, barriers)?
Have you had any previous partners?
Any past male partners? (If yes, ask about condom use.)
Ever diagnosed or treated for any sexually transmitted infections?

Screening History:

Has she ever had a pap smear before?
Awareness about cervical cancer and HPV?

Impact Assessment:

Explore emotional effect:

"How has receiving this letter made you feel about your care or trust in our service?"

Ask if it is affecting her willingness to engage with healthcare.

3. Reassure

Acknowledge and Normalize Emotions:

"It's completely normal to feel upset, especially when it feels like personal details haven't been considered.
I just want to reassure you — receiving this letter wasn't a mistake. It's automatically generated for anyone aged between 25 and 65 who has a cervix, based on national health guidelines — not individual case reviews."

Address Confidentiality and Inclusivity:

"We aim to treat everyone respectfully, regardless of sexuality or gender identity. I'm really sorry if the system made you feel otherwise.
Our focus is your health and safety."

4. Educate

Explanation about Cervical Screening:

What is a Pap Smear?

"A Pap smear screens for early changes in the cells of the cervix and for HPV infection — the main cause of cervical cancer."

Who needs a Pap Smear?

"Anyone who has a cervix and has ever been sexually active — with partners of any gender — is recommended to have regular screening.
This is because HPV can be transmitted between female partners as well, even without penetrative sex."

Why you're still at risk:

"Even if you've only had female partners, HPV transmission can still happen through skin-to-skin genital contact.
If you have had any past male partners, even once, that slightly increases the risk too."

National Screening Guidance:

"Screening is advised every 3 years from 25 to 49 years, and then every 5 years until 64 years.
Early changes picked up by screening can prevent cervical cancer."

What happens during the test?

"A small sample of cells is gently collected from your cervix using a soft brush.
It usually takes just a few minutes and can be made more comfortable with simple adjustments if needed."

Addressing discomfort/fear:

"You can request a female doctor or nurse, take breaks during the procedure, and we can talk through every step beforehand if that would help you feel more at ease."

5. Management Plan

Offer time to think:

"You don't have to decide today. You're welcome to think it over and come back when you're ready."

Offer flexible support:

"We can book an extended appointment slot so you're not rushed.
You could also bring a trusted friend for support if you'd like."

If patient declines today:

"Even if you decide not to proceed now, please remember that cervical screening is about your future health — the choice is always yours, and we'll support you either way."

Leaflets and resources:

Offer information leaflet about cervical screening and LGBTQ+ inclusive resources if available.

Safety Netting:

"If you notice any unusual symptoms — like bleeding between periods, pain during sex, or unusual discharge — please don't hesitate to contact us."

Pap Smear for a Transgender Man

Setting: GP Clinic
Role: FY2 Doctor
Patient: 25-year-old transgender man (assigned female at birth, transitioned to male)
Presenting Complaint: Asks whether a cervical screening test is required

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C – Clarify the Concern

"Hi, I'm one of the doctors here today. Thanks for coming in. How can I help you?"

Patient says: "Doctor, do I need to have a pap smear?"

"Thanks for bringing that up — and it's really good that you're thinking about your preventive health. Could I ask — is there anything in particular that's made you think about this today?"

(Clarifies whether it's due to worry, reminders, or general health check)

A – Assess the Background (Full Detailed History)

"Would it be okay if I ask you a few questions, just to get a full picture before we decide together what's right for you?"

Gender Transition History

"Have you undergone any surgical procedures as part of your transition?"

(e.g. top surgery, bottom surgery)

"Are you currently taking testosterone? How long have you been on it?"

"Are you still getting periods?"

"Just to clarify — do you still have your cervix?"

(Expected: Patient still has cervix)

Understanding of Screening

"Have you had a pap smear before?"

"Do you know what it involves and why it's done?"

(Expected: unsure)

→ "It's a screening test to look for early cell changes that could lead to cervical cancer. It's not a diagnostic test, but it helps catch any changes early before they become serious."

Sexual History (sensitively and inclusively)

"Are you currently sexually active?"

"Do you tend to be sexually active with partners who have a penis, a vagina, or both — or is it not something relevant right now?"

"Do you usually use protection, like condoms or barriers?"

"Have you ever been screened for STIs or had the HPV vaccine?"

"Any use of shared sex toys or anal/vaginal penetration?"

(This screens for HPV exposure – the main risk factor for cervical cancer.)

Medical and Psychosocial

"Do you have any long-term conditions or medications I should be aware of?"

"How do you usually feel about intimate exams? Have you had any previous difficult experiences with smear tests or pelvic exams?"

"Is there anything that might help make the process feel safer or more comfortable for you?"

R – Reassure the Patient

"Thanks so much for answering all of that — and again, I really appreciate you bringing this up."

About Risk

"Because you still have a cervix and have been sexually active, you do remain at risk of developing cervical cancer — just like anyone else who has a cervix."

"Even if you're on testosterone and not having periods, the cervical tissue can still develop early cell changes, especially if there's been HPV exposure."

About the Procedure

"The pap smear is a brief procedure where a small plastic device is gently inserted into the vagina so we can collect cells from the cervix using a soft brush. The whole thing takes just a couple of minutes."

"That said, I completely understand that for many trans and non-binary people, this can feel distressing or dysphoria-triggering — so we take extra steps to make it as respectful, private, and comfortable as possible."
"You can let us know what language and approach you'd prefer, request a clinician of a specific gender, and even bring someone along if that helps."
"You're in control throughout. If anything feels too uncomfortable, we'll stop right away."

E – Educate and Empower

Screening Recommendations

"In the UK, the NHS recommends cervical screening every 3 years for anyone aged 25 to 49 who still has a cervix — regardless of gender identity."
"It's not based on how you identify or which hormones you take, but simply whether your cervix is still present."

HPV and Cancer Prevention

"HPV is a common virus that can cause cervical cell changes. Most people are exposed at some point, and often it clears on its own — but sometimes it leads to cancer if we don't monitor it."
"That's why smear tests are so important: they help us catch any changes early, when they're easy to treat."

Flexible Options and Consent

"If you're feeling unsure, we can also delay it and give you time to decide. You're absolutely entitled to change your mind later."
"You don't need to go through this alone, and we're always here to support you — now or in the future."

Closing and Encouragement

"You're doing the right thing by thinking about this and looking after your long-term health."
"Would you like to go ahead with booking the smear test, or would you prefer to have a bit more time to think about it?"
"Either way, we can also give you a leaflet on trans-inclusive smear testing and what to expect."
"If any worries or questions come up later, you can always come back — we'll support you every step of the way."

Candidate Note

25-year-old transgender man enquiring about cervical screening. Retains cervix, currently on testosterone. Sexually active with unclear HPV status. Patient unsure about process and risks. Counselling included risk explanation, screening recommendations, and patient-sensitive procedural guidance. Empowered to proceed or delay. Inclusive language and respect for gender identity maintained throughout. NHS guidance (screening every 3 years for those with a cervix aged 25–49) followed.

Persistent Acne – Request for Isotretinoin

Setting: GP Surgery

Patient: 19-year-old female with acne since puberty, currently on COCP for contraception, no prior acne treatment, now requesting isotretinoin and asking why she still has acne after teenage years.

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1. Clarify the Concern

"What exactly is the patient worried about – and why?"

Anchor Phrase: *"Let's start with what's on your mind."*

"Hi, thanks for coming in today. Let's start with what's on your mind. I understand you're hoping to talk about treatment for your acne — could you tell me what made you want to discuss this today?"
"Have you seen or read something recently about isotretinoin that made you consider it?"
"What are your thoughts about the acne at this stage? And are you hoping I can prescribe something specific today?"
Goal: Understand that the patient is frustrated about persistent acne despite being 19, has seen online success stories about isotretinoin, and wants something 'stronger' that works.

2. Assess the Relevant Background
"What clinical and personal context do I need before I can safely advise?"
Anchor Phrase: *"Can I ask a few questions so I can guide you properly?"*
"Can I ask a few questions so I can understand things better and offer the right advice?"
History of Acne:
- "How long have you been dealing with acne?"
- "Where do you usually get the breakouts — mostly face, chest, or back?"
- "Are the spots mainly red, inflamed ones or whiteheads and blackheads?"
- "Have you ever had any scarring or painful cysts?"

Previous Treatments:
- "Have you tried any creams, gels, or tablets specifically for acne before?"
  (*Patient: No, only been on the pill.*)

Current Medications and Triggers:
- "How long have you been taking the combined pill?"
- "Do you notice any triggers — like stress, periods, or skincare products?"
- "Do you use any protein supplements or biotin?"

Psychosocial Impact:
- "Has this been affecting your self-confidence or daily life?"
- "Is there anything in particular that's made it harder to cope lately?"

Rule out PCOS:
- "Have you noticed any extra hair growth on your face or body?"
- "Are your periods regular?"
- "Any recent weight changes?"

Safety Checks:
- "Do you have any allergies to medications?"
- "Are you on any other regular medicines?"

Goal: No features of PCOS. Acne is facial, inflammatory but not cystic. No scarring or prior treatments. Clear psychological impact. COCP started for contraception, not acne.

3. Reassure & Explain
"Now explain — clearly, calmly, and respectfully."
Anchor Phrase: *"Let me break this down in a simple way."*

"Let me break this down in a simple way. I know it feels frustrating to still have acne at 19 — many people think it only happens during the teenage years. But it's actually very common to have acne in your early 20s, especially in women. It's not your fault — it happens because of how your skin reacts to hormones and how your pores produce oil."

About isotretinoin (Roaccutane):

"You mentioned isotretinoin. It's a strong medication used for severe or resistant acne. But because it has serious side effects — like effects on mood, liver, and it can cause serious birth defects — it's only started by hospital skin specialists, not GPs."

"They also require that you've first tried the standard treatments for at least 12 weeks. That's what we haven't done yet — and that's the next step I'd recommend."

What works well for most people:

"We usually start with a special gel that combines two ingredients — one unclogs the pores and the other kills bacteria. If your acne is moderate, this alone often works. If not, we can consider adding an oral antibiotic later."

Goal: Provide a balanced explanation of acne persistence, explain isotretinoin limitations gently, and build trust in the standard first-line approach.

4. Engage in a Shared Plan

"Let's now decide what to do – together."

Anchor Phrase: *"Let's decide this together – you're not alone in this."*

"Let's decide this together — you're not alone in this."

Immediate plan:

- "I'd recommend starting with a gel that combines adapalene and benzoyl peroxide — it's applied once a day and helps clear blocked pores and reduce inflammation."
- "You can continue your contraceptive pill alongside it — that may help too."

What to expect:

- "You may notice some dryness or peeling in the first few weeks — that's normal. Improvement usually takes 6–12 weeks, so don't be discouraged early on."

Next steps:

- "We'll review things in 12 weeks. If the acne hasn't improved enough, we'll discuss adding an oral antibiotic like lymecycline."
- "If that still doesn't help, I'll refer you to a dermatologist to consider stronger options like isotretinoin, if needed."

Safety netting:

- "If your acne becomes painful, cystic, or you develop scarring or feel it's badly affecting your mental health, please come back sooner."

Resources:

- "I'll give you an NHS leaflet with advice on acne and how to use the gel properly."

Follow-up:

- "Let's book a follow-up in 12 weeks — or sooner if you're not coping."

Goal: Shared decision, clear pathway, reassurance without dismissing concern, option of escalation if needed.

Diagnostic Reasoning

This is a case of **moderate acne** in a 19-year-old woman with no prior topical or oral treatment. She requests isotretinoin due to frustration but has not met the criteria for referral. NICE and NHS CKS guidance recommend starting with **topical combination therapy** (e.g., adapalene + benzoyl peroxide) for at least **12 weeks**. Oral antibiotics or specialist referral are only considered if there's inadequate response. No red flags or PCOS features were present. The priority is to explain management clearly, support patient understanding, and avoid premature escalation.

Discharge Discussion with Relative

Setting: Acute Medical Unit
You are: FY2 Doctor
Scenario: 80-year-old woman admitted after a fall and wrist fracture, now medically fit for discharge. You are speaking to her son, who is upset and wants her placed in a nursing home. The patient has capacity and has consented for this discussion.

Introduction

"Hello, I'm Dr [Your Name], one of the doctors on the team here.
Could I please confirm your name and how you're related to the patient?"
(If he is standing or appears agitated)
"Would it be okay if we sat down and spoke through everything together?"

C – Clarify the Concern

"Thank you for coming in today. I understand you've just heard your mum is ready to be discharged.
I really want to understand your thoughts before we go further — would you mind sharing what's worrying you most right now?"
Common concerns raised:

- "I came all the way from London and now you're just sending her home?"
- "She has a stick — clearly she's not okay."
- "She's confused sometimes. I think she should be in a nursing home."
- "I don't feel this is safe."

Respond empathetically:

"I hear you. It's clear you care deeply and want what's safest for your mum — and I appreciate how far you've travelled to be with her.
Let's go through everything together, and I'll answer all your concerns honestly."

A – Assess the Background

"To make sure we're on the same page — she came in yesterday after a fall at home, and was found to have a wrist fracture.
It's her non-dominant hand, and it's been placed in a plaster cast by the orthopaedic team."
"We were also concerned there could have been a medical reason for the fall — so she had a full assessment, including blood tests, blood sugar, and a CT scan of the head. Thankfully, all of these were normal."
"She's been reviewed by both the physiotherapy and occupational therapy teams, and based on their assessment, she's able to walk independently using a stick.
They've also recommended some home support."

Further clarification questions:

- "Has anything like this happened before?"
  → Helps assess if this was a first fall or part of a recurrent pattern
- "Before this incident, was she managing her meals, dressing, and getting around on her own?"
  → Assesses pre-morbid independence
- "When you say she gets confused sometimes — does she manage okay day to day?"
  → Distinguishes age-related forgetfulness vs dementia
- "Is she on any regular medications at home?"
  → Screens for falls risk due to medications
- "Does she live alone? Does anyone usually check in on her?"
  → Identifies social support and risks of isolation

Acknowledge:

"Thank you — that gives me a fuller picture. From what you've shared and what we've seen, this fall appears to be an isolated event, and she's usually quite independent."

R – Reassure & Explain

Medical Safety:

- No serious cause for the fall was found
- Wrist fracture managed conservatively
- No signs of confusion, infection, or acute illness during admission

Functional Safety:

- Walks independently using her unaffected hand
- Stick was advised by physio as a temporary support during wrist healing
  → "So the stick is actually a precaution — not a sign that she's suddenly unable to cope."

Social Support:

- Carers arranged to visit twice a day for meals, hygiene, and dressing
- She is comfortable with this plan and has expressed clearly that she wants to go home

Hospital Risks:

"It's also important to say that keeping her in hospital longer when she doesn't need to be here could do more harm than good — hospitals increase the risk of infections, reduced mobility, and confusion in older patients."

E – Engage in Shared Plan

"You've asked about a nursing home — and I understand why. That can feel like the safest option, especially when you're far away.
But a nursing home is usually only considered when someone cannot manage at home even with support — and that's not where she is right now."
"She has the mental capacity to make decisions and has been clear that she doesn't want to go into a home — and we must respect that."

Offer solutions:

- **GP follow-up:** We'll notify her GP to visit her at home within 2–3 days
- **Carer support review:** If two visits aren't enough, they can be increased up to four times a day
- **Social care contact:** If she deteriorates or shows signs of increasing confusion, she can be reassessed for permanent care
- **You'll have contact details** for the care team and GP to ring for help if needed

Re-address Emotional Comments (if required)
"I came all the way from London..."
"It means a lot that you came to be with her — and I can see how strongly you feel about her safety.
This plan isn't about sending her off — it's about supporting her in the way that she wants and giving you confidence that there's a system behind her."
"She's got a stick — she's not okay"
"I understand why that feels concerning. The walking stick wasn't given because she's suddenly dependent — it's a temporary support to help with balance while her wrist heals.
Her dominant hand is fine, and she's walking steadily."
"She gets confused — won't she be safer in a nursing home?"
"That's a really good point. We've been monitoring her throughout her stay, and she's been alert, oriented, and engaging fully with us and the therapists.
There's no sign of confusion right now — and she's been able to make decisions clearly, including expressing that she wants to go home.
And we must respect her choice if she's able to make informed decisions, which she absolutely can."
"She'll be lonely."
"You've raised an important emotional concern. Loneliness is real — but we've tried to balance that by putting structured support in place.
Carers will visit her twice a day, and if she ever needs more help — whether physical or social — we can increase that to up to four visits daily."

Offer Before Closing:

- Leaflet on falls prevention at home
- Contact details for social care and GP
- Reassurance that the system is in place and responsive to changing needs

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Chapter 19: Abuse and Safeguarding

Safeguarding scenarios test your ability to recognise abuse, respond sensitively, and act protectively within your role as an FY2 doctor. These stations are not about solving complex social problems but about recognising red flags, supporting the patient, and ensuring safe escalation to the appropriate services.

Why These Scenarios Are Tested
You are expected to:

- Be the **first line of defence** for vulnerable patients
- Show understanding of **legal and ethical responsibilities**
- Communicate in a **non-judgmental and supportive** way
- Know when and how to **escalate concerns appropriately**

Core Safeguarding Principles

1. **Identify**: Be alert to verbal and non-verbal clues.
2. **Support**: Provide a safe, empathic space to open up.
3. **Do Not Investigate**: Your role is not to gather proof.
4. **Escalate**: Follow local safeguarding protocols.
5. **Document**: Accurately record facts and statements.

Basic Structure for Safeguarding Scenarios in PLAB 2

Use this structure to guide most consultations involving suspected abuse:

1. Start with the Presenting Complaint

- Let the patient express their concern in their own words.
- Watch for hesitation, emotional cues, or vague answers.

2. Acknowledge and Offer Confidentiality

- "You seem a bit worried—please feel free to speak openly. This is a confidential space, unless there's a serious risk to you or others."

3. Explore Gently but Thoroughly

Use the following steps (E-S-I-S-M):

- **E**xplore what happened (what, when, who, how, where?)
- **S**upport: "Have you been able to speak to anyone about this?"
- **I**mpact: "How has this been affecting you physically, emotionally, or at home?"
- **S**ocial history: relationships, children, finances, home situation
- **M**edical history and risk factors (including alcohol, drugs, mental health)

4. Explain Your Concerns and Reassure

- "From what you've shared, I'm concerned that this may be abuse."
- "It's not your fault, and you're not alone in this."

5. Management Plan (4S)

- **Support**: Offer resources (referrals, helplines, safeguarding teams)
- **Senior**: Inform your senior or safeguarding lead
- **Safety**: Ensure immediate safety (especially for children or high-risk adults)
- **Schedule**: Arrange a clear follow-up plan within 1–2 weeks

6. Document and Escalate

- Use exact phrases when possible (e.g., "He hit me").
- Do not interpret—record what was said and what actions you took.

What to Avoid

- Don't **accuse anyone** directly
- Don't **promise confidentiality** if someone is at risk
- Don't try to **solve the situation alone**
- Don't make assumptions—**let the patient lead the disclosure**

Elderly Abuse

Scenario:

You are an FY2 doctor working in the acute medical ward. A 70-year-old woman has been brought in after a fall by her daughter. On examination, the patient has bruises of different ages and mild chest pain. The patient has mild dementia but has capacity and has consented for you to speak with her daughter.

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1. Introduction

"Hello, I'm one of the doctors on the ward looking after your mother today. I understand you brought her in after a fall—thank you for coming in. Would it be okay if I ask you a few questions about what happened and about your mother's general health, just to make sure we don't miss anything important?"

(Confirm consent to speak with daughter has been given by the patient.)

2. Presenting Complaint

Start by exploring the incident in detail.

- "Can you tell me exactly what happened today?"
- "Do you know when it happened? Did you witness the fall?"
- "Was anyone else at home at the time?"
- "How long after the fall did you bring her in?"
- "Did you consider calling an ambulance?"

Watch for:

- Delayed presentation
- Reluctance to involve emergency services
- Gaps in the timeline

3. Differential Screening

Explore common medical causes of falls:

- "Does your mother have any medical problems that could lead to falls—like low blood pressure or dementia?"
- "Is she on any medications, especially blood pressure tablets or aspirin?"
- "Does she use any mobility aids?"
- "Has she had any previous falls?"

4. Targeted Risk Factor History

Understand home dynamics and carer situation:

- "Who does she live with?"
- "Are you her main carer?"
- "How much help does she need with daily activities?"
- "Which tasks can she manage herself, and which ones need assistance?"
- "How are you managing with work and caregiving?"
- "Do you have other responsibilities, like children or work?"
- "Have you had support from any services like home carers or social services?"
- "Has help ever been offered but declined?"

5. ICE (Ideas, Concerns, Expectations)

- "What do you think might be going on with your mother?"
- "Do you have any concerns about her safety or well-being?"
- "What were you hoping we could do for her today?"

6. Red Flag Review – (Sensitive Exploration)

Once physical findings (bruises of various ages) are documented and patient has consented to discussion:

- "I just wanted to talk to you about something we noticed. Your mother has a few bruises in different areas, and they appear to be from different times. Do you know how she might have gotten these?"
- "Caring for someone elderly, especially with memory problems, can be incredibly stressful. Sometimes people act out of frustration. Has anything like that ever happened while you've been looking after her?"

Daughter discloses:

"Yes, I've pushed her a few times. Especially when I'm running late and she stands in my way."

Follow-up gently:

- "Thank you for being honest. Would you feel okay telling me a bit more about what's been happening?"
- "Is there anything else that has happened that you feel I should know about?"

7. Acknowledge and Empathize

- "I'm really sorry to hear how difficult things have been. I can see that you've been trying to manage a lot on your own—your job, your children, and your mum's care. It's completely understandable to feel overwhelmed."

8. Explain Your Concern and Duty

- "Thank you for sharing this with me. I need to explain that what you've described—pushing your mother—is considered a form of physical abuse, even if it wasn't intentional."
- "My role is not to judge but to ensure your mother's safety and also make sure you get the support you need."

9. Management Plan (Safeguarding + Medical)

- "Here's what I'll be doing next:
    - I'll speak to my senior team to make sure we address this correctly.
    - We'll treat your mother's chest pain and manage her bruises appropriately.
    - We'll refer her to social services to explore care options and support.
    - Since your mother has capacity, they will involve her directly in decisions about her care, but they may also involve you as her main carer."

10. Addressing Concerns

Daughter: "Are they going to take my mum away?"

You:

- "That's a fair question. Social services are not here to punish or break up families—they work to protect vulnerable people and support carers. Removal from the home would only ever be a last resort, if her safety couldn't be guaranteed in any other way."

11. Provide Support and Signposting

- "You've been under a lot of pressure. There are services that offer support for carers—things like respite care, emotional support, and practical help at home. Would you like me to share those resources with you?"

12. Safety Netting and Follow-Up

- "We'll monitor your mother closely while she's admitted. Social services will meet with her during her stay or after discharge. I'll document everything we discussed today clearly in the notes, and I'll make sure senior staff are aware and involved."

How Was the Diagnosis Made?

The pattern of bruises of different ages, vague fall history, and caregiver disclosure of physical pushing under stress strongly point to **elder abuse due to carer stress**. This diagnosis is based on clinical suspicion supported by history, observation, and safeguarding principles—not on proof.

Suspected Non-Accidental Injury – Spiral Fracture in a Child

Setting: Paediatrics (Acute Ward)
Role: FY2 Doctor
Patient: 3-year-old boy
Presenting Complaint: Swelling in the arm
Key Finding: X-ray shows a spiral fracture of the humerus

Clue: Spiral fracture is unusual in children — raises suspicion
Parent Present: Biological mother. Boyfriend (biological father) was primary carer overnight.
Safeguarding Concerns: Inconsistent history, delayed presentation, spiral fracture

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1. Introduction
"Hello, I'm one of the doctors on the paediatrics team. I understand you've brought your son in because of some swelling in his arm—thank you for coming in. I'll need to ask you a few questions to understand what's happened, and to make sure we give your child the best possible care. Is that okay?"
(Ensure consent is confirmed and you are speaking with the legal guardian.)

2. Presenting Complaint
"I understand the swelling was first noticed this morning—can I ask what time that was?"
"Were you able to bring him in straight away?"
"When did you last see your child before noticing the swelling?"
"Was everything fine at that point?"
"Who was looking after him between then and now?"
"Was anyone else at home at the time?"
"Has anything like this happened before?"
(Look for any delayed presentation, vague answers, or discrepancies.)

3. Differential Screening
"Just to check for other possible causes—does your child have any medical issues that might make him more prone to fractures or falls?"
"Has he ever been hospitalised or had injuries in the past?"
"Is he an active child? Has he ever had any serious falls or accidents?"
"Does he use any mobility aids, or does he run around normally?"
(Rule out underlying bone conditions or accidental trauma.)

4. Targeted Risk Factor History
"Can I ask a bit about your pregnancy with him—was it planned, and were there any complications during pregnancy or delivery?"
"Are both you and your boyfriend his biological parents?"
"Do you have any other children at home?"
"Is there anyone else involved in his care regularly—family, neighbours, or a nursery?"
"Have there been any issues with your child's development or behaviour?"
(Identify risk factors like unplanned pregnancy, household stress, lack of support.)

5. ICE – Ideas, Concerns, Expectations
"What do you think might have caused this swelling?"
"Is there anything in particular that you're worried about?"
"What were you hoping we could do for you today?"
(Gauge the parent's insight, worries, and expectations.)

6. Explore Home and Social Environment
"How are things at home these days—are you managing okay?"
"Do you work night shifts often?"
"Would you say things are stable in your relationship?"

"Any stress at home—financial worries, emotional strain?"
"Is there any alcohol or drug use in the home?"
"Has there ever been aggression or conflict involving anyone in the household?"
"Has your partner ever behaved roughly with your child or with anyone else?"
(This is key to identifying risk of abuse and patterns of harm.)

7. Escalation Discussion Based on Clinical Findings
"Thanks for explaining everything so far. I wanted to talk to you about what we've found."
"Your son has a fracture in the upper part of his arm, called a spiral fracture. This kind of injury isn't very common in children of his age. It usually occurs when a twisting force is applied to the arm, or after a fall from a significant height."
"Right now, we don't have a clear or consistent explanation for how this injury happened. When that's the case—especially in children—we have to consider the possibility that the injury might not have been accidental."
"This doesn't mean we're accusing anyone, but it does mean we need to take this seriously and follow safeguarding procedures to protect your child and support your family."

8. Acknowledge and Empathise
"I understand that this must be incredibly upsetting to hear. You've done the right thing by bringing your child in today, and that tells me that you care deeply about him."
"I know these questions can feel difficult or even intrusive, but our job is to make sure your son is safe and gets the right care. When we see injuries like this without a clear cause, we have a legal duty to act."

9. Management Plan (Safeguarding + Medical)
"So, here's what we need to do next:

- First, we'll treat the fracture and provide appropriate pain relief
- We'll arrange a full skeletal survey to check for any other injuries
- I'll be discussing this case with my senior team and our safeguarding lead
- We'll make a referral to social services, who will want to speak with you and your partner
- Since your child is still very young, this process is designed to understand the situation and offer support where needed"

10. Addressing Parental Concerns
If asked: "Why social services?"
"In any case where a child has an injury like this without a clear explanation, we are legally required to involve social services. Their role is to understand the context and prevent future harm. They start by speaking to you and your partner and exploring whether support can be offered. Removal from the family is never the first step—it's a last resort, only used if absolutely necessary."
If asked: "Why can't I see my child right now?"
"He's currently undergoing tests and receiving treatment. You'll be able to see him as soon as it's safe and appropriate. This is not to keep you apart—it's to make sure his medical needs are fully met."
If asked: "Do you think I'm a bad parent?"
"Not at all. You did the right thing by bringing him in. That shows responsibility and love. These processes are in place to protect children and support families—not to judge."

11. Safety Netting and Follow-Up
"We'll be keeping your child admitted while we complete all investigations and referrals. Social services may want to speak with you while he's here or afterwards. I'll also be documenting everything clearly and making sure my

senior team is fully informed. Once all the steps are complete, we'll decide the best plan for ongoing care and follow-up."

12. Documentation and Escalation

- Document **exact clinical findings**: spiral fracture of humerus
- Note timeline, who was caring for the child, and any inconsistencies
- Record questions asked and factual responses, using the parent's wording where appropriate
- State clearly: *Safeguarding referral made, skeletal survey arranged, senior informed*
- **Avoid interpretation** — stick to facts and observations
- Document emotional state of caregiver if relevant

How Was the Diagnosis Made?

A **spiral fracture** in a young child without a clear trauma mechanism, combined with vague overnight history, care by someone else, and household risk factors, is **highly suspicious for non-accidental injury**. This is not a definitive diagnosis of abuse, but it warrants escalation, skeletal survey, and safeguarding referral as per **NICE**, **RCPCH**, and **GMC** guidance.

Domestic Violence in Pregnancy

Setting: Emergency Department
Role: FY2 Doctor
Patient: 30-year-old woman, currently pregnant
Presenting Complaint: Vaginal bleeding
Key Findings: No active bleeding, normal scan, bruises on arm resembling grip marks
Safeguarding Clue: Subtle withdrawal, unexplained bruises, behavioural cues

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1. Introduction

"Hello. I'm Dr [Your Name], one of the doctors here in A&E. I understand you came in because of some bleeding during your pregnancy. Thank you for coming in. Before we begin, would it be alright if I ask you a few questions to make sure everything is okay with both you and your baby?"
(Confirm identity, gain consent, sit at eye level, warm and steady tone.)

2. Presenting Complaint

"We've completed the examination and scan. The good news is that there's no active bleeding, and your baby appears healthy on the scan. How are you feeling about that?"
(Pause and allow reaction. Acknowledge relief.)
"You should be able to go home soon, but before we discharge you, I'd just like to check a few more things to ensure your overall well-being and safety — would that be okay?"

3. Explore Behaviour and Encourage Disclosure

(Start gently, building trust.)
"I've noticed that you seem a little quiet and withdrawn. Is there anything you'd like to talk about?"
(If she doesn't respond:)
"Can you tell me how this bleeding started?"
"I want you to know that anything you share here will remain confidential. Is there something on your mind that you'd like to talk about?"
(If still hesitant:)
"I've also noticed some bruising on your arm — they look like grip marks. Would you feel comfortable telling me

how you got those?"
"Is there anyone at home who may be hurting you?"
(If silence continues:)
"I'm asking because you're pregnant, and we want to make sure that both you and your baby are safe. If there's anything happening in your life that might be affecting your safety, you can speak freely. I promise you this conversation is private."
(If patient responds with a guarded disclosure:)
"I'm not allowed to talk about this."
"Who's not allowing you? Is it your partner? I want to reassure you — no one else will know what we speak about here unless you ask us to involve someone."
Patient Discloses: "My husband kicked me in the stomach."
(Respond calmly and compassionately – no dramatic reaction.)
"I'm really sorry to hear that. That must have been incredibly difficult for you."

4. Detailed History – Domestic Violence Assessment
A. Explore the Situation
- "Would you be able to tell me more about what happened?"
- "How long has this kind of behaviour been going on?"
- "Has he been physically violent in other ways?"
- "Does he ever insult you, call you names, or try to make you feel worthless?"
- "Does he try to control who you talk to or where you go?"
- "How often does this happen? Is it occasional or more frequent?"

B. Actions Taken
- "Have you spoken to anyone about this before or tried to seek help?"
- "Have you considered leaving or reaching out to family or services?"
- "Can I ask what's made that difficult?"
- "What would you like to see happen in your relationship?"

C. Impact Assessment
- "How has this been affecting your emotional health?"
- "Have you had any thoughts about harming yourself or feeling hopeless?"
- "How is your sleep at the moment?"
- "Do you generally feel safe at home?"

D. Social History
- "Do you have any other children at home?"
- "Is your husband the biological father of this baby?"
- "What does he do for a living?"
- "Does he drink or use drugs?"
- "Are you currently working, or financially dependent on him?"
- "Do you have friends or family nearby who might be able to support you?"
- "Are you originally from this area?"

E. Medical History
- "Do you have any other health problems or take any regular medication?"
- "Are you taking your prenatal supplements?"

5. Acknowledge and Reassure
" I'm truly sorry to hear that you've been going through this. You've shown incredible courage by speaking about it. What you've described is domestic violence — and I want to say very clearly: it is not your fault. You don't

deserve this treatment, and you're not alone. There are many women who go through similar situations, and there is help available."

6. Management Plan (Immediate Medical + Safety)

- "From our side, we can offer you **admission tonight** if you feel unsafe going home. That would give you a bit of space to think in a safe setting."
- "If you prefer to go home, we will arrange for your **GP to follow up** with you within two weeks."
- "Because this affects your safety and your baby's well-being, we will also make a **referral to social services**. This is not to judge or take the baby away — it's to ensure you're supported, and the environment is safe."
- "I'll also be discussing your case with my **senior team** to make sure we're doing everything we can to help."

7. Offer Specific Sources of Help

"There are several places you can turn to for support, all confidential and available 24/7:

- **National Domestic Abuse Helpline** – offers advice and support at any time
- **Women's Aid** – a charity specialising in helping women in abusive situations
- In an emergency, you can always call **999**. If you can't speak, you can press **55** to alert the police
- You can also go to any **Boots pharmacy** and ask for **'ANI' (Action Needed Immediately)** — the staff are trained to discreetly help you"

8. Consulting Seniors

"I'm going to speak to my senior colleagues right away and update them on what you've shared. We'll work together to make sure you're safe and supported before you leave."

9. Safety Netting and Follow-Up

"We'll make sure you receive a follow-up appointment in two weeks — either with your GP or maternity services — so we can check on your health, safety, and the progress of your pregnancy. Please do your best to attend."

How Was the Diagnosis Made?

The combination of unexplained bruises resembling grip marks, vague body language, PV bleeding with no medical cause, and eventual disclosure of assault during pregnancy supports a strong clinical suspicion of **domestic abuse**. Diagnosis was confirmed based on structured exploration, safeguarding cues, and direct disclosure.

Domestic Violence - Insomnia

Setting: General Practice
Role: FY2 Doctor
Patient: 32-year-old woman
Presenting Complaint: Difficulty sleeping for the past 2 weeks
Clue: Underlying distress, guarded history, eventual disclosure of physical and emotional abuse by husband
Safeguarding Concern: Domestic violence presenting through a non-obvious route (insomnia)

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1. Introduction

"Hello, [Patient Name]. I'm Dr [Your Name], one of the doctors here at the practice. I understand you've come in with trouble sleeping — thanks for coming in. Would it be okay if I ask you a few questions to understand more about what's going on?"

(Warm tone, calm posture, open body language)

2. Presenting Complaint
"Can you tell me more about the sleeping issues?"
"Are you having trouble falling asleep, staying asleep, or both?"
"What time do you usually go to bed? When do you actually fall asleep?"
"How many hours of sleep are you getting each night?"
"Did anything happen around the time this started?"
(She mentions marital problems.)

3. Explore Behaviour and Encourage Disclosure
(Observe: withdrawn body language, anxious tone, avoiding eye contact.)
"I've noticed you seem a bit uncomfortable and anxious today. Is there anything else that's been worrying you recently, maybe at home?"
(Pause. If no disclosure yet, offer confidentiality repeatedly.)
"I want to reassure you that anything we talk about today stays between us — unless there's a serious safety concern. Is there anything going on at home that you'd like to talk about?"
(If still no response)
"Please don't feel pressured — I'm here to help, and I understand these things are hard to talk about. Just know this is a safe and private space."
(After further prompting, she says: "He gets angry a lot. I'm always worried about what might set him off.")
"That sounds very distressing. When he gets angry, what sort of things does he say or do?"
"Has he ever physically hurt you or threatened to?"
(She discloses pushing, grabbing, and bruises.)
"Thank you for telling me. I'm really concerned about what you've described. This sounds like domestic violence, and I want to reassure you — it's not your fault, and you don't deserve to live in fear."

4. Detailed History – Abuse Exploration
A. Explore the Situation
- "Can you tell me more about what's been happening at home?"
- "What kind of things tend to trigger his anger?"
- "How long has this behaviour been going on?"
- "When he's angry, what does he do or say?"
- "Has he ever hit you, slapped you, or done anything physically violent?"
- "Does he try to control who you talk to or what you do?"
- "Would you say this happens every day, or occasionally?"

B. Actions Taken
- "Have you told anyone or reached out for help?"
- "Have you considered leaving or speaking with family?"
- "If not — is it because you're worried about what might happen if you do?"
- "What do you want to happen in this relationship?"

C. Impact Assessment
- "Besides the insomnia, how has this been affecting your health?"
- "Do you often feel low or anxious?"
- "Have you had thoughts of harming yourself or feeling hopeless?"
- "What do you experience when you try to sleep?"
- "Do you feel safe at home?"

D. Social History
- "Do you have any children?"
- "What does your husband do for work?"

- "Does he drink excessively or use substances?"
- "Are you currently working?"
- "Are you financially dependent on him?"
- "Do you have any friends or family nearby who could support you?"
- "Are you originally from this area?"

E. Medical History

- "Do you have any existing health problems?"
- "Any medications currently?"
- "Have you ever sought help for mental health issues in the past?"

5. Acknowledge and Reassure

"I'm truly sorry that you've been going through this. It's incredibly brave of you to talk about it. What you've described is domestic violence — and I want you to know very clearly: it's not okay, and it's not your fault."
"You're not alone in this. Many women experience similar situations, and support is available. You've taken a huge step by speaking today."

6. Signpost Support Services

"There are trusted organisations that can help:

- **National Domestic Abuse Helpline** – open 24/7 for confidential advice: 0808 2000 247
- **Women's Aid** – charity offering practical and emotional support
- In an emergency, **call 999**, or dial **55** if you can't speak
- You can also walk into any **Boots pharmacy** and ask for **'ANI' (Action Needed Immediately)** — the staff are trained to help discreetly
- I can also provide you with local support service contact details if you'd like"

7. Management Plan – Medical + Safeguarding

"This is what I'd recommend we do now to help you:

1. I'll prescribe a short course of sleeping tablets to help in the short term — but I'd like us to address the root cause as well
2. I can refer you to a trained **counsellor who specialises in domestic violence**
3. With your permission, I'd like to refer you to our **local domestic abuse support service**
4. I'd like to do a full physical check-up to ensure you're okay medically
5. We'll arrange **regular follow-up appointments** — starting with next week
6. If you're comfortable, I'd also like to document what you've told me today. This can be helpful if you ever decide to take action
7. I won't be suggesting couple counselling — it's not appropriate or safe in abusive relationships"

8. Consult with Seniors

"I'll also be discussing your case confidentially with my senior GP to make sure we're doing everything we can to support you safely."

9. Arrange Follow-Up

"I'd like to see you again in one week to check on your sleep and how you're feeling overall. We'll then plan regular reviews to keep track of your well-being. If anything gets worse before then, please don't wait — come back in immediately."

10. Safety Planning

"I'd like us to discuss some steps you can take for your immediate safety — just in case:

1. Pack an emergency bag with important documents, keys, and essentials
2. Identify a safe place you can go — even temporarily
3. Memorise key numbers or keep a written copy hidden
4. Use a **code word** with someone you trust to signal if you're in danger
5. Most importantly — trust your instincts. If something feels unsafe, it probably is. Leave only when it's safe, and call the police if needed"

How Was the Diagnosis Made?
The patient presented with insomnia, but the lack of identifiable physical causes, recent onset, and vague history prompted further exploration. Her anxious demeanour, avoidance, and eventual disclosure of emotional and physical abuse by her partner confirmed **domestic violence** as the underlying cause. The diagnosis was made through structured, non-judgmental history taking and safeguarding cues — not through direct symptom correlation.

Patient–Counsellor Relationship

Setting: GP Practice
Role: FY2 Doctor
Patient: 35-year-old woman
Presenting Complaint: Requests a change of counsellor
Clue: Initially vague reason; eventual disclosure of romantic and sexual relationship with the counsellor
Safeguarding Concern: Abuse of professional boundary by the healthcare provider

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1. Introduction
"Hello, [Patient Name]. I'm Dr [Your Name], one of the doctors here at the practice. I understand you've asked to change your counsellor — would it be okay if I ask you a few questions to understand what's happened and how we can best support you?"
(Calm tone, seated, open body posture. Ensure confidentiality.)

2. Presenting Complaint
"Can you tell me a little more about why you want to change your counsellor?"
"Are you currently seeing the counsellor as part of your treatment for depression?"
"Is there anything specific about your experience that made you feel uncomfortable?"
(Patient becomes hesitant.)
"You don't have to share anything you're not ready to — but I want you to know this is a confidential and safe space. If something's been bothering you, I'm here to listen and support you."
(Eventually, she discloses: "We had a sort of relationship.")

3. Encourage Disclosure and Explore
(Avoid pressuring, maintain neutral expression.)
"Thank you for trusting me with that. Just so I understand better — when you say a relationship, do you mean a romantic or sexual relationship with your counsellor?"
"How did that begin?"
"Was this contact only during counselling sessions or outside as well?"
"Did the relationship ever involve any physical or sexual contact?"
"How long has this been going on?"

4. Detailed History – Abuse and Impact Assessment

A. Explore the Relationship

- "Did he ever initiate physical contact during your sessions?"
- "Was there any pressure to enter the relationship?"
- "Has he ever threatened you, directly or indirectly?"
- "Has he ever asked you to keep this hidden or made you feel guilty for being involved?"
- "Has he ever been aggressive or controlling?"

B. Actions Taken

- "Have you confronted him or spoken to him since?"
- "Have you told anyone else about this — friends, family, another healthcare professional?"
- "Did he ever suggest you shouldn't tell anyone?"

C. Impact Assessment

- "How has all of this affected you emotionally?"
- "Do you feel your depression symptoms have returned or worsened?"
- "Have you experienced low mood, crying spells, or hopelessness again?"
- "Have you had any thoughts of harming yourself?"
- "How do you feel now, especially after seeing him with someone else?"

5. Psychiatric and Medical History

- "Can you tell me a bit about your depression — when were you first diagnosed?"
- "Have you been on any medication for it?"
- "Are you still taking it or just attending therapy?"
- "How long had you been seeing this counsellor?"
- "Before this happened, were you beginning to feel any better with treatment?"

6. Social History

- "Who do you live with at the moment?"
- "Do you have children?"
- "Are you currently working?"
- "Are you financially independent or reliant on anyone — including the counsellor?"
- "Do you smoke, drink alcohol, or use any substances?"
- "Did you ever share finances or commitments with him — joint accounts, rent, etc.?"

7. Acknowledge and Reassure

"I'm so sorry this has happened to you. What you've described is very serious, and I want to reassure you — you've done nothing wrong by coming forward."
"You've been extremely brave. This was not your fault. As healthcare professionals, we are in positions of trust, and there are strict rules about maintaining professional boundaries with patients."

8. Explain Your Position and Professional Duty

"This relationship should never have happened. It is against professional standards for a counsellor or healthcare worker to become romantically or sexually involved with someone under their care."
"He should have known that this behaviour was wrong. As a doctor, I am professionally obligated to take this seriously — and I will be discussing this with senior staff so we can make sure this is addressed appropriately."
"This isn't about punishing you or blaming you — it's about protecting you, and potentially protecting other patients too."

9. Management Plan

- "You will not be asked to see this counsellor again."
- "I will arrange a **new counsellor** for you. If you prefer a **female counsellor**, we will try our best to accommodate that — I'll make a note of your request."
- "I'll arrange for an urgent review with **mental health services** as well — to ensure you get appropriate ongoing support."
- "At the moment, I don't think we need to start medication unless your symptoms worsen, but we'll keep that under review."
- "I'll carry out a **risk assessment** and review your current mental health today."

10. Consult with Seniors

"I will be discussing this case confidentially with my senior colleague. We are required to report this professionally, but the report will not identify you publicly. This step ensures the matter is investigated appropriately and protects others from possible harm."

11. Address Patient Concerns

If patient says: "I don't want him to get in trouble."
"I completely understand. But this is something that I'm not allowed to handle privately — once a healthcare professional crosses that line, we have a duty to report it. It's not about punishment — it's about safety, safeguarding, and ensuring it doesn't happen to anyone else."
If patient says: "Did I make a mistake by telling you?"
"Not at all. You absolutely did the right thing. You've been very strong to come forward, and this might help prevent him from doing something similar to another patient in the future."

12. Safety Netting and Follow-Up

- Arrange a **follow-up appointment in 2 weeks** to assess emotional wellbeing
- Provide details of **local mental health support services** and **crisis helplines**
- Advise to return immediately if mood deteriorates or she has thoughts of self-harm
- Maintain open access policy: "If anything gets worse, please don't wait — contact us immediately"

How Was the Concern Identified?

The patient requested a change in counsellor but was vague initially. A calm, open approach and multiple confidentiality reassurances encouraged disclosure of a romantic and sexual relationship initiated by her therapist. As this is a breach of GMC/NMC/NHS standards and a safeguarding violation, it required escalation, structured support, and mental health follow-up.

Workplace Harassment – LGBT Discrimination

Setting: GP Practice
Role: FY2 Doctor
Patient: 20-year-old lesbian individual
Presenting Complaint: "I want to speak to a doctor"
Clue: Hesitant to open up; eventually discloses targeted bullying at work related to sexual orientation
Safeguarding Concern: Psychological harm from discrimination and identity-based harassment

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1. Introduction
"Hello, I'm Dr [Your Name], one of the doctors here at the practice. I understand you requested an appointment to speak with a doctor — how can I help you today?"
(Pause. Maintain warmth and open posture. No assumptions. If hesitant:)
"Please take your time. Whatever you'd like to discuss will stay between us. You're safe here."

2. Presenting Concern and Encouraging Disclosure
(Patient eventually discloses: "Two women at work talk about me being lesbian.")
"I'm really sorry to hear that. Would you feel okay telling me what they've been saying, or how that's made you feel?"
(Patient describes it as 'disgusting' and 'bullying'.)
"I'm really sorry you're going through this. Can I ask — are they saying these things directly to you or behind your back?"
"How long has this been happening? Is it ongoing?"
"Does it happen in specific places at work — for example, in shared spaces or meetings? Or have you noticed anything on social media?"

3. Explore the Workplace and Social Context
"Who are these individuals? Do you work closely with them?"
"How long have you worked there?"
"Are they more senior or junior than you?"
"Do you feel like others in the workplace are supportive? How about your manager or HR team?"
"Have you spoken to anyone else about this — a colleague or supervisor?"

4. Actions Taken
"Have you taken any steps so far, like speaking to someone at work or making a complaint?"
"If not — can I ask what's made that difficult for you?"
"Do you feel like your workplace would take it seriously if you did raise a complaint?"

5. Impact Assessment
"How is this affecting you emotionally?"
"Do you feel anxious or upset when going to work?"
"Are you experiencing any physical symptoms, like palpitations or headaches?"
(Patient says: "I get palpitations every morning before work.")
"How long has that been happening? Do you take anything for it?"
"Has it affected your sleep?"
"Are you losing interest in your work or avoiding going in?"
"Do you generally feel safe at your workplace?"

6. ICE (Ideas, Concerns, Expectations)
"What do you think is going on here?"
"What are you most worried about — personally or professionally?"
"What were you hoping we could do for you today?"

7. Social History
"Who do you live with?"
"Are you currently in a relationship?"
"Is your partner aware of what's been happening? Is she supportive?"

"Have you spoken to your family about this? Do they know about your orientation, and are they supportive?"
"Do you feel like you have people you can trust or talk to?"
(Note: Isolation is common in LGBTQ+ harassment cases.)

8. Substance Use and Risk Screening
"Do you smoke, drink alcohol, or use any recreational drugs?"
(Patient says: "I drink a bottle of wine every day because of this.")
"Was the drinking something that started after this situation began?"
"I understand this is a coping mechanism — we'll talk through some healthier alternatives in a moment."

9. Medical History
"Do you have any long-term health conditions?"
"Any mental health concerns in the past — depression, anxiety?"
"Are you currently on any medication?"

10. Acknowledge and Reassure
"I'm really sorry to hear how this has been affecting you. No one should be treated this way at work or anywhere else. I want you to know — what you've described is harassment. You don't have to tolerate it, and there are steps we can take to protect your wellbeing and your rights."

11. Management Plan
A. Empower the Patient
"What's happening to you is legally considered **harassment** under the **Equality Act 2010**. Harassment includes any behaviour that makes someone feel intimidated, degraded, humiliated, or offended — including bullying someone for their sexual orientation."
"You have a right to a safe and respectful workplace."
B. What You Can Do
- "Start by writing a **formal complaint** to your HR department or line manager."
- "If your organisation doesn't respond or protect you, you can contact an **employment tribunal** or take legal action."
- "You can also contact external organisations for support and legal advice — such as the **LGBT Foundation** or **Stonewall**."
- "There may be **free legal aid** available if needed."

C. What I Will Do as Your Doctor
- "I'll refer you for **counselling or talking therapy**, so you can speak to someone regularly about the emotional toll of all this."
- "We also need to address the drinking. It's understandable why you've turned to it, but long-term it can make things worse. Let's start with some **simple strategies** to reduce it slowly — like exercise, breathing techniques, or reconnecting with friends or hobbies."
- "If needed, we can involve our local **alcohol recovery services**, but I'd like to support you gently first."

D. Offer Safety Net and GP Support
- "I'm always available if you need support — whether things improve or get worse. You can always come back to see me."

12. Follow-Up and Escalation
"I'd like to see you again in **two weeks** to check in on how you're coping, both emotionally and physically."
"I'll also be discussing this with my **senior GP** to ensure we are offering you all the right resources and handling this properly from a safeguarding perspective."

How Was the Concern Identified?
Patient booked an appointment without specifying a reason. Through gentle encouragement and repeated reassurance of confidentiality, she disclosed that colleagues were making offensive comments about her sexual orientation. With further exploration, it became clear this was a case of workplace harassment, now impacting her mental health and leading to harmful coping strategies (daily alcohol use, palpitations, loss of interest in work).

Rape Disclosure

Setting: General Practice
Role: FY2 Doctor
Patient: 19-year-old university student
Presenting Complaint: Requests sick note for missed academic obligations
Key Concern: Eventually discloses sexual assault by a known individual

1. Introduction
"Hello, I'm Dr [Your Name], one of the doctors here. I understand you've booked an appointment today. How can I help you?"
(He appears tense, fidgeting hands, rubbing shoes on the floor. Avoid commenting on behaviour directly.)
2. Presenting Concern & Engagement
"I need a sick note."
"Of course — may I ask what's been happening that's made you feel unfit for studies?"
"I have an exam next week. I can't go."
"Okay, is it because you're feeling physically unwell? Or has something happened recently that's made things harder?"
"I just can't concentrate. Too much stress."
(At this point, the patient still avoids giving a reason. Continue gently encouraging.)
"I understand. When someone says 'stress and everything,' it often means there's more going on. You seem a little anxious — is everything okay, George?"
"I'm fine. I just want the sick note."
"Okay. Just so you know — whatever we talk about here stays confidential, unless there's a serious risk to your safety or someone else's. I'm here to support you, not to judge. Is there anything else you'd like to share that might help me understand how best to help you?"
(Pause – patient looks away, silent. After a few seconds…)
"Doctor… actually… I got raped."
"I'm really sorry to hear that. That must have been incredibly difficult. Thank you for trusting me. Would it be okay if I ask you a few more questions to understand what happened?"

3. History Taking – Focused and Sensitive
A. Event Details
- "When did this happen?"
- "Where were you at the time?"
- "Who was involved? Were you familiar with the person?"
- "Was there alcohol or any substances involved for either of you?"
- "Did he force any sexual activity — including oral or anal intercourse?"
- "Were there any physical injuries or pain during or after the incident?"
- "Did you try to call for help? What happened after?"

B. Immediate Response

- "Have you spoken to anyone about this since it happened?"
- "Have you reported it or sought medical help anywhere else?"
- "Has the person contacted or threatened you since the incident?"

C. Psychological Impact

- "How has this affected you emotionally?"
- "Are you having trouble sleeping or concentrating?"
- "Do you feel safe when out or around others now?"
- "Have you been avoiding university or social events?"
- "Do you feel low, hopeless, or anxious most days?"
- "Have you had any thoughts of harming yourself?"

4. Social and Sexual History

- "Who do you live with currently?"
- "Do you have someone close to talk to — a friend, partner, or family?"
- "Do your family know about your orientation or the incident? Are they supportive?"
- "Are you in a relationship currently?"
- "Can I ask about your sexual orientation and whether you had been sexually active before this?"

5. Medical History

- "Any ongoing medical conditions?"
- "Are you currently taking any medications?"
- "Any allergies or past mental health concerns?"

6. Acknowledge, Reassure and Support

"I'm really sorry this happened to you. It takes a lot of courage to speak about something like this. You've done the right thing by coming in. I want to make sure you get all the support you need, at your pace."

7. Explain Options & Legal Rights

"What you described is sexual assault. It is a serious crime. Whether or not you want to report it is entirely your choice. If you don't want to now, that's okay. Just know that there is **no time limit** — you can report it anytime."

8. Offer Referral to SARC (Sexual Assault Referral Centre)

"There is a specialist service called a Sexual Assault Referral Centre, or SARC. They can:

- Perform confidential forensic examinations (ideally within 7 days of the incident)
- Screen and treat for sexually transmitted infections
- Offer professional counselling and mental health support
- Support you with legal reporting if and when you choose

You don't need to go through every part of the service — you choose what you're comfortable with."

9. Provide Sick Note Support

"We can provide a medical certificate to your university. It will state that you are **unfit for study or assessment** for medical reasons. It won't mention the incident. I suggest starting with two weeks, and we can review if you need longer."

10. Senior Involvement
"I'll be discussing this confidentially with one of my senior colleagues. It's standard practice to ensure we give you the best possible care. Nothing will be shared without your consent."

11. Arrange Follow-Up
"I'd like to see you again in **two weeks**, just to check in and see how you're coping. But if you ever feel things are too much before then, you can always contact us sooner."

Clinical Note on Diagnosis
This is a case of sexual assault disclosed by a 19-year-old male patient. His request for a sick note revealed deeper psychological trauma. The diagnosis is based on the patient's direct disclosure, consistent emotional signs (distress, poor concentration, avoidance), and symptoms of acute stress. Management involved emotional support, safeguarding, and onward referral to SARC with appropriate medical certification and follow-up.

Domestic Violence – Same-Sex Relationship

Setting: A&E
Role: FY2 Doctor
Presenting Complaint: Right ankle pain after a fall one week ago
Background: History of three prior A&E visits for facial injuries with self-discharge
Clue: Hesitant history, prior injuries, eventually admits fear and physical abuse by male partner

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1. Introduction
"Hello, I'm Dr [Your Name], one of the doctors here at the practice. I understand you requested an appointment to speak with a doctor — how can I help you today?"
(Pause. Maintain warmth and open posture. No assumptions. If hesitant:)
"Please take your time. Whatever you'd like to discuss will stay between us. You're safe here."

2. History of Presenting Complaint – Ankle Pain
Ask about the current injury in a stepwise manner:

- **When** did the pain start?
  → "About a week ago."
- **How** did the injury happen?
  → "I slipped and tripped." *(tone hesitant, avoiding eye contact)*
- **Where** did the incident happen?
  → *(No clear answer)*
- **Any visible bruising or swelling?**
  → "A bit of swelling."
- **Can you bear weight on it? Walk?**
  → "Yes, but painful."
- **Was any other body part injured?**
  → "No, just the ankle."

Note: The story is vague, timeline unclear, and not consistent with prior injuries (facial trauma). This should raise suspicion and trigger gentle safeguarding exploration.

3. Red Flag Clue – Previous Attendances
Bring up the prior attendances sensitively:

"I noticed in your notes that you've visited A&E a few times recently with facial injuries and left before being assessed. I hope you don't mind me asking — was everything alright then?"
→ *(Patient hesitates)*
→ Shrugs or says "I didn't think it was serious" or "Just wanted to go home."
Gently reinforce a safe space:
"Sometimes when people come in with repeated injuries or feel unsafe, it can be hard to talk about. I want you to know this is a confidential space — unless there's a serious risk to you or others, nothing leaves this room."
Wait for a pause. Then proceed to general social context.

4. Social and Relationship Context
Who do you live with?
→ "With my partner."
How long have you been in this relationship?
→ "Four years."
How is the relationship going lately?
→ "It's okay."
Do you argue often? Or is it generally peaceful at home?
→ "We have our ups and downs."
Do you feel safe at home? *(pause if needed)*
→ "Sometimes… other times it gets scary."
This is a critical moment. The patient is now **implicitly disclosing** domestic abuse.

5. Domestic Abuse Disclosure – Initial Admission
Continue with supportive questioning:
What do you mean by scary?
→ "He gets angry… he's pushed me a couple of times."
Pause. Acknowledge and thank the patient:
"Thank you for telling me that. That sounds difficult. Would it be okay if I ask a few more questions just to understand better and make sure you're safe?"

5. HARK Abuse Screening
Structured screening once abuse suspected:

- **H – Humiliation:** "Does your partner insult you or make you feel worthless?" → Yes
- **A – Afraid:** "Do you ever feel afraid of your partner?" → Yes
- **R – Rape/Coercion:** "Has your partner ever forced you to have sex when you didn't want to?" → Once, implied coercion
- **K – Kick/Physical harm:** "Has he hit, slapped, or otherwise physically harmed you?" → Pushed; past facial injuries

6. Substance Use and Control

- **Does your partner use alcohol or drugs?** – No
- **Was he under the influence when the abuse occurred?** – No
- **Does he have any known mental health problems?** – No
- **Does he have a criminal record?** – No
- **Do you have financial independence?** – No; patient says partner controls his bank account
- **Do you have a support system?** – No friends/family nearby; feels isolated
- **Are children involved?** – No children at home

7. Examination (Verbalised)

- General inspection: no bruises noted elsewhere today
- Vitals: within normal range
- Ankle exam: mild lateral swelling, tenderness over lateral malleolus, intact range of motion, weight-bearing with pain
  → Likely Grade I/II ankle sprain

8. Provisional Diagnosis

- **Ankle sprain**, likely mechanical
- **Underlying safeguarding concern:** suspected ongoing **intimate partner violence (IPV)** in a same-sex relationship

9. Explanation and Discussion

- Explain to patient:
  "Based on your history and previous attendances, I'm concerned that you might be experiencing abuse at home. You've done the right thing by telling us."
- Clarify that partner's behaviour — verbal, financial, and physical control — meets criteria for domestic violence
- Emphasise it is **not the patient's fault**, and that support is available
- Ask if the patient would like support today — reassure that it can be done discreetly and respectfully

10. Management Plan

Ankle Injury Management:

- PRICE protocol: Protection, Rest, Ice, Compression, Elevation
- Short course analgesia: Paracetamol or NSAID
- Safety net: return if worsening, inability to bear weight, or signs of infection
- Physiotherapy referral if no improvement in 10–14 days

Safeguarding Management:

- Reassure: *"What you're experiencing is not okay – and help is available."*
- Offer same-day contact with safeguarding lead, domestic abuse advocate, or hospital social worker
- Provide printed contact information for:
  - **Men's domestic abuse helplines** (e.g., Respect Men's Advice Line)
  - **LGBT domestic violence services** (e.g., Galop UK)
- Offer referral to **MARAC (Multi-Agency Risk Assessment Conference)** — multidisciplinary panel for safety planning
- Inform patient of **option to involve police**, only if he wishes
- Ask permission to document abuse history and referral discussion
- Document injuries factually using the patient's own words
- Consult safeguarding lead and senior for guidance
- Reassure about discretion — no disclosure will be made without his consent unless risk escalates

11. Safety Netting and Follow-Up

- Offer follow-up within one week for reassessment (ankle + emotional wellbeing)
- Advise patient to return earlier if:
  - Any escalation in abuse
  - New injuries
  - Mental health deteriorates
- Provide out-of-hours contact number for safeguarding team

Diagnostic Summary
This is a case of a mild ankle sprain in the context of **suspected domestic violence** in a **male same-sex relationship**. Concerns arose from vague trauma history, repeated injury attendances, and eventual disclosure of physical and emotional abuse. The diagnosis of domestic abuse was made based on verbal disclosure, risk factors, and observed behaviour.

Red Flag Pitfalls – Abuse and Safeguarding

Essential Clinical and Communication Guidance for PLAB 2
Abuse-related scenarios in PLAB 2 include child safeguarding, domestic violence, elderly abuse, sexual violence, professional boundary violations, and coercive control. These are high-stakes stations that test your emotional sensitivity, legal awareness, patient-centred communication, and structured escalation. This sheet outlines the key principles and common errors to avoid across all safeguarding contexts.

1. General Principles Across All Abuse Scenarios

- Always prioritise patient safety and well-being above all else.
- Maintain a calm, non-judgmental, and empathetic approach throughout the consultation.
- Encourage disclosure gently and patiently. Do not rush.
- Use structured questioning but allow the patient to speak at their own pace.
- Be clear about what constitutes abuse or inappropriate behaviour.
- Offer appropriate support and resources. Involve safeguarding services or senior colleagues where required.
- Ensure timely and appropriate follow-up is arranged for the patient.
- Document all findings, concerns, discussions, and actions accurately.

2. Child Safeguarding

- Use a 3-tier questioning system to assess risk in a sensitive, non-leading way.
- Do not accuse parents or caregivers directly. Focus on fact-finding.
- Never promise confidentiality. Explain that certain information may need to be shared to protect the child.
- Clarify that your role is to identify and escalate concerns—not to make legal decisions.
- Follow local safeguarding protocols and always involve senior colleagues before escalating.
- Look out for clues: inconsistencies, carer anxiety, unexplained bruises, or reluctant speech.

3. Domestic Violence and Coercive Control

- Be patient and supportive. Disclosure may not happen immediately.
- Avoid terms like "physical abuse" or "psychological abuse." Instead, describe behaviours.
- Do not recommend couples counselling or mediation—this may endanger the patient.
- Avoid telling the patient to confide in friends or neighbours.
- Emphasise available services and resources but never pressure the patient to leave the relationship.
- Recognise presentations of disguised abuse—insomnia, anxiety, unexplained bruises, recurrent UTIs, or vague pain.

4. Elder Abuse and Carer Stress

- Support both the elderly patient and their carer. Carer burnout may lead to neglect.
- Do not make assumptions based on age, frailty, or living situation.

- Ask about living arrangements, financial control, personal care, and safety without making direct accusations.
- Respect patient autonomy if they have capacity, but assess mental state carefully.
- Offer written resources and follow-up even if formal safeguarding is not initiated immediately.

5. Sexual Violence and Harassment

- Avoid using emotionally charged or legal terms (e.g., "rape," "vulnerable," "illegal"). Use language like "the incident," "sexual violence," or "what happened."
- Never react with shock or overfamiliarity. Use calm, professional phrasing.
- Validate the patient's feelings and acknowledge the difficulty of disclosing.
- Avoid suggesting direct confrontation with the perpetrator.
- Offer appropriate support such as SARC referral, a sick note, and explanation of rights.
- In workplace harassment scenarios, explain the complaint process and refer to organisational policy or Equality Act protections.
- Do not delay starting the management plan—leave enough time to explain what will happen next.

6. Specific Safety Protocols to Follow

- In all abuse cases, consult seniors and follow local safeguarding procedures.
- Explain when and why you may need to break confidentiality.
- Provide safety netting: offer contact details for support services and plan for safe follow-up.
- In teenage cases, assess Gillick competence. Do not involve parents without consent if the patient is deemed competent.
- Always respect the patient's autonomy in adult cases—even if they choose not to report abuse.

7. Common Pitfalls to Avoid

- Do not accuse or confront suspected abusers directly.
- Avoid making promises about outcomes (e.g., "you'll definitely be safe").
- Do not rush the history or jump into management without understanding the patient's full story.
- Avoid using leading questions or trying to confirm your own suspicions prematurely.
- Do not provide generic advice like "just leave" or "talk to someone" without a safety plan.
- Avoid delaying serious safeguarding actions while waiting for more disclosure—act on reasonable concern.
- Never forget the impact of trauma on communication, consent, and trust.

This summary is designed to help you stay clinically safe, emotionally grounded, and legally compliant in one of the most challenging domains of PLAB 2. Strong safeguarding consultations require a balance of structure, empathy, and professional clarity.

Chapter 20: Gender Identity and Inclusive Care

Gender Dysphoria in a 16-year-old

Scenario Context:
You are an FY2 doctor in a GP clinic. A 16-year-old patient has booked an appointment alone. They would like to talk about changing their sex from girl to boy. This is their first contact with healthcare for this issue.

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1. Introduction & Consent

"Hi there, I'm one of the doctors here today. Thanks for coming in. Could I please confirm your full name and age?"

"Great, thank you. I understand you've come in today to talk about something personal. Please take your time — I'm here to listen and support you without any judgment."

2. Focused History – The Six Ps Approach

P1: Past

- "How long have you been feeling this way about your gender identity?"
- "Over that time, have you done anything to explore this or seek support?"
- "Have you read about transitioning or spoken to anyone — like counsellors, doctors, or support groups?"
- "Have you tried any treatments, supplements, or lifestyle changes?"
- "Have you started dressing differently or changed your name, for example?"

P2: Present

- "Can you tell me about your day-to-day life right now?"
- "How do you present yourself — for example, your clothes, hairstyle, or the name you use?"
- "Which toilets or changing rooms do you feel comfortable using?"
- "Who do you tend to spend time with — do you feel more yourself around boys or girls?"
- "Do you feel your current appearance and routine reflect how you feel inside?"

P3: Preferences

- "If you could, how would you like to present yourself — in terms of clothes, name, pronouns?"
- "What would feel more 'you' — hairstyle, activities, even the way others speak to you?"
- "Is there anything you've wanted to do but haven't been able to yet?"

P4: Perception of Puberty Changes

- "Since puberty, have any physical changes like periods or breast development caused you distress?"
- "Do you feel upset about not having features like a deeper voice or facial hair?"
- "Can you tell me more about how those changes have affected you emotionally?"

P5: Personal Life

- "Who do you live with?"
- "Have you spoken to your family about how you feel? Do you think they would be supportive?"
- "Have you ever experienced bullying, harassment, or felt unsafe?"
- "Do you smoke, drink, or use any recreational drugs?"
- "Are you in a relationship or have you ever been?"

P6: Psychological Impact

- "Has all of this had an effect on your mental health — like low mood or anxiety?"
- "Do you feel isolated, afraid to speak about this, or worry about how people might react?"
- "Are there any other stresses affecting you right now?"

3. PMAFTOSA (Brief Screening)

- **Past Medical History**: "Any long-term conditions or hospital admissions?"
- **Medications**: "Do you take any regular medications or supplements?"
- **Allergies**: "Any allergies?"
- **Family History**: "Anyone in the family with mental health issues or hormonal disorders?"
- **Social**: Already covered in P5
- **Travel**: Not relevant
- **Occupation**: School student

- **Smoking/Alcohol/Drugs**: Already screened

4. ICE

- **Ideas**: "In your own words, how would you describe what you're experiencing?"
- **Concerns**: "Is there anything that worries you most about all this?"
- **Expectations**: "What kind of support are you hoping to receive today?"

5. Effect on Life

"How has all of this affected your day-to-day life — at home, school, and emotionally?"

6. Examination

"With your permission, I'd like to check two things today — your blood pressure and BMI. These are part of routine health checks for any young person seeking support with identity-related concerns."
(No genital examination. No need to check secondary sexual characteristics.)

7. Provisional Diagnosis

"From what you've told me, it sounds like you could be experiencing something called **gender dysphoria**."
Lay Explanation:
"Gender dysphoria is a type of emotional distress that some people experience when their gender identity — how they feel inside — doesn't match the sex they were assigned at birth. This can affect how someone feels about their body, the way they're treated by others, and their role in society. It's not a mental illness, but it can have a big impact on mental wellbeing. The good thing is, there's support available to help you through this."

8. Management Plan

Referral Process:

- "I'll be referring you to a **specialist team who supports young people** with these kinds of feelings — usually either the **Child and Adolescent Mental Health Services (CAMHS)** or the **paediatric team**."
- "They'll speak with you more in depth, looking at your emotional wellbeing, family and social life, and any other support you might need."

Next Steps after CAMHS/Paediatrics:

"If the specialist team at CAMHS feels it's appropriate, they'll refer your case through the **National Referral Support Service**, which helps coordinate care across England. From there, you'll be referred to one of the regional NHS gender services for young people, where you'll get specialised support."

Support Offered:

- "At your age, the main focus is on **psychological support**, helping you explore your identity and talk about your experiences safely."
- "Treatments like hormones or physical changes are not started routinely before age 18 — and puberty blockers are now only used in very specific clinical trial settings."

Your Ongoing Support:

- "We'll continue to support you while you're waiting for specialist input. If you ever feel overwhelmed, low, or unsure, please come back to speak to us at any time."

9. Safety Netting

- "If you ever feel unsafe or overwhelmed, there are 24/7 helplines like **Childline (0800 1111)** or **The Mix (for under 25s)**."
- "If you ever feel at risk or in crisis, please go to A&E or call 999 immediately."

10. Follow-Up Plan

- "I'll send your referral today. You should hear from CAMHS or the paediatric team within the next few weeks."
- "In the meantime, you're always welcome to return if anything changes or you'd like more support."

11. Leaflet and Resources

- "You might find **Trans Wiki** useful — it's a website with respectful, easy-to-understand information about gender identity."
- "There are also support organisations like **Mermaids UK** or **Gendered Intelligence** who work with young people and families."

12. Final Encouragement & Check

- "You've done something incredibly brave today by coming in and talking about this."
- "Do you feel everything we've talked about makes sense?"
- "Is there anything you'd like me to explain again or anything else you want to ask?"
- "We'll be here for you throughout the process."

Diagnostic Note for Candidate

This is a first-time presentation of gender dysphoria in a 16-year-old with no prior medical or psychological input. Updated NHS guidance (post-Cass Review) requires referral to CAMHS or paediatrics, who will conduct a full assessment and may escalate to regional gender identity services. No GP direct referral. Hormonal/surgical options are not available at this stage. Focus is on psychological support and safety-netting.

UTI in a Transgender Male (Post-Transition)

Setting: GP Clinic
Role: FY2 Doctor
Patient: 20-year-old transgender male (assigned female at birth, has completed gender-affirming transition)
Presenting Complaint: Painful urination

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1. Introduction & Identity Confirmation

"Hello, I'm one of the doctors here today. Could I confirm your name and age, please?"
"I also see that our records list a previous name. Just to clarify — is everything on file correct as it stands now?"
"Thanks for confirming that. How can I help you today?"

2. Presenting Complaint

- "What symptoms have brought you in today?"
  (Expected: Burning sensation while passing urine)

3. Focused History –

- **Onset**: "When did the discomfort start?"
- **Duration**: "Is it there throughout the day or only while urinating?"
- **Intensity**: "How painful would you say it is on a scale from 1 to 10?"
- **Progression**: "Have you had this before?"
  "Has it worsened or stayed about the same?"
- **Associated Symptoms**:
  - "Any increased frequency or urgency?"
  - "Any blood in the urine?"

- "Any lower abdominal pain or back pain?"
- "Any fever or chills?"
- "Any discharge or unusual genital symptoms?"

4. Differential Screening

- **Sexual history (non-judgmental)**:
  - "Have you been sexually active recently?"
  - "Do you use protection during sex?"
- **STI screen**: "Any genital discharge, sores, or rashes?"
- **Kidney involvement**: "Any pain around your sides or back?"
- **Trauma**: "Any recent vigorous exercise, catheter use, or injury?"
- **Dehydration**: "Are you keeping well-hydrated day to day?"

5. Medical History (MMA)

- "Do you have any long-term conditions or past medical issues?"
- "Are you currently on any regular medications — including hormones or supplements?"
- "Do you have any allergies to medications?"

6. Gender-Affirming History – Structured & Respectful

Past Transition History (P1)

- "Would it be okay if I ask a few questions about your medical transition — just to make sure we're providing the right care?"
- "Have you undergone any surgical procedures?"
- "Have you had any hormonal treatment, such as testosterone?"

Current Status (P2)

- "What's your current situation in terms of your transition? Are you still attending any follow-up care?"

Personal Impact (P5)

- "Has your transition affected your daily life in any way — for example, how comfortable you feel in public spaces, like work or using facilities?"

Psychological Impact (P6)

- "Emotionally, how has the transition process been for you overall?"
- "Do you feel well-supported, or are there areas you're still finding difficult?"

7. Relevant Exploration – Toilet Use

If patient mentions being hesitant to use public toilets:

- "Thanks for sharing that — it's completely understandable. May I ask if you sometimes delay using the toilet or avoid going outside the house?"
- "Holding in urine for long periods can increase the risk of infections like this one. It's something we can work around if it's been affecting you."

8. Examination and Investigations

- "To help confirm the diagnosis, I'd like to test your urine with a dipstick — is that okay?"
  → *Expected result: Positive for nitrites and/or leukocytes*
- "I'd also like to check your temperature and blood pressure while you're here."

9. Provisional Diagnosis

"From what you've described and the urine test, this appears to be a **urinary tract infection**."

Lay Explanation:
"A UTI is an infection in the bladder or urinary system, usually caused by bacteria entering the urethra. This can happen more easily if urine is held in for long periods, if there's reduced fluid intake, or depending on your anatomy. Even after transition, some individuals still have certain structures that can make UTIs more likely, and that's completely normal. The good news is, it's very treatable."

10. Management Plan

Antibiotic Treatment

- "I'll prescribe a short course of antibiotics — usually **trimethoprim** taken for **three to five days**. Most people feel significantly better within 48 hours."

Hydration Advice

- "Drink plenty of water — about six to eight glasses a day helps flush out the infection."

Bladder Care Advice

- "Try not to hold urine for long periods. If public facilities feel difficult to access, we can talk about ways to make things more manageable."

When to Seek Help

- "If you develop a fever, worsening pain, or vomiting — or if your symptoms don't improve within 48 hours — please let us know straight away."

11. Follow-Up Plan

- "If this is a one-off, you likely won't need any further investigations."
- "But if you develop recurrent infections — more than two in six months — we may need to check for other causes."
- "You're welcome to come back for review if symptoms persist."

12. Final Check and Support

- "Does everything we've discussed today make sense?"
- "Is there anything I've said that you'd like me to go over again?"
- "You've been really open and clear, and I appreciate that. If anything changes or you have more questions, feel free to book in again — we're here to support you."

Candidate Note

This is a case of a 20-year-old transgender male presenting with dysuria. The approach includes respectful identity confirmation, structured UTI history using OEDIPA, and appropriate transgender history (P1, P2, P5, P6). Diagnosis is supported by positive urine dipstick. Management includes trimethoprim, hydration advice, and toilet access discussion. Reassurance, psychological sensitivity, and clear safety netting are essential.

Pulmonary Embolism in a Transgender Patient on Oestrogen Therapy

Setting: GP Clinic or A&E (adjust to task)
Role: FY2 Doctor
Patient: 25-year-old undergoing gender-affirming hormonal therapy
Presenting Complaint: Sudden chest pain and shortness of breath

---

1. Introduction

"Hello, I'm one of the doctors here today. Thanks for coming in. Could I confirm your name and age, please?"
"How can I help you today?"

2. Presenting Complaint (Let the Patient Lead)

Patient says: "I've been having chest pain and I feel breathless."

- "Thanks for letting me know. Let's talk through this in a bit more detail."

3. Chest Pain History – SOCRATES

- **Site**: "Where exactly is the pain?"
- **Onset**: "When did it start — did it come on suddenly or gradually?"
- **Character**: "Is it sharp, dull, tight, or burning?"
- **Radiation**: "Does it move to your arm, neck, back, or anywhere else?"
- **Associated symptoms**:
  - "Any shortness of breath or dizziness?"
  - "Any cough — dry or with blood?"
  - "Any palpitations or racing heartbeat?"
  - "Any fever or chills?"
  - "Have you ever fainted or nearly fainted during the episode?"
- **Timing**: "How long does it last — is it constant or does it come and go?"
- **Exacerbating/Relieving**: "Does anything make it worse — like breathing in, movement, or lying flat?"
- **Severity**: "How bad is the pain on a scale of 1 to 10?"

4. Shortness of Breath – Structured Screen

- "Do you feel short of breath at rest, when walking, or only on exertion?"
- "Has it worsened since it started?"
- "Do you feel it's getting better or worse now?"
- "Any wheezing or noisy breathing?"
- "Any swelling in your legs or ankles?"

5. Differential Diagnosis Screening

Cardiac

- "Any past history of heart problems?"
- "Any chest tightness on exertion?"
- "Any known blood pressure issues or palpitations?"

Respiratory

- "Any history of asthma or lung problems?"
- "Any cough, fever, or signs of infection — like sputum or chills?"

Gastro-Oesophageal (GORD/Muscular)

- "Any acid reflux, heartburn, or indigestion?"
- "Is the pain worse after meals or when lying down?"
- "Any recent heavy lifting or trauma to the chest wall?"

Vascular/Clot Risk

- "Any pain, swelling, or redness in your legs recently?"
- "Any long flights, recent surgery, or being bed-bound for long periods?"
- "Do you smoke?"

6. Focused History

P1 – Past Transition History

- "I understand you're undergoing gender transition — would it be okay to ask a few related questions to help guide your care today?"
- "How long have you been transitioning?"

- "What steps have you taken so far — counselling, hormones, or surgery?"

P2 – Current Treatment

- "Are you on any hormone therapy at the moment?"
  (Expected: oestrogen tablets, patches, spironolactone)
- "Are you taking everything as prescribed, or any extra doses?"
  (Expected: Taking extra oestrogen to speed up transition)
- "Any other medications or over-the-counter supplements?"

P5 – Personal Functioning

- "Has this journey impacted your day-to-day life in any way — at work, socially, or in how others treat you?"

P6 – Psychological Wellbeing

- "How are you coping emotionally with everything?"
- "Have you felt supported or has it been difficult at times?"

7. Medical History (MAP)

- **Medications**: Already discussed
- **Allergies**: "Do you have any allergies to medications?"
- **Past Medical History**: "Any long-term conditions or previous clots?"
- **Family History**: "Any family members with clotting disorders or history of DVT or PE?"

8. Examination Plan (If In-Person Scenario)

- "I'd like to check your heart rate, breathing rate, blood pressure, oxygen levels, and temperature."
- "Would it be okay if I examine your legs as well — just to check for any signs of a clot?"
  → *Expected: Increased respiratory rate, O2 desaturation, calf tenderness*

9. Provisional Diagnosis

"Based on your symptoms — sudden chest pain, breathlessness, leg pain, and recent use of hormone therapy — this could be a **pulmonary embolism**, or blood clot in the lungs."

10. Lay Explanation

"A pulmonary embolism is when a blood clot blocks the blood vessels in your lungs. It can happen if a clot forms in your leg and travels to the lungs.
Hormone medications — especially oestrogen — can increase this risk, and taking additional doses can make it even higher. It's a serious condition that needs immediate hospital care, but it's treatable if caught early."

11. Management Plan

Immediate Actions

- "You'll need urgent hospital tests and treatment today. I'll arrange for you to be transferred right away." *(If in GP)*
- "At the hospital, they'll do a few tests:
  - A blood test called **D-dimer**,
  - A **chest X-ray**,
  - And a special CT scan called **CT pulmonary angiogram (CT-PA)**."

Treatment

- "If the diagnosis is confirmed, the treatment is **blood thinning medication** — like apixaban or rivaroxaban. These help stop the clot from growing and prevent new clots."

12. Hormone Medication Discussion

If patient confirms extra oestrogen use:

"Thank you for being open. I understand how much this treatment means to you and how far you've come."

"But we're very concerned that taking high doses — especially unprescribed ones — may have triggered this clot. A repeat episode could be life-threatening."

"For now, we recommend pausing hormone therapy temporarily — just until you recover. After that, we'll involve your specialist to review your treatment safely. There may be options to adjust the dose, restart under supervision, or consider surgical options."

"At this stage, it's hard to tell whether your normal dose or the extra dose caused the clot — so it's important we don't restart anything without careful discussion."

13. Negotiation and Support

If patient resists:

"I truly understand that this medication is part of who you are, and stopping it even briefly can be upsetting."

"But this is a serious and potentially life-threatening condition. Continuing as you are would be too risky."

"This is not a permanent stop — just a pause. We'll work together with your specialist to find a safe, sustainable way forward."

14. Safety Netting

- "If you feel sudden worsening chest pain, breathlessness, or fainting, call 999 or go to A&E immediately."
- "Don't restart hormone medication without speaking to your specialist."

15. Follow-Up Plan

- "Once you're stable, we'll refer you to an endocrinologist or gender specialist to review your hormone plan."
- "We can also arrange emotional and psychological support if needed during recovery."

16. Final Check and Encouragement

- "Does everything we discussed today make sense?"
- "Is there anything you'd like me to go over again?"
- "You've done the right thing by coming in — we'll make sure you get the best care moving forward."

Diagnostic Note for Candidate

25-year-old transgender patient on oestrogen presents with pleuritic chest pain, dyspnoea, tachycardia, and unilateral calf pain. High suspicion of PE. History includes recent hormone use with self-medication. Differential screening includes MI, pericarditis, pneumonia, GORD, and MSK. Requires immediate referral for CT-PA, D-dimer, and anticoagulation. Hormonal therapy to be paused pending specialist review. Empathy and shared planning are essential.

Headache and Recurrent Nosebleeds in Transgender Patient Self-Medicating with Testosterone

Setting: GP Clinic
Role: FY2 Doctor
Patient: 20-year-old, assigned female at birth, awaiting assessment at a transgender clinic
Presenting Complaint: Headache and multiple episodes of nosebleed

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1. Introduction
"Hello, I'm one of the doctors here today. Could I confirm your full name and age, please?"
"Thanks. How can I help you today?"

2. Presenting Complaint
Patient says: "I've been having headaches and nosebleeds."

- "Thanks for sharing that. Let's talk about each of those a bit more."

3. History of Presenting Symptoms
Headache – SOCRATES

- **Site**: "Where exactly is the pain?"
- **Onset**: "When did it start?"
- **Character**: "Is it throbbing, tight, sharp, or dull?"
- **Radiation**: "Does the pain spread anywhere else?"
- **Associated symptoms**:
  - "Any nausea, vomiting, visual changes, or sensitivity to light or sound?"
  - "Any recent fever or neck stiffness?"
- **Timing**: "How long does it last?"
- **Exacerbating/Relieving factors**: "Does anything make it better or worse?"
- **Severity**: "How bad is it on a scale of 1 to 10?"

Nosebleeds – Focused History

- "Can you tell me more about the nosebleeds?"
- "When did they start and how often do they happen?"
- "How long do they last each time?"
- "Does the blood come from one nostril or both?"
- "How much blood are you losing each time — just a few drops or more?"
- "Any bleeding from other sites — gums, bruises, or black stools?"
- "Any trauma to the nose recently?"

4. Differential Diagnosis Screening
Hypertension-related causes

- "Do you feel your heart racing or have you been told your blood pressure is high?"

Bleeding/clotting issues

- "Do you bruise easily or bleed longer than usual after cuts?"
- "Any family history of bleeding disorders?"

Other causes

- "Do you use any nasal sprays or recreational drugs?"
- "Any recent infections — sinus, cold, or dry air exposure?"

5. Specific History
P1 – Past Transition Context

- "I understand from your notes that you've been referred to a gender identity clinic — would you be comfortable telling me more about your journey so far?"

P2 – Present Medical Actions

- "Are you currently taking any treatments or hormones to support your transition?"
  (Pause if patient hesitates)
- "Just to reassure you — everything we discuss here is confidential."

Patient may now say: "Yes, I've been taking testosterone."

- "Thanks for being open with me. Did a doctor prescribe it or have you been sourcing it yourself?" *(Expected: "I bought it online.")*
- "Do you know the name or label of the product?"
- "Do you know how much you're taking or how often?"

P5 – Personal Impact

- "How has all of this been affecting your day-to-day life — work, social life, or public spaces?"

P6 – Psychological Wellbeing

- "Emotionally, how are you coping with everything — the wait, the transition, and the stress in general?"
- "Would you say it's been overwhelming at times?"

6. Medication History (including self-medication)

- "Do you take any other regular medications — prescribed or over-the-counter?"
- "Any allergies?"
- "Are you taking any other medications not prescribed by a doctor — vitamins, supplements, or hormone-related products?"

7. Examination

- General appearance: Patient alert, no distress
- Focused:
  - **Nasal examination** → Small clot visible, no active bleeding
  - **Blood pressure** → 169/xx (elevated systolic)
  - Heart rate and oxygen saturation normal

8. Provisional Diagnosis

"Your symptoms of nosebleeds and headaches seem to be due to **high blood pressure** — your reading today is significantly elevated."

9. Lay Explanation

"High blood pressure can sometimes cause headaches and lead to small blood vessels in the nose bursting — which is likely what's causing your nosebleeds."
"You've mentioned that you've been taking testosterone you bought online. One of the known side effects of testosterone — especially if taken without supervision — is **raising blood pressure**. So this medication may be directly contributing to your symptoms."

10. Management Plan

Immediate Advice

- "At this point, you don't need to go to hospital — but your blood pressure is definitely high and we need to address that seriously."
- "We need to **stop the testosterone** you're taking for now — especially because it hasn't been prescribed or monitored."
- "Using unregulated medication from the internet is risky — the dose may be unknown, and the content may not be safe."

Onward Steps

- "I'll arrange a review of your blood pressure in a few days to see if it settles."
- "If it remains high, we may need to run some blood tests or discuss starting treatment."

Transgender Clinic Referral

- "Your referral to the gender identity clinic is already in progress. Unfortunately, it may take time — that's a known issue due to high demand and limited specialist centres."

- "They see patients based on when they were referred, and currently there is no way to speed that up."
- "But we'll support you in the meantime."

Mental Health Support

- "It's clear this delay has been distressing. I can offer to refer you to a counsellor — someone who can help you cope while you wait."

11. Safety Netting

- "If you have severe nosebleeds that won't stop, worsening headaches, blurred vision, chest pain, or feel faint — please go to A&E immediately."
- "If anything else worries you, just call the clinic or come in."

12. Follow-Up Plan

- "We'll recheck your blood pressure in a few days."
- "In the meantime, please stop the testosterone and avoid any medication bought online."
- "Let's also book a call with one of our counsellors if you'd find that helpful."

13. Final Check and Encouragement

- "Does all of that make sense to you?"
- "Do you feel okay with the plan we've made together?"
- "Thanks again for being honest about the medication — we'll support you through this safely."

Diagnostic Note for Candidate

20-year-old patient with headache and epistaxis. Known to be awaiting transgender clinic assessment. Admits to unsupervised testosterone use due to frustration with waiting time. BP elevated to 169 systolic. Diagnosis: secondary hypertension likely induced by unregulated hormone use. No red flags requiring hospital admission. Patient education, hormone cessation, BP monitoring, and counselling offered. Transgender-sensitive, non-judgmental approach essential.

Sexuality Concerns

Setting: GP Clinic
Role: FY2 Doctor
Patient: 16-year-old male
Presenting Complaint: "I have a personal problem"

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1. Introduction

"Hi, I'm one of the doctors here today. Thanks for coming in. How can I help you?"
Patient replies: "I have a personal problem."

- "That's completely okay. Would you feel comfortable telling me a bit more about what's been on your mind?"

2. Exploring the Concern

- "Can you tell me what this personal problem is about?"
- "What's been bothering you?"
- "What led you to book this appointment?"

Patient discloses: "I like a boy in my class."

- "Thanks for sharing that. It's good that you've come to talk to someone about it. What would you like to discuss about this — are you looking for advice, or are you feeling confused or worried?"

3. Exploring Meaning and Feelings

- "When you say you like him, do you mean you're emotionally close, romantically interested, or sexually attracted?"
- "Do you want to be in a relationship with him, or is this more about exploring how you feel?"
- "Have you felt like this before?"

4. Timeline and Current Dynamics

- "How long have you had these feelings?"
- "Have you talked to him about it?"
- "Do you two usually talk, spend time together, or message each other?"
- "Do you think he might feel the same?"
- "Do you know whether he's in a relationship or what his orientation might be?"

5. Safeguarding Considerations – Age & Relationship

- "Is he in the same class as you?"
- "Do you know how old he is?"
  (Important to assess for any safeguarding issues if there's an age gap or power imbalance)

6. Exploring Past Experience

- "Have you had any relationships before?"
- "Were they with boys or girls — or both?"
- "Were they romantic or sexual relationships?"
- "How did you feel in those relationships?"
- "What made them end, if you don't mind me asking?"

7. Exploring Future Attraction

- "At the moment, do you still feel attracted to girls?"
- "Do you think you could still be attracted to girls in the future?"
- "Would you describe yourself as unsure, attracted to both, or more strongly attracted to boys?"

8. Family Dynamics

- "Can I ask a little about your family — who lives at home with you?"
- "Do you talk openly with your parents or siblings about relationships?"
- "Have your family ever talked about same-sex relationships — positively or negatively?"
  (Patient may say: "My dad laughs at gay people.")
- "Do you think your family would be supportive if you opened up about this?"

9. Social, Emotional, and Risk Screening

- "How are things going at school — academically and socially?"
- "Do you feel safe and comfortable in your environment?"
- "Any issues with bullying, feeling left out, or being picked on?"
- "Do you smoke, drink, or use any other substances?"
- "How have your mood and mental health been recently — any feelings of low mood, anxiety, or loneliness?"

10. Medical History (Brief)

- "Do you have any long-term health issues?"
- "Are you taking any regular medication?"
- "Any past support from counsellors or psychologists?"

11. Provisional Assessment and Explanation

Option 1 – Bisexuality

- "Based on what you've told me, it's possible that you may be bisexual — that means being attracted to both males and females. This is completely normal."

Option 2 – Homosexuality

- "You may be gay — meaning you're primarily attracted to people of the same sex. This is also completely normal."

Lay Explanation:

"In the UK, around 1.3% of people identify as bisexual and 1.5% identify as gay or lesbian. That's over a million people altogether. You are definitely not alone, and many people your age are exploring and learning about their identity."

12. Addressing Concerns About Disclosure

If patient asks: "What if my parents find out?"

- "I understand that's a big concern. Just so you know, even though you're 16, your conversations with us are **confidential** unless there's a serious risk of harm — and this doesn't fall into that."
- "There's no pressure at all to tell your family unless and until you feel ready."
- "The best thing is to give yourself time. You don't need to decide or declare anything now. What matters is how you feel and having a safe space to explore it."
- "In time, if you do decide to talk to them, we can help you plan how and when to do that in a way that feels safe."

13. Support and Reassurance

- "Everything you're feeling is completely valid. Many young people go through a period of questioning their orientation, and that's totally okay."
- "It's not something to be rushed — and you don't need to label yourself unless and until you want to."
- "You've done the right thing by reaching out and speaking to someone about it."

14. Management Plan

Offer follow-up or further support:

- "Would you be interested in speaking to a counsellor — someone trained in working with young people exploring identity and relationships?"
- "We can refer you confidentially to someone who can give you time and space to talk this through."

If risk of isolation or bullying:

- "We can also speak with your school support services, but only with your consent."

Encourage safe peer support (optional):

- "There are also confidential helplines and youth groups you can access if you ever want to talk to others going through similar things."

15. Safety Netting

- "If at any time you feel overwhelmed, unsafe, or very low, please come back and speak to us — or call a helpline like Childline."
- "You're always welcome here, no matter what."

16. Final Check and Closing

- "Is there anything I said today that you'd like me to explain again?"
- "How are you feeling after this conversation?"
- "Would you like a follow-up appointment or time to think first?"
- "Thanks again for trusting me with this — you've shown a lot of maturity, and we'll support you however you need."

Candidate Note

16-year-old male presenting with sexuality-related concern. Discloses same-sex attraction, uncertain identity. Assessed respectfully using neutral language. Explored relationships, safety, support systems, and family attitudes. No safeguarding risks or mental health concerns disclosed. Explanation given regarding normalcy of orientation. Confidentiality, support, and optional counselling offered. Patient reassured, no pressure applied regarding disclosure.

Red Flag Pitfalls – LGBTQ+ and Gender Identity Scenarios

Essential Clinical and Communication Guidance for PLAB 2

LGBTQ+ consultations in PLAB 2 test your ability to maintain professionalism, cultural competence, and clinical safety in sensitive settings. These stations often involve concerns related to identity, transition, sexuality, mental health, and barriers to accessing appropriate care. This summary outlines critical actions to take—and avoid—during these encounters.

1. General Principles Across All LGBTQ+ Scenarios

- Use the patient's **preferred name and pronouns** consistently and without drawing attention to it.
- Create a **non-judgmental, confidential, and safe space** for disclosure and conversation.
- Maintain focus on the **presenting complaint**, while being aware of how identity-related issues may influence the patient's health or decisions.
- Avoid politicised or overly corrective language—**be clinically respectful**, not performatively cautious.
- Do not assume sexual activity, orientation, or gender identity based on appearance or prior medical notes.

2. Transgender Patient Scenarios

- Address both the **immediate medical issue** and the **broader gender-affirming care context**.
- Be prepared to explain how **hormone therapy** may affect physical symptoms, lab values, or cardiovascular risk.
- If treatments (e.g., testosterone) need to be adjusted or paused, explain this is **temporary and based on safety**, and that it will be re-evaluated by the gender specialist.
- Acknowledge long NHS wait times for transgender services. Offer **supportive care** such as counselling, but **do not promise to expedite referrals**.
- Avoid examining or discussing genitals unless directly relevant to the presenting complaint and with full consent and clinical justification.
- Never suggest that the patient is "confused" or that their identity is a phase—especially if they've had consistent experience or feelings over many years.

3. Sexuality Disclosure and LGBT Youth

- Do not force disclosure to family, especially if the patient expresses **fear, hesitation, or safety concerns**.

- Use neutral language when discussing sexual orientation. Do not assume heterosexuality or label the patient prematurely.
- Support the patient in navigating **identity, family pressure, and social isolation**, particularly if the person of interest is significantly older or there are safeguarding concerns.
- Respect privacy and autonomy—disclosure to family should be led by the patient and their comfort level.
- Be prepared to **gently correct misconceptions**, provide reassurance, and affirm that different sexual orientations are normal and accepted.
- In youth cases, be aware of vulnerability to bullying, coercion, and mental health challenges.

4. Medical Risks and Practical Support

- In hormone-related consultations, be ready to explain the **risks of self-medication** (e.g., buying testosterone online), including clot risk, liver strain, or hormonal imbalance.
- Discuss regular follow-up and appropriate monitoring where possible, but avoid unrealistic promises about services you cannot directly control.
- Offer resources like **LGBTQ+ support groups, counselling**, and information about gender clinics or helplines.
- Avoid jumping into psychiatric assessments unless clearly indicated—**not all identity-related concerns are mental health conditions**.

5. Common Mistakes to Avoid

- Do not use outdated or non-affirming terms. Avoid words like "confused," "disorder," or "preference."
- Never examine or ask about genitalia unless medically required for the presenting concern.
- Avoid suggesting the patient's gender identity or sexuality is a phase or result of mental stress.
- Don't recommend family confrontation, forced disclosure, or "coming out" unless the patient initiates it and feels safe.
- Don't offer assurances like "we'll get you seen soon" if it's outside your control—set **realistic expectations**.
- Avoid trying to solve systemic barriers alone—your role is to validate, support, and refer appropriately.

6. Key Examiner Expectations

- Recognise that these scenarios are designed to test your **awareness of real-world barriers** and your ability to:
    - Protect confidentiality
    - Maintain safe, respectful dialogue
    - Balance medical decision-making with identity-related sensitivities
    - Handle difficult or emotional discussions with empathy and professionalism

This summary ensures you are prepared to approach LGBTQ+ scenarios in PLAB 2 with clarity, respect, and confidence—demonstrating your ability to treat the patient as a whole person, not just a diagnosis.

Chapter 21: Angry Patients

Framework for Dealing with Angry Patients in PLAB 2

The ILAR-SOLVE Approach

Invite – Listen – Acknowledge – Reassure – Seek Permission – Obtain History – Lay Explanation – Validate – Explore Solution

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1. Invite the Concern
Goal: Open the conversation without assumptions. Respect the patient's autonomy.
Use calm, professional phrasing:
"I understand you wanted to speak to one of the doctors today. I'm here to listen — would you be happy to tell me what's been going on?"

2. Listen Actively and Completely
Goal: Let the patient express themselves without interruption. This is where tension begins to ease.
Use:

- Non-verbal cues: soft eye contact, nodding
- Verbal cues: "I see", "Mm-hmm", "Go on…"
- Reflections: repeat back key phrases to show you've heard them

Patient: "No one told me this could happen!"
You: *(nodding gently)* "So you weren't warned that this might be a possibility…"
Avoid: Cutting them off, correcting, defending, or jumping to solutions.

3. Acknowledge the Emotion
Goal: Name what they're feeling and validate it.
This is the turning point — it softens their anger.
"I can see that this situation has really upset you."
"It's completely understandable to feel this way. Anyone in your shoes would feel the same."

4. Reassure Calmly and Professionally
Goal: Show them they're in capable hands and things will move forward.
Avoid false reassurance — be steady and clear:
"Let's go through everything carefully so we can understand what happened and what can be done."
"I'll do everything I can to help today."

5. Seek Permission to Explore Further
Goal: Shift naturally from emotion to information gathering.
"Would it be all right if I ask you a few questions, just so I can understand the full picture before we discuss the next steps?"

6. Obtain a Focused and Respectful History
Tailor your questions to the issue but avoid repeating what was already said. Instead, expand or clarify.
"Just to confirm — was this after the surgery on your shoulder?"
"Were you told anything at discharge about possible complications?"
Use a soft and curious tone. Avoid interrogation style.

7. Lay Explanation
Goal: Explain the situation using simple, transparent language.

- If clear: "From what I can see, this may have happened because…"
- If unclear: "I'm still looking into the full details, but here's what I understand so far…"

Avoid blaming staff or defending the system. Just stay factual and clear.

8. Validate Again and Apologize Appropriately
The second emotional checkpoint. Apologies should reflect *impact* (how it felt), not necessarily *fault*.

"I'm really sorry you've had to go through this."
"It sounds like we didn't communicate things clearly — and for that, I truly apologise."

9. Explore and Offer a Meaningful Solution
Tailor to context:

- Escalate to senior/relevant team
- Initiate complaints process (if appropriate)
- Arrange follow-up or explanation
- Clarify current plan and actions

"What I can do right now is…"
"I'll also raise this with our team so we can make sure it doesn't happen again."

Final Touch: Anchor the Resolution
End with steady reassurance:
"I appreciate you sharing this — it's important we get it right for you."
"Please feel free to raise anything else that's still on your mind."

Remember:
In PLAB 2, angry patients are not testing your clinical knowledge — they're testing your **empathy, professionalism, and ability to remain calm under pressure.**
Would you like this as a printable PDF one-pager for your book or flashcards? I can also provide a sample dialogue using this framework.

Things to Avoid

1. Interrupting while the patient is expressing their concerns.
2. Minimising or dismissing the patient's emotions or complaints.
3. Becoming defensive, argumentative, or attempting to justify before listening.
4. Rushing the consultation or skipping important steps to save time.
5. Overlooking or failing to respond to every issue the patient raises.
6. Asking questions the patient has already answered.
7. Ignoring subtle points that reflect poor past communication or care.
8. Using insensitive language, medical jargon, or statements that sound discriminatory.
9. Jumping to conclusions about errors or promising specific outcomes prematurely.
10. Offering to fix issues personally when it is beyond your role.
11. Over-apologising in a formal or scripted way that lacks sincerity.
12. Promising to escalate issues beyond your level or offer services you cannot guarantee.

Key Points to Remember

1. Read the scenario fully before entering — you may be dealing with a situation where readmission or inappropriate discharge is a risk.
2. Acknowledge emotions genuinely, using calm, appropriate tone and body language.
3. Take a focused and relevant history to understand what happened from the patient or relative's point of view.
4. Avoid unnecessary lifestyle or background questions if they're unrelated to the concern.
5. Clearly explain what went wrong (if known), or the possible reasons behind delays or miscommunication.
6. Propose realistic solutions — re-examination, repeat investigations, further monitoring, or a new plan.
7. Always offer the formal complaint pathway if the patient remains dissatisfied (e.g., PALS).
8. Ensure your manner is calm, warm, and professional — not overly formal or robotic.

9. Clarify your role and the roles of others — especially in GP settings where multiple doctors may be involved.
10. Document the conversation thoroughly and explain you will inform the team or escalate if needed.

Case-Specific Insights

Angry Relative After Missed Diagnosis or Poor Communication

- Clarify who was responsible and when, without blaming.
- Explain the continuity of care within teams and systems.
- Propose a clear plan of reassessment and explain how future errors will be avoided.
- Offer to follow up with a formal letter or documentation.

Post-Operative Complication or Wound Concern

- Explain risk factors clearly, especially lifestyle ones like smoking or early exertion.
- Acknowledge the concern but focus on what can be done now.
- Don't debate whether a past error happened — focus on reassessing and acting.

Child-Related Scenarios (Cerebral Palsy, Missed Ingestion, Missed Foreign Body)

- Treat parents as key partners, but remember legal responsibility lies with the medical team.
- Avoid offering non-NHS options or suggesting private care unless the scenario explicitly involves it.
- Reassure parents about equal treatment and explain decisions using clear medical reasoning.
- Discuss and explain x-rays or test decisions based on risk, not appeasement.

Discriminatory Allegations or Concerns About a Doctor's Identity

- Stay calm and redirect focus to the medical issue.
- Explain that NHS doctors are assigned based on competence and availability, not race or religion.
- Be firm but polite — explain that refusing care based on such grounds is not acceptable.

Final Takeaways

- Angry patient cases are communication stations first — not diagnosis stations.
- The priority is to de-escalate, explain clearly, and propose practical, safe next steps.
- You will be judged more on your emotional intelligence, structure, and diplomacy than your clinical content.
- These stations often have no "clinical emergency" — the emergency is how you handle the consultation.

C. difficile Infection After Clindamycin

Setting: FY2 doctor on the Medical Ward
Patient: 50-year-old female
Scenario Type: Angry patient following antibiotic-related complication
Key Issues: No warning about side effects; developed diarrhoea and was admitted; wants to complain

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I – Invite the Concern

"Hello, I'm one of the doctors on the ward. I understand you've been admitted recently with some diarrhoea, and that you wanted to speak to one of us. Would you be happy to tell me what's been happening or what's on your mind today?"

Purpose: Respectful, neutral entry that invites the patient to speak freely.

L – Listen Actively

(Let the patient speak. She may say:)

- "I had an infection in my foot… they gave me antibiotics… then this started."
- "No one told me I could get something like this."

- "Now I have to be admitted again."
- "I want to make a complaint."

Use reflection and validation:
"I can see how upsetting this must've been — you were treated for your foot, only to get a completely different infection that no one warned you about."
"It's really frustrating, especially when you've been doing what the doctors asked."

A – Acknowledge the Emotion
"You've had a lot to deal with — and I'm really sorry you ended up here again after already going through treatment for your foot."
"It's completely understandable to feel let down when no one explained that this could happen."

R – Reassure Support and Action
"Let me reassure you — we're already treating the infection, and I'll explain exactly what C. diff is, how this happens, and what we're doing next."
"But first, would it be okay if I ask you some questions about how this started and how you're feeling now?"

S – Seek Permission to Ask Questions
"Is it alright if I ask a few questions to understand how your symptoms started, what treatment you've had so far, and how you're coping?"

O – Obtain a Structured History
1. Current Diarrhoea
"When did the diarrhoea start — was it during or after your antibiotic course?"
"Roughly how many times per day are you opening your bowels?"
"What does the stool look and smell like — is it watery, any mucus or blood?"
"Are you having to rush to the toilet or stay there most of the day?"
2. Associated Symptoms
"Any abdominal cramping or pain?"
"Any fevers or chills?"
"Any nausea or vomiting?"
3. Dehydration Status
"Have you felt very tired or dizzy recently?"
"Have you been passing urine normally or is it less frequent?"
"Have you felt lightheaded when standing up?"
4. History of Antibiotic Use
"I understand you were treated with clindamycin — was that for cellulitis in your foot?"
"Did you complete the full course?"
5. Cellulitis History
"How did the foot infection start — was it from an insect bite or cut?"
"Has the foot improved since the treatment?"
"Was the wound ever discharging or painful?"
6. PMAFTOSA
Check:

- **Past Medical History**: "Any conditions like IBD, diabetes, previous C. diff?"
- **Medications**: "Were you on any other medications before this happened?"
- **Allergies**: "Any known drug allergies?"

- **Family History**: "Any bowel conditions in the family?"
- **Travel / Toileting**: "Any recent travel, unusual food, or contact with someone else who had diarrhoea?"
- **Smoking / Alcohol**: "Do you smoke or drink alcohol regularly?"

7. ICE (Ideas, Concerns, Expectations)
"What do you think may have caused this?"
"Is there anything you're particularly worried about now?"
"Is there something you'd like us to do or something you're expecting from our side?"
Anticipated concern: "No one told me this could happen."
Expectation: "I want to complain" → address in E.

L – Lay Explanation of the Diagnosis
"From the tests we've done, it looks like you've developed an infection called *Clostridioides difficile* — or C. diff for short."
"This is a type of bacteria that lives harmlessly in many people's guts. But after taking certain antibiotics — especially ones like clindamycin — the balance in the gut can change. Good bacteria get wiped out, and this one can take over and cause diarrhoea."
"It's not something that happens to everyone, and there's no way to perfectly predict who might be affected. But I do want to apologise that this possibility wasn't explained to you beforehand."

V – Validate Again and Apologise Sincerely
"You've absolutely got a right to feel upset. This has impacted your health, and it's frustrating that you weren't given clear information."
"I'm really sorry that this happened and that you weren't warned properly about the possible side effects."

E – Explore the Solution
What We're Doing Now
"You're already receiving treatment — we've started you on *metronidazole*, which is an antibiotic targeted specifically at C. diff."
"You're also being monitored closely for dehydration, and we're checking your blood tests and kidney function."
Investigations

- Blood tests: FBC, U&E, CRP
- Stool: C. diff culture and sensitivity

Advice & Prevention
"C. diff spreads easily in hospitals, so hand hygiene is incredibly important. Please wash your hands with soap and water after using the toilet — alcohol gels don't kill this bacteria."
"We'll make sure our team reports this to our hospital infection control team — that's standard procedure for every confirmed case."
Handling the Complaint
"If you feel you'd like to make a formal complaint or give feedback, that's completely your right. I can help you get in touch with our Patient Advice and Liaison Service (PALS). They'll ensure your experience is heard and followed up."
"Would you like me to get their contact for you or help you contact them?"
Safety Netting
"Most patients improve within a few days of antibiotics, but if you start feeling more unwell, dehydrated, or if the diarrhoea worsens or turns bloody — please let us know straight away."

Final Check
"I'm really sorry again that you've had to go through this. But I hope today's explanation has made things a little clearer."
"Before I go, is there anything else I can explain or help you with?"

Variation - C. Diff Ward Transfer

Setting: Phone call (FY2, medical ward)
Who: Son of a 70-year-old man admitted for chest infection, now transferred to C. diff ward
Concern: "Did my dad get food poisoning from hospital food? Why was he moved?"

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1. Invite the Concern
Doctor:
"Hello, my name is Dr. [Name], I'm one of the doctors on the medical team looking after your father. I understand you had some concerns and wanted to speak to someone — I'm here to listen. Would you be happy to share what's been going on from your side?"

2. Listen Actively and Completely
(Let the son speak without interruption. Use active listening cues.)
"Yes, he had diarrhoea suddenly — and now he's moved to some 'infectious ward' and no one even explained it properly! I'm worried. Did he get food poisoning? What are you all doing?"
Doctor:
"I see… so he had sudden diarrhoea and then got moved, but you didn't get any clear explanation and that's left you quite alarmed."
(Match his pace and tone gently but keep calm.)

3. Acknowledge the Emotion
Doctor:
"I can hear how upsetting and frustrating this must have been for you. It's completely understandable — anyone would feel anxious if their parent's health situation changed and they weren't kept informed."

4. Reassure Calmly and Professionally
Doctor:
"Let's go through everything clearly, and I'll do my best to answer all your questions. I want to make sure you feel informed and reassured by the end of this conversation."

5. Seek Permission to Explore Further
Doctor:
"Would it be alright if I ask a few questions first, just to understand what you've been told so far and what concerns you the most?"
(Patient agrees.)

6. Obtain a Focused and Respectful History
Doctor:
"Can I just confirm — were you informed about your father's original admission with a chest infection?"
"Did anyone mention the diarrhoea to you when it started?"
"Have you been told anything at all about why he was moved to a different ward?"
"Any other concerns on your mind — like what might have caused the diarrhoea or if he's getting worse?"

(Summarise gently what you've learned.)
"Okay, so you were aware of the initial chest infection, but you weren't updated about the diarrhoea or the ward transfer, and that's understandably made you concerned about his safety and the cause."

7. Lay Explanation (Simple, Clear, Factual)
Doctor:
"From what I can see, your father was started on antibiotics for his chest infection, and during his stay he developed new-onset diarrhoea. We tested his stool and found he had an infection called *Clostridioides difficile*, or *C. diff* for short."
"This type of infection isn't due to food poisoning. It's actually a known side effect of antibiotics. When antibiotics disturb the normal balance of bacteria in the gut, *C. diff*, which can live harmlessly in some people, can grow too much and cause diarrhoea."
"He was moved to a specialist ward — not because he got worse — but to prevent spread to other patients and so that trained staff can manage the infection more safely. He's currently being given specific antibiotics that are effective against *C. diff*, and he is being monitored closely."

8. Validate Again and Apologise Appropriately
Doctor:
"I'm really sorry you had to find out about all this in such a confusing and sudden way. It sounds like we didn't communicate the developments in your father's condition clearly enough — and for that, I truly apologise."

9. Explore and Offer a Meaningful Solution
Doctor:
"What I can do now is speak to the senior team on the ward and ask that you be kept updated more regularly. I'll also make a note of your concerns so this doesn't happen again in future."
"If you'd like, I can also arrange a call with the ward consultant or one of the infection specialists so they can go into more detail about his current treatment and progress."
"In terms of next steps — we'll continue treating your father with the appropriate antibiotics and keep him isolated until the infection clears. Once he's stable and symptom-free, he'll be transferred back to a general ward or considered for discharge."

Final Touch: Anchor the Resolution
Doctor:
"I really appreciate you raising these concerns — they matter. I hope today's explanation has helped a bit. If you think of anything else or would like further clarification, please don't hesitate to call the ward or ask to speak with me again."

Common Pitfalls Avoided

- Did **not** interrupt the caller during emotional parts
- **Did not** dismiss concerns ("It's just diarrhoea")
- Avoided defending the system or blaming food
- Gave clear **lay explanation** of *C. diff*
- Apologised for **communication gap**, not for clinical care
- Ended with a clear **solution and follow-up offer**

Diagnostic Reasoning Note (for student)
The diagnosis of *C. difficile* infection was made based on new-onset diarrhoea in a hospitalised patient receiving antibiotics — a classic presentation. Food poisoning was ruled out because *C. diff* is not acquired from food but

typically from antibiotic disruption of gut flora. The ward transfer was done for infection control and specialist management.

Rash After Amoxicillin

Setting: ED, Paediatrics
Role: FY2 Doctor
Patient: 4-year-old girl
Accompanying Adult: Mother (42 y/o)
Background: Prescribed amoxicillin yesterday for chest infection → developed rash today
Core Issue: Mother believes her daughter was wrongly given a drug she's allergic to and is visibly upset. You're handling a **parent-initiated angry patient consultation**.

I – Invite the Concern
Purpose: Create space for the parent to speak without assumptions.
"Hello, I'm one of the doctors here in the paediatric department. Thanks for waiting. Are you her mother? And just to confirm, what's her full name and age?"
(She responds – then opens angrily with concern about the rash.)
"I understand you asked to speak to one of the doctors today. Would you be happy to tell me what happened?"
Why this matters: This prompt respects the parent's initiative and allows her to explain the problem in her own words — a key step in de-escalating tension.

L – Listen Actively
Purpose: Allow uninterrupted expression of anger and concern. Use reflections and cues to show you're fully present.
(Let her explain that the child was seen yesterday, was given amoxicillin, and has now developed a rash. Mother is upset and worried it's an allergy.)
Active techniques:

- Nod gently
- Say: "Mm-hmm", "I see", "Go on..."
- Reflect key points:

"So she took amoxicillin this morning, and a few hours later you noticed a rash spreading over her body?"
"You're concerned this could be an allergy — and that maybe this should've been avoided?"
Why this matters: Listening is evaluated in PLAB 2. Letting the parent feel heard helps reduce emotional intensity and shows professionalism.

A – Acknowledge the Emotion
Purpose: Name and validate their feelings — this is the heart of the angry patient station.
"I can see this has really upset you. It must've been very distressing to see a rash like that appear so suddenly — especially after being told she could go home yesterday."
"I'm truly sorry you've had this experience. You've done the right thing by bringing her straight back in."
Why this matters: Acknowledging emotions builds trust. Without this, no explanation or reassurance will land effectively.

R – Reassure Support and Action
Purpose: Show that you're taking ownership and will address the concern thoroughly.
"Let's go through this carefully together and make sure we treat her safely. I'll ask a few questions to understand what's happened and explain the plan clearly."

"We'll also look at whether any past allergy information was missed or not recorded."
Why this matters: Angry patients want to know three things: Am I safe? Will you fix this? Do you care? This addresses all three.

S – Seek Permission to Explore Further
Purpose: Transition gently from emotion to clinical assessment.
"Would it be all right if I ask you a few questions about the rash, what medication she took, and whether anything like this has happened before?"
Why this matters: Keeps the consultation respectful and patient-centred. Prevents further escalation by maintaining consent-based interaction.

O – Obtain a Structured History
A. About the Rash (Morphology – Evolution – Symptoms)
- "What kind of rash is it — red, raised, flat?"
- "Where did it first appear?"
- "Has it spread?"
- "Is it itchy or painful?"
- "Any blisters or swelling?"

B. Timeline and Medication Use
- "When did she take the first dose of amoxicillin?"
- "How many doses has she had so far?"
- "How long after the last dose did the rash appear?"

C. Anaphylaxis Screen
- "Has she had any breathing difficulties?"
- "Any swelling of the lips, eyes, or tongue?"
- "Any vomiting, dizziness, or sleepiness?"

D. Allergy History
- "Has she ever taken this antibiotic before?"
- "Do you know if she's allergic to penicillin?"
- "Did anyone ask about allergies yesterday?"
- "Have you told a doctor about any drug allergies before?"

E. Past Similar Episodes
(If she says this happened before:)
"I'm sorry to hear that. Could you tell me more about what happened that time — what medication was it, and how was it managed?"
F. Record Check
- "Was this allergy ever officially recorded by your GP or in her hospital notes?"

G. Examination
"I'd like to examine her if that's okay."
(Mother shows a photo – visible urticarial rash)
- Check vital signs (normal)
- No swelling or respiratory signs
- Well-appearing, alert, playing

L – Lay Explanation of the Problem
"Thanks for explaining everything. Based on what you've told me and what I can see from the photo, this looks like a *delayed allergic reaction* — we call it *urticaria* — which is quite common after antibiotics like amoxicillin."

"It's not dangerous like an anaphylactic reaction, but it is a clear sign that she's allergic to this type of medication."
"Amoxicillin is a form of penicillin, so she should avoid all penicillin-based antibiotics from now on."
Why this matters: Use plain, non-jargon terms. Avoid trying to justify the error. Focus on clarity and calm tone.

V – Validate Again and Apologize Appropriately
"I'm really sorry this happened, and that this wasn't picked up earlier. I can only imagine how upsetting it's been — especially when you trusted that everything was safe."
"Thank you for raising this so quickly. It's really important, and we take it very seriously."
Why this matters: Closing the emotional loop ensures the patient/parent feels acknowledged. Without this, even correct management can feel cold.

E – Explore the Solution
Management Plan
"Here's what we'll do now:"
1. **Stop the amoxicillin immediately**
2. **Start clarithromycin** (a safe antibiotic for penicillin-allergic patients)
3. **Give chlorpheniramine** to relieve the rash and itching
4. **Add the allergy to her official NHS record**
5. **Monitor at home** (child is clinically well, no admission needed)

Safety Netting
"If she becomes drowsy, vomits, has facial swelling, or has trouble breathing, please bring her straight back in or call 999."
"The rash should improve in the next 2–3 days. If not, or if it worsens, get in touch with us again."
Incident Reporting and Follow-Up
"We'll also report this as a *significant event*, which means we'll investigate why the allergy wasn't flagged earlier — whether it was never recorded or just not seen. You'll be informed once the review is completed."

Final Check
"Before we finish, is there anything else that's still on your mind or anything you'd like me to explain again?"

Cerebral Palsy – Allegation of Discrimination After Missed X-ray

Location: Emergency Department
Patient: 17-year-old boy with cerebral palsy
Accompanied by: Father
Scenario Type: Angry relative, follow-up complaint about care received during previous ED visit

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I – INVITE the Concern
Opening Statement:
"Hello, I'm one of the doctors in the A&E team. Thank you for coming in today. I understand your son was seen here last week — would you be happy to tell me what's brought you both back in today?"
Rationale: Allows the father to lead with his concern without assumptions. Prevents premature defensiveness. Builds initial rapport while keeping the tone calm and professional.

L – LISTEN Actively
(Let the father speak without interruption. Common phrases may include:)
- "He still can't walk properly!"

- "They didn't even do an x-ray."
- "Is it because he has cerebral palsy that they didn't take him seriously?"

Use non-verbal listening cues:

- Gentle nodding
- Eye contact
- Calm facial expression

Reflect key concerns:

"So your main concerns are that he's still in pain, he hasn't improved, and you feel the previous team may have missed something?"

"And you're also wondering whether his condition might have influenced how seriously he was taken?"

Rationale: Emotional validation is achieved through active reflection of specific concerns — not vague empathy. This builds credibility and earns trust.

A – ACKNOWLEDGE the Emotion

"I can see this has been really upsetting for you. You've been trying to get help for your son, and you feel his concerns weren't properly addressed the first time."

"I'm really sorry this experience left you feeling this way."

Rationale: Empathy must be situation-specific. Avoid generic phrases like "anyone would feel the same," which could feel dismissive or inadvertently discriminatory.

R – REASSURE Calmly and Professionally

"Let's go over everything again today — I'll take a full history, examine him properly, and explain my findings clearly."

"I'll also explain how we decide when tests like x-rays are needed — and if anything wasn't communicated well last time, I'll do my best to clarify that for you now."

Rationale: Show you're taking control of the situation while remaining collaborative and open.

S – SEEK Permission to Ask Questions

"Would it be okay if I asked a few questions to understand exactly what happened last time and how he's doing now?"

Rationale: Keeps the consultation respectful and family-centred. Crucial when prior care is being questioned.

O – OBTAIN a Structured History

1. About the Fall

"Could you walk me through exactly what happened when he fell from the sofa?"

"Did he land on one side in particular?"

"Was there any visible swelling, bruising, or redness?"

2. After the Fall

"How did he behave afterward — was he able to bear weight or walk at all?"

"Has the pain improved, worsened, or stayed the same since then?"

3. About the Last Visit

"Do you recall what the doctors said at the time?"

"Did they examine the ankle thoroughly?"

"Did they mention why they weren't doing an x-ray?"

"Were you satisfied with the explanation at the time?"

"What treatment was given — was he prescribed any painkillers or given any advice?"

4. About Today's Concerns
"What's made you bring him back today?"
"What are his current symptoms — is it just pain, or has he developed any new problems like swelling or redness?"
5. Functional and Past Medical History
"Just to clarify, is he usually able to walk independently?"
"Any previous problems with this ankle?"
"Any other long-term conditions apart from cerebral palsy I should be aware of?"
Rationale: A comprehensive history helps differentiate between ongoing soft-tissue injury vs missed fracture, and clarifies if the previous care deviated from guidelines.

L – LAY EXPLANATION of Findings
"Thank you for going through that with me. I've now examined your son's ankle again, and I haven't found any bony tenderness — which means it's very unlikely to be a fracture."
"This looks consistent with a soft tissue injury, like a sprain. That's when the ligaments get overstretched — and these can take a couple of weeks to heal fully."
"Sometimes children and young adults with cerebral palsy may move differently, which can mask pain responses. But from what I see, the joint itself is stable and not showing signs of a break."
Rationale: Clear, jargon-free explanation. Frames cerebral palsy as a context consideration, not a reason to dismiss or over-medicalise.

V – VALIDATE Again and Address Allegation of Discrimination
"I really appreciate you sharing your concerns so openly. I'm truly sorry if you felt that your son's condition affected the quality of his care — that should never happen."
"I want to reassure you — we follow the same clinical standards for every patient, regardless of medical history. When there's no bony tenderness, we don't routinely perform x-rays, because unnecessary radiation can do more harm than good."
"But your feedback is important — and if anything was unclear or rushed last time, I completely agree that should've been explained better."
Rationale: Defends the care pathway **without becoming defensive**. Reinforces non-discrimination and evidence-based rationale.

E – EXPLORE the Solution and Management Plan
Plan:
- Continue pain management (paracetamol or ibuprofen)
- Cold compress and leg elevation
- Educate on PRICE: *Protection, Rest, Ice, Compression, Elevation*

Further reassurance:
"We'll also update today's notes with our reassessment so everything is clearly documented."
"If there's no improvement in a few more days, or if things worsen — we'll absolutely re-review and consider imaging then."
Optional escalation:
"If you still feel unhappy with how things were managed, I can guide you on how to leave formal feedback — we take all concerns seriously."

Final Check
"I know this hasn't been easy — and I really appreciate how clearly you've expressed everything. Before we wrap up, is there anything else I can do or clarify for you today?"
Rationale: Leaves space for follow-up concerns. Ends the conversation respectfully and professionally.

GP Missed Mother's Lung Cancer Diagnosis

Setting: Respiratory ward
Role: FY2 doctor
Patient: 72-year-old female, admitted with lung cancer
Accompanied by: Son
Concern: Son believes GP missed the diagnosis and delayed her treatment.
Note: *This is not a medical error station. Do not speculate, blame, or defend the GP.*

I – Invite the Concern
"Hello, I'm one of the doctors looking after your mother on the respiratory ward. I've been told you wanted to speak with someone from the team — would you be happy to tell me what's on your mind today?"
Purpose: Creates space for the son to speak freely without assumptions. Sets a respectful, neutral tone.

L – Listen Actively
(Allow the son to speak uninterrupted. He may say:)

- "She's had this cough for months!"
- "Why didn't the GP pick this up earlier?"
- "They kept treating her for infections — now it's cancer."
- "Is this because she was just seen as an old lady with COPD?"

Reflect key points:
"So from what you're saying, you feel her symptoms were ongoing for a while, and the diagnosis has only just been made now — and you're wondering if more could've been done earlier?"
Purpose: Shows you're listening. Avoids arguing or defending. Avoid "but" — just reflect and confirm his experience.

A – Acknowledge the Emotion
"I'm really sorry your mother has been diagnosed with lung cancer. That must've been an incredibly difficult thing to hear."
"I can hear how concerned and frustrated you are about what's happened — and I appreciate you bringing it up. It shows how much you care about your mum."
Purpose: Validate his feelings specifically. Avoid generic phrases like "anyone would feel the same" — could feel dismissive or stereotyping.

R – Reassure Support and Action
"Let's go through this carefully — I'll ask you a few questions to better understand your mother's symptoms and her previous care."
"Then I'll explain what we can do next, and how your concerns will be looked into appropriately."
Purpose: Prevents the son from feeling ignored or dismissed. You're promising structured support without overstepping your role.

S – Seek Permission to Ask Questions
"Would it be alright if I asked a few questions about what's been happening over the past few weeks or months, just so I can understand the full picture?"
Purpose: Maintains patient-centred tone. Helps transition gently from emotion to history.

O – Obtain a Structured History

1. Presenting Concerns

"What made you think the GP might have missed something?"

"Was there a point where you felt things weren't getting better or needed more investigation?"

2. Symptom Timeline & GP Visits

"How long has she had symptoms like the cough or breathlessness?"

"Has she ever coughed up blood?"

"Any weight loss, chest pain, or general unwellness?"

"How often was she visiting the GP recently?"

3. Actions Taken by GP (as far as known)

"Do you know what the GP did at the time?"

"Were any tests done — like bloods, x-rays, or scans?"

"Did they diagnose her with anything else — like infections?"

"Was she prescribed any treatments like antibiotics — and did they help?"

4. Risk Factors

"How long has she had COPD?"

"Do you know how much she smokes per day?"

"Any work in industries like mining or construction in the past?"

5. Social History & Decision-Making

"Does she live with anyone?"

"Are you her next of kin?"

"Has she ever appointed anyone to make decisions for her — like a lasting power of attorney?"

6. Expectations and Concerns

"What are you hoping we can do now?"

"Is there something in particular you'd like us to look into?"

Purpose: Fact-finding without assigning blame. Keeps the focus on understanding, not judgment.

L – Lay Explanation of the Situation

"Thanks for explaining everything so clearly. At the moment, I don't have full access to her records from the GP — so I can't comment on exactly what was done or what they were thinking at the time."

"We don't yet know what tests were done before, or whether there were reasons to suspect cancer earlier — so I can't say whether anything was missed or delayed."

"But now that she's here, we'll make sure her treatment is properly coordinated, and your concerns are taken seriously."

Purpose: Stay neutral. Never speculate. Be clear about your knowledge boundaries.

V – Validate Again and Offer Respectful Clarification

"You've asked an important question, and you absolutely deserve to know whether anything was missed."

"If you're still worried that this could have been picked up earlier, I can escalate that to the senior team, and we can help you start a formal process if needed."

"We also have a team called the Patient Advice and Liaison Service (PALS). They support families in raising concerns and can help review her records properly."

Purpose: Empathise without confirming any wrongdoing. You're offering structure, not defensiveness or speculation.

E – Explore the Solution

Next Steps

"Here's what will happen next:"

- "I'll escalate this concern to my senior team — a consultant or registrar may review it."
- "They'll look into your mother's hospital notes and request her GP records."
- "If they feel something might have been missed, a more formal investigation may be started."
- "If any issues are found, it may be reviewed by regulatory bodies like the GMC."

Answering Specific Concerns & Questions

1. "Why didn't the GP pick this up earlier?"

"That's a fair question — but I don't have access to your mum's GP records or the full details of her earlier care."
"Right now, we can't say what the GP saw, suspected, or tested at the time."
"But because you've raised this, we'll escalate it so her full records can be reviewed — and if anything was missed, it'll be looked into."

2. "Was this because she had COPD — and they just assumed it was that?"

"I understand why you might think that. COPD and lung cancer can share some symptoms — like cough and breathlessness — but without seeing exactly what happened in her earlier visits, I can't confirm that's what occurred."
"That said, we take your concern seriously and will make sure it's investigated further."

3. "Will the GP be punished?"

"That decision isn't made by the hospital or by doctors like me. If a formal review finds a serious concern, it may be referred to the GMC — that's the body that regulates doctors."
"They carry out their own investigation, and if they find anything wrong, they can take action ranging from formal warnings to removal from the register — but only after a thorough, fair process."

4. "Can I take legal action?"

"I can't advise you for or against legal action — but you absolutely have the right to raise formal concerns if you feel your mother's care wasn't appropriate."
"In the hospital, we have a service called PALS — the Patient Advice and Liaison Service. They can help you submit a formal complaint and guide you on how to request a full review."

5. "Can I speak to someone more senior about this?"

"Yes — that's entirely reasonable. I'll pass your concern on to the consultant looking after your mother. They may arrange a time to speak with you or review the case more formally."

Final Check

"Before we finish, is there anything else you were worried about or anything I haven't explained clearly?"
Purpose: Closes the conversation with care and professionalism. Ensures all concerns are addressed.

Medication Change Not Informed to Daughter

Setting: GP surgery
Role: FY2 doctor
Patient: 75-year-old female with hypothyroidism
Accompanied by: Daughter
Scenario: Daughter upset that her mother's levothyroxine dose was reduced after blood results without informing her, despite prior agreement that she would be updated. The patient may have cognitive impairment or live in a nursing home.

I – Invite the Concern
"Hello, I'm one of the doctors here at the practice. I understand you wanted to speak to someone about your mother's recent treatment. Would you be happy to tell me what's been going on?"
Purpose: Establishes a safe space and invites the daughter to express herself without interruption.

L – Listen Actively
(Let the daughter express her concern. Common comments:)
- "Why did you change her dose without telling me?"
- "We agreed I'd be informed about any medication changes."
- "This isn't the first time this has happened."

Use active listening:
- Nod gently
- Use short affirmations: "I see…", "Right…", "That must've been frustrating…"
- Reflect and summarise:

"So, from what you're saying, you were expecting to be informed about any changes to her medication, and this change happened without your knowledge — and understandably, you're upset about that?"

A – Acknowledge the Emotion
"I can see that you're quite upset. I'm really sorry this happened — especially after there was an agreement in place to keep you informed."
"I completely understand why this has made you feel let down. Thank you for coming in and raising it with us."
Purpose: Validates feelings without sounding scripted or defensive. Avoids minimising language.

R – Reassure Support and Action
"Let me reassure you that I'll do my best to explain what happened, and how we can stop this from happening again."
"Before I do that, would it be okay if I asked a few questions so I can fully understand the background?"

S – Seek Permission to Ask Questions
"Would it be alright if I asked you a few questions about how you found out, your understanding of your mother's condition, and how communication has worked so far?"

O – Obtain a Structured History
1. Discovery of the Medication Change
"Can I ask — how did you come to know that the medication had been changed?"
(Expected answer: "The nursing home staff told me.")
2. Understanding of Her Condition
"Could I check what you already know about your mother's health conditions?"
"Are you aware she's taking levothyroxine — and why she's on it?"
(Expected answer: "Yes, for underactive thyroid")
3. Communication Process History
"How have doctors usually kept you updated in the past?"
"Was it usually through phone calls, letters, or in-person meetings?"
"How often do these discussions happen — was there a set arrangement?"
"Has anything like this happened before, where you weren't informed of a change?"
"When was the last time you were updated by the practice about her medications?"
4. Family Role

"Are you her next of kin?"
"Is anyone legally appointed as her lasting power of attorney?"
"Are you the main person involved in her care and decision-making?"

5. Concerns and Expectations

"What are you most concerned about right now?"
"Is there something specific you were hoping we could do about this?"
Expected concerns:

- "She could've had a reaction and no one would've known."
- "I want to be included in decisions like we agreed."
- "How do I know this won't happen again?"
  These will be directly addressed in the "E – Explore the Solution" section.

L – Lay Explanation of the Problem

"Let me explain what happened from a clinical perspective. Your mum has a condition called hypothyroidism, which means her thyroid is underactive, and we use a medication called levothyroxine to replace that hormone."
"We did a routine blood test which showed her thyroid hormone levels were too high. That suggests she may have been over-treated — which can lead to problems like fast heartbeat, weight loss, or confusion."
"To protect her, the doctor reduced the dose from 75 to 50 micrograms — which is the usual next step in this situation."

V – Validate Again and Apologize Sincerely

"But I completely agree that you should have been informed — especially if there was a prior agreement."
"I'm really sorry that didn't happen. That's not how we want families to feel — and I appreciate how important it is to be kept in the loop."

E – Explore the Solution

Answering Specific Concerns

1. "Why wasn't I informed, when you promised you would?"

"That's a fair concern. I don't know the exact reason why the message wasn't passed on — but I'll look into that with the team and get back to you. It may have been an oversight, but we'll make sure it's addressed properly."

2. "What if she'd had a reaction? I wasn't there!"

"That's a very valid worry. The reduced dose was actually meant to reduce risk, not increase it — but I agree you should've been informed so you could watch for any changes."

3. "How can I trust this won't happen again?"

"Here's what I'll do today:

- I'll document in your mother's records that all future medication changes must be communicated to you directly.
- I'll also send a message to all doctors in the practice — we're a team, and different clinicians may see your mum.
- I'll recommend that her next medication review is flagged for discussion with family in advance."

Preferred Communication Method

"Can I check — what's the best way to reach you next time? Phone call, letter, or email?"
"Would you like a copy of any changes to be shared with the nursing home as well?"

Escalation/Complaint Path

"If you'd prefer to make a formal complaint, that's completely your right — and I can help you contact our practice manager or PALS team for support."

Final Check
"Thank you again for raising this. Before we finish, is there anything I haven't explained properly, or anything else you'd like us to address?"

Child Left Soiled and Tube Displaced

Setting: Paediatrics – General Ward
Role: FY2 doctor
Patient: 5-month-old baby (with maturity of 2–3 months)
Accompanied by: Mother
Scenario Type: Disappointed parent (not angry), upset about basic care and monitoring
Main Issues: Baby found covered in stool and vomit; NG tube out; mother feels child is being neglected

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I – Invite the Concern
"Hello, I'm one of the doctors here in the paediatric unit. I understand your baby is currently admitted here, and I've been told you wanted to speak to one of the doctors. Would you be happy to tell me what's been going on today?"
Purpose: Professional and neutral opening that invites the mother to express her concern on her terms.

L – Listen Actively
(Let the mother speak. She may say:)

- "Doctor, I'm not happy."
- "When I came in, my baby was covered in poo and vomit."
- "The feeding tube was out."
- "Why is no one changing or looking after my child?"

Use active listening tools:

- Nodding, eye contact
- "I see…", "I understand…"
- Reflect back:

"So when you arrived today, you saw your baby in a soiled condition with the feeding tube out — and understandably, that's really upset you."

A – Acknowledge the Emotion
"I'm really sorry to hear that. I can see how upsetting that must've been."
"It's completely understandable to feel disappointed and worried when you see your baby like that."
"Thank you for telling me — I'm really sorry you found her in that condition."
Purpose: Gentle validation without making excuses. Distinguishes between disappointment and escalation.

R – Reassure Support and Action
"Let me reassure you — we take this seriously. I'll speak to the team, check your baby now, and ensure things are put right."
"Before that, would it be alright if I ask you a few questions so I understand exactly what happened and what you saw?"

S – Seek Permission to Explore
"Would it be okay if I ask you some questions about what happened today and how things have been so far during your child's admission?"

O – Obtain a Structured History

1. Incident History

"When did you arrive today?"
"What did you notice — was it a full nappy or only a little?"
"Was there vomit as well?"
"Was the NG tube completely out?"
"Did you speak to any of the nurses?"
"Did anyone respond or clean her afterwards?"
"Has something similar happened on a previous day?"

2. Additional Concerns

"Do you think your baby might be unwell because of this?"
"Have you noticed a fever or any other signs that worry you?"

3. Birth and Medical Background

"Could I ask — how early was she born?"
"Was there any problem during pregnancy or delivery?"
"Has she been diagnosed with any medical conditions since birth?"
"Is she on any medications?"

4. Family Expectations

"Is there anything specific you'd like us to do about this today?"
"What would help you feel more confident in her care?"

L – Lay Explanation of the Situation

"Thank you for explaining everything. Your baby was born early and is still quite vulnerable. She's now in a paediatric ward, which has a different staff structure compared to neonatal intensive care."
"In neonatal units, there's typically one nurse per baby. On paediatric wards, nurses look after several children during a shift, and although we try our best, sometimes we fall short — and I'm really sorry you experienced that."
"Agency nurses may sometimes be used when a regular nurse is unavailable. They are fully qualified and trained, but they may not always be familiar with your baby's needs at first."

V – Validate Again and Apologize Sincerely

"You've absolutely done the right thing by speaking up. I'm really sorry you found your child in that condition. No parent should have to feel like their child is being neglected."
"Your concern is entirely justified — and we'll take it seriously."

E – Explore the Solution

Immediate Actions

"I'll go check your baby myself right now, ensure she's cleaned, and the feeding tube is repositioned safely."
"I'll speak directly with the nurse looking after her and the nurse in charge to understand how this happened."
"I'll document this in your baby's notes and request that it's also recorded in the nursing records."

Addressing Specific Concerns

1. "Why isn't she in the neonatal unit?"

"That's a very reasonable question. Neonatal units are designed for the first few weeks of life — once babies are medically stable, they're transferred to the paediatric ward."
"We still provide close care, but the staff-to-patient ratio is different. That said, basic care like nappy changes and feeding should never be missed."

2. "Was this because of agency nurses?"

"Sometimes agency nurses are used when regular staff are unavailable — but I want to reassure you that all agency nurses are fully trained and qualified."

"Regardless of who was on duty, your baby deserves the same standard of care — and I'll speak with the team about what happened today."

3. "Can I take her to a private hospital?"

"I can understand your frustration, but clinically, it's not necessary to transfer her. We're managing her medical needs here, and I'll make sure the care going forward is more consistent."

"If you have any ongoing worries, I'll ensure you have a named nurse you can speak with during each visit."

Final Check

"Thank you for bringing this up. I'll check on your child immediately and update you as soon as possible. But before I do that — is there anything else on your mind?"

Heart Failure and Haematuria in Mother

Setting: Acute Medical Ward
Role: FY2 doctor
Patient: 65-year-old woman, admitted with angina and haematuria, currently under investigation for possible heart failure
Accompanied by: Son
Scenario Type: Angry relative – communication breakdown and unresolved concerns

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I – Invite the Concern

"Hello, I'm one of the doctors in the medical team looking after your mother. I understand she's been admitted with us, and I've also been told that you wanted to speak to someone. Would you be happy to tell me what's been going on or what's been on your mind?"

Purpose: Neutral, respectful prompt — lets the son lead with his concerns naturally.

L – Listen Actively

(Let the son speak without interruption. He may say:)

- "No one ever answers my calls."
- "Your colleague was rude and dismissive."
- "Why has no one told me what's going on with my mother?"

Active listening tools:

- Maintain soft eye contact
- Nodding gently
- Verbal cues: "I see…", "Right…", "That must've been frustrating…"

Reflect:

"So it sounds like there have been some ongoing issues — you've struggled to get through to anyone, you had an upsetting experience with one of the doctors, and you feel you haven't been given enough information about what's actually happening with your mother?"

A – Acknowledge the Emotion

"I can see that you're very upset — and rightly so. You've been trying to get updates about your mother, and it sounds like no one has taken the time to explain things properly."

"I'm really sorry this has been your experience. That's not what we want for any family."

Purpose: Directly names the emotion, validates it, and keeps the tone sincere.

R – Reassure Support and Action
"Let me reassure you that I'll do my best to explain what I can and help get your concerns addressed. But first, would it be okay if I ask a few questions so I understand exactly what's been happening from your side?"

S – Seek Permission to Ask Questions
"Would it be alright if I ask a few questions about your experience over the past few days — with phone calls, staff interactions, and what you've been told about her condition so far?"

O – Obtain a Structured History
1. Difficulty Reaching Doctors
"Can I ask — how long have you been trying to contact the hospital?"
"Have you been calling at specific times?"
"What were you trying to find out when you called?"
"Did anyone ever promise a callback?"
"Were you ever able to speak to a doctor at all?"
2. Negative Interaction with Staff
"You mentioned you had an interaction with one of my colleagues. Would you be comfortable telling me more about what happened?"
"Do you remember their name, or what they said that made you feel disrespected?"
"Was there anything in particular you were hoping to hear that wasn't explained at that time?"
"Did the doctor say a consultant would speak to you — and has that happened yet?"
3. Unclear Understanding of Diagnosis
"Can I ask what you've been told so far about why your mum was admitted?"
"Have you been told anything about her heart or the bleeding in her urine?"
"Do you know if any tests have been done — like scans, blood tests, or ECGs?"
"Has anyone explained what the team is currently doing to help her?"
4. Expectations
"Is there anything in particular you were hoping I could do for you today?"
"What would help you feel more informed or reassured about your mother's care?"
Purpose: Gathers a complete picture while staying calm, focused, and patient-centred.

L – Lay Explanation of the Situation
"Thanks for explaining all of that so clearly. I can understand why you've been feeling out of the loop."
"Your mother came in with chest pain and blood in the urine. At the moment, the doctors suspect that she may be experiencing heart failure — that's when the heart doesn't pump as effectively, and it can lead to fluid build-up and affect the kidneys as well."
"When the heart isn't working well, the kidneys can struggle to filter properly, and this can sometimes lead to blood appearing in the urine."
"There are still some tests ongoing, but this is one of the main working diagnoses right now."

V – Validate Again and Apologize Sincerely
"I really appreciate you being so clear about your concerns. You've been trying to get information and haven't been heard — and that's not fair."
"I'm also very sorry to hear about your experience with one of our doctors. That's not how we want our families to feel."

E – Explore the Solution

Issue 1: Difficulty Reaching Doctors

"Doctors aren't always on the ward — they're often doing ward rounds, arranging scans, going to clinics, or covering emergencies. That's why nurses are often the first point of contact. They're trained and can give you general updates."

"That said, I'd like to make sure you're kept informed properly going forward. Would you be happy to leave your phone number with me now? I'll record it, and if there are any significant updates, we'll do our best to reach out to you."

Issue 2: Negative Interaction with Doctor

"I'm really sorry you had such a poor experience. I'll let the team know that you weren't happy with how things were handled — especially if you were told a consultant would see you and that didn't happen."

"I can't speak on my colleague's behalf, but I will pass this on to my seniors so it can be looked at more carefully."

Issue 3: Lack of Diagnosis Explanation

"Thank you for raising this — you deserve clear information. I'll speak to the consultant on the ward and make sure you're updated properly today."

"And in the meantime, if anything changes, I'll make sure someone contacts you as soon as possible."

If Son Says: "I don't want that doctor seeing my mum again"

"I hear that you're uncomfortable — and I'll let my seniors know about your concern. But I should explain that in the NHS, we can't always promise that a specific doctor won't be involved again. We work as a team, and every doctor is qualified and here to help."

"That said, I'll absolutely pass your feedback on."

Final Check

"Before we finish, is there anything else you'd like to ask or anything you feel I haven't explained clearly?"

"Thank you for bringing all this to us today — it really helps us improve, and we'll make sure your mother is looked after properly."

Infected Hernia

Setting: A&E
Role: FY2 doctor
Patient: 45-year-old male
Scenario Type: Angry patient – post-operative wound infection following hernia repair
Key Features: Confrontational opening, perceived neglect, visible wound infection, risk factors present (smoking, chronic cough, early work)

I – Invite the Concern

"Hello, I'm one of the doctors here in A&E. I understand you've come in today after recently having surgery. I've been asked to come see you — would you be happy to tell me what's brought you in?"

If the patient responds angrily (e.g., "Where is your senior?" or "I don't want to talk to you") → stay calm and continue:

"I'm really sorry about that. At the moment, the senior doctors aren't here, but I've been asked to assist and help you. Let me introduce myself — I'm Dr. [Your Name], one of the doctors in the emergency team. Could I confirm your name and age, please?"

L – Listen Actively

(Allow the patient to vent. He may say:)

- "I had surgery three weeks ago."

- "Now it's infected — there's pus, and it stinks."
- "No one is helping me."
- "Why has this happened?"

Use short affirmations and reflection:
"I hear that you're really frustrated about how things have gone since surgery."
"It sounds like you're concerned the wound hasn't healed and may be infected — and that you've felt ignored or neglected so far?"

A – Acknowledge the Emotion
"I can see that you're really upset — and I want to say I'm very sorry that you've had this experience. It's completely understandable to feel this way when you've had an operation and things aren't healing the way you expected."

R – Reassure Support and Action
"Let me reassure you that we'll go through everything carefully today. I'll ask a few questions, examine the wound, and we'll make sure the right treatment is started promptly."
"Would it be alright if I asked you a few questions to better understand what's been going on?"

S – Seek Permission to Explore
"Would it be okay if I ask you a few questions about your symptoms, how things have been since the surgery, and your medical history?"

O – Obtain a Structured History
1. Presenting Symptoms
"What kind of symptoms have you been experiencing with the wound?"
"When did you first notice any pus or smell?"
"Has it been getting worse over the last few days?"
2. Systemic Symptoms
"Have you had a fever, chills, or felt generally unwell?"
"Any nausea or vomiting?"
"Are you breathing okay — any shortness of breath?"
3. Surgery Details
"Can I confirm what surgery you had — was it an open or laparoscopic hernia repair?"
"When exactly was the surgery — about three weeks ago?"
"Was everything okay immediately after the procedure?"
4. Infection Risk Factors

- **Before surgery**: "Did you have any medical problems that may have affected recovery?"
- **After surgery**:
  "How was the wound being cared for after discharge?"
  "Was the dressing changed regularly?"
  "Did anything come into contact with the wound that might've caused contamination?"

5. Medical History
"Do you have any chronic illnesses — like diabetes or chronic cough?"
Expected answer: Patient has a chronic cough, which is a known hernia repair risk factor.
6. Medications
"Are you currently on any medications?"
7. Occupation & Recovery Compliance
"What kind of work do you do?"
"Were you advised to take time off after the operation?"

"May I ask why you returned to work earlier than recommended?"
Expected answer: Financial pressure, manual job.

8. Social History
"Do you smoke?"
Smoking is an additional infection risk factor.

L – Lay Explanation of the Problem
"Thanks for explaining everything. From what you've told me and from examining the wound, it does look like the area is infected. That means some bacteria have gotten into the wound site and are now causing pus and an unpleasant smell."
"Infections like this can happen even after straightforward operations — especially when certain risk factors are present. Returning to work too early, having a persistent cough that puts pressure on the area, and smoking all increase the chance of delayed wound healing or infection."

V – Validate Again and Apologize Gently
"I completely understand why you're upset — you've been through a surgery expecting to recover, and now you're dealing with pain, infection, and stress."
"I'm sorry you've had to go through this. But we'll act on this straight away."

E – Explore the Solution
Plan of Action
"Here's what we'll do now:"

1. **Admission to Surgical Ward** for proper management
2. **Examine and clean the wound**
3. **Take a wound swab** to identify the bacteria causing infection
4. **Start intravenous antibiotics**
5. **Order blood tests** to check infection markers and kidney function
6. **Ensure pain control and wound dressing protocol**
7. **Once things begin improving**, we'll switch to oral antibiotics and plan for safe discharge

Discussing Risk Factors
"Your return to work, smoking, and chronic cough may have contributed to the delayed healing — but now that we've identified the infection, we'll give it the proper treatment."
Next Steps
"I'll speak to the surgical team now so they can continue your care once you're admitted. We'll also make sure your pain is managed in the meantime."

Final Check
"Is there anything else you'd like to ask or anything I haven't explained clearly?"
"Thanks for being open about what you're going through — I know this has been frustrating, but we'll get it sorted from here."

Infected Cyst – Post-Op Wound Infection

Setting: Surgical Ward
Role: FY2 doctor
Patient: 42-year-old woman

Scenario Type: Disappointed patient seeking explanation before discharge after 3-day admission for infected wound following cyst removal
Status: Treated with IV antibiotics, stable, ready to go home
Key Pitfall: Do *not* offer antibiotics or readmission again — patient has already been managed appropriately.

I – Invite the Concern
"Hello, I'm one of the doctors from the surgical team. I understand you've been admitted for the last few days after your surgery and are going home today. I've also been told that you wanted to speak with someone before discharge — would you be happy to share what's on your mind?"
Purpose: Calm, warm opening that frames the conversation without assumptions.

L – Listen Actively
(Patient may say:)

- "Why did I get an infection?"
- "No one explained anything to me."
- "Why wasn't I given antibiotics earlier?"
- "Why did I have to be readmitted?"
- "This doesn't happen to everyone — I followed everything they said."

Active listening behaviours:

- Nodding
- Open posture
- "I see…", "Right…", "Thank you for telling me that."

Reflect:
"So from what I understand, you're really frustrated that you got this infection in the first place, and that no one clearly explained why it happened or why you had to come back in?"

A – Acknowledge the Emotion
"I can see that you're quite upset — and honestly, that's completely understandable. No one expects to need another admission after surgery, and I'm really sorry you've had to go through this."
"We want to make sure you feel fully supported before you leave — and that you get the answers you deserve."

R – Reassure Support and Action
"Let me go through this carefully with you. I'll ask you a few questions about how things went before the infection started, and I'll explain what we know — and what we can find out if something's still unclear."

S – Seek Permission to Ask Questions
"Would it be alright if I ask you a few questions about your recovery, how the wound was managed, and whether there might've been any factors contributing to the infection?"

O – Obtain a Structured History
1. Symptoms of Infection
"Can you tell me what symptoms you noticed?"
"Was there any pain, redness, swelling, or discharge from the wound?"
"Did you have any fever or feel generally unwell?"
"When did these symptoms start?"
2. Reason for Readmission
"What made you come to the hospital three days ago?"
"Were you feeling particularly unwell at the time?"

3. Risk Factor Screen

- **Before surgery**: "Were you ever told about any infection risk before the operation?"
- **During surgery**: "Were there any complications during the procedure?"
- **After surgery**:
  "Were you given wound care instructions?"
  "Did you perform the dressing yourself or get help from a nurse?"
  "Was the wound kept clean and dry?"
  "Any exposure to tap water or swimming?"

4. Medical History

"Do you have any ongoing health problems like diabetes?"
"Do you take steroids or other long-term medications?"
"Were you already on antibiotics before being readmitted?"

5. Occupation and Lifestyle

"What kind of work do you do — and had you resumed working?"
"Were you advised to avoid heavy lifting or specific activities?"
"Do you smoke?"
"Were you mostly mobile or on bed rest after the procedure?"

6. ICE – Ideas, Concerns, Expectations

"What do you think might have caused this infection?"
"Is there anything you're particularly worried about — for example, long-term effects?"
"Is there anything specific you'd like us to do before you leave?"
Purpose: Ensures complete emotional and risk factor understanding, leading into appropriate reassurance and planning.

L – Lay Explanation of the Situation

"From everything you've shared, it doesn't sound like there were any obvious risk factors in your case — you followed instructions, and the wound was being looked after."
"But unfortunately, even in healthy people, a small percentage can still develop an infection after surgery. It's nothing you did wrong — just one of those rare and unfortunate outcomes."
"I don't have your surgical notes with me right now, but if you'd like, I can speak to the team and look into whether anything else was noted — and let you know if we find anything different."
"As for antibiotics — they aren't routinely given to everyone after surgery, unless there's a specific risk. That might be why you didn't get them earlier — but once the infection was recognised, you were brought in and treated properly."
"And I want to reassure you — our hospital's infection rate is actually below the national average."

V – Validate Again and Apologize Sincerely

"I'm really sorry this happened. You've been through something unpleasant, and it's completely fair to feel frustrated or anxious about it."
"Thank you for speaking so openly — it helps us learn and improve."

E – Explore the Solution

Immediate Summary

"You've been treated with the right antibiotics, you're doing much better, and from the examination notes, your wound looks healthy enough for discharge."

What Happens Next

"You'll go home today, and we'll give you clear wound care instructions."
"You may receive a follow-up appointment if the team needs to check the wound again."

"If you notice any signs of recurrence — fever, pain, redness, or discharge — you can call us or come back straight away."

Offer Further Support

"If you still feel unhappy about how this was handled, or if you'd like to raise any concerns formally, I can help you get in touch with our Patient Advice and Liaison Service (PALS). They're here to support patients and answer any further questions."

"Would you like me to give you their contact details?"

Final Check

"Before we wrap up, is there anything else I can help you with or anything you feel hasn't been explained clearly?"

"I really appreciate you taking the time to raise your concerns — and I hope you feel more reassured now."

DNAR Concern – Upset Son

Setting: Acute Medical Ward
Role: FY2 doctor
Patient: 80-year-old man with terminal prostate cancer, non-responsive to treatment
Accompanied by: Son
Scenario Type: Angry relative – ethical and emotional discussion about end-of-life decision

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I – Invite the Concern

"Hello, I'm one of the doctors looking after your father. I understand you wanted to speak to someone about his care. Would you be happy to share what's been troubling you?"

Purpose: Neutral and open invitation to allow the son to express himself freely.

L – Listen Actively

(Allow the son to speak. He may say:)

- "Why did you sign a DNAR without telling me?"
- "Did you force him to agree to this?"
- "Is this because he's old or has cancer?"
- "Why are you not treating him properly?"

Reflective listening:

"So from what you're saying, you're worried this decision was made behind your back, and that your father may not be getting all the care he needs?"

A – Acknowledge the Emotion

"I can see that this has come as a shock, and it's understandably upsetting. These decisions are never easy to hear — especially when it's someone you love. I'm really sorry this has caused you distress."

R – Reassure Support and Action

"I'm here to explain everything clearly and answer every question you have. We genuinely have your father's best interests at heart — and I want to make sure you understand exactly what a DNAR means, and what it doesn't mean."

"Would it be okay if I asked a few questions so I can understand your perspective better?"

S – Seek Permission to Ask Questions

"Would it be alright if I ask a few questions about what you've been told so far, and your understanding of your father's condition and the DNAR order?"

O – Obtain a Structured History (Four-Box Approach)
Understanding of DNAR and CPR
"Can I ask what you understand by the term DNAR?"
"Have you heard of CPR before — what it involves?"
Clarify if needed:
"CPR stands for cardiopulmonary resuscitation. It involves strong chest compressions, sometimes a mask or tube to help breathing, or even electric shocks to restart the heart if it stops."
"For people with serious or terminal illnesses like your father, CPR has a very low chance of working. It can cause more harm than good, such as broken ribs, pain, and distress — often without improving outcomes."
Understanding of Father's Condition
"Can I ask — what have you been told about your father's prostate cancer?"
"Do you know how well the treatment has been working so far?"
"Has anyone discussed his prognosis with you?"
Clarify gently:
"From the medical records, your father's cancer has unfortunately not responded to treatment, and we've now reached a stage where our focus is on comfort and dignity."
Family Structure and Involvement
"Are you the next of kin?"
"Is there a Lasting Power of Attorney for Health and Welfare?"
"Are there any other family members closely involved in your father's care decisions?"

L – Lay Explanation of DNAR and Ethical Reasoning
"Let me clarify what DNAR means. It only applies if someone's heart or breathing were to stop — in that moment, we would not attempt CPR. But it doesn't mean we stop all other treatments. Your father will continue receiving full care, including medication, oxygen, fluids, or anything needed to keep him comfortable and well."
"CPR can sometimes be successful in younger, healthier patients. But in someone with advanced cancer — where the illness isn't responding to treatment — CPR almost never works. Worse, it can be traumatic, break ribs, and may lead to distress in the final moments."
"That's why, after reviewing his case carefully and discussing it among the team, the DNAR decision was placed. It's not about giving up. It's about avoiding harm."
"If your father had capacity, we would've absolutely spoken to him. If he didn't, we follow what we believe to be in his best interest. No one is forced — and we do not make these decisions lightly."

V – Validate Again and Apologise Sincerely
"I really appreciate you sharing your thoughts so openly — and I'm sorry this wasn't explained earlier, because I can see it's caused a lot of worry."
"This conversation should have happened sooner, and I'm really sorry it didn't."

E – Explore the Solution
Addressing Specific Concerns
1. "Why didn't you tell me?"
"That's a very fair concern. We should always try to involve families in these discussions — especially when emotions are involved. I apologise if this wasn't communicated properly — that's not acceptable, and I'll raise this with the team."
2. "Did you force my father to agree?"

"Absolutely not. DNAR is never forced. If your father was capable of understanding and making decisions, we would always ask him directly. If not, we make a decision in his best interest — always with dignity and comfort as our priority."

3. "Is he still getting proper care?"

"Yes — DNAR doesn't mean we stop treatment. We continue all care to keep him comfortable — including fluids, pain relief, and treatment of infections. We're here to support him, not to withdraw care."

4. "Can this be reversed?"

"Yes — if your father has capacity, he can request to change the DNAR decision. And if circumstances change or his wishes evolve, we're always open to revisiting it."

5. "What if we go to another hospital?"

"A DNAR is valid across different NHS institutions — but it can always be reviewed based on the patient's condition and wishes at the time."

Next Steps and Support

"Would it help if I spoke to the consultant and asked them to update you as well?"

"If you'd like to raise a formal concern, I can help you contact our Patient Advice and Liaison Service (PALS) — they can help clarify any unanswered questions."

"But I'm also happy to keep answering anything else directly, right now."

Final Check

"Before I go, is there anything else I can help explain — or anything you feel hasn't been made clear?"

"Thank you for being here and for caring so much about your father. I know this isn't easy, and we're here to support both of you."

MRSA Colonisation

Setting: Medical Unit
Role: FY2 doctor
Patient: 55-year-old male, admitted for COPD exacerbation, now MRSA-positive (nasal colonisation)
Relative: Wife (angry, confused, anxious)
Scenario Type: Angry relative + infection control counselling

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I – Invite the Concern

"Hello, I'm one of the doctors looking after your husband. I understand you've been worried about some changes in his care and wanted to speak to someone. Would you be happy to tell me what's been concerning you?"

Let the wife express concerns – she will likely mention masks, isolation, and fears about leprosy or infection risk.

L – Listen Actively

(Allow the wife to speak freely. Likely complaints include:)

- "Why is everyone wearing gloves and masks — are you treating him like he's contagious?"
- "Why is he in a separate room?"
- "Why didn't anyone explain this earlier?"
- "I read MRSA can kill people — is he going to be okay?"

Active listening responses:

"I see... That must have been quite alarming to walk in and see all the precautions."

"So you're understandably upset because no one explained what's going on."

A – Acknowledge the Emotion

"I'm really sorry we didn't explain this earlier — I can completely understand why you're feeling confused and concerned. This should have been communicated to you clearly, and I apologise for that."

R – Reassure Support and Action
"Let me explain everything about what's going on, why your husband is being cared for this way, and what it actually means. I'll also make sure all your questions are answered."

S – Seek Permission to Ask Questions
"Would it be okay if I ask just a couple of questions first to understand what you've been told so far?"

O – Obtain Relevant History (Focused and Concise)
"Would it be okay if I ask a few questions so I can better understand how this has been explained to you?"
1. Understanding So Far
"Has anyone spoken to you yet about what's going on with your husband?"
"What have you been told about the swab results?"
"Has anyone used the term 'MRSA' with you before?"
Purpose: Identify knowledge gaps and misconceptions (e.g. thinking it's an infection or leprosy).
2. Current Concerns
"What was it that worried you the most when you saw him in the side room with staff wearing masks and gloves?"
"Was it the way he was being treated, or something someone said that alarmed you?"
Purpose: Uncover emotional trigger – sudden isolation, PPE, no explanation.
3. Impact on Family / Risk Concerns
"Have you been in close contact with your husband since he was admitted?"
"Is there anyone else at home — elderly, with wounds, or on long-term medication?"
"Are you worried about possibly catching something from him?"
Purpose: Screens for vulnerable contacts, allows tailored safety netting.
4. Pre-existing Beliefs / Misunderstandings

"Have you ever heard about MRSA before — maybe in the news or from others?"
Purpose: Let the patient express fears in their own words (e.g. "kills everyone"). Allows you to address public/media misinformation.
5. Expectations
"Is there anything in particular you were hoping we could do today?"
"Would it help if we went through what this actually means and what happens next?"

L – Lay Explanation of MRSA (Simple, Reassuring, Professional)
"Your husband has not developed an infection. He's been found to carry a bug called **MRSA** — *Methicillin-Resistant Staphylococcus Aureus* — in his nose. This is called **colonisation**, which means the bacteria are living on his skin or in his nose, but they're not causing any harm."
"This is actually quite common in hospitals, which is why we screen patients routinely with nose swabs. Many healthy people carry these bugs without ever knowing."
"However, if someone with MRSA develops a wound or becomes unwell, there's a small risk that these bacteria can cause infection — so we take precautions like using gloves, masks, and isolating patients. It's not to treat him like he's infectious — it's to protect both him and others."
"We're treating this now with a short course of antiseptic cream in the nose and antibacterial shampoo — usually for five days."

V – Validate Again and Apologise Sincerely
"I'm really sorry that this wasn't explained clearly before. You've had to see it all suddenly, and that's understandably upsetting. But I want to reassure you: he's not unwell because of this, and he's not dangerous to be around."

E – Explore the Solution and Reassure Further
Address Specific Questions
"Can I visit him?"
"Yes, absolutely. You can visit — but we do recommend washing your hands before and after, and you may be asked to wear gloves or aprons just as a precaution."
"Can I get infected?"
"It's very unlikely — especially if you're healthy. MRSA spreads by contact, not through the air. So washing hands and not sharing towels or personal items is enough."
"Will he be okay?"
"Yes — he's doing well, and this isn't an infection. It's just something we're treating to prevent future problems."
"Did he get it from the hospital?"
"It's hard to say where it came from. MRSA can live on skin without symptoms, and people can carry it for years without knowing. It's not about blame — it's about identifying it and managing it early, which we've done."
"Can he go home?"
"Yes — but we'd ideally like to finish his decolonisation treatment here, which only takes five days. That way, we can check again with a swab to confirm he's no longer carrying the bug before going home."
"Can I get screened too?"
"Yes — if you'd like to be screened, you can ask your GP, who can arrange a swab and treatment if needed. This is optional but often offered for close contacts."

Summarise Key Actions
- Decolonisation: Naseptin 3x daily + antiseptic body wash
- Infection control: Gloves/aprons, hand hygiene, isolation
- Screening offered for family if concerned
- Leaflet and written guidance available
- Offer to follow up again later if more questions arise

Final Check
"I know this was a lot of information, and I'm really grateful that you brought your concerns to us. Is there anything else I can explain or help with today?"
"Would you like a leaflet that goes over everything we've discussed about MRSA?"

Chapter 22: Medical errors

Medical Error Case - Structure

For any scenario where **you must inform a patient or relative** about a **mistake in medical care.**

1. Professional, Clear Introduction
You are *not* here to explore their complaint — you are *delivering difficult news*. Be clear, warm, and focused.

"Hello, I'm one of the doctors here at the hospital. Thank you for coming in today."
"There's something important about your recent care that I need to speak with you about."
"Is it okay if we sit down and go through everything carefully?"

Do not ask "How can I help you today?"
Do make clear that the doctor is initiating the conversation.

2. Contextual History (if relevant)
This step helps ensure you understand what the patient already knows.
"Before I begin, would it be alright if I check how you've been feeling since your last visit?"
"Do you recall what was done during your previous admission — like the [scan/test/procedure]?"
Keep this **very focused** — just enough to anchor your narrative.

3. Warning Shot – Gently Prepare the Patient
Introduce the topic gradually — this is where you start breaking the news.

"There's an important issue related to your treatment that I've been asked to explain."
"Unfortunately, it looks like something went wrong, and I want to walk you through what happened."
Avoid abruptness.
Tone = slow, clear, and sincere.

4. Chronological Story – Calm and Honest Narrative
Lay out events *step by step*. Don't jump straight to "the mistake".

"As we understand it, on [date], you were seen for [reason]..."
"A [test/procedure] was carried out and sent to [department/laboratory] ..."
"Unfortunately, we didn't receive the expected report/results, and this led us to investigate..."
"And sadly, we've now confirmed that..."
Use "Unfortunately" before each negative event.
Stick to **facts only**, no assumptions or blame.
Do not say "it got lost" casually — say "it appears the sample was not processed / was misplaced."

5. Final News Delivery – Clear and Sincere

"I'm really sorry to tell you that... [the test was lost / the fracture was missed / the wrong report was issued]."
"This clearly should not have happened."
This is the **emotional peak** of the station. Deliver it **slowly** and **without medical jargon**.

6. Pause. Let Them React.

- Do **not** interrupt.
- Give **emotional space**.
- If they express anger, proceed to the next step.

7. Apply the AVE Protocol – For Emotional Management
Acknowledge
"I can see this has come as a shock, and you're clearly upset."
Validate
"Anyone in your position would feel exactly the same. It's completely understandable."
Empathise
"I'm truly sorry this happened, and I want to reassure you we're taking this very seriously."
Avoid saying "I understand how *you* feel" – say "*anyone* would feel this way."
Don't interrupt, justify, or defend during this phase.

8. What Happens Next – Clinical Reassurance

"Right now, our first priority is your health."
"We've already arranged for [repeat scan / review / senior opinion], and this will happen without delay."
"We'll ensure you get everything needed to move forward safely from here."
Keep it simple, action-oriented, and relevant to **fixing the immediate harm**.

9. Hospital Protocol for Medical Errors
These 5 points **must be said**. This shows duty of candour and full transparency.

1. **Reporting**: "This has been formally reported as a serious incident within the hospital."
2. **Investigation**: "A senior member of the team will investigate exactly what happened."
3. **Accountability**: "The hospital will follow its internal protocols to ensure appropriate action is taken."
4. **Senior Contact**: "A senior consultant or manager will follow this up with you directly."
5. **PALS**: "And if you'd like to make a formal complaint or speak to someone impartial, I can help you contact the Patient Advice and Liaison Service. That's absolutely your right."

Don't wait for the patient to ask about PALS. Always offer it voluntarily.

10. Address Likely Questions Proactively
The patient may or may not ask, but you should still cover these two points:
Q: Whose mistake was it?
"We're still reviewing the details, so I can't say for certain yet. But we will find out and let you know."

Q: What happens next?
"Clinically, you'll be cared for without any further delay. Administratively, the hospital is following its incident process, and we'll keep you fully informed."
Never shift blame or speculate. Be transparent but careful.

11. Final Reassurance and Closure
"I'm truly sorry again that this has happened."
"We'll make sure that you're supported throughout, and I'll be here if you'd like to go over anything again."
"Please don't hesitate to ask — we want to make this right."

Medical Error Cases – Red Flag Guide

This page serves as an internal checklist to help you avoid critical mistakes and manage these challenging scenarios effectively.

Common Mistakes to Avoid

Don't start with generic lines like **"How may I help you?"** — it feels impersonal in emotionally charged cases.
Never say **"I'd like to apologize on behalf of my team"** — it can sound defensive or deflective.
Avoid cross-talking, interrupting, or speaking while the patient is expressing anger.
Don't **delay offering PALS** or wait for the patient to ask — always include it naturally in your plan.
Avoid abrupt transitions like jumping straight into the error without paraphrasing or checking how the patient is feeling.
Don't try to **blame others or minimize** what happened — focus on shared responsibility and next steps.
Avoid saying **"I'm going to do this"** — use phrases like **"What needs to happen now is..."** to reflect collaborative planning.

Don't get flustered if the patient becomes emotional — maintain steady tone and structure.
Never suggest going to the patient's home or breaking standard protocol.
Don't maintain a rehearsed or angry tone during roleplay — your energy should help diffuse, not escalate.

Best Practices

- Introduce yourself clearly, regardless of prior meetings or phone setting.
- Take a brief and focused history to understand the context and patient's concerns.
- Acknowledge what the patient is feeling before offering any explanation.
- Deliver the information in a calm, structured way that is easy to follow.
- Take ownership of the issue without blaming others.
- Emphasize what has changed since the error and what is being done now to prevent a repeat.
- Offer next steps clearly — whether it's a new test, another appointment, or further review.
- Always offer the option to speak to the patient liaison service, whether or not they ask.
- If the patient hesitates about repeating a test or attending again, acknowledge the hesitation and help them understand the need for follow-up.

Communication Tips

- Maintain a steady, respectful tone — not overly apologetic or too casual.
- Use normal human expressions of concern, but avoid being overly dramatic.
- If the patient is angry or emotional, stay calm and give space without becoming silent or disengaged.
- Show that you understand the impact of the error, not just the facts.
- Don't use rehearsed-sounding lines or formulaic responses.
- Focus on what needs to be done now — not just on what went wrong.

Handling Special Situations

- For missed diagnoses (like MI, fractures, or foreign bodies), explain that subtle signs were overlooked and now steps are being taken.
- For delays in diagnosis or treatment, emphasize safety and the importance of completing follow-up investigations.
- If the parent or patient is reluctant to come back, explain the risks clearly but gently — and negotiate where possible.
- If the error involves a child, explain clearly but avoid alarming language.

Final Reminders

- These stations are not just about saying sorry — they test whether you can manage emotion, explain clearly, and plan safely.
- Keep history-taking brief and relevant. The explanation and next steps matter more in these cases.
- Your tone, empathy, and clarity are just as important as your content.
- Stay focused, structured, and responsive — especially when the consultation becomes emotionally intense.

Lost Renal Biopsy

Setting: Hospital follow-up, face-to-face consultation
Role: FY2 doctor asked to speak to the patient about the lost renal biopsy
Patient: 18-year-old male

1. Professional Introduction & Clear Agenda
"Hello, I'm one of the doctors here on the renal team. Thank you for coming in today."
"There's something important regarding your recent biopsy that I've been asked to speak with you about, and I'd like to go through it carefully with you now."

2. Contextual History (Brief, Focused)
"Before I explain everything, could I quickly check a few things about your health?"

- "Can you tell me why the biopsy was done in the first place?"
- "Have you had any symptoms recently — like changes in the amount or colour of your urine, swelling in your legs or face, or any issues with breathing?"
- "Do you have any long-term medical conditions like high blood pressure, diabetes, joint or skin problems?"
- "Are you currently taking any medications, either prescribed or over the counter?"
- "Has anyone in your family had kidney problems?"
- "And how was the biopsy experience for you — was it straightforward, or did anything concern you?"

(Let the patient respond – actor might say "It was painful" or "I just had blood in my urine.")

3. Warning Shot – Gentle Preparation
"There's something quite important I need to explain regarding that biopsy."
"Unfortunately, something has gone wrong, and I'd like to walk you through exactly what happened."

4. Chronological Narrative of Events
"As we understand it, two days ago, your renal biopsy was carried out as planned."
"The sample was sent to the laboratory, and we've been waiting for the results."
"We didn't hear anything back, so we assumed the report might take a little longer — but we were expecting it to arrive by now."
"When it didn't come, we followed up by calling the lab."
"Unfortunately, they told us they hadn't received the sample."
"We immediately checked at our end — in the unit, in the pathology transfer logs, and even in the transport chain — but unfortunately…"

5. Final Delivery of the News
"…I'm really sorry to tell you that it seems the biopsy sample has been lost."
"It's a clear mistake on our part, and I'm truly sorry this has happened."

6. Manage the Patient's Reaction – AVE Protocol
(Patient may say: "What? Are you serious?" or "That was so painful – and now it's gone?")
Acknowledge:
"I can see this is incredibly frustrating, especially after going through the procedure."
Validate:
"Anyone in your position would feel the same way. It's completely understandable to be upset."
Empathy:
"We're truly sorry. This is something that shouldn't have happened, and I want to reassure you that we're taking it very seriously."

7. Clinical Plan – What Happens Next Medically
"The reason the biopsy was done is because your GP suspected a condition called *glomerulonephritis* — which means inflammation of the kidneys."

"The reason we need a biopsy is to find out *exactly what kind* of inflammation is present — because different types are treated differently."
"At the moment, without the tissue result, we won't be able to confirm the exact cause, and that can delay starting the correct treatment."
"So we're hoping you might be willing to help us by having another biopsy."

8. Negotiation if the Patient Refuses (if applicable)
(If patient hesitates or says "No – it was too painful")

"I completely understand — many people do find the procedure uncomfortable, and I'm really sorry you had a difficult experience."
"This time, we can speak to the consultant team and ask them to use a smaller needle."
"We can also make sure you're given local anaesthetic to numb the area — or even use sedation to help make it more comfortable."
"We'll do everything we can to make sure you don't go through the same pain again."
"Would that sound more manageable?"
(If patient still refuses)
"The only worry is that without a biopsy, we might delay finding the right treatment."
"And sometimes, delays in treating kidney conditions can cause complications or long-term damage."
"That's why we're keen to move forward as soon as you feel ready."

9. Hospital Protocol for Medical Errors – Duty of Candour

"We take this sort of incident very seriously as a hospital."

1. **Reporting** – "It has already been logged as a significant event."
2. **Investigation** – "A senior clinician will be looking into how and where the mistake happened."
3. **Action** – "We'll take necessary steps to prevent this from happening again."
4. **Senior Contact** – "You'll also be seen or contacted by a senior member of our team about this."
5. **PALS** – "And if you'd like to make a formal complaint or speak to someone outside the medical team, I can put you in touch with the Patient Advice and Liaison Service — PALS. That's your right, and I can help you with that."

10. Address Likely Questions
Q: Whose mistake was it?
"Right now, we're not entirely sure where along the chain the error occurred, but we are investigating and will update you as soon as we know."
Q: What happens now?
"Medically, we'd like to repeat the biopsy as soon as you're comfortable. Administratively, the hospital is following its error protocol, and we'll keep you informed throughout."

11. Final Reassurance and Closure

"Ben, I just want to say again — I'm so sorry that this has happened."
"We'll do everything we can to support you and make this process as smooth and safe as possible."
"If you have any other questions at all, please feel free to ask — I'm here for you."

Missed Blood Sample

Setting: Surgical Assessment Unit or Orthopaedics
Format: Telephone consultation
Role: FY2 doctor
Patient: 50–55-year-old man (Edward Jones), scheduled for elective knee replacement

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1. Telephone Opening & Identification
"Good morning. Am I speaking to Mr. X?"
"Hi, Mr. X — this is Dr. Surname, one of the doctors you met yesterday when you came in for your pre-op bloods."
"I'm calling about something related to the blood sample we took yesterday. Is now a good time to speak for a few minutes?"
"Before we go any further, just to confirm I'm speaking to the right person — could you please confirm your age and the first line of your address for me?"

2. Brief History (Surgery Context & Risk Screening)
"Thank you. Just before I explain what's happened, I'd like to ask a couple of quick questions to make sure we've got everything right for your upcoming surgery."

- "Can I check — what sort of surgery are you scheduled for?"
- "When is it planned for, and how long have you been waiting for it?"
- "What was the reason for the surgery — have you been having knee pain for a while?"
- "How have these symptoms been affecting your daily activities or work?"
- "How important is this surgery to you, personally?"

"And just a few quick health checks, if that's okay:"

- "Do you have any ongoing medical problems — like high blood pressure or diabetes?"
- "Have you ever had issues with wound healing or infections after a surgery?"
- "Do you have any bleeding tendencies or blood-related conditions?"
- "Any family history of clotting or bleeding problems?"
- "Do you remember when your last blood test was — and were the results normal?"

These questions establish surgical risk factors and why the blood sample matters clinically.

3. Warning Shot – Prepare for Disclosure
"Thanks for that, Mr. X. I now need to explain something important about the blood test we did yesterday."
"Unfortunately, something didn't go as planned, and I'd like to walk you through exactly what happened."

4. Narrative of the Error (Use "Unfortunately" Repeatedly)
"As you'll recall, we took a blood sample yesterday to prepare for your upcoming surgery."
"It was sent to the laboratory as usual, and we were expecting results by today."
"Unfortunately, this morning I received a call from the lab."
"They told us that the sample was not labelled properly — and because of that, they weren't able to process it."
"Unfortunately, whenever a sample is unlabelled, it must be discarded to avoid mix-ups or incorrect results."
"I'm really sorry to tell you that your blood sample had to be discarded, and we'll now need to take another one."

5. Acknowledge the Error – Empathy for Inconvenience
"I can understand this may be frustrating, especially since you've already come in and had it done."

"Anyone in your position would feel the same — we do appreciate your time and effort."
"I'm really sorry this has happened, and I want to sincerely apologise for the inconvenience."

6. Explain the Need for Repeat Testing
"Just to clarify why these pre-op blood tests are so important — they help us check whether there are any risks that need to be managed before your surgery."
"We check things like your blood count to see if you're anaemic, kidney and liver function, and whether your blood is clotting normally."
"This ensures you're fit for surgery and reduces the chance of complications during or after the operation."
"Without these results, we may not be able to proceed safely, and sometimes even a small abnormality needs a few days to correct before we operate."

7. Ask for a Repeat Sample – With Empathy
"I'm really sorry again to ask, but would it be possible for you to come in and give us another blood sample?"
(Pause and listen. If the patient agrees, thank them. If they refuse or hesitate, proceed to next section.)

8. If Patient Refuses – Acknowledge and Negotiate
"I understand — it can be difficult to take time out again, especially with work and everything else going on."
"Would it help if we arranged the sample collection for early morning or late afternoon, outside your work hours?"
"Alternatively, would you be able to give the sample at your GP surgery? If so, we can contact your GP directly and arrange it on your behalf."
"Would any of these options work for you?"
Shows flexibility, patient-centered planning, and collaborative problem-solving.

9. Explain Consequences if Still Reluctant
"The only concern is that without the blood test, your surgery could be delayed."
"If the results show something that needs attention — like low haemoglobin or kidney changes — we'd need time to address it."
"That's why it's so important to repeat the sample as soon as possible."

10. Offer Reflection Time If Needed
"If you'd like to think about it, that's absolutely fine."
"Would you prefer to call us back later, or would it be easier if we gave you a call tomorrow to check in?"

11. Apology and Reassurance Again
"I'm really sorry again for the inconvenience this has caused, Mr. X."
"Thank you so much for your patience — we truly appreciate your understanding, and we'll make sure the process is smoother this time."

12. Close the Call Naturally
"Do you have any questions at all before we end the call?"
"Thanks again for your time today — we'll be here if you need anything further."

Wrong Chest X-ray

Setting: Hospital outpatient follow-up clinic
Role: FY2 doctor
Patient: ~55-year-old male, previously admitted with suspected pneumonia 6 weeks ago

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1. Professional Introduction & Agenda Setting
"Good morning, Mr. X. I'm one of the doctors working in the outpatient clinic. Thank you for coming in today."
"I understand you were admitted about six weeks ago, and you've come in today for your follow-up review."
"There's also something important about your previous hospital admission that I've been asked to discuss with you."

2. Current Status – Focused History (Current First)
"Before we go into everything, how have you been feeling lately?"

- "Are you still having any symptoms like cough or chest discomfort?"
- "Any shortness of breath, wheezing, or fatigue?"
- "Any chest pain, dizziness, or ongoing tiredness?"

(Patient may say: "No, I've been fine since I was discharged – just had diarrhoea after the antibiotics.")

3. Previous Admission – Focused Review of Events
"Thanks for that. Just to confirm — when you were admitted six weeks ago:"

- "What symptoms did you have at the time?"
- "Do you recall if they did any tests — like blood tests or an x-ray?"
- "What did the team tell you about those results?"
- "Were you told you had a chest infection or pneumonia?"
- "What treatment were you given? Did it help?"
- "How long were you admitted for?"
- "Did you experience any side effects — especially from the antibiotics?"

This helps **confirm the patient's understanding** of what happened before the error is disclosed.

4. Warning Shot – Prepare to Deliver the Error
"Thanks for sharing that. The reason I wanted to speak with you is because we've received some updated information about your previous admission — and unfortunately, something has come to light that we need to talk through."

5. Narrative of Events – Chronological, Calm
"As we understand it, you were admitted with chest symptoms and had some tests, including a chest x-ray."
"Based on the x-ray at the time, you were diagnosed with pneumonia and treated with antibiotics."
"You were then discharged once you improved."
"However, after you left the hospital, we received the formal radiology report from the x-ray department."
"That report stated that the chest x-ray was completely normal."
"When we saw that, we immediately reviewed everything carefully to find out what happened."

6. Final News Delivery – Simple, Sincere
"I'm really sorry to tell you — it looks like you were treated based on someone else's x-ray."
"Your actual x-ray report was normal, and you didn't have pneumonia at the time."
"This means that the treatment you were given was based on an error in identifying the imaging."

7. Manage the Reaction
(Patient may say: "Are you joking? So I didn't even need antibiotics?")

Acknowledge: "I can see that this is very upsetting to hear."
Validate: "Anyone in your position would feel frustrated and concerned — that's completely understandable."
Empathy: "We're truly sorry this happened. It's clearly a mistake on our part, and I want to offer our sincere apology."

8. Explain the Current Medical Situation
"At the moment, the good news is that you've completed the course of antibiotics, and you've made a full recovery."
"There's no need for further treatment, and we don't expect any complications based on what's happened."

9. Reassure About Long-Term Safety
"I know you mentioned some diarrhoea after the antibiotics — that can happen, but it usually settles once the course is complete."
"In terms of long-term effects, a single short course of antibiotics is very unlikely to cause any permanent harm."
"We generally only worry if someone is on repeated or prolonged antibiotics, which can lead to resistance — but that's not the case here."

10. Hospital Protocol – Duty of Candour Steps
"We're taking this very seriously as a department."
"This has already been reported as a significant incident."
"A senior clinician is reviewing the case to find out exactly where the mistake occurred."
"The hospital will follow up appropriately, and we'll make sure everything is open and transparent."
"A senior member of our team will also be in touch to speak with you directly."

11. Offer PALS – Right to Complain
"Mr. Johnson, you absolutely have the right to make a formal complaint if you wish to."
"If you'd like to speak to someone impartial about this, I can help you contact the Patient Advice and Liaison Service — or PALS."
"They're here to support you, and I can give you their contact details if you'd like."

12. Anticipate and Address Key Patient Questions
Q: "Will this happen again to someone else?"
"We're actively investigating the root cause to make sure this doesn't happen again."
"We'll also be discussing this case during clinical meetings and safety briefings so staff are more aware."
"Part of that includes encouraging doctors to double-check results and always seek second opinions when needed."

Q: "What about the other patient who didn't get treatment?"
"That's a valid concern — although I don't have the details right now, I can assure you that as soon as we detect any missed care, we always contact the patient and offer them the treatment immediately."
"That will have been followed up, and we'll find out exactly what happened."

Closure – Final Reassurance and Support
"I really want to thank you for your patience and understanding today."
"We're very sorry again for what's happened, and we'll continue doing everything we can to make sure this doesn't happen again — to you or to anyone else."
"Do you have any other questions or concerns you'd like me to go over?"

Missed Myocardial Infarction (MI)

Setting: Coronary Care Unit (CCU) – face-to-face consultation
Role: FY2 doctor
Patient: Male patient admitted two weeks ago, currently receiving post-MI treatment
Context: Patient had chest pain three days prior to admission, visited A&E, was discharged; diagnosis was missed at the time

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1. Professional Introduction & Agenda
"Good morning, Mr. [Surname]. I'm one of the doctors on the cardiology team. Thank you for taking the time to speak with me today."
"I understand you've been here with us for the past two weeks, and you've been receiving treatment for a heart condition."
"There's also something important about your earlier visit to A&E that I've been asked to explain to you today."

2. Brief, Focused History (3 Minutes Max)
"To begin, could I just check — what have you been told so far about your condition?"
- "What's your understanding of why you were admitted here?"
- "What do you know about what happened during your hospital stay?"

"And how are you feeling now?"
- "Any chest pain at the moment?"
- "Have you had any palpitations, shortness of breath, dizziness, or swelling?"
- "Any signs of fever or feeling generally unwell?"

"Could we go back briefly to the first time you came to A&E, about three days before this admission?"
- "What brought you in that day — was it chest pain?"
- "Can you describe the pain — was it going anywhere, like to your left arm?"
- "Did you have any other symptoms that day — like sweating, shortness of breath, or feeling faint?"
- "Do you recall what tests they did — an ECG, blood tests?"
- "Do you remember what they told you the diagnosis was?"
- "Were you told everything looked normal and you could go home?"
- "How did things change before you returned to hospital?"

This confirms the patient's perspective and gently sets up the timeline for error disclosure.

3. Warning Shot – Prepare the Patient
"Thanks for sharing that. The reason I've been asked to speak with you today is because, after reviewing everything that happened during your earlier visit, we've discovered something that went wrong — and I'd like to explain it clearly."

4. Narrative of Events – Step-by-Step
"As we understand it, you came to the emergency department a few days before this current admission because of chest pain."
"At the time, you had an ECG and a blood test. You were told the ECG looked normal, and that it may have

been musculoskeletal pain."
"You were then sent home."
"However, more recently, one of the cardiologists on our team reviewed all your initial results."
"They looked closely at the ECG and also rechecked the blood test that was done on that day."

5. Final Disclosure – Honest and Direct
"I'm really sorry to tell you this — but it looks like you had a heart attack during that first visit, and it was missed at the time."
"The ECG showed signs of a heart attack, and the blood test result — which we didn't check before discharge — was also positive for a heart attack."
(Pause to allow reaction.)

6. Manage the Reaction – Acknowledge, Validate, Empathise
"I can see that this is deeply upsetting to hear, and I truly understand why."
"Anyone in your situation would feel the same — especially after doing the right thing and coming in for help."
"This was clearly a mistake on our part, and I want to sincerely apologise."

"We should have been more careful in reviewing your test results before sending you home."
"This should not have happened."

7. Explain How the Error Happened (If Asked)
"They did carry out the right tests — including an ECG and a blood test — but the ECG changes weren't recognised at the time."
"And unfortunately, although the blood test was done, the result wasn't checked before discharge."
"These test results were later reviewed and showed that you had already had a heart attack on your first visit."

8. Clarify Why It Couldn't Have Been Prevented (If Asked)
"I understand why you might ask if this could have been prevented."
"The heart attack itself had already happened by the time you came to the hospital — that's why the blood test was positive."
"The mistake was in not identifying it — not in causing it."
"So while the heart attack itself couldn't have been prevented, recognising it earlier might have changed how we managed your care from the beginning."

9. Current Situation & Complication Assessment
"The good news is that you've been receiving the correct treatment since you were admitted, and we've been monitoring your recovery closely."
"To be thorough, we'll continue to assess whether there have been any complications — such as rhythm disturbances or heart function changes — but so far, your progress has been encouraging."

10. Hospital Protocol – Serious Incident Management
"This incident has been reported as a serious clinical issue by our team."
"It will be formally investigated by a senior consultant to understand how the error occurred."
"The hospital will take necessary action in line with its protocols."
"We'll be open and transparent throughout the process, and a senior member of the team will be speaking to you personally."
"We're also discussing the case internally to ensure something like this doesn't happen again."

11. Offer PALS – Complaint Support Option
"Mr. [Surname], you also have every right to raise a formal concern if you wish."
"If you'd like support or want to make a formal complaint, I can help you get in touch with the Patient Advice and Liaison Service — PALS."
"They can help you through the process and act on your behalf."

12. Final Reassurance & Closing
"I'm truly sorry again that this happened, and I want to thank you for your time and patience in letting us explain everything properly."
"If there's anything unclear or anything else you'd like to ask, I'm here to answer."
"We'll make sure you're fully supported moving forward."

Missed Foreign Body

Setting: Emergency Department
Format: Telephone consultation
Role: FY2 doctor
Patient: 4-year-old girl brought in 3 hours ago after possible ingestion of foreign body
You: Performed X-ray → reported as normal → later reviewed by radiologist and found to be abnormal

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1. Telephone Opening & Identification
"Hello, am I speaking to Mrs. X?"
"Hi, this is Dr. Surname — I'm one of the doctors from the emergency department. I saw your daughter earlier this afternoon."
"I'm calling because I've been asked to speak with you regarding something important about your child's recent visit."
"Is it okay if we speak for a few minutes?"
"Before I continue, could I please confirm your daughter's full name and age just to make sure I have the correct record in front of me?"

2. Brief History – Do Not Skip
"Thanks for confirming. I know we saw your daughter earlier, but I'd like to check how she's doing right now — just to be sure nothing has changed."

- "Is she currently eating and drinking normally?"
- "Is she active and playful?"
- "Are you noticing any symptoms at the moment — like [select based on version]:"

For button battery (oesophagus):

- Any tummy pain?
- Difficulty swallowing?
- Vomiting?
- Drooling?
- Gagging or chest pain?

For Lego toy (lungs):

- Any difficulty breathing?
- Wheezing or noisy breathing?
- Coughing or choking?
- Any bluish discoloration of her lips or hands?

"Just to recap — can you tell me what exactly happened when she swallowed the object earlier?"

- "Did you see her swallow something?"
- "How long ago did this happen?"
- "Did she have any symptoms immediately after that?"
- "When you brought her in, did any other staff assess her — a nurse or another doctor?"
- "Was she given any medication or tests apart from the X-ray?"

Ensures you cover the clinical picture fully before breaking bad news, despite prior consultation.

3. Warning Shot – Prepare for Disclosure
"Thank you, Mrs. X. I now need to explain something important that has come to our attention."
"Unfortunately, something went wrong with your child's care earlier, and I'd like to walk you through what we've found."

4. Chronological Narrative – Calm and Clear
"As we understand it, you brought your daughter to the hospital because you were concerned she may have swallowed something."
"We examined her and performed an X-ray, which we initially told you looked normal."
"However, as part of routine safety protocols, all X-rays are reviewed again later by a senior radiologist."
"And unfortunately…"

5. Final News Delivery – Sincere Disclosure
Version 1 – Button Battery in Oesophagus

"I'm really sorry to tell you that the radiologist has found a button battery lodged in her food pipe (oesophagus)."
Version 2 – Lego Toy in Lung

"I'm really sorry to tell you that the radiologist has found an object — a small plastic toy — lodged in her left lung."
Pause and allow mother's reaction before continuing.

6. Manage the Reaction – AVE Protocol
Acknowledge: "I can hear how shocked and worried you are, and I completely understand."
Validate: "Anyone in your position would feel the same way — it's absolutely natural to be upset."
Empathy: "This was a mistake on our part, and I am so sorry this happened. We should have been more careful when reviewing the X-ray."

7. Explain the Urgency – Safety First
If Button Battery in Oesophagus:
"This is considered a medical emergency because button batteries can cause serious harm very quickly — they can burn the surrounding tissue or move into the airway."
"This needs to be removed as soon as possible."

If Lego Toy in Lung:
"Right now, she may not look unwell, but the toy is sitting inside one of her lungs."
"If it shifts or causes a blockage, it can lead to breathing problems or infection, so it must be taken out urgently."

8. Request Immediate Action – With Escalation Plan
"Could you please bring your daughter straight back to the hospital?"

If Lego toy:
"We're arranging an ambulance for you. Would you be able to come with her in the ambulance?"
(If no: "Can I ask why?" → "Is there anyone else who could bring her?")

"This is something we don't want to delay. The longer the object remains inside, the higher the risk of complications."
"If left untreated, it could affect her breathing or cause more serious damage."

9. Explain the Treatment Plan
"When she arrives, we'll repeat the X-ray to confirm the exact position of the object."
"Then we'll arrange for a procedure to remove it — usually using a small camera either through the mouth (called endoscopy) or via the airway (bronchoscopy)."
"She'll be carefully monitored throughout and treated by a specialist team."

10. Hospital Protocol – Duty of Candour
"I also want to reassure you that the hospital takes this kind of incident very seriously."
"This will be reported as a significant event, and a full investigation will be carried out."
"A senior clinician will speak to you directly, and the necessary steps will be taken to ensure this doesn't happen again."
"You also have every right to make a formal complaint if you wish — I can give you the contact details for the Patient Advice and Liaison Service (PALS), who are there to support you."

11. If Asked: "How did you miss it?" / "How will you prevent this?"
"Even though we followed the normal steps and did an X-ray, the object wasn't spotted during the initial interpretation."
"Thankfully, the radiologist's second review caught it."

"This incident will be investigated thoroughly. Personally, this has been a strong lesson for me — and if I ever see a similar case in the future, I will not hesitate to ask for a second opinion immediately."
"As a hospital, we will use this case to raise awareness and prevent similar mistakes from happening again."

12. Final Reassurance and Closing
"Mrs. X, I'm truly sorry this happened and that you're now having to go through all this again."
"We'll do everything we can to make sure your daughter is treated safely and quickly."
"Do you have any questions at all before we hang up? I'll stay on the line if you'd like to ask anything."

Missed Hairline Fracture

Setting: Emergency Department
Format: Face-to-face (parent and child present)
Role: FY2 doctor
Patient: Child seen two days ago for limb pain following a fall
Error: X-ray was reported as normal at discharge → later review by radiologist revealed a hairline fracture
Task: Explain the error, assess current symptoms, and arrange appropriate management

1. Professional Introduction & Agenda Setting
"Hello. I'm one of the doctors working in the emergency department today — thank you for coming back in with your son."
"I understand he was seen here a couple of days ago after a fall — and that he had an X-ray done."
"There's something important that came to light during a later review, and I'd like to go through everything with you carefully."

2. Brief History – Current Symptoms First
"Before I explain further, could I just check how your son is doing at the moment?"

- "Is he still having pain in his [arm/leg]?"
- "Is he able to move it?"
- "Has the pain worsened or improved?"
- "Is he able to walk/use the limb as usual?"
- "Any swelling, redness, or new symptoms?"
- "Has he been eating, sleeping, and playing normally?"

Confirms current status and rules out complications such as displacement, swelling, or neglect.

3. Confirm Parent's Understanding of Previous Visit
"And just to clarify — when you brought him in last time, do you remember what the doctors said?"

- "Do you recall what the x-ray result was at the time?"
- "Were you told that there were no fractures and it was likely just a soft tissue injury?"

4. Warning Shot – Prepare to Disclose the Error
"Thanks for that. I wanted to speak with you today because we've reviewed the case again, and unfortunately, something has come to our attention."
"There's been a development regarding the x-ray that was taken."

5. Chronological Narrative – Calm and Factual
"As part of routine practice, all X-rays taken in the department are reviewed later by a senior radiologist."
"Although the x-ray was initially thought to be normal, the radiologist picked up something on a closer look."
"Unfortunately, I'm really sorry to tell you — it looks like your son does in fact have a small hairline fracture in the [bone/area affected]."
"This was missed at the time of discharge, and I understand how concerning that must be to hear now."

6. Manage Parent's Reaction
Acknowledge: "I can see that this must be quite frustrating to hear, especially since you were told everything was fine."
Validate: "Anyone in your position would be upset and confused by this — it's completely understandable."
Empathise: "I'm truly sorry this happened. This was a clear oversight, and we take full responsibility for the delay in getting him the care he needed."

7. Address: "Will this cause long-term damage?"
"That's a very reasonable question, and I'm glad you asked."
"The good news is that hairline fractures are very small, and they don't usually cause any long-term complications — even if treatment is started a couple of days later."
"The bone is still in place, and children's bones heal very well. As long as we now protect the area properly, he should make a full recovery without any issues."

8. Explain Next Steps – Management Plan
"What we'll do now is repeat a clinical assessment to confirm the findings."
"Depending on the exact site of the fracture, we'll likely need to:"

- Immobilise the area (splint or cast)
- Refer him to the orthopaedic team for further advice
- Possibly do a repeat X-ray to reassess healing progress

"We'll make sure everything is done to support full healing and follow-up will be arranged if needed."

9. Hospital Protocol – Duty of Candour
"I also want to let you know that the hospital takes this sort of incident very seriously."
"This will be reported as a significant clinical event."
"There will be a formal review to understand what went wrong and how we can prevent it from happening again."
"You'll also have the chance to speak with a senior clinician from the department."

10. Offer PALS – Right to Complain
"Also, you have every right to make a formal complaint if you'd like."
"I can help you get in touch with the Patient Advice and Liaison Service — or PALS — who are there to support families in situations like this."

11. If Asked: "How did this happen?" / "How will it be prevented?"
"Although the x-ray was done correctly, the initial review didn't detect the small fracture — which can be difficult to see on first glance."
"This is why we have a system where radiologists double-check all images — but ideally, this should've been picked up earlier."

"There will be a full investigation, and recommendations will be made."
"Personally, as a junior doctor, I've learned a great deal from this and in future, I'll be more cautious and never hesitate to ask for a senior opinion if there's any uncertainty."
"We'll also make sure the whole department is aware of this, so that similar issues are discussed and prevented."

12. Final Reassurance & Closure
"Again, I'm so sorry this happened and that you had to come back in."
"The most important thing now is that your son gets the right treatment from here on — and we'll make sure that happens smoothly."
"Do you have any questions at all, or anything you'd like me to clarify?"

Missed Glass Piece in Leg

Setting: Orthopaedics
Format: Telephone consultation
Role: FY2 doctor
Patient: 3-year-old child brought in yesterday after beach injury
Error: X-ray reported as normal → consultant review today revealed a piece of glass in the leg
Task: Call the parent, explain the error, assess the child's current condition, and arrange management

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1. Telephone Opening & Identification
"Hello, am I speaking to Mr. X?"
"Hi, I'm Dr. Surname — one of the doctors from the orthopaedic department. I believe you brought your son to the hospital yesterday."
"I'm calling today because I've been asked to speak with you about something important regarding your child's recent visit."
"Is it okay if we talk for a couple of minutes?"
"Before I go on, can I please confirm your son's full name and age — just to make sure I have the right notes in front of me?"

2. Brief History – Yesterday's Visit
"I understand your son was brought in after hurting his leg — could you tell me a bit about what happened?"

- "What symptoms did he have when you brought him in — was there pain, swelling, or bleeding?"
- "Was he able to walk on the leg at the time?"
- "Did you notice any redness or discharge around the wound?"
- "Do you remember what tests we did?"
- "Was he given an X-ray?"
- "What were you told about the X-ray results yesterday?" *(Key question)*
- "What treatment did he receive — was he given painkillers, antibiotics, any dressing or a tetanus shot?"

3. Current Condition Check – Presenting Symptoms
"Thanks for clarifying that. Just so I understand how he's doing now:"

- "Is he still in pain?"
- "Is there any swelling or redness at the site?"
- "Is there any discharge or bleeding?"
- "Is he able to walk or stand normally?"
- "Is he eating, drinking, and playing as usual today?"

4. Warning Shot – Prepare for the Error Disclosure
"Mr. X, I really appreciate you going through that with me. The reason I'm calling is that we've reviewed your son's X-ray again today — and unfortunately, something's come to light that we need to discuss."

5. Chronological Narrative – Calm and Clear
"As part of our routine protocol, all X-rays are later reviewed by a senior consultant radiologist."
"Although the X-ray was initially thought to be normal yesterday, the radiologist picked up something that was missed in the first review."
"I'm really sorry to tell you that there is actually a small piece of glass visible in your son's leg on the X-ray."
Pause and allow the parent to react.

6. Manage Reaction
Acknowledge: "I completely understand that this may come as a shock, especially after being told everything looked normal."
Validate: "Anyone in your position would be concerned — it's completely understandable."
Empathise: "I'm truly sorry this was missed. It was a mistake on our part, and I want to reassure you that we're now taking the right steps to address it."

7. Explain the Need to Return – Emphasize Safety
"We'd like you to bring your son back to the hospital as soon as possible so we can remove the piece of glass and reduce the risk of infection or further complications."
"This is not something we would want to leave in the tissue, as it can cause pain, inflammation, or potentially infection."

8. Explain the Treatment Plan
"When you arrive, our team will assess the wound and may use a local anaesthetic to remove the piece of glass safely."
"Because the injury happened at the beach — which is a potentially contaminated environment — we may also give him a short course of antibiotics."
"If he hasn't already had a tetanus vaccine recently, we'll check his records and administer it if needed."
"He might also need a new dressing to protect the area."

9. Ask and Arrange Return
"Would you be able to bring him back to the hospital today?"
(If any resistance: "May I ask if there's anything making it difficult to come in?")
("Is there someone who could accompany you or help you bring him?")

"I know it's been a long day already, but this is important to treat now before it causes more discomfort or infection."

10. Hospital Protocol – Duty of Candour
"I also want you to know that the hospital takes this sort of incident very seriously."
"This will be reported as a significant clinical event."
"There will be a full investigation into how it was missed during the initial review."
"Necessary action will be taken according to hospital guidelines to reduce the chance of it happening again."
"A senior doctor will also be speaking with you personally once you arrive."
"And of course, if you wish to make a formal complaint, I can give you the details of the Patient Advice and Liaison Service (PALS), who support patients in these situations."

11. If Asked: "How did this happen?" / "Why wasn't it seen yesterday?"
"Glass can sometimes be difficult to detect on X-rays, especially if it's small and deep in the soft tissue."
"That's why we have a second review process where a radiologist looks at all images again in more detail — which is how this was caught today."
"I wish we had seen it earlier, but I'm glad we've picked it up now before it caused any serious harm."

12. Final Reassurance and Closing
"Mr. X, I want to apologise again that this was missed."
"We're going to make sure your son receives the right treatment now and that everything is done safely."
"Do you have any questions or concerns I can address before we end the call?"

Missed Femoral Fracture in Elderly Patient

Setting: Orthopaedics Ward
Format: Face-to-face consultation with angry relative
Role: FY2 doctor
Patient: 91-year-old woman from nursing home

Relative: Son with Lasting Power of Attorney (LPA)
Error: Initial X-ray reported as normal → patient treated with physiotherapy → CT done due to pain → CT showed femoral fracture → review of initial X-ray confirmed it was missed

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1. Professional Introduction & Acknowledge Anger
"Hello Mr. X, I'm Dr. Surname — one of the doctors involved in your mother's care here in the orthopaedics ward. First of all, thank you for coming in."
"I understand that you're upset about the information you've received from the nursing home, and I completely understand why you're feeling that way."

Acknowledge: "I can see you're quite upset."
Validate: "Anyone in your position would feel the same. There's absolutely no doubt about that."
Empathise: "I'm really sorry this wasn't communicated clearly earlier. I want to take full responsibility for making sure you now understand exactly what happened and what we're doing about it."

2. Seek Permission to Clarify – Start Focused History
"In order for me to explain everything clearly, would it be okay if I asked a few quick questions first?"

- "What have you been told so far about your mother's condition?"
- "How did you come to know about the fracture — was it through the nursing home staff?"
- "Has anyone from the hospital team spoken to you since then?"
- "Did you know about the X-ray that was done when she was admitted?"
- "Did anyone tell you about the CT scan that was done later?"
- "Have you been informed about any treatments being offered since then?"

"And just to clarify — you have lasting power of attorney, is that correct?"

- "Are you also the next of kin?"
- "Are there any other family members involved in her care?"
- "Apart from dementia, does your mother have any other long-term conditions that we should be aware of?"

This keeps the history tightly focused on what's necessary for context — without wasting time.

3. Explain the Error – Chronological Narrative
"Let me now explain exactly what happened, step by step."

- "Your mother had a fall at the nursing home and was brought into hospital."
- "We admitted her, and as per protocol after a fall, an X-ray of the hip was done."
- "At the time, the X-ray was reported as normal — so we assumed there was no fracture."
- "Physiotherapy was started to help her mobilise again."
- "However, during physio, she was clearly in a lot of pain and wasn't improving as expected."
- "Because of that, we did a CT scan to investigate further."
- "Unfortunately, the CT scan showed that she has a fracture in her hip — more specifically, a fracture of the neck of the femur."
- "We then went back and re-reviewed the original X-ray and found that the fracture was actually visible but had been missed."

4. Apology and Acceptance of Responsibility
"I'm really sorry that this happened. It's clearly a mistake on our part."
"We should have picked it up earlier, and we should have been more careful in reviewing the original images."
"Please accept our sincere apology."

5. Hospital Protocol – Duty of Candour (Cascade)
"We are taking this matter very seriously."
"This will be reported as a significant incident under our hospital's safety protocols."
"There will be a formal investigation to understand exactly how the error occurred."
"Necessary action will be taken to ensure this doesn't happen again."
"A senior member of the department will also be speaking with you directly."
"If you would like to make a formal complaint, you're absolutely entitled to do so — I can help you contact the Patient Advice and Liaison Service, or PALS, who support patients and families in situations like this."

6. Explain the Treatment Plan
"In terms of moving forward — our orthopaedic team has assessed the CT scan, and we will now be offering full treatment for the fracture."
"Her management plan may involve either conservative treatment with a cast or possible surgical intervention depending on her condition and mobility."
"She will remain admitted and cared for closely by our team, and all pain and mobility concerns will be managed carefully from here on."

7. If Asked: "Who made the mistake?"
"According to our records, the initial X-ray report came from the Department of Radiology — and that's where the fracture was missed."
"I want to be transparent with you — this wasn't picked up at the time, but it was later identified when we repeated imaging due to her ongoing symptoms."

8. If Asked: "How will you prevent this from happening again?"
"This incident will be thoroughly investigated, and lessons will be learned."
"We will be raising awareness across the team so that doctors and radiologists are more careful and vigilant during X-ray interpretation — especially in frail elderly patients where fractures can be subtle."
"We will also improve communication and supervision to make sure similar situations are flagged and acted on earlier."
"Personally, I can say that I've learned a lot from this already — and I'll be far more cautious and proactive in similar cases going forward."

9. Final Reassurance and Closure
"I truly understand how upsetting this has been for you — and again, I want to say how sorry we are that this mistake happened."
"We'll make sure your mother now receives the correct treatment, and that you're kept fully updated."
"If you have any questions or concerns, I'll stay here as long as you need."

Chapter 23: Colleague Related Scenarios

Colleague-Related Scenarios in PLAB 2 – Brief Introduction

These stations test your **professionalism, empathy, insight, and ability to maintain patient safety** when a fellow healthcare professional is struggling, behaving inappropriately, or raising concerns. You may be speaking to an FY1, medical student, nurse, or another colleague.
The goal is **not to investigate or discipline**, but to respond with **professional concern, clear communication, and supportive guidance**—while protecting patients and following **GMC Good Medical Practice**, **NHS expectations**, and your own duty of candour.

Key principles:

- Maintain **professional, non-judgmental tone**
- Address the **issue early and clearly**, without assumption
- Explore the **underlying causes** sensitively
- Explain the **implications** on patient care and professional conduct
- Offer **appropriate support** (Occupational Health, supervisor, pastoral services)
- Document and **escalate if needed** – always prioritize patient safety

Use a **structured, calm, and supportive approach** like the **SUPPORT framework**, which helps you cover all domains naturally. These scenarios are as much about demonstrating your own fitness to practice as they are about handling the colleague's concern.

SUPPORT Framework for Colleague-Related PLAB 2 Stations

S – Set the Stage

Start with a professional, warm introduction. Establish who you are, acknowledge previous interaction if relevant, and break the ice in a respectful, non-intrusive way.

Example

"Hi, are you __? I'm X, one of the FY2s on the team — I believe we met briefly last week. How's your rotation going so far?"

Key Pointers

- Be warm but professional — avoid being too familiar.
- If they're a medical student, ask how their studies are going.
- If they're a junior doctor, ask about how they're finding the workload.

U – Understand Their Side

After building rapport, gently bring up the concern. Use neutral, non-accusatory language, and invite them to share their perspective before jumping to conclusions.

Examples

- "I hope you don't mind me asking, but I've noticed a bit of a smell of alcohol — I just wanted to check in with you about that."
- "I've heard there was an incident on the ward this morning — I wanted to understand what happened from your point of view."

Then follow up with open-ended questions:

- "Can you tell me a bit more about what's been going on recently?"
- "Has anything been affecting you — either at work or outside?"
- "Have you been feeling overwhelmed or stressed lately?"

Why these matters (GMC alignment):

GMC expects doctors to take prompt action if patient safety, dignity or comfort may be compromised, including speaking up if a colleague's fitness to practise is in doubt.

P – Probe the Underlying Causes

Gently explore contributing factors: stress, burnout, illness, personal issues. Understand the *why*, without judging the *what*.

Questions to ask:

- "Have you been feeling under pressure?"

- "Is there anything affecting your sleep, mood, or wellbeing?"
- "Are you finding it hard to keep up with the workload?"

This helps you demonstrate **insight, empathy, and safeguarding of both colleagues and patients**, as per NHS and GMC guidance.

P – Provide Perspective and Reframe

Once you've understood their situation, explain **why the issue is serious** using NHS/GMC-aligned language — not to accuse, but to inform.

Examples

- "Even small amounts of alcohol can affect concentration or clinical judgment — and that could put patients at risk, even unintentionally."
- "What we post on social media, even privately, can be seen as a reflection of the profession. It's something the GMC takes seriously under professionalism and patient confidentiality."

Why these matter (GMC/NHS standard):

Doctors must make the care of the patient their first concern and act with integrity and professionalism at all times — including outside of direct clinical work.

O – Offer Supportive Solutions

Shift focus to helping them. Be clear that you're here to support, not punish. Offer appropriate resources:

- **Occupational Health** (for alcohol, stress, mental health)
- **Educational Supervisor** (if struggling with workload)
- **Debrief or mentoring** (if overwhelmed on the ward)
- **Confidential staff support services**

Example phrasing

"There's no shame in needing support — many of us do at some point. Would you be open to having a confidential chat with Occupational Health or your supervisor?"

R – Reassure and Normalise

Reaffirm that you respect their honesty. Remind them this can be a turning point, not a black mark.

Example

"I really appreciate how open you've been. This doesn't define you as a doctor. What's important is how you respond — and seeking support is absolutely the right step."

Professional Insight

GMC expects doctors to reflect on and learn from feedback, and take steps to maintain their wellbeing and performance.

T – Take It Forward Together

Close the loop with a shared plan. Clarify what will happen next and ensure they're comfortable. Encourage future communication.

Example

"So just to summarise — we'll link you in with Occupational Health and let your supervisor know that you might need a bit of extra support. Does that sound okay to you?"

Optional additions:

- "Would it help if I checked in with you again next week?"

- "If you ever need to talk again, I'm here."

Medical Student Repeatedly Arriving Late

Setting:
You are an FY2 doctor in the general surgery department.
A fifth-year medical student has been arriving one hour late consistently during the rotation.
This is your own ethical concern — no one asked you to address it.
Medical students in final year have a provisional GMC registration.

S – Set the Stage
"Hi there — are you one of the fifth-year medical students on this rotation? Thanks for taking a few minutes. I'm one of the FY2s here — I think we may have briefly met during handover the other day.
Before we start — how are you today?
How's the rotation going for you so far — are you managing to get what you need out of it?
And how's everything with fifth year generally? Busy time with finals coming up, I'm sure."
(Purpose: Friendly but professional tone. This builds comfort without acting overly familiar.)

U – Understand Their Side
"Thanks for that. The reason I wanted to have a quick word is that I've noticed you've been arriving a bit late on a few occasions — sometimes by nearly an hour. I just wanted to check — is everything alright? Is there anything that's been making it difficult to arrive on time?"
If denied:
"I completely understand, and I appreciate you sharing that. It's just something that's been noticed by a few members of the team, including nursing staff — so I thought it was worth checking in."

P – Probe Underlying Causes
(Take a full, supportive, non-judgmental lifestyle history)
"Do you live far from the hospital or nearby?"
"How do you usually get here — are you driving, using public transport, or being dropped off?"
"What time do you typically wake up for your shift?"
"Do you tend to sleep late or have trouble falling asleep?"
"What's your usual bedtime — do you stay up late doing anything in particular?"
If they mention gaming or internet use:

- "Do you play games regularly or casually?"
- "How much time do you usually spend on it each night?"
- "Are you involved in any streaming or competitive matches?"
- "Is it something you do to unwind, or has it started to interfere with your routine?"

If social media is mentioned:

- "Do you run any pages or follow particular content creators?"
- "Roughly how many hours a day would you say you're on it?"
- "Do you sometimes lose track of time while scrolling or posting?"

If alcohol is hinted at:

- "I hope you don't mind me asking — do you drink alcohol?"
- "How often would you say you drink in a week?"

- "Do you ever drink on nights before placement?"
- "Has anyone else ever commented that it might be affecting your mornings?"

Academic and emotional wellbeing check:

- "How are you finding fifth year overall?"
- "Are exams going okay?"
- "Are you managing the stress of placements and study?"
- "Are you sleeping and eating okay?"
- "Have you felt low, anxious, or unmotivated recently?"

P – Provide Perspective and Explain Implications

(Natural, clear, structured explanation – no threats, just facts.)

"I really appreciate your honesty — and I know how overwhelming fifth year can be.
I just want to explain why even seemingly small issues like timing can be significant — especially now that you're in clinical years and have provisional GMC registration."

Professionalism:

- "As future doctors, we're expected to uphold professional standards — and punctuality is part of that."
- "Whether it's for patient handovers, ward rounds, or theatre briefings, being on time shows respect and reliability."

Team dynamics:

- "If someone consistently arrives late, it can affect the morale of the whole team — especially in surgery, where punctuality is important for coordinated care."

Learning impact:

- "You may miss out on seeing key procedures, ward discussions, or teaching sessions. These are things that can't be repeated later."
- "Consultants and seniors might also assume a lack of interest, even if that's not the case."

Portfolio and references:

- "Your performance here contributes to your logbook and e-portfolio — and punctuality is something that consultants may comment on."
- "References for foundation year jobs often reflect your reliability and professionalism."

O – Offer Supportive Solutions

"If it's been more of a routine issue, would you consider adjusting your sleep cycle a little?
Maybe setting a consistent bedtime and avoiding screens late at night?"
"If social media or gaming is eating into your sleep, maybe try limiting usage to earlier in the evening — even shifting it by an hour could make a difference."
"If it's more than just routine — like if you've been feeling down, anxious, or burned out — I'd strongly encourage you to speak with your educational supervisor or the university's student wellbeing service. They've helped a lot of students through exactly this."

R – Reassure and Normalize

"I really respect that you've been open in talking about this — it's not always easy to acknowledge things that are affecting our performance."
"Final year is stressful, and we've all struggled at some point. What matters most is recognising it and acting early."

"You're not in trouble — this isn't about punishment. It's just a chance to get back on track before it affects your progress or learning."

T – Take It Forward Together
"So, how does this sound to you — would you be okay with trying to come in earlier starting tomorrow?"
"Would you be open to having a quick word with your educational supervisor too? Just to flag this and get some structured advice?"
"If I get a chance to speak with the team consultant, I might mention that we had this chat — just so they're aware you're addressing it. But that would only be to support you, not to report you."
Final check:
"Does that sound reasonable? Is there anything else I can help you with today?"

Colleague Smelling of Alcohol and Coming Late

Setting:
You are an FY2 doctor in the surgical department.
A fellow FY2 doctor has been observed arriving late, **smelling of alcohol**, and has been described by nurses as **clumsy** during patient care.
You have chosen to speak to them privately out of **professional concern**, without being asked to do so.

S – Set the Stage (with Proper Introduction and Rapport)
"Hi, do you have a moment? Would it be okay if we had a quick word in private?"
"Thanks — I appreciate you taking the time.
I'm X, one of the FY2s in surgery — I believe we've briefly met during handover last week."
(Pause briefly to soften the tone.)
"I just wanted to check how things have been for you lately. How are you finding the rotation so far?"
"Are you managing okay with the shifts and workload?"
"Has everything been alright outside of work as well?"

U – Understand Their Side
"I wanted to bring something up that's been on my mind.
Over the past few days, I've noticed a few things — and I just wanted to check in with you first, without assuming anything."
"I've noticed a smell of alcohol on you during a few morning shifts.
It's not just me — a couple of nurses have quietly mentioned it, and some patients have expressed concern that you seemed a bit off during interactions."
"There's also been a pattern of you coming in quite late — and all of this together made me think it's important we talk about it privately."
(Pause here to let them respond. Be open to their side.)

P – Probe for Underlying Causes
"I'm not here to blame or judge — I genuinely just want to understand if something's going on and whether you're okay."
Alcohol-specific history (conversational tone):

- "Can I ask — do you drink alcohol?"

- "Do you sometimes drink the night before work?"
- "Roughly how often do you drink during the week?"
- "Have you noticed it affecting how you feel in the mornings?"
- "Do you find yourself drinking more than you used to?"
- "Have you tried cutting back before?"
- "Do you ever feel shaky or unwell if you don't drink?"

Work and routine:

- "Have you been struggling to wake up on time lately?"
- "How's your sleep been?"
- "Is it hard to fall asleep, or do you tend to stay up late?"
- "Are there any personal stresses at home or outside of work that might be contributing?"

Direct patient involvement check:

- "Have you been involved with any patients today?"
- "Have you prescribed, discharged, or done any procedures today?"
- "Do you have a list of the patients you've reviewed this morning?"

(Don't over-medicalise or use CAGE. Keep it natural and focused on insight and concern.)

P – Provide Perspective (Explain Why This Matters)

"Thanks for being honest — I really respect you for that.
I just want to explain why I felt it was important to raise this."

Professional conduct and image:

- "As doctors, even the **appearance** of being under the influence is enough to cause concern. Patients trust us to be clear-headed and safe at all times."
- "When you come in smelling of alcohol — even if you feel fine — it can raise serious doubts among patients and staff."

Patient safety:

- "Alcohol, even in small amounts from the night before, can affect our alertness and decision-making. In surgery especially, that can pose real risks — not just to patients, but to the whole team."

GMC accountability:

- "We're part of a regulated profession. Even if nothing has gone wrong yet, this kind of concern — if it were escalated formally — could have professional consequences."

(Tone: calm, clear, and focused on safety, not guilt.)

O – Offer Support and Solutions

"I'm not here to punish or lecture — I just want to help you take the right next step now before this gets any worse."

Immediate actions:

- "I'd recommend that you **don't continue seeing patients today** — just to be on the safe side."
- "We can ask someone to cover your list — the priority right now is making sure patients are safe and that you're okay."

Next steps for you:

- "Would you be open to speaking with your GP or Occupational Health? They can support you confidentially with alcohol concerns or stress."
- "There's also a doctor support line and wellbeing service in the trust that's very approachable."

My own steps:

- "As part of my responsibility, I will need to **speak with the on-call consultant** today.
  This isn't to report you — but because you've seen patients and it's a safety issue, and they need to be aware."

R – Reassure and Normalize

"I want to be really clear — this is not the end of the world.
What matters is that you're open and willing to get help."
"Everyone struggles at some point. You're not alone. Many doctors have gone through this and come back stronger.
You're doing the right thing by facing it now."

T – Take It Forward Together

"So here's what we'll do:

- You'll head home now — and rest.
- I'll make sure the shift is covered, and patients are looked after.
- I'll speak with the consultant today so we can document things properly.
- I really encourage you to speak to your GP or Occupational Health within the next couple of days — just to get some proper support."

"Does that sound okay to you?
Is there anything you want me to pass on to the team or anything else you need right now?"

FY1 Doctor Smelling of Alcohol

Setting:
You are an FY2 in the surgical department.
You've been asked to speak to an F1 colleague who is **currently on shift**, has been **smelling of alcohol**, and has reportedly interacted with patients.
This is a new, acute concern — not a long-standing issue.

S – Set the Stage (Warm, Professional Introduction)

"Hello — I'm X, one of the FY2s on the surgical team. I believe we've briefly worked together during handover earlier this week."
(Brief pause, professional tone.)
"Thanks for taking a moment. I just wanted to have a quick word as a colleague — nothing formal — about something that's come up today."
(Gentle tone, friendly but focused.)
"But before we go into that, how have you been lately?
Are you managing okay with the rota and workload?
Is everything alright outside of work as well?"

U – Understand Their Side (Raise the Concern Gently)

"I'll come straight to the point, if that's okay.
I wanted to have a word because today I've noticed a smell of alcohol, and it's something I've picked up more than once."

"I just wanted to check in with you directly and hear your side — have you had anything to drink recently?"
(If they respond with frustration or say "Yes, everyone drinks")
"I completely understand — I'm not here to judge or criticise. I just want to talk openly because this is a safety-sensitive environment, and I want to make sure you're okay."

P – Probe for Underlying Causes (Acute Alcohol History)
"Thanks for your honesty. Can I ask a few questions just to understand better what's been going on?"

- "How long have you been drinking recently?"
- "Has anything happened recently that's triggered this?"
- "Has this started in the last couple of weeks, or has it been longer?"
- "Are you drinking daily or just on certain nights?"
- "What sort of alcohol are you drinking?"
- "Roughly how much do you have when you do drink?"
- "Have you ever come into work after drinking?"
- "Have you ever had a drink while on duty — during breaks, night shifts, or after lunch?"

(If they mention a breakup, stress, or personal issue:)
"I'm really sorry to hear that — breakups can be extremely difficult, especially with the pressure we're all under at work."

P – Patient Safety and Clinical Involvement
"Can I just check — have you seen any patients today?"

- "Roughly how many?"
- "Were you involved in any procedures or prescribing?"
- "Have you written any discharge or admission notes?"

(This helps clarify potential patient exposure and determine urgency of escalation.)

O – Offer Support and Explain Implications Clearly
"I really appreciate how open you've been, and I want to explain why I'm bringing this up."
Lay out the implications calmly, with no judgment:

- "As doctors, we're held to a high standard — and even the smell of alcohol during a shift raises serious concerns."
- "It can damage trust with patients and staff, and make people question whether we're fit to practice."
- "Even alcohol from the night before can impair your judgment, concentration, or physical coordination — especially in high-pressure environments like surgery."
- "We're in a regulated profession. If this were formally reported, it could lead to an investigation by the GMC."

R – Reassure and Normalize
"I want to reassure you — this conversation isn't about punishing you or making you feel like you've failed. You're clearly going through something, and what matters now is recognising it and taking the right next step."
"You're not the first doctor to feel overwhelmed or turn to alcohol after a difficult life event — what matters is getting support early."
"This doesn't define you. I know you're capable, and I'm here to support you through this."

T – Take It Forward Together (Clear Next Steps)
"Here's what I think we should do now, and I'll help you through each step."
Immediate actions:

- "You'll take a break from clinical duties for the rest of the day."
- "I'll take over your patient list and ensure anything urgent is followed up."
- "I will also speak to the on-call consultant. Not as a report — but because you've been involved with patient care today, and they need to be aware for safety reasons."

Support for the colleague:

- "I strongly encourage you to speak with your GP or Occupational Health — they can offer support confidentially, and help you manage what you're going through."
- "You might also want to speak to your rota coordinator about taking some leave — even a short break might help you reset."

Encouragement:

- "The fact that you're able to talk about it shows real insight — and that's a strength, not a weakness."

Final check:
"Does that plan sound okay to you?
Is there anything you need from me right now or anything you'd like me to tell the team on your behalf?"

Medical Student Taking Drugs

Setting:
You are an FY2 doctor in the surgical department.
Yesterday at a department party, you saw a fifth-year medical student sniffing a white powder, suspected to be cocaine.
This morning, departmental staff have been discussing the incident, and the student is noticeably hyperactive.
He has interacted with clinical areas but is not licensed or treating patients directly.
You are now addressing this concern.

S – Set the Stage (Warm, Professional Introduction)
"Hello — I'm X, one of the FY2s on the surgical team. I believe we've worked together a few times during this rotation."
(Maintain a friendly but professional tone.)
"Thanks for stepping in. I wanted to have a quick word — just as a colleague — about something that came up, and I thought it'd be best to speak directly."
"But before we go into that — how have things been with you lately?
How are you finding the rotation?
And how are things going with medical school — exams, placements, all that?"
(Expect a slightly hyperactive or defensive tone; remain calm and steady.)

U – Understand Their Side (Raise the Concern)
"Actually, what I wanted to talk to you about was something I observed at the departmental party last night."
"I was there too — it was nice seeing everyone outside of work. Did you enjoy it?"
(Pause briefly, then continue with a serious tone.)
"While I was there, I noticed you and another person sniffing a substance. From what I could see, it looked like it might have been cocaine. I wanted to ask directly — do you take any drugs at all?"

P – Probe for Underlying Issues (Denial, Deflection, Admission)

If they deny it:

"I understand — but just so you're aware, this has also been discussed by staff this morning.
You also seem noticeably more energetic today than usual — which is why I felt it was important to talk."

If they deflect (e.g., "Everyone drinks — do you take alcohol?"):

"Well, personally, I don't drink alcohol or take drugs. But this isn't about me — it's about whether there's something going on that could affect your training or safety."

If they say "Maybe I did," or admit it:

"I appreciate your honesty. I'd like to understand a bit more, if that's okay."

Take a focused, simple drug history:

- "How often do you take drugs?"
- "On what occasions do you usually use them?"
- "Where do you get these substances from?" *(Important for legal risk.)*
- "Have you ever had any involvement with the police or legal problems related to drugs?"
- "How long have you been using recreational substances?"
- "Apart from cocaine, do you take any other substances?"
- "Do you inject anything at all?"

Ask about academic functioning:

- "How are your studies going?"
- "Have drugs ever caused you to miss a class, tutorial, or placement?"
- "Are you currently on track with your exams?"

Ask about alcohol use:

- "Do you drink alcohol regularly?"
- "How often and how much would you say you drink?"
- "What kind of alcohol do you usually drink?"

Ask about patient contact today:

- "Have you seen any patients today?"
- "Have you been involved in any history taking, examination, or written notes?"
- "Have you handled any prescriptions or discharge documents?"

P – Provide Perspective and Explain Serious Implications

"Thanks for being honest with me — I really appreciate you speaking openly."

Explain clearly and simply why this is a serious concern:

- "As medical students and doctors, we're held to a very high professional standard — and drug use isn't allowed under any circumstances, even privately."
- "The medical profession is regulated by the GMC. Recreational drug use is considered a breach of fitness to practise — whether it happens on a weekend, at a party, or during university."
- "Even occasional use can affect your eligibility to qualify as a doctor. If this were to be formally investigated, it could prevent you from being granted a license."
- "In some cases, medical schools may award a BSc instead of an MBBS — which would end your clinical career."
- "Drugs also carry the risk of addiction — and even occasional use can become regular. Once that happens, it may affect your ability to function safely as a clinician."

O – Offer Support and Immediate Solutions

"Look, what's most important now is that you get the right support — and take steps to stop this from becoming more serious."

Practical, non-punitive advice:

- "First, please do not use any recreational drugs again — not even socially."
- "Second, you should speak to someone you trust. That could be your educational supervisor, a university mentor, or the student support team."
- "There are counsellors and wellbeing services who work specifically with medical students — they can help you understand what to do next."

Your actions:

- "I will also need to speak to the consultant leading the team today — not to report you, but to discuss how we can support you appropriately."
- "You've been on the ward, and it's important that the team knows so we can ensure everything is handled professionally."

Offer follow-up:

- "I'd also like to check in with you again next week — just to see what steps you've taken and how things are progressing. We'll talk again and plan from there."

R – Reassure and Normalize Support

"I understand this must feel overwhelming — but your career is not over."
"You've made a mistake, but you've also had the insight to talk about it.
And as a medical student, there's a lot of support available to help you move forward."
"The medical school, unlike the GMC, is often more flexible — especially when you engage early and honestly. They want to help you qualify safely."

T – Take It Forward Together

"So just to summarise —

- You'll reach out to someone at the medical school — maybe your student support officer.
- I'll speak with our consultant so we can support you here.
- And you and I can talk again next week to follow up."

"Does that sound reasonable?
Is there anything you'd like me to pass on to the team, or anything else I can do right now?"

Social Media Misconduct – Tweets About Patients and Staff

Setting:
You are an FY2 doctor in the surgical department.
A colleague (another FY2) has approached you to raise concerns about a junior doctor (FY1) who has posted tweets about patients and consultants — including inappropriate language and a video that may risk confidentiality.

S – Set the Stage

"Hello — are you ___? I'm X, one of the FY2s on the surgical team. I believe we've worked a few shifts together recently."
(Warm and professional tone.)

"Thanks for reaching out. I understand you wanted to discuss something — before we go into it, how are you finding the rotation so far?
Is this your first post? Have you been settling in alright?"
(Purpose: brief rapport, professional tone, sets up a safe space without being over-familiar.)

U – Understand Their Side
"So, you mentioned you wanted to talk — what's on your mind?"
(Let them explain the issue in their own words without interruption.)
"Okay, I see. Just so I understand clearly — you're concerned about some things a colleague posted on social media?"
"Thank you for sharing that with me — I can see this must have been difficult to bring up."

P – Probe for Details
"Could you tell me exactly what was posted about the patient?"
"Was it a written tweet, a photo, a video, or a combination?"
"What was visible in the video — could you see the patient's face or any part of their body?"
"Was there anything in the post that could be used to identify the patient — like their name, diagnosis, or bed number?"
"What kind of comment was made about the consultant or other team members?"
"Have you noticed how others have reacted to the posts? Are they being shared or talked about by colleagues?"
"Do you know if the tweets are still public?"
"Have you had a chance to speak to the person who posted it?"
(If not): "That's understandable — may I ask what made you hesitate?"
(Purpose: Gather all factual details in a calm, non-leading way before drawing any conclusions. Separate from explanation.)

P – Provide Perspective
"Thanks for explaining all of that. I'd like to take a moment to share why this is a serious concern — not to alarm you, but to explain what's at stake."
Professionalism:
- "As doctors, we're expected to maintain professional conduct at all times — even outside of work."
- "Making critical or mocking comments about patients or colleagues online is considered unprofessional."

Confidentiality:
- "Even if no names are mentioned, images or comments that involve patient care — especially if a patient's body is shown — can potentially breach confidentiality."
- "The moment something is posted online, we lose control over who sees it and how it's interpreted."

Public Trust and Perception:
- "Patients and the public place a great deal of trust in us. Seeing content like that can damage their confidence in our professionalism and our care."

GMC Guidance:
- "This kind of behaviour doesn't align with GMC Good Medical Practice, which includes specific guidance on how doctors should behave on social media."
- "We're expected to show the same professionalism online as we do on the ward."

(Use "can be" a breach – not definitive legal claims.)

O – Offer Supportive Solutions

"You've done the right thing by raising this. The goal now is to help that colleague understand the risk and correct things before it escalates."

Use the DELETE – TALK – READ framework:

1. **Delete**
   "The first step is to make sure the posts are taken down. Even if the damage seems minor, deleting them quickly can help prevent further consequences."
2. **Talk**
   "If you feel comfortable, I'd suggest speaking to them yourself — just to let them know quietly that this may cause issues.
   You're actually doing them a favour by flagging it early."

(If they're uncomfortable:)

"I'm happy to speak to them myself or bring in a senior to handle it more formally if needed."

3. **Read**
   "They should also have a look at the GMC's guidance on social media — it's a short document but really clear about what is and isn't okay."

R – Reassure and Address Concerns

"I know this probably feels awkward — but it's far better to catch something early than let it become a complaint or a formal investigation."

If asked "Will they get in trouble?"

- "It's hard to say what might happen — but if the content is removed quickly and no harm was caused, then it's likely that this can be dealt with quietly and constructively."

If asked about anonymity:

- "I understand you'd prefer to stay out of it. I think we can manage this in a way that keeps things calm and discreet — the focus is on supporting our colleague to do the right thing."

T – Take It Forward Together

"So just to recap our plan:
– We'll make sure the posts are taken down.
– We'll either speak with the colleague directly or involve a senior for support.
– And we'll make sure they're pointed towards the GMC's guidance on social media."

"Does that sound okay to you? Would you like me to take the lead, or would you prefer to speak to them with someone?"

"Thank you again for coming forward — it shows real insight and responsibility."

Facebook - Adding patients

Setting:

You are an FY2 doctor in the surgical department.

A staff nurse has approached you regarding concerns about a junior doctor (FY1) who is allegedly **adding patients and their relatives on Facebook**, **possibly receiving gifts**, and **blurring professional boundaries**.

S – Set the Stage
"Hello — ___, right? I'm X, one of the F2s here on the surgical team.
Thanks for taking a moment to speak. I understand you wanted to raise something — but before we go into that, how have you been?
How's the department been treating you lately?"
(Short pause. Keep the tone professional and warm without over-familiarity.)

U – Understand Their Side
"I understand you mentioned wanting to speak with me — what's been happening?"
(Let the nurse describe the situation in their own words. Listen attentively and without interruption.)
"Thank you for letting me know. Just to clarify, the concern is about a colleague using Facebook in a way that may involve patients?"

P – Probe for Details
"Can you tell me more about what you've been noticing on Facebook?"
"Is he adding patients directly, or are their relatives also being included?"
"How did this come to your attention — are you connected to him on Facebook?"
"Roughly how many people do you think he's added? Is it just a few, or quite a lot?"
"Does it seem like he's just being friendly, or does it come across as more personal?"
"Has he posted or commented anything clinical — like advice, medical discussions, or treatments?"
"You mentioned gifts — what kind of gifts are we talking about?"
"Do you know how often he's receiving these? Are any of them particularly expensive?"
"Have you seen or heard of patients giving sweets or small presents, or anything more than that?"
"Apart from Facebook, how is he in general? Is he providing good patient care?"
"Have you noticed any other boundary concerns, like meeting patients outside of hospital settings?"

P – Provide Perspective and Explain Implications
"Thank you for being open about all this. I just want to explain why this situation can be problematic — not to alarm anyone, but so we're clear on the implications."
Social Media and Professional Boundaries:

- "As doctors, we're not permitted to add or communicate with patients via personal social media — even if it seems harmless."
- "Accepting Facebook friend requests, or attending patients' personal events like weddings or birthdays, crosses professional boundaries."
- "It may come across as friendly, but it can cause confusion about the professional relationship and lead to ethical issues."

Gift Reception:

- "Receiving gifts isn't strictly wrong — small tokens like sweets or thank-you cards can be acceptable."
- "But there are rules: gifts should be received on behalf of the **entire team**, not individuals, and expensive gifts should always be avoided."
- "Gifts over £50 must be documented and declared — usually with the Patient Advice and Liaison Service or in the doctor's appraisal portfolio."
- "Different hospitals have specific policies, but generally speaking, transparency is key."

Public Trust and GMC Standards:

- "If patients or colleagues become aware of boundary crossings — whether online or in person — it can damage trust in the doctor and in the profession."
- "The GMC considers this a breach of Good Medical Practice. We're a regulated profession and are expected to maintain proper boundaries and integrity at all times."

O – Offer Supportive Solutions

"So the next step is to make sure the colleague involved understands this and is given a chance to correct things professionally."

Recommended actions:

- "We should advise him to **unfriend any patients** he's added on Facebook and stop engaging with them via personal platforms."
- "He should be encouraged to **read the GMC guidance** on professional boundaries and use of social media — it's a short but clear set of principles."
- "It would also be helpful for him to **review the hospital policy** on gift reception and start recording anything he receives in a transparent way."

Offer to take the lead:

- "If you don't feel comfortable discussing this with him yourself, I'm happy to take responsibility and speak to him directly."

R – Reassure and Normalize

"Thank you for raising this. I know it can feel awkward, but you've done the right thing — not just for patients, but to protect your colleague before things escalate."

If the nurse expresses hesitation:

- "That's perfectly understandable. You're not trying to get him in trouble — you're actually helping him avoid future problems."

If the nurse highlights that his clinical care is good:

- "That's very important — good clinical care is the foundation of trust. This makes it even more worthwhile to help him correct these smaller issues before they affect his reputation."

T – Take It Forward Together

"So to summarise:
– We'll make sure he unadds any patients from Facebook.
– We'll encourage him to read the GMC guidance and review hospital policies on gift reception.
– I'm happy to speak with him myself to handle this discreetly.
– And we'll make sure it's dealt with supportively, without confrontation."
"Does that sound okay to you?
Would you prefer that I handle it entirely, or is there anything you'd like to be involved in?"
"Thanks again for raising this — it's a mark of true professionalism."

Posting Inappropriate Comments About a Patient on Facebook

Setting:

You are an FY2 doctor in the Emergency Department.
You've seen a Facebook post made by an FY1 colleague describing a psychiatric patient with mocking language

and possible identifying details.
You are now speaking directly to the doctor in a private cubicle to address this concern.

S – Set the Stage
"Hello — I'm X, one of the F2s here in the Emergency Department.
I think we've worked together on a few shifts recently."
(Maintain a neutral, professional tone.)
"Thanks for taking a moment to chat. Before we get into the reason I wanted to speak with you, how's everything going?
How are you finding the rotation so far?"
(If they respond enthusiastically or mention personal outings, respond politely but don't engage deeply.)

U – Understand Their Side
"Actually, I wanted to speak with you about something I came across recently.
It's regarding a post I saw on your Facebook account, and I thought it was important to discuss it directly."
"It seemed to mention a patient, and I wanted to understand your side first — before we talk about anything else."
(Pause to let them speak. If they downplay it or laugh, maintain a calm and serious tone. Do not engage in humour or show agreement.)

P – Probe for Details
"Just to clarify — the patient you mentioned in your post, who claimed to be the Queen — was that someone we've treated recently?"
"Where was the patient being seen? Was it in our ED?"
"Were you directly involved in this patient's care — or was it a case you observed?"
"Do you know whether this patient has the capacity to understand and make decisions?"
"Have you ever interacted with them in a clinical context, or was this just from observation?"
"Was the patient accompanied by anyone — or from a care home or facility?"
"Do you know what the formal diagnosis was, or who the consultant in charge was?"
"Regarding Facebook — do you identify yourself as a doctor on your profile?"
"Who can see your posts — are they public or only shared with friends?"
"Is it possible for people to share your posts or take screenshots?"
"Since posting, have you noticed how others have responded — comments, reactions?"
(This phase ensures a full understanding of the clinical, ethical, and digital context of the post.)

P – Provide Perspective
"Thanks for explaining — I want to be honest with you about why I felt this was something we needed to discuss."
Confidentiality breach:

- "Any post that describes a patient — even without using their name — can potentially be a breach of confidentiality."
- "Details like behaviour, diagnosis, or circumstances, especially in a small department, can easily be recognised by others."

Loss of control on social media:

- "Once something is shared on social media, it's essentially public. Even if it's on your personal page, people can screenshot or share it, and you lose control over how far it spreads."

Unprofessional language:

- "Referring to a patient as 'insane' and adding 'haha' makes the situation seem mocking or dismissive — which is inappropriate, especially when we're dealing with vulnerable patients."
- "Using that kind of language doesn't reflect the values of our profession — it can affect how people view us as clinicians."

GMC standards:

- "This kind of post doesn't align with **GMC Good Medical Practice** — which includes guidance on using social media responsibly and maintaining professional behaviour at all times."

O – Offer Supportive Solutions

"The most important thing now is to correct it quickly — and learn from the experience."

What they should do:

- "I'd strongly recommend you delete the post immediately — even if you think it was lighthearted, it's been seen, and it's best to take it down."
- "You should also take a few minutes to review the GMC guidance on social media use. It's concise and really clear on what's acceptable."
- "If you're ever unsure in future, it's better to check or ask before sharing anything related to work."

Offer non-judgmental support:

- "I'm not here to escalate or report — I'm trying to help you avoid further consequences and understand how to move forward professionally."

R – Reassure and Address Concerns

If they ask, "Am I in trouble?"

- "It's hard to predict how far something like this might go. Sometimes these posts are shared more widely than expected — and if someone takes offence or reports it, it could become a formal issue."
- "However, if it's deleted quickly and there's no further harm done, then hopefully it can be treated as a learning point."

"The main takeaway here is that anything patient-related — even without names — is never safe to share online. It's a lesson many of us have to learn early in our careers."

T – Take It Forward Together

"So to summarise:
– Please delete the post as soon as possible.
– Have a read through the GMC's Good Medical Practice guidance — especially the section on social media.
– And if you'd like, I can check in with you again next week just to make sure everything's okay."
"Does that sound alright to you?"
"Thanks for listening — I know this wasn't easy to hear, but I really appreciate you taking it seriously."

Delay in Discharge Summary

Setting:
You are an FY2 doctor on a busy medical ward.
A patient's family became frustrated and lodged a complaint because the patient's **discharge was delayed**, even though they were told they'd be going home that morning.

The reason: the **discharge summary hadn't been completed by the FY1**.
You've been asked by the **ward manager** to speak with the FY1, offer support, and find out what happened.

S – Set the Stage
"Hi — thanks for taking a minute. I just wanted to catch up with you about something that came up earlier."
(Gentle tone, friendly but focused)
"This isn't anything formal or disciplinary — just a quick check-in.
I understand from the ward manager that one of the patient's families was quite upset today. They'd been told their relative was being discharged but ended up waiting most of the day — and the discharge summary hadn't gone through yet."
(Pause. Tone softens.)
"I know how intense the shift can get — I just wanted to hear how your day's been, and whether there's anything we can do to make it easier going forward."

U – Understand Their Side (Expanded History-Taking)
"How's your shift been today overall?"
"What was your morning like after the ward round?"
"Did you already know this patient was due for discharge today — or was it added on short notice?"
"When were you first aware that the family was waiting for discharge?"
"Did you get a chance to speak with them — or were you tied up with other tasks?"
"How were you managing your workload at that point? Was this something you were planning to get to?"
"How are you feeling about how things went today?"
(Purpose: gather honest account, identify awareness of the situation, and gauge emotional response. Leave plenty of room for them to explain – this helps build trust and avoids defensive responses.)

P – Probe for Causes (Deeper Exploration of Contributing Factors)
"Was there anything that made it harder to keep up today? For example:
– Was anyone unexpectedly off the rota?
– Did you have to review any unwell patients suddenly?
– Were there multiple discharges or unplanned admissions?"
"Were you on your own for a chunk of the shift — or was there anyone else available to share the load?"
"Did any other urgent tasks come up — like cannulas, reviews, or medication issues?"
"Have you had a similar situation before — or was this your first experience of a patient family escalating a concern?"
"Did you feel like there was space to ask for help at the time — maybe from the nurse-in-charge or the senior?"
"Do you usually complete discharge summaries right after the ward round, or do you hold off until later?"
(Goal: understand task prioritisation, time pressure, clarity of responsibility, and help-seeking culture.)

P – Provide Empathy and Validation
"It sounds like you were really up against it today. Honestly — when you're trying to juggle sick patients, multiple discharges, and constant bleeps, it's no surprise something slipped through."
"Most of us have had that moment — the first time a patient complaint lands on you, it feels bigger than it is. But it's also a normal part of learning."

"The fact that you've shown up today, still working and reflecting on it — that says a lot. You're clearly someone who takes your job seriously."
"It doesn't mean you're not good at what you do — it just means today was one of those overwhelming days."

O – Offer Practical Support and Solutions
"Would it help if we looked at a few ways to make discharge days a bit easier?"
Tactical suggestions:

- "One thing that's helped me is writing discharge summaries **during the ward round itself** — or immediately after, even if it's just in rough."
- "I started keeping a **simple list by my workstation**: discharges, cannulas, referrals. I check them off as I go — it sounds basic, but it genuinely helps."
- "Even if you're running behind, just letting the patient or family know — something like, 'Still finishing up your paperwork, might be another hour' — really helps manage expectations."

Help-seeking and escalation:

- "Next time you're swamped — even just feeling pulled in every direction — don't hesitate to say something. Speak to me, the nurse-in-charge, or your reg.
  That's not weakness — that's good teamworking."

"Do you have a few summaries left now? If so, I'm happy to give you a hand with those."

R – Reassure and Motivate
"Look — I've seen you work. You care, you try, and you show up. That's what matters."
"One complaint doesn't reflect your ability as a doctor. It just means you're learning under pressure — like we all did."
"And honestly — how you handle this now is more important than the delay itself. You're taking responsibility, thinking it through, and you're open to learning. That's professionalism."
"Also — check in with yourself too. If this keeps happening, or you ever feel like it's getting too much, please don't bottle it up. Speak to one of us early — we'd always rather help than let you struggle quietly."

T – Take It Forward Together
"Would it be helpful if we briefly caught up after handover tomorrow to plan out which patients are due for discharge early — and flag them ahead?"
"We could also suggest that the nurse-in-charge gives us a heads-up when there are multiple families waiting — just so we prioritise who's going home first."
"Let's check in again at the end of the week — even just a quick chat — to see how things are going. And if anything feels off before then, you know where to find me."

Repeated Task Dumping by Another FY2

Setting:
You are an FY2 doctor.
A fellow FY2 has approached you to talk privately about an ongoing issue.
They are being regularly messaged by another FY2 during shifts to take over tasks such as **chasing bloods**, **reviewing patients**, or **completing jobs unrelated to their own list**.
They feel uncomfortable but are unsure how to say no.

S – Set the Stage
"Thanks for taking the time to talk. I'm here to listen, so please feel free to tell me what's been happening."
(Maintain an open, relaxed posture and a non-judgmental tone.)
"I really appreciate you reaching out early. It's important that you feel safe and respected at work — and whatever the issue is, we'll try to find a constructive way forward."

U – Understand Their Side (Expanded History)
"Can I ask how long this has been going on?"
"What kind of tasks are they usually asking you to do?"
"Is it during your shared shifts — or do they message you even when you're covering different areas?"
"Have you found that it's affecting your ability to manage your own responsibilities?"
"Has this ever led to missing important jobs or delaying your patient care?"
"Have you ever had a chance to tell them directly that this isn't okay — or has it been difficult to bring up?"
"How has this situation been making you feel personally?"
"Do you find yourself dreading shifts where you're scheduled together — or checking your phone with anxiety?"
"Are you worried that saying no might affect your evaluations, relationships, or team dynamics?"
(Let them speak freely. Validate any emotional distress. Allow room for them to explain how the situation has grown or changed over time.)

P – Probe for Causes and Context
"Do you think the other doctor is genuinely overwhelmed — or does it feel like they're just passing work to you inappropriately?"
"Have you seen them do this with others — or do you feel like you're being singled out?"
"Do you think there's any dynamic between you — maybe prior friendship, seniority, or informal expectation — that's making it hard to say no?"
"Has this escalated over time — or did it start off feeling like a one-off favour?"
"Do you think they're even aware of the pressure this is causing you — or do they assume you'll always help?"
(Purpose: This allows the examiner to see that you're not just listening but analysing interpersonal, structural, and emotional context fairly.)

P – Provide Empathy and Validation
"It sounds like you've been put in a really difficult position — trying to be helpful, but now it's becoming completely unsustainable."
"You're not being unreasonable at all. It's absolutely okay to protect your own workload and your boundaries."
"You're not alone — a lot of junior doctors face this at some point, especially when roles blur under pressure. But it's good that you're speaking up before it starts affecting your patient care or well-being."
"You've handled this very professionally already — and it's brave to bring it up before it builds up any further."

O – Offer Practical Support and Solutions
"Can I share a few things that might help you manage this going forward?"
1. Setting Clear Boundaries
"It's perfectly professional to say no when your own responsibilities are full. You could try something like:
'I'm sorry, I'm tied up with my own list just now — I won't be able to take that on.'
The tone matters — it can be polite, but clear."

"You're not refusing to be a team player — you're just drawing a fair line so patient care isn't compromised."

2. Keeping a Record

"It may help to keep a brief note or screenshot of any repeated messages — not to escalate straight away, but in case this becomes a pattern or you need to justify your concern."

3. Escalation Channels (Natural Tone)

"If it continues, or if it starts affecting your well-being or performance, you're completely within your rights to speak to your **clinical supervisor** or **educational supervisor**. They'll take it seriously."

"If you're not sure about making it formal, you could get advice from the **Freedom to Speak Up Guardian** — everything stays confidential, and they're there exactly for this sort of situation."

4. Well-being Support

"If you've been losing sleep, feeling more anxious, or emotionally drained — I'd really suggest speaking with **Occupational Health** too. They're very supportive, and it's not recorded on your training file. It's just about keeping you safe and supported."

R – Reassure and Motivate

"You've handled this with a lot of thought already — and your instinct to speak up shows insight and integrity."

"You're not letting anyone down by setting boundaries. In fact, protecting your mental space means you're able to care better for your patients."

"Raising concerns isn't about getting someone in trouble — it's about protecting your ability to work safely, and keeping the ward team balanced."

"There's nothing wrong with being kind — but kindness shouldn't come at the cost of your own well-being."

T – Take Forward Actions Together

"Would it help if we thought through a few calm but confident replies you could use next time they message you?"

"I'm also happy to check in with you later this week — just to see how things are going."

"And if things do change — like the tone of messages becomes inappropriate, manipulative, or makes you feel unsafe — please escalate it straight away.

You deserve a respectful and safe work environment."

Red Flag Pitfalls – Colleague and Professionalism Cases

In PLAB 2, colleague scenarios test your ability to communicate serious issues like lateness, alcohol misuse, unprofessional behaviour, boundary violations, or concerns about patient safety with empathy, clarity, and a strong understanding of GMC guidance. These scenarios require a tone that is firm but fair, supportive but structured.

1. General Principles for All Colleague Scenarios

- Always maintain a professional tone, even if the colleague is dismissive, casual, or emotional.
- Start with a brief, respectful introduction — never assume the colleague knows you.
- Focus on patient safety and professional standards, not personal judgement or gossip.
- Be supportive, but avoid being overfamiliar, vague, or overly casual in serious discussions.
- Avoid giving the impression that issues can be ignored, covered up, or managed informally.
- Consult with a senior or supervisor in all serious or unresolved cases — this must always be part of your plan.
- Document concerns where appropriate and offer clear next steps for follow-up and support.

2. Lateness, Poor Engagement, or Disinterest (e.g., FY1 showing up late or distracted)

- Acknowledge the concern but approach with kindness and curiosity, not accusation.
- Avoid phrases that trivialise the issue (e.g., "Can you just come earlier next time?").
- Never offer conditional warnings or ultimatums (e.g., "If it happens again, I'll tell the seniors.").
- Always present seniors as supportive allies, not threats.
- Stay focused on the main concern and avoid turning the conversation into a lecture.

3. Unprofessional Behaviour or Social Media Concerns

- Address social media posts or public conduct with seriousness and confidentiality.
- Avoid using the term "illegal" or threatening disciplinary language.
- Focus on Good Medical Practice and the principle of public trust in doctors.
- Do not assume the colleague acted out of malice — frame it as a learning opportunity.
- Never suggest involving patients in resolving professionalism issues (e.g., social media posts or gifts).

4. Breach of Confidentiality or Patient Boundaries

- Treat breaches of confidentiality with the same gravity as clinical errors.
- Emphasise the irreversibility of social media once posted and the implications for patient trust.
- Avoid downplaying the situation or joking along if the colleague is casual.
- Be clear that doctor–patient boundaries are regulated and must be upheld.
- Offer clear steps for reflection, support, and supervisory follow-up.

5. Alcohol or Drug Concerns Among Colleagues

- Maintain a serious but supportive tone if a colleague appears intoxicated or smells of alcohol.
- Do not attempt or suggest testing for alcohol or drugs — this is not a UK protocol.
- Do not confront the colleague as if they are a patient. Avoid questionnaires like CAGE.
- Immediate action must be taken: ensure patient safety and escalate to a consultant.
- Do not suggest rehab or long-term plans in the acute setting. Focus on stopping work, ensuring safety, and seeking help.

6. Mental Health or Emotional Distress in Colleagues

- Be alert to signs of emotional exhaustion, burnout, or recent personal difficulties.
- Be empathetic and suggest time off, speaking to a senior, or contacting occupational health or their GP.
- Avoid sharing personal experiences or over-identifying with the colleague.
- Do not assume they need psychiatric care unless there is clear evidence of impairment.
- Emphasise that the system has structures to support doctors in distress — they are not alone.

7. Boundaries and Ethics in Professional Discussions

- Avoid using extreme phrases like "illegal," "unacceptable," or "you must apologise" unless clearly justified.
- Refrain from using over-enthusiastic responses like "Absolutely!" or "Of course!" in sensitive discussions.
- Avoid moralising or using guilt-based language. Let the GMC framework guide your reasoning.
- Use clear, factual phrasing about what happened, what the impact is, and what steps should follow.

8. Common Mistakes to Avoid

- Don't accuse or confront the colleague aggressively.
- Don't try to manage everything alone. Always offer or include escalation to seniors.
- Avoid covering up mistakes or inappropriate behaviour, even if the colleague is your friend.

- Don't make assumptions about their intentions — assume lack of awareness or stress, not malice.
- Never ignore the issue because "patient care is good." Professionalism matters regardless.
- Don't delay serious conversations to "sort things out later" — deal with issues in a timely and structured way.

This summary will help you approach all colleague-related PLAB 2 stations with professionalism, clarity, and compassion, ensuring your communication reflects the values expected of a UK Foundation Year 2 doctor.

Chapter 24: Breaking Bad News and End of Life

Introduction: How to Break Bad News in PLAB 2

Breaking bad news is one of the most emotionally charged and challenging aspects of clinical communication. In PLAB 2, your approach must strike a balance between **clarity, honesty, and compassion**, while maintaining professionalism and supporting the patient or their family. This summary outlines the **core principles** that should guide your delivery:

Core Principles for Delivering Bad News

1. Clarity and Honesty Without Cruelty

- Be **clear that the patient is not going to recover**. Avoid giving **false hope**.
- Use direct but compassionate phrases like: *"He's not going to make it."* Avoid euphemisms (e.g., don't say "passed away" or "gone") but also avoid cold phrases like "he's dying."
- Never say, *"we've given up"* — instead say, *"we're now focusing on comfort."*

2. Palliative Focus: Comfort, Not Cure

- Explain that the **goal has shifted** to palliative care: **symptom relief, dignity, and comfort**, not prolonging life at all costs.
- Clarify that **pain relief and IV fluids** will still be provided.
- If treatments are being stopped, explain it's to avoid **unnecessary suffering**, not because care is being withdrawn.

3. Language: Simple, Human, Non-Jargon

- Avoid medical jargon entirely. Instead of "infarction," say "a type of stroke caused by blocked blood flow to the brain."
- Replace "space-occupying lesion" with "brain tumour," and "ischemic stroke" with simply "stroke" unless further detail is requested.
- Be mindful to **not describe euthanasia or end-of-life interventions as 'killing'** — instead, say *"cause death"* where necessary.

4. Emotional Presence: Pause, Validate, Support

- Allow time for **silence**, processing, and **questions**.
- Acknowledge emotions: *"I can see this is incredibly difficult to hear."*
- Be prepared for **anger, tears, or blame**, especially if complications occurred after surgery or during hospital stay.
- Stay calm if accused of mistakes — respond factually and compassionately: *"I understand your concern. Unfortunately, this is a known complication, even when everything is done correctly."*

5. Prognosis: Set Expectations Carefully

- Make it **clear how critical** the situation is.

- Don't promise outcomes. Say, *"We are still waiting for the specialist's opinion,"* or *"It's too early to say for certain."*
- Emphasize that **stroke recovery is variable**, and **elderly patients** may have a slower or limited recovery.

6. Family, Support, and Follow-Up

- Suggest informing other family members *"because of how serious things are"*, not just for emotional support.
- Offer continued support: *"Would you like to speak to someone from our support team?"*
- Ask about the caregiver's wellbeing and **offer resources** if needed.
- Avoid discussing **legality** of care or drawing diagrams unless specifically requested.

Key Don'ts

- Don't rush the conversation or give scripted reassurances like *"don't worry."*
- Don't use inappropriate or irrelevant risk screening (e.g., asking about blood thinners in a stroke due to bleed).
- Don't focus on hospital policies or legal aspects unless directly asked.
- Don't minimise complications. Explain that a **major bleed** or **post-op stroke** is a serious event, and the team is managing it as best as possible.

Final Note

The most important part of breaking bad news is to **honour the humanity of the patient and their family**. Speak simply, act kindly, listen well, and stay composed. Deliver the truth with compassion, and remember that your calm presence, not just your words, will shape how this moment is remembered.

Structure of a Breaking Bad News Case

1. Check if They're Ready to Talk

Before delivering any serious news, ensure the person is in the right frame of mind and setting.
"I've been asked to speak with you about an important update.
Before we go ahead, are you okay to talk right now?"
"Are you alone? Would you like someone with you?"
"Would you prefer to speak here, or is there somewhere more private?"
If over the phone:
"Are you somewhere safe at the moment? Are you driving?"
"Would you prefer to come in and speak with us in person?"

2. Build the Context Naturally

Rather than giving the diagnosis abruptly, provide a brief summary to help them understand what has happened so far. This softens the delivery and makes the news easier to process.
"As we understand it, your [relative] was brought in earlier today and assessed by the medical team.
We carried out some urgent tests to understand what's going on."

3. Give a Warning Before the News

Use a simple phrase to prepare them for what's coming. This step allows the listener to emotionally brace themselves.
"I'm afraid I don't have good news."
or
"Unfortunately, what we've found is quite serious."

4. Deliver the News Clearly and Gently
Avoid medical jargon. Be honest but calm. Pause and allow silence after delivering the information.
"I'm really sorry to tell you that [the condition] is very serious.
Based on the results and the team's assessment, it's not something we're expecting to improve.
This means we're not expecting [them] to recover, I'm afraid."
Then **pause**. Give them time to absorb and react.

5. Respond to the Emotional Reaction
Show empathy. Don't rush into explanations or problem-solving right away.
"I'm really sorry. I can only imagine how difficult this must be."
(Offer tissues, water, or silence if in person)
(If on phone: "Would you like a moment? I can call you back if that would help.")
Let them speak, cry, or go quiet. Respect the silence.

6. Gently Explain What Happens Next
Once they're ready, explain what the medical team is doing — and not doing — using clear and kind language.
"From here, we'll focus on keeping them as comfortable and supported as possible."
"We're offering something called palliative care — it doesn't aim to cure the illness, but it helps ease symptoms like pain or distress."
"Everything we're doing is in their best interest."

7. Address Common Questions Honestly
Be direct, but sensitive. Avoid guessing exact timelines, and don't offer treatments that are no longer appropriate.
If asked:

- *"Is there any chance they'll survive?"* → "I'm afraid not. We're not expecting them to recover from this."
- *"How long do they have?"* → "It's hard to say exactly, but this may be a matter of hours to days."
- *"Why can't you do more?"* → "We've consulted the senior team, and unfortunately, no further treatment would change the outcome — it may cause more harm than good."

8. Reassure Ongoing Support
It's important they don't feel abandoned.
"We'll continue to monitor them and keep you updated.
Our priority now is comfort, dignity, and making sure you're supported throughout this."

Summary: Helpful Phrases for Breaking Bad News

Intent	*Example Phrase*
Signal seriousness	"I'm afraid I don't have good news."
Deliver news	"I'm so sorry to tell you that…"
Acknowledge emotion	"I can only imagine how hard this must be."
Explain palliative focus	"We'll focus on keeping them as comfortable as possible."
Clarify non-recoverable state	"We're not expecting them to recover, I'm afraid."
Reassure commitment	"We're still here with them. This isn't about giving up."

Intracerebral Haemorrhage

Setting: Emergency Department or Acute Medical Unit
Role: FY2 Doctor
Patient: Elderly individual brought in unconscious by ambulance following collapse

Relative: Next of kin (e.g., spouse or adult child) – either in person or by phone
Task: Take brief history, explain findings, break bad news, and offer appropriate support and palliative plan

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Introduction & Identity Confirmation
In-person version:
"Hello, I'm one of the doctors working in this department.
Before we speak further, could I confirm your name, please?
Is it alright if I call you [preferred name]? And just to double-check, may I confirm how you're related to the patient and their age?"
If interrupted or visibly distressed:
"I can see you're very worried and I'm here to support you. But if you're okay with it, could I check a few details first before we continue?"

Telephone version:
"Hello, is this [next of kin]? I'm one of the doctors calling from the emergency department.
Before I go ahead, may I confirm the patient's age and the first line of their address, just to make sure I'm speaking with the right person?
Are you in a safe place right now and okay to speak?"

Brief History – Confirm Timeline and Background
If relative is present and aware of the event:
"Would you be able to tell me what happened earlier today?"

- "When and where did they collapse?"
- "Was anyone there when it happened?"
- "Were they speaking or conscious beforehand?"
- "Did they mention feeling unwell—such as headache, drowsiness, or nausea?"
- "Did they lose consciousness completely?"
- "Did they have a seizure?"
- "Was there any head injury or bleeding?"

Clarify relevant medical history:

- "Do they have any medical conditions such as high blood pressure, diabetes, or heart disease?"
- "Do you know if they take any regular medications, particularly anything like aspirin, warfarin, or blood thinners?"
- "Has anything like this happened before?"
- "Have they been keeping up with their medications and reviews?"
- "Does anyone else in the family have a history of stroke or sudden death?"

If unaware (e.g., telephone):
"Have you seen or spoken to them recently? Were they feeling unwell?"
"Do you know if they live alone or with someone?"
"Has anyone who lives with them mentioned any recent concerns?"

Check Prior Understanding and Appoint Consent
"Has anyone spoken to you yet about what's going on?"
"What do you understand about the situation so far?"
"Have you been updated by any other staff members before I came in?"

Invite – Ensure They're Ready for Serious Information
"I've been asked to update you about your [relative].
Before I continue, are you okay to speak now?
Would you like someone else to be with you at the moment?"
On phone:
"Would you prefer to come to the hospital to talk in person, or would it be alright to continue speaking over the phone?"

Narrate – Build Clinical Context Gently
"As we understand it, your [relative] was found collapsed earlier today and brought in by ambulance.
They were unconscious on arrival and were immediately assessed by our medical team, including senior specialists.
We performed a CT scan of the head, which is an advanced brain imaging test, to understand what might be causing this."

Warning Shot – Prepare Them for Serious News
"I'm afraid I don't have good news."

Deliver – Clear, Honest Explanation of Diagnosis
"I'm really sorry to tell you that the scan showed a **major bleed inside the brain**, something we call a severe intracerebral haemorrhage.
This type of bleeding affects parts of the brain that control essential functions like breathing and consciousness.
Unfortunately, the level of damage is extensive. After reviewing everything, the team has concluded that **the condition is terminal**, which means we are not expecting them to recover."
(Pause. Let them absorb the news. Be quiet and present.)

Address the Emotional Reaction
"I'm so sorry. I can only imagine how difficult this is for you right now."
(Offer water, tissues, or simply remain silent if in person)

If on the phone:
"Would you like a moment to process this? I can stay on the line, or call back in a few minutes if you'd prefer."

Explain the Prognosis and Care Plan Clearly
"We are now focusing on **palliative care**, which is a type of supportive treatment.
This means our goal is not to cure the condition, but to make sure they are not in pain or distress.
We will monitor them closely and make sure they remain peaceful and as comfortable as possible."

Address Common Questions and Concerns
"Why can't you do surgery?"
"The bleeding is widespread and deep inside the brain. Surgery would not improve the situation and might cause further suffering."
"Why not take them to ICU or use machines?"
"Intensive treatments like ventilation or surgery would not benefit them at this stage. They would not change the outcome and may only add distress."
"Are they going to die?"
"Yes… I'm very sorry. We are not expecting them to survive this."

"How long do they have?"
"It's difficult to predict exactly, but this could be a matter of hours or a few days."
"Why did this happen?"
"This type of bleeding often happens when a blood vessel in the brain suddenly bursts, usually due to high blood pressure or an abnormal vessel. Unfortunately, it can occur without warning."
"Should I inform family abroad?"
"I think that would be a good idea. It's best that close family members are informed now."
"Can we take them home?"
"Did they ever express a wish to be cared for at home? If so, we can speak to the senior team and see if that can be arranged safely.
But generally, staying in hospital ensures access to medications and support if anything changes quickly."
"Will you give fluids or feed them?"
"The palliative care team will assess this. In some cases, fluids may cause more harm than benefit. Our decisions are made with their comfort as the top priority."

Reassure Ongoing Support
"Please know that we will stay with them and continue to monitor closely.
You're welcome to be with them, and our team will support you throughout this process. You're not alone."

Follow-Up and Next Steps

- Offer contact with the palliative care or chaplaincy team
- Clarify who is the official next of kin for documentation
- Encourage them to ask questions at any time
- Offer privacy or a quiet room if needed
- Document the conversation clearly and escalate any requests (e.g., home discharge)

Bilateral Stroke

Setting: Emergency Department or Acute Medical Unit
Role: FY2 Doctor
Patient: Elderly individual with history of stroke, now in coma after a second stroke
Relative: Next of kin (e.g., adult child or spouse) – in person
Task: Take relevant background history, break the news, explain prognosis, and provide support

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Introduction & Identity Confirmation
"Hello, I'm one of the doctors working in this department today. Before we begin, could I please confirm your name?
Is it alright if I address you as [preferred name]? And just to confirm, how are you related to the patient?
Do you happen to know their age?"

Clarify Understanding and Background
"I've been asked to speak with you about your relative's current condition. Before I explain anything further, would you mind telling me what you've been told so far?"

Clinical History – First and Second Stroke
For the first stroke:
– "When they had the first stroke, what symptoms did they develop?"
– "What kind of tests were done at the time?"

– "What were you told about the stroke—where it was, and how serious?"
– "How were they treated, and how did they respond?"
– "Were they improving before this second event?"

For the second stroke:
– "When did this second event happen?"
– "Were you informed about what symptoms they developed this time?"
– "What treatment has been offered since the second stroke?"
– "Were there any signs of improvement at all?"

Past Medical, Medication, Family, and Social History

- "Do they have any long-term medical conditions—such as high blood pressure, diabetes, or high cholesterol?"
- "Have they ever had a heart attack or a mini-stroke before this?"
- "Do they take any regular medications—for blood pressure, cholesterol, or anything else?"
- "Has anyone in your family had a similar history of stroke or heart problems?"
- "Do they smoke or drink alcohol regularly?"
- "Are they generally independent—do they live at home, or in a care setting?"
- "Was your relative working or retired before all this happened?"
- "Are you the next of kin? Do you know if they've ever appointed someone legally as power of attorney?"

Check Readiness for Bad News
"I have been asked to give you an important update about your relative's condition.
Before I continue, are you here alone today, or is there someone you'd like to be with you?
Are you okay for me to go ahead and explain things now?"

Clinical Context – Build the Narrative Gently
"As we understand it, your relative had a stroke a few weeks ago. They were started on treatment and showed some signs of improvement.
Unfortunately, they then suffered a second stroke more recently and are now in a coma.
They've been assessed by our team of doctors and specialists, and a CT scan was done to understand the extent of the stroke."

Warning Shot
"I'm really sorry, but I don't have good news regarding the results of that scan."

Deliver the News – Clear and Honest Language
"The scan shows that the stroke has affected **both sides of the brain**, and the damage is very extensive.
Because of the severity of this injury, we are **not expecting them to recover**. The team has assessed that this is now a **terminal condition**."
(Pause. Allow silence. Let the relative process and respond.)

Address Reaction – Offer Emotional Support
"I'm really sorry you're having to go through this.
I can only imagine how difficult this must be for you right now."
(Offer water, tissues, or sit quietly if needed. Avoid rushing the conversation.)

Explain Prognosis and Management Plan Clearly
"We are now offering **palliative care**. This means the goal is no longer curative treatment, but instead to ensure your relative is **comfortable, pain-free, and at peace**.
They will be closely monitored, and we will provide medications such as **painkillers** to ease any potential discomfort.
Fluids will be given to help maintain comfort. Everything we're doing is in line with making sure their remaining time is peaceful and respectful."

Address Common Questions and Concerns
"Are you giving up on them?"
"I understand it may feel that way. Please know that we're not giving up—we're changing the focus of care to ensure they don't suffer.
When treatment can no longer change the outcome, the kindest and most appropriate option is comfort-focused care."
"Can you delay their death?"
"Sadly, this is a condition that cannot be reversed, and we can't delay what's already happening inside the brain. Trying to extend life artificially could cause more harm than good. Our goal is to allow this process to happen naturally while keeping them as comfortable as possible."
"Can someone else review the case?"
"That's understandable. The current plan has been made after careful review by the senior medical team.
But if you'd like, I can absolutely arrange for you to speak with one of the senior doctors directly."
"Will you feed them?"
"In this condition, tube feeding is unlikely to help and might cause additional distress.
That's why it's not part of the plan right now—but we're making sure their mouth is kept moist and they're not uncomfortable."
"Will you give antibiotics?"
"At this point, there's no indication for antibiotics. In some cases, they may be used to manage discomfort or prevent complications, but in this situation, they are not expected to make a meaningful difference."

Safety Netting, Follow-Up, and Support

- "You're welcome to stay with them, and we'll make sure you're kept informed of any changes."
- "If there are any specific wishes or religious needs, we'll do everything we can to accommodate them."
- "Would you like us to arrange a conversation with the palliative care team or chaplaincy support?"
- "You're not alone in this. Please let us know if there's anything you need, now or later."

Massive Unilateral Stroke

Setting: Emergency Department or Acute Medical Unit
Role: FY2 Doctor
Patient: Elderly person found unconscious at home after stroke, no meaningful improvement after 7 days
Relative: Adult child or next of kin, in person
Task: Take appropriate history, explain CT findings, deliver bad news sensitively, provide prognosis and supportive care plan

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Introduction & Identity Confirmation
"Hello, I'm one of the doctors working in this department.
Before we go further, could I confirm your name please?
And may I ask how you're related to the patient? Just to be certain, could I also confirm their age?"

Establish Understanding & Invite Conversation
"I've been asked to speak with you about your relative's current condition.
Before I explain further, could you help me understand what happened from your point of view?
What have you been told so far?"

History – Stroke Presentation and Clinical Background
Incident history:
– "Can you tell me when and where the event happened?"
– "Did anyone witness the collapse?"
– "Was your relative acting normally before it happened? Any signs like drowsiness, confusion, weakness, or headache?"
– "How long did it take for you to realise something was wrong?"
– "When did you call the ambulance, and what happened when they arrived?"
– "Has your relative regained consciousness at any point since the event?"
– "Has there been any noticeable improvement in the past few days?"
Hospital course:
– "Do you know what tests have been done so far?"
– "What treatments were started? Have the doctors said how they've been responding?"
Medical background:
– "Do they have any long-term health conditions like high blood pressure, diabetes, or high cholesterol?"
– "Any previous stroke, mini-stroke, or heart disease?"
– "Have they had any hospital admissions before?"
– "Are they on any medications—such as for blood pressure or diabetes?"
Family and social history:
– "Do you know if anyone else in the family has had similar medical issues—like a stroke or heart disease?"
– "Do they smoke, or have any other lifestyle factors you're aware of?"
– "Were they living alone, or with someone else?"
– "Do they live in their own home or a care facility?"
– "Were they still working or retired?"
– "Do you happen to know if you're the next of kin or whether a legal power of attorney has been appointed?"

Invite – Check If Ready for Serious News
"I have been asked to give you an important update about your relative's condition.
Are you here on your own, or would you like someone with you for this conversation?
Would you like me to continue now?"

Narrate – Build the Clinical Context
"As we understand, around a week ago, your relative was brought to the hospital after collapsing at home.
They were diagnosed with a stroke and were started on treatment. Over the past several days, we've been closely monitoring their condition and hoping for signs of improvement.
Unfortunately, there was no meaningful progress, so we carried out a repeat CT scan to reassess the situation."

Warning Shot
"I'm really sorry, but the CT scan has shown some very difficult findings."

Deliver – Clear and Honest Disclosure

Version 1 – End-of-Life Care (when death is imminent)

"I'm really sorry to tell you that the CT scan shows a large part of the brain has been severely affected.
After a full review by the team, we've reached the conclusion that, sadly, there is no chance of meaningful recovery.
We are now focusing on **end-of-life care**, which means we'll be keeping them comfortable and pain-free in their final hours or days.
I'm truly sorry—we don't expect them to survive this."

Version 2 – Palliative Care (for symptom control but not necessarily imminent death)

"I'm really sorry to tell you that the CT scan has shown significant damage to the brain due to a major stroke.
Based on the findings and discussion with the specialists, we believe that active treatment won't help improve the situation.
We are now planning to shift to **palliative care**, which focuses on managing symptoms, ensuring comfort, and maintaining quality of life for as long as possible.
We'll continue to support them and you throughout this process."
(Pause. Remain silent and allow time for the information to be processed.)

Address Reaction – Support Emotionally

"I can only imagine how hard this must be for you. I'm truly sorry you're going through this."
(Offer tissues, a glass of water, or simply stay present. Avoid interrupting.)

Explain Prognosis & Management Plan

Version 1 – End-of-Life Care (when death is expected soon)

"At this point, we are now focusing on **end-of-life care**.
This means that we are no longer continuing treatments that aim to cure or prolong life, because unfortunately, they are no longer helping.
Instead, our goal is to keep your loved one as **comfortable and pain-free as possible** during the time they have left.
Everything we do from this point will be about **dignity, comfort, and supporting both them and the family** through this process."

Version 2 – Palliative Care (when prognosis is limited, but not necessarily imminent death)

"We are now offering **palliative care**, which is a type of supportive treatment.
Do you know what that means?
Palliative care is focused on **relieving symptoms**, such as pain, breathlessness, or anxiety, and **improving quality of life**.
It doesn't aim to cure the underlying condition, but it helps the patient feel more comfortable and supported for as long as they live.
The team will continue to assess their needs and make sure they're not in pain or distress."

Address Common Questions and Concerns

"Why did it take a week to tell us this?"

"I understand that this is difficult to hear. The team initially hoped there might be some recovery with treatment. We monitored closely for any signs of improvement. Unfortunately, the recent CT scan has shown that the stroke was far more severe than initially thought."

"Why are you stopping treatment?"

"We've reached a point where continuing medical treatment would not help and might even cause more harm.

The decision was made to stop life-prolonging interventions because they are no longer in your relative's best interest."
"Is this euthanasia?"
"No, this is not euthanasia. We're not doing anything to hasten death. We're simply allowing the natural process to take its course, while making sure they are comfortable, peaceful, and not suffering."
"Can you delay their death?"
"I wish that were possible, but we can't delay or prevent what's already happening inside the brain. We'll be here to support them and you during this process."
"Can I speak to someone senior?"
"Absolutely. I can ask one of the senior doctors involved in their care to come and explain everything to you. But I want to be honest—this decision was made by the full medical team after careful assessment, and it's unlikely to change."
"When will they die?"
"It's very difficult to say. It could be a matter of hours, days, or even a week or more. We'll continue to monitor closely and keep you updated."

Reassure Support and Involvement
"You're welcome to stay with your relative. Our nursing team will be checking on them regularly.
If there's anything they or you need—whether it's religious, emotional, or practical—please let us know.
We'll make sure they're not in pain and that you're supported every step of the way."

Follow-Up Plan and Safety Netting
- Offer contact with palliative care team
- Ask if they'd like a family member or chaplain present
- Reassure they can return to you with any further questions
- Ensure they know how to reach staff at any time
- Document conversation and decisions in medical notes

Post-Operative Bleeding

Setting: Surgical ward / Recovery unit
Role: FY2 doctor
Patient: Adult who underwent aorto-femoral bypass earlier today
Relative: Next of kin (e.g. spouse), in person
Task: Take brief relevant history, explain current complication, deliver the news, provide reassurance and clear next steps

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Introduction & Identity Confirmation
"Hello, I'm one of the doctors here looking after patients on the surgical unit.
Could I confirm your name, please? And just to clarify, how are you related to the patient?
Do you happen to know their age as well?"

Establish Understanding and Background
"I understand your [relative] had surgery earlier today. I've been asked to speak with you about their current situation.
Before I go ahead, can I ask—what have you been told so far?"

Focused History Gathering

- "Do you know what surgery was done today?"
- "Did anyone explain the type of surgery and the reason it was needed?"
- "Did you have a discussion with the doctors beforehand about the risks or possible complications?"
- "What symptoms was your [relative] experiencing before the operation—like pain or difficulty walking?"
- "How long had those symptoms been going on, and how were they affecting daily life?"
- "Did you get to speak to the surgical team after the operation finished?"
- "Have you been told why they were taken back to the theatre?"

Past Medical History:

- "Do they have any medical conditions such as diabetes, high blood pressure, or liver problems?"
- "Have they ever had issues with bleeding or needed blood transfusions before?"
- "Do you know if they're on any medications, particularly blood thinners?"
- "Has anyone in the family had bleeding disorders or clotting issues?"

Social Context:

- "Are they usually active and independent? Are they working or retired?"
- "Who do they live with?"
- "Do you have children or other close family around?"
- "Are you the next of kin, and do you know if they've appointed anyone for legal decisions?"

Invite – Check Readiness to Hear Difficult News

"I have an important update about your [relative] that I've been asked to share with you.
Before I continue, are you here on your own?
Would you like to call someone to be with you before we talk?
Are you okay for me to go ahead?"

Narrate – Build the Clinical Picture Clearly

"As you know, your [relative] had a procedure called an **aorto-femoral bypass** today. This surgery is done to bypass blockages in the main blood vessels supplying the legs, in order to improve circulation.
The operation itself went well, and they were transferred to the recovery area for close observation.
As part of routine monitoring, we check the surgical drain to look for any signs of internal bleeding.
Unfortunately, we noticed a larger amount of blood than expected coming from the drain, which raised concern.
This led the team to carry out an urgent examination."

Warning Shot

"I'm afraid we didn't receive good news from that examination."

Deliver – Clear, Honest, and Supportive Disclosure

"I'm really sorry to tell you that your [relative] has developed **a major internal bleed** following the surgery.
They have lost a **significant amount of blood**, and the situation is serious.
Because of this, the team has had to take them back to the operating theatre for emergency surgery to try and stop the bleeding."
(Pause. Allow space for processing.)

Address Reaction – Support Emotionally

"I'm so sorry. I can only imagine how difficult this is for you right now.
We understand this is a very stressful and unexpected development."
(Offer water, tissues, or quiet support. Remain present and patient.)

Explain Current Plan and Prognosis

"At the moment, the surgical team is working on locating the source of the bleed and controlling it.
We have already given multiple units of blood to replace what was lost. This is a large volume, and it confirms that the bleeding was quite serious.
The situation is **critical**, but your [relative] is in expert hands. The surgeons managing this are very experienced, and they are doing everything possible right now."

Address Common Questions and Concerns

"How could this happen?"

"I understand your concern. Unfortunately, while the surgery went well, bleeding is a known risk—especially when large blood vessels like the aorta and femoral artery are involved. It's not something we expect or want to happen, but it can occur despite precautions."

"Why did you even do the surgery if this could happen?"

"The surgery was necessary to treat the poor blood flow to the legs, which was already affecting their quality of life. Every operation carries some risk—but the benefits of improving circulation were considered to outweigh that risk at the time. This complication was unfortunate and not something that could have been predicted."

"Is this a mistake?"

"I can assure you that no error has been identified. This is a recognised complication, and the team acted promptly the moment it was detected."

"Are they going to die?"

"The situation is very serious, and we can't predict the outcome with certainty.
They've lost a lot of blood. However, I want you to know that every effort is being made to help them recover.
Let's remain hopeful and wait to see how things progress in theatre."

"How long will the operation take?"

"These kinds of procedures typically take five to six hours, depending on the complexity and the time it takes to control the bleeding."

"Is six units of blood a lot?"

"Yes, it is. Six units of blood indicates a **major haemorrhage**. We're replacing the blood as quickly and safely as we can while surgery is ongoing."

"Should I call my children abroad?"

"Yes, I think it would be a good idea to inform close family that your [relative] is in a critical condition. It doesn't mean we've given up—it just helps to ensure everyone is informed and supported."

"Are you only telling me to call family because they're dying?"

"I understand that worry. But we ask families to update others not because we believe death is certain, but because we're in a critical situation. If anything changes, it's helpful for everyone to be prepared and supported."

"Is this related to smoking or alcohol?"

"This complication isn't directly caused by smoking or alcohol. However, long-term smoking can contribute to the underlying vascular disease. Alcohol can affect blood clotting, but in this case, the main cause of the bleeding is likely related to the surgical site and the large arteries involved."

Reassure Support and Monitor Closely

"The team will keep you updated as soon as they have more information from the theatre.
Please know that you are not alone—we are here to support you through this.
If there's anything we can do—arranging someone to sit with you, calling another family member, or providing updates—please let us know."

Follow-Up Plan and Safety Netting

- Offer a private space to wait or speak with staff

- Inform them how they will be updated
- Arrange a check-in in a couple of hours or sooner if surgery ends
- Document all communication clearly in notes
- Provide emotional support team or chaplain referral if appropriate

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Post-Operative Stroke

Setting: Neurosurgical ward or ICU
Role: FY2 doctor
Patient: Elderly individual who underwent brain surgery and developed a stroke post-op
Relative: Next of kin (e.g. adult child), in person
Task: Take relevant history, explain the event, break bad news, and provide ongoing plan and support

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Introduction & Identity Confirmation
"Hello, I'm one of the doctors working in this department.
May I know your name, please? And just to clarify, how are you related to the patient?
Could I also confirm their age?"

Establish Understanding and Invite Conversation
"I understand your [relative] has been admitted with us following surgery.
Before I explain further, can I ask—what is your understanding of what's happened so far?"

Focused History
Surgical awareness:

- "How much do you know about the surgery that was performed?"
- "Did anyone explain what type of surgery was planned, and why it was needed?"
- "Had you or your relative spoken with the doctors beforehand about potential risks or complications?"
- "What symptoms had your relative been having before surgery—such as headaches, weakness, or changes in memory?"
- "How long had these symptoms been present, and how were they affecting daily life?"

Post-op awareness:

- "Did you manage to speak with the surgical team after the operation?"
- "Has anyone explained what's been happening since the surgery?"
- "Do you know why a CT scan was done?"

Medical history:

- "Does your relative have any conditions such as high blood pressure, diabetes, or heart disease?"
- "Has there ever been a previous stroke, mini-stroke, or heart attack?"
- "Do you know if they take any medications regularly—especially for blood pressure or cholesterol?"
- "Does anyone in your family have a history of stroke or similar issues?"
- "Do they smoke or drink alcohol?"

Social and legal context:

- "Do they live independently, or with someone?"
- "Are they usually active? Were they working or retired?"
- "Are you the next of kin? Have they legally appointed anyone as lasting power of attorney?"
- "Do they have other children or family members involved in their care?"

Invite – Check Readiness for Difficult News
"I've been asked to share an important update about your relative.
Before we continue, are you here alone? Would you like to call someone to be with you?
Are you okay for me to go ahead?"

Narrate – Build the Clinical Story
"As you know, your relative had surgery today. The operation was done to remove a brain tumour.
The surgery itself went well, and they were transferred to recovery.
As part of our routine checks after brain surgery, we regularly perform neurological assessments to check movement and responsiveness.
During these checks, we noticed they were unable to move one part of the body. Because of that, we carried out an urgent CT scan."

Warning Shot
"I'm afraid we didn't receive good news from the scan."

Deliver – Clear and Compassionate Explanation
"I'm really sorry to tell you that the CT scan has shown that your relative has suffered a **stroke** after the surgery.
This means a part of their brain has been affected by reduced blood flow, and it's currently not functioning as it should."
(Pause. Allow silence. Stay present and supportively quiet.)

Address Reaction – Emotional Support
"I'm truly sorry. I can only imagine how upsetting this must be for you.
Please take your time. I'm here if you have questions or need a moment."
(Offer water, tissues, or sit quietly if needed.)

Explain Prognosis and Next Steps
"Let me explain what's happening now.
Your relative has been moved to the **intensive care unit** for close monitoring.
They've been started on **treatment for the stroke**, and we're waiting for a **stroke specialist** to assess them further.
We're doing everything we can to support recovery and manage any complications.
At this stage, it's too early to predict the outcome."

Address Common Questions and Concerns
"Is this stroke a complication of the surgery?"
"It's hard to say with certainty. While weakness and bleeding can occur after brain surgery, this appears to be an **ischaemic stroke**, which means a clot has blocked blood flow to part of the brain.
This is more common in elderly patients and may not be directly caused by the surgery, but we're waiting for the specialist to review the full picture."
"Is she going to die?"
"Right now, the situation is serious. It's difficult to say how things will unfold.
She's had major surgery, and on top of that, a stroke.
But she is receiving treatment, and we're doing everything possible to support her.
Let's stay hopeful, and we'll know more once the specialists complete their review."
"Will she recover? Will she walk again?"
"That depends on how much damage the stroke has caused. Some people recover fully, others partially, and some do not recover.

At the moment, we don't yet know the full extent of the impact. We'll be able to give you more information after the stroke team has reviewed her."
"Why did this happen after a successful surgery?"
"Stroke is a rare complication in this context, but it can still occur, especially in older patients. The cause might be unrelated to the surgery itself.
We're still investigating, and we'll share more information with you as soon as we know."

Reassure Ongoing Support and Monitoring
"She's being looked after very closely by a team of specialists.
We'll monitor her around the clock, and you'll be updated regularly.
If there's anything we can do to support you, whether emotionally or practically, please let us know."

Safety Netting and Next Steps
- Offer to update again once the stroke specialist has reviewed
- Provide a quiet space to wait and process information
- Ensure the relative knows they can return with questions
- Document the conversation clearly in the patient's notes
- Offer support from nursing staff, chaplaincy, or palliative liaison (if needed later)

Osteosarcoma

Setting: GP surgery
Role: FY2 doctor
Patient: 19-year-old presenting with persistent knee pain, now attending for X-ray result
Task: Deliver suspected cancer result, explain findings, address concerns, and arrange urgent referral

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Introduction
"Hello, I'm one of the doctors here at the practice.
Could I confirm—are you Max? And can I check your age as well?
I understand you're here for your recent test results. Before we go through them, could you tell me in your own words—what brought you in originally?"

History – Structured Assessment
Pain (SOCRATES-based):
– "Can you tell me more about the pain you've been having?"
– "Where exactly is the pain? Can you point to the area?"
– "Did it start suddenly or gradually?"
– "Is it sharp, dull, throbbing?"
– "Does the pain go anywhere else?"
– "Is it worse at night?"
– "Have you tried painkillers? Did they help?"
– "Does anything make it worse—like touching or movement?"
Lump / Swelling / Neuro:
– "Have you noticed any swelling or lump in the area?"
– "Any numbness or tingling in that leg?"
– "Any difficulty walking or limping recently?"
– "Have you noticed any weakness or balance problems?"

Systemic cancer features:
– "Any recent weight loss or fatigue?"
– "Have you had frequent bruising or headaches?"
– "Any new fractures or sudden pain with no trauma?"
– "Any constipation, thirst, or confusion?" *(to screen for hypercalcaemia)*
Risk factors and background:
– "Have you ever had chemotherapy or radiotherapy as a child?"
– "Have you had an eye condition called retinoblastoma?"
– "Any previous bone or joint problems?"
– "Are you on any regular medication?"
– "Any family history of cancer or bone problems?"

ICE and Social Context
– "What do you do for a living, or are you studying?"
– "You mentioned playing football—do you play professionally, or is it more casual?"
– "Who do you live with? Do you have good family support?"
– "Have you had any thoughts about what could be causing your symptoms?"
– "Is there anything you're particularly worried about today?"
– "What were you expecting from the X-ray?"

INVITE – Check if Ready for Result Discussion
"I have your test results here and I've been asked to discuss them with you.
Would you like to hear them now?
Is there anyone you'd like to have with you, or would you prefer to call someone before we talk?"

NARRATE – Build Clinical Context
"From what you've told me, you've had pain and swelling around the knee for the last month, which began while playing football.
The doctors did an X-ray to investigate this, and we also checked your bloods, which came back normal.
But the X-ray has shown something that we need to discuss further."

WARNING SHOT
"I'm afraid the X-ray didn't bring us good news."

DELIVER – Break the Bad News Clearly
"I'm really sorry to tell you this, but the X-ray shows a change in the bone that looks suspicious.
The doctors reviewing the scan suspect it could be **a type of bone cancer called osteosarcoma**."
(Pause. Allow silence and give space for a reaction.)

ADDRESS REACTION
"I'm really sorry—this is a lot to take in.
I can only imagine how difficult this is to hear. Please take your time.
If you'd like a moment or someone to talk to, I can step out and come back."
EXPLAINING THE CONDITION IN SIMPLE TERMS
"Osteosarcoma is a rare form of bone cancer that usually starts near the ends of long bones, such as around the knee.
It develops from bone cells and often causes pain and swelling.
In early stages, the tumour can grow deep inside the bone, which is why many people don't notice a visible lump

at first.
It's not caused by anything you've done, and there's nothing you could have done to prevent it.
The most important thing now is to move forward with urgent investigations and treatment."

MANAGEMENT PLAN – NICE/NHS CKS Aligned
– **Urgent referral:** "Because of your age and the scan findings, we need to refer you to a **specialist team within 24 hours**, ideally today. You'll be admitted and seen by orthopaedic and cancer specialists."
– **Further investigations:** "They'll likely do a **CT scan or MRI** to see the extent of the lesion and surrounding structures.
They might use those scans to guide treatment directly, without a separate biopsy."
– **Treatment:** "If confirmed, treatment usually involves a **leg-sparing surgery** to remove the tumour while saving the limb.
Chemotherapy or radiotherapy may also be used before or after the surgery."
– **Newer treatments:** "There's also a medicine called **Mifamurtide**, which is sometimes used alongside standard treatment, and has shown benefit in young patients with osteosarcoma."
– **Support:** "You'll be looked after by a full team—orthopaedic surgeons, oncologists, physiotherapists, and counsellors to help guide you through this process."

COMMON QUESTIONS AND NATURAL RESPONSES
"Will I be able to play football again?"
"Unfortunately, it's unlikely you'll be able to return to high-impact sports like football. After surgery, the bone will be weaker, and the risk of fracture is higher.
But we'll focus on helping you regain your mobility and independence."
"Can I delay my referral? I have an exam coming up."
"I understand how important your exam is, but this needs to be prioritised.
If we delay, the tumour could grow or spread, which may reduce your treatment options.
We can give you a letter to postpone your exam. But the earlier we act, the better your chances of a full recovery."
"Why didn't I feel a lump?"
"This type of cancer grows deep inside the bone, so early on, people often just feel pain and not a noticeable lump."
"Why did this happen?"
"We don't always know the cause. Some people have risk factors, but in most cases, it's spontaneous. The important thing now is to move forward with treatment."
SAFETY NETTING & NEXT STEPS
– "You'll be contacted very soon—likely today—for admission to the specialist centre."
– "If you have any pain, concerns, or questions before then, you can contact us here or the hospital team."
– "Do you have someone to go home with today or talk to after this conversation? We can arrange support if needed."

Breast Cancer

Setting: GP surgery or breast clinic
Role: FY2 doctor
Patient: Female adult, attended screening or breast clinic, now returning for biopsy result
Task: Take structured history, deliver biopsy result, explain diagnosis and next steps, address concerns

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Introduction
"Hello, I'm one of the doctors here today.
Can I confirm—are you here for the results of your recent breast biopsy?
Before we discuss those results, I'd like to ask a few questions just to understand more about your background and what brought you in. Is that okay?"

History – Structured Data Gathering
Initial presentation and pathway:
– "Could you take me through what led to this test? Was it part of a routine screening or did you come because of a concern?"
– "Do you recall what happened during your mammogram or scan?"
– "Were you told why they needed to take a biopsy or tissue sample?"
– "Did you feel any lump in your breast or under your arm before the scan?"
– "Have you ever been taught how to do a breast self-examination?"
– "Any changes in breast size, shape, skin texture, or nipple discharge or bleeding?"
Systemic red flags:
– "Have you experienced any weight loss recently?"
– "Any tiredness, back pain, or just feeling generally unwell?"
Medical history:
– "Do you have any other health conditions or take regular medication?"
– "Have you ever had breast problems before?"
– "Have you used hormonal contraception or HRT in the past?"
– "Have you had any radiation therapy before?"
Family history and reproductive factors:
– "Has anyone in your family had breast cancer, ovarian cancer, or any other form of cancer?"
– "If you remember—when did you have your first period?"
– "Have you had children, and did you breastfeed them?"
– "Do you recall when your last period was?"
Social History and ICE
– "Do you smoke or drink alcohol?"
– "Who do you live with? Is there someone at home supporting you?"
– "Have you shared with anyone that you're waiting for these results today?"
– "What do you do for work or during the day?"
– "What have you understood so far about the investigations?"
– "Have you had any worries about what the result might be?"
– "What are you hoping to hear or find out from today's appointment?"

INVITE – Check Readiness to Receive News
"I've reviewed the biopsy results and I've been asked to share them with you today.
Before I go ahead—are you here on your own? Would you like to call anyone to join you?
Are you okay for me to continue?"

NARRATE – Build the Clinical Context
"As we understand it, you went for a scan or screening recently. During that appointment, they noticed some changes in your breast, and a biopsy was done to examine the tissue in more detail.
Your blood tests and general check-up were otherwise normal."

WARNING SHOT
"I'm afraid the biopsy didn't bring us good news."

DELIVER – Break the Bad News Clearly
"I'm very sorry to tell you this, but the biopsy has confirmed that you have **breast cancer**.
Specifically, it's a type called **ductal carcinoma in situ**—which means the cancer cells are contained within the milk ducts and have not yet spread.
"I know this is difficult to hear. But what I can tell you is that this has been caught at a very early stage, and early-stage breast cancer often responds very well to treatment."
(Pause. Give time for emotional processing. Stay silent unless they speak.)

ADDRESS REACTION – Acknowledge and Support
"I'm really sorry. I can only imagine how difficult this is to hear.
Please take your time. If you need a moment, I'm here. If you'd prefer to speak again later, that's okay too."
(Offer water, tissues, or pause the discussion based on patient cues.)

EXPLAINING THE CONDITION AND PROGNOSIS
"This is an early, non-invasive type of breast cancer. It means that although abnormal cells have been found, they haven't spread into the surrounding breast tissue or anywhere else in the body.
The treatment outcomes for this stage are excellent, and many people go on to live completely normal lives afterward."

MANAGEMENT PLAN
"You'll be referred now to a specialist breast team.
You'll receive a letter within the next few days with an appointment—usually within one or two weeks.
At that appointment, the specialist will go through everything again and begin planning treatment."
Treatment options may include:

- **Surgery:**
  "Most people at this stage have surgery as the first step. There are usually two options:
  1. **Breast-conserving surgery** – where only the lump and surrounding tissue are removed
  2. **Mastectomy** – where the entire breast is removed, often with the option for immediate reconstruction
     The surgical team will explain both and help you decide."
- **Sentinel lymph node biopsy:**
  "During surgery, they may also remove a small group of lymph nodes under your arm to check if the cancer has started to spread."
- **Hormonal therapy:**
  "If your cancer cells have certain hormone receptors, you may be offered tablets after surgery to reduce the chance of recurrence. This is usually taken for 5 years."
- **Radiotherapy or chemotherapy:**
  "Radiotherapy may be offered depending on the exact stage and the surgery type.
  Chemotherapy is less likely in early-stage cases like yours but will be discussed if needed."
- **Macmillan support:**
  "You'll be assigned a cancer nurse specialist who will support you throughout this process. You'll also be offered written information and details of support groups or counselling if you want."

COMMON CONCERNS

"I didn't even feel a lump. How can it be cancer?"

"That's very understandable. In early stages like this, there's often no lump, which is why screening and early detection are so important."

"Why would the whole breast need to be removed?"

"That depends on how much of the breast is affected. Some women prefer to have the whole breast removed, especially if there's a higher risk of recurrence.

But your surgeon will explain your exact options and help you make the best decision for your body and lifestyle."

SAFETY NETTING & NEXT STEPS

– "You'll receive a letter from the hospital with your specialist appointment soon."

– "If you have any pain, change in symptoms, or questions in the meantime, you're always welcome to contact us here."

– "We can also connect you with the Macmillan team right away if you'd like more support today."

Dementia

Setting: Hospital ward or GP follow-up

Role: FY2 doctor

Task: Speak to the daughter of an elderly patient admitted due to severe weight loss and diagnosed with advanced dementia. Explain the situation and discuss prognosis and care plan.

Introduction

"Hello, I'm one of the doctors involved in your mother's care.

Before we begin, may I confirm your name and relationship to her?

And just to be sure—can you confirm her age for me as well?

I understand you brought her in recently, and I've been asked to speak to you about her current condition. Is it okay if we talk now?"

History – Structured Information Gathering

Presenting issue and nutrition history:

– "What made you bring her to the hospital this time?"

– "When did you first notice the weight loss? Has it been gradual or sudden?"

– "Do you know roughly how much weight she's lost?"

– "How has her eating been lately? What has she been managing to eat or drink?"

– "Has she needed help with feeding? Has she tolerated liquids or soft foods?"

– "Has she ever had difficulty swallowing or been refusing food?"

Dementia history:

– "When was she diagnosed with dementia?"

– "Has she been on any treatment, and did it help?"

– "How has her condition changed in the last year or so?"

– "How has this affected her memory, mobility, and independence?"

Past medical and medication history:

– "Does she have any other long-term health conditions?"

– "Is she taking any regular medications?"

– "Any history of previous hospital admissions?"

Social history of patient and carer:

– "Where has she been living until now? At home or in a care facility?"

– "Is she mobile? Can she walk with or without support?"
– "What is she able to do on her own—eating, dressing, washing?"
– "Who has been helping her day to day?"
– "Are you her main carer? Do you live with her? Are you getting any help?"

Support and coping:

– "How are you managing personally? Do you have other responsibilities?"
– "Have you spoken to her GP or social services about getting more support?"
– "Is there a lasting power of attorney in place?"

ICE – Ideas, Concerns, Expectations

– "What do you think has been going on with your mother lately?"
– "Is there anything in particular that you're worried about?"
– "What were you hoping we could do for her today?"

INVITE – Check Readiness to Hear the News

"I have an important update regarding your mother's health.
Are you okay for me to go ahead and share this with you now?
Would you like to call anyone to be with you?"

NARRATE – Build the Story First

"As we understand, your mother was brought in because of severe weight loss.
We've done several tests, including scans and blood investigations, and everything has come back normal in terms of other causes.
Our current understanding is that her weight loss and decline are due to the **progression of her dementia**."
"Just so we're on the same page—can I check what you understand about dementia so far?"
(If needed, explain:)
"Dementia is a condition that gradually affects how the brain works. It often starts with memory problems, but as it gets worse, it can affect thinking, speaking, swallowing, walking—even appetite. It's a progressive condition, which means it slowly worsens over time."

WARNING SHOT

"I'm afraid I don't have good news about her current health."

DELIVER – Breaking the Bad News

"I'm really sorry to tell you, but your mother's dementia has now reached an advanced or terminal stage.
Unfortunately, this means she's not expected to recover or improve from this. Her body is gradually shutting down, and we're not seeing any signs that she will regain her strength or appetite."
(Pause. Allow the daughter to respond. Acknowledge emotions gently.)

ADDRESS REACTION – Empathetic Support

"I'm so sorry this is happening. I can only imagine how difficult it must be for you to hear this.
Take your time—I'm here if you need me to explain anything again or pause for a moment."

EXPLAINING PROGNOSIS

If offering Palliative Care:

"We're now shifting our focus to **palliative care**, which means rather than trying to reverse her condition, we'll be helping her stay as comfortable and free of distress as possible.

This includes making sure she's not in pain, supporting her with feeding as far as she can tolerate, and helping you access the care and emotional support you need."
"We'll work with palliative nurses and other professionals to support both of you—at home, or in a hospice if needed."

If offering End-of-Life Care:
"Because her condition is so advanced, we've made the decision to start **end-of-life care**.
This is a gentle form of care we provide when someone is approaching the final stage of their life.
Our focus will be entirely on comfort—making sure she is not in pain, is not distressed, and is treated with dignity in her final days or weeks.
We usually give small injections under the skin for medications, rather than IV lines or pills, as this is easier and less distressing for someone in this stage."

ADDRESS COMMON CONCERNS
"Can she be fed through a tube?"
"I understand this is upsetting. But at this stage, tube feeding wouldn't be beneficial. It can cause more distress than help—especially in someone with dementia who may pull it out or accidentally inhale the food.
We'll continue offering soft food and sips of liquid that she can tolerate naturally."
"Will she feel hungry?"
"Towards the end stages of life, the body's need for food and fluids naturally reduces. People often don't feel hunger in the same way, and forcing food can sometimes cause more harm."
"Can I take her home?"
"Yes, with the right support, it's possible. We'll involve social services, palliative nurses, and therapists to ensure her needs—and your needs as a carer—are fully supported at home before discharge."
"Why does she shout at me or not recognize me anymore?"
"That must be incredibly hard. But please know—it's not personal.
Dementia affects parts of the brain that control memory, recognition, and even behaviour.
Sometimes, shouting or agitation is how people with dementia express discomfort. Other times, it's due to confusion or fear."

SAFETY NETTING & SUPPORT
– "You're not alone in this.
We'll refer you to a full support team—including Macmillan or local palliative care nurses, social services, and charities that can provide emotional and financial support."
– "If you ever feel overwhelmed or need urgent help, please contact us or out-of-hours services right away."

FOLLOW-UP PLAN
– "You'll be hearing from the community palliative care team very soon."
– "If you have any worries or questions, or if things change, you can reach out to us at any time."
– "We're here to support both of you through this."

Refusal of Cannula – Terminal Bladder Cancer with UTI

Setting: Hospital ward
Role: FY2 doctor
Task: A 65-year-old man with terminal bladder cancer was admitted yesterday with UTI. His cannula is now blocked, and IV antibiotics are due. You've been asked to replace the cannula. The patient says, *"Let me go home. I*

don't have much time." He is aware of his prognosis and wants to spend time with his wife. Please speak to him, address his concerns, and manage appropriately.

Introduction
"Hello, I'm one of the doctors on the team looking after you. I've come because your cannula is blocked and your next dose of antibiotics is due.
Before we talk about that—can I confirm your name and age, please?
Thank you. I understand you were admitted yesterday with a urinary tract infection. How are you feeling today?"

Acknowledge the Concern
"I hear you're saying you'd like to go home. That's completely understandable, and I'd really like to help make that possible if we can.
Would it be alright if I ask a few questions to understand what matters most to you and check what we can safely do next?"

Data Gathering
Reason for Refusal
– "Is there anything in hospital making you uncomfortable?"
– "Or is it mainly about wanting to be with your wife and spend your time at home?"
Current UTI Symptoms & Treatment
– "Do you still have any pain, fever, or discomfort when passing urine?"
– "Since starting the antibiotics yesterday, do you feel any better?"
Understanding of Treatment & Cannula
– "Do you understand why we were giving IV antibiotics and what the cannula is for?"
– "Would you like me to explain what happens if we don't give the rest of the doses?"

Explanation:
"The antibiotics through the cannula help treat the infection faster and more effectively. If the full course isn't completed, there's a chance the infection could worsen or return. That said, if you're stable, we may be able to look at safe alternatives."

Prognosis Understanding & Future Planning
– "Have you had a chance to speak with your consultant about your cancer and what to expect?"
– "Do you feel clear about where things stand with your overall condition?"
Only if prompted by patient's remarks like "I don't have much time":
"It sounds like you're very aware of where things are heading. If you feel that more hospital treatment isn't what you want now, we can look at a comfort-focused approach that supports you at home, with full medical help if needed."
e. Goals of Care
– "Have you thought about what kind of care you'd want if the infection comes back—more antibiotics or mainly relief from symptoms?"
– "Has anyone discussed Do Not Attempt Resuscitation (DNAR) or future hospital visits?"
Social & Support
– "Who is at home with you?"
– "Do you have any support from family or carers?"
– "Have you had any help from palliative care nurses or community nurses before?"

ICE
– "What's most important to you right now?"
– "Is there anything you're afraid of or worried might happen?"
– "What were you hoping we could do for you today?"

Explanation & Reassurance
"I completely respect your wish to be at home. It's your time, and you want to spend it with the people you love. That's not only valid—it's something we all want to support.
You've had some antibiotic treatment already. If you're stable, we may be able to either switch to oral antibiotics or, if needed, arrange IV antibiotics at home."

Shared Plan (if stable)
"Here's what we can do:
– I'll ask the team to assess if you're clinically stable.
– If safe, we'll switch you to oral treatment or arrange community IV antibiotics.
– We'll coordinate discharge with a full care plan.
– I'll also involve the palliative care team to make sure you're supported with nurses, medications, and visits at home."

End-of-Life Discussion
"Since you mentioned you don't want to stay here and that time feels limited, it might be helpful to talk about what matters most to you in the time ahead.
We can move from hospital-based treatment to what we call supportive or end-of-life care. That means focusing on your comfort, keeping you symptom-free, and making sure you're where you want to be.
It's not about giving up—it's about giving you peace and dignity, with full support from the community team."

Addressing Concerns
Q: Why not just let me go now?
"If your body is stable enough to stop IVs, we'll arrange for you to go home today or tomorrow. We just need to confirm it's safe. That's our only reason for caution."
Q: Will I be in pain at home?
"We'll make sure you go home with strong pain relief and the right instructions. You'll have 24/7 access to support if things change."
Q: I don't want any more hospital admissions.
"We can set a clear care plan and note your preference to avoid hospital unless absolutely necessary."

Support & Safety Net
– "I'll speak with the senior doctor, palliative care team, and nurses today.
– We'll arrange for community services to take over care at home.
– You'll have contact numbers and medications ready."
– "If anything changes—like fever, breathlessness, or confusion—your family can call your GP or community nurse directly."

Closing the Consultation
"Thank you for speaking so openly. You've made your wishes clear, and we'll do everything we can to support that. I'll come back to you shortly with the full plan, but please know you're not alone in this—we'll walk with you through it."

Refusal of Breast Cancer Treatment

Setting: General Practice (Telephone)
Role: FY2 Doctor
Task: Speak to a 45-year-old woman recently diagnosed with DCIS (Ductal Carcinoma In Situ) who has made a phone appointment to refuse treatment. Address her concerns, offer support, and promote treatment options empathetically and clearly, in line with NICE and NHS CKS guidance.

Introduction
"Hello, am I speaking to [Patient's Name]? I'm Dr. [Your Name], one of the doctors at the practice. I understand you've booked this call with us today—how can I help you?"

Clarification and Empathy
Patient: "I don't want to go for the treatment."
Doctor: "Thank you for sharing that. Can I ask, just to be sure—what treatment are you referring to?"
Patient: "I don't want to go for the breast cancer treatment."
Doctor: "First of all, I'm really sorry that you've had to go through this. This must be a very overwhelming time. Can I ask what's making you feel this way about the treatment?"

Active Listening Phase

- Allow the patient to speak without interruption
- Nod, listen with an empathetic expression (if on video), and show visible concern
- Do not paraphrase or summarise prematurely

Patient Concerns

- Fear of death from cancer regardless of treatment
- Past loss of friends to cancer
- Misinformation from social media
- Fear of body image change, hair loss, loss of femininity
- Hopelessness, depression, trouble sleeping

Acknowledging and Thanking the Patient
"Thank you so much for being so open and honest. I can only imagine how hard this must be for you. I'm really sorry that you're having to face this."

Gentle Exploration (If Time Allows)

- "Has anyone explained what stage your cancer is at?"
- "Have you been told about how well the treatment can work at this stage?"
- "Who do you have at home supporting you—family, partner, children?"

Explanation: Hope and Possibility

- "Let me explain why we would always encourage you to consider treatment."
- "You've been diagnosed with DCIS—which is an early, non-invasive form of breast cancer. It means the cancer cells are confined and haven't spread."
- "Because it's caught early, this is one of the most treatable forms of breast cancer. Many people become cancer-free after treatment."
- "With modern treatment, many women go on to live full, healthy lives with their families."

Addressing Specific Concerns with Practical Solutions

- **Mental Health:**
  "You mentioned difficulty sleeping and feeling low. That's completely understandable. We can offer talking therapy—like Cognitive Behavioural Therapy (CBT)—which many patients find really helpful."
- **Hair Loss:**
  "Hair loss, if it happens, is usually temporary. Hair does grow back. There are excellent wigs and hair donation services that offer real-hair wigs."
- **Breast Loss:**
  "If surgery is needed, reconstruction options are available, often done at the same time as removal. Many women tell us they feel confident after reconstruction."
- **Misinformation:**
  "There's a lot online that can be frightening and not accurate. We recommend trusted resources like NHS or Macmillan, which give reliable and up-to-date information."

Emotional Reassurance and Support Network

- "I want you to know you're not alone. Your family sounds like a great source of strength, and we're here to support you too."
- "You don't have to make any decisions today, and it's okay to take time."

Shared Planning and Options

- Offer follow-up: "Would you be open to speaking with the breast care nurse or specialist team again?"
- Offer to send printed or digital resources to read
- Discuss possible involvement of a Macmillan nurse or patient support group

Safety Netting

- "If you notice any new changes—such as pain, swelling, or worsening mood—please call us immediately."
- "Even if you change your mind later, that's completely okay. We'll support you at any point."

Closure

"Thank you for sharing everything so openly. We will always be here for you—whether it's to talk again, help with decisions, or just listen. There is real hope, and you have a strong team and family to support you."

Post MI Medication Refusal

Setting: GP Practice – Routine Diabetic Annual Review
Patient Profile: 82-year-old woman, history of MI (10 years ago), well-controlled diabetes, BP, and cholesterol

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Introduction

"Hello, I'm Dr [Your Name], one of the doctors at the practice. Could I confirm your full name and age, please? Thank you. I understand you're here for your diabetes review. How have you been feeling recently?"

Acknowledge Statement and Paraphrase Concern

Patient says: "I want to stop taking medication. My results are normal."
"Thank you for sharing that. If I understood correctly, you're thinking about stopping your medications because your recent test results have been good—is that right? Could you tell me a little more about what made you feel this way today?"

Data Gathering (Gentle Exploration)

A. Understand Current Situation

- "How have things been with your diabetes lately?"
- "Any recent symptoms like tiredness, dizziness, chest pain or breathlessness?"
- "Are you taking your medication regularly or have you already made some changes?"

B. Cardiovascular History

- "I understand you had a heart attack in the past. Have you had any symptoms recently?"
- "Do you remember what treatments were started after that event?"

C. Explore Daily Life

- "How are things generally at home?"
- "Who do you live with? Do you have family around?"

D. Psychosocial & Functional Assessment

- "How are you managing with daily tasks like cooking, dressing, or moving around?"
- "How has your mood been recently? Have you felt low or without purpose lately?"

E. Emotional & Existential Expression

If after much gentle prompting, patient says: "I don't want to live anymore. I've lived my life."

- "Thank you for sharing that with me. That must be incredibly difficult to carry. Can I ask what's been going through your mind lately?"
- "Is this something you've felt for a while, or did it start more recently?"
- "Have you felt like this before?"
- "Have you ever thought about harming yourself?"

Explore Wishes & Future Care Plans

- "When you say you've lived your life, can I ask what matters most to you right now in terms of your health and care?"
- "Have you ever thought about making plans in case you become unwell in future?"
- "Some people in your situation choose to make a decision called a DNACPR—do not attempt resuscitation—in case their heart stops. Is that something you've ever considered or discussed with anyone before?"

(If not previously discussed, explain briefly in simple terms)

- "This doesn't mean we stop caring for you at all—it just means that if your heart were to stop, we would not do CPR, which can be quite aggressive and not always helpful in older patients."

ICE

- **Ideas:** "What do you believe about why your tests are normal?"
- **Concerns:** "Is there something in particular that's worrying you about continuing the medication?"
- **Expectations:** "What were you hoping would happen next after today's visit?"

Explanation (Supportive and Respectful)

A. Medication Purpose

- "I can see your results have been excellent—and that's because your medications are doing their job."
- "If we stop them, it could increase your risk of another heart attack or stroke—even if you feel well right now."

B. Personalised Care Frame

- "Our aim isn't to keep giving you pills forever—it's to help you feel well, live independently, and avoid unnecessary hospital visits."

C. Emotional Validation

- "What you've said about feeling like you've lived your life—it's powerful, and it's something many older patients feel. You're not alone in thinking that."

D. Advance Planning Support

- "If you're thinking about the future more now, we can have proper discussions—about things like palliative care, DNAR, and support at home. We can arrange for a nurse or someone from the palliative team to speak with you as well."

Management Plan (Respectful Shared Decision-Making)

- Arrange full medication review together
- Explore whether a simplified regimen is possible
- If patient is still reluctant:
    - "Would it help if we spoke with your family about what you're thinking?"
    - Offer to involve GP, palliative team, or advanced care planning
    - Offer referral to CBT or emotional wellbeing service

Safety Netting

- "If anything changes—your mood, your health, your thoughts—please reach out. You don't need to go through this alone."
- "If you ever feel unsafe or like you might hurt yourself, please come to us or call emergency services. We will always listen and support you."

Closure

- "Thank you for being so open with me today. I'm here to support you whatever you choose. I'll summarise what we've talked about and get back to you shortly after speaking with the team. We'll move forward in a way that respects your wishes, but also keeps you safe."

Support Offered:

- Medication review
- Offer of DNACPR discussion and leaflet
- Referral to wellbeing/CBT support
- Offer of palliative team input if appropriate
- Involve family/carers if patient agrees

Post-MI Medication Refusal + DNAR Request – Elderly Male

Setting: GP Practice
Role: FY2 Doctor
Patient: 82-year-old male, history of MI (10 years ago), routine diabetic/cardiac review
Presenting Concern: Wants to stop all medications, expresses emotional exhaustion, asks for DNACPR form and next steps. Lives alone. Fully understands his condition and treatment.

C – Clarify the Concern

"You've mentioned that you'd like to stop your medications and that you feel you don't want to continue like this anymore.
First of all, thank you for sharing that — I can imagine it took a lot of strength to say this out loud.
Can I ask — what made you bring this up today? What's been going through your mind lately?"

Explore Gently:

- "Is this something you've been feeling for a while, or is it more recent?"

- "Was there something specific — like your health, living alone, or day-to-day routine — that's become more difficult?"
- "Do you feel like you've lost interest in life, or more that you've made peace with things and are ready to slow down?"

If he says:
"I've lived my life. I'm tired. I just want peace. I understand my condition and I want to stop all treatment. I don't want to be resuscitated."

A – Assess the Background
"Of course. I'd like to understand a little more so we can make the right plan for you."
A. Physical Health & Function

- "Have you had any recent chest pain, shortness of breath, or changes in your energy or mobility?"
- "Are you still taking your usual medications every day — or have you already started skipping some?"
- "How have you been managing at home? Are you able to cook, shop, and keep on top of your routines?"

B. Mental & Emotional Wellbeing

- "Have you felt down, tearful, or anxious lately?"
- "Is this more of a general feeling of being done, or have you ever had thoughts of harming yourself?"
  (*Patient confirms no active suicidal ideation, just a wish to prepare for the future and live without interventions.*)

C. Social Circumstances

- "You mentioned you live alone. Do you have any family, friends, or neighbours who help or check in?"
- "If you ever felt unwell or needed help, who would you usually call?"

D. Understanding & Insight

- "Can I ask — in your own words, what do you understand about your condition and what the medications are doing?"
  (*Patient answers accurately – he understands they are for prevention, not for current symptoms.*)

R – Reassure and Respect the Choice
"Thank you for sharing all of that so clearly. It's very clear that you've put a lot of thought into this — and I want to reassure you that I will fully respect your decisions, and I'll help you make a safe and clear plan."
"It's completely normal for someone in your situation to start thinking about the future, and to consider stopping treatment that no longer feels useful. This doesn't mean we'll stop supporting you. You still deserve good care — just on your own terms."

E – Educate & Engage (Including DNACPR)
A. Stopping Medication – Simple Explanation
"The reason your blood pressure, cholesterol, and heart have remained stable is because the medication has helped keep things in balance.
But if you now feel the burden of taking them is too much, we can go through them one by one. Some may still offer value, others we may agree to stop."
B. DNAR – What It Means
"You also mentioned wanting a **DNAR** form — that stands for *Do Not Attempt Resuscitation*.
It means that if your heart were to stop, we would **not do CPR** — no chest compressions or electric shocks.
CPR in older people rarely works and can often lead to broken ribs, pain, and poor recovery.
Choosing not to have CPR is a **kind and considered decision**, and many people in your situation choose it to avoid unnecessary suffering."
"A DNAR only applies to that one situation — if your heart stops.
It doesn't mean we won't treat infections, or that we stop caring for you. We still support you completely."
C. Advance Care Planning – Gentle Offer

"Would you be open to discussing a bit more about the future — for example, if you were to get seriously unwell, what kind of care would you want or not want?
We can help document your preferences clearly, and make sure others know how to care for you in the way you want."

Management Plan (Collaborative, Respectful)
1. DNAR Completion
- Complete DNAR documentation
- Add to GP records, summary care record, and ambulance database
- Provide printed copy for patient to keep at home

2. Medication Review
- Go through current medications with patient
- Safely deprescribe those agreed to be non-essential
- Document decisions clearly with reasoning

3. Palliative & Community Support (if patient agrees)
- Offer referral to community palliative team for future planning
- "They're not just for end-of-life — they help people live more comfortably and independently."

4. Mental Health & Emotional Support
- Offer referral to wellbeing or talking therapy service
- "Not because I think you're unwell, but because sometimes it helps to have someone to talk to when you're navigating these decisions."

5. Follow-Up
- Arrange GP or nurse follow-up in 1–2 weeks
- Check on adjustment after medication changes
- Review emotional wellbeing and safety

Safety Netting
"If anything changes — your mood, your health, or even your decision — please reach out. We'll always be here to support you."
"If you ever feel unsafe, unwell, or even unsure, you can call us, NHS 111, or emergency services.
You're not alone in this."

Closure
"You've made your wishes very clear today, and I want to thank you for your honesty.
We'll make sure everything is recorded so that your care is respectful and aligned with your values.
If there's ever anything you need — support at home, planning help, or just someone to talk to — please let us know. You don't have to carry this alone."

Refusing Cannula – Pneumonia

Setting: FY2 in Medical Ward
Patient: 80-year-old man admitted with pneumonia, coexisting heart failure, long-standing comorbidities
Presenting Concern: Refuses cannula replacement and IV antibiotics; expresses desire to go home and stop medications

Introduction & Identity Check
"Hello, I'm one of the doctors on the team looking after you during this admission. Could I confirm your full name and age, please? Thank you."
Sit down, engage gently with calm tone.

Presenting Concern & Paraphrase
"I understand you've been admitted with a chest infection, and the team is planning to restart intravenous antibiotics through a new cannula. But I've been told you've asked not to continue with that. I'd really like to understand how you're feeling about everything."

Focused History & Context
a. Explore Understanding of Current Admission
- "Do you know why you were brought into the hospital this time?"
- "What have the doctors told you about the infection and the treatment you're receiving?"
- "Are you feeling more tired or breathless than usual lately?"

Confirms he understands he has pneumonia. Appears alert and oriented.

b. Confirm Capacity
- "Can I ask, are you able to understand the situation and what it might mean if we don't treat the infection?"
- "Do you feel like you're able to make your own decisions right now?"
- "Are you able to weigh the pros and cons and tell me clearly what you want?"

If he can explain clearly and consistently, he has capacity. Continue the discussion.

Explore PMAFTOSA & Social Background
- **P**: "Do you have any other medical conditions apart from your heart problems and this infection?"
- **M**: "Are you taking many regular medications at the moment?"
- **A**: "Any allergies?"
- **F**: "Can you manage your basic activities like dressing or washing on your own?"
- **T**: "Any recent trips to hospital or surgeries apart from this one?"
- **O**: "Any past serious infections or breathing problems?"
- **S**: "Are you sleeping or eating okay?"
- **A**: "Any recent falls, weight loss, or weakness?"

Gently transition to social context:
- "You mentioned your daughter earlier—do you live with her or on your own?"
- "Is there someone who helps you at home?"
- "Do you feel supported at home or is it getting difficult to manage things?"

Explore Reason for Refusal
- "Can I ask what's made you decide not to have the cannula changed?"
- "Is it the pain or discomfort of the procedure, or is it something more?"
- "Do you feel the treatments are becoming too much?"
- "Have you had this feeling for a while, or is it recent?"

He may say he's tired of the hospital and doesn't want to burden his daughter.

Explore Advance Planning and Legal Documents
- "I heard that you've signed an advance directive. Is that correct?"

- "Have you also made any decisions regarding a Lasting Power of Attorney—for example, someone to help make health-related decisions if needed?"
- "Have you discussed these wishes with your daughter?"
- "Would you like us to involve her in this discussion now or later?"
- "Have you made a Record of Wishes or any plan for where you'd like to be if things become more serious?"

Clarify details and gently prompt sharing.

ICE

- **Ideas:** "What's your understanding of what's going on with your health now?"
- **Concerns:** "What's your biggest worry about continuing treatment?"
- **Expectations:** "What do you feel would help you feel more at peace or more in control right now?"

Mood & Meaning

- "Have you been feeling down, low, or hopeless recently?"
- "Do you still enjoy small things like reading, watching TV, or talking to your daughter?"
- "Are you feeling like life has become a bit too much?"

Assess for depression or emotional fatigue; if any doubt, escalate for mental health input.

Explanation – Implications of Refusal

- "I appreciate that you've been through a lot, and I can only imagine how exhausting all this must feel."
- "If we don't replace the cannula and give you IV antibiotics, there's a significant chance that the pneumonia may worsen."
- "You may become more unwell and potentially pass away from this infection. I just want to make sure you fully understand that."
- "Stopping your heart medications can also increase the risk of fluid buildup and breathlessness, but we can support you to be as comfortable as possible if that's what you choose."

End-of-Life Care Options

"If you're feeling that you'd prefer not to continue aggressive treatment, we can support that fully and with dignity. There is something called *End of Life Care* or *Palliative Care*, which helps patients focus on comfort, symptom control, and emotional support in the last stages of life."

Supportive Options:

- **Where:** "You can receive this at home, in a hospice, or even here in hospital if needed."
- **Comfort:** "Our team can manage your symptoms like breathlessness, pain, or anxiety effectively."
- **Control:** "We'll involve you in every step. It's about what *you* want."

DNAR and LPA Clarification

- "Would you like to talk about DNAR, which means *Do Not Attempt Resuscitation*?"
- "It means that if your heart stops or you stop breathing, we wouldn't try CPR, as it's unlikely to succeed in someone with your health conditions and might be undignified."
- "It doesn't mean we stop caring for you—we'll still give all other treatments for comfort and support."
- "Have you discussed this with your daughter? Would you like us to explain it to her too?"

Plan, Safety Net, and Escalation

- "You absolutely have the right to make your own decisions."

- "If your decision remains not to proceed with IV treatment, I will respect that and make sure your care is comfortable and dignified."
- "I'll also inform the consultant and involve our palliative care team to make sure your wishes are followed properly."
- "Would you like to go home? If so, we can start organising discharge with community support."
- "And just so you know, even if you change your mind at any point, we'll be here to support that too."

Refusal of Admission – Elderly Patient with Suspected Pneumonia

Setting: A&E
Role: FY2 Doctor
Patient: 82-year-old man brought in from nursing home
Presenting Complaint: Cough, shortness of breath
Observations: SpO_2 92% on room air
Background: Diabetic (details to be confirmed)
Situation: Refusing hospital admission and wants to return to care home

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1. Introduction & Consent
"Hello, I'm one of the doctors here in A&E. Thank you for speaking with me today.
Can I just confirm your full name and age, please?
I understand you've been brought in from your nursing home because you weren't feeling well.
Would it be okay if I asked a few questions to understand what's going on, then we can talk through the best next steps?"

2. Presenting Complaint – Focused Symptom History (ODIPARA)

- "Can you tell me what's been bothering you?"
- "When did the cough and shortness of breath start?"
- "Has it been getting worse or staying about the same?"
- "Are you bringing up any phlegm? What colour is it?"
- "Have you had any fever, chills, or sweating?"
- "Do you feel breathless even at rest or only on movement?"
- "Any chest pain when breathing in or coughing?"
- "Have you been feeling more tired than usual?"
- "Any dizziness or confusion recently?"

3. Relevant Medical & Medication History

- "Have you been diagnosed with any long-term conditions like diabetes, high blood pressure, or heart or lung problems?"
- "Have you had chest infections like this before?"
- "Do you remember the last time you were admitted to hospital?"
- "Do you take any regular medications?"
    - "Any tablets for blood sugar, blood pressure, heart, or breathing?"
    - "Any inhalers or blood thinners?"
- "Do you take your medication by yourself, or does someone help you with them at the home?"
- "Any known drug allergies?"

4. Functional & Social Background (Brief, Practical)

- "Do you normally get around the care home by yourself, or do you need help?"

- "Do staff usually notice changes in your health quickly?"
- "Any recent falls or memory problems?"
- "Do you remember being confused in the past with infections?"

5. Explore Refusal – ICE

- "What do you think is going on today with your health?"
- "Do you feel better now than when you came in?"
- "Is there something in particular that's making you want to go back rather than stay here?"
  (*Patient says: "I'm feeling a bit better now, I just want to go home to rest."*)
- "Was there something about your last hospital stay that worried you?"

6. Capacity Check – Respectful & Structured

- "Would it be okay if I asked you a few questions to check that you're in the right state of mind to make this decision?"
- "Can you tell me what we've found today, and what the doctors have told you so far?"
- "What do you think might happen if we don't treat this infection in hospital?"
  (*Patient explains clearly. Alert, oriented, retains and weighs information – has capacity.*)

7. Provisional Diagnosis + Lay Explanation

Diagnosis: Likely *community-acquired pneumonia* in a high-risk elderly patient

Lay Explanation:

"It sounds like you've developed a **chest infection**, which is causing your breathing trouble and lowering your oxygen levels.

People your age — especially those with other health issues — are more at risk of this turning serious quickly, which is why we normally treat it here in hospital.

We'd usually give **antibiotics through a drip**, some oxygen if needed, and keep a close eye on your breathing."

8. Risks of Refusing Admission – Clear, Non-Threatening

"I understand you're feeling a bit better, and it's completely your right to make this decision — but I do need to explain the risks.

Without hospital treatment, the infection may get worse. Your oxygen levels are already lower than they should be.

It could lead to serious complications like fluid in the lungs, confusion, or a widespread infection called **sepsis** — which can be life-threatening."

9. Offer Reasonable Compromise

"If the hospital setting is uncomfortable, we could:

- Admit you just for 24 hours to monitor your oxygen and start treatment
- Arrange an early discharge if you're improving
- Keep your stay as short and supported as possible
  Would you be open to that idea as a middle ground?"

10. If Still Refusing – Escalate Respectfully

"If you're still sure you'd like to return to the nursing home, that's your decision — but I will:

- Ask a senior doctor to speak with you as well
- Make sure you understand and accept the medical risks
- If you agree, we'll ask you to sign a form confirming this
  We'll also call the nursing home staff and your GP to arrange follow-up care."

11. Safety Netting & Emergency Advice
"If you do decide to go home, please watch out for signs like:

- Worsening breathlessness
- High fever
- Feeling more sleepy or confused
- Chest pain or not being able to eat or drink

If any of those happen, please come back to A&E immediately or call 999. We'll also make sure the nursing home knows exactly what to watch for."

12. Follow-Up Plan & Documentation

- Inform nursing home staff of discharge and treatment refusal
- Notify patient's GP
- Offer safety-net leaflet (chest infection advice)
- Refer to community or rapid response team if available

Student Note: How the Diagnosis Was Made
82-year-old man presented with cough, breathlessness, and SpO_2 92%. Likely diagnosis is **community-acquired pneumonia** based on age, symptoms, and vital signs.
He has multiple risk factors (age, likely diabetes, care home setting). Patient assessed to have full capacity.
Refusal handled by respectful discussion, explanation of risks, compromise attempts, safety netting, and escalation to senior team.

Chapter 25: Miscellaneous Cases

Learning Disability Consultations

I. Key Principles to Remember

1. **Adapt your communication style**
    - Use clear, simple, patient-friendly language at all times.
    - Speak slowly and clearly without being patronising.
2. **Be patient and calm**
    - Expect to repeat or rephrase information multiple times without showing frustration.
3. **Check understanding periodically**
    - Use open phrases like "Does that make sense so far?" or "Would you like me to go over that again?" rather than asking after every sentence.
4. **Acknowledge and respect the patient's difficulties**
    - If the patient discloses they have a learning disability, respond supportively and thank them for sharing.
5. **Focus on practical, easy-to-follow instructions**
    - Break down steps for tasks like medication timing or insulin administration.
    - Provide clear structure (e.g., "Take this tablet once in the morning, after breakfast.")
6. **Use visual aids or written formats if helpful**
    - Offer diagrams, easy-read formats, or written summaries, but first check if the patient can read or write.
7. **Ensure empathy and warmth throughout**
    - A kind, encouraging tone is essential. This domain is heavily scored in LD stations.
8. **Involve carers when appropriate**

- With consent, family members or caregivers can be included to support understanding and adherence.

9. **Tailor the safety netting**
   - Provide clear, specific signs to watch for and explain when to seek medical help.
10. **Ensure follow-up is well-understood**

- Schedule review appointments clearly and explain their purpose in simple terms.

II. Things to Avoid in Learning Disability Cases

1. **Do not use complex medical terms without explanation**
   - Avoid words like "hypertensive," "metabolism," or "contraindicated" unless you explain what they mean clearly.
2. **Don't speak too fast**
   - Pace your words, and pause to check comprehension.
3. **Never assume the patient's understanding level**
   - Each patient is different. Explore how much support they need without making assumptions.
4. **Don't oversimplify to the point of condescension**
   - Stay respectful. Avoid phrases or tone that sounds childish or dismissive.
5. **Don't forget to check literacy**
   - Before handing over written materials, gently check if the patient is comfortable reading.
6. **Don't rush the consultation**
   - Give the patient time to respond and ask questions.
7. **Avoid informal or unclear terminology**
   - Terms like "jelly scan" or "oven scan" may confuse the patient unless clearly explained.
8. **Don't ignore the patient by addressing the carer only**
   - Always speak to the patient directly and include the carer only with consent or for support.
9. **Avoid overwhelming the patient**
   - Space out the information and confirm one idea before introducing the next.
10. **Don't skip exploring their specific learning challenges**

- Ask about memory issues, routines, support systems, or anything they find hard to manage.

III. Additional Considerations

- **Anticipate a chaotic or disorganised consultation style**
  - Some scenarios may feel confusing or erratic—maintain structure and calmness throughout.
- **Medication adherence is often tested**
  - Emphasise the importance of taking medications regularly and explore barriers to this.
- **Respect autonomy while ensuring safety**
  - If the patient lacks capacity, follow up appropriately (e.g., capacity assessment, best interest decision).
- **Be kind but firm when medical intervention is necessary**
  - In serious conditions, proceed with clear justification even if full understanding is limited.

IV. Follow-Up and Safety Netting

- **Always give a clear follow-up plan**
  - "We'll review this again in two weeks to make sure you're feeling better and coping well."
- **Explain red flag symptoms simply**
  - "If you feel much more tired, dizzy, or your breathing becomes difficult, please call us straight away."
- **Offer written or visual information if suitable**

- But always check the patient's literacy or ask if they would prefer someone to explain it with them at home.

Rivaroxaban Follow-Up – Learning Disability

Setting: Anticoagulation Clinic
Patient: 40-year-old male with learning disability
Diagnosis: Deep Vein Thrombosis (DVT) diagnosed 6 weeks ago
Current Issue: Not taking rivaroxaban regularly

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1. Introduction
"Hello, I'm one of the doctors here at the clinic. Thanks for coming in today. Before we start, could I confirm your full name and age, please? Great. I'll be having a chat with you today about your leg problem and the tablet you were given for it."
[Pause, make eye contact, keep voice slow and friendly]
"I also learned from my notes that you have some learning difficulties. If it's okay with you, I'd like to understand this better so I can help you in the best way possible."

2. Learning Difficulty Assessment
- "Can you tell me a bit more about the kind of difficulties you have?"
- "Are you able to read or write?"
- "Do you manage your medications yourself?"
- "Is there someone who helps you every day or reminds you to take your tablets?"

(Adapt how you explain and how fast you speak based on what the patient says)

3. Reason for Visit
- "You've come today for a check-up about the medicine you're taking for your leg."
- "Do you remember what happened to your leg a few weeks ago?"

Expected patient confusion or limited understanding

4. Explain the Condition (Lay Explanation – Check Understanding)
"Let me explain what happened with your leg — our blood usually flows like water. But sometimes it becomes thick, like jelly, in one place. That thick blood, called a clot, can block the flow and cause pain and swelling. This is what we call a clot or DVT."
"This medicine — called Rivaroxaban — is what helps to stop the blood from going thick again."
- "Is that clear so far?"
- "Do you want me to repeat anything?"

5. Explore Patient's Understanding of Medication
- "Do you know the name of the tablet you're taking?"
- "Can you try saying it after me? It's called *Rivaroxaban*."
- "How often do you take it?"
- "Do you take it every day, or only when you feel pain?"

If patient says: "Only when I have pain"
- "Okay, thank you for telling me. I'm really sorry — I don't think we explained this well last time. That's our fault."

6. Assess Current Symptoms and Side Effects

- "Is there still any swelling or pain in your leg?"
- "Does the leg feel hot or red?"
- "Do you have any bleeding — in your mouth, gums, in your poo or urine?"
- "Any bruises showing up easily?"
- "Any chest pain, breathing trouble, or fast heartbeat?"

7. Social Background & Support

- "Who do you live with?"
- "Does anyone help you at home?"
- "Is there a carer who visits you?"
- "Are you able to do things like cooking or shopping by yourself?"

(Skip formal "occupation" questions. Keep it simple.)

8. Management Plan (Explain Clearly and Slowly)

"Let's fix the main problem first. The tablet you're taking — Rivaroxaban — needs to be taken every day. Not just when there's pain. This is because it stops the clot from coming back."
"Try to take it at the same time every day. For example, can we pick 6 o'clock in the evening?"

- "What do you usually do at 6 pm?"
- "Is there a TV show you like to watch then?"
- "You could take the tablet just before that show. Or would setting an alarm at 6 pm help?"

"Does that sound okay to you?"

9. Explain Risks of Missing Medication

"If you forget this medicine, the blood clot can come back. The clot can even travel to your lungs, which can be very dangerous and make it hard to breathe."

- "That's why it's very important to take it every single day."
- "Even if you feel fine — you still need to take it."
- "Is this clear so far?"
- "Do you want me to go over it again?"

10. Safety Netting

"While on this medicine, please watch out for signs of bleeding. That means bleeding from the mouth, gums, nose, or when you go to the toilet. If you get a lot of bruises or feel very dizzy, speak to a doctor."
"If you fall and hit your head — go straight to hospital. You might need a brain scan, even if you feel okay."
"Also, don't take tablets like aspirin or ibuprofen from the pharmacy without checking with us first."
"If you see a dentist or any doctor — tell them you take Rivaroxaban."

11. Final Check and Offer Written Info

- "Do you have any questions for me?"
- "Would you like me to write any of this down for you?"
- "Is there someone at home who can help remind you?"

Provide simple printed information if patient is able to read, or offer verbal plan with carer support if not.

12. Close

"You've done great today, thank you for telling me everything. I know it can be hard sometimes when doctors use confusing words. I'll keep it simple and make sure you're always comfortable to ask."
"We'll see you again soon to make sure everything is going well."

Insulin Management – Learning Disability

Setting: Outpatient Medical Clinic
Patient: 24-year-old male with learning disability
Reason for Visit: Annual diabetes review
Recent History: DKA admission 2 weeks ago
Current Treatment:
• Rapid-acting insulin – 3 times/day
• Long-acting insulin – once at night
Support: District nurse helps with insulin
Today's Blood Sugar: 11 mmol/L

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1. Introduction
"Hello, I'm one of the doctors here in the clinic. Thank you for coming in today. Could I check your full name and age, please?"
[Warm tone, gentle pace]
"I understand you've come in for a diabetes check-up today."
"Also, I see in my notes that you have some learning difficulties. If you're comfortable, could you tell me a little more about the kind of difficulties you face? That way, I can explain things in the way that suits you best."

2. Understanding Their Challenges
- "Are you able to read or write?"
- "How do you usually manage your medications?"
- "Is there someone who helps you at home or reminds you to take your medicines?"
- "Do you sometimes forget things?"

Expected patient response: "Sometimes I forget things, doctor."

3. Explore Past Admission
- "You were admitted to the hospital recently. Do you remember what happened?"
- "Would you like to tell me in your own words why you were admitted?"

Likely reply: "I was feeling very sick."

4. Lay Explanation of Diabetes and DKA
"You have a condition called diabetes. That means your body has too much sugar in the blood."
"Two weeks ago, you were admitted because your body didn't get enough insulin — the medicine that helps control the sugar."
"When sugar levels go too high and there's no insulin, your body makes something called ketones. These ketones can make you feel very sick. That's why you had to go to hospital."
- "Do you understand so far?"
- "Would you like me to explain again?"

5. Explore Current Understanding and Medication Use
- "What do you understand about your insulin treatment?"
- "Do you take your insulin regularly?"
- "How often do you take it?"

If patient says: "Only when I eat sugary things"
- "Thanks for telling me that. I'm sorry we didn't explain this better before — it's not your fault."

- "Has anyone explained the difference between the two types of insulin?"

6. Symptoms and Complications

- "Do you feel okay these days?"
- "Do you feel tired, thirsty, or needing to pass urine often?"
- "Have you had any headaches, blurry vision, or fast heartbeat?"
- "Do you feel shaky or sweaty at times — like your hands shake or you feel dizzy?"

7. Social Support

- "I understand a nurse helps you with the insulin. Is that right?"
- "How often do they visit?"
- "What kind of help do they give you — do they give you the injection or remind you?"
- "Who do you live with?"
- "Do you do your meals and medicines yourself, or do you have someone to help?"
- "What sort of things can you do on your own during the day?"

8. Management Plan – Review of Blood Sugar

"We checked your sugar today — it was 11. For your condition, we usually aim for it to be under 9."
"This means your sugar is still a little high, and we need to make sure you're taking the insulin at the right times."

9. Insulin Education – Simple Language

"You have been given two types of insulin — one for the day and one for the night."

Short-Acting Insulin

"This one is taken **three times a day** — once with **breakfast**, once with **lunch**, and once with **dinner**."
"Before each meal, you take this insulin. Then, you must eat **within 15 minutes**."
"This is your *daytime insulin*. It may come with an orange or yellow label — like the sun."

Long-Acting Insulin

"This one is taken **once a day**, at night before sleep."
"It helps keep your sugar controlled while you sleep."
"It may come with a blue label — like the moon."

10. Hypoglycaemia Education

"Sometimes insulin can make your sugar go too low. You may feel dizzy, sweaty, shaky, or hungry."
"If this happens, stop what you're doing and eat something sugary — like a chocolate bar, glucose tablets, or a sugary drink."
"It's best to **always carry something sweet** with you — in your bag or pocket — just in case."

11. Practical Tips to Improve Adherence

"Let's make this easier for you."

- "I'll write down the timing for both insulins and give it to you."
- "You can stick it on your fridge or table."
- "Having a clock nearby might also help — when you see the time, it can remind you."
- "You can also ask the nurse or someone at home to help remind you."

"Would that work for you?"

12. Safety Netting & Follow-Up
"We'll let your GP and district nurse know about this visit."
"We'll also ask the diabetic nurse to follow you up and help you understand things better."
"If you ever feel very unwell — like breathing fast, feeling very tired, or being confused — please go to hospital straight away."

- "Do you have any questions before we finish?"
- "Would you like me to explain anything again?"

[Close with kindness and encouragement]
"You're doing really well. It's not always easy, but we'll help you along the way."

DVT Diagnosis – Learning Disability

Setting: A&E
Patient: 25–28-year-old man with learning disability
Presenting Complaint: Leg pain
Doppler Scan: Confirmed DVT

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1. Introduction
"Hello, I'm one of the doctors here in A&E. Thanks for coming in today. Can I check your full name and age, please?"
[Warm tone, slow pace, maintain eye contact]
"I understand from my notes that you have some learning difficulties. If it's okay, can you tell me a bit more about what kind of difficulties you have? That'll help me explain things in a way that makes sense for you."

- "Are you able to read or write?"
- "How do you usually understand your medical information?"
- "Is there anyone who helps you with medicines or hospital appointments?"

2. History of Presenting Complaint (Leg Pain)
"Would you like to tell me what happened with your leg?"

- "When did the pain start?"
- "Does the pain stay all the time or does it come and go?"
- "Have you noticed any swelling?"
- "Is the skin red or warmer than the other leg?"
- *If patient struggles, rephrase gently: "Is your leg hotter than normal?"*

3. Screening for Pulmonary Embolism (PE)
"Sometimes, a problem in the leg like this can affect your breathing. So I just want to check a few things."

- "Have you felt breathless recently?"
- "Have you had any chest pain?"
- "Have you been coughing? Did you see any blood when you coughed?"

4. Screening for Risk Factors

- "Have you ever had a clot in your leg or lungs before?"
- "Has anyone in your family had a similar problem?"
- "Are you taking any hormone medicines like testosterone or anything similar?"
- "Have you been on a long journey, like a long flight or bus ride?"
- "Have you been in bed for a long time or had any surgeries recently?"
- "Have you lost weight without trying?"

- "Have you felt feverish or had a temperature?"
- "Have you noticed any new lumps or bumps in your body?"

Reassure: "These are routine questions – we ask them to understand why the clot may have happened."

5. Verbalised Examination Summary (MAFTOSA)
"I've had a look at your leg – it's swollen and painful, with some redness and warmth. Your pulse and blood pressure are okay. The scan we did today – called an ultrasound – showed a clot in your leg."
Explain: "Ultrasound is a scan that uses sound waves to look at your blood flow. We put some gel and use a small machine over your leg to see the veins."

6. Lay Explanation of DVT
"Usually, blood flows in the body like water in a river. But sometimes, blood can become thick and sticky – like jelly – and get stuck in one place."
"This has happened in your leg, which is why it's swollen and painful. This is called a DVT – a blood clot in the leg."
"Sometimes, a small bit of the clot can move to the lungs and cause breathing trouble. That's why I asked about chest pain and breathlessness."

- "Do you understand so far?"
- "Would you like me to repeat that?"

7. Admission Plan
"We need you to stay in hospital for a little while so we can keep an eye on you and start your treatment safely."
Tests we will do:

- "A **chest X-ray** – that's a picture of your lungs"
- "An **ECG** – that's a heart tracing to see how your heart is working"
- "A **CT scan** if needed – this looks closely at your lungs to check for any clots"
- "Some **blood tests**, including one called D-dimer, to check the clot and your general health"

8. Treatment Plan
"We'll start you on a medicine that helps thin the blood. This helps stop the clot from getting bigger and helps your body slowly break it down."

- "The medicine may be called **Rivaroxaban** or **Apixaban** – we'll choose what suits you best."

Duration:

- "If we're not sure what caused it, you'll need to take the medicine for at least **6 months**."
- "If we find a reason, like a long journey or surgery, you might need it for **3 months** to start with."

"You'll stay in hospital just for a short while. Once things are stable, you'll go home and continue the medicine."

9. Addressing Patient Concerns
If patient asks why it happened:
"Sometimes, clots can happen without a clear reason."
"In some people, it may be because of their genes – something they inherit from family."
"Sometimes, we never find out exactly why. But the good news is we found the problem, and we are treating it."

10. Safety Netting
"When you go home, it's important to watch out for any signs of trouble."

- "If your leg gets more swollen or painful, or you feel short of breath or dizzy – call the hospital or go to A&E straight away."
- "Always take your medicine every day – that's really important."

11. Follow-Up and Support
"We'll arrange a follow-up clinic to check how you're doing."
"If you ever forget how to take your medicine or feel unsure, you can call your GP or come back to the hospital."
"If someone at home helps you, I can also give a written sheet with instructions."

- "Would you like something written down?"
- "Do you want me to go over anything again?"
- "Is it okay if we ask your carer to help remind you if needed?"

12. Closing the Consultation
"You've done really well today. I know this is a lot of information. Thank you for telling me everything honestly."
"We'll take good care of you in hospital, and I'll make sure everything is clearly written down for you."
"Please don't hesitate to ask me again if anything feels unclear."

ACE Inhibitor–Induced Angioedema

Station Type: History + Explanation + Management (Medical Side Effect)
Setting: GP clinic – Same-day appointment
Role: FY2 doctor

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1. Introduction
"Hello, I'm one of the doctors here today. Thank you for coming in. Could I confirm your full name and age, please?"
[Sit down, open body language, friendly tone]
"I understand you've come in because of some swelling — is that right?"
[Allow patient to describe complaint. Then paraphrase]
"So you've noticed swelling on your face/lips. Let's go through it in detail, and I'll do my best to help you."

2. History – Data Gathering
Presenting Complaint

- "Can you show me exactly where the swelling is?"
- "When did it first start?"
- "Is it staying the same, or is it getting worse or spreading?"

Description

- "Is it painful or itchy?"
- "Do you feel any tightness or tingling?"
- "Have you had anything like this before?"

Red Flag Symptoms

- "Have you had any difficulty breathing?"
- "Any changes in your voice, hoarseness, or trouble swallowing?"
- "Have you felt dizzy or noticed any rash or chest pain?"

Possible Triggers

- "Have you started any new medicines recently?"
- "Are you on any tablets for blood pressure, like Ramipril or Lisinopril?"
- "Do you remember when you started them?"
- "Has the dose changed recently?"

Differential Screening

- "Do you have any known allergies?"
- "Have you eaten anything new recently?"

- "Have you had a cold, cough, or fever?"
- "Have you noticed a dry cough recently?"

Systems Review

- "Any weight loss, fever, or tiredness?"
- "Any palpitations or chest tightness?"

3. PMAFTOSA

- PMH: "Any known heart, kidney, or autoimmune conditions?"
- Meds: "Can you list all the medications you're taking?"
- FHx: "Anyone in your family had similar swelling or reactions?" (→ hereditary angioedema)
- SHx: Smoking, alcohol, lifestyle
- Allergies: Confirm none recorded or if Ramipril is suspected
- Functioning: "Has this swelling made it difficult for you to talk, eat, or go to work?"

4. ICE – Ideas, Concerns, Expectations

- **Ideas**: "What do you think might be causing this?"
- **Concerns**: "Is there anything you're especially worried about?"
- **Expectations**: "What were you hoping I could do for you today?"

5. Examination

Explain each step gently, especially if swelling is visible

- General: Facial swelling, distress, voice quality
- Vitals: HR, RR, BP, O2 sats, Temp
- Airway: Look for lip/tongue swelling, stridor
- Chest: Listen if breathlessness present

No signs of airway compromise in this case – treated as stable outpatient

6. Diagnosis Explanation

"From what you've told me — and based on your medication — I believe this swelling is caused by a side effect of your blood pressure tablet, likely Ramipril."

"This side effect is called **angioedema**. It's not an allergy, but something this medicine can rarely cause. It makes some body chemicals build up, leading to sudden swelling — especially in the face, lips, or tongue."

"Even though your breathing is fine now, this can be serious if it happens again — especially if it affects the throat or airway. So we need to act on it today."

- "Does that make sense so far?"
- "Would you like me to go over anything again?"

7. Management Plan

1. Stop ACE Inhibitor

- "We'll stop your Ramipril today and mark it clearly in your records as a dangerous reaction."
- "You must never take any ACE inhibitor again — anything ending in '-pril'. The next episode could be more serious."

2. Change to Safer BP Medication

- "We'll change your blood pressure medicine to something safe — like Amlodipine, which does not cause this kind of swelling."

3. Supportive Medications

Even though this is not an allergy, these help settle the reaction

- "We'll give you an **antihistamine**, like Chlorphenamine."

- "You'll also take a **short course of steroids**, like Prednisolone, to reduce the swelling."

4. No Adrenaline

- "Adrenaline is only used if the swelling causes breathing problems, which isn't the case right now."

8. Advice to the Patient

- "Avoid **all ACE inhibitors** in the future — check for medications ending in '-pril'."
- "Please tell any doctor, nurse, or dentist you meet that this happened."
- "You can wear a **MedicAlert bracelet** or carry a card so others know quickly in an emergency."
- "We'll ask you to keep a blood pressure diary to monitor your readings at home."

9. Safety Netting

"If the swelling comes back — especially if it affects your voice, tongue, or breathing — please **call 999** immediately or go straight to A&E."
"If the swelling worsens over the next day or two, come back to this clinic or go to urgent care."

10. Follow-Up Plan

- "We'll arrange a **GP follow-up in one week** to:
  - Check your new medication is working
  - Review your blood pressure
  - Ensure the swelling has fully settled"
- "If anything changes before that — call us or come in."

11. Leaflet

"I'll give you a leaflet from the NHS that explains this condition and what to look out for."

12. Closing

"Thank you for explaining everything clearly today — I know this must have been worrying. You've done the right thing by coming in. I'll make sure your records are updated and you're on the right treatment moving forward."

Student Note: How the Diagnosis and Plan Were Made

A patient on Ramipril presented with facial swelling and no airway compromise. History ruled out allergy and infection. Red flags like voice change and SOB were absent. This was a textbook case of ACEI-induced angioedema. Medication was stopped, supportive therapy given, and safe long-term antihypertensive planned. Education and safety netting were emphasized. Clear, slow explanations and patient understanding checks ensured communication was adapted for patient safety and learning needs.

Steroid-Induced Acne

Station Type: History + Examination + Explanation + Management
Setting: GP Surgery
Patient: Mr X, 28 years old
Role: FY2 Doctor

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1. Introduction

"Hello, I'm one of the doctors at the practice. Thanks for coming in today. Could I please confirm your full name and age?"
[Establish rapport, sit at eye level, relaxed tone]
"Before we begin, is it okay if I ask you a few questions to understand the issue better?"

2. History – Focused Data Gathering

Presenting Complaint

- "What brings you in today?"

Patient reports recent acne breakout ongoing for 2 months, worse with sweating at the gym.

A. Acne Symptom History

- "When did you first notice the acne?"
- "Has it changed or spread over time?"
- "Where do you notice the spots — just on the face or elsewhere too?"
- "Do they form whiteheads, blackheads, or large lumps?"
- "Any pain, itching, or pus coming out of them?"
- "Does anything make it worse — like gym, heat, or products?"

B. Aggravating Factors & Skin Care

- "Do you use any face creams, oils, or specific soaps?"
- "Do you usually wash your face after gym sessions?"
- "Do you ever pick or squeeze the spots?"

C. Supplement & Drug Use

- "Are you taking any supplements, protein powders, or hormone boosters?"

Patient reports Dianabol use for 4 months (anabolic steroid).

- "Any other medications or over-the-counter skin treatments?"

D. Steroid-Related Systemic Effects

- "Have you noticed any mood changes or trouble sleeping?"
- "Any increased sweating, acne on chest or back, or hair thinning?"
- "Any changes in sex drive or testicle size?"

E. ICE – Ideas, Concerns, Expectations

- **Ideas**: "What do you think might be causing the acne?"
- **Concerns**: "Are you worried about scarring or how long this will take to go away?"
- **Expectations**: "What were you hoping I could help with today?"

Patient asks: Will acne go away if I stop steroids? Can I keep working out?

3. PMH / Lifestyle / Psychosocial

- **Past Skin History**: "Have you had skin issues before?" → *Mild teenage acne*
- **Medications**: *None apart from steroids*
- **Allergies**: *None*
- **Lifestyle**: Explore gym routine, sleep, alcohol, smoking, diet
- **Social**: Ask about occupation, mental wellbeing, and support at home or gym

4. Examination

- **General**: Look for signs of distress, steroid side effects
- **Inspect**:
  - Face, shoulders, back, chest
  - Count lesions; check for whiteheads, blackheads, nodules, scarring
- **Assess for steroid use signs**:
  - Oily skin
  - Male-pattern baldness
  - Gynecomastia
  - Testicular atrophy

5. Provisional Diagnosis

"Based on your history and examination, this appears to be **steroid-induced acne**. Steroids like **Dianabol** can increase oil production in the skin. This extra oil clogs the pores and leads to red, inflamed breakouts. The good news is — this is treatable, especially once the cause is removed."

6. Management Plan

A. Immediate Advice – Stop Anabolic Steroids

- "These steroids are the likely cause of your acne. Stopping them is the most important step."
- "They can also harm your liver, affect your natural hormone levels, and raise your cholesterol."

B. Investigations

- **Liver Function Tests (LFTs)** → due to liver toxicity risk
- **Hormonal Profile**: Testosterone, LH, FSH
- **Lipid Profile** → steroids can elevate cholesterol
- **FBC/U&E** if oral treatment is planned

C. Medical Management – Based on Severity

If Mild to Moderate Acne (non-scarring):

- Topical combination treatment:
  - **Benzoyl peroxide 5%**
  - **Topical retinoid** (e.g., adapalene)
  - **Topical antibiotic** (e.g., clindamycin)

If Moderate to Severe Acne:

- Add oral antibiotics for 8–12 weeks:
  - **Doxycycline** or **Lymecycline**
  - Review at 6–8 weeks
- *Avoid combining oral and topical antibiotics unless using fixed combinations*

If Nodulocystic or Scarring Acne:

- **Refer to dermatology** for:
  - Oral **isotretinoin**
  - Specialist care and monitoring (due to liver/mood risks)

D. Lifestyle & Skin Care Advice

- Use a **non-comedogenic face wash** twice daily
- Shower promptly after workouts
- Avoid greasy moisturizers and hair products
- Do not pick or squeeze spots
- *Reassure*: "You can keep working out — sweating doesn't cause acne as long as you shower and keep skin clean."

7. Safety Netting

- "Come back sooner if the acne worsens, becomes painful, or you feel low in mood."
- "Seek urgent help if you get chest pain, extreme tiredness, or yellowing of the eyes (signs of liver strain)."

8. Follow-Up Plan

- Repeat blood tests in **4–6 weeks**
- Review acne response in **6–8 weeks**
- Refer to dermatology if:
  - No improvement
  - Scarring
  - Abnormal blood tests

9. Leaflet & Support

- **Provide NHS Acne Leaflet**
- **Provide NHS LiveWell steroid harm resource** (link or printed handout)

10. Addressing Patient Concerns

"Yes, stopping the steroids is very likely to reduce the acne significantly over time."
"And yes — you can absolutely continue exercising. Sweating is not the problem — it's the effect of the steroids on your skin glands."

Student Note: How the Diagnosis and Plan Were Made

Young male with recent acne flare, distribution and features consistent with steroid-induced acne. Confirmed use of anabolic steroid (Dianabol), with additional systemic features. History, exam, and patient concern suggest cosmetic and hormonal impact. Clear, non-judgmental explanation given. Anabolic steroids stopped, bloods arranged, appropriate acne treatment started based on severity. Follow-up planned, lifestyle and safety netting advice provided. Patient education and support offered using NHS resources.

Post-operative Constipation After Hip Surgery

Station Type: History + Explanation + Management
Setting: Orthopaedic Ward
Patient: Mrs. X, 78-year-old female
Role: FY2 doctor on the ward team
Post-op Day 5 – Total Hip Replacement
Vitals: Haemodynamically stable, no systemic red flags

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1. Introduction

"Hello Mrs. X, I'm one of the doctors on the team looking after you. I understand you had hip surgery a few days ago and haven't had your bowels open since. I'd like to ask a few questions to understand what's going on and make a plan together. Is that okay with you?"

2. History of Presenting Complaint

- "When was the last time you opened your bowels?"
- "So it's been 5 days since the operation?"
- "Before your surgery, how often did you usually pass stool?"
- "Has anything helped so far — like eating more, walking, or any medicines?"

Associated Symptoms:

- "Have you had any tummy pain or bloating?"
- "Any nausea or vomiting?"
- "Have you been able to pass wind?"
- "Any discomfort when trying to open your bowels?"

3. Red Flag Screening

- "Have you vomited recently?"
- "Are you completely unable to pass wind?"
- "Is the pain very severe or crampy?"
- "Any blood in the stool?"
- "Any fevers or chills?"

- "Any previous bowel problems like IBS or obstruction?"

4. Review of Pain Control

- "Are you currently taking co-codamol for pain?"
  (Codeine is a common cause of post-op constipation)
- "How often are you taking it?"
- "Are you on any other painkillers like paracetamol or ibuprofen?"
- "How would you rate your pain right now out of 10?"

5. MAFTOSA Review

- **M**: "Have you had constipation before or any bowel issues like IBS?"
- **A**: "Do you have any allergies to medications?"
- **F**: "Any family history of bowel disease or bowel cancers?"
- **T**: "Have you travelled recently or been immobile before the surgery?"
- **O**: "What sort of work did you do before retirement?"
- **S**: "Do you live alone or have someone at home to help you?"
- **A**: "Have you tried any herbal remedies or over-the-counter laxatives already?"

6. DESA – Lifestyle Factors

- **Diet**: "How's your appetite lately? Are you eating fruits, vegetables, or fibre?"
- **Exercise**: "Have you been able to walk around a bit or are you still in bed most of the day?"
- **Smoking & Alcohol**: "Do you smoke or drink alcohol or caffeine?"

7. ICE – Ideas, Concerns, Expectations

- **Ideas**: "Do you think this is related to your surgery or medications?"
- **Concerns**: "Are you worried something serious might be going on?"
- **Expectations**: "Were you hoping we could give you something today to help move things along?"

8. Examination (Verbalised)

- "I'd now like to check your vitals and examine your tummy."
  - Pulse, blood pressure, temperature
  - Look for distension or tenderness
  - Listen for bowel sounds
- "If you're comfortable with it, I'd also suggest a brief rectal examination to check if there's stool in the back passage — it can help us decide the next best step."

9. Diagnosis Explanation

"Mrs. X, based on your history and the medication you're on, this sounds like constipation caused by the **codeine** in your painkillers. You've also been less mobile than usual, and your diet may have changed a bit — these all add up."
"Constipation is quite common after surgery, but we should treat it now so it doesn't become more uncomfortable or harder to manage."

10. Management Plan

1. Stop or Switch Offending Medication

- "We'll stop your co-codamol and switch to **paracetamol** instead."
- "If needed, we may add **ibuprofen** if your stomach and kidneys are healthy."
- "We'll monitor your pain and adjust if needed — we won't let you be in pain."

2. Start Laxatives

First-line Treatment:

- **Lactulose 15 ml BD** (Osmotic laxative):
  "It draws water into the stool and softens it — usually works in 1 to 2 days."
- **Senna 7.5–15 mg at night** (Stimulant laxative):
  "It helps the bowel muscles push the stool through."

3. Rectal Measures (if not improving or impaction suspected)

- **Phosphate Enema**:
  "A small amount of medicine into the back passage to help you go — usually works within hours."
- **Suppositories** (e.g., glycerin or bisacodyl): If preferred
- **Manual Disimpaction**:
  Only if very hard stool is felt on rectal exam

4. Non-pharmacological Measures

- "Drink plenty of fluids — aim for at least 1.5 to 2 litres per day."
- "Try to include more fruits, vegetables, and whole grains in your meals."
- "Work with physio to increase walking, even short steps help."
- "If it's difficult to reach the toilet, we can arrange a commode or ensure privacy."

11. Investigations (Only if Indicated)

Not routinely required unless constipation persists >7 days or red flags are present

- **Bloods**: FBC, U&E, LFTs
- **Abdominal X-ray (AXR)**: If signs of bowel obstruction

Otherwise, manage empirically as per **NICE guidelines**

12. Safety Netting

"We expect things to start moving today or tomorrow. But if any of these happen, please let us know straight away:"

- Severe tummy pain or cramping
- Vomiting
- A swollen or hard abdomen
- Fever
- No wind or stool at all

13. Follow-Up Plan

- Nurse to **administer enema** and start **lactulose today**
- **Review in 24 hours** for bowel activity
- Update **drug chart** to reflect medication changes
- Continue laxatives **while on opioids**, if resumed
- Ensure **bowel movement before discharge**

14. Addressing Patient Concerns

If patient is reluctant to change pain medication:

"I understand your concern about stopping the painkillers. We'll monitor your pain closely and if the new combination isn't enough, we'll adjust it — you won't be left in pain. But switching from codeine will really help your bowels."

Hair Loss in a Kidney Transplant Patient (on Tacrolimus)

Station Type: History + Explanation + Management
Setting: GP Surgery
Patient: 57-year-old female
You Are: FY2 Doctor

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1. Introduction
"Hello, I'm one of the doctors here at the practice. Thank you for coming in today. How can I help you?"
[Allow patient to respond]
"I understand you've been experiencing hair loss, which can understandably be upsetting. I'll ask a few questions so we can work out what might be causing it and help you manage it. Is that okay?"

2. History of Presenting Complaint
- "When did you first notice the hair loss?"
- "Is it falling out in patches or more of a general thinning?"
- "How quickly has it progressed?"
- "Roughly how much hair are you losing each day?"
- "Have you ever had a similar issue in the past?"

Associated Symptoms
- "Is your scalp itchy, sore, red, or flaky?"
- "Have you noticed hair loss from your eyebrows, eyelashes, or other body areas?"

Emotional Impact
- "Has this affected your confidence or mood?"
- "Are you avoiding social situations or feeling low because of it?"

3. Differential Screening – Explore Possible Causes
Medication History
- "You've had a kidney transplant — are you currently taking tacrolimus?"
- "Have you started any new medications recently?"
  (e.g., blood pressure tablets, antidepressants, antibiotics)

Contributing Factors
- "Have you experienced any major stress lately?"
- "What's your current diet like?"
- "Do you take any supplements or follow a special diet?"

Hair Care Routine
- "Do you use hair dye, bleach, straighteners, or tie your hair tightly?"

Family History
- "Does anyone in your family have hair thinning or baldness?"

4. PMAFTOSA
- **P**: When was your kidney transplant? Any complications since?
  Any history of anaemia, thyroid disease, or autoimmune disorders?
- **M**: Confirm current use of tacrolimus and ask about other prescribed or OTC medications
- **A**: Any allergies to medications, dyes, or hair products?
- **F**: Family history of autoimmune conditions or inherited hair loss?
- **T**: Any recent travel? Fever or infection?
- **O**: What type of work do you do? Is it physically or emotionally stressful?

- **S**: Who do you live with? Do you have emotional or practical support at home?
- **A**: Alcohol or smoking habits (if relevant for general health)

5. ICE – Ideas, Concerns, Expectations

- **Ideas**: "What do you think might be causing the hair loss?"
- **Concerns**: "Is there anything in particular you're worried about?"
- **Expectations**: "Were you hoping for an explanation or treatment plan today?"

Effect of Symptoms

- "Has this affected your daily routine or self-confidence?"
- "Are you feeling low or anxious because of it?"
- "Are you managing to cope emotionally?"

6. Examination *(Verbalised or Performed)*

- "With your permission, I'd like to examine your scalp and do some quick checks."

General Observations

- Temperature, blood pressure, pulse

Focused Examination

- Inspect scalp: patchy vs diffuse loss, signs of scaling, redness, inflammation
- Hair pull test: to assess fragility
- Check body hair (eyebrows, eyelashes) if relevant
- Check nails and skin: rashes, lupus features, vitiligo, etc.

7. Diagnosis

"From what you've told me and what I've seen on examination, this appears to be **hair loss related to tacrolimus** — the immunosuppressant you take after your kidney transplant."
"This is a known side effect of tacrolimus. It doesn't mean the medicine isn't working, and it's not dangerous in itself, but I understand it's distressing."

8. Explanation to the Patient

"Tacrolimus is important for preventing your body from rejecting the transplanted kidney. But a side effect in some people is thinning or loss of hair."
"The good news is — this type of hair loss is often not permanent. Sometimes it improves if the dose is adjusted. But this can only be done by your transplant specialist — never stop or change the dose on your own."

9. Management Plan

A. Do Not Stop Tacrolimus

- "It's vital to continue taking tacrolimus to protect your kidney."
- "Please don't stop or reduce your dose — we'll speak to your transplant team first."

B. Referral to Transplant Team

- "I'll send an **urgent but non-emergency referral** to your transplant team. They'll review your medication and see whether a change or dose adjustment is possible."

C. Dermatology Referral

- "If the hair loss becomes more severe, affects your mental wellbeing, or has unusual features like inflammation or scarring, we'll refer you to a **skin specialist** for further treatment."

D. Supportive & Cosmetic Advice

- "Use **mild, non-perfumed shampoos**."
- "Avoid dyes, bleach, or excessive heat styling."
- "Try not to tie your hair tightly."

- "A **soft scarf or hat** outdoors helps with sun protection."
- "We can also give you information on wigs or hairpieces if you'd like."

E. Nutritional Support

- "Try to include enough **protein**, **iron**, **zinc**, and **vitamin D** in your diet."
- "Some people try **multivitamins** or **biotin** — there's limited evidence, but it's generally safe if you want to try a basic supplement."

F. Investigations (If Clinically Indicated)

- Blood tests only if needed to rule out other causes:
  - **FBC**, **TSH**, **Ferritin**, **Vitamin B12**, **Vitamin D**

10. Safety Netting

"Please return if the hair loss worsens, or if you develop any new symptoms like fatigue, skin rashes, or weight changes."
"And if you ever feel low or anxious, we're here to help with that too."
"Most importantly, keep taking your immunosuppressant unless the transplant team tells you otherwise."

11. Leaflet & Follow-Up

- "I'll give you a leaflet from the **NHS** website about hair loss and immunosuppressants."
- "Once we hear back from your transplant team, we'll arrange a **follow-up** to see what the next steps are."
- "In the meantime, feel free to contact the surgery if you have any worries."

Student Note: How the Diagnosis and Plan Were Made

This 57-year-old kidney transplant recipient presented with diffuse hair loss. History and exam suggested medication-related alopecia, most likely due to tacrolimus. No red flags, autoimmune, or infectious signs. Management involved reassurance, continuation of tacrolimus, referral to transplant team for medication review, and supportive cosmetic advice. Dermatology input considered if hair loss progresses or affects wellbeing.

Oxybutynin Side Effects – Male Patient with Urinary Frequency

Station Type: Medication Side Effect + History + Explanation + Management
Setting: GP Clinic – Follow-up Review
Patient: Male, aged 60–75 (typical age group)
You Are: FY2 Doctor

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1. Introduction

"Hello, I'm one of the doctors here at the practice. Thank you for coming in today. I understand you've come in for a follow-up regarding your urinary symptoms and the medication you were given. How have you been feeling recently?"
Allow patient to speak freely – this is a known 'talkative' scenario. Avoid interrupting.

2. History of Presenting Complaint

If patient says "I've had some funny turns":

- "Could you tell me more about that? What do you mean by funny turns?"
- "What exactly happened during those episodes?"
- "Were you aware of what was happening at the time?"
- "Did anyone else notice or say you were acting differently?"

Example cues: confusion at hotel reception, difficulty navigating back to room, poor performance during poker or golf

Other Potential Presenting Complaints:

- "Any episodes of confusion, dizziness, or fainting?"
- "Have you noticed a dry mouth or dry eyes recently?"
- "Any changes in your bowel habits — constipation or diarrhoea?"
- "Any tummy discomfort, increased gas, or bloating?"
- "Have you had any issues passing urine — like pain, difficulty, or feeling that your bladder doesn't empty fully?"

3. Screening for Oxybutynin Side Effects

Dry Symptoms:

- "Any trouble with a dry mouth or dry eyes?"
- "Any difficulty urinating or pain during urination?"
- "Any constipation?"
- "Have you felt like your bladder doesn't empty completely?"

Gastrointestinal Symptoms:

- "Any nausea, vomiting, or tummy upset?"
- "Loose stools or diarrhoea?"
- "Increased gas, belching, or flatulence?"

Neurological Symptoms:

- "Any blurred vision or light-headedness?"
- "Any headaches or sensitivity to heat?"
- "Have you had trouble swallowing?"
- "Have you felt confused, forgetful, or fainted?"

4. Medication History

- "Are you still taking your Oxybutynin?"
- "Did you increase the dose to 10 mg as advised, or did you stay on 5 mg?"
- "How long were you taking it before these symptoms started?"
- "Did you notice improvement in your urinary symptoms while on the medication?"
- "Have your original urinary problems returned after stopping the medicine?"
- "Do you remember why you were prescribed Oxybutynin?"

5. Memory Screening (if concern raised or patient asks about dementia)

- "How has your memory been lately?"
- "Do you forget names or appointments more than usual?"
- "Any problems with daily tasks at home?"
- "Do you forget familiar places or get lost easily?"
- "Has your driving been affected in any way?"
- "Do you feel like you're coping okay emotionally with these changes?"

6. PMAFTOSA

- **P**: Past medical history — prostate symptoms, urinary issues, diabetes, hypertension?
- **M**: Medications — confirm Oxybutynin; ask about others like tamsulosin, diuretics, antidepressants
- **A**: Allergies — medications, food, dyes?
- **F**: Family history — dementia, prostate disease, bowel issues
- **T**: Recent travel, stress, changes in fluid intake
- **O**: Occupation or daily routine — any physical or cognitive demands?
- **S**: Social support, living situation
- **A**: Smoking, alcohol, caffeine use, hydration habits

7. Lay Explanation
"Based on what you've told me, I believe the symptoms you're experiencing — including the confusion and possibly dry mouth or tummy upset — are side effects from a medication called **Oxybutynin**, which was prescribed to help with your urinary frequency."
"Oxybutynin works by calming down bladder muscles, but it also affects other parts of the body — especially in higher doses. It can cause **dryness, tummy issues, and in some people, confusion or forgetfulness**."
"This doesn't mean anything is seriously wrong, but we do need to stop the medication and reassess things."

8. Management Plan
1. Temporarily Stop Oxybutynin
- "We'll stop the medication today to see if the symptoms improve. Please **do not restart it** unless advised."

2. Reassess in 2–3 Weeks
- "We'll review how you're doing after 2 to 3 weeks. Most side effects, including memory problems, should improve after stopping the drug."

3. Lifestyle Advice
- "Try to reduce your fluid intake slightly, especially before bed — but don't let yourself get dehydrated."
- "Avoid caffeine, alcohol, and smoking as these can irritate the bladder."
- "Regular gentle exercise can also help bladder control."
- "Establish a routine for using the toilet, and avoid holding urine for too long."

4. Alternative Options if Symptoms Persist
- "If the urinary symptoms return and are bothersome, we can explore other options, like **alpha-blockers** such as tamsulosin, which tend to have fewer side effects."

9. Safety Netting
"If you feel more confused, have worsening tummy pain, stop passing urine, or feel faint again — please call us or attend urgent care."
"If memory issues or funny turns continue even after stopping the medication, we'll arrange further assessments."

10. Follow-Up Plan
- Arrange a **review in 2–3 weeks**
- Document medication change
- Monitor cognitive symptoms and urinary complaints
- Consider referral to urology if symptoms persist and need further management

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Student Note: How the Diagnosis and Plan Were Made
This was a follow-up consultation for urinary frequency in a male patient prescribed Oxybutynin. Symptoms including confusion, dry mouth, and GI upset were likely due to anticholinergic side effects, particularly at increased dose. History confirmed medication use, onset of symptoms, and cognitive effects. Management included stopping Oxybutynin, safety netting, lifestyle advice, and plan to reassess and explore safer alternatives. Cognitive screening was included to address patient concerns sensitively.

Lithium Toxicity

Setting: A&E (Emergency Department)
You Are: FY2 Doctor
Presenting Complaint: Brought in by son due to tremor and unsteadiness
Background: Patient on lithium for bipolar disorder

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1. Introduction
"Hello, I'm one of the doctors in the emergency team. Thanks for bringing your father in. I understand he's been having some shakiness and walking difficulties — I'd like to ask a few questions to understand what might be going on and make sure we support him properly. Is that okay?"

2. Focused History & Context
- "Can you tell me when the tremor started?"
- "Has it been constant or does it come and go?"
- "Has he had trouble walking or standing?"
- "Any recent falls?"

Neurological Screening
- "Any dizziness, slurred speech, or vision problems?"
- "Any confusion, tiredness, or difficulty concentrating?"

Gastrointestinal Symptoms
- "Has he had any nausea, vomiting, or metallic taste?"

Urinary Symptoms
- "Any problems passing urine or wetting himself recently?"

3. Explore ICE
- **Ideas**: "Do you have any idea what might be causing this?"
- **Concerns**: "Is there anything specific you're worried about right now?"
- **Expectations**: "Were you hoping we could give an answer today, or are there any treatments you were expecting?"

4. Clear Result Disclosure / Clarify Medication Use
Patient may not initially mention lithium. Ask specifically.
- "Is your father on any medications for mental health, like lithium?"
- "Do you know how long he's been on lithium?"
- "Has the dose changed recently?"
- "Has he missed any doses or accidentally taken more?"
- "Has he had regular blood tests for lithium levels?"
- "Has he started any new medications recently — like painkillers, blood pressure tablets, or water tablets?"

5. Lay Explanation of the Diagnosis
"From what you've described — including the tremor, walking issues, and his medication — I'm concerned this might be **lithium toxicity**. Lithium is used to treat conditions like bipolar disorder, but if it builds up in the body, it can cause serious side effects — especially affecting the brain, stomach, and kidneys."
"This doesn't mean it's permanent or untreatable, but we need to act quickly to bring the level down."

6. Structured Management Plan
A. Immediate Actions
- **Stop lithium** immediately
- **Start IV fluids** to help flush lithium from the system and protect the kidneys
- **Monitor lithium blood levels** every 6–12 hours
- **Check renal function** (U&E), ECG, FBC
- **Monitor vitals and fluid balance closely**

B. Target Lithium Range
- Normal: **0.6 – 1.0 mmol/L**

- Toxic: **>1.5 mmol/L**
- **>2.5 mmol/L** or severe symptoms → consider **dialysis**

C. Supportive Measures

- Antiemetics if nauseated
- Falls prevention
- Neurological monitoring

7. Addressing Concerns

Son's Mental Health Concerns

"I understand lithium is important for your father's mental health. Right now, our priority is his safety. Once the levels settle, our psychiatric team will reassess and decide whether to restart lithium or choose a safer alternative."

Question about Antidote

"There's no specific antidote for lithium, but we can lower the levels by stopping the medication and giving fluids. In some cases, dialysis is used if levels are very high."

8. Follow-Up Plan

- **Psychiatric team referral** once patient is medically stable
- Review mental health medication plan
- Reintroduce lithium only under specialist guidance or consider alternatives
- Reinforce **regular lithium level monitoring** and **kidney checks** going forward
- **Educate** about hydration, drug interactions (e.g., NSAIDs, ACE inhibitors, diuretics), and early toxicity signs

9. Safety Netting

"If your father ever develops similar symptoms in the future — such as tremor, drowsiness, vomiting, or confusion — please seek medical help immediately."

"Make sure he has blood tests at least every 3 months when on lithium, or more often if advised."

10. Leaflet & Final Check

- "I'll give you an information leaflet about lithium and how to use it safely."
- "Is there anything else you'd like to ask today?"
- "Would it help if I wrote some of this down for you?"

Student Note: How the Diagnosis and Plan Were Made

This 70-year-old male presented with tremor and unsteadiness. Careful history-taking revealed chronic lithium use for bipolar disorder. Symptoms were consistent with lithium toxicity, likely exacerbated by age-related renal impairment or drug interactions. Management included stopping lithium, IV fluid resuscitation, and monitoring. Psychiatric input was planned for long-term treatment review. Family concerns were addressed with clear education and safety netting.

Cat Bite – from Turkey

Station Type: Animal Bite (Follow-Up/First Presentation) + Infection Risk + PEP Management
Setting: GP Clinic / A&E
You Are: FY2 Doctor
Patient: Adult (Mr/Ms X), recently returned from Turkey

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1. Introduction & Consent

"Hello, I'm one of the doctors here today. Thanks for coming in. I understand you were bitten by a cat while you were abroad. I'm very sorry to hear that — I'd like to ask a few questions to understand the situation properly and explain how we can help. Is that okay?"

2. Focused History & Context

Cat Bite Details

- "Can you tell me where and when the bite happened?"
- "Was it in Turkey?"
- "Was the cat a stray or did it belong to someone?"
- "Do you remember if it looked unwell or was acting strangely?"
- "Did it bite or scratch you? Was it one bite or multiple?"
- "Where exactly were you bitten?"
- "Was it a deep wound or more of a surface break?"
- "Did the bite bleed?"

Post-Bite Care Abroad

- "Did you wash the wound with soap and water?"
- "Did you get any medical care while you were there?"
- "Were you given any antibiotics, wound dressings, or injections like tetanus or rabies vaccine?"
- "When did you return to the UK?"

Current Symptoms

- "How is the wound now?"
- "Any redness, swelling, or warmth?"
- "Is there any pus or discharge?"
- "Do you have pain, fever, or stiffness in the area?"

3. Explore ICE

- **Ideas**: "What do you think about the bite — do you think it needs treatment?"
- **Concerns**: "Have you heard anything worrying about rabies or animal bites?"
- **Expectations**: "Were you hoping for an injection or any specific treatment today?"

4. Clarify Risk Factors (PMAFTOSA)

- **P**: Any long-term conditions like diabetes, kidney problems, immunosuppression, or previous wound infections?
- **M**: Are you allergic to penicillin or any other medications?
- **A**: Any history of allergic reactions to vaccines, antibiotics, or bites before?
- **F**: Any family members at home who are immunocompromised?
- **T**: Confirm recent travel to Turkey (rabies-endemic)
- **O**: What kind of work do you do? (e.g., animal exposure, healthcare?)
- **S**: Any pets at home? Is anyone else at home also bitten or exposed?
- **A**: Do you smoke or drink alcohol regularly? (relevant to wound healing)

5. Tetanus & Rabies Risk Assessment

- "Have you had a tetanus booster in the last 10 years?"
- "Have you ever received a rabies vaccine before — either before travel or after animal bites?"
- "Have you had any contact with animals in high-risk areas like this in the past?"

6. Examination

Explain the examination clearly and request consent.

Vitals: Temp, HR, BP

Local Exam:

- Inspect bite site: redness, swelling, pus, wound depth
- Check for signs of cellulitis, abscess, or necrosis
- Assess for neurovascular compromise
- Palpate regional lymph nodes: Are they tender or swollen?

7. Lay Explanation to Patient

"Animal bites — especially from cats — can carry bacteria that cause serious infections. More importantly, because this happened in **Turkey**, which is a country where **rabies** is still present, we need to **treat this as a possible rabies exposure**."

"Rabies is extremely rare in the UK but is **almost always fatal** if not treated quickly after exposure. Fortunately, we can **prevent rabies completely** with the right post-exposure treatment — which includes **vaccines and a special injection of antibodies**."

"We also need to give you **antibiotics** to prevent infection in the bite itself, and a **tetanus booster** if you haven't had one in the last 10 years."

8. Structured Management Plan

A. Wound Care

- Clean and irrigate thoroughly with **saline**
- Dress the wound — **leave open unless deep or bleeding heavily**
- Monitor for signs of local infection

B. Antibiotics (per NICE/NHS guidance)

- **Co-amoxiclav 625 mg TDS for 7 days**
- If penicillin allergy: **Doxycycline + Metronidazole**

C. Tetanus Prophylaxis

- If unsure/incomplete tetanus history:
  - Give **Revaxis** (tetanus booster)
  - If high-risk wound and poor immunisation: consider **Tetanus Immunoglobulin (TIG)**

D. Rabies Post-Exposure Prophylaxis (UKHSA Protocol)

If **no prior rabies vaccination**:

1. **Human Rabies Immunoglobulin (HRIG)** – infiltrated around wound
2. **Rabies Vaccine** – IM into deltoid at:
   - **Day 0, 3, 7, and 21/28**

If **previous rabies pre-exposure vaccine**:

- No HRIG needed
- Give **Rabies Vaccine on Day 0 and Day 3** only

9. Public Health Notification

- **Inform UKHSA** (formerly PHE) as this is a **possible imported rabies exposure**
- Document:
  - Country of exposure
  - Animal type (stray cat)
  - Date and nature of bite
  - Treatment already received

10. Safety Netting
"Please come back or seek urgent help if:
• The bite becomes more painful, red, swollen, or starts to ooze pus
• You develop a fever, chills, or feel generally unwell
• You experience any unusual symptoms like muscle twitching, difficulty swallowing, or confusion — these are rare but urgent signs of rabies"
"If you feel faint or have a reaction after the injection, stay nearby for 15–30 minutes and let us know."

11. Follow-Up Plan

- **Book next rabies vaccine dose** (Day 3), and plan for Day 7 + Day 21/28
- **Wound review in 48 hours** to check for infection
- **Ensure documentation of all vaccines** and referrals made
- Monitor for allergic reaction post-vaccination
- Liaise with GP or infectious diseases team if any uncertainty

12. Leaflet & Final Check

- Provide:
  - **Rabies vaccine information leaflet**
  - **Animal bite wound care leaflet**
- Signpost to:
  - NHS Rabies Advice
  - TravelHealthPro / FitForTravel guidance
- "Do you have any questions or concerns before we finish today?"

Student Note: How the Diagnosis and Plan Were Made
Adult patient presented with a cat bite sustained abroad in Turkey (rabies-endemic). No treatment received abroad. History and examination confirmed need for full post-exposure prophylaxis per UKHSA guidelines. Bite site showed no severe infection but warranted antibiotics. Tetanus and rabies vaccines were initiated. Public health authorities were informed, and follow-up arranged. Full patient education, safety netting, and documentation provided.

Antibiotic-Associated Diarrhoea After Dog Bite

Setting: GP Clinic / Urgent Care
You Are: FY2 Doctor
Patient: Mr./Ms. [Name], 35-year-old adult
Presenting Complaint: Watery diarrhoea after antibiotics for dog bite

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1. Introduction & Consent
"Hello, I'm Dr [Name], one of the doctors here today. It's nice to meet you. Could I confirm your full name and age, please?"
"I understand you were treated for a dog bite recently and started antibiotics — and now you're experiencing some diarrhoea. Is that right?"
"I'm really sorry you've had this experience. I'll ask a few questions to understand what's going on and see how we can help. Is that okay?"

2. Focused History & Context
Dog Bite History

- "When exactly did the dog bite happen?"
- "Where on your body were you bitten?"
- "Did you see a GP or go to A&E?"
- "What antibiotic were you prescribed?"
- "Did they clean or stitch the wound?"
- "How many days of antibiotics did you take?"
- "Is the wound healing well now?"

Diarrhoea History

- "When did the diarrhoea start?"
- "How many times a day are you opening your bowels?"
- "Is the stool watery or semi-formed?"
- "Any blood or mucus in the stool?"
- "Do you have abdominal pain or cramps?"
- "Any nausea or vomiting?"
- "Have you had a fever or chills?"
- "Any signs of dehydration — dry mouth, dizziness, or less urine?"

3. Explore ICE

- **Ideas**: "Do you have any thoughts about what might be causing this?"
- **Concerns**: "Is there anything you're worried this could be?"
- **Expectations**: "What were you hoping we could do for you today?"

If the patient seems frustrated, use EVE Protocol:

- **Explore**: "I can see that you're not happy with what's happened."
- **Validate**: "Anyone in your position would feel concerned."
- **Empathise**: "I'm really sorry to hear you've been feeling this way."

4. Clarify Background & Rule Out Other Causes

- "Have you travelled recently?"
- "Did you eat out at a restaurant or try new foods before this started?"
- "Has anyone else around you had similar symptoms?"
- "Have you started any other medications recently?"
- "What's your current diet like?"

5. Red Flag Screening

Actively ask about:

- Blood in stool
- Persistent vomiting
- High fever
- Severe dehydration symptoms
- Recent weight loss
- Reduced urine output

6. PMAFTOSA

- **P**: Any long-term conditions — IBD, IBS, diabetes, recent infections?
- **M**: Confirm medication — co-amoxiclav for dog bite? Any other meds?
- **A**: Any allergies, especially to antibiotics?
- **F**: Any family history of GI disorders?
- **T**: Confirm no recent travel other than local outings

- **O**: What's your job? Are you able to stay home if needed?
- **S**: Who do you live with — any risk to vulnerable people?
- **A**: Alcohol and smoking status — relevant to gut health and wound healing

7. Effect of Symptoms

- "Is this affecting your ability to eat, sleep, or work?"
- "Have you been able to stay hydrated?"
- "Is it affecting your routine or causing embarrassment at work?"

8. Examination

Explain clearly and request consent before examining

- **Observations**: Temp, HR, BP — *all normal*
- **Abdominal Exam**: Soft, non-tender, no masses
- **Wound Site**: Local tenderness, but no signs of infection
- **PR Exam** (if done): No blood, mucus; stool watery

9. Lay Explanation to Patient

"Based on everything you've told me and the examination today, it sounds like the diarrhoea is due to the **antibiotics** — specifically co-amoxiclav — which can sometimes disrupt the healthy bacteria in your gut."
"This isn't an allergy. Rather, it's a **known side effect**, especially with stronger antibiotics. The imbalance in gut flora often leads to loose stools while the course is ongoing or just after."
"At this point, there's **no sign of a serious infection like C. difficile**, which can happen in some cases. But we'll keep monitoring."

10. Management Plan

If Symptoms Mild (No Red Flags)

- **Complete current course** of co-amoxiclav if only 1 day remains
  "Would you prefer to finish the final dose today, or would you be more comfortable stopping now and we can extend with a safer alternative if needed?"
- **Hydration Advice**:
  - Drink plenty of fluids and consider **oral rehydration salts**
  - Eat light, bland meals (e.g. bananas, toast, rice)
- **Stool Sample**:
  - Offer to send a sample to **rule out C. difficile toxin or other causes**
  - "We'll send a sample just to be safe, and follow up when results are back."
- **Reassurance**:
  - "Most cases like this settle within 1–2 weeks as the gut flora recovers naturally."

If Moderate to Severe or Red Flags Present

- **Stop co-amoxiclav immediately**
- **Send stool sample** for C. difficile toxin
- **Seek microbiology input** for further antibiotic guidance
- **Start oral vancomycin 125 mg QDS for 10 days** (only if C. difficile confirmed)
- **Consider admission** if patient is very unwell or dehydrated

11. Prevention Advice

"This type of diarrhoea can sometimes be passed to others, so here's how to reduce the risk:"

- Wash hands thoroughly with **soap and water** (not just alcohol gel)

- Avoid preparing food for others until symptoms settle
- Don't return to work **until you've been symptom-free for 48 hours**
- Clean the toilet and surrounding surfaces regularly
- Avoid sharing towels or toiletries

12. Safety Netting
"Please come back or seek urgent care if you notice any of the following:"
- Blood in your stool
- Severe tummy pain or high fever
- Feeling very weak or dehydrated
- No improvement after 48 hours

"We've arranged for you to be followed up if your symptoms continue."

Follow-Up Plan
- Review in **48–72 hours** if symptoms persist
- Follow up **stool test results** if sent
- Reassess wound site and consider extending antibiotics (if clinically needed)
- Coordinate with microbiology if treatment adjustment is required

Addressing Common Concerns
1. **"Why am I having diarrhoea?"**
   "It's a known side effect of antibiotics — they disrupt healthy gut bacteria."
2. **"Am I allergic to this medication?"**
   "Not likely — this is a side effect. Allergies usually involve rashes or breathing problems."
3. **"Why wasn't I warned?"**
   "It's a common side effect and I'm sorry if it wasn't clearly explained before."
4. **"Can I go back to work?"**
   "Please stay off work until you've been symptom-free for **48 hours**."
5. **"Will this go away on its own?"**
   "In most cases, yes — symptoms usually improve once the antibiotic finishes and your gut settles."

Citalopram-Induced Hyponatremia

Station Type: Test Result Discussion
Setting: GP Surgery
You Are: FY2 Doctor
Patient: Elderly lady, started on Citalopram 6 weeks ago for depression
Presenting Issue: Routine sodium check due to fatigue — result shows **moderate hyponatraemia (Na^+ = 128 mmol/L)**

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1. Introduction & Consent
"Hello, I'm one of the doctors here at the practice. Thanks for coming in. Before we begin, could I confirm your full name and age, please?"
"I understand you've come in to discuss your recent blood test results. Before we go over them, would it be okay if I ask a few questions about how you've been feeling?"

2. Focused History & Context
"Can I check what made you come in for the blood test in the first place?"
Patient: "I've been feeling tired lately."
"Thanks for sharing that. Let's explore that a bit more."

- "When did the tiredness start?"
- "Is it constant, or does it come and go?"
- "Any issues with your sleep, energy, or appetite?"
- "Any dizziness, headaches, or muscle cramps?"
- "Have you had any episodes of confusion or feeling unsteady on your feet?"

3. Structured Medication History

- "Can I confirm — have you been taking Citalopram regularly since it was started?"
- "Have you noticed any other changes since starting it — things like dry mouth, sweating, nausea, or changes in mood or appetite?"
- "How was your mood before starting the medication — and how has it been recently?"
- "Have you noticed any change in your sleep, energy, or interest in daily activities?"

4. Relevant System Review & Red Flags

- "Have you had any falls, blackouts, or near-misses?"
- "Any vomiting, confusion, or loss of appetite?"
- "Any changes in fluid intake or recent infections?"

5. Examination (Verbalised)
"Before we finalise the plan, I'd like to check your blood pressure and general condition."

- **Vitals**: BP, pulse, temperature → stable
- **General**: Alert but slightly fatigued appearance
- **No signs of dehydration or confusion**
- **Gait appears slow but steady**

6. Explore ICE

- **Ideas**: "Did you have any idea what might be causing the tiredness?"
- **Concerns**: "Is there anything in particular you were worried about?"
- **Expectations**: "Were you hoping for an explanation or a treatment today?"

7. Clear Result Disclosure
"Thanks for your patience. I've had a look at your blood results. One of the important salts in your body — **sodium** — is lower than normal. A normal sodium level is between **135 and 145**, and yours is **128**."
"This is called **hyponatraemia**, and it explains why you've been feeling so tired."

8. Lay Explanation of the Condition
"Sodium is one of the body's essential electrolytes — it helps regulate fluid balance and is involved in energy, muscle function, and brain signalling. When sodium gets too low, it can cause **fatigue, dizziness, confusion, or even falls** — especially in older adults."
"The most likely cause in your case is the **antidepressant medication** you started about 6 weeks ago — **Citalopram**. It's a known side effect, especially in elderly patients."

9. Management Plan (Immediate & Longer-Term)
"Because your sodium is low and you're having symptoms, we need to send you to the hospital today."

A. Hospital Admission

- "In hospital, they'll likely give you a **strong salt solution via a drip** to gently raise your sodium levels."
- "They'll also monitor your fluid balance and watch for complications."

B. Medication Change

- "Since Citalopram caused the drop in sodium, we'll need to **stop it** and start you on a **different antidepressant** that's safer in older adults — a common choice is **Amitriptyline** at a low dose."
- "This change can be made here in the GP setting — we don't need a psychiatrist referral for this."

10. Safety Netting

"If at any point you feel more confused, dizzy, or unwell before going to hospital, please **call 999** or let someone nearby know."
"Also let the hospital staff know if you notice nausea, vomiting, or increasing sleepiness."

11. Follow-Up Plan

- "Once you've been treated in hospital and your sodium is back to normal, we'll bring you back in to **review your mood and check how you're doing on the new medication**."
- "We'll also repeat your blood tests within **1–2 weeks** of discharge to monitor sodium and kidney function."

12. Final Check & Leaflet

- "Does everything I've said so far make sense?"
- "Would you like me to write anything down for you?"
- "I'll also give you a leaflet about **hyponatraemia** and **safe antidepressant use in older adults**."

Student Note: How the Diagnosis and Plan Were Made

This elderly patient was started on Citalopram 6 weeks ago for depression. She presented with fatigue and was found to have **moderate hyponatraemia (Na^+ 128)**. Citalopram is a known cause of SIADH in elderly patients. No other risk factors or red flags identified. Immediate management included **hospital admission** for IV correction of sodium, and **switching to an alternative antidepressant (Amitriptyline)**. Follow-up and safety netting arranged. Explanation was clear, supportive, and patient-centred.

Chronic Fatigue Syndrome

Setting: GP Clinic
You Are: FY2 Doctor
Patient: Adult, presenting with persistent fatigue

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1. Introduction

"Hello, I'm one of the doctors here at the practice. Thank you for coming in today. Could I confirm your full name and age, please?"
"I understand you've been feeling extremely tired lately. I'll ask a few questions to explore that further and see how we can help."

2. Presenting Complaint (ODIPARA – Fatigue)

- "When did this tiredness first start?"
- "Is it there all the time or does it come and go?"
- "How does it feel — more like exhaustion, weakness, or sleepiness?"
- "Does anything make it better or worse?"

Expected: "Even after rest I still feel tired."

- "Have you noticed it affecting your ability to work, exercise, or do normal activities?"
- "Does exercise improve or worsen the symptoms?"

Expected: "It makes it worse."

3. Differential Diagnosis Screening

"I'll also ask some questions to rule out other possible causes of tiredness."

Systemic:

- "Have you had any fever, weight loss, or night sweats?"
- "Any recent infections – like COVID, TB, or flu?"

Haematological:

- "Any pale skin, tongue soreness, or breathlessness on walking?"

Endocrine:

- "Have you felt cold easily or noticed constipation, dry skin, or hair loss?" *(Hypothyroidism)*
- "Any increased thirst, urination, or blurred vision?" *(Diabetes)*

Cardiac/Renal:

- "Any chest pain, palpitations, or ankle swelling?"
- "Have you noticed changes in your urine – darker colour, frothy, or reduced amounts?"

Mood/Neuro:

- "How has your mood been recently?"
- "Do you feel low, anxious, or unmotivated?"
- "Have you lost interest in things or had trouble concentrating?"

4. Targeted Risk Factor History

- "Have you had frequent flu-like illnesses over the past year?"

Expected: "Yes, last month and before that too."

- "Do you feel stiffness when you walk or first wake up?"
- "How is your sleep – is it broken, shallow, or has your sleep pattern changed?"
- "Do you find it hard to remember things, concentrate, or find words?"
- "Have you had any issues with doing everyday tasks like calculations or multitasking?"

5. PMAFTOSA

- **P**: Any other long-term health conditions (thyroid, autoimmune, etc.)?
- **M**: Are you on any regular medications or supplements?
- **A**: Any known allergies?
- **F**: Any family history of autoimmune conditions, thyroid disease, or depression?
- **T**: Any recent travel or infections abroad?
- **O**: What do you do for work? Have you had to take time off?
- **S**: Do you live alone or with family? Are you getting support?
- **A**: Any smoking, alcohol, or substance use?

6. ICE

- **Ideas**: "What do you think might be causing your tiredness?"
- **Concerns**: "Is there anything in particular you're worried this could be?"
- **Expectations**: "Were you hoping we could run tests or offer a diagnosis today?"

7. Effect on Life

- "Has this tiredness affected your ability to work or socialise?"

- "Are you able to go shopping, cook, or do housework like before?"
- "Has it changed your daily routine significantly?"

8. Examination (Verbalised)
"I'd like to examine you and check a few things, including your blood pressure, heart rate, and general condition."

- Vitals: HR, BP, Temp – normal
- GPE: Patient appears alert but tired
- BMI recorded
- Cardiovascular and respiratory exams: NAD
- No lymphadenopathy or localised signs
- Neurological exam normal
- No signs of anaemia or thyroid disease clinically

9. Provisional Diagnosis
"Based on what you've told me — especially that the tiredness has lasted more than six weeks, isn't relieved by rest, and actually gets worse after exercise — this may be a condition called **Chronic Fatigue Syndrome**, also known as **Myalgic Encephalomyelitis** or **ME**."

10. Lay Explanation of the Condition
"It's a condition where the body seems unable to produce enough energy for normal activity, even though there's no clear structural disease. It can affect sleep, thinking, memory, and physical ability — and it's often triggered after a viral illness."
"It's what we call a **functional disorder**, meaning it's very real and disabling, but not always visible in scans or tests."
"The diagnosis is made after ruling out other treatable causes."

11. Management Plan
A. Blood Tests
"We'll first do a set of blood tests to rule out conditions like anaemia, thyroid issues, diabetes, kidney or liver problems, and infections."
B. Referral
"Once these are done, we'll refer you to a **specialist clinic** — often run by a **rheumatologist** — who can confirm the diagnosis and guide the treatment plan."
C. Treatment
"There's no single cure, but you'll be offered a mix of:"

- **Energy management therapy** (pacing activity through the day)
- **Physiotherapy or occupational therapy**
- **Sleep hygiene advice** (avoiding naps, improving routine)
- **Talking therapies** (only if needed, not mandatory)

D. Vitamins
"If you're asking about multivitamins — we'll check your vitamin levels in the bloods. If you are low in anything, we'll treat it. But in general, **vitamins don't help if CFS is the cause**, and if correcting vitamins resolves the symptoms, then it probably wasn't CFS in the first place."

12. Safety Netting & Follow-Up

- "Please come back sooner if you develop any new symptoms like persistent fever, significant weight loss, or symptoms that worry you."
- "We'll call you when your blood results are back and make the referral to the specialist clinic."

- "In the meantime, if you'd like to read more, I'll give you a leaflet and a reliable website."

Student Note: How the Diagnosis and Plan Were Made
Patient presents with >6 weeks of fatigue not relieved by rest, worsened by exercise, associated with flu-like symptoms, cognitive dysfunction, and non-refreshing sleep. Red flag screening and PMH do not suggest an alternative diagnosis. Clinical suspicion of **Chronic Fatigue Syndrome**. Plan includes **blood tests**, **referral to specialist clinic**, and **supportive therapy**. Vitamin deficiencies will be tested, not presumed. Patient reassured and engaged in management plan.

Vitamin D Deficiency - Test Result

Setting: GP Clinic
You Are: FY2 Doctor
Patient: 55-year-old female schoolteacher
Presentation: Tiredness and constipation
Concern: Worried she may have hypothyroidism like her sister
Test Results:

- **FBC, glucose, thyroid profile (TSH, T3, T4), B12**: Normal
- **Vitamin D**: 14 (Low. Normal: 90–100)

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1. Introduction & Consent
"Hello, I'm Dr [Name], one of the doctors here at the practice. Thank you for coming in today. Could I confirm your full name and age please?"
"I understand you've been feeling tired and constipated lately and were concerned it might be related to your thyroid. I've reviewed your test results — would it be okay if I ask a few questions first before we go through them together?"

2. Focused History & Context (ODIPARA – Tiredness)

- "When did the tiredness first start?"
- "Is it there throughout the day or does it vary?"
- "Has it been getting worse or staying the same?"
- "Is it relieved by rest or sleep?"
- "Does anything make it better or worse?"
- "How has it been affecting your daily life — have you been able to go to work?"

Patient: "I've had to take two weeks off school."

3. Symptom Screening – Vitamin D Deficiency
"I'd also like to ask a few questions to check for other symptoms that can be linked with vitamin D deficiency."

- "Do you get any **bone pain**, particularly in your **back or hips**?"
- "Have you had any **falls or fractures** recently?"
- "Any **muscle cramps or generalised weakness**?"
- "Any changes in your **mood** or have you been feeling a bit low or foggy?"
- "Do you find yourself **sweating more than usual**, especially around your face or scalp?"
- "Can you tell me more about your **constipation** — how often, and any other bowel changes?"
- "Have you had any **tingling, numbness, or weakness** in your limbs?"

4. Risk Factor History – Causes of Vitamin D Deficiency
"Let's explore a few reasons why vitamin D might be low."

- "How often are you able to get outside during the day — especially in spring and summer?"
- "When you're outside, do you usually use sunscreen?"
  Explain if needed: "Sunscreen is excellent for skin protection, but it also blocks UV rays needed for vitamin D production."
- "Can you tell me about your typical diet — do you regularly eat foods like oily fish, egg yolks, liver, or fortified cereals or dairy?"
- "Have you had any gut or bowel issues — like inflammatory bowel disease, chronic diarrhoea, or previous bowel surgery?"
  Explain if needed: "Vitamin D is fat-soluble, so problems with fat absorption can lower your levels."

5. PMAFTOSA

- **P**: Any long-term health conditions like thyroid disease, diabetes, or osteoporosis?
- **M**: Are you on any regular medications or supplements?
- **A**: Any known allergies?
- **F**: You mentioned your sister has hypothyroidism — any other family history of thyroid or autoimmune conditions?
- **T**: Any recent travel or infections?
- **O**: You mentioned you're a teacher — is the fatigue affecting your ability to work or concentrate?
- **S**: Who do you live with? Do you have help at home?
- **A**: Any smoking, alcohol, or substance use?

6. ICE

- **Ideas**: "Were you thinking this might be related to your thyroid, like your sister?"
- **Concerns**: "Is there anything you're particularly worried this might be?"
- **Expectations**: "Were you hoping for treatment or further testing today?"

7. Examination (Verbalised)

"Your blood pressure and general observations today are within the normal range. You appear generally well but understandably fatigued. There are no signs of muscle wasting or neurological concerns on brief assessment."

8. Clear Result Disclosure

"Thanks for being patient. I've reviewed your results, and the good news is your **thyroid function is completely normal**. That includes your **TSH, T3, and T4**."
"Your **blood count, sugar, and B12** levels are also normal."
"However, your **vitamin D level is low — it's 14**, while we expect it to be between **90 and 100**."

9. Lay Explanation of the Condition

"Vitamin D doesn't work alone, but it helps your body **absorb and regulate calcium**, which is essential for bone strength and muscle function."
"When your vitamin D is low, it can cause **fatigue**, **muscle weakness**, **bone aches**, and in some cases, even **constipation** — since calcium is also needed for smooth muscle movement in the gut."
"So it's very likely that your tiredness and constipation are due to this deficiency."
"And to reassure you — this is **not hypothyroidism**. Your thyroid results were completely normal. So you don't need thyroid medication like your sister does."

10. Management Plan

"To treat this, we'll start you on a **loading dose of vitamin D** to bring your levels up."
A. Vitamin D Supplementation

- "You'll take **50,000 units once a week for 6 weeks** — this is the high loading dose."

- "After that, we'll switch to a **maintenance dose of 1,000 units daily**."

B. Lifestyle Advice

- "Try to get **15–20 minutes of sunlight exposure per day** when safe to do so."
- "Consider including vitamin D-rich foods in your diet: oily fish (like salmon or mackerel), egg yolks, red meat, liver, and fortified cereals or milk."

11. Safety Netting

"Please let us know if your tiredness gets worse, you develop **numbness, confusion, unsteadiness, or severe constipation**."
"If you experience any new symptoms or side effects from the medication, let us know."

12. Follow-Up Plan

"We'll book you for a **follow-up in 6 weeks** to see how your symptoms are improving and possibly recheck your vitamin D level."
"If you're still having symptoms despite treatment, we can explore other causes."

Student Note: How the Diagnosis and Plan Were Made

Patient presented with tiredness and constipation. Family history of hypothyroidism raised concern, but thyroid tests, glucose, B12, and FBC were normal. Vitamin D was severely deficient (14). History and symptom profile consistent with vitamin D deficiency. Explained clearly that this was the likely cause of her symptoms and not hypothyroidism. Started on **50,000 IU/week loading dose for 6 weeks**, followed by **daily 1,000 IU maintenance**. Safety netting and follow-up arranged. Lifestyle and dietary advice provided.

Septic Arthritis

Scenario:

You are an FY2 doctor in GP/Urgent Care. A 60-year-old man presents with sudden swelling and pain in his right knee. He is diabetic and previously had gout in the opposite foot. Vitals show:
HR 105 | Temp 38.4°C | RR 20 | BP 128/84

Introduction

"Hello, I'm one of the doctors here today. Thank you for coming in.
Just before we begin, could I confirm your full name and age, please?
And what brought you in today?"
(Patient likely says: "My right knee started hurting and swelling up suddenly.")

Presenting Complaints

"Let me ask a few questions to understand the pain better."

- **S**ite – Is the pain located in just one knee or does it affect both?
- **O**nset – When did the pain start? Was it sudden or gradual?
- **C**haracter – How would you describe the pain — sharp, throbbing, constant?
- **R**adiation – Does the pain move anywhere else?
- **A**ssociated symptoms – Any swelling, redness, warmth, stiffness, or fever?
- **T**iming – Is the pain always there or does it come and go?
- **E**xacerbating/Relieving – What makes it worse or better — movement, rest?

Differential Diagnosis Screening

"To make sure we don't miss anything important, I'd like to ask about a few other possible causes."

Septic Arthritis (suspected)

- Have you felt feverish, sweaty, or unwell recently?
- Have you noticed any chills or shaking?
- Have you had any open wounds or skin infections near the knee?
- Any history of infections elsewhere — like your chest, urine, or stomach — in the past week?

Gout / Pseudogout

- Have you ever had a similar joint problem before?
- Have you missed or recently restarted any gout medications like allopurinol?
- Have you had recent illness, dehydration, or dietary changes?

DVT (less likely)

- Any pain in the calf?
- Any recent travel, long immobility, or surgery?
- Have you noticed swelling or colour change in the whole leg?

Reactive Arthritis

- Any recent stomach upset or diarrhoea?
- Any burning or discomfort while passing urine?
- Any rashes or mouth ulcers recently?

Trauma / Haemarthrosis

- Any recent injury, twist, or strain to the knee?
- Are you on blood thinners like warfarin or aspirin?

Targeted Risk Factor History

- Have you been diagnosed with diabetes? How is it controlled?
- Do you take steroids or any medications that affect your immune system?
- Have you ever had joint injections or surgery to this knee?
- Any known autoimmune conditions like rheumatoid arthritis?
- Do you have any metal implants or joint replacements?

PMAFTOSA

"Just a few general questions, if that's alright."

- **Past Medical History** – Any other health conditions apart from diabetes or gout?
- **Medications** – What medications are you taking regularly? Any recent changes?
- **Allergies** – Do you have any allergies to medications?
- **Family History** – Any family history of joint problems or autoimmune disease?
- **Tobacco** – Do you smoke?
- **Occupation** – What kind of work do you do? Any recent changes?
- **Social** – Do you live alone or with someone? Any mobility concerns?
- **Alcohol** – Do you drink alcohol? If yes, how much?

ICE

- **Ideas** – What do you think this might be?
- **Concerns** – Is there anything you're particularly worried about?
- **Expectations** – What were you hoping we could do for you today?

Effect on Life

- Has this affected your ability to walk or get around at home?
- Are you able to climb stairs, get to the toilet, or manage daily tasks?
- Has the pain kept you from sleeping or working?

Examination
"I'd like to have a look at your knee."
Findings:

- Right knee visibly swollen, warm, erythematous
- Marked tenderness, especially on movement
- Decreased range of motion
- No signs of trauma, no wounds
- No similar findings in other joints
- Vitals: **HR 105, Temp 38.4°C, RR 20, BP normal**

Diagnosis and Explanation
"Thanks for telling me all that. Based on your symptoms and what I've found on examining your knee, I'm quite concerned that this could be a **serious joint infection**, called **septic arthritis**.
It's when bacteria get into a joint — sometimes from the bloodstream — and cause sudden pain, swelling, and inflammation.
This needs urgent treatment, as delay can damage the joint or let the infection spread."

Management Plan
"Joint infections are considered a medical emergency because they can cause joint damage quickly. Here's what we need to do:"

- **Urgent hospital admission**
  - Explain: "You'll need to go to hospital straight away so they can confirm the diagnosis and start treatment."
- **Joint aspiration** (in hospital)
  - To test for infection and check for crystals (to rule out gout or pseudogout)
- **Blood tests**: FBC, CRP, ESR, blood cultures, glucose control
- **IV antibiotics**: Broad-spectrum IV antibiotics will be started immediately after aspiration
- **Orthopaedic review**: They may need to wash out the joint (arthroscopic lavage)
- **Monitor vitals** and blood glucose

If the patient is hesitant to go to the hospital, explain:
"I understand you may be a bit unsure about going to hospital right now — especially since you weren't expecting that — but let me explain why it's important. You'll need to go to hospital today so they can do some urgent tests and start treatment. If this is caught early, the outcome is usually good. But if treatment is delayed, it can lead to joint destruction or spread of infection. This isn't something we can treat safely in a GP clinic or with tablets at home. Getting hospital care now will give you the best chance of full recovery. You'll be monitored closely in hospital, and they'll keep you updated every step of the way."

Safety Netting, Follow-up, Leaflet

- "If the hospital team finds that it's not an infection but something else like gout or pseudogout, they'll adjust the treatment accordingly."
- "Please don't wait at home with this — even if the pain feels better later today. The infection can worsen very quickly."
- Offer to call the hospital and arrange immediate transfer
- Provide written info leaflet on **septic arthritis** (or explain it will be given in hospital)

Student Note

- **Acute monoarthritis with systemic signs** = septic arthritis until proven otherwise
- History of gout but in **different joint**, and no current triggers
- Diabetes = strong risk factor
- Crystal arthritis and trauma are possible but less likely given systemic response
- **Joint aspiration + culture** is diagnostic and should precede IV antibiotics
- Hospital referral is mandatory

Frontotemporal Dementia (FTD)

Setting: GP Surgery / Memory Clinic
You are: FY2 Doctor
Patient: Elderly person with suspected Frontotemporal Dementia
You are speaking to: Their caregiver (e.g., son, daughter, spouse) who has been noticing worrying changes in the patient's behaviour.

Introduction & Rapport Building

- Greet the caregiver respectfully and introduce yourself:
  "Hello, I'm Dr [Your Name], one of the doctors here. Thank you for coming in today."
- Confirm:
  - The patient's full name and age
  - The caregiver's name and relationship to the patient
- Paraphrase the concern:
  "From what I understand, you've been seeing some recent changes in [patient's name]'s behaviour — and you're hoping we can explore this further today."
- Acknowledge caregiver's efforts:
  "Thank you for looking out for them — I understand this can be difficult, and I appreciate you taking the time to come in."

History – Data Gathering (from Caregiver)
Presenting Complaints – Explore in Detail

- **Onset:**
  "When did you first start noticing changes? Was it sudden or gradual?"
- **Specific behavioural or personality changes:**
  Ask open and targeted questions:
  - "Have they done or said anything that seems inappropriate in social situations?"
  - "Have they seemed more emotionally flat or withdrawn lately?"
  - "Any new repetitive behaviours, habits, or routines?"
  - "Have they lost interest in others' feelings or become less caring?"
  - "Have you noticed them eating more — especially sweets — or eating things they normally wouldn't?"
  - "Any issues with speech — like struggling to find words, mix up names, or not understanding what's being said?"
- **Impact on Daily Life:**
  - "How have these changes affected their daily activities or independence?"
  - "Have their relationships or routines changed noticeably?"
  - "Any recent safety concerns — like wandering off, getting lost, or making risky decisions?"

Red Flag / Associated Symptoms

- "Have you noticed any memory loss or confusion?"
- "Any hallucinations or seeing things that aren't there?"
- "Any movement issues, such as tremors or stiffness?"
- "Has their sleep pattern changed — for example, being awake at night and sleepy during the day?"

Medical & Psychiatric History

- "Do they have any previous psychiatric or neurological diagnoses?"
- "Any history of head trauma, stroke, or seizures?"
- "Could I check their regular medications — including over-the-counter or herbal ones?"
- "Any known allergies?"

Family History

- "Is there any family history of early-onset dementia or psychiatric illness?"

Social History

- "Where are they currently living — alone, with family, or in a care home?"
- "Who looks after them day to day?"
- "How are you managing with caring for them?"
- "Do you work or have other responsibilities that make this more difficult?"
  → Screens for carer strain and caregiver availability

ICE – Ideas, Concerns, Expectations

- "What do you think might be going on with them?"
- "Is there anything in particular that you're worried about?"
- "What were you hoping I could help with today?"

Explanation – Frontotemporal Dementia (FTD)

Gently introduce the possibility:
"Based on what you've described, one of the conditions we're considering is called **Frontotemporal Dementia**. It affects the front part of the brain — which controls behaviour, emotions, and speech."
Clarify key points:

- "This is different from Alzheimer's — in fact, memory is often not the first thing affected."
- "It's important to know this is not the patient's fault — these changes are due to brain changes, not a sign of them being 'difficult' or behaving badly."
- "Caring for someone with this condition can be emotionally and practically very hard — and you're not alone in feeling overwhelmed."

Management Plan

Referrals

- Neurology or **Memory Clinic** for formal assessment
- **Cognitive testing** and **MRI brain scan** to confirm diagnosis

Investigations

- Blood tests to **rule out reversible causes** (e.g., B12, thyroid)
- Imaging (e.g., **MRI**) to assess frontal and temporal lobe changes

Multidisciplinary Involvement

- **Occupational therapy** and **social worker** to assess daily function and safety
- **Psychiatrist** (if behavioural disturbance present)
- **GP follow-up** and regular dementia care reviews

Support for the Caregiver

- Provide written information and **leaflets** about the condition
- Offer access to **support groups**, **respite care**, or **counselling**
- Screen for and **address carer strain** or mental health issues
- Consider referral to **Adult Social Services** for needs assessment

Advance Planning (if appropriate)

- **Lasting Power of Attorney**
- **Driving status** – ensure DVLA notification if applicable
- Future care options and planning discussions

Safety Netting

- "If [patient's name] shows signs of sudden deterioration, starts wandering, becomes aggressive, or you feel unsafe or overwhelmed, please don't hesitate to reach out."
- Provide:
  - Contact number for GP/dementia team
  - Emergency services or 111 as needed

Follow-Up

- "We'll send a referral to the memory clinic — you should hear from them shortly."
- Offer:
  - Interim follow-up with GP
  - Contact with the **community dementia nurse or support team**

Information & Resources

- Leaflets:
  - Frontotemporal Dementia (FTD) overview
  - Alzheimer's Society or Dementia UK resources for caregivers
- Recommend websites for reliable reading:
  - www.dementiauk.org
  - www.alzheimers.org.uk

Obsessive-Compulsive Disorder (OCD) - Housewife

Setting: GP Clinic
Role: FY2 Doctor
Patient: 40-year-old housewife with 2 children
Presenting Concern: Repetitive behaviours and checking
Findings: Normal exam, no safeguarding concerns

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1. Introduction & Consent

"Hello, I'm one of the doctors here at the clinic. Thank you for coming in today.
Can I just confirm your full name and age, please?"
"Great. So I understand you've been having some repeated behaviours — like cleaning and handwashing — that have been bothering you. If it's okay, I'd like to ask a few questions to understand this better, then we can talk about what might help."

2. Focused History – Presenting Symptoms

"Let's start with what's been happening lately."

- **Onset & Pattern**:
  "When did these habits first start?"
  "Have they been getting worse over time?"
- **Behaviours**:
  "What exactly do you find yourself doing over and over again?"
  "How many times a day would you say this happens?"
  "Do you feel better afterwards — or does the feeling come back again soon?"
- **Obsessive Thoughts**:
  "Before you act, do you get a strong thought or feeling — like something bad might happen if you don't do it?"
  "Do you feel that these thoughts are your own, or do they feel pushed on you somehow?"
- **Control & Impact**:
  "Can you resist the urge to act on these thoughts?"
  "How much time do you spend on these behaviours each day?"
  "Has it affected your daily life — like looking after the kids, getting out of the house, or sleeping?"

3. Red Flag Screening

- "Do you ever feel overwhelmed or hopeless?"
- "Have you ever had thoughts of hurting yourself or ending your life?"
- "Do you feel able to manage things at home, like cooking, cleaning, and taking care of your children?"

4. Screening for Other Diagnoses

- **Depression**: "Do you feel low, tearful, or like you've lost interest in things you used to enjoy?"
- **Generalised Anxiety**: "Do you worry a lot about many different things — not just cleaning or checking?"
- **Psychosis**: "Have you seen or heard things others haven't?"
- **Bipolar**: "Have you ever had periods of very high energy where you couldn't sleep and felt on top of the world?"

5. FAMISH (Psychiatric Background)

- **F** – Family history of mental health problems or OCD?
- **A** – Any alcohol, smoking, or drug use?
- **M** – Any long-term physical illnesses or medications?
- **I** – "Do you believe these thoughts and actions are part of a mental health condition?"
- **S** – Any support at home — your husband, family, or friends?
- **H** – Any history of hallucinations or feeling paranoid?

6. MAFTOSA + LMP

- **Marital**: Married, lives with husband and two children
- **Allergies**: No known allergies
- **Function**: Currently a full-time homemaker
- **Travel**: No recent travel
- **Occupation**: Housewife
- **Smoking/Alcohol**: Does not smoke or drink
- **LMP**: "When was your last period?" (rule out postpartum or hormonal causes)

7. ICE *(Ideas, Concerns, Expectations)*

- "Have you had any thoughts about what might be causing this?"
- "Is there anything in particular you're worried about — like your health or how this affects your family?"

- "What were you hoping we could do to help you today?"

8. Examination Summary (Verbalised)
"Your physical examination and vital signs are normal. I did notice you tapping your fingers a few times — does that happen a lot?"
(*Helps reveal compulsive movements with insight*)

9. Provisional Diagnosis + Lay Explanation
Diagnosis: Obsessive-Compulsive Disorder (OCD)
Lay Explanation:
"It sounds like what you're experiencing is a condition called **OCD**.
This is a mental health condition where people have **unwanted thoughts** (we call them obsessions), and to reduce the anxiety those thoughts cause, they feel the need to do certain actions repeatedly (we call those compulsions).
For example, if you feel something is dirty, you might wash your hands several times — not because they are truly dirty, but because the thought keeps coming back.
You're not alone in this — it's actually quite common, and there are very effective treatments available."

10. Management Plan
First Line – Talking Therapy

- "The main treatment is **Cognitive Behavioural Therapy (CBT)** — a structured type of therapy that helps you break the cycle of thoughts and compulsions."
- "It includes a method called **Exposure and Response Prevention (ERP)**, where you slowly learn to face the thoughts without giving in to the compulsion."
- "It's very effective and can be life-changing."

Medication Option – If Moderate/Severe or Therapy Delayed

- "If your symptoms are more severe or therapy isn't available quickly, we can also offer medication. This would be a type of antidepressant called an **SSRI** — like fluoxetine, sertraline, or escitalopram."
- "These help reduce both the obsessive thoughts and the urge to perform the behaviour."
- "They take **about 6–12 weeks** to work and might cause some early side effects like nausea or sleep changes — but those usually settle."

11. Safety Netting

- "If your symptoms suddenly get worse, or if you feel low or unsafe in any way, please contact us urgently or go to A&E."
- "We'll keep a close eye on your mood and make sure you're not feeling overwhelmed."
- "Sometimes these conditions can affect sleep and energy, so let us know if that happens."

12. Follow-Up & Resources

- "We'll book a **review in 1 week** if you start medication — to check for any side effects or concerns."
- "If you're referred for CBT, the mental health team will be in touch within a few weeks."
- Offer **leaflet on OCD** and suggest **OCD Action**, **Mind**, or NHS Talking Therapies
- "You're not alone, and many people recover well with the right support."

Student Note: How Diagnosis Was Made
The patient describes classic **obsessions** (fear of contamination, uncertainty about locks) and **compulsions** (repeated washing, checking, tapping).
She is distressed, aware of her behaviour, and trying to resist — consistent with **OCD with preserved insight**.

There are no signs of psychosis, mania, or self-harm risk currently.
Diagnosis is supported by history and impact on function, as per NICE OCD diagnostic framework.

Confusion in Elderly – Hyponatraemia & Suspected Renal Failure

Setting: FY2 in Acute Medical Unit (AMU)
Patient: 70-year-old man, brought in by daughter
Pre-Station Data:

- Na+ low
- Urea and creatinine raised
- Haemoglobin low
- On enalapril for 2–3 years

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1. Introduction & Consent
"Hello, I'm one of the doctors here in the acute unit. Thank you for coming in with your father today.
Just to confirm, are you his daughter? And may I check his full name and age please?
I've seen some blood test results attached here — if you're happy, I'd like to ask a few questions and then explain what we've found and what we plan to do."

2. Presenting Complaint – Confusion History

- "Could you tell me what's been going on — how did you notice the confusion?"
- "When did it start? Was it sudden or gradual?"
- "Has he been drowsy, agitated, or saying unusual things?"
- "Is it constant or does it come and go?"
- "Any history of confusion in the past?"

3. Differential Diagnosis Screening (Confusion)
Infection

- "Any recent fever, cough, or breathing problems?"
- "Has he had any pain or burning while passing urine?"
- "Any recent falls or head injuries?"

Electrolyte/metabolic causes

- "Has he been eating and drinking properly over the last few days?"
- "Any vomiting, diarrhoea, or excessive water intake?"
- "Any known thyroid or adrenal problems?"

CNS causes

- "Any history of seizures, strokes, or memory problems like dementia?"
- "Has he had a headache, neck stiffness, or vision changes?"

Medication-related

- "Is he on any new medications recently?"
- "Do you know how long he's been taking enalapril?"

4. Targeted History: Suspected Renal Failure Symptoms

- "Have you noticed any swelling in his feet, legs, face, or tummy?"
- "Is he passing more or less urine than usual?"
- "Any blood or foam in the urine?"
- "Has he been breathless, especially when lying flat?"
- "Has he had any recent weight loss, poor appetite, or nausea?"

- "Has he been more tired or sleepy over the past few weeks?"

5. PMAFTOSA (Condensed & Combined with Risk Factors)

- **P**: High blood pressure (on enalapril), no known kidney diagnosis?
- **M**: Enalapril, other meds? NSAIDs? Diuretics? Diabetes meds?
- **A**: "Any past admissions or kidney infections?"
- **F**: "Any family history of kidney or heart conditions?"
- **T**: "What does he normally do during the day — is he independent?"
- **S**: "Does he smoke or drink alcohol?"
- **O**: "Has he travelled recently or been unwell abroad?"

6. ICE

- **Ideas**: "What do you think might be causing this?"
- **Concerns**: "Is there anything you're particularly worried about?"
- **Expectations**: "Is there anything specific you were hoping we could do?"

7. Effect on Life

- "How has this affected his ability to do things — like eating, walking, or going to the toilet?"
- "Has he needed help at home before this happened?"

8. Examination (Verbalised if not performed)

- "We will check his vital signs, listen to his chest, and possibly examine his abdomen and check his fluid status."
  (If prompted: check BP, HR, JVP, lung bases, peripheral oedema, cap refill, urine dip)

9. Provisional Diagnosis + Lay Explanation

Diagnosis: Likely *hyponatraemia* and *acute on chronic kidney disease (CKD)*, possibly triggered or worsened by long-term enalapril use, dehydration, or infection.

Lay Explanation:

"So what we've found is that your father has low levels of sodium — one of the salts in the blood — and this can directly affect how the brain functions, which explains the confusion.

He also has signs of reduced kidney function. The kidneys act as filters, and when they don't work properly, toxins and fluid build-up. This can disturb the salt balance and cause other symptoms like swelling or tiredness."

10. Management Plan

Hospital Admission

– "We're going to admit him to monitor and treat him closely."

Correcting Sodium

– "We'll treat the low sodium with a controlled IV fluid — usually a high-salt solution (3% hypertonic saline) if needed — but we'll increase it slowly to avoid complications like brain swelling."

– "We'll check sodium levels every 4–6 hours and monitor his alertness."

Managing Kidney Injury

– "We'll stop the enalapril as it can sometimes worsen kidney function."

– "We'll keep him well hydrated and may start him on alternative BP medication, like amlodipine, depending on his blood pressure."

Specialist Referral

– "We'll involve a **nephrologist** — a kidney specialist — to assess whether this is long-standing kidney damage or

something new."
– "They may arrange a kidney ultrasound and further blood tests."
Dialysis (if needed)
– "If the kidneys don't improve or toxin levels build up, they may consider **dialysis**, which is a process that filters the blood using a machine — but that decision will come later based on how he responds."
Medication & Supportive Care
– Monitor fluid input/output
– Avoid nephrotoxic medications
– Consider erythropoietin or iron support if anaemia is severe
– Dietitian input if dietary restrictions needed

11. Safety Netting

- "We'll monitor his heart rhythm, breathing, and fluid status very closely while correcting his sodium."
- "We'll be watching for any signs of worsening confusion, seizures, or other changes and will escalate care if needed."
- "If he doesn't improve, we may need to consider more urgent tests or treatment in a higher dependency unit."

12. Follow-Up & Final Check

- "Once things are stable, we'll discuss a long-term plan — including whether he needs follow-up in a renal clinic."
- "His GP will also be updated so they can monitor his blood pressure and kidney function."
- "Would it be helpful if I gave you a leaflet on low sodium or kidney conditions?"
- "Is there anything you'd like me to go over again or any questions you have?"

Diagnostic Reasoning – Student Note
Confusion in an elderly patient with **hyponatraemia**, **elevated urea/creatinine**, and **low haemoglobin** suggests **acute-on-chronic kidney disease**.
Long-term **enalapril use** and possible dehydration or infection likely precipitated this.
Low sodium (likely hypotonic hyponatraemia) explains the altered mental status.
Further nephrology input is essential to determine reversibility, assess CKD stage, and rule out obstructive or secondary causes.

Hyponatraemia due to SIADH (Suspected Lung Cancer)

Setting: GP Surgery
Role: FY2 Doctor
Patient: 70-year-old man
Background: Long-standing COPD, current smoker, tiredness → blood test
Result: Sodium 124 mmol/L (severe hyponatraemia), mild anaemia
Objective: Explain results, assess cause (possible SIADH), arrange urgent referral

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1. Introduction & Consent
"Hello, I'm Dr [Name], one of the doctors here at the practice. Could I confirm your full name and age, please? Thank you. I understand you've come in today to discuss some recent blood tests. Before we go over the results, would it be okay if I asked a few quick questions about how you've been feeling lately?"

2. Presenting Complaint – Tiredness (ODIPARA)

- "Can you tell me how long you've been feeling tired?"

- "Has it been getting worse or staying about the same?"
- "Does rest or sleep make it better?"
- "Any dizziness, loss of energy, or difficulty with your usual tasks?"
  (*Patient reports general tiredness over the last few weeks*)

3. Hyponatraemia Symptom Screening
"In your blood test, one of the body's salts — sodium — was found to be quite low, which may explain the tiredness.
To help us understand how it's affecting you, can I check if you've had any of the following recently?"

- Energy: Drowsiness? Fatigue?
- Muscles: Weakness? Muscle cramps or spasms?
- Brain: Headaches? Nausea? Feeling confused? Irritability or restlessness?

(*Patient reports fatigue and mild nausea, no confusion or seizures*)

4. Screen for Causes of Hyponatraemia

- "Are you on any regular medications — particularly for blood pressure or mood?"
- "Have you had any episodes of vomiting or diarrhoea?"
- "Any known problems with your heart, kidneys, or liver?"
  (*No medications, no fluid loss, no known organ failure*)

5. Focused History for SIADH & Cancer Screening
"You mentioned you've had COPD for a while — I'd like to ask a few more questions about your lungs, just to rule out anything serious."

- "How long have you had COPD?"
- "Have you noticed any recent changes in your cough?"
- "Have you been coughing up blood regularly?"
- "Any unexplained weight loss, night sweats, or chest pain?"
- "Any recent fevers, loss of appetite, or hoarseness of voice?"

(*Patient confirms chronic cough, increasing haemoptysis, and mild weight loss over past 2 months*)

6. MAFTOSA (Focus: Smoking History + Support System)

- "Do you currently smoke?"
- "How many cigarettes per day, and for how many years?"
- "Do you live alone or with someone?"
- "Any history of cancer in the family?"
  (*Patient smokes 15 cigarettes/day, 40 pack-year history; lives with wife; no family history*)

7. Examination (Verbalised if not performed)

- "I'll also check your blood pressure and do a quick chest examination today."
- "At this point, your blood test and symptoms already suggest a serious problem, so we'll focus more on arranging the right care."

8. Provisional Diagnosis + Simple Explanation
Provisional Diagnosis: Severe hyponatraemia due to suspected SIADH, possibly secondary to lung malignancy.
Explanation:
"Your blood test showed a **very low sodium level** — 124, when the normal range is 135 to 145. This explains the tiredness and nausea you've been experiencing.
We think this may be due to a condition called **SIADH**, which happens when the body produces too much of a

hormone called ADH. This hormone makes the body hold on to water and dilute the salt in the blood."
"SIADH is often linked to **lung conditions** — and because you have long-standing COPD, you're a smoker, and you've recently started coughing up blood, we're concerned that this may be caused by a **lung tumour** triggering the hormone imbalance."

9. Management Plan – NICE/NHS CKS Aligned
Hospital Referral (Urgent)

- "Because of the low sodium and the possibility of an underlying serious condition, this is something that needs hospital treatment right away."
- "At the hospital, they'll correct your sodium levels carefully using a **strong salt solution (3% saline)** through a vein."
- "They'll also monitor your brain, heart, and fluid levels very closely while doing this."

Specialist Referrals

- "You'll be seen by an **endocrinologist**, a hormone specialist, to confirm the diagnosis and investigate the cause."
- "We'll also refer you to a **lung specialist** to investigate further. This will likely involve:
    - Chest X-ray or CT scan
    - Possibly a scan called a PET scan or a biopsy
    - Blood and sputum tests"
- "If a tumour is confirmed, the treatment will depend on the type and stage — which might involve surgery, chemotherapy, or radiotherapy."

10. Reassurance & Support
"I know this might be overwhelming — but you've done the right thing by coming in today.
We'll get you the care you need quickly, and you won't be alone through this. I'll write a clear referral and call the hospital to let them know you're coming."

11. Safety Netting
"If your symptoms worsen at any point — especially if you feel more drowsy, confused, or have difficulty walking — please go straight to A&E or call 999.
This salt imbalance can become dangerous if not treated in time."

12. Follow-Up Plan

- Written urgent referral to medical team
- Flag for 2WW referral if cancer confirmed
- Notify hospital that patient is arriving for emergency management
- GP team to follow up once diagnosis is confirmed and specialist care begins

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Student Note: How Diagnosis Was Made
70-year-old man with COPD, chronic cough, and haemoptysis presented with fatigue and hyponatraemia (Na^+ 124 mmol/L). Classic signs of SIADH + red flag symptoms (weight loss, smoking, haemoptysis) point toward possible **paraneoplastic SIADH due to lung cancer**.

Bulimia Nervosa – Electrolyte Disturbance – Test Results

Setting: GP Clinic
Role: FY2 Doctor

Patient: Young adult attending to discuss recent blood test results
Background: Tiredness, vomiting history (revealed during history), borderline low sodium (135 mmol/L), low potassium

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1. Introduction & Consent
"Hello, I'm one of the doctors at the practice. Thanks for coming in today.
Before we begin, could I confirm your full name and age, please?
I've had a look at your recent test results, and I'd like to explain what we found and talk through some next steps — is that alright with you?"

2. Focused History & Context
"Before we look at the results, can I ask — what led to these blood tests? Was it part of a general check-up or were you experiencing any symptoms?"
(*Patient says: "I've been feeling tired lately"*)

Explore further:
Presenting Complaint – Explore Tiredness (ODIPARA)
- "Can you tell me how long you've been feeling tired?"
- "Has it been getting worse or staying the same?"
- "Does rest help at all?"
- "Any dizziness, difficulty concentrating, or low energy?"
  (*Patient reports tiredness over past few weeks*)

Symptom Screening – Hyponatraemia and Hypokalaemia
"Some of your symptoms could be linked to low salt levels in your blood. Can I ask if you've had any of the following?"
- Muscle cramps or weakness?
- Nausea or vomiting?
- Feeling confused or irritable?
- Palpitations or dizziness when standing?
  (*Patient reports occasional cramps and fatigue*)

Explore Vomiting – Direct but Gentle
- "Have you had any vomiting recently?"
  (*Patient says yes*)
- "Has it been happening on its own, or do you sometimes make yourself vomit?"
  (*Patient admits inducing vomiting*)
- "Can I ask how you do that — for example, do you use your fingers or anything else?"
- "How often would you say this happens in a week?"
- "What makes you want to vomit — is it after meals or certain foods?"
- "You mentioned trying to lose weight — can I ask what led to that decision?"

SCOFF Screening (Screening for Eating Disorders)
- "Do you ever make yourself **S**ick because you feel uncomfortably full?"
- "Do you feel you lose **C**ontrol over how much you eat?"
- "Have you lost more than **O**ne stone (14 pounds) in a 3-month period?"
- "Do you believe yourself to be **F**at when others say you are too thin?"

- "Would you say that Food dominates your thoughts or daily life?"
  (*Patient answers yes to several questions → positive screen*)

Mood & Risk Assessment

- "How has your mood been recently?"
- "Have you felt low, anxious, or withdrawn from others?"
- "Have you had any thoughts of harming yourself or ending your life?"
  (*Patient says mood is low but no active suicidal ideation*)

Past Medical and Mental Health History (MAFTOSA)

- "Have you ever been diagnosed with an eating disorder before?"
- "Any history of depression, anxiety, or self-harm?"
- "Do you have any other long-term conditions or take any regular medications?"
  (*No previous formal diagnosis, no regular medications*)

Explore ICE

- **Ideas**: "What do you think might be causing the tiredness?"
- **Concerns**: "Is there anything in particular that's been worrying you lately — either about your health or the test?"
- **Expectations**: "What were you hoping we'd discuss or do today?"

4. Clear Result Disclosure

"Thanks for sharing all of that — it really helps me understand the bigger picture.
Your blood results showed that **two salts in your blood — sodium and potassium — are low**. Sodium is just below the normal range, but **potassium is significantly low**, which could explain your tiredness and muscle symptoms."

5. Lay Explanation of the Condition

"Based on what you've told me — especially about inducing vomiting to manage your weight — this may point to a condition called **bulimia nervosa**.
This is an **eating disorder** where someone feels the urge to eat large amounts of food, followed by behaviours to avoid weight gain, such as vomiting.
Vomiting can cause your body to lose vital salts like sodium and potassium. If not treated, it can lead to complications like irregular heartbeat, muscle weakness, or more serious issues."

6. Structured Management Plan

Urgent Medical Management

"Because your potassium is quite low, I'd recommend that we arrange for you to go to **hospital today**. There, they'll:

- Monitor your heart and electrolytes
- Give you fluids with potassium (usually as a drink or drip)
- Recheck your blood levels
  This isn't a punishment or a scare — it's simply to protect your body from any risks associated with low potassium."

Specialist Referral

"Once you're stable, I'd like to refer you to a **specialist eating disorder clinic**.
They can offer support with:

- **Cognitive Behavioural Therapy (CBT)**

- Help with healthy eating habits
- Advice from dietitians
- Medication if needed
- A safe space to talk through your experience"

Mental Health Support
"If you're finding this emotionally difficult, we can also link you to a **counsellor or wellbeing support** team through the NHS.
These services are there to help you feel more in control, not judged."

7. Safety Netting
"If you feel worse — more tired, dizzy, low in mood, or feel like harming yourself — please don't wait. Come back to us or go to A&E. Your health and safety are the priority.
And if you're ever unsure whether it's serious, it's always okay to call 111."

8. Follow-Up Plan
"Once your salt levels are corrected in hospital, we'll follow up at the GP clinic to:

- Review your bloods again
- Check on how you're doing physically and emotionally
- Begin your referral to the eating disorder service
- Make sure you're supported throughout this process"

9. Offer Leaflet & Final Check
"There's a leaflet here with some information about bulimia and how support services work — would you like me to go through it with you or would you prefer to read it on your own later?
Do you feel everything we've discussed today made sense? Would you like me to explain anything again or in a different way?"

Student Note: How Diagnosis Was Made
Patient attended to discuss blood results showing **borderline hyponatraemia (135 mmol/L)** and **hypokalaemia**. On history, patient admitted to **self-induced vomiting to lose weight**. SCOFF questions positive. Diagnosis of **bulimia nervosa** suspected. Urgent hospital referral made for electrolyte correction. Referral to eating disorder clinic initiated. Insight present, no current suicidality.

SIADH Secondary to Infection – Elderly Confusion

Setting: Acute Medical Ward
Role: FY2 in Acute Medicine
Patient: 65-year-old lady
Relative: Daughter is present and concerned
Background:

- Patient brought in for new-onset confusion
- Sodium low
- CT head normal
- CRP elevated
- Recent viral illness (flu)
- On thiazide diuretic and citalopram

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1. Introduction & Consent
"Hello, I'm one of the doctors looking after your mum today. Thank you for coming in with her.
Before we start, can I just confirm — your mum's full name and age?
I'd like to go over what we've found so far and explain what we think is going on. Is that okay?"

2. Focused History & Context
(Daughter says: "Is she having a stroke?")
"Thanks for raising that — I completely understand how scary this must have been. We've already done a CT scan of her head, and I can reassure you it came back normal — she's not having a stroke right now."
Now gather more context:

- "Can you tell me exactly what happened this morning that made you bring her in?"
- "What do you mean by confused — was she saying unusual things or not recognising people?"
- "When did this start? Has it been getting worse or staying the same since then?"
- "Was she completely normal yesterday?"
- "Has anything like this ever happened before?"

Screen for hyponatraemia symptoms:

- "Has she seemed very tired or weak recently?"
- "Any nausea, vomiting, or headaches that you noticed?"
- "Has she seemed irritable or more emotional than usual?"

3. Explore ICE

- **Ideas**: "Did you or your mum have any idea what might be causing this confusion?"
- **Concerns**: "Is there anything you've been particularly worried about, like a stroke or dementia?"
- **Expectations**: "What were you hoping we'd be able to help with today?"

4. Clear Result Disclosure
"Thank you — that's really helpful to understand.
We've run some urgent blood tests and a brain scan. The **CT scan was normal**, which is great news. But one thing that stood out was that her **sodium level is low** — this is one of the salts in the blood that helps keep the brain working normally.
We also found signs of an infection, possibly from a recent flu."

5. Lay Explanation of the Condition
"What we think is happening is something called **SIADH**, or Syndrome of Inappropriate Antidiuretic Hormone secretion.
In simple terms, her body is holding on to too much water, which dilutes her sodium levels. This can happen after infections — even viral ones like the flu — or due to certain medications like **citalopram** (for depression) and **thiazide diuretics** (for blood pressure).
When sodium gets too low, it can affect the brain and cause symptoms like confusion or agitation — which is likely why she's behaving differently today."

6. Structured Management Plan
Immediate Plan
"We'll keep her in hospital to treat this safely. The team will:

- Start a controlled salt replacement using fluids through a vein
- Monitor her sodium closely over the next 24–48 hours
- Start antibiotics or antivirals if needed to treat any ongoing infection"

Medication Review
"We'll review her regular medications as well:

- **Switch her antidepressant** to something safer for sodium levels — like **amitriptyline** or another suitable option
- **Stop the thiazide** and change to a different blood pressure tablet that doesn't affect salt balance — usually a calcium channel blocker like **amlodipine**"

Further Monitoring & Support
"We'll also assess for other contributing factors like kidney or heart issues, just to be thorough. And once her sodium improves, we'll reassess her memory and mood to make sure nothing else is going on."

7. Safety Netting
"If at any point she becomes more drowsy, has a seizure, or is difficult to rouse, we'll escalate her care immediately. You can also speak to any member of the ward team at any time if you feel something isn't right."

8. Follow-Up Plan
"Once she's medically stable, we'll:

- Recheck her bloods
- Review her medications with the pharmacist and GP
- Arrange outpatient follow-up with the medical team or possibly a memory service, depending on how she recovers"

9. Offer Leaflet & Final Check
"Would you like a leaflet that explains low sodium and how medications and infections can affect it?
Have I explained everything clearly? Is there anything you'd like me to go over again?"

Student Note: How Diagnosis Was Made
65-year-old with sudden confusion. CT normal, sodium low, CRP raised. History of flu. On citalopram and thiazide diuretic. Likely SIADH secondary to viral infection and medication effect. Sodium correction + medication review initiated.

Chapter 26: Teaching

Introduction to PLAB 2 Teaching & Procedure Stations

PLAB 2 contains a wide range of **clinical procedure stations** — some where you're expected to *perform a procedure*, and others where you *teach the same skill* to a medical student or nurse. Though both formats assess similar knowledge, the **expectation and communication style differ significantly** — and being able to switch between the two confidently is what makes a 12/12 candidate.

Understanding the Station Format
Procedure Station:

- You perform the task yourself.
- Focus: **Execution, confidence, safety, consent, communication**.
- Target audience: **Patient or mannequin**.
- IPS lens: Prioritise comfort, reassurance, consent, dignity, safety-netting.

Teaching Station:

- You explain or demonstrate the task.
- Focus: **Clarity, logic, pacing, visual cues, engaging the learner**.

- Target audience: **Student or junior colleague**.
- IPS lens: Be collaborative, non-condescending, check understanding, adapt to their level.

How to Study & Practise Effectively
Master the WHY, not just the HOW
Don't just memorise steps. Understand *why* each step matters:

- Why gloves *before* tourniquet?
- Why label *after* removing gloves? This gives you flexibility when the flow changes.

Build a DIY Sim Lab at Home
You don't need a SimMan to master these. Use household tools:

- Pen as a cannula
- Rubber tube or shoelace as a vein
- Bowl of water and tubing to simulate flushing
- Gloves and apron for muscle memory
- Use trays, lids, boxes to mimic sterile fields
- Tissue for dressing or catheter lubricant

You can practise steps **alone or with a peer**. If alone:

- Say everything aloud.
- Use a mirror or record yourself.
- Replay to check tone, clarity, confidence, and pace.

Prepare Both Versions
For every core skill (blood sampling, catheterisation, DRE, ABG), learn:

- How to perform it (PROCEDURE)
- How to explain and demonstrate it (TEACHING)

Most high-yield procedures may come up in **both forms**.

IPS & Examiner Impressions
For both types of stations, never let the task overpower your communication. Scoring high in PLAB 2 comes down to this:

IPS Tip	*Why It Matters*
"Let me know if anything feels uncomfortable."	Empathy, sensitivity
"Does that make sense so far?"	Active engagement
"We'll ensure your privacy and dignity throughout."	Respect and professionalism
"Feel free to stop me anytime."	Collaboration
"Are you happy for me to continue?"	Consent & partnership

Tone matters. Confident but gentle. Clear but not robotic. Clinical but compassionate.

PLAB 2 Teaching Station Framework

Professional, Friendly Introduction

- "Hi, I'm [First Name], one of the FY2s here."
- "You must be [Student's Name], right? Nice to meet you."
- "I understand you'd like to go through [topic] today — happy to help."

Key Tip:
Use only your first name (not "Dr."). Keep your tone warm and professional, maintaining eye contact and calm energy. This builds initial rapport and scores well for communication.

Build Quick Rapport
Ask 1–2 short, supportive questions to set the tone:
- "How's your rotation going so far?"
- "Have you had a chance to see this being done before?"
- "Any assessments coming up?"

Time: ~30 seconds
Avoid overly casual phrasing. You're a supportive senior colleague — not a buddy.

Set the Agenda Clearly
- "Let's make this a relaxed, interactive session — feel free to stop me anytime if you'd like me to repeat or clarify something."
- "We might get interrupted, but if we do, I'll make sure to send you a reliable link or finish it later."
- "Shall we start?"

Why it matters:
This shows time-awareness, sets shared expectations, and earns high marks under "Structure" and "Rapport."

Assess Learning Needs (The 4 Ws)
Tailor your teaching with these:
- "What do you already know about this topic?"
- "What would you like to focus on today?"
- "Why are you particularly interested in this — have you seen a case on the ward?"
- "When do you think this is usually done clinically?"

Why it matters:
This avoids wasting time, ensures relevance, and supports learner-centred teaching — a key GMC teaching standard.

Teach the Concept or Skill
Adapt depending on whether it's a **procedure** or **concept**:
If it's a practical skill (e.g. injection, ECG, ABG):
- Demonstrate step-by-step, clearly and calmly
- Use real equipment or props in the cubicle
- Verbalise your safety checks (e.g., allergies, consent, PPE)
- Use phrases like:
  - "We usually begin by ensuring…"
  - "Then you want to…"
  - "You'll often see people do this, but best practice is…"

If it's a concept (e.g. cancer pathway, ECG interpretation):
- Use pen and paper or gestures
- Break it down into logical parts
- Use professional, simplified language (avoid over-explaining)
- If helpful: use metaphors/analogies rooted in patient care
  - e.g. "Think of ECG waves as electrical snapshots of each heartbeat"

Don't quiz or ask them to repeat anything. This is not an exam.

Involve the Student

- "Does this pace feel okay for you?"
- "Would you like me to slow down or clarify any step?"
- "Would it help if I show you again from here?"

Scoring Boost:
This checks understanding, encourages questions, and scores high for **Language**, **Listening**, and **Rapport**.

Wrap-Up & Reinforce the Key Points

- "To summarise, we went through [main steps/key principles]."
- "The key things to remember are [highlight 2–3 takeaway points]."
- "Don't feel you need to memorise it — it'll make more sense with practice."
- "Here's a good NHS/Trust resource you can read in your own time."

Don't know an answer?
Say: "That's a great question. I'm not sure off the top of my head, but I'll look it up and send it to you later."

Final Encouragement & Open Door

- "You've done really well — thanks for being so engaged."
- "You're going to be a great doctor — keep up the curiosity."
- "Please feel free to ask me anytime if you want to go over anything else."

Last impression matters.
GMC values encouragement, mentorship, and open communication.

Optional: If Time Runs Out or You're Interrupted

- "We may get interrupted, but if that happens, I'll make sure you get the full explanation later."
- "I'll send you a quick resource so you're not left hanging."

EpiPen

Professional, Warm Introduction
"Good morning, I'm [Dr. Last Name], one of the FY2 doctors here."
"Before we begin an you confirm your name and relationship to [Patient]. It's lovely to meet you. I understand you're here today to learn how to use the EpiPen that's been prescribed for your son."
"I'm really glad you've come in — it's incredibly important, and I'll walk you through everything step-by-step."

Build Quick Rapport
"How has he been doing since the reaction last week?"
"Did the hospital visit go smoothly — were you happy with the care he received?"
"You've done exactly the right thing coming in today. We'll make sure you leave confident about what to do if this ever happens again."

Set the Agenda Clearly
"So today, I'll take you through **when to use the EpiPen**, **how to use it**, and **what to do afterwards**. You'll also get to practise with this trainer pen."
"We'll go at your pace, and feel free to ask questions at any point."
"If we're interrupted or need to pause, I'll make sure we arrange a second session or share a resource for you to go over later. Does that sound okay?"

Assess Learning Needs – "4 Ws"

"To tailor this better for you, could I ask:"

- "What do you already know about your son's allergy and how severe it might be?"
- "Have you seen an EpiPen before, or do you know how to use it?"
- "Why did you want to go through this today — were there any concerns?"
- "Have you ever witnessed someone needing one — or had to use one before?"

(If she's unsure, reassure: "That's completely fine — we'll take it from the top.")

Teach the Concept or Skill

When to Use the EpiPen – Recognising Anaphylaxis

"You'll want to use the EpiPen at the **first sign of a severe allergic reaction** — this is called *anaphylaxis*. Key things to look out for include:

- Sudden **difficulty breathing** or **wheezing**
- **Swelling** of the lips, tongue, throat, or face
- A widespread **skin rash** or hives
- Dizziness, clamminess, fainting, or confusion
- A fast, pounding heartbeat
- A feeling that something's very wrong or your child looks very unwell

If you spot **two or more of these symptoms** together — even if you're unsure — use the pen. It's always safer to treat early."

"Do you feel confident spotting these symptoms now?"

What the EpiPen Is and How It Works

"The EpiPen is an automatic injection device containing **adrenaline** — which works very quickly to reverse life-threatening allergic reactions."

"It:

- **Opens the airways** to ease breathing
- **Reduces swelling** in the throat
- **Stabilises blood pressure**

The pen has two ends:

- The **orange end** is where the needle comes out. It's **spring-loaded** and **retracts automatically**, so you won't see the needle before or after use.
- The **blue cap** is the safety lock.

Easy way to remember: *Blue to the sky, orange to the thigh.*"

How to Use the EpiPen

"Let me show you how to use it step by step. Would you like to practise along with the trainer?"

1. **Hold** the pen in your dominant hand like a fist — **don't put your thumb over either end.**
2. **Remove** the blue cap.
3. **Swing and push** the orange end firmly into the **outer mid-thigh** — it can go through clothing.
4. You'll hear a **click** — that means it's worked.
5. **Hold it in place for 10 seconds** — count slowly: *"1 elephant, 2 elephant…"*
6. **Remove it and massage** the site gently for a few seconds.

"Would you like to try that again using the trainer?"

What to Do After Using the EpiPen

"Once you've used it:"

- **Call 999 immediately** and clearly say *"ANAPHYLAXIS"*. This ensures the fastest possible ambulance response.

- **Lay your child flat** (or in a comfortable position) and **stay calm** — your presence helps him feel safe.
- If there's **no improvement after 5 minutes** and help hasn't arrived, use the **second EpiPen** if available.
- Once at hospital, doctors will **observe him for a few hours**, because sometimes symptoms can return.

Addressing Common Concerns

What if it wasn't actually anaphylaxis?

"Great question. If the reaction turns out to be milder, adrenaline might still cause a fast heartbeat or shaking — but it's **safe**, and far less risky than waiting too long."

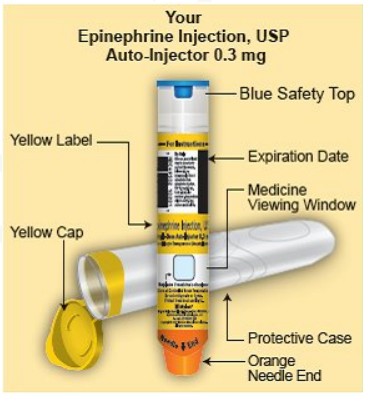
What if one pen doesn't work?

"Sometimes the first dose isn't enough — that's why it's important to always carry **two pens**. You can give the second dose **after 5 minutes** if symptoms haven't improved."

"Is there anything about that you'd like me to go over again?"

Involve the Parent Throughout

- "Would you like to try another round with the trainer?"
- "Is this making sense so far?"
- "Anything you'd like me to repeat before we wrap up?"
- "How confident are you feeling about using it if needed?"



Wrap-Up & Reinforce Key Points

"To summarise what we covered today:

- Recognising anaphylaxis symptoms early
- How the EpiPen works and how to use it safely
- What to do immediately after using it
- When to use the second pen
- Why it's safe even if you're unsure

Here's an NHS leaflet you can take home, and I'll set a reminder for the prescription renewal so it doesn't expire."

Final Encouragement & Open Door

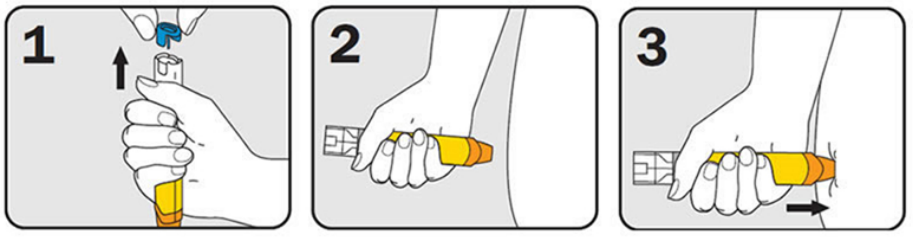
"You've done brilliantly — it's clear you're doing everything you can to protect your child."

"Hopefully you'll never need to use the EpiPen again, but now you know exactly what to do if you have to."

"Feel free to come in any time for a refresher — or give us a call if anything's unclear."

Bonus Safety-Netting Reminders (Fully NICE/NHS-aligned)

- **Check expiry date** regularly — replace it if it's close to expiry or after use.
- **Store at room temperature** — avoid keeping it in cars or fridges.
- **Always carry two pens** in a **labelled, hard-case** container.
- Make sure **school staff, family, and carers** are trained and informed.



Urine Dipstick Test

Professional, Warm Introduction
"Hi, I'm [First Name], one of the FY2 doctors in the department — really nice to meet you."
"I understand you're keen to learn about urine dipstick testing today — that's a great skill to get confident with, and I'm happy to go through it with you step by step."
(Smile, relaxed posture, warm but professional tone. Stand or sit at eye level. Avoid over-familiarity.)

Build Quick Rapport
"How's your clinical placement going so far?"
"Have you had a chance to observe any urine dipstick testing before on the wards?"
(Allow 20–30 seconds. Keep it brief but warm – this fosters a psychologically safe learning space.)

Set the Agenda Clearly
"So, here's what we'll do: I'll walk you through what the test is, how to interpret it, and then we'll go over how to physically perform the steps — using proper technique and PPE."
"If we're interrupted at any point, I'll make sure to follow up with you or send a useful resource for revision."
"Feel free to stop me anytime — I'd rather this be interactive than a lecture. Shall we begin?"

Assess Learning Needs – The "4 Ws"
"To tailor this to you, can I ask…"

- "What do you already know about urine dipsticks — have you seen them done before?"
- "Which parts would you like to focus on today?"
- "Why are you interested in this skill now — has a case prompted this?"
- "And when do you think we typically use dipstick testing in clinical practice?"

If they struggle, provide context:
"We commonly do this test at the bedside — especially when patients present with abdominal pain, suspected UTI, fever, unexplained delirium, or potential diabetes complications."

Teach the Concept and Demonstrate the Skill

Preparation & Equipment "Let's start with what we need:"

- Gloves and apron (PPE)
- Tissue/paper towel
- Urine sample pot (labelled with name, date, time)
- Dipstick container (with expiry date checked)
- Reference chart for result interpretation

Note: Dipsticks are chemical test strips – they react to the components in the urine. Exposure to air, moisture, or expiry can affect accuracy – so we keep the container tightly closed.

Preliminary Sample Assessment "Before dipping anything, just looking at the sample gives us valuable clues."

- **Colour**:
  - Normal is pale yellow.
  - Dark = dehydration
  - Red = blood or pigment (e.g. rhabdomyolysis)
  - Brown = bile pigments or old blood
- **Clarity**:
  - Cloudy = pyuria (pus), phosphates, or crystals → think UTI

- **Odour**:
  - Strong/foul = possible UTI
  - Sweet = possible ketonuria/glycosuria → think diabetes

Performing the Dipstick Test "Here's how we do the test safely and correctly:"

1. Put on apron and gloves.
2. Open the container and remove a strip **without touching the chemical squares**.
3. Immediately reseal the container.
4. Dip the strip fully into the urine sample — all squares should be immersed.
5. Remove it and gently tap against the pot to remove excess.
6. Lay the strip flat on a tissue — **keep it horizontal** to avoid cross-contamination.
7. Wait 30–120 seconds (depending on reagent type).
8. Use the **colour chart** on the container to interpret the results.

"It's like multi-lab test paper — each pad reacts to a specific component."

Key Dipstick Findings & Clinical Interpretation

Pad	*What It Detects*	*Raised Suggests*
Protein	Albumin	UTI, glomerulonephritis, diabetes, dehydration
Leukocytes	WBCs	UTI or inflammation
Nitrites	Bacterial conversion	Suggests UTI (esp. gram-negatives)
Blood	RBCs/myoglobin	Infection, trauma, stones, tumour
Ketones	Fat metabolism	Diabetes, fasting, starvation
Glucose	Hyperglycaemia	Diabetes, Cushing's
Bilirubin/Urobilinogen	Liver pathology	Liver disease or haemolysis

Tip: "Dipstick is only a screening test. Abnormal findings should always prompt clinical correlation and further lab investigations (e.g. MSU, cultures, renal profile)."

Involve the Student

"Would you like to try the next test strip yourself?"
"Does the pace feel okay?"
"Would you like me to go over any part of the process again?"
(Use gentle questioning to assess understanding – show encouragement and flexibility. Avoid quizzing.)

Wrap-Up & Reinforce Key Points

"Let's quickly recap what we covered today:"

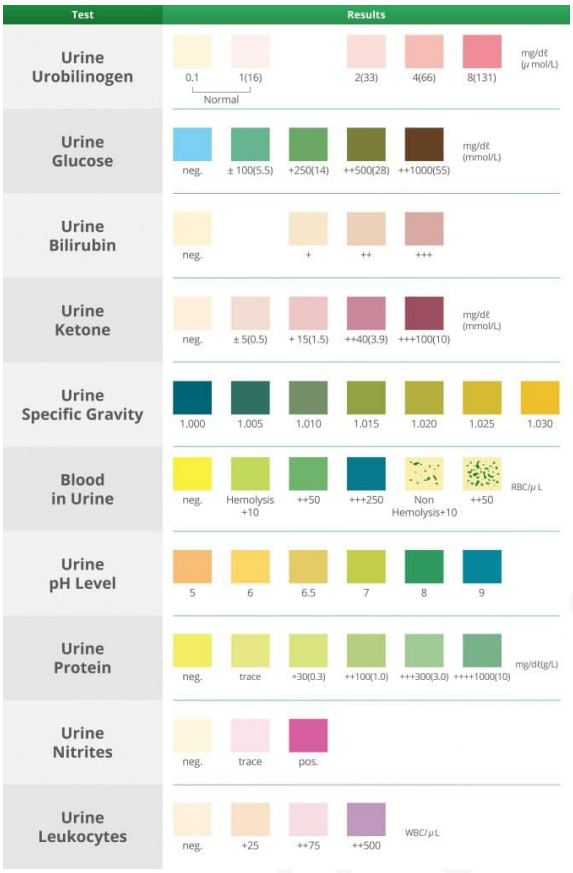
- Visual inspection of the urine — looking at colour, clarity, smell.
- How to prepare safely and correctly.
- Performing the dipstick and interpreting results accurately.
- Understanding what abnormal results mean and when to escalate.

Always correlate findings with the patient's symptoms, and don't over-rely on a single result.

Final Encouragement & Open Door

"You've done really well today — it's great to see you taking initiative like this."
"If you'd like to practise again or go over another bedside test like ECG or ABG, just give me a shout."
Create psychological safety. Your body language and tone must reflect genuine warmth and approachability.

Optional Safety-Net (If Time Runs Out)
"If we didn't get through everything, I'll send you an NHS resource you can review later — and I'd be happy to arrange a follow-up."



Subcutaneous Injection

Professional, Warm Introduction
"Hi, I'm [First Name], one of the FY2 doctors here on the ward — really nice to meet you."
"I understand you're hoping to learn how to perform a subcutaneous injection today — absolutely happy to guide you through that step-by-step."
Tone: Friendly but professional. Avoid "Dr.", sit or stand at eye level.

Quick Rapport & Encouragement
"How's your placement been so far?"
"Have you had a chance to observe this done on the wards yet?"
Keep this light – around 20 seconds – but it helps set a relaxed, engaging tone. Encourage their curiosity.

Set the Agenda Clearly
"Here's how we'll run this session:

- We'll first go over what subcutaneous injections are and when we use them.
- I'll demonstrate the full technique step by step.
- And then we'll make sure your questions are answered, including the ones you mentioned about sites, technique, and common errors."

"If I'm bleeped or interrupted, I'll make sure we revisit it later — or I'll share a resource you can revise with."

Tailor to Their Learning – The 4 Ws
"To make this session more useful for you…"

- "What do you already know about this?"
- "What would you like me to focus more on?"
- "Why are you particularly interested in this skill now — have you seen any patients needing it?"
- "When do you think this technique is most commonly used?"

If unsure, explain: "It's frequently used in general medicine, diabetes care, surgery wards, palliative care, and even community settings."

Teach the Skill: Concept + Demonstration
When & Why We Use This Route
"Subcutaneous injections deliver medication into the fatty layer under the skin — allowing for slower, more sustained absorption compared to intramuscular or intravenous routes."
Common examples:

- **Insulin** – diabetes
- **Low Molecular Weight Heparin (e.g., enoxaparin)** – VTE prophylaxis
- **Morphine or antiemetics** – palliative care
- **Hormonal injections** – fertility or HRT regimens

Analogy: "Think of it like placing medication in a sponge under the skin, where it gets absorbed gradually."

Equipment Checklist
Gloves
Apron
Syringe – pre-filled or drawn up
Alcohol swab
Gauze or cotton
Sharps bin
Clinical waste bin
Prescription or drug chart
"Always check the prescription for **Right drug, dose, patient, time, and route** — the 5 rights of drug administration."

Common Injection Sites
"We usually choose from four areas:"

1. **Outer upper arms**
2. **Abdomen** – 2 inches away from the umbilicus (preferred site for insulin)
3. **Outer upper thighs**
4. **Upper gluteal area**

Avoid sites that are: inflamed, bruised, scarred, or infected.
Rotate sites regularly – injections should be spaced at least 1 inch apart to reduce tissue damage and ensure proper absorption.

Step-by-Step Procedure (Verbal Demonstration)

1. **Wash hands**, don apron and gloves
2. **Confirm identity** and check prescription
3. **Explain the procedure** to the patient and gain verbal consent
4. **Position** the patient comfortably and expose only the area needed
5. **Choose injection site** and clean with alcohol swab (circular motion, allow to dry)
6. **Hold syringe like a pen**, keeping fingers away from the plunger

7. **Pinch skin** between thumb and index finger to elevate subcutaneous tissue
8. **Insert needle at 45–90° angle** (90° for obese patients, 45° for thin)
9. **Inject medication slowly and steadily**
10. **Withdraw needle** quickly at the same angle, apply gauze gently
11. **Dispose of syringe immediately** into sharps bin
12. **Document** administration – date, time, site, dose, batch number

We do NOT aspirate in subcutaneous injections – there are no large blood vessels in the layer, and aspiration adds unnecessary discomfort.

Involve the Student

"Would you like to come a bit closer to see this angle?"
"Does this pace feel okay?"
"Would you like me to go over any part again or clarify anything about the technique or safety checks?"
This supports listening, rapport, empathy, and learner-centred education – all highly valued in PLAB 2 marking.

Wrap-Up & Key Reinforcement

"To quickly recap:

- Subcutaneous injections are used when we want slow, steady absorption
- We choose from four key sites, avoiding any compromised skin
- We demonstrated the full procedure step-by-step — from prep to safe disposal
- And we covered the clinical reasoning behind the route and drug selection."

"Always remember: document everything, rotate sites, and check for allergies or contraindications."

Final Encouragement & Open Door

"You've asked excellent questions — and you're clearly paying close attention to safety and precision, which is brilliant."
"Feel free to shadow me again anytime — and if there's another skill you'd like to practise, I'd be more than happy to go over it with you."

Bonus: Common Student Questions (IPS Bonus Points)

Can we reuse the same site repeatedly?

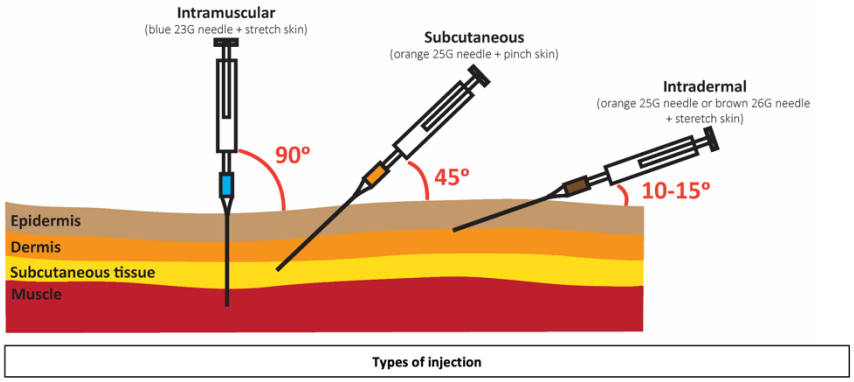
"No — repeated use can cause lipodystrophy or poor absorption. Always rotate sites by at least an inch."

Why don't we aspirate?

"There are no major blood vessels in the subcutaneous layer, so aspiration isn't necessary — and it actually increases discomfort."

What if I hit a blood vessel accidentally?

"It's very unlikely — but if you notice bleeding or bruising, apply pressure and choose a new site next time."



Types of injection

ECG Teaching

Professional, Warm Introduction
"Hi, I'm [First Name] — one of the FY2 doctors here in the cardiology department."
"You must be on placement with us this week — really nice to meet you."
"I heard you're keen to go through the basics of ECG interpretation — I'd be happy to walk you through it."
Use only first name (not Dr), maintain eye contact, speak clearly and warmly.

Quick Rapport Building
"How's your rotation going so far?"
"Have you had the chance to observe or interpret any ECGs on the ward yet?"
This short exchange creates a safe learning space. 20–30 seconds max.

Set a Clear Agenda
"Here's what we'll cover today:

- First, we'll go over the basic principles of ECGs — what they measure and why we use them.
- Then we'll break down the normal ECG waveform using a visual sketch.
- I'll show you how to calculate heart rate, assess rhythm, and identify some key red flags.
- And I'll point you to a reliable online resource for further practice."

"Please feel free to stop me anytime if something's unclear."
Shows planning, time awareness, and shared agenda – all rewarded in PLAB 2.

Assess Learning Needs — The 4 Ws
"Before we dive in, can I check a few things?"

- "What do you already know about ECGs?"
- "Anything specific you'd like to get clearer on?"
- "Why are you particularly interested in this now — have you seen it used in a clinical case?"
- "When do we typically use ECGs in practice — can you think of any scenarios?"

Use responses to adjust your depth and focus – e.g. rate/rhythm vs MI patterns.

Teach the Concept — Clear, Visual, Applied
Analogy – What is an ECG? "An ECG is like the electrical signature of the heart — each beat leaves a trace, and that trace tells us how the heart is functioning."
Visual Aid – Sketch and Simplify
(Draw a simple heart with SA node, AV node, bundle branches and label the waves.)

- **P wave** → Atrial depolarisation (atrial contraction)
- **QRS complex** → Ventricular depolarisation (ventricular contraction)
- **T wave** → Ventricular repolarisation (ventricular recovery/reset)

"Think of it like a cycle — fire, contract, reset."

Rate Calculation

- If **rhythm is regular**:
  → Count large squares between **R waves**, then:
  300 ÷ number of squares = bpm
  e.g. 4 big boxes = 75 bpm
- If **rhythm is irregular**:
  → Count **R waves in 30 large squares**, then multiply by 10

- Normal HR = **60–100 bpm**
    - <60 → bradycardia
        - 100 → tachycardia

What ECGs Can Reveal
Use simple language, no jargon, no quizzing.

- **Arrhythmias** (e.g. AF, bradycardia, SVT)
- **Myocardial infarction** (ST elevation, T-wave inversion, Q waves)
- **Electrolyte disturbances** (e.g. tall T waves in hyperkalaemia)
- **Conduction delays** (e.g. bundle branch blocks)
- **Pericarditis** (saddle-shaped ST elevation)
- **Pulmonary embolism** (S1Q3T3 pattern)

Clinical Red Flag
"If you see **ST elevation** in two or more contiguous leads and the patient has **central chest pain radiating to the arm or jaw** — this could be a heart attack. You must escalate immediately."

Involve the Student
"Would you like to take a look at this strip and tell me if the rhythm looks regular?"
"Was that a clear way to explain the waves?"
"Would you like me to go through rate calculation again — or would it help if I drew it out?"
This helps hit rapport, language, IPS and teaching domains naturally.

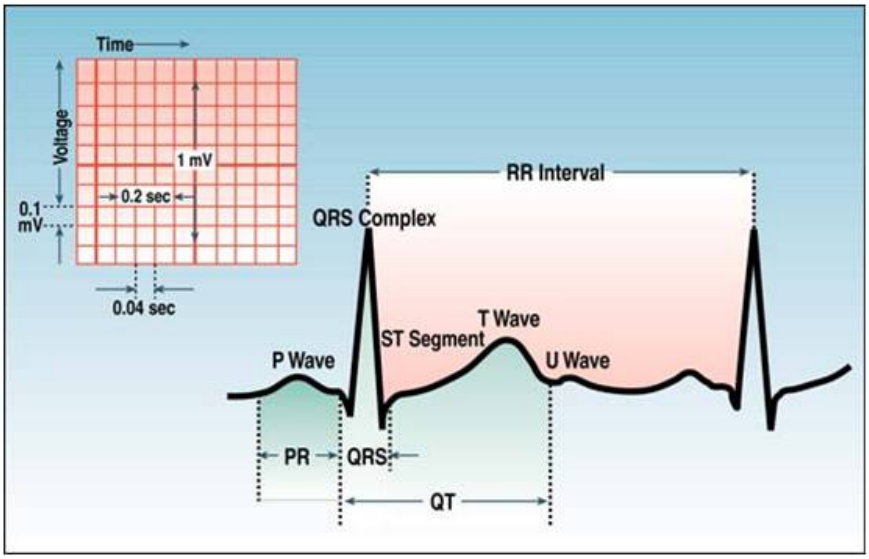
Recap & Reinforce
"Let's summarise what we've covered:

- The ECG shows us the heart's electrical activity — each wave has meaning.
- The **P, QRS, and T** waves represent atrial contraction, ventricular contraction, and recovery.
- You can calculate the heart rate using the **300 rule** (regular) or **30 box rule** (irregular).
- ECGs help us identify rhythm problems, heart attacks, drug effects, and more."

"There's an excellent free resource for practice called *Life in the Fast Lane ECG Library* — I'd highly recommend it for visual learning and case examples."

Final Encouragement & Open Invitation
"You've done really well — the questions you're asking show great clinical insight."
"Don't hesitate to bring any ECGs you find interesting during your rotation — I'd be happy to review them with you."

Bonus: Addressing Common Questions
What's the difference between AF and sinus arrhythmia?
"AF has an irregularly irregular rhythm without P waves. Sinus arrhythmia still has a pattern and visible P waves."
How accurate is heart rate from the monitor vs ECG?
"Always check the strip — sometimes motion artefacts or misplacements can mislead automated readings."
When do we repeat an ECG?
"If the patient deteriorates, has ongoing symptoms, or new findings — repeat and escalate."



Adult Basic Life Support (BLS)

Introduction

"Hi, I'm [First Name], one of the FY2 doctors working here in A&E."

"I understand you're here to go through Basic Life Support — that's an essential skill, and I'm really glad you're keen to learn it today."

Use a confident but warm tone, eye contact, and avoid overly casual language.

Build Quick Rapport

"How's your clinical placement been going so far?"

"Have you had a chance to see an emergency case or cardiac arrest on the ward yet?"

"That's totally fine — we'll make sure you feel confident by the end of this session."

Set the Agenda Clearly

"Here's the plan — I'll explain what BLS is, walk you through the Resus Council UK algorithm, and then demonstrate chest compressions step-by-step. You'll get a chance to practise on the mannequin, and I'll guide and correct your technique. If we get interrupted or short on time, I'll make sure you have a reliable NHS resource to revise later."

Assess Learning Needs – The '4Ws'

"To tailor this to you a bit more — can I ask:"

- "What do you already know about adult BLS?"
- "Have you tried doing chest compressions before?"
- "Why did this topic come up for you now — did you miss your formal session or see it done recently?"
- "And do you know when we initiate BLS in clinical settings?"

Mini Summary:

"Perfect. So to clarify — we begin BLS when someone is unresponsive and not breathing normally, whether due to cardiac arrest, trauma, drug overdose, or airway obstruction. It's the first line of response until advanced care arrives."

Teach the Concept – Adult BLS

Step-by-Step BLS Algorithm

1. Check for Danger
   "Make sure the area is safe — no electrical wires, traffic, or bodily fluid hazards. Your safety comes first."
2. Check for Response
   "Tap the person's shoulder and shout, 'Are you alright?' If no response — shout for help immediately."
3. Open Airway
   "Use a head tilt–chin lift to open the airway. If there's a possible spinal injury, use jaw thrust instead."
4. Check for Breathing
   "Look, listen, and feel — watch chest movement, listen for breath sounds, and feel air on your cheek for up to 10 seconds."
5. Call for Help
   "If not breathing normally, call 2222 (in-hospital) or 999 (in the community). Say clearly, 'Adult in cardiac arrest.' Ask someone nearby to bring an AED."
6. Start Chest Compressions
   "Begin CPR immediately — 30 compressions to 2 breaths."

Chest Compressions – Gold Standard Technique

- Hand position: Heel of one hand in the centre of the chest (lower half of sternum), other hand on top.
- Elbows locked, shoulders over hands.
- Compression depth: At least 5–6 cm
- Rate: 100–120 per minute
- Allow full recoil between compressions
- Minimise interruptions

Tip: "Use the beat of *'Stayin' Alive'* or a metronome app to maintain rhythm."

Rescue Breaths

- Ratio: 30 compressions to 2 breaths
- Each breath over 1 second — watch for chest rise.
- Use a mask if available.
- If you're not trained or no equipment is available — continue hands-only CPR.

Never perform rescue breaths on a mannequin.

Using an Ambu Bag (If Equipment Provided)

- Ensure airway is open (head tilt–chin lift)
- Form a tight seal with the mask
- Connect to oxygen if available
- Squeeze the bag to give one visible chest rise per breath

When to Stop CPR

Stop only if:

- The patient starts breathing/moving
- The resus team arrives and takes over
- You're too exhausted to continue safely

Involve the Student – Practise with Feedback

"Would you like to have a go at compressions now?"
→ [Observe the student on the mannequin]
"Your positioning is good — now try pushing a little deeper."
"Great rhythm — just keep your elbows locked and body weight centred."

Offer calm, confident reinforcement while correcting technique.

Wrap-Up & Recap

"Let's recap what we covered:

- Assess danger, check response and breathing
- Call for help and start chest compressions (30:2)
- Maintain correct depth and rate — 100–120 per minute
- Use rescue breaths if trained and equipped
- Continue until advanced help arrives or signs of life return"

"I'll also send you the Resus Council UK BLS Adult Guide — it's a great visual summary."

Final Encouragement & Open Invitation

"You've done brilliantly today. This is a lifesaving skill and it's great to see you so proactive."

"If you want to come back to practise again — especially with the Ambu bag or AED — just drop me a message."

Bonus: Common Student Questions

Q: Could CPR cause a rib fracture?

"Yes, it's possible — but saving a life takes priority. We'd rather risk a fracture than delay CPR."

Q: Do we still do BLS during COVID or infection risk?

"Yes — but we may modify technique. Mask yourself first, avoid rescue breaths unless you have PPE and a filter device, and focus on compressions."

Paediatric Basic Life Support (PBLS)

Professional, Warm Introduction

"Hi, I'm [First Name], one of the FY2s working here in Paediatrics today."

"I understand you're one of the medical students on placement — lovely to meet you."

"I hear you're here to learn about paediatric basic life support — I'll guide you step by step on what to do if a child collapses, and we'll practise chest compressions together."

Tone: professional, warm, approachable – no over-familiarity.

Build Quick Rapport

"How's the rotation been so far for you?"

"Have you had the chance to observe any real emergencies or CPR events?"

This opens the space for conversation, lowers anxiety, and builds comfort before teaching.

Set the Agenda Clearly

"Let's keep this interactive and practical. I'll walk you through what to do if a 5-year-old collapses, demonstrate the key steps, and then help you practise compressions on the manikin."

"If we get interrupted, I'll make sure you get time later to complete this or I'll send over a trusted summary you can revise with."

Shows planning, time awareness, and clarity – great for scoring in organisation and communication.

Tailor the Session (The '4Ws')

"Before we dive in, just so I can make this most useful for you—"

- "What do you already know about paediatric BLS?"
- "What would you like to focus on today — rescue breaths, compressions, or recognising arrest?"

- "Why did this come up now — have you seen a case recently?"
- "And are you aware how PBLS differs from adult BLS?"

If unsure, explain: "In children, arrest is usually respiratory first — so the emphasis starts with rescue breaths."

Teaching the Skill – Step-by-Step PBLS (Aligned with Resus Council UK)

Step 1: Ensure Scene Safety

"Before anything else, always check the environment is safe — for yourself, the child, and others."

Step 2: Check for Responsiveness

"Call their name, tap their shoulder — in infants, rub the chest or sole of the foot."
"If there's no response — shout for help immediately."

Step 3: Open the Airway

"Use a head tilt–chin lift if there's no suspicion of trauma."
"If you suspect spinal injury (e.g., fall or RTC), use a jaw thrust."
Always inspect for obvious obstruction – remove visible objects but don't do blind sweeps.

Step 4: Look, Listen & Feel for Breathing and Signs of Life

"Place your cheek near the mouth and nose, and watch the chest — check for no more than 10 seconds."
"We don't rely on checking pulses in children — instead we look for *signs of life*: movement, coughing, or normal breathing."

Step 5: Give 5 Initial Rescue Breaths

"In paediatrics, we give 5 rescue breaths first — most arrests are due to hypoxia."

- **Infants (<1 year)**: Seal *mouth and nose* with your mouth.
- **Children (>1 year)**: *Pinch the nose*, seal over the mouth.
- **Each breath**: Blow gently for 1 second — watch for chest rise.

Do not perform mouth-to-mouth on the manikin.

Step 6: Start CPR – 15 Compressions: 2 Breaths

"If no signs of life or breathing — start CPR immediately."

Compressions:

- **Infants**: 2 fingers (or 2-thumb encircling technique)
- **Children (1–puberty)**: 1 hand (or 2 if needed for depth)

Rate: 100–120 per minute
Depth: About ⅓ of chest depth (~4 cm infant, ~5 cm child)
Ratio: 15 compressions to 2 rescue breaths
"Allow full recoil between compressions — don't lean on the chest."

Step 7: Use of Bag-Valve Mask (if applicable)

- Ensure a neutral head position
- Create a good seal over mouth and nose
- Give two slow breaths — each for 1 second
- Watch for visible chest rise

Step 8: When to Stop

- If child shows signs of life (movement, normal breathing)

- If the resus team arrives and takes over
- If you become physically exhausted and can no longer continue safely

6. Involve the Student
"Would you like to try compressions now on the manikin?"
→ *Observe and correct gently:* "Nice rhythm. Try a bit more depth here — aim for one-third of chest depth."
"Good recoil — just make sure to keep elbows locked."

7. Wrap-Up & Reinforce Key Learning
"Let's recap quickly:

- Always check safety and response first
- Give **5 rescue breaths first** (different from adults!)
- Follow with **15 compressions: 2 breaths**
- Use age-specific technique: fingers/thumbs for infants, palm for older kids
- Always look for chest rise with rescue breaths
- Use bag-valve mask if trained and available
- Stop only if help arrives, signs of life appear, or you're exhausted

"I'll share the Resus Council UK paediatric algorithm with you so you can review it visually later."

8. Final Encouragement & Open Invitation
"You've done really well — and the fact you're learning this early shows you care about being a safe doctor."
"Anytime you want to practise or shadow a simulation — feel free to join in with our team."

Common Student FAQs
Q: Can CPR cause rib fractures in children?
"Yes, rarely — especially in older children. But the priority is circulation. It's far better to risk minor injury than delay life-saving action."

Q: Do we still do mouth-to-mouth in COVID era?
"If it's a high-risk situation or you don't have PPE — hands-only CPR is better than doing nothing. If you have a bag-valve mask, use that instead."

Speculum Examination

Professional, Warm Introduction
"Hi, I'm [First Name], one of the FY2 doctors in the department today."
"You must be one of the medical students on rotation with us — really nice to meet you."
"I understand you'd like to learn how to perform a pelvic examination, including bimanual, speculum, and Pap smear techniques. I'm happy to guide you through that today step-by-step."
Use first name only – no "Dr." needed when speaking to a peer or student.

Build Quick Rapport
"How's your OBGYN rotation going so far?"
"Have you had the chance to observe a pelvic exam yet, or is this your first time learning it in detail?"
Short and friendly — helps reduce anxiety and establish a relaxed teaching tone.

Set the Agenda Clearly
"Let's keep this interactive — feel free to stop me if you'd like anything repeated, or if any part is unclear."
"We'll go through the indications, bimanual and speculum techniques, how we collect a cervical smear, and address key communication points with patients."
"If we're interrupted, I'll make sure we follow up later or send you a useful NHS reference to review."

Assess Learning Needs – The "4 Ws"
"Before we begin — just to tailor the session to your level:

- What do you already know about pelvic exams?
- What would you like to focus on — the speculum, bimanual part, or Pap smear?
- Why does this topic interest you now — did you encounter a relevant case?
- And are you familiar with when and why we perform these exams?"

Explain if unsure:
"We perform pelvic exams to assess symptoms like abnormal bleeding, discharge, pelvic pain, or suspected pelvic masses. They're also key for cervical screening."

Teach the Skill — Fully Structured, Step-by-Step
Indications & Contraindications

Indications:

- Abnormal vaginal bleeding
- Pelvic pain
- Vaginal discharge
- Routine cervical screening (Pap smear)
- Suspicion of prolapse, infection, or malignancy

Contraindications (relative):

- Active menstruation (Pap smear only)
- Recent sexual activity or spermicidal gel use
- Active vaginal bleeding or painful vulval cysts
- Visible uterine prolapse

Patient Safety, Comfort & Consent

- Always ensure a **chaperone** is present (mandatory).
- Provide **verbal and written information** beforehand.
- Explain the procedure is not painful but may be uncomfortable.
- Offer a **stop option**: "You can ask me to stop at any point."
- Maintain **modesty and dignity**: curtain, sheet, closed doors.

Example explanation:
"This is a routine vaginal examination. I'll be gently inserting a lubricated device called a speculum to visualise the cervix and vaginal walls. You may feel some pressure, but I'll be as gentle as possible. We'll have a chaperone present, and you can ask to stop at any time."

Bimanual Examination (Perform Before Speculum)
Purpose: Assess uterus, cervix, and adnexa (ovaries/fallopian tubes)

Steps:

1. Wear gloves, apron. Lubricate index and middle fingers.
2. Gently part the labia with your non-dominant hand.

3. Insert fingers gently, palm facing laterally.
4. Use the other hand to palpate the suprapubic region.

Assess:

- **Vaginal walls**: tone, masses
- **Cervix**: position, consistency, motion tenderness (e.g., PID)
- **Uterus**: size, shape, mobility, tenderness
- **Adnexa**: masses or tenderness (left and right)

"Cervical motion tenderness is often a clue to pelvic inflammatory disease."

Speculum Examination

Equipment:

- Speculum (correct size)
- Light source
- Lubricating gel
- Gloves & apron
- Paper towels
- Clinical waste bin

Steps:

1. **Positioning**: Flat on back, heels to bottom, knees apart.
2. Explain you will **touch the external genitalia** to inspect for:
    - Redness, swelling, ulcers, discharge, scarring, signs of FGM.
3. **Lubricate** the blades of the speculum.
4. Separate labia and insert the speculum **sideways, angled down**.
5. Rotate 90°, open slowly, and **lock** in position.
6. Visualise the **cervix** — observe:
    - Os appearance, discharge, erosion, bleeding, masses
7. Inspect **vaginal walls** for trauma, atrophy, ulcers.

Cervical Smear (Pap Smear) — <u>if asked or indicated</u>

Steps:

1. Use cyto-brush (or verbalise if not available)
2. Insert brush into **external os**
3. Rotate **5 full turns clockwise**
4. Carefully remove without touching vaginal walls

Transfer sample:

- **SurePath**: Detach brush tip, drop into sample pot
- **ThinPrep**: Rinse brush 10 times in solution, discard brush

Label, document, and send sample to lab.

Speculum Removal and Aftercare

Steps:

1. Loosen locking nut, partially close blades
2. Rotate back to insertion position
3. Withdraw slowly, inspecting vaginal walls
4. Dispose of speculum safely
5. Remove gloves/apron and dispose of clinical waste

Tell the patient:

- "You may have some spotting for a few hours — that's normal."
- "If you develop heavier bleeding or pain, contact your GP or the clinic."

Involve the Student

- "Would you like to come closer to see the hand position clearly?"
- "Let me know if you'd like to try guiding the light source or ask any questions."
- "Is the explanation so far making sense?"

Avoid quizzing — instead, encourage questions and pace adjustment.

Wrap-Up & Recap Key Points

"Let's quickly summarise what we covered today:

- Indications and contraindications
- Communication and consent
- Step-by-step bimanual and speculum technique
- Cervical smear collection
- Key findings and documentation
- Maintaining comfort, safety, and dignity throughout"

Offer to share NHS Cervical Screening guidance or Trust SOP on speculum technique for review.

Final Encouragement & Open Door

"You followed along really well — this can feel like an intimidating skill at first, but with good technique and respectful communication, it becomes routine."

"Feel free to shadow again or practise positioning with the sim model anytime."

Inguinoscrotal/Testicular/Hernia Examination

Professional, Warm Introduction

"Hi, I'm one of the FY2 doctors in the surgical team. You must be the medical student on rotation today — welcome! I understand you're here to learn about how we perform an inguinoscrotal examination. I'd be happy to go through it with you."

Build Quick Rapport

- "How's your rotation going so far?"
- "Have you seen any surgical cases in the ward or theatre this week?"
- "It's great that you're keen to learn this — it's a really important skill for evaluating groin swellings."

3. Set the Agenda Clearly

- "Let's make this a relaxed and interactive session. Feel free to stop me and ask questions anytime."
- "We'll cover when we do this exam, what we look for, and how to do it safely and confidently."
- "We'll also discuss key clinical signs, red flags, and common questions around management."

4. Assess Learning Needs (4Ws)

- "What do you already know about the inguinoscrotal exam?"
- "Is there any specific part you'd like me to focus on — anatomy, technique, interpretation?"

- "Have you had a chance to observe this in clinic or theatre before?"
- "Do you know when and why we perform this exam?"

"Perfect – we typically perform an inguinoscrotal examination when a patient presents with a groin swelling, scrotal lump, pain, or suspicion of a hernia."

Teach the Concept or Skill
Step-by-Step Teaching Begins
First — Understand Hernia: "Hernias occur when an internal structure, like bowel or fat, pushes through a weakness in the muscle wall. In the groin, this most commonly involves the inguinal canal."
Causes of Hernia:

- Chronic cough (e.g., COPD)
- Chronic constipation or straining
- Heavy lifting
- Previous abdominal surgery
- Congenital weakness in the abdominal wall

Anatomy Refresher (Use Diagram if Available):

- "The most important landmark is the **pubic tubercle**."
- "Draw a line from the **anterior superior iliac spine (ASIS)** to the **pubic tubercle** — that's the **inguinal ligament**." • **Deep inguinal ring** → ½ inch above midpoint of the ligament
- **Superficial ring** → just above the pubic tubercle
- The **inguinal canal** runs obliquely between these two.

Types of Hernia:

- **Indirect hernia**: enters via the deep ring and follows the canal — more common in younger males
- **Direct hernia**: pushes through a weak spot in the posterior wall of the inguinal canal (Hesselbach's triangle) — common in older adults

How to Examine a Groin Lump (Standing Position):
Inspection

- Look at the groin area: "Note the size, site, shape, skin changes, whether it's unilateral or bilateral."
- If no swelling is visible, ask the patient to **cough or strain**.

Palpation

- Temperature: "Compare the groin with surrounding skin."
- Tenderness: "Tender lumps may indicate **strangulation** — especially if accompanied by vomiting or constipation."
- Palpate above and medial to the pubic tubercle (inguinal hernia) and below and lateral (femoral hernia).
- Check consistency:
  - Doughy = omentum
  - Elastic = bowel
  - **Cough impulse**: If felt, hernia is likely not strangulated.

Zieman's 3-Finger Test (If swelling not obvious): • Place:

- Index finger on **deep ring**
- Middle finger on **superficial ring**

- Ring finger on **femoral canal**
  - Ask patient to cough.
  - Impulse felt:
- Under index = **indirect hernia**
- Under middle = **direct hernia**
- Under ring = **femoral hernia**

Percussion

- Resonant → bowel
- Dull → omentum

Auscultation

- Bowel sounds suggest bowel content in hernia
- Absent sounds + tenderness may indicate **strangulation**

Post-Exam Summary

"Cover and thank the patient, document findings, and escalate if any red flags like tenderness, irreducibility, vomiting or systemic signs."

Involve the Student

- "Would you like me to recap that part again?"
- "Was the 3-finger test clear?"
- "Any part of the anatomy or examination steps you'd like me to explain again?"

Wrap-Up & Reinforce Key Points

- "So to recap, we covered the anatomy of the inguinal region, direct vs indirect hernia, how to examine standing, and how to interpret cough impulse, percussion, and auscultation findings."
- "Key things to always check are tenderness, irreducibility, and bowel involvement — those are surgical emergencies."

Final Encouragement

- "You've done great today — this exam can feel a bit tricky, but it becomes second nature with practice."
- "Feel free to approach me again if you'd like to see one being performed on the ward."

Key Questions Answered

What's the difference between direct and indirect hernia?

- Direct hernias protrude through a weakness in the posterior wall of the canal.
- Indirect hernias enter via the deep ring and follow the canal.

Causes of groin lumps:

- Hernias (inguinal, femoral)
- Lymphadenopathy
- Lipoma
- Undescended testis
- Hydrocele/Varicocele
- Femoral artery aneurysm

When do you operate?
- **Elective repair**: reducible, uncomplicated
- **Emergency repair**: strangulated or obstructed
- **Laparoscopic or open**, depending on case and surgeon preference

Gender preference for chaperones?
- Respect patient request if they ask for a specific gender
- Ideally use trained medical staff
- If unavailable, explain options and document discussion and consent

Cancer Referral Pathway

Professional, Warm Introduction
"Hi, I'm [First Name] – one of the FY2s here in the unit today."
"You must be on your final-year placement – great to meet you."
"I understand you wanted to learn about the cancer referral process and how we communicate suspected or confirmed cancer to patients – I'm glad you brought that up, it's a vital part of our practice."

Build Quick Rapport
"How's your placement been going so far?"
"Have you seen any cancer referrals or oncology cases during your rotation?"
"It's great to see your interest – this area really tests both clinical decision-making and communication skills."

Set the Agenda Clearly
"Let's make this relaxed and interactive."
"I'll walk you through when we suspect cancer, how the NHS 2-week wait referral works, and how to speak to patients in these situations – both when we're not sure yet, and when it's a confirmed diagnosis."
"If anything is unclear, feel free to ask, and I'll also point you to some NHS resources after."

Assess Learning Needs – "4 Ws"
"Before we start, can I ask –"
- "What do you already know about cancer pathways or the 2-week wait system?"
- "Anything specific you'd like to focus on – red flags, investigation, communication?"
- "Why does this topic interest you today – any recent case or clinic you've seen?"
- "Do you know when and why we use the urgent suspected cancer (USC) referral?"

Brief Explanation if Needed:
"In the NHS, we use the '2-week wait' (2WW) pathway for patients with symptoms suggestive of cancer. This ensures they see a specialist within 14 days. If confirmed, treatment should ideally begin within 31 days."

Teach the Concept or Skill
A) When Do We Suspect Cancer?

Organ-Specific Red Flags:
- Persistent cough, blood in sputum → Lung
- Change in bowel habit, rectal bleeding → Bowel
- Breast lump, nipple changes → Breast

- Postmenopausal bleeding → Gynaecological

Non-Specific Red Flags:
Mnemonic: **FLAWS**
- **F**ever (unexplained)
- **L**oss of weight (unintentional)
- **A**ppetite loss
- **W**eakness/fatigue
- **S**weating at night

"We don't say 'FLAWS' to patients — it's just a quick memory aid for doctors when reviewing vague presentations."

B) Clinical Assessment & Initial Workup
- Take a focused history — organ-specific and systemic review
- Full physical exam including lymph node check
- Order:
  - FBC, U&Es, LFTs
  - Inflammatory markers (CRP/ESR)
  - Tumour markers (only if indicated — e.g., PSA for prostate)
  - Imaging — chest X-ray, ultrasound, or others as clinically appropriate

C) The 2WW (Urgent Suspected Cancer) Pathway
- GP or hospital doctors can initiate it
- Patients **must be seen by a specialist within 14 days**
- If cancer is confirmed, treatment should begin **within 31 days** of decision to treat
- Covers both symptomatic patients and those flagged via screening

"This pathway exists to reduce delays in diagnosis and improve outcomes — even when cancer isn't ultimately found, it helps exclude it quickly and offers reassurance."

D) Investigations (Based on Symptoms)
- Bloods as above
- Imaging: e.g., ultrasound (breast, abdomen), CT, MRI
- Endoscopy if GI-related (e.g., for change in bowel habit)
- **Biopsy is essential** for confirmation
- Multidisciplinary Team (MDT) meeting discusses all confirmed cancer cases and plans treatment

E) Explaining the Referral to Patients
If Cancer is Suspected (but NOT confirmed):
- "We use best-case/worst-case phrasing."
- "Explain that while the symptoms may have a benign cause, we need to rule out anything serious — including cancer — which is why we're referring them under the urgent 2-week pathway."
- Reassure: "Most people referred this way don't have cancer, but if they do, early diagnosis makes all the difference."

If Cancer is Confirmed:
Use the **SPIKES** framework:
1. **S**etting – private, quiet, seated
2. **P**erception – "What do you understand about your symptoms so far?"

3. **I**nvitation – "Would you like me to explain all the results now?"
4. **K**nowledge – Break bad news gently: "I'm afraid the results do show cancer…"
5. **E**motion – Pause. Let them react. Offer tissues, space, empathy
6. **S**trategy – "Let's talk about the next steps. You'll have a full team guiding your care."

"It's not about saying everything at once — it's about saying it clearly, calmly, and supportively."

F) Post-Diagnosis Management (Overview)

- Surgery
- Chemotherapy
- Radiotherapy
- Immunotherapy or hormonal treatment
- MDT decides best treatment plan based on cancer type/stage
- Consider palliative care or holistic support early if prognosis is limited

G) Safety Netting and Follow-Up

- "If your symptoms get worse before the specialist appointment, please come back or call 111."
- "If you've not heard back in 2 weeks, call us and we'll chase the referral."
- "And if you notice new symptoms, it's always okay to re-discuss."

Involve the Student

- "Would you feel comfortable explaining a 2WW referral to a patient?"
- "Do you want to role-play breaking suspected cancer news using SPIKES?"
- "Anything unclear in terms of investigations or timeline expectations?"

Wrap-Up & Reinforce Key Points

Summary:

- Know the **red flags** and **FLAWS** symptoms
- Refer under 2WW for suspected cancer
- Start treatment within **31 days** once confirmed
- Use **SPIKES** to break news compassionately
- Safety net every patient

"I'll share a simple referral guide and SPIKES summary PDF with you after this, so you can revise at your pace."

Final Encouragement & Open Door

"You've done really well — this is a tough but crucial topic. Your questions showed maturity and insight. And I think you'll manage these conversations sensitively when the time comes. Feel free to observe one of these discussions in clinic next week — I'd be happy to include you."

Toddler Developmental Milestones

Warm, Professional Introduction

"Hi, I'm [First Name], one of the FY2s on the paediatrics team today.
You must be on rotation with us this week — nice to meet you."
"I understand you're here to go over how we assess developmental milestones in toddlers — really glad you brought this up. It's a key part of paediatrics and often missed in early clinical exposure, so let's go through it properly."

Build Quick Rapport
• "How's your placement going so far?"
• "Have you had a chance to do any developmental reviews yet in clinic or community?"
• "Great — this can seem a bit abstract at first, but it's really about spotting early signs of delay and giving kids the best chance."

Set the Agenda Clearly
• "Let's structure this in a way that makes it easy to remember and apply on the wards."
• "We'll talk about what milestones to expect in toddlers, how we assess them across the 4 key domains, and when we should worry — including how to escalate concerns."
• "If anything's unclear as we go, just stop me. I'll also share a resource afterward."

Assess Learning Needs (The 4 Ws)
• "What do you already know about toddler development?"
• "Have you seen these assessments done in clinic?"
• "Why do you want to go over this now — are you expecting to clerk a child?"
• "Do you know how we split up developmental screening in real life?"
Summary: "We divide development into 4 domains — gross motor, fine motor, language, and social. Each toddler develops at their own pace, but knowing the expected milestones and red flags helps us catch delays early."

Teach the Concept – Toddler Development Assessment (Age 1–3 Years)
Overview: Four Developmental Domains
When we assess a toddler (1–3 years), we break development into 4 areas. Here's how I usually explain it:

Domain	*Anchor Phrase*	*What You're Looking For*
Gross Motor	"Think: Big Moves"	Walking, running, climbing stairs
Fine Motor	"Think: Hands"	Scribbling, building towers, feeding self
Language	"Think: Talking"	Words at 1 year, 2-word phrases by 2, sentences by 3
Social/Cognitive	"Think: People"	Eye contact, pretend play, playing with others

Expected Milestones by Age (Rough Guide)
1 Year Old
- **Gross Motor:** Pulls to stand, cruises, may take 1–2 steps
- **Fine Motor:** Picks up small objects with pincer grip, bangs toys together
- **Language:** Says 1–2 clear words, follows simple instructions
- **Social:** Stranger anxiety, waves goodbye

2 Years Old
- **Gross Motor:** Runs, climbs onto furniture, walks upstairs (2 feet/step)
- **Fine Motor:** Builds tower of 4–6 blocks, feeds with spoon
- **Language:** 2-word phrases ("more juice"), points to named objects
- **Social:** Parallel play, points to body parts

3 Years Old
- **Gross Motor:** Climbs stairs with alternate feet, pedals tricycle
- **Fine Motor:** Draws a circle, builds tower of 9 blocks

- **Language:** Speaks in 3–4 word sentences, clear to strangers 75% of time
- **Social:** Plays with other children, shows empathy, toilet training underway

Red Flags (When to Escalate)
At 2 Years:

- Not walking or running
- No words or echolalia only
- Not following simple commands
- No eye contact

At 3 Years:

- Not speaking in phrases (e.g., "I want toy")
- Persistent falling or unsteady gait
- No interest in other children or pretend play
- Loss of previously acquired skills

NHS/PLAB 2 Escalation: "If any of these red flags are seen, we refer to community paediatrics or child development clinic for further multidisciplinary assessment — typically involving paediatrician, SALT, physiotherapy, and early intervention."

How We Assess
"Assessment is done through observation, interaction with the child, structured play, and parent history. We often use validated tools like the Ages & Stages Questionnaire or the Denver scale."
"You may also measure weight, height, and head circumference — plotted on the WHO growth chart to identify growth faltering."
"We don't expect a toddler to hit every milestone precisely — but the pattern of development and whether skills are being lost is key."

Involve the Student
• "Would you like to try categorising some of these behaviours into domains?"
• "Would you feel confident spotting a red flag in a 2-year-old with only a few words?"
• "Shall I show you a quick chart we use to visualise this on the ward?"

Recap & Reinforce Key Points
• "We assess toddler milestones across 4 domains: gross motor, fine motor, language, and social."
• "Each age group has general expectations — but we mainly watch for red flags or regression."
• "If any concerns arise, early escalation leads to better developmental outcomes."
"I'll share a quick NHS child development leaflet and the RCPCH 'Child Development at a Glance' chart — they're handy for revision."

Final Encouragement & Open Door
• "You followed that really well — your interest in this will really help in paediatrics and GP."
• "Feel free to join any of our developmental clinics this week or shadow a community referral if you'd like more hands-on experience."

Informed Consent

Professional, Warm Introduction
"Hi, I'm [First Name] — one of the FY2s working with the surgical team today."
"You must be [Name] — really nice to meet you."
"I understand you're interested in learning more about informed consent. That's a really important topic, and I'd be happy to go through it with you."

Build Quick Rapport
• "How's the rotation going so far?"
• "Have you had a chance to observe any consent discussions in theatre or clinic yet?"
(Keep it friendly but brief – just enough to ease in.)

Set the Agenda Clearly
"Let's keep this focused and practical."
"We'll talk through:
- What consent means and when it's required
- How we assess capacity
- How we approach special cases like children, unconscious patients, or Jehovah's Witnesses
- And how to take surgical consent safely"
"Please feel free to jump in with questions any time."

Assess Learning Needs – "The 4 Ws"
"Before we start –"
• "What do you already know about informed consent?"
• "Is there a specific area you're unsure about — like mental capacity, legal frameworks, or emergency scenarios?"
• "Why does this topic interest you — did it come up on your placement?"
• "Do you know when we're legally required to take consent?"

Clarify if needed:
"Consent is a fundamental legal and ethical principle. We need it before carrying out any test, treatment, or procedure — even something as routine as checking blood pressure. The aim is to empower the patient to make an informed choice, not just to tick a form."
Teach the Concept or Skill
What Makes Consent Valid?
Consent must meet **three key criteria**:
1. **Voluntary** – Given freely, without coercion.
2. **Informed** – The patient must understand risks, benefits, alternatives, and consequences of refusal.
3. **Capacity** – The patient must be able to understand, retain, weigh the information and communicate a choice.

Anchor Phrase:
"We're not just explaining — we're supporting their right to choose."
"Even if it's life-saving, we must respect a competent refusal."

How Do Patients Give Consent?

Type	*When It's Used*
Verbal	Minor procedures (e.g. blood tests)
Written	Major procedures (e.g. surgeries)
Implied	Routine exams (e.g. offering arm for BP)

Always document verbal consent clearly in the notes.
Use written consent for invasive or higher-risk interventions.

If the Patient Lacks Capacity
Follow the **Mental Capacity Act (2005)**:

- **Presume capacity unless proven otherwise**
- Assess if they can **understand, retain, weigh, and communicate**
- If they lack capacity → act in their **best interest**

Check for:

- **LPA (Lasting Power of Attorney)**
- **ADRT (Advance Decision to Refuse Treatment)**

Quick Definitions:

- **LPA**: Legally appointed person to make healthcare decisions
- **ADRT**: Legally binding refusal of specific treatments in the future

Anchor Phrase:
"If capacity is lacking, we act in the patient's best interest — unless an advance decision or LPA exists."

Special Scenarios
Jehovah's Witnesses

- May carry a valid **'No Blood' ADRT**
- Must be respected **if capacity is intact**
- Always **document refusal** clearly, with consultant sign-off
- Explore **non-blood options**: iron, EPO, cell salvage

Children & Young People

- Under 16 → can consent **if Gillick competent**
- If not competent → consent from someone with **parental responsibility**
- Refusal of life-saving care may be overruled by **the Court of Protection**

Emergencies

- If unconscious or incapacitated → treat in **best interest**
- **Document your rationale** clearly
- **Explain later** once the patient recovers

Mental Health Act Scenarios

- You can treat mental illness without consent under the **MHA**
- But physical conditions **still need consent**, unless life-saving

Taking Consent for Surgery

1. Confirm identity and understanding
2. Explain the **diagnosis and need for surgery**
3. Describe the **procedure in lay terms**
4. Discuss:
    - Benefits
    - **Common and serious risks** (don't skip rare but serious ones)
    - Alternatives (including doing nothing)
5. Ask patient to **repeat back key points**
6. Answer questions
7. Emphasize that **they can withdraw consent at any time**

8. Complete and countersign the **written consent form**

Anchor Phrase:
"Consent is a process — not a signature. It's a conversation that empowers the patient."

Involve the Student
- "Would you feel confident explaining consent to a patient now?"
- "Would it help to roleplay taking surgical consent together?"
- "Want me to go over Jehovah's Witness or capacity laws again?"

Wrap-Up & Reinforce Key Points
"To sum up:
- Consent must be **voluntary, informed, and with capacity**
- Even refusal of life-saving care is valid if capacity is present
- There are special considerations for **children, unconscious patients, and faith-based refusals**
- **ADRTs and LPAs** are legally binding
- Always **document your discussion clearly**"

Offer further reading:
"I'd recommend checking the GMC's guidance on consent and the NHS Trust's consent policy — really helpful to consolidate this."

Final Encouragement & Open Door
"You've engaged really well today — your questions were insightful and show great clinical maturity."
"Feel free to come back anytime if you'd like to practice a consent conversation or observe one in clinic."

Childhood Vaccination & NHS Schedule

Professional, Warm Introduction
"Hi, I'm [First Name], one of the FY2 doctors here in Paediatrics."
"You must be Mike — really nice to meet you."
"I heard you're interested in learning about childhood vaccinations — I'll walk you through the core schedule, highlight what vaccines do, and share a few tips to remember them."

Build Quick Rapport
"How's your paeds rotation been so far?"
"Have you seen any immunisation clinics or spoken with parents about vaccines?"

Set the Agenda Clearly
"Let's make this a quick and interactive session. We'll cover:
- What vaccines do and why they matter
- The UK childhood schedule — with a simple way to remember it
- Common side effects and what to say to parents
- A brief note on what to do if parents decline"

"Feel free to stop me anytime if anything isn't clear."

Assess Learning Needs — "The 4 Ws"
- "What do you already know about the vaccine schedule?"
- "Is there any part you're unsure about — maybe the timing, side effects, or what to say to hesitant parents?"

- "Why are you interested in this today — seen a case on the ward or in clinic?"
- "When do you think we typically give vaccines?"

Teach the Skill or Concept

What Are Vaccines?

"Vaccines teach the immune system to recognise and fight specific infections. They prevent severe illness, long-term complications, and even death."

NHS Childhood Vaccination Schedule (2024 – Core)

Here's a simple way to remember it:

"8–12–16 → 1 → 3.5 → 12 → 14"

Age	*Diseases Protected Against*	*Vaccine(s) Given*
8 weeks	Diphtheria, tetanus, pertussis (whooping cough), polio, Haemophilus influenzae type b (Hib), hepatitis B	DTaP/IPV/Hib/HepB
	Meningococcal group B (MenB)	MenB
	Rotavirus gastroenteritis	Rotavirus
12 weeks	Diphtheria, tetanus, pertussis, polio, Hib, hepatitis B	DTaP/IPV/Hib/HepB
	Pneumococcal (13 serotypes)	PCV
	Rotavirus gastroenteritis	Rotavirus
16 weeks	Diphtheria, tetanus, pertussis, polio, Hib, hepatitis B	DTaP/IPV/Hib/HepB
	Meningococcal group B (MenB)	MenB
1 year (on or after the child's first birthday)	Hib and Meningococcal group C (MenC)	Hib/MenC
	Pneumococcal	PCV booster
	Measles, mumps, rubella (MMR)	MMR
	Meningococcal group B (MenB)	MenB booster
2–3 years	Influenza (each year from September)	Live attenuated influenza vaccine (LAIV)
3 years 4 months	Diphtheria, tetanus, pertussis, polio	dTaP/IPV
	Measles, mumps, rubella (MMR) (2nd dose)	MMR
12–13 years	Human papillomavirus (HPV)	HPV (2 doses, 6–12 months apart)
14 years (school Year 9)	Tetanus, diphtheria, polio	Td/IPV
	Meningococcal groups A, C, W, Y	MenACWY

Upcoming Changes:

- **From 1 July 2025**:
  - The second dose of the MenB vaccine will be administered at **12 weeks** instead of 16 weeks.
  - The first dose of the PCV vaccine will be administered at **16 weeks** instead of 12 weeks.
  - The combined Hib/MenC vaccine (Menitorix) will be discontinued for children born on or after 1 July 2024.

- **From 1 January 2026**:
  - Introduction of a new routine vaccination appointment at **18 months** for children born on or after 1 July 2024, to receive:
    - **4th dose of DTaP/IPV/Hib/HepB** (hexavalent vaccine).
    - **2nd dose of MMR** vaccine.

Anchor Phrase for PLAB:
"8-12-16 weeks, 1 year, preschool, teens"

Why It Matters

- **Individual benefit:** prevents severe disease (e.g. meningitis, measles)
- **Community benefit:** herd immunity — protects vulnerable individuals
- **Public health:** some diseases (e.g. polio, smallpox) eradicated or nearly so in the UK

Common Vaccine Side Effects

• Mild fever
• Pain or swelling at injection site
• Irritability or fatigue

"Usually settle within 48 hours — managed with paracetamol if needed."
Severe reactions like anaphylaxis are **very rare**, and we monitor all children after vaccination.

Missed Vaccines / Delays

"If a dose is missed, we **don't restart** the series — we simply **resume from where we left off** using a catch-up schedule."

Vaccine Refusal — Quick Note

"If a parent declines vaccination, our role is to gently **explore their concerns**, offer clear, evidence-based reassurance, and document the discussion.
Only if there's clear evidence of harm or neglect — like **deliberate medical neglect** — would safeguarding come into play, and even then, it would be a team decision."
Anchor phrase:
"Explore, educate, document – don't escalate unless clearly harmful."

Involve the Student

• "Want to try listing the core ages and what's given at each?"
• "Would you like to practice how you'd explain this to a concerned parent?"
• "Any particular diseases you'd like me to explain the vaccine for?"

Wrap-Up & Recap Key Learning

"To recap:
• Vaccines are safe, effective, and protect both individuals and the public
• The schedule starts at 8 weeks and ends around age 14
• Most side effects are mild and temporary
• If missed, we catch up — no need to restart
• Parental refusal should be met with empathy, education, and documentation"

Final Encouragement

"You've done great — and you're asking the right questions."
"This is something you'll explain a lot in practice — so the more confident and clear you are now, the better."
"If you'd like a summary table or a vaccine wall chart, I'm happy to send one across."

Vaccination Refusal

Professional, Warm Introduction
"Hi, I'm [First Name], one of the FY2 doctors here in Paediatrics."
"You must be Mike — really nice to meet you."
"I understand you're here to learn more about what to do when a parent refuses vaccination — great topic, happy to talk you through it."

Build Quick Rapport
"How are you finding your rotation so far?"
"Have you seen or been involved in any vaccination clinics or conversations yet?"
[Warm tone, relaxed style — <30 seconds.]

Set the Agenda Clearly
"Let's keep this interactive. We'll cover:

- Why some parents might refuse vaccines
- How to counsel them in a respectful, evidence-based way
- What to document
- Whether school attendance or safeguarding comes into play
  You can stop me at any point with questions — sound good?"

Assess Learning Needs (4 Ws)
"Just before we start:
• What do you already know about vaccine refusal?
• Is there a particular bit you find tricky — like side effects or legal aspects?
• Why are you interested in this now — have you seen a recent case?
• Do you know how refusal is managed within the NHS?"
Clarify if unsure: "In the UK, vaccines are strongly recommended but not legally compulsory. Parents have the right to decline, but we still have a duty to inform them clearly, respectfully, and thoroughly."

Teach the Concept or Skill
Why Do Parents Refuse?
Common reasons include:

- Fear of side effects
- Misinformation (e.g. MMR and autism myth)
- Religious or cultural beliefs
- Distrust in pharmaceutical companies or government
- Preference for 'natural immunity'

"It's important to approach this with curiosity rather than confrontation — ask what concerns them, then explore."

How to Counsel Them (Respectfully & Clearly)
Emphasise the **benefits**:

- Protects the child from serious illness (e.g. measles, meningitis, polio)
- Helps protect vulnerable people in the community (herd immunity)
- Some diseases have been nearly eradicated due to vaccines

Be honest about **side effects**:

- **Common:** Mild fever, swelling, redness at the injection site

- **Rare:** Anaphylaxis — but we monitor children after vaccines and have trained staff ready

Address the **MMR-autism myth**:
"There's no scientific evidence linking the MMR vaccine to autism. The original claim was retracted, and large international studies have proven it's safe."
Give real-world context:

- Recent **measles outbreaks** due to falling vaccine uptake
- COVID vaccine success reducing hospitalisations and deaths

Anchor Phrase:
"We don't just vaccinate to protect one child – we do it to protect everyone they come in contact with."

What If They Still Refuse?
Respect their right to decline

- We never force or coerce.
- We document the discussion and their decision.
- We invite them to return if they change their mind later — it's never too late.

Documentation

- Use a **vaccination refusal form** (if available)
- Otherwise, clearly note:
  - Information given
  - Parental concerns
  - Their decision
  - Your invitation to return anytime
  - Your name, date, time, and signature

School attendance

- Vaccination **is not required** for school attendance in the UK
- However, schools may request vaccination records in the event of an outbreak or public health risk

Safeguarding

- **Refusal alone is not a safeguarding issue**
- But if refusal forms part of **a wider pattern of neglect**, or if a child with complex medical needs is denied vital vaccines, it **may warrant escalation** to the safeguarding team

Anchor Phrase:
"Refusal doesn't equal neglect – unless there's wider concern for the child's safety or wellbeing."

Involve the Student

- "Would you like to try explaining this to me as if I were a concerned parent?"
- "Do you feel confident in how to document this in notes?"
- "Want to practise what you'd say about MMR and autism?"

Wrap-Up & Reinforce Key Points
"To recap:

- Vaccine refusal is legal, but we must explore and inform
- Always document discussions and offer open-door follow-up
- School attendance isn't blocked by refusal — but herd immunity is at risk
- Refusal alone doesn't equal safeguarding — but escalate if there are broader concerns
- Our role is to educate, support, and protect — not to persuade at all costs"

Final Encouragement
"You've really thought this through, and your questions show strong clinical judgment."
"Handling vaccine refusal well takes empathy and clarity — you'll definitely build more confidence each time you

do it."
"If you'd like to shadow a vaccine clinic or help field questions from parents, let me know — we'd love to have you involved."

Teaching Digital Rectal Examination (DRE)

Professional, Warm Introduction
"Hi, I'm [First Name], one of the FY2s on the team today."
"You must be [Student's Name] — nice to meet you."
"I hear you're here to learn how to perform a digital rectal exam — happy to walk you through it today."
Build Quick Rapport
• "How's your rotation going so far?"
• "Have you had the chance to observe or perform this exam yet?"
(Use this to ease nerves and set a supportive tone.)

Set the Agenda Clearly
"Let's go step by step — we'll first cover when and why we do a DRE, then how to explain and perform it, and what to look for."
"I'll also give you tips on positioning, communication, and interpretation."
"Please stop me any time if something's unclear."

Assess Learning Needs (The 4 Ws)
• "What do you already know about DRE?"
• "Any parts you find tricky — like consent, tone assessment, or interpretation?"
• "Why does this interest you today — did you see a case on the ward?"
• "Do you know when and why we'd usually do this?"
Clarify:
"We often use DRE for patients with bowel or prostate symptoms — things like bleeding, altered bowel habit, rectal pain, or to assess prostate size or tone."

Teach the Skill: Step-by-Step Technique
Focused History (Before Exam)
Ask about:

- Urinary symptoms: frequency, hesitancy, dribbling, nocturia, weak stream
- Bowel: constipation, bleeding, mucus, tenesmus
- Red flags: FLAWS – Fatigue, Loss of weight, Appetite loss, Weakness, Sweating
- PMH: Prostate disease, GI conditions
- Medications, allergies, family history

Pre-Examination Explanation (How You'd Explain to the Patient)
Anchor phrase:
"Mr. X, I'd now like to do a rectal examination — just to feel inside and check for any unusual lumps or signs of prostate enlargement."
"It shouldn't be painful, though it may feel a little uncomfortable. I'll use a lubricated glove, and I'll be as gentle as possible."
"I'll ask you to lie on your left side with your knees drawn up, and we'll have a chaperone present for the entire procedure. Are you happy for me to go ahead?"
Cover:

- Purpose
- What it involves
- Chaperone
- Consent
- Positioning
- Exposure needs
- Privacy and dignity

Equipment

- Non-sterile gloves
- Apron
- Lubricating gel
- Paper towels
- Clinical waste bin

Tip: In OSCE, say "Assume I'm gloved and the equipment is ready."

Examination Technique

1. **Position** – Left lateral, knees to chest, bottom to bed's edge
2. **Inspection**
    - Separate buttocks
    - Look for fissures, ulcers, rashes, haemorrhoids, prolapse
    - Ask them to cough → check for prolapse or external haemorrhoids
3. **Insertion**
    - Lubricate gloved finger
    - Rest at anal verge for a few seconds to allow sphincter to relax
    - Gently insert finger while warning the patient
4. **Internal Assessment**
    - Feel around the rectal walls using a slow circular motion
    - Palpate anteriorly for the prostate (smooth, rubbery = normal)
    - Nodular, firm, or asymmetrical → suspicious
    - Ask patient to bear down slightly → assess anal tone
5. **Withdrawal**
    - Warn the patient
    - Gently withdraw, inspecting glove for blood, mucus, stool
6. **Aftercare**
    - Offer paper towels, allow privacy
    - Dispose of gloves & gel appropriately
    - Wash hands

Anchor Phrases:

- "Smooth, firm prostate — symmetrical = normal"
- "Hard, irregular, or nodular = red flag — escalate"

Involve the Student

- "Would you like to walk me through how you'd explain this to a patient?"
- "Which part of the technique feels most awkward to you?"
- "Would a side-by-side diagram help visualise the anatomy?"

Encourage clarity and comfort without quizzing.

Wrap-Up & Reinforce Key Points

Recap:

- Always begin with clear history and consent
- DRE is essential in GI, prostate, and rectal pathologies
- Be gentle, communicate throughout, maintain dignity
- Red flags: hard prostate, abnormal tone, rectal mass, visible bleeding
- Document findings and escalate appropriately if anything abnormal

"It's one of those skills that feels awkward at first, but with confidence and good explanation, patients usually tolerate it very well."

Final Encouragement

"You've done great — and I really like the questions you asked."
"Next time you're in clinic, ask if you can observe one being done — and feel free to shadow me anytime."

Teaching Breast Examination

Professional, Friendly Introduction

"Hi, I'm [First Name], one of the FY2s here."
"You must be [Student's Name], right? Lovely to meet you."
"I heard you'd like to learn how to perform a breast examination today — I'm happy to walk you through it."
(Tone: calm, warm, professional. Use just your first name. Maintain comfortable eye contact.)

Build Quick Rapport

"How's your current placement going?"
"Have you had the chance to observe or practise a breast exam before?"
(This sets the tone as a supportive peer, not a strict instructor.)

Set the Agenda Clearly

"Let's keep this relaxed and interactive — if anything feels unclear or you'd like me to repeat a step, just let me know."
"Sometimes we get pulled away in the hospital, but if that happens, I'll send you a summary or finish the explanation later."
"Shall we get started?"

Assess Learning Needs (4 Ws)

"What's your current understanding of how a breast exam is performed?"
"Is there anything specific you want to focus on today — for example, lymph node exam or how to approach a patient with a lump?"
"Have you seen any breast complaints on the ward or in clinic recently?"
"When do you think we typically perform this exam in clinical practice?"
(This ensures relevance, avoids redundancy, and makes the session learner-centred – which is a GMC teaching expectation.)

Teach the Skill – Breast Examination

How to Start: Explaining the Exam to a Patient

"A sensitive, professional explanation is absolutely essential here. I'll show you how I'd say it to the patient."

Model the full consent explanation out loud to the student:

"Thank you, Mrs. X, for answering my questions. Now, I'd like to examine your breasts to help identify the cause of your symptoms.

This examination involves looking at and gently feeling both breasts and your underarms. It won't be painful but may feel slightly uncomfortable at times.
I will need you to undress from the waist up, including your undergarments, so that I can examine your breasts properly while you're sitting, standing, and lying down.
A female member of the medical team will be present throughout as a chaperone, and I will make sure your privacy is fully respected at all times.
Do I have your consent to proceed?"

Emphasise to the student:

- This phrasing shows respect, dignity, and clarity
- Always request a chaperone
- Always maintain eye-level, respectful tone, and a calm pace
- Explain each phase of the exam before beginning

Patient Positioning & Exposure

"The patient needs to be undressed from the waist up, including removing their undergarment. Ideally, they should wear a hospital gown that they can lower during the exam.
We examine the patient in **three positions**:

1. Sitting upright — for inspection
2. Lying at a 45° angle — for palpation
3. Standing — for axillary lymph node exam."

"Use drapes or the gown to preserve modesty between steps. Always tell the patient what's coming next."

Step-by-Step Technique

A. Inspection (With the Patient Sitting Upright)

Explain:
"We visually assess for skin changes, asymmetry, or abnormal nipple appearance. To do this thoroughly, we ask the patient to perform a few simple arm movements."
Guide the student through each of these manoeuvres:

1. **Rest hands on lap** – observe natural position and contour of breasts
2. **Place hands on hips and lean forward** – reveals skin tethering or dimpling
3. **Raise arms above head and clasp hands behind head** – helps observe the upper poles and nipple symmetry
4. **Lift both breasts with her hands** – to inspect the infra-mammary folds
5. **Gently squeeze each nipple** – to check for any discharge (only if indicated)

Teach: Look for **redness, lumps, nipple retraction, peau d'orange, scars, surgical marks, asymmetry, or skin dimpling.**

B. Superficial Palpation (Patient Lying at 45°)

"Now we palpate each breast systematically, starting superficially. The aim is to assess for warmth, tenderness, and superficial changes."
Steps:

- Use **back of hand** to compare temperature across quadrants
- **Lightly palpate all 4 quadrants** of each breast and the **axillary tail**
  (Use flat pads of 3 fingers in circular motion)
- Observe the patient's face for signs of discomfort
- **Palpate the areola gently with one finger**, avoiding direct pressure on the nipple

C. Deep Palpation (Same Position)
"We now repeat the palpation more firmly, this time assessing for any underlying masses."
Teach:

- Palpate all quadrants again using **deeper circular motion**
- If a lump is found, assess:
    - **Site** – which quadrant
    - **Size** – in cm
    - **Shape**
    - **Surface** – smooth/irregular
    - **Consistency** – soft, firm, hard
    - **Mobility** – fixed or mobile
    - **Tenderness**

Tip:
"Always document and compare bilaterally. If patient reports pain or lump, start with the unaffected side first."

D. Axillary Lymph Node Examination (Patient Standing)
Teach:
"Lymph node palpation is just as important. Most breast malignancies spread to axillary nodes first."
Demonstrate:

1. Ask patient to **rest their right arm on your left shoulder**
    - Use your **right hand** to palpate:
        - Anterior (pectoral)
        - Medial
        - Apical
2. Repeat on the left side
3. Ask patient to **cross their arms** across chest
    - Stand behind and palpate:
        - Posterior (subscapular)
        - Lateral (along the humerus)

Tips:

- Be gentle, explain each step
- Palpate using firm but comfortable pressure
- Always examine **bilaterally**

Involve the Student
"Would you like me to go over the palpation part again?"
"Does the order of the lymph node examination make sense?"
"Would you feel comfortable trying the superficial palpation step on the mannequin?"
Encourage clarification, respond positively, and adjust based on their pace.

Wrap-Up & Reinforce Key Points
"So to summarise, we discussed how to:

- Explain the exam clearly and respectfully to the patient
- Perform thorough visual inspection in sitting position
- Systematically palpate each breast, both superficially and deeply
- Examine axillary lymph nodes with patient standing
  Key points to remember are:
- Always request a chaperone

- Preserve dignity with drapes
- Document any lump in detail

You don't need to memorise the script — with practice, it becomes second nature."

Offer a quick recap sheet or visual guide if you have one.

Final Encouragement & Open Door

"Thanks so much — you followed along really well. This is a sensitive exam but once you get comfortable with the steps, it becomes a routine clinical skill.

If you'd ever like to practise this on a model or go through findings again, feel free to ask me anytime."

Teaching Abdominal Examination

Professional, Warm Introduction

"Hi, I'm [First Name], one of the FY2s working on the ward today."

"You must be [Student's Name], right? Nice to meet you."

"I understand you'd like to go through how to perform an abdominal examination — happy to walk you through it today."

Build Quick Rapport

• "How's the rotation going so far?"

• "Have you had the chance to observe or practise any abdominal exams on the ward yet?"

(Keep it relaxed and supportive – 20–30 seconds max.)

Set the Agenda Clearly

• "Let's make this session practical and step-by-step. I'll demonstrate the full abdominal exam, and highlight important things to look for, how to position and speak with the patient, and how to document or escalate if needed."

• "Feel free to ask anything at any point — and I'll share a structured summary at the end."

Assess Learning Needs (4Ws)

• "What do you already know about abdominal examination?"

• "Which parts do you find most challenging — inspection, percussion, interpretation?"

• "Why is this a priority for you right now — have you seen any relevant cases?"

• "When do we typically perform a full abdominal exam in hospital settings?"

Clarify:

"We typically examine the abdomen in anyone presenting with pain, distension, nausea, vomiting, changes in bowel habit, jaundice, or urinary issues. It's a key part of both surgical and medical workups."

Teach the Skill: Step-by-Step Abdominal Examination

Pre-Examination: Focused History (Brief Overview)

Before examination, we'd typically gather a focused history including:

1. **Presenting symptoms** (use **SOCRATES** for pain or **ODIPARA** for distension)
2. Associated symptoms – vomiting, diarrhoea, constipation, jaundice, dysuria
3. Red flags – **FLAWS**: Fever, Lumps, Appetite loss, Weight loss, Night Sweats
4. Past medical/surgical history, medications, allergies
5. Smoking, alcohol, and relevant family history

Verbalise Examination Introduction to Patient
Use this phrasing to model good patient communication:
"Thank you for answering my questions, Mr X. Now I'd like to examine your tummy to help us understand what's causing the symptoms. This won't be painful, but it might feel slightly uncomfortable."
"During this examination, I'll be looking at, feeling, tapping and listening to your abdomen."
"To do this, I'll need you to lie flat, be uncovered from just below your chest to your mid-thigh. You can keep your undergarments on. I'll ensure your privacy, and we'll have a chaperone with us throughout."
"Is that okay with you? Do I have your consent to proceed?"

Stepwise Physical Examination (Using: "Look, Feel, Tap, Listen")
Anchor phrase: "We start with looking, then feeling, tapping, and listening."

1. Inspection
- Stand at the end of the bed and look across the abdomen.
- Verbalise:

"I'm observing for any distension, surgical scars, visible pulsations, hernias, or skin changes like bruising or rashes."
- Inspect from both sides.

2. Palpation
Split into **Superficial** and **Deep**:
Superficial Palpation
- Check temperature (back of hand): compare abdomen to thighs.
- Lightly palpate all 9 regions, watching patient's face.

"I'm checking for tenderness, guarding or rigidity."
Deep Palpation
- Palpate deeper for masses or organomegaly.
- Assess liver edge and spleen from RIF/LIF upward using standard technique.

Murphy's Sign (if RUQ pain):
"Place hand at the right costal margin and ask the patient to inhale. If they stop due to pain, this is positive and suggests cholecystitis."
Rebound Tenderness (if suspected peritonitis):
"Press deeply over the tender area, then release quickly. Pain on release suggests peritoneal inflammation."

3. Percussion
- Percuss from epigastrium to umbilicus and both flanks.
- If dullness is noted → check for **shifting dullness** (sign of ascites).
- If shifting dullness is positive → demonstrate the **fluid thrill test**.

Explain as you do it:
"This helps us differentiate fluid from solid organ enlargement."

4. Auscultation
- Auscultate over the **right iliac fossa**.

"Ideally, I'd listen for up to 2 minutes to assess bowel activity."
- If vascular causes suspected → auscultate aortic, renal, or femoral bruits.

5. Examination Completion
"To complete my examination, I would also:
– Examine the hernial orifices
– Inspect the external genitalia
– Check for sacral and lower limb oedema
– Consider a digital rectal exam if clinically appropriate"

Interpretation & Escalation
"If I find signs of peritonism, organomegaly, or concerning masses — I would escalate to the surgical/medical team urgently, initiate relevant bloods/imaging, and document findings thoroughly."

Involve the Student
- "Would you like to go through any step again — like fluid thrill or Murphy's sign?"
- "Is the examination order clear — Look, Feel, Tap, Listen?"
- "Do you feel confident explaining the verbalisation and escalation steps?"

Wrap-Up & Reinforce
"To summarise:
– We start with inspection
– Then palpate lightly and deeply
– Percuss for dullness or shifting fluid
– Auscultate for bowel sounds or bruits
– And verbalise our full completion plan"
"I'll share a stepwise OSCE checklist with you later for your own revision. And you can practise organ palpation using a pillow or water bottle under a shirt to simulate the liver edge!"

Final Encouragement
"You've done really well — abdominal exam is all about flow and confidence. Once you practise it a few times, it becomes second nature."
"Feel free to shadow me the next time I'm doing a real assessment — it's the best way to reinforce these steps in context."

Teaching Elbow Examination

Professional Introduction & Rapport
"Hi, I'm Dr [Your Name], one of the FY2 doctors on the team — you must be the student joining us for this orthopaedics rotation. Welcome!"
"How's your ortho rotation going so far?"
"Have you had the chance to examine any joints or observe elbow injuries in clinic yet?"
Builds comfort and primes engagement.
"I understand you're here to learn how to examine the elbow — happy to go through it with you today. We'll make it practical, so feel free to stop me anytime or ask questions as we go."
IPS Tip: Maintain eye contact, calm tone, and use positive reinforcement ("Good question", "Great observation", etc.).

Set Clear Agenda
"Here's what we'll cover today — I'll teach you how to examine the elbow step-by-step, including inspection, palpation, movement, and special tests.

We'll also go over your specific questions about range of movement and how to tell tennis and golfer's elbow apart.
Feel free to stop me at any point."

Explore Learning Needs (4Ws)
"Before we begin —"
• "What do you already know about elbow exams?"
• "Anything you're unsure about — anatomy, special tests, or joint movement?"
• "Have you seen any relevant patients recently?"
• "And do you know when we typically assess elbows in practice?"
Clarify: "Elbow exams are most often done when there's pain, swelling, limited movement, or suspected soft tissue injury — especially from repetitive strain."

Teach the Examination
1. Inspection
"Always start by looking. We inspect both elbows — front and back — for swelling, deformity, asymmetry, muscle wasting, scars or bruising."
"Compare both sides from multiple angles — anterior, lateral, posterior — while the patient is standing or sitting comfortably."

2. Palpation
"First, always ask if there's any pain before touching the joint."
"Use the back of your hand to assess for warmth. Then systematically palpate these key landmarks:"
- **Lateral side**: radial head, radio-capitellar joint, lateral epicondyle
- **Posterior**: olecranon process
- **Medial side**: medial epicondyle
- **Muscles**: triceps, biceps, and forearm muscles
- **Joint line**: feel for tenderness, crepitus, or swelling

Anchor phrase: "Landmarks first, then soft tissue."

3. Movement
"We assess active *and* passive range of motion, comparing both sides."
Ask the patient to:
- **Bend (flexion)** and **straighten (extension)** the elbow
- **Turn the palm up (supination)** and **down (pronation)**

Then do the same movements passively to check for restriction.
Student concern:
"What's the normal range of movement?"
"Roughly 0–140° for flexion-extension. Supination and pronation are each around 80–90° — but instead of memorising numbers, look for symmetry and any discomfort."

4. Special Tests
A) Medial Epicondylitis (Golfer's Elbow)
- Stabilise the forearm with one hand.
- Palpate the **medial epicondyle**.
- Ask the patient to flex the wrist against your resistance.

"Pain on resisted flexion = Medial Epicondylitis"

B) Lateral Epicondylitis (Tennis Elbow)

- Stabilise forearm, palpate the **lateral epicondyle**.
- Ask patient to extend wrist against resistance.

"Pain on resisted extension = Lateral Epicondylitis"

5. Final Checks

"After the elbow, always examine the joint *above and below* — that means the shoulder and wrist."
"Don't forget **neurovascular status** — check cap refill, sensation, power, and reflexes in the arm and hand if needed."

Involve the Student

"Would you like to practise the special tests or run through the movements?"
"Do you want to try locating the epicondyles and radial head on me first?"
Encourage hands-on confidence and real-time correction

Recap & Reinforce Core Concepts

"Just to summarise what we covered today:
• Inspect for deformity and wasting
• Palpate bony and soft tissue landmarks
• Test range of motion actively and passively
• Special tests help us distinguish common tendon overuse syndromes"

Address Student Concerns Naturally

Q1: What's the range of movement in the elbow?
"Around 0–140° for flexion-extension, 80–90° for supination and pronation. But always compare sides and check for pain or restriction."

Q2: How to differentiate Golfer's vs Tennis elbow?
"Simple trick: *Medial = Flexion pain*, *Lateral = Extension pain*. Palpate the epicondyle and resist the relevant movement."

Final Encouragement & Return Offer

"You've done really well. With MSK exams, it's all about structure and practice."
"If you'd like to go through shoulder or wrist exams next time, or see one on a real patient, you're welcome to join me again."

Feature	*Golfer's Elbow*	*Tennis Elbow*
Site	Medial epicondyle (inner elbow)	Lateral epicondyle (outer elbow)
Muscles	Flexor-pronator group	Wrist extensors (ECRB)
Pain with movement	Wrist flexion & pronation	Wrist extension & supination
Special test	Resisted wrist flexion	Resisted wrist extension
Common causes	Golf, lifting, rock climbing	Tennis, typing, backhand sports

Teaching Female Urethral Catheterisation

Professional, Warm Introduction
"Hi Tony — I'm Dr [Your Name], one of the FY2s here. Nice to meet you."
"I heard you're keen to learn how we do **female catheterisation** — happy to walk you through it today. It's a core skill, especially in surgery, geriatrics, and emergency medicine."

Build Quick Rapport
"How's your rotation been going so far?"
"Have you had a chance to observe or try this procedure before?"
[Tone warm and encouraging. Max 30 seconds.]

Set the Agenda Clearly
"Let's make this a relaxed and practical session. I'll cover:
– When and why we catheterise
– The equipment
– Aseptic technique
– Step-by-step procedure
– Safety, troubleshooting, and documentation."
"Feel free to stop me anytime with questions — I'll also get you involved in a hands-on practice at the end if you're comfortable."

Assess Learning Needs – 4Ws
"Just before we begin —"

- "What do you already know about urethral catheterisation in females?"
- "Is there anything specific you'd like to focus on — like the no-touch technique or balloon inflation?"
- "Why did this come up today — did you see a relevant case?"
- "And do you know the key differences between male and female catheterisation?"

Anchor explanation if needed:
"Female urethral catheterisation is usually more straightforward than male, due to a shorter urethra. But maintaining dignity and asepsis is just as important."

Teach the Concept or Skill – Step-by-Step Breakdown
Indications
"We do this to:

- Relieve acute/chronic urinary retention
- Monitor strict fluid balance
- Facilitate surgery or post-op care
- Collect sterile urine samples if unable to void
- Manage neurogenic bladder or end-of-life care"

Equipment
Here's what we need:

- Female Foley catheter (12–14Fr)
- Anaesthetic gel (e.g. lidocaine 1%)
- 10 mL sterile water in syringe (for balloon)
- Antiseptic solution / saline
- Sterile forceps
- Cotton/gauze ×3
- 2 kidney trays
- Sterile gloves ×2 pairs

- Urine bag and connector
- Tegaderm and catheter fixation device
- Drapes (if available)
- Apron and PPE

Tip: "Always check the expiry date, balloon integrity, and patient allergies."

Preparation and Positioning
"Patient should be lying supine, knees bent, hips relaxed."
"Expose from waist to mid-thigh while preserving dignity. Drape if available."
"Wear apron and **double sterile gloves**."

Aseptic Cleaning
"Use non-dominant hand to separate labia — that hand now stays in place."
"With sterile forceps in dominant hand:

- Soak gauze in antiseptic
- Clean labia and urethral meatus front to back using 3 separate gauze pieces
- Dispose in clinical bin"

Anaesthetic Gel
"Tell the patient you're applying gel to reduce discomfort."

- Insert tip of prefilled anaesthetic syringe into urethra
- Slowly instill full contents
- Wait 3–5 minutes to allow effect
  Anchor phrase: "Always wait — don't rush past the gel step."

Catheter Insertion (Non-Touch Technique)

- Partially expose catheter without touching it
- Warn patient: "You may feel pressure now"
- Insert catheter gently until **urine starts draining**
- Advance to the **Y-junction** (ensures balloon is inside bladder)
- Inflate balloon with 10 mL sterile water slowly
  – Watch face for discomfort or resistance
- Withdraw catheter slightly until resistance is felt

Connect and Secure

- Attach drainage tubing securely
- Place bag **below bladder level**
- Secure catheter with Tegaderm
- Dispose waste, gloves, and used equipment into clinical waste bin

Documentation
"We always record:

- Date and time
- Catheter size and balloon volume
- Colour and volume of drained urine
- Reason for catheterisation
- Our name and signature"
  Tip: "Also monitor BP post-catheter — sudden decompression can cause hypotension."

6. Involve the Student
"Would you like to try loading the catheter using the no-touch technique?"
"Should we practice the cleaning steps together with the dummy setup?"
"Do you feel comfortable with balloon inflation and the Y-junction marker?"

Recap & Reinforce Key Points
"To recap:

- Maintain aseptic technique throughout
- Always instill anaesthetic gel and wait
- Advance catheter until the **Y-junction**, then inflate balloon
- Secure catheter, position bag below bladder, document everything
- Never inflate balloon unless urine is draining first — this confirms you're in the bladder"

"And always preserve patient dignity, use a chaperone, and explain each step clearly."

Final Encouragement & Open Door
"You've followed that really well — it's a great skill to master."
"If you'd like to observe or assist in the next real case, I'll be happy to supervise you."
"Feel free to come back with any questions or if you'd like a quick checklist to revise from."

Teaching Phlebotomy (Blood Sample Collection)

Skill Taught: Safe and accurate venipuncture for paracetamol level (or other tests)
Teaching Type: Practical Skill Demonstration

Professional, Friendly Introduction
"Hi, I'm [First Name], one of the FY2s here."
"You must be [Student Name], right? Lovely to meet you."
"I understand you'd like to learn how to perform phlebotomy — happy to guide you through it step by step."

Build Quick Rapport
"How are you finding this rotation so far?"
"Have you had a chance to observe or practise venipuncture before?"

Set the Agenda Clearly
"Let's go through the full procedure for collecting a blood sample — starting from how to approach the patient, then preparation, performing the procedure, and finally how to wrap things up."
"Feel free to stop me at any point if anything's unclear, and you're welcome to try parts of it as we go along."
"Shall we begin?"

Assess Learning Needs (4 Ws)
"What do you already know about this procedure?"
"Any particular steps you'd like me to focus on more — like vein selection or sample handling?"
"Have you seen this done in the ED or ward?"
"When do you think this procedure is typically needed in practice?"

Teach the Skill – Phlebotomy (Step-by-Step)

A. Approach to the Patient – PPECC Framework

Model the explanation you'd give the patient using clear, respectful phrasing:
"I'd like to take a blood sample from your arm to measure the paracetamol level."
"This involves inserting a small needle into a vein. It shouldn't be painful, but you might feel a sharp scratch and a bit of pressure."
"I'll need you to roll up your sleeve and rest your arm straight on the armrest."
"A colleague from the medical team will be present as a chaperone, and I'll ensure your privacy throughout."
"Is that okay with you? Do I have your consent to proceed?"
Also explain:
"Before starting, always ask:

- 'Do you have a preferred arm?'
- 'Do you have any bleeding disorders or are you on blood thinners?'
- 'Any pain or injury to either arm?'"

B. Preparation – PREP Framework

Set-Up (Verbalise while demonstrating):

- Wash hands and clean tray
- Lay out and name equipment:
    - Tourniquet
    - Alcohol swab
    - Blood collection tube (e.g., yellow-top for toxicology)
    - Vacutainer holder and green needle
    - Cotton wool
    - Plaster
    - Gloves and apron
    - Sharps bin and clinical waste bag

"Always wear gloves and apron. This is your sterile field. Keep all items within this tray."

Vein Selection:

- Palpate antecubital fossa for a suitable vein (median cubital is ideal)
- Apply tourniquet just before cleaning

C. Perform the Procedure (Demonstration)

Skin Cleaning:
"Clean in circular motion for 30 seconds — centre to periphery — then allow it to **air dry** to prevent contamination."

Insertion & Collection:
"Loosen needle cap without touching the tip."
"Warn the patient: 'You'll feel a small scratch now.'"
"Insert bevel-up at 15–30° angle."
"Once flashback appears, push the tube in and fill to the mark (~3ml)."
"Loosen the tourniquet as soon as blood flows."

Sample Handling:

- Remove tube and mix by gentle inversion (5–6 times)
- Withdraw needle and immediately apply cotton wool
- Offer a plaster once bleeding has stopped
- Dispose of needle in sharps bin straight away
- Discard remaining items into clinical waste

D. Post-Procedure (PAUSE + PROVIDE)
Clear Up & Safety:

- Confirm bleeding has stopped
- Label sample at bedside:

"I'm labelling this with your full name, age, hospital number, and today's date and time."

- State: "I'll send this sample to the lab urgently for testing."
- Ensure tray is cleared — **only the labelled sample remains**

Reassurance:
"That's all done — thank you, Adam. You did really well."

Involve the Student
"Would you like to try vein selection on the mannequin?"
"Let me know if you'd like me to show the insertion part again."
"Do you want to go through the post-procedure clean-up together?"

Wrap-Up & Reinforce Key Points
"To summarise, we covered the full phlebotomy process — from explaining the procedure, preparing your tray, selecting a vein, inserting the needle safely, collecting the blood, and finally labeling and disposing of the materials."
"Top tips to remember:

- Maintain hand hygiene and PPE
- Always loosen the tourniquet once blood is flowing
- Never leave a sharps device unattended
- Always label the sample at the bedside"

"With practice, this becomes second nature — focus on staying calm and structured."

Final Encouragement & Open Door
"You followed that really well — I can tell you've got good clinical awareness already.
Let me know anytime you want to practise this again, or if you'd like a simple checklist to revise from."

Chapter 27: Procedures

PLAB 2 Procedure Station Template

Professional Introduction & Agenda (INFORM)
"Hello, my name is [First Name], I'm one of the FY2 doctors in the team."
"Can I confirm your full name and age, please?"
"I understand you've been asked to have a [procedure name] today — I'd like to walk you through what we're doing, explain what to expect, and then carry it out if you're happy for me to proceed."

Focused Safety History (Optional Mini-History)
"Just before we begin, I'd like to ask a few quick questions for safety."

- Do you have any allergies?
- Are you on any blood thinners or medications like aspirin or warfarin?
- Do you usually feel faint with needles or blood tests?
- Do you have a preferred arm or side for this procedure?

Note: Tailor further questions based on the specific procedure (e.g., anticoagulants for ABG, recent cannulas, or infections for blood culture, etc.)

Clear, Structured Explanation (PPECC)
"Just to explain what we'll do —"

- **P (Purpose):**
  "This test is to help identify the cause of your symptoms and guide the next step in your care."
- **P (Procedure):**
  "I'll use a small needle to take a sample from one of your veins here in the arm — it usually takes just a few minutes."
- **E (Exposure):**
  "I'll need you to roll up your sleeve, please."
- **C (Chaperone & Privacy):**
  "A member of the clinical team will be present during the procedure, and I'll make sure your privacy is maintained."
- **C (Consent):**
  "It's not painful, but it may be briefly uncomfortable. I'll be as quick and gentle as I can.
  Does that sound okay to you? Are you happy for me to go ahead?"

Marking domains hit here: rapport, communication, safety, consent

Preparation (PREP)
Before touching mannequin or patient:

- Wash hands
- Clean tray (verbalise: "I'm cleaning my tray as a sterile field.")
- Collect all required equipment (e.g., gloves, apron, tourniquet, alcohol swabs, blood bottles, gauze, plaster, label)
- Put on gloves (and apron if provided)
- Position the patient comfortably
- Inspect both arms → select best site

Procedure Steps (PERFORM)
"I'm now going to apply the tourniquet and clean the site."

- Apply tourniquet just before needle insertion
- Clean with alcohol swab in circular motion for 30 seconds (verbalise)
- Let it dry completely
- Warn: "You'll feel a small scratch now."
- Insert needle with bevel up
- Once flashback seen, loosen tourniquet
- Fill required bottles in order
- Remove needle
- Apply pressure with gauze or cotton
- Offer a plaster if needed
- Label samples (verbalise patient name, DOB, time/date)

Sharps into sharps bin. Dispose waste. Clear tray.

Aftercare & Safety-Netting (PAUSE + PROVIDE)
"That's all done — thank you for staying still."

- "Do you feel okay? No dizziness or discomfort?"
- "If you notice any swelling, redness, or pain at the site later — please let us know or call 111."
- "Your sample will be sent to the lab shortly, and the results will help us decide the next step in your treatment."

- "Is there anything you'd like to ask before I leave?"

Examiner-Facing Final Summary
Before leaving the room, say clearly:
"I have completed the procedure, disposed of all sharps and waste appropriately, labelled the samples with full patient details, and I'll document everything in the notes."

Quick Recall: "INFORM – PREP – PERFORM – PAUSE – PROVIDE"

Step	*What It Covers*
INFORM	Intro, identity, purpose, PPECC, consent
PREP	Wash, tray, gloves, site selection
PERFORM	Clean, insert needle, collect sample, safe disposal
PAUSE	Apply pressure, offer plaster, label sample, clear station
PROVIDE	Reassure, safety net, document, ask if patient is okay

Blood Sampling (Venipuncture) – Paracetamol Overdose

INFORM
Introduction & Purpose
- "Hello, my name is Dr [First Name], one of the doctors here in A&E."
- "You're Adam, is that right? Nice to meet you."
- "I understand from my notes that you're here after taking some paracetamol tablets. I'm really sorry you've had a rough time — but you're in safe hands now."

Safeguarding Rapport *(Sensitive case)*
- "Everything we discuss here is confidential. My consultant has asked me to take a blood sample to check how much paracetamol is in your system — that will guide us on the next steps."

PPECC (Purpose–Procedure–Pain–Exposure–Chaperone–Consent)
"I'd like to take a blood sample from your arm to measure the level of paracetamol."
"This involves using a small needle into one of your veins. It shouldn't be painful, but you might feel a sharp scratch and a bit of pressure."
"I'll need you to roll up your sleeve and rest your arm straight."
"One of my medical colleagues will be present as a chaperone, and I'll make sure your privacy is respected."
"Is that okay with you? Do I have your consent to go ahead?"

Additional Prep Questions
- "Do you have a preferred arm you'd like me to use?"
- "Do you have any bleeding disorders, liver or kidney problems, or are you on blood thinners?"
- "Is there any soreness or injury to either arm?"

PREP
Set-Up
- Wash hands thoroughly.
- Clean and prepare tray → verbalise: "This is my sterile field."
- Collect and arrange equipment:
  - Tourniquet
  - Alcohol swab
  - Yellow-top tube (toxicology priority), or red-top if unavailable

- Vacutainer + needle
- Cotton wool
- Plaster
- Gloves and apron
- Sharps bin and clinical waste bin

PPE

- Wear apron and non-sterile gloves.

Vein Selection

- Inspect and palpate antecubital fossa for a suitable vein.
- Apply tourniquet just before cleaning.

PERFORM

Skin Cleaning

- Clean the site in a circular motion for 30 seconds.
- Verbalise: "I'm allowing this to air dry to reduce infection risk."

Insertion & Collection

- Loosen green needle cap (prepare without touching tip).
- Warn patient: "You'll feel a small scratch now."
- Insert bevel-up at a 15–30° angle.
- Secure the vacutainer and fill to the indicated line (~3ml).
- Once blood flows, loosen tourniquet.

Sample Handling

- Remove tube, turn it gently 5–6 times to mix.
- Remove needle and apply pressure with cotton.
- Offer plaster once bleeding stops.
- Dispose of needle into sharps bin immediately.
- Discard all used materials into clinical waste.

PAUSE

Clear Up & Safety

- Confirm bleeding has stopped.
- Offer a plaster if appropriate.
- Label sample (verbalise): "I'm labelling this with your full name, age, hospital number, date and time."
- State: "I will send this to the lab urgently for analysis."
- Clear tray completely — only the labelled sample remains.

PROVIDE

Reassure and Safety Net

- "Thank you, Adam. That's all done now — you did really well."
- "This sample will help us decide whether any treatment is needed based on a chart that shows safe paracetamol levels."

Explain Next Steps

- "You'll be staying in our observation area while we wait for the result."
- "If the level is high, we may need to start a medicine called NAC (N-acetylcysteine), which helps protect your liver."
- "Once you're medically stable, a specialist mental health team will come to speak with you to offer support."

Red Flag Safety Netting

- "If you notice any arm swelling, bleeding, or pain where we took blood, please let us know."
- "Also, if you feel drowsy, confused, have abdominal pain, or your eyes or skin become yellow, let a staff member know right away."

Close Confidently

- "Do you feel okay at the moment?"
- "Would you like me to get someone to speak to you further?"
- "If you need anything at all, just let one of us know — we're here to help."

Blood Culture Sampling

Scenario: Post-op patient with fever, suspected sepsis
Patient: Underwent appendectomy 3 days ago

INFORM

1. Professional, Empathetic Introduction

"Hi Tom, I'm [Your First Name], one of the doctors looking after you on the surgical team."
"I can see you had your appendix removed 3 days ago, and your temperature has been a bit high today. I'd like to take a blood sample to help us find out if there's any infection and what's causing it — this will help guide the right antibiotics."

2. Early Rapport & Soft Screening

"How are you feeling overall today?"
"Have you noticed any pain or discharge from your surgical site?"
(Observe cues: patient looks unwell, sweating, drowsy, etc.)

3. Explain the Procedure (PPECC)

Anchor Phrase: "This won't be painful, but it might be briefly uncomfortable — I'll talk you through it."

- **P – Purpose:** "We're sending this sample for a *blood culture*, to check for any bacteria in the blood."
- **P – Procedure:** "This involves using a small needle to draw blood from your vein."
- **P – Pain:** "It won't be painful, but might feel like a small scratch."
- **E – Exposure:** "I'll just need access to your arm — would it be okay to roll your sleeve up?"
- **P – Position:** "Would you mind straightening your arm on the pillow?"
- **C – Chaperone & Consent:**
  "A colleague is here as a chaperone to ensure comfort and privacy.
  Are you happy for me to go ahead?"

PREP

1. Wash Hands – Verbalise

2. Prepare Sterile Field (out loud):

"This is my clean area where I'll lay out everything I need."

3. Equipment Checklist (verbalise each step):

- Tourniquet
- Blood culture bottles: aerobic & anaerobic (check expiry, flip caps, disinfect tops with chlorhexidine wipes)
- Alcohol swab for skin
- 2x chlorhexidine (2%) wipes – one for each bottle
- Butterfly needle

- Gloves and apron
- Cotton wool/gauze, plaster
- Sharps bin and clinical waste bin
- Labelling stickers for bottles

Exam Tip: Always clean **each bottle top** with a **separate wipe**, and allow the skin swab to fully dry.

PERFORM

1. Reinspect Vein and Apply Tourniquet

"Just applying the tourniquet now to help locate a suitable vein."

2. Clean Site with Alcohol Wipe

"Cleaning in a circular motion — and I'll wait for that to dry completely."

3. Warn Patient Before Insertion

"You'll feel a small scratch now — try to keep your arm relaxed."

4. Insert Needle – Collect Blood (8–10ml)

- Use bevel up
- Hold needle securely at all times
- Once flashback seen, **loosen tourniquet**
- Distribute blood equally into aerobic and anaerobic bottles
- Gently invert bottles 8–10 times
  Do not shake!

5. Withdraw Needle and Apply Pressure

"That's done. I'm just going to press here for a moment — would you like a plaster?"

6. Safe Disposal

- Needle → sharps bin
- Gloves & wipes → clinical waste bin
- Keep tray tidy

PAUSE

1. Label Sample Bottles

"Now labelling both bottles clearly with your name, age, hospital number, and time."

2. Verbalise Sample Dispatch

"These will be sent straight to the lab for urgent processing."

3. Clear Tray

Ensure nothing but labelled samples remain.

PROVIDE

1. Reassure & Wrap-Up

"Thanks for being so cooperative, Tom. You did great."

2. Safety Net for the Procedure:

"If you notice any swelling, redness, or ongoing soreness in the area, let us know."

3. Safety Net for Clinical Concern:

"If your pain increases, if you feel more confused or nauseous, or if your wound looks red or starts oozing — please press your buzzer or speak to the nurse."

4. Next Steps in Management:

- Keep patient in the observation bay

- Start broad-spectrum IV antibiotics per local protocol
- Send off full septic screen if required
- Await culture and sensitivity to guide antibiotics

Anchor Phrase: "Early cultures help tailor the treatment — we don't want to delay starting the right antibiotics."

IV Cannulation

Scenario: post-appendectomy (3 days ago)
Task: Cannula replacement for ongoing IV morphine

INFORM

1. Introduction and Rapport

"Hi Jamie, I'm [Name], one of the junior doctors looking after you today."
"I can see from your notes that you had your appendix removed three days ago — I hope you're feeling a bit more settled now?"
[Observe non-verbal cues: pain, fatigue, concern.]

2. Reframe Purpose

"Your nurse mentioned that your cannula isn't working properly, and my consultant has asked me to replace it so we can continue giving you your medications and fluids safely — especially your IV morphine."

3. Focused History (Concise, Procedure-Oriented)

- **Cannula concerns**: Any pain, redness, discharge, or swelling at the old site?
- **Current condition**: Abdominal pain, nausea, vomiting, constipation, urinary issues
- **Past history**: Bleeding disorders? Diabetes? Previous cannulation issues?
- **Drugs**: On any anticoagulants or steroids? Allergies?
- **Social**: Any IV drug use?
- **Red flags**: Signs of sepsis (fever, chills, confusion), infection at cannula site

4. PPECC + Consent (Patient-Friendly Framing)

- **P – Purpose**: "I'd like to change your cannula to make sure we can keep giving your pain medication safely."
- **P – Procedure**: "This involves inserting a small plastic tube into a vein in your arm using a thin needle — I'll talk you through it."
- **P – Pain**: "It may feel like a small scratch, but I'll be gentle and quick."
- **P – Position**: "Could you straighten your elbow and relax your arm?"
- **E – Exposure**: "Would you mind rolling up your sleeve?"
- **C – Chaperone & Confidentiality**: "One of our team members is here to maintain your comfort and privacy."
- **C – Consent**: "Are you happy for me to go ahead with this?"

PREP

1. Remove the Old Cannula

- Gently remove the blocked cannula
- Offer gauze and ask the patient to hold firm pressure
- Dispose safely into the **clinical waste bin**

2. Prepare the Tray (Maintain Sterile Field)

- Say: "I'll now clean and prepare everything I need on a sterile tray."

3. Gather Equipment
- Tourniquet
- Appropriate size IV cannula
- Alcohol swabs
- 2cc saline flush
- Tegaderm dressing
- Gauze + cotton wool
- Gloves and apron
- Syringe (pre-filled with 0.9% saline)

4. Prepare Equipment
- Loosen caps on cannula
- Peel swabs and dressing wrappers
- Prepare the saline flush
- Lay out dressing tabs for easy access

5. Wash Hands + Don PPE
- Apply alcohol gel
- Wear gloves and apron

PERFORM

1. Identify Insertion Site
- Inspect and palpate veins
- Ask: "Do you have a preferred arm or vein that's worked well before?"

2. Apply Tourniquet
- Apply **just before insertion** (not too early)

3. Clean Site
- Use **alcohol swab**: circular motion for 30 seconds
- Say: "I'll let that dry completely to reduce infection risk."

4. Cannulation Technique
- Insert needle bevel-up at ~15 degrees
- Confirm flashback → advance needle 2mm further
- Stabilise needle → advance cannula off needle fully
- Loosen tourniquet
- Apply gauze underneath
- Remove and **safely dispose** of needle in sharps bin
- Insert stopper into cannula hub

5. Secure and Flush
- Stick two sides of Tegaderm
- Attach saline syringe → flush slowly
- Ensure no resistance or swelling
- Close port and complete Tegaderm application
- Label cannula dressing with **date and time**

PAUSE

1. Post-Procedure Clean-Up
- Offer gauze or plaster if needed
- Remove gloves, wash hands
- Discard all waste appropriately
- Verbalise sample/cannula site documentation

"I'll make a quick note of the new cannula site, size, and time of insertion in your records."

PROVIDE

1. Reassure and Reassess

"That's all done now — thank you for staying still."
"Are you feeling okay?"
"If the site becomes painful, swollen, or starts leaking, let a nurse know straight away."

2. Monitor and Management Plan

- Check vital signs (BP, HR, SpO2, temp)
- Review morphine chart (last dose 1 hour ago — do not repeat morphine)
  → Offer **1g IV paracetamol** for current pain
- For nausea: **IV Metoclopramide 10mg**
- If fever present: **Paracetamol**
- Document cannula change, site, and saline flush in notes
- Reassess in 15 minutes if pain persists

3. Safety Net

- "Let the team know if you develop fever, increased abdominal pain, vomiting, confusion, or if the cannula area becomes red or swollen."

4. Final Encouragement

"You've done really well — I'll update the team now that the new cannula is in and ready."

Arterial Blood Gas (ABG)

Patient: 49-year-old male with COPD, now short of breath

INFORM – Introduce, Context, Consent

Warm Introduction

"Hi, I'm Dr [Your Name], one of the doctors here in A&E. Am I speaking to Mr Peter Fey?"

Recap the Situation

"I see you've come in today with some breathing difficulty, and I understand from your notes that you have COPD. Is that right?"

Purpose & Framing

"My consultant has asked me to take a small sample of blood from the artery in your wrist. It's called an ABG – an arterial blood gas test – and it helps us check how well your lungs are oxygenating your blood."

Explain the Difference

"This is slightly different from a regular blood test — instead of a vein, we'll take the sample from an artery. It can feel a bit sharper, but I'll be as gentle and quick as I can."

Safety Questions (Check Before You Start)

- "Are you on any blood thinners like warfarin, aspirin or apixaban?"
- "Any history of problems with circulation to your arms, like blocked arteries or surgery?"
- "Do you have any dialysis access or infections on either wrist?"

Position, Privacy & Consent

"Would you be happy to roll your sleeve up and rest your arm palm-up on the pillow here?"
"I'll ensure your privacy, and a chaperone will be present throughout."
"Are you happy for me to go ahead?"

PREP – Setup & Safety Check

Tray & Sterile Field

"I'm setting up a clean tray with all the equipment I need."

Equipment Checklist

- ABG syringe (heparinized)
- Alcohol swabs / 2% chlorhexidine
- Cotton wool or gauze
- Gloves and apron
- Green cap for ABG syringe
- Sharps bin
- Label stickers

Perform Allen's Test (Collateral Circulation Check)

"Before I go ahead, I'll just check the blood supply to your hand."

1. Ask patient to make a fist
2. Compress both radial and ulnar arteries
3. Ask patient to open the hand
4. Release the ulnar artery
   If hand turns pink within 5–7 seconds → proceed
   If not → try the opposite wrist

Wash Hands & Don PPE

PERFORM – Procedure Step-by-Step

1. Locate & Clean

- Palpate the radial artery with 3 fingers (index, middle, ring)
- Remove middle finger to leave space for insertion
- Clean site with alcohol/chlorhexidine in circular motion (30 seconds)
- Let it dry completely

2. Prepare Syringe & Warn Patient

- Loosen cap on syringe
- "You'll feel a sharp scratch now."
- Insert needle at 45–90° angle, bevel up, like a pen

3. Collect the Sample

- Blood should **self-fill** due to arterial pressure (do not pull the plunger)
- Collect ~1 mL or as required

4. Withdraw & Secure

- Withdraw needle smoothly
- Immediately apply **firm pressure** to site with gauze for at least **5 minutes**
- Ask the patient to hold it if able

5. Needle Safety & Disposal

- Use the **table to engage the safety cap**, not your hand
- Detach the needle and dispose of it in sharps bin
- Seal the syringe with the **green cap**

PAUSE – Finalise & Document

Label the Sample Clearly

"Now I'm labelling your sample with your full name, NHS number, date, time, and your oxygen levels at the time of sampling."

Verbalise Immediate Dispatch
"I'll take this straight to the ABG machine myself, so we can get the results quickly."
Clear Up
- Tidy the tray
- Discard used items
- Leave no clinical waste on patient

PROVIDE – Reassure, Safety Net, Plan
Thank & Reassure
"Thanks for being so cooperative. That's all done now."
Safety Net (Procedure)
"If you notice bruising, numbness, pain, or excessive bleeding at the site later, please let us know straight away."
Safety Net (Condition)
"Also, let us know if your breathing worsens, or you feel dizzy, confused, or get chest pain."
Next Steps
"We'll check the result now — based on that, we can adjust your oxygen or medications if needed. You'll remain in the observation unit for now."

Quick PLAB 2 Tips for ABG:

Task	*Tip*
Allen's Test	Required before every ABG. Say it and do it clearly.
Tourniquet	**Never** used in ABG
Label	Include FiO2 (oxygen concentration) on label
Sample Handling	Gently invert. Do **not** shake or flick
Pain Description	Say: "It may feel sharper than a regular blood test"
Patient Comfort	Always give pressure advice post-procedure

Male Urethral Catheterisation

Introduction & Identity Check
"Hello, my name is Dr [Your Name], one of the doctors working in the Emergency Department today."
"Could I confirm your full name and age, please?"
"I can see you've come in today with some tummy discomfort — is that right?"
"I'll do everything I can to help you feel better. Is it alright if we have a quick chat so I can understand what's going on?"

Focused History – Diagnose Acute Urinary Retention
Presenting Complaint
"Could you tell me more about this pain — when did it start?"
→ Use **SOCRATES** for pain
Associated Urinary Symptoms
"Have you had any difficulty passing urine today?"
"When was the last time you passed urine?"
"Any urgency, burning, or dribbling?"
"Any swelling or discomfort in the lower tummy?"

System Review
"Any nausea, vomiting, fever, or back pain?"
"Any confusion or feeling lightheaded?"
Relevant Medical History
"Do you have any known prostate or kidney issues?"
"Any recent procedures involving your urinary tract?"
Medication, Allergy, Bleeding Risk
"Are you on any blood thinners like warfarin or aspirin?"
"Any allergies — particularly to latex or medications?"
"Any history of bleeding disorders?"
Contraindications to Procedure
"Have you ever had trauma, bleeding, or discharge from the penis?"
"Any known narrowing or strictures?"

Focused Examination (Verbalised)
"I'd like to check your vital signs — blood pressure, heart rate, oxygen levels, and temperature."
"I'd also perform a general physical exam and examine your tummy gently for any swelling or tenderness."
Provisional Diagnosis: "Based on your history and exam, I believe you're having trouble passing urine due to a condition called *acute urinary retention*. This can happen with prostate enlargement, infection, or other causes. The best next step is to relieve the pressure using a urinary catheter."

Patient Preparation – PPECC
P – Purpose:
"I'd like to insert a small tube called a urinary catheter to drain the urine from your bladder — this will help relieve the pressure and discomfort."
P – Procedure:
"It involves inserting a thin, soft tube through the opening of your penis into the bladder. I'll be as quick and gentle as possible."
P – Pain:
"This may feel a little uncomfortable but shouldn't be painful — I'll use anaesthetic jelly to help."
E – Exposure:
"I'll need you to lie on your back with your legs slightly apart and be undressed from the waist down. I'll keep you covered and maintain your dignity at all times."
C – Chaperone & Consent:
"One of our trained staff will be present as a chaperone. I'll maintain your privacy throughout. Do I have your consent to proceed?"
Preference:
"Do you have any soreness or preference for which side I should use?"

Procedure – "INFORM – PREP – PERFORM – PAUSE – PROVIDE"

PREPARE
1. Gather Equipment:
- 2 Kidney trays
- Sterile gauze
- 3 Cotton balls
- Sterile forceps
- Antiseptic solution or normal saline

- Anaesthetic gel syringe (1%)
- Distilled water syringe (10ml)
- Foley catheter (12–14Fr)
- Urine bag
- Sterile gloves, apron, drape

2. Sterile Setup:

- Clean tray
- Open all sterile packs using non-touch technique
- Check catheter balloon for patency
- Place kidney tray between patient's thighs
- Place stickers from Tegaderm on the tray sides

3. Don apron and double gloves

PERFORM

1. Cleanse Area

- Hold penis with non-dominant hand and do not release until catheter fully inserted
- Use forceps to clean the glans in concentric circles with 3 cotton swabs (one per circle)
- Discard forceps and swabs into clinical waste

2. Insert Anaesthetic Gel

- Explain and administer gel into urethra slowly
- Wait 3–5 minutes for effect

3. Insert Catheter Using Non-Touch Technique

- Advance catheter steadily while unwrapping it
- Insert fully up to the bifurcation (Y-junction)

4. Inflate Balloon

- Attach prefilled 10ml syringe of water
- Inflate while monitoring patient's face for discomfort
- Withdraw catheter slightly until resistance is felt

5. Connect Drainage Bag

- Remove drainage cap and connect urine bag
- Secure catheter to thigh using tape
- Ensure urine bag is below bladder level

PAUSE & CLEAN UP

- Reposition foreskin (if applicable)
- Clean patient, ensure they are dressed and covered
- Discard all equipment in clinical waste
- Remove gloves and wash hands
- Thank the patient

PROVIDE – Management & Documentation

Immediate Actions

- Document: date/time, catheter size, balloon volume, urine colour/volume
- Re-check vitals after decompression (risk of hypotension)
- Monitor urine output hourly
- Start fluid balance chart

Investigations
- FBC, U&Es, LFTs, CRP
- Urine dipstick & send for MC&S
- Ultrasound if indicated

Medications
- Analgesia: IV paracetamol
- Fluids: IV normal saline if signs of dehydration
- Antibiotics if infection suspected

Safety Net
- "Let us know if you have any pain, blood in the bag, or feel faint."
- "We'll review you in a few hours and once you're stable, discuss next steps."

Final Wrap-Up & Summary
"Mr. X, we've successfully inserted the catheter and drained the urine. I'll check your blood tests and we'll monitor how you're feeling over the next few hours. If you feel any discomfort, please let us know."

Female Urethral Catheterisation

Introduction & Identity Check
"Hello, my name is Dr [Your Name], one of the doctors working in the Emergency Department today."
"Could I confirm your full name and age, please?"
"I can see you've come in today with some tummy discomfort — is that right?"
"I'll do everything I can to help you feel better. Is it alright if we have a quick chat so I can understand what's going on?"

Focused History – Diagnose Acute Urinary Retention
Presenting Complaint
"Could you tell me more about this pain — when did it start?"
→ Use **SOCRATES** for pain
Associated Urinary Symptoms
"Have you had any difficulty passing urine today?"
"When was the last time you passed urine?"
"Any urgency, burning, or dribbling?"
"Any swelling or discomfort in the lower tummy?"
System Review
"Any nausea, vomiting, fever, or back pain?"
"Any confusion or feeling lightheaded?"
Relevant Medical History
"Do you have any known kidney issues?"
"Any recent procedures involving your urinary tract?"
Medication, Allergy, Bleeding Risk
"Are you on any blood thinners like warfarin or aspirin?"
"Any allergies — particularly to latex or medications?"
"Any history of bleeding disorders?"
Contraindications to Procedure
"Have you ever had trauma, bleeding, or discharge from the vagina or urethra?"
"Any known narrowing or strictures?"

Focused Examination (Verbalised)
"I'd like to check your vital signs — blood pressure, heart rate, oxygen levels, and temperature."
"I'd also perform a general physical exam and examine your tummy gently for any swelling or tenderness."
Provisional Diagnosis: "Based on your history and exam, I believe you're having trouble passing urine due to a condition called *acute urinary retention*. This can happen with infections or other causes. The best next step is to relieve the pressure using a urinary catheter."

PPECC Consent
"Just to explain — this procedure involves placing a soft, sterile tube called a catheter into your bladder through your urethra to help drain urine.
You may feel a little pressure, but it shouldn't be painful. I'll be using local anaesthetic gel to make it more comfortable.
To perform this properly, I'll need you to lie flat with your knees bent and hips relaxed.
We'll expose the area from the waist down, and I'll use drapes to ensure your privacy throughout.
A female chaperone will be present at all times.
Does that sound okay to you? Are you happy for me to go ahead?"

PREP – Setup and Aseptic Preparation

1. **Hand hygiene and apron**
2. **Tray setup** – Verbalise: "I'm preparing a clean sterile field."

Equipment checklist (verbalise each item):

- Female Foley catheter (12–14Fr)
- Anaesthetic gel (lidocaine 1%)
- 10 mL syringe with sterile water
- Antiseptic solution/saline
- Sterile forceps
- 3 gauze swabs
- 2 kidney trays
- 2 pairs of sterile gloves
- Urine drainage bag + connector
- Tegaderm or fixation device
- Drapes (if available)
- Clinical waste bag and sharps bin

"I've checked the balloon integrity, expiry date, and confirmed no allergies to latex or lidocaine."

PERFORM – Step-by-Step Catheter Insertion
Patient Positioning
"Ensure the patient is lying supine with knees bent and hips relaxed.
Expose from waist to mid-thigh while preserving dignity. Drape if available."

1. **Don sterile gloves**
2. **Use non-dominant hand to part the labia** → this hand is now **non-sterile**
3. **Using forceps with dominant hand**:
    - Soak gauze in antiseptic
    - Clean labia and urethral opening **front to back** using **3 separate gauze pieces**
    - Dispose into kidney tray
4. **Instil Anaesthetic Gel**:
    - Inform the patient again: "I'm going to insert some anaesthetic gel to numb the area."

- Gently insert the nozzle into the urethral opening
- Instil full contents of the gel syringe
- **Wait 3–5 minutes** (verbalise this)
  Anchor phrase: "Always wait — don't rush past the gel step."

Catheter Insertion
"Now I'll insert the catheter. You may feel a bit of pressure — please let me know if it's uncomfortable."

1. Partially expose catheter **without touching the tip**
2. Gently insert catheter until **urine flows**
3. Advance further **to the Y-junction**
   "This ensures the balloon is fully inside the bladder."
4. Inflate the balloon with **10 mL sterile water** slowly
   - Watch for patient discomfort or resistance
5. Gently withdraw the catheter **until resistance is felt**

Connect and Secure

- Attach catheter to urine drainage bag
- Place the bag **below bladder level**
- Secure catheter with Tegaderm or fixation device
- Remove gloves and dispose of waste appropriately
- Clean and clear station

PAUSE – Post-Procedure Checks
"Thank you, the catheter is now in place. I'll just check a few things before we finish."

- Ensure urine is draining freely
- Confirm patient is comfortable
- Check BP if large volumes drained (risk of post-obstructive diuresis or hypotension)

PROVIDE – Reassure, Safety Net, and Document
"You've done really well — thank you for staying still."
"If you notice any discomfort, bleeding, or the bag stops draining, please let a nurse or doctor know straight away."
"I'll now document everything we've done."
Immediate Actions

- Document: date/time, catheter size, balloon volume, urine colour/volume
- Re-check vitals after decompression (risk of hypotension)
- Monitor urine output hourly
- Start fluid balance chart

Investigations

- FBC, U&Es, LFTs, CRP
- Urine dipstick & send for MC&S
- Ultrasound if indicated

Medications

- Analgesia: IV paracetamol
- Fluids: IV normal saline if signs of dehydration
- Antibiotics if infection suspected

Safety Net

- "Let us know if you have any pain, blood in the bag, or feel faint."

- "We'll review you in a few hours and once you're stable, discuss next steps."

Final Wrap-Up & Summary
"Mrs. X, we've successfully inserted the catheter and drained the urine. I'll check your blood tests and we'll monitor how you're feeling over the next few hours. If you feel any discomfort, please let us know."

Chapter 28: SimMan

General Approach to SimMan Stations

What Is a SimMan Station?

SimMan is a high-fidelity mannequin simulating an emergency or deteriorating patient. Though often feared, it's one of the easiest stations when approached with structure, confidence, and verbalization.
Same protocol every time → **ABCDE + Emergency Personality**. You don't need perfect medicine. Just safe, vocal, structured management. You only fail if the patient "dies" (i.e., critical mismanagement). Speak, act, structure your care. Passing is likely if the protocol is followed.

What's in the Room?

1. **SimMan mannequin** attached to monitor:
    - BP, HR, SpO2, RR, Temp, ECG
    - Monitor updates only when you act or request vitals
2. **ABCDE Crash Cart (Drawer System)**:
   [Actual exam might have crash carts with different system or more drawers – BE CAREFUL!!!)
    - **Airway**: NPAs, OPAs
    - **Breathing**: NRB masks, Venturi masks (blue first), nebulisers
    - **Circulation**:
        - Cannulas (pink, green, orange)
        - Vacutainers (purple, yellow, blue, grey)
        - IV fluids, blood bags
        - Medication vials/stickers (e.g., salbutamol, adrenaline, naloxone)
    - **Disability**: Glucometer, torch, GCS tools
    - **Exposure**: Catheters, warming items
3. **Examiner**: Seated quietly; controls vitals and responses

Patient Types and How to Respond

Talking & Unstable (e.g., SOB, Asthma)

- Acknowledge distress: *"Mr. X, I can see you're struggling to breathe. I'm here to help you today."*
- Immediate actions:
    - *"I'd like to call for help."*
    - *"I'll raise the head of the bed to help you breathe."*
    - *"Let me start my ABC protocol to help you."*
- Airway: *"Since you're talking, I assume your airway is patent."*
- Transition to breathing: *"Let me check the oxygen level and respiratory rate on the monitor."*

Talking & Stable (e.g., Acute Limb Ischemia)

- Confirm complaint: *"You're here because of pain in your leg. I'm here to help."*
- Proceed with ABCDE (no need to call for help or reposition the bed)

- Airway: *"Since you're talking, I assume your airway is patent."*
- Breathing: *"Let me check oxygen level and respiratory rate."*

Mumbling/Confused Patient (e.g., Delirium, Sepsis)

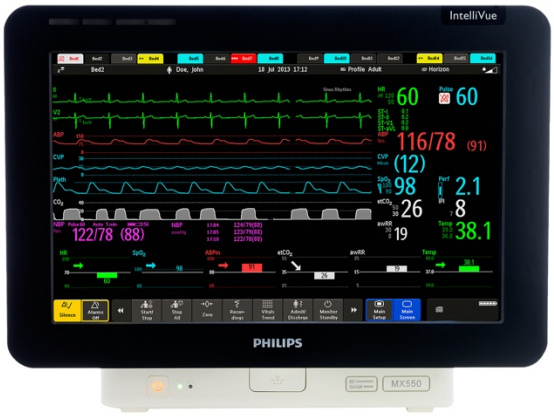
- Say: *"Hello, can you hear me?"*
- Tap shoulder if needed
- Acknowledge: *"My patient is mumbling. I assume airway is at risk."*
- Check ID from wristband aloud
- Start ABCDE: *"I'll call for help and begin my ABC protocol."*
- Open mouth, check airway:
    - *"Oral cavity clear."*
    - *"I'll prepare a nasopharyngeal airway."*
    - *"Now performing head tilt and chin lift."*
    - *"Securing airway with NPA."*

Emergency Personality & Communication

- Be **loud and calm**: assert control without panic
- Show urgency: *"I'm doing everything I can to help you today."*
- Don't appear passive or flat → be sharp, engaged, responsive
- **Think movie-doctor**: take charge, be fast but focused
- Verbalize everything:
    - *"Inserting a large-bore cannula now. Sharp scratch coming."*
    - *"Administering salbutamol via nebuliser mask – 5 mg oxygen-driven."*
    - *"Checking sugar with finger prick."*

Key Tips to Remember

- Speak non-stop: vitals, observations, interpretation, actions
- Vitals change only when YOU act or request
- Reassess after each intervention
- Time is short → be quick with crash cart (ABCDE drawer logic)
- Don't say "airway compromised" → say "airway at risk"
- Always knock. Always check wristband if patient is unresponsive



Structure of the consultation

The First 4 Steps

1. **Knock before entering**
    - A fundamental step in all real-life and simulated emergency settings.
2. **Greet the examiner and introduce yourself**
    - *"Hello, I'm Dr. [Your Name], GMC Number [XXXXX]."*
3. **State safety and preparation**
    - *"I've taken all universal precautions and ensured scene safety."*
4. **Introduce yourself to the patient and confirm identity**
    - *"Hello, I'm Dr. [Your Name], one of the doctors here today."*
    - *"Can I confirm your full name and age, please?"*
    - *If the patient is unresponsive, say " I am checking the identity from the wristband."*

The Next 4 Steps

1. **Scan the room and acknowledge the situation**
    - *"I can see the patient is connected to a monitor. I'll be keeping an eye on the vital signs continuously."*
2. **Reassure the patient**
    - *"You're in safe hands. I'm here to help and will talk you through everything I do."*
    - If unresponsive, still explain your actions clearly.
3. **Begin focused history (if appropriate)**
    - *"Can you tell me what's been happening?"*
    - If able, explore:
        - Onset and duration
        - Associated symptoms and red flags
        - Past medical history, medications, allergies (MMA)
4. **Gain consent for any examination**
    - *"Mr/Ms [Name], I'm going to examine your chest, abdomen, and limbs. This will require exposing some areas of your body, including the more private parts. I'll make sure a chaperone is present and ensure your dignity throughout. Is that alright with you?"*

NEWS Chart (National Early Warning Score)

What is it?

The National Early Warning Score (NEWS) is a standardized scoring system used across the NHS to identify acutely unwell patients and guide timely escalation. It is calculated based on:

- Respiratory rate
- Oxygen saturation
- Systolic blood pressure
- Heart rate
- Temperature
- Consciousness level (AVPU or GCS)
- **+2 points** if the patient is on supplemental oxygen

In real-world scenarios, the NEWS2 score and the ABCDE assessment should be used **in conjunction** with each other, rather than in a strict "before or after" sequence. However, for the exam purpose and to avoid confusion, it is advised to proceed as below:

When the NEWS Chart Is Pre-Filled:

1. **Acknowledge the score at the start**
   "The NEWS score is 6 — this indicates moderate to high risk. I will start an immediate ABCDE assessment and escalate appropriately."
2. **Don't recite every parameter**
   No need to repeat all vitals unless you are **responding to a specific abnormality**.
   e.g., "Due to an SpO_2 of 85%, I will start high-flow oxygen via non-rebreather mask."
3. **Begin ABCDE assessment immediately**
   Treat the patient, not the score. Investigate and intervene step-by-step while verbalising.
4. **Reassess NEWS if prompted**
   "Following oxygen and nebulisers, I will recheck vitals and recalculate the NEWS score."
5. **Include it in your SBAR handover**
   "The initial NEWS was 6. I administered oxygen and bronchodilators, and the patient has improved. Awaiting bloods and CXR."

When the NEWS Chart Is *Not* Pre-Filled (You Must Calculate It):

1. **Gather all vital signs yourself**
   During your ABCDE assessment, actively check:
   - RR, HR, BP, Temp, SpO_2, Mental status
   - Whether the patient is on oxygen
2. **Calculate the NEWS score <u>once you've completed ABCDE</u>**
   "Now that I've assessed all parameters, I will complete the NEWS chart."
   → This prevents premature or inaccurate scoring.
3. **Announce the score and interpret**
   "The NEWS score is 3, which is low risk. I'll continue observation and treat the underlying cause."
4. **Act accordingly**
   Treat based on clinical findings — not just the number.
5. **Mention in SBAR if you calculated it**
   "After assessment, I calculated a NEWS score of 2. The patient remains stable and is responding to treatment."

When the NEWS Chart Is Pre-Filled with Observations but Not Scored:

- Begin ABCDE immediately — do not delay to calculate.
- After ABCDE, calculate the score based on the vitals provided.
- Then interpret: "The NEWS score is 3 — this indicates low risk but still warrants careful observation."
- Include NEWS in SBAR if needed.

NEWS Chart Status	*What You Should Do*
Prefilled and scored	Acknowledge the score, then proceed to ABCDE
Prefilled, not scored	Start ABCDE → calculate NEWS after D/E
Blank chart	Start ABCDE → gather vitals during B–E → score NEWS after full assessment

ABCDE Protocol

A – AIRWAY
Goal: Establish and maintain a patent airway

Assessment
- Is the patient speaking in full sentences? (✔ = patent airway)
- Listen for abnormal sounds: gurgling, stridor, snoring, silence
- Look inside mouth: blood, vomit, foreign body, swelling, burns
- **Monitor:** SpO_2

Sample dialogue:
- *"Mr. X, I can see you're struggling to breathe. Can you talk to me?"*
- *"Mr. X, I'm just going to have a look inside your mouth and check your oxygen level."*
- *"He's talking → airway patent. But I'll still check his oral cavity to rule out obstruction."*

Immediate Interventions
- Head tilt–chin lift or jaw thrust if trauma suspected
- Suction if secretions present
- Insert airway adjuncts:
  - **NPA** for semi-conscious
  - **OPA** for unresponsive without gag reflex

Oxygen Therapy
- **No COPD:** NRM 15 L/min
- **COPD:** Venturi 24% at 4 L/min
- **Target sats:** 94–98% (or 88–92% in COPD)

Sample dialogue:
- *"I'm going to give you some oxygen now to help your breathing."*
- *"I'm inserting an oropharyngeal airway and administering 15 L of oxygen via non-rebreather mask."*

Reassessment
- Check SpO_2 again
- *"Mr. X, are you breathing easier now with the oxygen?"*

If patient is unresponsive or mumbling, airway is considered at risk. You will formally assess GCS/AVPU in the 'D' section to determine if GCS < 8 and intubation is needed.

B – BREATHING
Goal: Support ventilation and identify reversible causes

Assessment (in this specific order)
- **Look:** RR, chest rise, use of accessory muscles, signs of cyanosis
- **Feel:** Tracheal position (central?), chest expansion symmetry
- **Tap:** Check for dullness (effusion) or hyperresonance (pneumothorax)
- **Listen:** Bilateral breath sounds (don't forget lung bases!)
- **Monitor:** RR, SpO_2, respiratory pattern

Sample dialogue:

- *"Mr. X, I'm going to check your chest now. I'll look, feel, tap and listen your chest."*
- *"I'm observing chest movement, palpating trachea and chest expansion, and auscultating both lung bases."*

Immediate Interventions

- **Wheeze:** Salbutamol 5 mg + ipratropium 500 mcg via oxygen-driven nebuliser
- **Oedema/crepitations:** IV furosemide 40 mg
- **Opioid overdose:** Naloxone 400 mcg IV or IM

Sample dialogue:

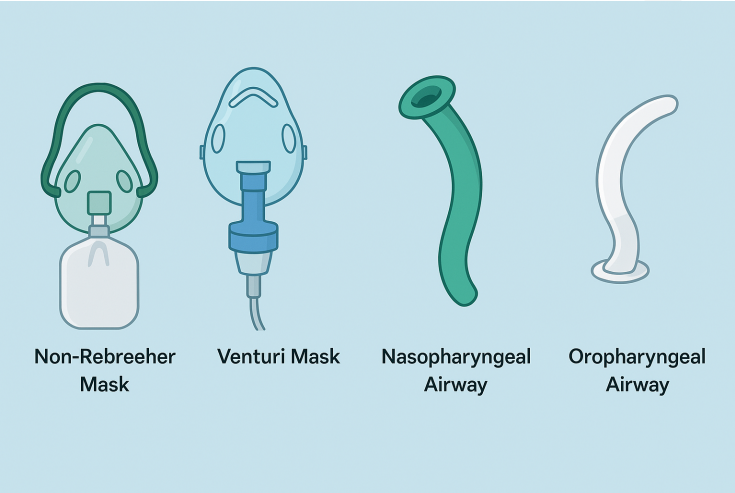
- *"I'm giving you a nebuliser now to open up your airways. Breathe normally through the mask."*

Investigations

- **CXR:** *"I'd like to request a chest X-ray to rule out infection, fluid, or pneumothorax."*
- **ABG:** *"I'm performing an arterial blood gas to check for oxygen levels in your blood. Sharp scratch coming."*

Reassessment

- Re-check RR, SpO_2
- *"Mr. X, is your breathing feeling easier now after the nebuliser?"*



C – CIRCULATION

Goal: Maintain perfusion and prevent or manage shock

Assessment

- **Pulse:** Radial (bilaterally), carotid (if unresponsive), dorsalis pedis (if shock suspected)
- **Capillary refill time:** <2s is normal
- **Monitor:** BP, HR, ECG (lead II)
- Check for signs of bleeding, cyanosis, pallor

Sample dialogue:

- *"Mr. X, I'm going to feel your pulse and check your blood pressure and circulation."*
- *"CRT is delayed and BP is 85/55. Patient is cold and pale–likely hypovolaemic."*

Immediate Interventions

- Insert **2 wide-bore IV cannulas** (orange or green)
- Start **IV fluids (0.9% saline 500 mL bolus)**
- Control any external bleeding

Sample dialogue:

- *"I'm going to place a cannula in your arm and start some fluids to improve your blood pressure. Sharp scratch coming."*

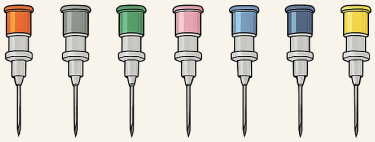
Investigations

- **Bloods: (state vacutainer colours)**
  - Purple (FBC), Yellow (U&E, LFTs), Blue (coagulation), Grey (glucose, lactate), others as appropriate
- **ECG:** *"I'll attach ECG leads to assess for cardiac rhythm or ischaemia."*

Reassessment

- Re-check BP, HR, CRT
- *"BP is now 100/65, CRT improved–responding to fluids."*

IV CANNULA GAUGE SIZES



Gauge (G)	Color	External Diameter	Flow Rate (mL/min)	Common Use Cases	Common Use Cases
14G	Orange	2,0 mm	~240	Major trauma	Major trauma, massive bleeding, resuscitation
16G	Grey	1,7 mm	180	Rapid	Rapid fluid replacement
18G	Green	1,3 mm	90	Blood transfusis	Blood transfusions, IV fluids, emergency meds
20G	Pink	1,1 mm	60	General	General IV access (sf pssec)
22G	Blue	0,9 mm	36	Elderly/o	Elderily or pediatric patients, small veins
24G	Yellow	0,7 mm	20	Infants, neonates	Infants, neonates, difficult access

D – DISABILITY

Goal: Assess neurological status and correct metabolic disturbances

Assessment

- AVPU (Alert, responds to Voice, Pain, Unresponsive)
- Say: *"I'm assessing the patient's level of consciousness using the AVPU scale."*
- Ask:
  - "Can you open your eyes? Do you know where you are?"
  - "Can you move your hand?"
- If no response: *"Applying pain stimulus now."*
- Interpret:
  - Responds = GCS > 8 → no intubation
  - No response = GCS < 8 → *"Calling anaesthetics for intubation."*
- Pupils: size, symmetry, reactivity to light
- Blood glucose via finger prick

Sample dialogue:

- *"I'm going to check your pupils, and your blood sugar with a quick finger prick."*
- *"Patient only responds to pain—GCS estimated below 8. Pupils equal and reactive. Glucose is 2.3."*

If GCS < 8 or AVPU = P/U, airway is at risk. Escalate for possible intubation now.

Immediate Interventions

- If hypoglycaemia: **Administer 100 mL of 10% dextrose IV**
- If pyrexial or in pain: **Paracetamol** (IV or oral)
- If GCS low and unexplained: escalate for CT head

Sample dialogue:

- *"Your blood sugar is low; I'm giving you some glucose through your IV to help."*

Investigations

- **Capillary glucose**
- **Serum electrolytes** if altered consciousness
- **CT head** if neurological signs present

Reassessment

- Recheck GCS or AVPU
- *"Patient is now alert to voice. GCS improved after dextrose."*

E – EXPOSURE

Goal: Identify hidden signs and manage temperature

Assessment

- **Expose and examine:**
  - Abdomen: look for tenderness, distension, rigidity
  - Skin: rashes, bruises, petechiae, needle marks
  - Legs: swelling, DVT signs, wounds
  - Genitals/surgical sites: bleeding, discharge
- **Monitor:** Temperature

Sample dialogue:

- *"I'm going to gently examine your body to check for any signs of bleeding or infection. I'll keep you covered as much as I can to keep you warm."*
- *"I'm inspecting the abdomen and limbs for bruising or rashes. I'll re-cover the patient promptly to avoid hypothermia."*

Immediate Interventions

- Cover patient to prevent heat loss
- Apply dressing if active bleeding found
- Insert catheter if fluid monitoring is necessary

Investigations

- **Urinalysis / Culture** if sepsis suspected
- **Consider temperature-related causes** (e.g., sepsis, hypothermia)

Reassessment

- Check temperature again

SBAR Handover Template

S – Situation

"Hello, I'm Dr. [Your Name], FY2 doctor in [Department]. I'm calling regarding [Patient Name / Bed Number / NHS Number if applicable], a [Age]-year-old [Male/Female], who has [brief reason for referral or concern, e.g., *become acutely unwell*, *deteriorating vital signs*, or *needs urgent review*]."

Example:

"I'm calling about a 72-year-old male patient who has become acutely confused and hypotensive in the last hour."

B – Background

"He has a past medical history of [List key conditions] and is currently on [List regular medications if relevant]. [Known allergies].

This episode started [Timeframe] and was [sudden/gradual/uncertain].

[Recent relevant history – e.g., surgery, infection, admission details, key events]."

If you don't have full details, say:

"Background information is limited at this stage but I will update as I get more."

A – Assessment

"On my assessment using the ABCDE approach:

- **Airway** – [Patent / any concerns].
- **Breathing** – [RR, SpO_2, any interventions given].
- **Circulation** – [BP, HR, cap refill, IV access, fluids given].
- **Disability** – [GCS or AVPU, blood glucose, pupils].
- **Exposure** – [Temperature, any rashes, wounds, bleeding, other findings].

Example:

"Airway is patent. Breathing: RR 28, SpO_2 90% on room air, oxygen given via NRB. Circulation: BP 95/60, HR 110, IV fluids started. Disability: Alert, glucose 5.6. Exposure: Temp 37.3°C, no signs of rash or injury."

R – Recommendation

"My initial management has followed the ABCDE protocol. I would appreciate:

- A **senior review / urgent medical review / specialist input**,
- **Advice on further management** (e.g., investigations, escalation),
- Or **transfer to higher level of care**, if appropriate.

I will continue to monitor the patient and reassess regularly.

Please let me know if you'd like any specific observations or updates in the meantime."

Optional Add-ons (if patient is stable):

"I'm also planning to initiate basic investigations including bloods, ECG, chest X-ray."

"Once stable, I'll ensure medication review, safety netting, and discharge or referral arrangements as needed."

Key Rules & Habits

These are the most important habits and behaviours that will help you **score full marks** and make a strong clinical impression during PLAB 2 SimMan stations:

1. Treat the Mannequin Like a Real Patient

- Make **eye contact**, explain your actions, reassure constantly.
- Use **clear, layman language**: "I'm going to help you breathe easier now."
- Maintain a **2-way conversation**, not a monologue.

2. Don't Touch Without Consent

- Always **signpost examination**:

"I'd like to examine your chest now. I'll ensure privacy and a chaperone is present."

- Then proceed.

3. Never Talk About the Patient in Third Person

- Don't say "*The patient is...*" — speak **directly to the SimMan**.

Say: "Mr. X, I'm checking your pulse now."

4. Cover the Patient Promptly

- After examining the **chest or abdomen**, say:

"I'm re-covering the patient to maintain warmth and dignity."

5. Be Explicit About ABCDE

- Say:

"I'll now begin an ABCDE assessment, starting with Airway."

- Use each step to **guide and verbalise** your actions clearly.

6. Reassess After Each Intervention

- Pause and give treatments time to act before moving on.
- Say:

"I'll reassess SpO_2 and breathing now that the nebuliser has been started."

7. Don't Move On Without Treating

- If you find a life-threatening issue (e.g., low sats, hypotension):

Treat first, then reassess before continuing to the next step.

8. Focus on Stabilisation First

- The goal is to **keep the patient alive and improve** key vitals — not fix everything.
- Prioritise **oxygen, fluids, glucose, analgesia** as needed.

9. Don't Assume

- Don't say "probably COPD" or "might be sepsis" unless you've gathered and stated supporting signs.

Use: "Based on the raised RR, low sats, and NEWS 6, I'm concerned about a respiratory deterioration."

10. Ignore the Examiner

- Do **not** look at, speak to, or expect cues from the examiner.
- Interact **only with the SimMan** and act naturally.

11. Verbalise Oxygen Clearly

- Always state:

"I'm giving oxygen at 15 L/min via non-rebreather mask."

12. Verbalise Medications Accurately

- Include **dose + route** every time:

"I'm giving 5 mg of salbutamol via oxygen-driven nebuliser."
"Administering 100 mL of 10% dextrose IV."

Acute Exacerbation of Asthma

Where you are: FY2 doctor in A&E
Who the patient is: A 35-year-old male presenting with acute shortness of breath
Monitor findings:
SpO_2: 86% on room air
HR: 115 bpm
RR: 26
BP: 100/70
Temp: 36.5°C
Position: Patient is already in semi-sitting position
Background: Known asthma (5 years), using blue and brown inhalers

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Initial Steps

1. Knock and enter
2. Greet examiner:
   "Hello, I'm Dr [Name], GMC number [XXXXX]. I've taken universal precautions and ensured the scene is safe."
3. Greet patient and confirm identity:
   "Hello, I'm one of the doctors here today. Could I confirm your full name and age?"
4. Acknowledge situation:
   "You seem quite breathless. I'll begin an emergency assessment and help stabilise you."

If the patient can speak in full sentences – take focused history early

"Since you're able to talk, I'll ask a few quick questions while I assess you."

- Onset and duration of breathlessness
- Associated symptoms: cough, fever, chest pain, leg swelling
- Triggers: exercise, pets, smoking
- Past medical history, regular medications, allergies

If the patient cannot speak in full sentences:
"You're too breathless to talk right now. I'll begin treatment first, and come back to questions later."

A – Airway

- "The patient is speaking, so the airway appears patent."
- "Checking the oral cavity: no obstruction or secretions."
- "Starting oxygen at 15 litres per minute via non-rebreather mask."

B – Breathing

- "Respiratory rate is 26. Oxygen saturation is 86 percent. Accessory muscles in use."
- "On auscultation: bilateral wheeze heard."
- "Administering salbutamol 5 milligrams via oxygen-driven nebuliser at 6 litres per minute."
- "Requesting a chest X-ray and performing arterial blood gas."
- "I'll complete circulation and reassess the chest response shortly."

C – Circulation

- "Pulse is 115 beats per minute. Blood pressure is 100 over 70. Capillary refill is under 2 seconds."
- "Inserting a large-bore intravenous cannula."

- "Sending bloods: full blood count, urea and electrolytes, liver function tests, CRP, coagulation profile, and ECG."

Return to Breathing – Reassessment

"Now reassessing breathing: RR remains high, wheeze still present, SpO_2 not improved."
"I'm adding ipratropium bromide 500 micrograms via nebuliser."

D – Disability

- "The patient is alert. Blood glucose is 6.2. Pupils are equal and reactive to light."
- "Temperature is 36.5 degrees Celsius."

"If breathlessness continues after bronchodilators, I'm now administering intravenous hydrocortisone 100 milligrams."
"If no response, I'll escalate for intravenous magnesium sulphate or aminophylline under senior guidance."

E – Exposure

- "Inspecting chest, abdomen, back, and limbs for rashes, swelling, or signs of infection."
- "No abnormal findings. I'm re-covering the patient to maintain warmth and dignity."

SBAR Handover

S – Situation
"This is a 35-year-old male with known asthma presenting with acute shortness of breath."
B – Background
"He has had asthma for 5 years, uses salbutamol and steroid inhalers. No known allergies. Likely trigger unknown at present."
A – Assessment
"Airway is patent.
Breathing: RR 26, SpO_2 86%, bilateral wheeze.
Circulation: HR 115, BP 100/70.
Disability: Alert, blood sugar 6.2.
Exposure: No rashes, swelling, or signs of infection.
Given oxygen, salbutamol, ipratropium, and IV hydrocortisone. Chest X-ray and ABG requested."
R – Recommendation
"Admit under medical team.
Monitor response closely.
Consider magnesium sulphate or aminophylline if wheeze persists.
Refer to asthma clinic on discharge.
Educate on inhaler technique and trigger avoidance.
Provide a written asthma action plan and safety netting advice."

Acute Exacerbation of COPD

Where you are: FY2 doctor in A&E
Who the patient is: A 55-year-old male presenting with acute shortness of breath
Monitor findings:
SpO_2: 86%
HR: 92 bpm
RR: 20
BP: 120/80

Temp: 37°C
Position: Patient is already in a semi-sitting position
Background: Diagnosed COPD on inhalers

Initial Steps

1. Knock and enter
2. Greet examiner:
   "Hello, I'm Dr [Name], GMC number [XXXXX]. I've taken universal precautions and ensured the scene is safe."
3. Greet patient and confirm identity:
   "Hello, I'm one of the doctors here today. Could I confirm your full name and age?"
4. Acknowledge situation:
   "You seem quite breathless. I'll begin a structured assessment and help stabilise you."

If patient can speak in full sentences – take focused history before ABCDE

"Since you're able to talk, I'll ask a few quick questions while I assess you."

- Onset, duration, and severity of breathlessness
- Cough, volume and colour of sputum, fever, chest pain, leg swelling
- Past medical history: COPD, medications, allergies
- Smoking status

If the patient cannot speak in full sentences:
"You're very breathless right now. I'll stabilise you first, then return for more questions."

A – Airway

- "The patient is speaking, so the airway appears patent."
- "I'll inspect the mouth and throat for obstruction or secretions — clear."
- "Starting controlled oxygen via Venturi mask at 24 percent to target SpO_2 between 88 and 92 percent."

B – Breathing

- "RR is 20. SpO_2 is 86 percent. Patient is using accessory muscles."
- "On auscultation, there are scattered wheezes bilaterally."
- "Administering nebulised salbutamol 5 milligrams and ipratropium bromide 500 micrograms via air-driven nebuliser."
- "Requesting a chest X-ray and performing an arterial blood gas to check for CO_2 retention and hypoxia."

C – Circulation

- "Pulse is 92, blood pressure is 120 over 80, capillary refill time is under 2 seconds."
- "Inserting a large-bore IV cannula."
- "Sending bloods: full blood count, urea and electrolytes, CRP, LFTs, clotting profile, and ECG."

Return to Breathing – Reassessment

"Reassessing chest now: wheeze still present but SpO_2 has improved to 90 percent on controlled oxygen. RR remains stable. Will continue to monitor response."

D – Disability

- "Patient is alert and oriented. Blood glucose is 5.8. Pupils are equal and reactive to light."
- "Temperature is 37 degrees Celsius."

E – Exposure

- "Inspecting chest, abdomen, limbs, and groin for any signs of infection, swelling, or rash."
- "No visible abnormalities noted. I'll re-cover the patient promptly."

SBAR Handover

S – Situation
"This is a 55-year-old male with known COPD presenting with acute shortness of breath."
B – Background
"He uses regular inhalers. No known allergies. Symptom onset was this morning. No chest pain. Reports increased sputum but no fever."
A – Assessment
"Airway is patent.
Breathing: RR 20, SpO_2 improved to 90 percent on Venturi. Bilateral wheeze.
Circulation: HR 92, BP 120/80.
Disability: Alert, glucose 5.8.
Exposure: No signs of infection or DVT.
Given controlled oxygen, salbutamol, ipratropium. Bloods, CXR, and ABG ordered."
R – Recommendation
"Admit under medical team.
If signs of infection develop, start antibiotics based on sputum colour, fever, and raised markers.
Start oral prednisolone 30 milligrams daily for 5 days.
Refer to respiratory clinic.
Review inhaler technique and arrange smoking cessation support.
Provide safety netting and discharge plan after improvement."

Anaphylaxis

Where you are: FY2 doctor in the Emergency Department
Who the patient is: A 60-year-old male recovering from abdominal surgery, now breathless post-transfusion
Monitor findings:
SpO_2: 86%
BP: 90/50
HR: 105 bpm
RR: 13
Temp: 37°C
Lead II: Sinus rhythm
Background: Received pain meds, fluids, and 1 unit of blood 15 minutes ago
Position: Patient is in a semi-sitting position

Initial Steps

1. Knock and enter
2. Greet examiner:
   "Hello, I'm Dr [Name], GMC number [XXXXX]. I've taken universal precautions and ensured the scene is safe."
3. Greet patient and confirm identity:
   "Hello, I'm one of the doctors here today. Could I confirm your full name and age please?"

4. Acknowledge and explain situation:
   "I understand you're feeling short of breath. I'll assess you right away. It may be a reaction to something you were recently given — I'll explain everything as I go."

If the patient can speak – take focused history quickly

- ODIPARA for breathlessness
- Associated symptoms: chest pain, cough, fever, leg swelling
- Recent medications, allergies, catheter timing (if present)

If patient cannot talk in full sentences:
"You're too breathless to talk right now. Let me stabilise you first, then I'll return to ask more."

A – Airway

- "Airway is partially compromised — swelling seen over lips and tongue."
- "I'm calling for immediate help."
- "Stopping all infusions and disconnecting the blood transfusion and urinary catheter — keeping IV access in place."
- "Giving 0.5 mL intramuscular adrenaline, 1:1000 concentration, into the mid-thigh."
- "Starting high-flow oxygen at 15 litres per minute via non-rebreather mask."
- To the patient:
  "You're having a severe allergic reaction, likely to something you were given. I've given you adrenaline and oxygen to help you breathe better and support your blood pressure."

B – Breathing

- "RR is 13. SpO_2 is 86% initially. Using accessory muscles."
- "On auscultation: bilateral wheezing."
- "Administering nebulised salbutamol 5 mg via oxygen-driven nebuliser at 6 L/min."
- "Requesting urgent chest X-ray and arterial blood gas."
- **Reassessing airway swelling and vitals:**
  "It's been approximately 5 minutes since the first adrenaline dose.
  If swelling persists or BP remains low, I will repeat 0.5 mL IM adrenaline."
- To the patient:
  "I'm monitoring your breathing closely. If you don't improve soon, I'll give another dose of adrenaline."

C – Circulation

- "HR 105, BP 90/50, capillary refill delayed."
- "Inserting two large-bore IV cannulas."
- "Laying the patient flat and elevating the legs to improve blood flow."
- "Starting IV normal saline, 500 mL over 15 minutes."
- "Requesting bloods: FBC, U&E, CRP, clotting, LFTs, tryptase, and ECG."

D – Disability

- "Patient is alert. Blood glucose is 6.0. Pupils equal and reactive."
- "Rechecking BP. If still low, administering a second IV fluid bolus of 500 mL over 15 minutes."

E – Exposure

- "Examining abdomen, limbs, and catheter site. Widespread urticarial rash noted."
- "Administering intravenous chlorpheniramine 10 mg to manage histamine release."

- "Re-covering the patient to maintain warmth and dignity."

Patient Explanation (After Stabilisation)

"Mr.X, you had a serious allergic reaction — what we call an anaphylactic reaction — likely to something you were recently given, such as the blood transfusion or equipment used during your care. This caused your blood pressure to drop and your breathing to become difficult.
I gave you an injection of adrenaline, oxygen, fluids, and some medication to calm the allergic response. You're stable now, but we'll be admitting you to a higher level of care for observation.
We've also taken a blood sample to confirm the cause and will report this to the safety team. You'll be referred to an allergy specialist so this never happens again. You did the right thing by alerting the nurse quickly."

SBAR Handover

S – Situation
"60-year-old post-op male developed acute shortness of breath and hypotension 15 minutes after blood transfusion."
B – Background
"He underwent abdominal surgery earlier today. No documented allergies. Received pain medication, IV fluids, and blood just prior to this event."
A – Assessment
"Airway: Tongue and lip swelling.
Breathing: SpO_2 86%, RR 13, wheeze present.
Circulation: HR 105, BP 90/50, CRT delayed.
Disability: Alert, glucose 6.0.
Exposure: Rash over torso.
IM adrenaline 0.5 mL given, oxygen started, salbutamol nebulised, IV fluids commenced. All medications and transfusion stopped. ABG, CXR, tryptase, ECG requested."
R – Recommendation
"Admit to high-dependency or critical care.
Repeat adrenaline as needed.
Monitor closely for biphasic reaction.
Send blood sample for cross-match and full documentation.
Complete incident form.
If allergic to catheter, ensure latex-free alternatives are used in future.
Refer to allergy clinic after recovery."

Acute Heart Failure (with AF)

Where you are: FY2 doctor in A&E
Who the patient is: 65-year-old male presenting with dizziness, palpitations, and shortness of breath
Monitor findings:
SpO_2: 86%
HR: 120 bpm
BP: 110/65
RR: 20
Temp: 36°C
Lead II: Atrial fibrillation
Position: Patient in semi-sitting position
Past medical history: Hypertension

Initial Steps

1. Knock and enter
2. Greet examiner:
   "Hello, I'm Dr [Name], GMC number [XXXXX]. I've taken universal precautions and ensured the scene is safe."
3. Greet patient and confirm identity:
   "Hello, I'm one of the doctors here today. Could I confirm your full name and age please?"
4. Acknowledge the situation:
   "You look quite breathless and dizzy — I'll assess you and treat you as we speak."

If the patient can talk – take focused history early while beginning assessment

"Can I ask a few quick questions while I examine you?"

- **ODIPARA** for dizziness, palpitations, and breathlessness
- Associated symptoms: orthopnoea, PND, chest pain, fainting, leg swelling, calf pain
- Past medical history, medications, allergies (hypertension)
- Confirm patient is in semi-sitting position

A – Airway

- "Patient is talking — airway is patent."
- "Inspecting oral cavity — no obstruction or swelling."
- "Starting oxygen at 15 litres per minute via non-rebreather mask."

B – Breathing

- "RR 20, SpO_2 86%. Observing chest wall movement."
- "On auscultation: bilateral basal crackles present — likely pulmonary oedema."
- "Inserting a large-bore IV cannula."
- "Administering IV furosemide 40 mg slowly."
- "Requesting chest X-ray and performing arterial blood gas."
- *If patient appears distressed*:
  "Administering 2.5 mg IV morphine with caution and monitoring closely."
- To the patient:
  "You've developed fluid on the lungs, which is why your breathing is difficult. I'm giving medication to help your body remove the excess fluid."

C – Circulation

- "HR 120, BP 110/65, CRT under 2 seconds."
- "Lead II shows atrial fibrillation."
- "Sending bloods: FBC, U&E, LFTs, troponin, BNP, D-dimer, and clotting."
- "Requesting 12-lead ECG."
- **Reassess circulation**:
  "Patient remains symptomatic and systolic BP remains above 90 mmHg, I will administer 2 puffs of glyceryl trinitrate (GTN) sublingually."
- To the patient:
  "Your heart is in an irregular rhythm, which may be contributing to your symptoms. We're working to stabilise your heart rate and blood pressure now."

D – Disability

- "Patient is alert. Blood glucose is 5.8 mmol/L. Pupils are equal and reactive."
- "Temperature is 36°C."

E – Exposure

- "Examining abdomen and lower limbs for oedema, and signs of fluid overload."
- "Evidence of leg swelling noted."
- "Inserting urinary catheter for fluid balance monitoring."

SBAR Handover

S – Situation

"This is a 65-year-old man presenting with dizziness, palpitations, and breathlessness."

B – Background

"Known hypertension. Symptoms began earlier today. ECG shows AF. Basal crackles present on auscultation. Hypoxia on arrival."

A – Assessment

"Airway is patent.
Breathing: SpO_2 86%, RR 20, bibasal crackles.
Circulation: HR 120, BP 110/65, AF on ECG.
Disability: Alert, GCS 15, glucose 5.8.
Exposure: Leg swelling noted.
Given oxygen, IV furosemide, morphine if required. Bloods sent, chest X-ray and ABG done. Catheter inserted."

R – Recommendation

"Admit under medical team.
Request transthoracic echocardiogram.
Discuss rate control and rhythm control with cardiology — likely to start digoxin.
Start anticoagulation depending on stroke risk (e.g., CHA_2DS_2-VASc).
Continue monitoring fluid output and oxygenation.
Provide safety netting and explain further management to patient."

Heart Failure (Chronic, Referred by GP)

Where you are: FY2 doctor in A&E
Who the patient is: 65-year-old male referred by GP due to worsening shortness of breath
Monitor findings:
SpO_2: 98%
HR: 90 bpm
BP: 130/65
RR: 14
Temp: 36°C
Lead II: Atrial fibrillation
Position: Patient is in semi-sitting position
Past medical history: Rheumatic heart disease

Initial Steps

1. Knock and enter

2. Greet examiner:
   "Hello, I'm Dr [Name], GMC number [XXXXX]. I've taken universal precautions and ensured the scene is safe."
3. Greet patient and confirm identity:
   "Hello, I'm one of the doctors here today. Could I confirm your full name and age please?"
4. Acknowledge the situation:
   "I understand you've been referred here due to breathing difficulties. I'll assess you now and explain everything as we go."

Take Focused History (while beginning assessment)

"Let me ask a few quick questions while I examine you."

- **ODIPARA** for breathlessness: On and off for months, now worsening on exertion
- Associated symptoms: chest pain, cough, fever, orthopnoea, PND, calf swelling
- Past medical history: Rheumatic heart disease
- Medications, allergies
- Confirm patient in semi-sitting position

A – Airway

- "The patient is speaking in full sentences. No signs of airway obstruction."
- "Mouth and airway are clear."

B – Breathing

- "RR 14, SpO_2 98% on room air. Chest symmetrical."
- "On auscultation: bibasal crackles heard, consistent with pulmonary congestion. A systolic murmur is also audible."
- "Inserting a large-bore IV cannula and administering IV furosemide 40 mg slowly."
- "Requesting chest X-ray and arterial blood gas."
- To the patient:
  "It seems like there's some fluid buildup in your lungs, likely related to your heart condition. I'm giving a medication to help reduce that fluid."

C – Circulation

- "Pulse is 90 and irregularly irregular. BP 130/65. CRT under 2 seconds."
- "Lead II confirms atrial fibrillation."
- "Sending bloods: FBC, U&E, LFTs, CRP, BNP, troponin, D-dimer, and clotting profile."
- "Requesting a 12-lead ECG."

D – Disability

- "Patient is alert. Blood glucose 6.0. Pupils equal and reactive."
- "Temperature 36°C — no evidence of infection."

E – Exposure

- "Examining abdomen and lower limbs — peripheral oedema noted bilaterally."
- "No signs of rash or surgical scars."
- "Inserting urinary catheter to monitor fluid output."

SBAR Handover

S – Situation
"65-year-old male referred by GP for worsening shortness of breath."
B – Background
"History of rheumatic heart disease. Symptoms suggest progressive heart failure. Now has signs of fluid overload and AF on monitor."
A – Assessment
"Airway patent.
Breathing: Bibasal crackles, RR 14, SpO_2 98%.
Circulation: HR 90 (AF), BP 130/65, CRT normal.
Disability: Alert, glucose 6.0, temp 36°C.
Exposure: Leg swelling.
Given IV furosemide. Chest X-ray, ABG, and full bloods requested. Catheter inserted."
R – Recommendation
"Admit under medical team.
Request urgent transthoracic echocardiogram to assess valvular function.
Involve senior and cardiology team.
Discuss long-term heart failure management and anticoagulation for AF."

Patient Explanation – If asked

"Mr. Allen, from what I've gathered, your symptoms are most likely due to heart failure — this means your heart isn't pumping blood as efficiently as it should. Based on your history of rheumatic heart disease and the murmur I heard on examination, it's possible that one or more of your heart valves are affected.
We're giving you medication to reduce the fluid buildup in your lungs and legs. I've also arranged an ultrasound scan of your heart and some blood tests. You'll need to stay in the hospital for further treatment and monitoring. Depending on what we find, you may need medications to help your heart pump better and to manage your heart rhythm. You're stable right now, and we'll keep you informed every step of the way."

Haematemesis

Where you are: FY2 doctor in the Gastroenterology department
Who the patient is: A 50-year-old man presenting with vomiting blood
Monitor findings:
SpO_2: 90%
BP: 80/55
HR: 120 bpm
RR: 30
Temp: 37°C
Lead II: Sinus rhythm
Position: Semi-sitting
Visual cue: Kidney dish full of fresh blood next to patient
Background: Had an upper GI endoscopy 2 days ago

Initial Steps

1. Knock and enter

2. Greet examiner:
   "Hello, I'm Dr [Name], GMC number [XXXXX]. I've taken universal precautions and ensured the scene is safe."
3. Greet patient and confirm identity:
   "Hello, I'm one of the doctors here today. Could I confirm your full name and age please?"
4. Acknowledge the situation:
   "You've been vomiting blood — I'm going to assess and treat you immediately."

If patient can speak – take focused history quickly

"Can I ask a few questions while I examine you?"

- **ODIPARA + TRAC** for haematemesis
- Associated symptoms: abdominal pain, black stools, bleeding elsewhere
- Ask about the recent endoscopy: indication, findings, interventions
- MMA: especially anticoagulants or NSAIDs
- Confirm semi-sitting position

If patient cannot speak in full sentences:
"I'll focus on stabilising you first, then return for questions."

A – Airway

- "Airway is patent, but I'm checking for blood or clots in the mouth."
- "Oral cavity shows fresh blood. No active choking."
- "Starting oxygen via nasal cannula at 4 L/min."
- "Explaining to patient: 'You're losing blood quickly — I'm giving you oxygen to help your body cope.'"

B – Breathing

- "RR is 30. SpO_2 is 90%. On auscultation: breath sounds equal bilaterally, no crepitations."
- "Ordering urgent chest X-ray and arterial blood gas to assess oxygenation and acid-base status."

C – Circulation

- "Pulse is 120, BP is 80/55, CRT is delayed — this indicates hypovolaemic shock."
- "Activating the major haemorrhage protocol immediately."
- "Inserting two large-bore IV cannulas."
- "Sending urgent bloods: FBC, U&E, LFTs, clotting profile, crossmatch, group and save, and lactate."
- "Starting 500 mL IV crystalloid fluid over 15 minutes."
- "Requesting 4 units of O-negative blood to transfuse one unit every 10 minutes once available."
- "Requesting a 12-lead ECG to assess for ischaemia or arrhythmia."
- To the patient:
  "You've lost a significant amount of blood, and I've activated our emergency protocol. We're starting fluids now and preparing for a transfusion to stabilise you."

D – Disability

- "Patient is alert. GCS 15. Blood glucose is 6.2 mmol/L. Pupils equal and reactive."
- "Temperature is 37°C."
- **Reassess BP**:
  "If blood pressure remains low, I will administer a second 500 mL IV fluid bolus."

E – Exposure

- "Examining abdomen — soft, mild tenderness in epigastrium."

- "No signs of external bleeding. No rash."
- "Examining lower limbs and groin for petechiae or other bleeding signs."
- "Inserting a urinary catheter to monitor output and guide resuscitation."

SBAR Handover

S – Situation
"50-year-old male presenting with acute haematemesis and haemodynamic instability."
B – Background
"Had an upper GI endoscopy 2 days ago — unclear indication or findings. Now vomiting fresh blood. No known comorbidities yet identified."
A – Assessment
"Airway patent with blood in mouth.
Breathing: RR 30, SpO_2 90%, equal chest sounds.
Circulation: HR 120, BP 80/55, CRT delayed. Two IV lines in. Fluids started. Major haemorrhage protocol activated.
Disability: Alert, glucose 6.2.
Exposure: Abdomen tender, catheter inserted.
Bloods, ABG, CXR, and ECG all requested. O-negative blood en route."
R – Recommendation
"Admit under gastroenterology and escalate for urgent endoscopy.
Prepare for possible repeat endoscopic control of bleeding.
Crossmatch and initiate blood transfusion as per protocol.
Continue haemodynamic monitoring.
Ensure clear documentation and discussion with senior."

Patient Explanation– If needed

"Mr. X, you've had a serious bleed from your upper digestive tract — this can happen after endoscopy, especially if a blood vessel was fragile or irritated.
You've lost a lot of blood, which is why you're feeling dizzy and breathless. I've started oxygen and fluids, and we've called for urgent blood transfusion.
We'll arrange another scan of your stomach using a camera to find the source of bleeding and treat it. You'll be admitted for close monitoring and further care. You're stable for now, and we'll stay with you throughout."

Postpartum Haemorrhage

Where you are: FY2 doctor in Obstetrics and Gynaecology
Who the patient is: 35-year-old woman, 1 hour post-vaginal delivery, now bleeding
Monitor:
SpO_2: 88%
BP: 77/50
HR: 120 bpm
RR: 30
Temp: 37°C
Lead II: Sinus rhythm
Setting: Blood-soaked pad visible; patient in semi-sitting position
Background: 5th delivery, placenta delivered, no medical conditions

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Initial Steps

1. Knock and enter
2. Greet examiner:
   "Hello, I'm Dr [Name], GMC number [XXXXX]. I've taken universal precautions and ensured the scene is safe."
3. Greet and identify patient:
   "Hello, I'm one of the doctors here today. May I confirm your full name and age?"
4. Acknowledge the scenario:
   "You're having quite a bit of bleeding. I'm going to assess and manage this right away and explain everything I do."

Focused History (if the patient can speak)

"While I assess you, may I ask a few quick questions?"

- **ODIPARA**: Onset, Duration, Intensity, Progression, Associated symptoms, Relieving/Aggravating factors
- **TRAC** for bleeding: trauma, retained placenta, anticoagulants, clots
- 4Ts:
  - **Tone**: Prolonged labour? Twins? Uterine massage done yet?
  - **Tissue**: Was the placenta complete?
  - **Trauma**: Any forceps/tears?
  - **Thrombin**: Any history of bleeding disorder or medications?
- MMA: Medications, Medical history, Allergies
- Confirm she is in semi-sitting position

If patient is too breathless or drowsy:
"Let me stabilise you first, and I'll ask more questions once you're feeling better."

A – Airway

- "The patient is conscious and speaking — airway is patent."
- "Inspecting oral cavity — no obstruction or bleeding noted."
- "SpO_2 88%. Starting oxygen at 15 litres per minute via a non-rebreather mask."

B – Breathing

- "RR 30, Chest movement is symmetrical."
- "Auscultation: breath sounds equal bilaterally."
- "Ordering chest X-ray and arterial blood gas."

C – Circulation

- "Pulse is 120 bpm, BP 77/50 mmHg, CRT is delayed — patient is in hypovolaemic shock."
- "Activating **major haemorrhage protocol**."
- "Inserting **two large-bore IV cannulas**."
- "Sending urgent bloods: FBC, U&E, LFTs, CRP, clotting profile, group and save, crossmatch, and lactate."
- "Starting **500 mL crystalloid IV fluid bolus over 15 minutes**."
- **Localise source**:
  "Confirming vaginal bleeding is ongoing."
  "Uterus feels enlarged and boggy → tone is poor → uterine atony confirmed."
- **Immediate treatment**:
  - **Administer IV oxytocin 10 units slowly over 2–3 minutes**
  - **Begin uterine massage immediately**

    - **Administer tranexamic acid 1 gram IV over 10 minutes**, then **prepare second 1g over 8 hours**
- "Ordering **4 units of O-negative blood**, to be transfused at 1 unit every 10 minutes once available."
- "Requesting a 12-lead ECG to assess for ischaemia or arrhythmia."

D – Disability

- "Patient is alert. GCS 15. Blood glucose 6.1 mmol/L. Pupils equal and reactive."
- "Rechecking BP after initial bolus:
  If still low, administering another **500 mL IV fluid** over 15 minutes."

E – Exposure

- "Examining abdomen and perineum — uterus is soft and enlarged, no visible lacerations or trauma noted externally."
- "Inserting a **urinary catheter** to monitor output and guide ongoing resuscitation."
- "Keeping patient covered to prevent hypothermia."

SBAR Handover (If asked)

S – Situation
"I'm Dr [Name], managing a 35-year-old woman, Mrs. Jefferson, who is 1 hour post-vaginal delivery and now experiencing heavy vaginal bleeding."
B – Background
"This was her 5th delivery. Placenta was delivered completely. No medical conditions. No history of bleeding disorders or allergies."
A – Assessment
"Airway is patent.
Breathing: RR 30, SpO_2 88%.
Circulation: HR 120, BP 77/50, uterus boggy.
Disability: Alert, glucose 6.1.
Exposure: Heavy bleeding confirmed.
She received 100% oxygen, 500 mL IV fluids, **10 units IV oxytocin**, **1 gram tranexamic acid**, uterine massage, and major haemorrhage protocol was activated. Bloods and crossmatch sent. ECG requested."
R – Recommendation
"Continue fluid and blood resuscitation.
Urgent obstetric review for escalation.
If no response, consider bimanual compression, intrauterine balloon tamponade, or surgical interventions.
Request urgent ultrasound to check for retained products."

Patient Explanation – If needed

"Mrs. X, you're experiencing **postpartum haemorrhage**, which means heavier bleeding than expected after delivery. This can happen when the womb doesn't contract properly.
To help you, I've given you medication to stop the bleeding, performed a massage to help the womb tighten, and started fluids and oxygen to support you. We've called the senior team and are preparing for a blood transfusion to replace what you've lost.
We're closely monitoring you and will act quickly if more treatment is needed — you're in safe hands."

Post-Hysterectomy Hypotension

Where you are: FY2 doctor in Obstetrics and Gynaecology
Who the patient is: 58-year-old woman, 1 hour post-hysterectomy, now hypotensive and desaturating

Monitor Observations

- **SpO_2**: 90%
- **BP**: 80/55 mmHg
- **HR**: 120 bpm
- **RR**: 30
- **Temp**: 36°C
- **Lead II**: Sinus rhythm
- **Setting**: Nurse has called for help; patient alert but pale in post-op bed

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Initial Steps

1. Knock and enter
2. Greet examiner:
   "Hello, I'm Dr [Name], GMC number [XXXXX]. I've taken universal precautions and ensured the scene is safe."
3. Greet patient and confirm identity:
   "Hello, I'm one of the doctors here today. Could I confirm your full name and age please?"
4. Acknowledge the situation:
   "I understand your blood pressure and oxygen levels have dropped. I'm going to assess you right away and explain what I'm doing."

Focused History (if responsive)

"While I examine you, is it alright if I ask you a few quick questions?"

- **ODIPARA**: "Have you had any pain since the surgery? When did it start? Has it been getting worse?"
- **Bleeding symptoms**: "Have you noticed any bleeding or dizziness?"
- **Breathlessness or chest symptoms**: "Any shortness of breath, chest pain, or cough?"
- **DVT/PE screen**: "Any leg swelling or calf pain?"
- **MMA**: "Are you on any regular medications or blood thinners? Any other medical conditions or allergies?"

If the patient is **drowsy or breathless**:
"I'll stabilise you first, and then ask more questions once you're feeling better."

A – Airway

- "The patient is conscious and speaking — airway is patent."
- "No obstruction noted on oral inspection."
- "Oxygen saturation is low → starting 100% oxygen via non-rebreather mask at 15 L/min."
- **Reassess SpO_2** after oxygen delivery.

B – Breathing

- "Respiratory rate is 30. Chest expands equally on both sides."
- "On auscultation, breath sounds are equal bilaterally, no added sounds."
- "Ordering **chest X-ray and ABG** to assess for hypoxia or possible aspiration."
- **Reassess RR and SpO_2** after oxygen and chest exam.

C – Circulation

- "HR 120, BP 80/55, CRT >2s — this suggests **hypovolaemic shock**."
- "Activating **major haemorrhage protocol**."
- "Inserting **two large-bore IV cannulas** (14–16G)."
- "Sending urgent bloods: **FBC, U&E, LFT, CRP, clotting profile, group and save, crossmatch, lactate.**"

- "Starting **500 mL of crystalloid IV fluid** over 15 minutes."
- "Checking **surgical site** for signs of bleeding or wound discharge."
- "Ordering **4 units of O-negative blood** — will transfuse at **1 unit every 10 minutes** as soon as available."
- "Requesting **12-lead ECG** to rule out any myocardial cause or arrhythmia."
- **Reassess pulse, BP, and CRT** after fluid bolus.

D – Disability

- "Patient is alert and oriented. **GCS 15.**"
- "Checking pupils — equal and reactive. Capillary blood glucose is 6.5 mmol/L."
- **Reassess BP** after first fluid bolus. If still low:
  "Administering **second 500 mL crystalloid bolus** over 15 minutes."

E – Exposure

- "Inspecting surgical dressing and abdomen for signs of **internal or concealed bleeding**."
- "Checking legs and groin for DVT or signs of haematoma."
- "Inserting a **urinary catheter** to monitor urine output."
- "Keeping patient warm and covered to avoid hypothermia."
- **Reassess surgical site and output** during reassessment.

SBAR Handover (if asked)

S – Situation:
"I'm Dr [Name], managing a 58-year-old patient who is hypotensive and desaturating post-hysterectomy."
B – Background:
"Surgery was completed an hour ago. Nurse noted a sudden drop in BP and called for review. No significant past medical history."
A – Assessment:
"Airway: patent.
Breathing: RR 30, SpO_2 90%.
Circulation: HR 120, BP 80/55, CRT >2s.
Disability: GCS 15, glucose 6.5.
Exposure: No overt external bleeding, surgical site inspected. Major haemorrhage protocol activated. Fluids and bloods sent. O_2 and crystalloid started."
R – Recommendation:
"Request **urgent obstetric review**.
Prepare for **possible return to theatre** if internal bleeding suspected.
Request **urgent abdominal ultrasound** or imaging if source unclear.
Continue **close haemodynamic monitoring** and transfusion as per protocol."

Patient Explanation – If needed

"Mrs. X, your blood pressure has dropped and your oxygen level is slightly low after surgery. This can occasionally happen due to internal bleeding or fluid loss.
We've started you on oxygen and IV fluids and sent urgent blood tests. We've also activated an emergency protocol to arrange for a blood transfusion. I've asked the senior obstetrics team to review you quickly, and we may need to do further imaging or even surgery depending on how you respond.
You're in safe hands and we're keeping a very close eye on everything."

Bleeding on Warfarin

Where you are: FY2 doctor in Emergency Department
Who the patient is: 32-year-old man presenting with per rectal bleeding while on warfarin
Setting: Patient alert, pale, in bed with pad soaked in fresh blood
Monitor:

- SpO_2: 89%
- BP: 80/55 mmHg
- HR: 110 bpm
- RR: 30
- Temp: 36°C
- Lead II: Atrial Fibrillation (AF)

Initial Steps

5. Knock and enter
6. Greet examiner:
   "Hello, I'm Dr [Name], GMC number [XXXXX]. I've taken universal precautions and ensured the scene is safe."
7. Greet patient and confirm identity:
   "Hello, I'm one of the doctors here today. Could I confirm your full name and age please?"
8. Acknowledge the situation:
   "You've had quite a bit of bleeding, and your blood pressure is low. I'm going to assess and stabilise you right away and explain everything I'm doing."

Focused History (if patient can respond)

"While I check you, I'd like to ask a few quick questions to understand what's going on."

- **ODIPARA** for PR bleeding: Onset, Duration, Intensity, Progression, Aggravating/Relieving factors, Associated symptoms
  → "When did the bleeding start? Was it sudden or gradual? Any pain or cramps?"
- **TRAC**: Trauma, Recent procedures, Anticoagulants, Clots
  → "Any straining or constipation recently? Any clots in the stool?"
- **Associated symptoms**:
  → "Any abdominal pain, vomiting, or bleeding from your mouth, nose, or urine?"
- **Recent history**:
  → "You had a colonoscopy 2 weeks ago — did they mention anything?"
- **MMA**:
  → "Are you taking any blood thinners like warfarin? Any other medications, medical problems, or allergies?"

If patient becomes drowsy or breathless:
"Let me stabilise you first, then I'll come back for more questions."

A – Airway

- "Patient is talking → airway is patent."
- "Inspecting oral cavity — no blood or obstruction."
- "SpO_2 is low — starting **100% oxygen via non-rebreather mask at 15 L/min**."
- **Reassess SpO_2** after oxygen delivery.

B – Breathing

- "RR 30. Chest expands symmetrically."
- "On auscultation, breath sounds equal with no added sounds."
- "Ordering **chest X-ray** and **ABG** to assess for respiratory compromise or hypoxia."
- **Reassess RR and oxygenation**.

C – Circulation

- "HR 110, BP 80/55, CRT >2s — patient is in **hypovolaemic shock**."
- "Activating **major haemorrhage protocol**."
- "Inserting **2 large-bore IV cannulas** (14G)."
- "Sending urgent bloods: **FBC, U&E, LFT, CRP, clotting profile, INR, group and save, crossmatch, lactate**."
- "Exploring **PR bleeding site** to confirm ongoing active bleed."
- "Starting **500 mL IV crystalloid** over 15 minutes."
- "Ordering **4 units O-negative blood**, transfusing **1 unit every 10 minutes**."
- "Administering **IV Vitamin K 5 mg** and **Prothrombin Complex Concentrate (PCC) 50 units/kg** immediately."
- "Requesting **12-lead ECG** to monitor for ischaemia or AF-related instability."
- **Reassess pulse, BP, and CRT** after fluid and PCC/Vit K administration.

D – Disability

- "Patient alert and speaking. **GCS 15.**"
- "Pupils equal and reactive. Blood glucose: 6.0 mmol/L."
- **Reassess BP** after initial fluid bolus.
- "Still hypotensive, administering **second 500 mL IV fluid** over 15 minutes."

E – Exposure

- "Inspecting perineal region — pad soaked with bright red blood → ongoing PR bleeding."
- "Abdomen: soft, no distension or peritonism."
- "Legs: no swelling or signs of DVT."
- "Inserting **urinary catheter** to monitor urine output as part of resuscitation."
- "Ensuring patient is kept warm with blankets to prevent hypothermia."

SBAR Handover (if asked)

S – Situation:
"I'm Dr [Name], managing a 32-year-old man with major PR bleeding on warfarin, now hypotensive and desaturating."
B – Background:
"He is on warfarin for atrial fibrillation. Colonoscopy 2 weeks ago showed diverticular disease. No known allergies."
A – Assessment:
"Airway: patent.
Breathing: RR 30, SpO_2 89%.
Circulation: HR 110, BP 80/55, active PR bleeding.
Disability: Alert, glucose 6.
Exposure: No external trauma, visible PR bleeding, abdomen soft.

He has received oxygen, IV fluids, 5 mg IV vitamin K, and PCC. Bloods and crossmatch sent. Major haemorrhage protocol activated."
R – Recommendation:
"Urgent review by **surgical and haematology teams**.
Consider imaging or **urgent colonoscopy** if bleeding continues.
Recheck INR and **coagulation profile in 15 minutes**.
Stop warfarin and reassess haemodynamic status continuously."

Patient Explanation – if needed

"Mr. X, you're having significant bleeding from your back passage, and since you're on warfarin — a blood thinner — that's likely made the bleeding worse.
We've given you oxygen, started IV fluids, and have given medication to reverse the effects of warfarin. Blood has been sent for urgent tests, and we've activated our emergency protocol to prepare for a blood transfusion.
We've also called the specialist teams to help decide the next steps. You're being monitored very closely, and we're doing everything to control the bleeding and keep you safe."

Acute Limb Ischaemia (ALI)

Where you are: FY2 doctor in A&E
Who the patient is: 55-year-old man with severe right leg pain since this morning
Monitor:

- SpO_2: 99%
- BP: 120/80 mmHg
- HR: 110 bpm
- RR: 24
- Temp: 36°C
- Lead II: Atrial Fibrillation (AF)

Initial Steps

9. Knock and enter
10. Greet examiner:
    "Hello, I'm Dr [Name], GMC number [XXXXX]. I've taken universal precautions and ensured the scene is safe."
11. Greet patient and confirm identity:
    "Hello, I'm one of the doctors here today. Could I confirm your full name and age please?"
12. Acknowledge the situation:
    "I understand you're in a lot of pain in your right leg — I'll assess you quickly and start treatment to make you more comfortable."

Focused History (while preparing resus)

"While I get things started, I'll ask a few quick questions."

- **SOCRATES** for pain:
  → "When did the pain start?"
  → "Is it sharp or dull? Constant or does it come and go?"
  → "Does it radiate anywhere?"
  → "What makes it worse or better?"
  → "How severe is the pain out of 10?"

- **Associated symptoms & differential screening**:
  → "Any swelling, bruising, or trauma to the leg?"
  → "Have you travelled recently or been immobile for long periods?"
  → "Any numbness, weakness, or change in leg colour?"
  → "Able to walk this morning?"
  → "Any past DVT or vascular issues?"
- **MMA**:
  → "Do you take any regular medications — especially blood thinners?"
  → "Any medical problems like diabetes, heart conditions?"
  → "Any allergies?"
- **Smoking history**:
  → "Do you smoke or have you smoked in the past?"

A – Airway

- "Patient is speaking full sentences — airway is patent."
- "No obstruction seen on inspection."
- "SpO_2 is 99% but due to critical limb threat, starting **15L 100% oxygen via non-rebreather mask** as per emergency protocol."

B – Breathing

- "RR 24. Chest expansion is symmetrical."
- "Auscultation: breath sounds equal and clear."
- "Ordering **chest X-ray** to look for cardiac pathology or fluid overload."
- "Requesting **ABG** to assess metabolic acidosis or shock."
- **Reassess RR and breath sounds** after oxygen delivery.

C – Circulation

- "HR 110, BP 120/80, CRT <2s, Lead II: Atrial fibrillation."
- "Assessing affected limb for vascular compromise."
  - "**Dorsalis pedis pulse is absent** on the right leg. Going proximally to locate pulse."
  - "6 Ps:
    - Pain
    - Pallor
    - Pulselessness
    - Paralysis — 'Can you wiggle your toes?'
    - Paraesthesia — 'Do you feel numbness or tingling?'
    - Perishing cold — comparing both legs' temperature with back of hand"
- "Diagnosis: **Acute Limb Ischaemia**, likely due to **embolic occlusion** from AF."
- "Inserting **2 large-bore IV cannulas**."
- "Sending urgent bloods: **FBC, U&E, LFT, CRP, clotting, glucose, lactate, group and save**."
- "Administering:
  - **Unfractionated Heparin 5000 units IV bolus**
  - **IV Morphine 5 mg** for pain
  - **12-lead ECG** to assess ongoing AF or cardiac strain"
- **Reassess pain and circulation after morphine and heparin**.

D – Disability

- "Patient alert and oriented. GCS 15."

- "Pupils equal and reactive."
- "Blood sugar: 6.3 mmol/L"
- **No neurological signs in upper limbs**
- "No focal deficit apart from right leg findings"

E – Exposure

- "Exposing and inspecting entire lower body and abdomen."
- "Abdomen soft, no pulsatile mass."
- "No signs of trauma."
- "No groin swelling or signs of DVT."
- "Private area and both legs inspected — right leg pale, cold, pulseless; left leg warm and pink."

SBAR Handover (if requested)

S – Situation:
"I'm Dr [Name], managing a 55-year-old man presenting with sudden onset of severe right leg pain."
B – Background:
"He has atrial fibrillation and is not on anticoagulants. No known allergies. No recent trauma or surgery."
A – Assessment:
"6 Ps suggest acute arterial occlusion.
Vitals: HR 110, BP 120/80, SpO_2 99%.
No distal pulses in right leg.
Heparin 5000 units IV given. Oxygen, morphine, and IV access initiated. ECG ordered."
R – Recommendation:
"Urgent **vascular surgery referral**.
Likely requires arterial Doppler and intervention — embolectomy, angioplasty, or thrombolysis.
Please advise if further imaging or prep is needed while we wait."

Patient Explanation – if needed

"Mr. X, your symptoms and examination suggest a **sudden blockage of blood flow to your leg**, which is why you're in so much pain and it feels cold and numb.
This is an emergency called **Acute Limb Ischaemia**, and we're already giving you strong blood thinners, pain relief, and oxygen to protect your leg. We're urgently calling the vascular team — they may need to do a scan and possibly surgery to restore the blood flow.
I know this is scary, but we're doing everything we can. The earlier we treat this, the better the chance of saving the leg."

Postoperative Pain Management

Where you are: FY2 doctor in the Obstetric Ward
Who the patient is: 35-year-old woman, 8 hours post elective caesarean section for twins
Monitor:

- SpO_2: 99%
- BP: 130/70 mmHg
- HR: 95 bpm
- RR: 18
- Temp: 37.4°C
- Lead II: Sinus Rhythm

Initial Steps

1. Knock and enter
2. Greet examiner:
   "Hello, I'm Dr [Name], GMC number [XXXXX]. I've taken universal precautions and ensured the scene is safe."
3. Greet patient and confirm identity:
   "Hello, I'm one of the doctors here today. Could I confirm your full name and age please?"
4. Acknowledge the situation:
   "The nurse mentioned you're in pain after your operation — I'll assess you now and do my best to help."

Focused History (while observing the patient)

Pain analysis using SOCRATES

→ "Can you tell me more about the pain you're having now?"
→ "Where exactly is it?"
→ "When did it start?"
→ "Does it move anywhere?"
→ "What kind of pain is it — sharp, cramping, constant?"
→ "How bad is it on a scale of 1 to 10?"
→ "Does anything help or worsen it?"

Screening for complications and differentials

→ "Have you had any fever or chills?"
→ "Are you able to pass urine normally?"
→ "Any difficulty opening your bowels or any bloating?"
→ "Any unusual vaginal bleeding or discharge?"
→ "Have you noticed any swelling, warmth, or pus from the wound?"

Post-op and breastfeeding context

→ "Were there any complications during delivery?"
→ "Are you breastfeeding both babies okay?"
→ "Any nausea, vomiting, or feeling faint?"

MMA check

→ "Do you take any regular medications?"
→ "Any other medical conditions I should know about?"
→ "Any allergies — especially to painkillers?"

A – Airway

- "Patient is alert, speaking in full sentences — airway is patent."
- "No obstruction noted."
- "SpO_2 is 99% — no oxygen required at this point."

B – Breathing

- "RR 18, no signs of distress."
- "Inspection: chest rising symmetrically."
- "Palpation, percussion, and auscultation: normal breath sounds bilaterally."
- "No signs of atelectasis or chest infection."
- "No clinical indication for chest X-ray or ABG at this stage."

C – Circulation

- "Pulse 95 bpm, BP 130/70, CRT <2s, Lead II: sinus rhythm."

- "Inserting one wide-bore IV cannula for access."
- "Requesting:
    - **FBC, CRP, U&E, LFTs** to rule out infection or anaemia
    - **Clotting profile** if wound concern
    - **Group and save** if bleeding increases"
- "Administering **IV Paracetamol 1g** — safe, effective first-line analgesia in post-Caesarean patients."
- "Explaining to patient: 'This medication is well-tolerated and often helps with pain after surgery. I'll reassess you soon to see if it's working.'"
- "Requesting **12-lead ECG** due to elevated HR and to exclude anaemia-related tachycardia."

D – Disability

- "Pupils equal and reactive."
- "GCS 15, alert and responsive."
- "Capillary blood glucose: 6.2 mmol/L"
- "No signs of neurological deficit."

E – Exposure

- "Fully expose the lower abdomen and inspect the surgical site."
- "Wound:
    - Clean
    - No active bleeding
    - No redness, swelling, or pus"
- "Palpation:
    - Mild tenderness around incision site
    - No rebound tenderness or guarding"
- "Lochia within expected limits."
- "Legs examined — no signs of DVT."
- "Private area examined for signs of haematoma or unusual bleeding."

Reassessment (10–15 minutes later)

- "Checking pain score again — patient reports mild improvement."
- "No new symptoms or instability."
- "Wound still clean. No fever. Vitals stable."
- "Paracetamol tolerated well — will continue regular doses as prescribed."

If Pain Persists

- "Mrs X, I understand you're still in pain. Paracetamol is the safest option after your surgery, especially while breastfeeding."
- "However, if the pain continues or worsens, we may consider **a stronger medication like morphine** — but that will need **senior review** and careful monitoring, as it can cause sleepiness, nausea, or affect breathing."
- "For now, I'll continue to monitor and reassess shortly."

Patient Explanation – if needed

"Mrs Wilson, your operation went well, and from examining you, there's no sign of infection, bleeding, or wound complications. Pain after a caesarean is common, especially as the spinal anaesthetic wears off. We've given you an effective painkiller that's safe during breastfeeding, and I'll keep reassessing you to make sure you're feeling better. If you still feel the pain is too much, we can involve a senior doctor to explore other options — though those need to be used carefully after surgery. You're doing well, and I'll continue to check on you."

Hypoglycaemia (Unconscious Patient)

Scenario Summary

Setting: A&E
Role: FY2 doctor
Patient: 28-year-old male, found unconscious at work, brought in by ambulance
Vitals: SpO_2 98%, BP 120/80, HR 80, RR 16, Temp 36.5
Status: Unconscious
Main concern: Suspected hypoglycaemia

Initial Steps

1. **Knock and Enter**
2. **Greet Examiner**

"Hello, I'm Dr [Name], GMC number [XXXXX]. I've taken universal precautions and ensured the scene is safe."

3. **Confirm Identity (via name tag)**

"I'll check the patient's name band to confirm identity."

4. **Acknowledge Situation**

"I understand the patient was brought in unconscious — I'll assess and stabilise him now."

A – Airway

- Check for obstruction or vomitus
- "Airway appears patent. No obstruction seen."
- *SpO_2 is 98% – oxygen not required at this stage unless signs of compromise emerge*

B – Breathing

- Verbalise: "I will examine the chest: inspection, palpation, percussion, auscultation."
- "Breathing is symmetrical, no added sounds."
- *Order chest X-ray and perform ABG to rule out other causes*
- *Continue monitoring RR*

C – Circulation

- "Checking pulse, BP, capillary refill time – CRT <2 seconds, pulse 80, BP stable."
- "Lead II shows sinus rhythm."
- Insert one wide-bore cannula
- "Taking bloods: FBC, U&E, LFTs, glucose, coagulation profile."
- Request 12-lead ECG

D – Disability

- "Checking pupils – equal and reactive."
- "Checking blood glucose now."
- **If blood glucose < 4 mmol/L**, say:
  "Blood sugar is low. I'll give 200 ml of 10% glucose IV over 15 minutes." *(alternative: 100 ml of 20% glucose)*
- If history suggests alcohol use:
  "To prevent Wernicke's encephalopathy, I'll give 2 vials of IV Pabrinex before glucose."

E – Exposure

- "I will examine the abdomen, groin, and limbs for signs of trauma, rashes, or signs of injection."
- "No abnormal findings noted on general exposure."

Reassessment

- "Rechecking blood glucose after 15 minutes."
- If glucose still < 4 mmol/L and patient remains unconscious:
  "Repeating same dose of glucose over 15 minutes."
- If patient regains consciousness but glucose still < 4:
  "I'll now give oral fast-acting sugar — like glucose gel."
- Once glucose > 4 and patient stable:
  "Giving long-acting carbohydrates — such as 2 biscuits or a glass of milk."

Focused History (once conscious)

- "Now that you're awake, I'd like to ask you a few questions to understand what happened."
- ODIPARA for fainting
- Ask:
  - Recent food intake
  - Missed meals or insulin doses
  - Type of diabetes and current medications
  - Alcohol use
  - Past hypoglycaemia episodes
  - Allergies and chronic conditions

Management Plan

- Admit for observation
- Refer to diabetes team
- Check HbA1c
- Adjust insulin or treatment plan if needed
- Provide patient education on recognising early signs of low blood sugar
- Discuss lifestyle, meal timings, and medication adherence

Patient Explanation (if conscious)

"Your sugar levels were very low when you arrived, which made you faint. We've corrected it now with glucose through a drip. We'll admit you to monitor things closely and ask our diabetes team to review your treatment plan. Once stable, we'll also go through steps to help you prevent this from happening again."

SBAR Handover

S – Situation:
"This is Mr. X, a 28-year-old male, brought in unconscious by ambulance. Initial observations were stable except for a very low blood glucose."
B – Background:
"No known history available initially. Now partially alert. He was found collapsed at work and is known to be diabetic according to ambulance staff. No trauma evident."
A – Assessment:
"Airway is patent, breathing is normal, cardio vascularly stable. Capillary blood glucose was <4 mmol/L. He received 200 ml of 10% glucose IV. He is now regaining consciousness and repeat sugar is improving."

R – Recommendation:
"I've initiated treatment and he's stabilising. I'd recommend admitting him under the medical team for monitoring, full diabetic work-up, and a diabetes nurse review. I'll also arrange for HbA1c and check for any precipitating causes."

Hypoglycaemia – Scenario 2

Where you are: FY2 in Emergency Department
Who the patient is: Mr X, 28-year-old male, brought in unconscious by ambulance after fainting at work. Nurse has seen him and ABG showed low glucose. Cannula already inserted.
Task: Assess and manage the patient. At the 2-minute bell, hand over to the examiner.

Initial Steps

1. **Knock and Enter**
2. **Greet Examiner**

"Hello, I'm Dr [Name], GMC number [XXXXX]. I've taken universal precautions and ensured the scene is safe."

3. **Confirm Identity**

"I'll check the patient's name band to confirm identity."

4. **Acknowledge Situation**

"I understand this patient collapsed at work and is currently unconscious. I'll begin immediate assessment and stabilisation."

Immediate Intervention

"Based on the ABG showing hypoglycaemia, I will immediately administer 200 ml of 10% glucose IV over 15 minutes."
(Alternative: 100 ml of 20% glucose IV over 15 minutes, if available.)

ABCDE Assessment

A – Airway

- Check for patency or obstruction.
- Confirm patient is breathing spontaneously without airway compromise.

B – Breathing

- SpO_2 = 98% — acknowledge normal saturation.
- Examine chest: *Inspection, Palpation, Percussion, Auscultation.*
- Order chest X-ray and ABG (though already partially done).

C – Circulation

- HR 80, BP 120/80 → Stable.
- Check capillary refill, pulse volume, ECG monitor (Lead II).
- Request 12-lead ECG to assess for any arrhythmias (e.g. from prolonged hypoglycaemia).
- Confirm IV cannula is patent.
- Request full bloods: FBC, U&E, LFTs, CRP, TFTs, HbA1c, clotting profile.

D – Disability

- Check pupils (size and reaction), GCS, and temperature.
- Blood glucose already confirmed low.
- **Reassess BG after 15 mins**:
    - If still <4 mmol/L **and unconscious** → repeat IV glucose.
    - If now conscious → give oral fast-acting carbohydrate (glucose gel, juice).
- Once BG >4 mmol/L and patient alert → give long-acting carbohydrate (e.g. biscuit, slice of toast, milk).

E – Exposure

- Examine abdomen (rule out signs of infection or trauma).
- Examine legs and groin area for signs of injection marks, skin signs of infection, or trauma.
- Maintain patient's dignity throughout.

Focused History *(once patient regains consciousness)*

"Now that you're awake, I'd like to ask a few quick questions to understand what may have caused this."

- Onset and duration of symptoms before collapse
- Diabetes history: Type 1 or 2?
- Current medications (e.g., insulin, sulfonylureas)?
- Recent missed meals, alcohol use, or increased activity?
- Any similar episodes in the past?
- Any recent infections or illness?
- Social history: support at home, alcohol use
- Allergies and medical history

SBAR Handover to Examiner

S – Situation:

"This is Mr X, 28, brought in unconscious after collapsing at work. He was found hypoglycaemic on ABG."

B – Background:

"No past medical history known yet. Nurse confirmed recent collapse. Cannula already inserted."

A – Assessment:

"ABCDE done. No airway or breathing compromise. Circulation stable. IV 10% glucose 200 ml given. Pupils normal. Blood sugar now improving. Awaiting further results."

R – Recommendation:

"I would admit him, monitor his glucose, request Diabetes Team input, and arrange full blood work including HbA1c. I will explore potential triggers once he's fully alert."

Hypoglycaemia – Post-Fall Elderly Woman

Where you are: FY2 in Emergency Department

Who the patient is: Mrs X, 65-year-old woman. Recently discharged post-fall. Collapsed during physiotherapy after becoming drowsy.

Task: Assess and manage the patient. At the 2-minute bell, hand over to the examiner.

Monitor: SpO_2 98%, BP 120/80, HR 80, RR 16, Temp 36°C

Initial Steps

1. **Knock and Enter**
2. **Greet Examiner**

"Hello, I'm Dr [Name], GMC number [XXXXX]. I've taken universal precautions and ensured the scene is safe."

3. **Confirm Identity**

"I'll check the patient's wristband to confirm her full name and age."

4. **Acknowledge Situation**

"This is a 65-year-old woman who lost consciousness during physiotherapy after recent hospital discharge. I'll begin immediate assessment and stabilisation."

Immediate Action
"Given the likely hypoglycaemia and unconscious state, I will immediately administer 200 mL of 10% glucose IV over 15 minutes."
(If glucose not available, give 1 mg glucagon IM.)

ABCDE Assessment
A – Airway
- Check for obstruction.
- Confirm airway is patent.
- SpO_2 is 98% — no immediate oxygen required, but have 15L non-rebreather mask ready if needed.

B – Breathing
- Inspect for respiratory effort and chest wall movement.
- Palpate for chest expansion.
- Percuss for resonance/dullness.
- Auscultate lung fields bilaterally.
- Order CXR and ABG to rule out pulmonary causes of collapse.

C – Circulation
- HR 80, BP 120/80 — stable.
- Assess CRT, peripheral pulses.
- Insert wide-bore IV cannula (if not already in situ).
- Send routine bloods: FBC, U&E, LFTs, CRP, glucose, clotting, TFTs.
- Request 12-lead ECG.

D – Disability
- Check temperature, pupils (size and reactivity).
- Check GCS if not fully unconscious.
- **Confirm blood glucose <4 mmol/L on capillary test or ABG.**
    - Already treated with IV glucose.
    - Reassess BG after 15 mins.
        - If still <4 and patient remains unconscious → repeat glucose IV.
        - If now conscious → give fast-acting oral sugar (juice/glucose gel).
- Once BG >4 and patient stable → give long-acting carbohydrate (2 biscuits / toast / milk).

E – Exposure
- Examine abdomen: look for tenderness, distension, or signs of infection.
- Examine legs and injection sites (if diabetic).
- Maintain patient warmth and dignity.

Focused History *(after patient is responsive)*
"Now that you're awake, I'd like to ask a few quick questions to help understand what happened."
- History of diabetes?
- Medications: insulin, sulfonylureas?
- Any recent changes to dose or meals skipped today?
- Alcohol use?
- Was she discharged with adequate support at home?
- Last blood sugar reading?
- Similar episodes in past?

Management Plan
- Admit for monitoring and evaluation.

- Arrange **Diabetes Specialist Team review**.
- Request **HbA1c** for long-term glucose control.
- Educate on:
    - Recognising early signs of hypoglycaemia: shakiness, sweating, dizziness, confusion.
    - Safe activity levels during recovery.
    - Importance of meals around medication/physio.
    - Emergency management (glucose gel / glucagon kit if applicable).

SBAR Handover
S – Situation:
"This is Mrs X, 65, recently discharged after a fall. She became drowsy and lost consciousness during physiotherapy today."
B – Background:
"She was admitted earlier for a fall, likely diabetic, possibly on hypoglycaemic medication. Cannula already inserted. ABG showed low glucose."
A – Assessment:
"ABCDE completed. No airway or respiratory issues. Circulation stable. Given 200 ml 10% glucose IV. Blood glucose improving. Awaiting further history and labs."
R – Recommendation:
"Admit under medical team. Diabetes review. Check HbA1c. Educate patient before discharge on safe activity, signs of hypoglycaemia, and medication timing."

Hospital-Acquired Pneumonia

Where you are: FY2 in Acute Medical Unit
Who the patient is: Mr X, 67M, admitted 3 days ago from care home with UTI, recovered and was awaiting discharge. Now suddenly unwell.
Your task: Assess and manage the patient. At 2-minute bell, hand over to examiner.
Vitals: SpO_2 87%, BP 88/50, HR 120, RR 24, Temp 39°C

Initial Approach

1. **Knock and Enter**
2. **Greet Examiner:**

"Hello, I'm Dr [Name], GMC number [XXXXX]. I've taken universal precautions and ensured the scene is safe."

3. **Confirm Patient ID:**

"I'll check the patient's wristband to confirm full name and age."

4. **Acknowledge Situation:**

"This is a confused 67-year-old man with new-onset deterioration on day 3 of admission — I will assess and manage him urgently."

ABCDE Assessment & Management

A – Airway

- Check for any visible or audible obstruction.
- Patient is responsive to voice — airway patent.
- **SpO_2 87% on room air** → Start **15L O_2 via non-rebreather mask** immediately.
- Reassess:
  "SpO_2 improving to 94% after oxygen administration."

B – Breathing

- Inspect for chest rise, accessory muscle use.
- Palpate for symmetry, percuss lung fields.
- Auscultate: coarse unilateral crackles (suggestive of consolidation).
- Order **chest X-ray** and **ABG**.
  "Requesting ABG — likely lactate >2 in this clinical context."
- Reassess after O_2 and fluids:
  "RR remains high at 24. Chest signs persist. Will proceed with full sepsis protocol."

C – Circulation

- Check CRT: >3 seconds
- Pulse: 120 bpm, thready
- BP: 88/50 → **sign of septic shock**
- **Start Sepsis 6 pathway immediately:**
  1. **Insert 2 wide-bore cannulas**
  2. **Send bloods**: FBC, U&E, LFTs, CRP, clotting, lactate
  3. **Blood cultures**
  4. **IV broad-spectrum antibiotics** (as per local hospital guideline, e.g. IV piperacillin-tazobactam)
  5. **500 mL IV normal saline over 15 minutes**, repeat up to 2 L in first hour
  6. **Insert urinary catheter**, send **urine for culture**
- Request **12-lead ECG** to check for sepsis-induced strain or baseline arrhythmia
- Reassess after each fluid bolus:
  "BP now 95/60 — will give second 500 mL bolus."

D – Disability

- GCS ~13 (confused but responsive to voice)
- Pupils: equal, reactive
- Capillary glucose: check and correct if low
- **Temp 39°C** → give **IV paracetamol 1g**
- Reassess LOC after fluids and antipyretics:
  "Patient remains drowsy but opens eyes to voice. Will continue monitoring."

E – Exposure

- Check for rash, IV site signs, pressure sores, leg swelling, etc.
- Abdominal exam: soft, non-tender
- No signs of new bleeding or infection elsewhere

Focused History *(post-stabilisation)*

"Once patient is stable, I will gather more background history from nursing notes and contact next of kin or care home."

Key questions to clarify:

- New or worsening cough, sputum?
- Known aspiration risk?
- Past respiratory infections?
- Antibiotic allergies?
- Fluid balance and output over last 24 hours?

Management Plan

- Continue high-flow oxygen.
- **Escalate to seniors** — this is a **suspected hospital-acquired pneumonia with sepsis** and hypotension despite fluids.

- Monitor **urine output hourly**.
- Adjust antibiotics when culture results return.
- Liaise with **ITU** for potential step-up care (e.g., vasopressors, ventilation).
- Daily NEWS scoring and close monitoring.

SBAR Handover

S – Situation:
"This is Mr X, a 67-year-old patient admitted 3 days ago for UTI. He was stable but became confused and hypotensive this morning."
B – Background:
"Previously well on the ward, was planned for discharge. No known allergies. Care home resident."
A – Assessment:
"SpO_2 was 87%, improved with 15L O_2. Crackles on one side, ABG awaited, temp 39°C, hypotension 88/50. Sepsis 6 initiated: antibiotics, fluids, blood cultures, catheterisation. Paracetamol given."
R – Recommendation:
"Patient needs urgent senior review. Escalate to ITU if no improvement after 2 L fluid. Continue sepsis protocol, monitor urine output, adjust antibiotics after sensitivities return."

Catheter-Associated Urinary Tract Infection - Sepsis

Where you are: FY2 doctor in the A&E
Who the patient is: Mr X, 60-year-old male brought in with acute confusion. Wife reports burning micturition and fever for 2 days. He had prostate surgery last week and has had an indwelling catheter since then.
Vitals: SpO_2 90%, BP 100/60, HR 120, RR 24, Temp 39°C, ECG: Sinus Rhythm
Task: Assess and manage the patient. At 2-minute bell, hand over to the examiner.

Initial Steps

1. **Knock and Enter**
2. **Greet Examiner:**

"Hello, I'm Dr [Name], GMC number [XXXXX]. I've taken universal precautions and ensured the scene is safe."

3. **Check Patient Identity:**

"I'll confirm his full name and age from the wristband."

4. **Acknowledge the Situation:**

"This is a confused patient with recent surgery and catheter in situ, showing signs of systemic infection. I'll assess and manage him immediately."

ABCDE Assessment & Management

A – Airway

- Look, listen, feel for obstruction
- Patient is vocalising — airway is patent
- **SpO_2 90% on room air → Start 15L O_2 via non-rebreather mask**
- Reassess:

"SpO_2 improving to 95% after oxygen — continue monitoring."

B – Breathing

- Inspect chest rise, respiratory effort
- Palpate, percuss, auscultate (no added sounds)
- Order **chest X-ray** to rule out concurrent pathology
- Request **ABG** — likely lactate >2 due to sepsis

- Reassess RR and oxygen response:

"RR still elevated. Chest exam unremarkable. Will proceed with circulation."

C – Circulation

- Check pulse (tachycardic), CRT >2s, BP 100/60
- Likely catheter-associated urosepsis with early shock

Start **Sepsis 6** immediately:

1. **Insert 2 large-bore cannulas**
2. Send **routine bloods + blood cultures**
3. **Give IV broad-spectrum antibiotics** (e.g., IV piperacillin–tazobactam)
4. **IV normal saline 500 mL over 15 min**, reassess BP
5. **Remove old catheter**, insert **new one**, send **urine sample for culture**
6. Monitor **urine output hourly** via catheter

- Request **12-lead ECG**
- Reassess after each 500 mL bolus up to 2L:

"BP after 500 mL now 105/65 — continue monitoring."

D – Disability

- GCS: confused but responsive to verbal
- Pupils: equal and reactive
- **Blood sugar:** check and correct if low
- **Temp 39°C** → give **IV paracetamol 1g**
- Reassess mental status:

"Still confused, no lateralising signs. Continue supportive care and monitor."

E – Exposure

- Check for rash, wounds, signs of infection or thrombosis
- Inspect surgical site and catheter area for inflammation or discharge
- Abdominal exam: soft, no guarding or distension
- Legs: no DVT signs

Focused History *(after stabilisation)*

"Once stable, I'll speak to the wife and review the notes."

Ask about:

- Surgery details and catheter issues since then
- Previous UTIs, antibiotic allergies
- Fluid intake, output, prior fever patterns
- Baseline cognition and function

Explain to Patient *(after stabilisation)- If asked in the question*

"Mr X, thank you for bearing with us. I want to explain what's been happening."

"You've come in today because you were quite confused and feeling unwell. Your wife mentioned that you had a fever and burning when passing urine, and we know you recently had prostate surgery and have had a catheter since then."

"From our initial checks, it looks like your oxygen was a bit low, and you had a high temperature and fast heartbeat. Your blood pressure was also on the lower side. These can be signs of a **serious infection** — what we call **sepsis** — and in your case, it may be coming from the urinary catheter."

"We've started emergency treatment straight away. That included giving you oxygen, IV fluids to bring up your blood pressure, and strong antibiotics that cover a wide range of bacteria. We also replaced your catheter and sent samples to check which bacteria are causing this and which antibiotics will work best."

"As your condition is serious, we're closely monitoring your urine output and blood tests. I've updated my senior and if there's any concern about your response, we'll ask the intensive care team to review you as well."
"Once the infection is under control, we'll switch to more targeted treatment based on the results of the tests, and monitor you here in hospital until it's safe for you to go home."

SBAR Handover

S – Situation:
"This is Mr X, 60 years old, brought in with confusion and fever. He had prostate surgery 1 week ago and has had a catheter in place since."
B – Background:
"His wife reported burning urine and fever for 2 days. Now tachycardic, febrile, hypotensive. This is likely catheter-associated UTI leading to sepsis."
A – Assessment:
"SpO_2 90%, BP 100/60, HR 120, Temp 39. Given O_2, IV fluids, IV antibiotics. Old catheter removed, urine sample sent. Cultures and bloods taken. Responding to fluids so far."
R – Recommendation:
"Needs senior review and ongoing sepsis monitoring. Will escalate to ITU if hypotension or mental status worsens. Awaiting cultures to adjust antibiotics accordingly."

Urosepsis

Where you are: FY2 doctor on the medical ward
Who the patient is: Mr X, 80-year-old male, admitted yesterday with a urinary tract infection (UTI), currently on antibiotics. Nurse has called you as he is acutely unwell and confused.
Vitals: SpO_2: 88%, BP: 85/50, HR: 120, RR: 24, Temp: 39°C, ECG: Atrial fibrillation (AF)
Special instruction: Use appropriate equipment from the trolley.
Task: Assess and manage the patient. At the 2-minute bell, discuss with the examiner.

Initial Steps

1. **Knock and Enter**
2. **Greet Examiner:**

"Hello, I'm Dr [Name], GMC number [XXXXX]. I've taken universal precautions and ensured the scene is safe."

3. **Confirm Patient Identity from wristband:**

"Could I confirm Mr Peter Lincoln's name and age from the name tag?"

4. **Acknowledge the Situation:**

"This is a confused elderly patient with signs of clinical deterioration. I will begin immediate assessment and resuscitation."

ABCDE Assessment & Management

A – Airway

- Look, listen, and feel for any obstruction
- Patient is vocalising → **airway patent**
- **SpO_2 88% on room air** → Give **15L O_2 via non-rebreather mask**
- Reassess:

"SpO_2 improved to 95% with oxygen — continue monitoring."

B – Breathing

- Inspect for chest rise and accessory muscle use
- Palpate, percuss, and auscultate chest

- Likely clear chest but infection source is urinary
- Order **chest X-ray** to rule out other infections
- Perform **ABG** to assess lactate (likely >2) and gas exchange
- Reassess RR:

"RR remains elevated at 24 — proceed to circulation."

C – Circulation

- Check: **CRT (>2s), weak pulse, BP 85/50**
- This is sepsis with hypotension – start **Sepsis 6** immediately:

1. **Insert 2 large-bore cannulas**
2. Send **routine bloods, infection markers, blood cultures**
3. Give **IV broad-spectrum antibiotics** (e.g., piperacillin–tazobactam)
4. Give **IV 0.9% saline 500 mL over 15 minutes**
5. Insert **urinary catheter**, send **urine sample for culture**
6. Monitor **urine output hourly**

- Request **12-lead ECG** → AF noted
- Reassess after 500 mL bolus:

"BP now 92/55 — will continue up to 2L within the hour if no improvement."

D – Disability

- GCS: Patient is confused (acute delirium)
- Pupils: Equal and reactive
- Check **blood sugar** — correct if <4 mmol/L
- **Temp 39°C** → Give **IV paracetamol 1g**
- Reassess cognition:

"No improvement in GCS. Continue fluids and monitoring."

E – Exposure

- Examine full body: surgical sites, pressure areas, rash, inflammation
- Abdominal exam: soft, may be mildly tender
- Legs: check for DVT or cellulitis
- Ensure the patient is warm and covered after exam

Focused History *(After Initial Stabilisation)*

Speak to nursing staff and check notes for:

- Start date and type of current antibiotics
- Fluid intake/output since admission
- Recent catheter or urological procedures
- Allergy history
- Baseline cognitive function

Explanation to the Patient (Once Stable)

"Mr X, I'd like to explain what happened. You were admitted with a urine infection and started on antibiotics yesterday. Today, your condition worsened — you developed a high fever, low blood pressure, and your oxygen level dropped a bit. You were also feeling quite confused."

"These are signs of **sepsis**, which is when the body reacts severely to an infection, in this case likely from your urinary tract. We immediately gave you oxygen, IV fluids to support your blood pressure, and stronger antibiotics. We also sent some blood and urine tests to confirm which bacteria are causing this so we can adjust your treatment."

"We're keeping you under close monitoring. Your urine output and blood pressure are key to seeing how you respond. I've updated my senior doctor and if we feel you're not improving quickly enough, we'll ask the intensive care team to help with further support."

SBAR Handover

S – Situation:
"This is Mr X, 80-year-old male, admitted yesterday with UTI, now acutely deteriorating with confusion, hypotension, and fever."
B – Background:
"No previous medical history. On antibiotics for UTI. Nurse noted sudden confusion and worsening vitals."
A – Assessment:
"SpO_2 88% (now improving with O_2), BP 85/50, HR 120, RR 24, Temp 39°C. ECG shows AF. Started Sepsis 6: O_2, fluids, antibiotics, cultures, catheterised and monitored output."
R – Recommendation:
"Needs urgent senior review. May require escalation to ITU depending on response. Awaiting bloods and cultures."

Morphine Toxicity

Where you are: FY2 doctor in the Emergency Department
Who the patient is: Mr X, 75-year-old male with CKD stage 4, recently prescribed morphine for back pain after a fall. Now presenting with dizziness, drowsiness, and low oxygen saturation.
Vitals: SpO_2: 88%, BP: 90/60, HR: 94, RR: 6, ECG: Sinus rhythm
Presentation: Patient is drowsy and cannot talk in full sentences.

Initial Steps

1. **Knock and Enter**
2. **Greet Examiner:**

"Hello, I'm Dr [Name], GMC number [XXXXX]. I've taken universal precautions and ensured the scene is safe."

3. **Confirm Patient Identity using name tag**
4. **Acknowledge the Situation:**

"This is a drowsy elderly patient with bradypnoea and recent morphine use. I'll begin immediate assessment and treatment."

ABCDE Assessment & Management with Reassessment

A – Airway

- Look for signs of obstruction
- Patient is breathing slowly but airway appears **patent**
- **SpO_2 is 88% → Administer 15L oxygen via non-rebreather mask**
- **Reassess SpO_2** after oxygen:

"SpO_2 now rising to 94% — continue oxygen."

B – Breathing

- **Respiratory rate is 6/min** – this is significant bradypnoea
- Chest exam: Inspect, palpate, percuss, auscultate — likely unremarkable
- Suspect **opioid-induced respiratory depression**
- Check **pupils** — pinpoint pupils confirm suspicion
- Administer **IV Naloxone 0.4 mg stat**
- Request **ABG** and **chest X-ray** to assess gas exchange and exclude aspiration

- **Reassess RR and GCS after 1–2 minutes**:

"No response — RR still 6, patient still drowsy → escalate naloxone."

C – Circulation

- Check: **CRT, pulse quality, BP**
- BP 90/60, CRT delayed — suggestive of opioid effect
- Insert **1 large-bore cannula**
- Send **routine bloods**, including U&Es (renal function), drug levels, LFTs
- Request **ECG** — sinus rhythm
- **Reassess BP and consciousness** after first naloxone dose:

"No improvement — administer IV Naloxone 0.8 mg."

D – Disability

- Check **GCS**, **blood glucose**, and **temperature**
- Blood glucose normal
- GCS remains low → administer another **0.8 mg Naloxone IV**
- If no change, escalate to **2 mg IV Naloxone**
- Reassess again after 1 minute → If still unconscious, give **4 mg IV Naloxone**

"After 4 mg, RR improving to 10/min and GCS now 13/15."

E – Exposure

- Examine: abdomen (for trauma/constipation), legs (DVT signs), back
- Check catheter site or bruising from fall
- Ensure the patient is kept warm and covered after examination
- Monitor for signs of **recurrence of toxicity** (Naloxone has a short half-life)

Focused History (after improvement)

Now that the patient is more responsive, ask:

- "Can you tell me what happened today?"
- "Have you taken your morphine today? Do you remember the dose?"
- "Have you been more drowsy or dizzy over the past few days?"
- "Any alcohol or other medications like sleeping pills or antihistamines?"
- "How has your urine been? Any recent issues with kidney function?"

Explanation to Patient (Once Conscious and Stable) – if asked

"Mr X, earlier today you were brought in because you were very drowsy and had slowed breathing. Your oxygen level and blood pressure were low, and you were having trouble staying awake. Based on your medication history, this was likely caused by a high level of morphine in your body."

"Morphine is strong and, in people with kidney problems like yours, it can build up in the body and cause dangerous side effects — including slow breathing and drowsiness. We gave you a medication called **naloxone**, which reverses the effects of morphine. You've started to recover now, but we'll continue to monitor you closely."

"We'll also review your pain management plan and may switch to a safer alternative that's easier on your kidneys. I've informed my senior doctor and we'll work together to keep you safe."

SBAR Handover

S – Situation:

"Mr X, 75 years old with CKD stage 4, presented drowsy and bradypnoeic after recent morphine prescription."

B – Background:

"Came last week with back pain after a fall and was prescribed morphine. Wife reports increasing drowsiness. Today found with RR 6, SpO_2 88%, BP 90/60."

A – Assessment:
"Suspected opioid toxicity — pinpoint pupils, low RR. Gave 0.4 mg IV naloxone, then 0.8 mg ×2, then 2 mg and 4 mg sequentially. Patient now awake with improving vitals. ABG and chest X-ray pending. ECG SR."
R – Recommendation:
"Needs admission, morphine to be stopped, switch to safer analgesia. Monitor vitals and GCS for at least 6 hours due to risk of recurrence. Involve renal and pain teams."

Atrial Fibrillation

Where you are: FY2 in A&E
Who the patient is: Mr [Name], 70-year-old presenting with dizziness and palpitations
Vitals: SpO_2: 91%, BP: 110/80, HR: 140 (irregular), RR: 18, ECG: Atrial Fibrillation
Presentation: Either drowsy or alert — two pathways covered
→ If patient **cannot talk in full sentences**: Postpone history
→ If patient is **alert and talking**: Start with history, then proceed to assessment

---

Initial Steps

1. **Knock and Enter**
2. **Greet Examiner:**

"Hello, I'm Dr [Name], GMC number [XXXXX]. I've taken universal precautions and ensured the scene is safe."

3. **Confirm Patient Identity from wristband:**

"Could I confirm this is Mr [Name]?"

4. **Acknowledge the Situation:**

"This is a patient with dizziness and suspected arrhythmia — I'll begin urgent assessment and stabilisation."

ABCDE Assessment & Immediate Management

A – Airway

- Look for signs of obstruction — Airway is **patent**
- If **SpO_2 <94%**, administer **15L O_2 via non-rebreather mask**

"SpO_2 is 91%, so I'm giving high-flow oxygen and will reassess."

B – Breathing

- Full chest exam: inspection, palpation, percussion, auscultation
- No wheeze or crackles
- Request **chest X-ray** to exclude heart failure or other causes
- Request **ABG** if hypoxic or drowsy

"Breathing is unlaboured, chest is clear, oxygen saturations improving — continue to monitor."

C – Circulation

- Check **CRT, pulse quality, BP** — pulse is **fast and irregular**
- Insert **1 large-bore cannula**
- Request:
  - **12-lead ECG** → confirms **AF**
  - **Routine bloods** (FBC, U&E, LFT)
  - **Cardiac enzymes** (Troponin)
  - **D-dimer** if any thrombotic concern
- **Assess AF duration:** Ask patient or family if onset is known
- If AF onset is **uncertain or >48 hours**, do **not cardiovert** — risk of embolism

"Patient's HR is 140, BP is stable, AF is likely not new-onset — proceeding with rate control."

- Start **rate control**:

- **If stable**: PO **Bisoprolol 2.5–5 mg** OR **Diltiazem SR 90–120 mg**
- Avoid beta-blockers if decompensated heart failure or asthma

"I'm starting oral rate control after checking contraindications — monitoring closely for response."

D – Disability

- Check **GCS**, **blood sugar**, and **temperature**
- Blood sugar normal
- GCS 15 if patient is alert

E – Exposure

- Examine for signs of infection, bleeding, or trauma
- Look for signs of DVT (possible embolic source)
- Keep patient warm and covered

Focused History (if alert)

- "When did you first feel dizzy?"
- "Have you had this before?"
- "Any chest discomfort or shortness of breath?"
- "Are you on any regular medications, especially blood thinners or BP tablets?"
- "Do you have any heart conditions or previous stroke?"
- "Any recent infections, surgeries, long travel, or alcohol intake?"

Explanation to Patient – if needed

"Mr [Name], from your symptoms and ECG, we've found that you have a condition called **atrial fibrillation**, where the upper chambers of your heart beat irregularly and very fast. That's why you've been feeling dizzy."
"This can sometimes be a short-term issue, but if it's been going on for longer than 48 hours — or we're not sure when it started — it's not safe to shock the heart back into rhythm straight away. Doing so might release a blood clot and cause a stroke."
"So our first step is to **control your heart rate** and keep you comfortable. You'll also likely need a **blood thinner** to prevent stroke, and we'll do an ultrasound of your heart called an **Echocardiogram** to look at its structure."
"I've informed the cardiology team and we'll manage this together. You'll need to stay in the hospital for monitoring."

SBAR Handover

S – Situation:
"Mr [Name], 70 years old, presented with dizziness and palpitations. Vitals show HR 140 irregular, BP 110/80, SpO_2 91%."
B – Background:
"No known prior AF. No anticoagulation. No recent illness reported. ECG shows atrial fibrillation."
A – Assessment:
"Patient is stable, AF likely longer than 48 hours. GCS 15, chest clear, no signs of acute HF. Rate control started with oral beta blocker. Bloods, CXR, ABG sent. Awaiting echo."
R – Recommendation:
"Admit under medical team. Cardiology input needed for rhythm vs rate strategy and anticoagulation. Echo pending. Monitor vitals and repeat ECG."

Chronic Bronchitis with NEWS Chart

Setting: You are the FY2 doctor in A&E.
Patient: Mr. X, 55-year-old male, presenting with acute shortness of breath.

Monitor: SpO_2 97% (room air), HR 95, RR 23, BP 120/80, Temp 37.5°C
Background: Known COPD on inhalers, chronic smoker. No fever, chest pain, leg swelling. COVID test negative. NEWS Chart available

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Initial Steps

1. **Knock and Enter**
2. **Greet Examiner:**
   "Hello, I'm Dr [Name], FY2, GMC number [XXXXX]. I've taken universal precautions and ensured the scene is safe."
3. **Confirm Identity from Name Tag:**
   "Could I confirm your name, please? Great — thank you, Mr. Jones."
4. **Paraphrase the Situation:**
   "I understand you've come in with shortness of breath. I'll assess your condition."

Focused History (while assessing consciousness)
If alert and speaking full sentences:

- "When did the breathlessness start?"
- "Are you coughing? Bringing up phlegm?" (white)
- "Any fever, chest pain, leg swelling, or urine changes?" (No)
- "How long have you had COPD? Which inhalers do you use?"
- "Do you use them daily?" "Ever needed hospitalisation for this before?"
- "Do you smoke?" (Yes – chronic smoker)

ABCDE Assessment
A – Airway:

- Patent airway
- SpO_2 97% – no oxygen needed

B – Breathing:

- Chest exam: mild accessory use, bilateral reduced expansion, wheeze
- → Give **Nebulised Salbutamol 5 mg + Ipratropium Bromide 500 mcg** via **air-driven mask**
- Order **Chest X-ray**
- Perform **ABG** to assess for CO_2 retention

C – Circulation:

- CRT <2 sec, HR 95, BP 120/80
- Insert 1 IV cannula
- Request: FBC, U&E, CRP, ABG, ECG, blood glucose

D – Disability:

- Alert, glucose normal, pupils equal/reactive

E – Exposure:

- Abdomen soft, legs normal, no DVT or cellulitis signs

NEWS Chart Scoring

Parameter	Value	Score
RR	23	2
SpO_2	97%	0
Oxygen Therapy	No	0
Temp	37.5°C	0

Parameter	Value	Score
Systolic BP	120	0
Heart Rate	95	1
Consciousness	Alert	0
Total NEWS		**3**

→ Low-risk category. Requires monitoring and treatment.

Diagnosis & Explanation to Patient

"Mr. X, you're experiencing an exacerbation of your chronic bronchitis, which is a type of COPD — Chronic Obstructive Pulmonary Disease. This means your airways are persistently inflamed, and during a flare-up, they become even more narrowed and irritated, making it harder for air to move in and out of your lungs.

The good news is that your oxygen levels, blood pressure, and overall condition are currently stable. Your sputum is white, and you have no fever or signs of serious infection, so this appears to be a milder episode. We're giving you bronchodilator nebulisers — Salbutamol 5 mg and Ipratropium Bromide 500 mcg — to help open up your airways. You'll also be starting oral steroids — Prednisolone 30 mg once daily for 5 days — to reduce the inflammation in your lungs.

Because you're doing well at the moment, we can manage you safely without admission. But we'll need to monitor you here briefly and arrange follow-up with your GP in the next couple of days."

Management Plan

- **Senior Review**
- Continue prescribed inhalers
- Start **Prednisolone 30 mg orally once daily for 5 days**
- **Check inhaler technique**
- Refer to **Smoking Cessation Clinic**
- Advise to avoid dust, fumes, and smoke
- Refer to **Pulmonary Rehabilitation Programme**

Safety Netting:

"If your symptoms get worse — more breathless, feverish, or chest pain — come back to A&E."

GP Follow-Up: In 48–72 hours

SBAR Handover – If asked

S – Mr. X, 55-year-old male with known COPD, presenting with 3 days of worsening shortness of breath and white productive cough.

B – Has had previous COPD exacerbations but no current fever, chest pain, or leg swelling. COVID-negative. On regular inhalers. Chronic smoker. No other comorbidities.

A – Vitals stable: SpO_2 97%, HR 95, RR 23. NEWS score 3. Chest exam: bilateral wheeze. ABG and CXR requested. Responding well to nebulised Salbutamol 5 mg + Ipratropium 500 mcg.

R – Started on oral Prednisolone 30 mg once daily for 5 days. Continue inhalers. Check technique. Arrange GP follow-up in 48–72 hours. Refer to smoking cessation and pulmonary rehabilitation. Discharge with safety netting unless deterioration.

S – 55-year-old male with known COPD presented with 3 days of worsening SOB and productive cough.

B – Regular inhaler use, no other major comorbidities. COVID negative.

A – Exam: bilateral wheeze, NEWS 3. SpO_2 normal. ABG and CXR requested. Nebulisers given.

R – Started oral Prednisolone. Stable for discharge. Needs GP review and smoking cessation referral.

Diagnostic Reasoning Note to Student

- Presentation fits **COPD exacerbation**: SOB, wheeze, productive cough, known COPD.
- No fever, clear sputum, stable observations → **low-risk flare**.
- ABG and CXR rule out pneumonia/hypercapnia.
- Managed with steroids and inhalers. No admission needed.

Chapter 29: Prescriptions

A full, detailed note for every individual case—complete with filled prescription charts—is beyond the scope of this book. However, a solid foundation is provided here to help you build confidence and accuracy in this domain. This chapter aims to equip you with the clinical reasoning and safety-first mindset needed to navigate prescription stations successfully.

This chapter offers a practical, exam-focused guide to the most commonly encountered prescription scenarios in PLAB 2. It begins with a concise summary of the core principles of safe prescribing, as expected of an FY2-level doctor in the UK. What follows is a structured overview of key case types, with targeted insights on approach, common pitfalls, and rationale for prescription choices.

Prescription writing in PLAB 2 is not just about knowing drug doses. It is a legal document that reflects your clinical judgement, professional conduct, and attention to safety. Every detail matters. Mistakes here can cost you the entire station.

This introduction will walk you through the key components of safe prescribing, the workflow you must follow, and common pitfalls to avoid.

MATERIALS AND SETUP

When you enter the prescription station, the following will be available:

- **Black pens** (use only black ink – blue or red may invalidate your script)
- Prescription forms (6-page adult drug chart, fluid chart, syringe driver, PROM chart, Vancomycin chart, etc.)
- BNF and BNF-C (for paediatrics)
- Patient details, including labels/stickers and charts

Before writing anything, test your pen on a scrap piece of paper to ensure it is working and black in colour.

STEPWISE PRESCRIPTION WORKFLOW

Start with the Administrative Sections

Complete these **before** prescribing any drugs:

- **Top of the chart**:
  - Hospital name, ward, consultant
  - Admission date (DD/MM/YYYY format)
  - Chart number (e.g., 1 of 1)
- **Patient identification**:
  - Use sticker if available (main page only)
  - On all other charts (fluid, syringe, PROM), either affix sticker or handwrite exact details
- **Your name and GMC number**:
  - Must appear on **every** page, including fluid and syringe charts
  - Sign every section you complete

Complete the Allergy Box Carefully

- If patient has **no allergies**: Write "**NKA**" (No Known Allergies)
- If allergic:

    - Write **drug name** + **reaction** (e.g., "Penicillin – rash" or "Clarithromycin – breathless")
- Then: **Sign** and **date** this box
- This step is legally critical – skipping it may result in zero marks

HOW TO WRITE PRESCRIPTIONS

Capital Letters and Legibility

- Use **ALL CAPITAL LETTERS** throughout
- Write neatly – examiners cannot interpret messy handwriting
- Drug name and route must stand out clearly

Abbreviations and Terminology

Use only safe, approved medical abbreviations:

- Routes: PO, IV, S/C, INH
- Frequency: OD (once daily), BD (twice), TDS (three), QDS (four), PRN (as needed)
- Units and micrograms must be written in full – do **not** write 'U', 'mcg', or 'µg'

MEDICATION SECTIONS

Each drug chart typically includes:

- **Once Only**: For stat medications (e.g., IV fluids, one-off antibiotics)
- **Regular**: For daily or long-term medications
- **PRN** (As Needed): For symptom relief (e.g., pain, nausea)

You must include the following:

- **Indication** (especially for antibiotics and PRNs)
- **Start and stop/review date** for antibiotics
- **Maximum 24h dose** for PRN medications

Example:

- PARACETAMOL 1G PO QDS PRN for pain. Max 4g/24h.
- CLARITHROMYCIN 500mg PO BD for pneumonia. Start: 12/06/2025. Stop: 17/06/2025.

USING THE BNF EFFECTIVELY

You are expected to **open and consult the BNF** during the station.

When to Use It

- To check dose, frequency, route, renal adjustments
- Especially for:
    - Antibiotics
    - Controlled drugs
    - Paediatric doses
    - Drug interactions (e.g., Clarithromycin + Atorvastatin)

How to Use It

- Go to the **index** at the back
- Look up the drug name → go to listed page
- Cross-reference for age, renal function, interactions

BNF vs Special Charts

Some drugs (e.g., Vancomycin, PROM steroids) have **dedicated charts** provided. These override the BNF. Always follow chart instructions over BNF if both are provided.

PROFESSIONAL ERROR MANAGEMENT

Minor Mistakes

- Cross through once with a single **diagonal line**
- Do **not** overwrite or scribble out
- Initial the correction and rewrite in a clean space

Major Mistakes Early On

- Silently discard the chart
- Take a fresh one from the stack
- Don't ask the examiner or explain

After the Exam

If you realise you've made a serious error **before leaving the centre**, notify staff immediately. Outside the exam room, no corrections are possible.

TIME AND CONDUCT

You get **8 minutes** per station. Aim to finish writing by minute 5–6, allowing time to double-check everything.

Professionalism matters:

- Sit upright, smile, stay calm
- Avoid fidgeting, sighing, or speaking aloud
- Handle materials gently and confidently
- Don't discuss errors with the examiner

Prescription Station Checklist

Use this checklist during practice and revision to ensure your station performance is complete, professional, and safe.

1. General Form Completion

- Black pen used only
- All entries written in CAPITAL LETTERS
- Clear and legible handwriting throughout
- Patient sticker attached on **main form (Page 1)**
- Patient sticker OR full details on **all additional forms** (e.g., fluid chart, syringe driver)
- Manual entry of patient details if sticker is missing
- Full **Name & GMC number** written on **main form (Page 1)**
- Full **Name & GMC number** on all **additional charts**
- Hospital and ward name accurately transcribed
- Consultant's name copied exactly as given
- Admission date written in correct **DD/MM/YYYY** format
- Chart number filled correctly (e.g., "1 of 1")
- Allergy section completed — either "NKA" or allergen + reaction
- Allergy section **signed and dated**

2. Medication Safety

- Only **approved abbreviations** used (e.g., PO, IV, OD, BD, TDS, QDS, PRN)
- "micrograms" and "units" written out fully — no µg or U
- All **PRNs** include indication and max 24h dose
- All **antibiotics** include:
    - Clear indication (e.g., UTI, CAP)

- Start date
- Stop/review date

3. Process and Professionalism

- BNF visibly opened and consulted during prescription
- Errors corrected using single line + initials/GMC
- Calm, professional behaviour maintained
- Top section (patient ID, allergy, prescriber info) completed **before** writing drugs
- Neat, systematic, and silent workflow

Utilizing Special Charts and Managing Fluid Therapy

This section explains the practical steps and safety considerations involved in IV fluid prescription and the use of specialized charts in PLAB 2 scenarios. It includes adult and paediatric fluid management, as well as guidance on using Syringe Driver, Vancomycin, and VTE assessment charts.

Intravenous Fluid Management

Adult Fluid Therapy

Maintenance Fluids

- **Standard Requirement**: ~30 ml/kg/day (~1.5–2.5 L/day).
- **Fluid Choice**:
  - **Hartmann's** – Preferred for initial post-op or general fluid replacement.
    - *Contains*: Na^+ 131 mmol/L, K^+ 5 mmol/L.
  - **0.9% Sodium Chloride (Normal Saline)** – For volume replacement or with additives.
    - *Na^+ 154 mmol/L.*
  - **4% Dextrose / 0.18% Saline (Dextrose Saline)** – For maintenance; risk of hyponatraemia.
    - *Na^+ 30 mmol/L.*
    - **Caution**: Max rate 1L over 12 hours (83 ml/hr). NEVER use for fluid challenge or resuscitation.

Electrolyte Supplementation

- Add **10–15 mmol KCl** per bag (commonly to NaCl or Dextrose Saline).
- Always assess serum K^+ and renal function before adding.

Chart Completion

- Document: **Fluid type, total volume, rate (ml/hr), additives, date/time**, and **signature**.
- Example: "Hartmann's + 15 mmol KCl, 1L over 12 hrs at 83 ml/hr".

Paediatric Fluid Therapy

Maintenance Calculation

- **Holliday-Segar Method**:
  - 0–10 kg: 100 ml/kg/day
  - 10.1–20 kg: +50 ml/kg/day
    - 20 kg: +20 ml/kg/day
- **4-2-1 Rule (per hour)**:
  - First 10 kg: 4 ml/kg/hr
  - Next 10 kg: 2 ml/kg/hr
    - 20 kg: 1 ml/kg/hr

Fluid Choice

- **Preferred**: Normal Saline + 5% Dextrose (N/S + D5%)
- **Add KCl**: 10 mmol per 500 ml bag (especially if glucose-containing fluid used).

Fluid Bolus

- **Shock or dehydration**:
  - 20 ml/kg **0.9% NaCl** over 15 min.
  - In **DKA or trauma**, start with 10 ml/kg.

Chart Completion

- Record: **Weight, fluid type, volume, rate, additives, indication ('M' for maintenance)**, and **signature**.
- Use **500 ml bags** in paediatric charts. Never fill nurse-admin fields.

Palliative Care

Palliative care prescriptions require careful attention to symptom control and patient comfort, especially when the patient cannot eat or drink.

General Rules for Palliative Care Prescriptions:

- **Omit Oral/IV Medications:** As a general rule, discontinue all routine oral and intravenous medications unless they are specifically for palliative symptom control and can be administered via an appropriate route (usually subcutaneous). Medications like Atorvastatin or oral Paracetamol for general pain (not breakthrough) are often omitted.
- **PRN (As Required) Section:** Most palliative care medications for symptom control are written in the PRN section of the prescription chart.
- **Subcutaneous (S/C) Route:** This is the preferred route for many palliative care medications when oral intake is not possible.
- **Task Instructions:** Dose, frequency, route, and maximum doses will usually be provided in the exam task; follow these instructions carefully.

Calculating Opioid Doses:

1. **Breakthrough Pain Dose:**
   - Formula: Breakthrough pain dose = Total 24-hour syringe driver dose / 6.
   - Example: If the 24-hour syringe driver morphine dose is 30 mg, the breakthrough dose is 30 mg÷6=5 mg.
   - This is prescribed in the PRN section.
2. **Syringe Driver Dose:**
   - Formula: Syringe driver dose = Breakthrough pain dose x 6.
   - This is written on a dedicated syringe driver prescription chart if available. If not, write it in the regular prescription section.

Opioid Conversion (Subcutaneous Routes):

- **Diamorphine to Morphine:** Multiply the diamorphine dose by 1.5.
- **Morphine to Diamorphine:** Divide the morphine dose by 1.5.

Specialized Prescription Charts

Syringe Driver Chart (Palliative Care)

Purpose:

Continuous S/C infusion for drugs like **morphine**, **metoclopramide**, **hyoscine**, etc.

Key Prescription Fields:

- Patient sticker and details

- **Drug name** (approved name), **Dose** (e.g., 30 mg/24 hr)
- **Route**: S/C
- **Diluent**: Water for injection or 0.9% NaCl
- **Start Date** + Doctor's signature
- Cross-reference on main drug chart

Nursing Responsibilities:

- Start date/time, infusion details, batch number
- 4-hourly monitoring (site, volume, function)

Vancomycin Prescription Chart

1. Authority:

- Supersedes BNF. Must follow the chart exactly.
- Often requires **microbiology consultation**.

2. Prescribing Guide:

- **Loading Dose**: Based on **actual body weight**.
  - e.g., 60–90 kg → 1.5 g in 500 ml 0.9% NaCl over 180 minutes.
- **Maintenance Dose**: Based on **eGFR**.
  - e.g., eGFR 40–54 → 500 mg Q12h in 250 ml over 60 min.
  - **Infusion concentration ≤5 mg/mL** and **rate ≤10 mg/min**.

3. Monitoring:

- **Trough level**:
  - Before 3rd/4th dose (BD) or 2nd/3rd (OD).
  - Target: **10–20 mg/L** (or 15–20 for deep infections).
- **Renal Function**: U&E, eGFR throughout.
- **Adjust dose after 1st trough level** but do **not delay next dose**.

VTE Risk Assessment Forms (e.g. Postnatal)

Function:

Identify **VTE risk** and guide LMWH prophylaxis.

Steps:

- Tick **all risk factors** under pre-existing, obstetric, and transient.
- Calculate total score to stratify **risk level**.
  - **Intermediate risk** → LMWH for 10 days.
  - **High risk** → LMWH for 6 weeks.
- Dose per weight; check renal function.

Summary Notes for Candidates

- **Fluid therapy is a drug prescription** — must be accurate.
- Use **correct fluid for correct purpose** (e.g., Hartmann's for replacement, NOT dextrose).
- In **paediatrics**, calculate meticulously using 4-2-1.
- **Electrolytes must be added carefully** — check renal function first.
- Use **specialized charts** where provided — BNF may not apply.
- In **Vancomycin**, ALWAYS match weight and eGFR to chart dosing.
- For syringe drivers, complete doctor section only and **cross-reference on main chart**.
- In **VTE**, don't forget to tick all applicable boxes, score accurately, and act accordingly.

Critical Drug Interactions and Safe Prescribing
In PLAB 2, your ability to identify and manage drug interactions is essential for safe patient care. This section highlights **high-risk interactions** and the **prescribing actions** required in real-world PLAB scenarios.

Lithium + NSAIDs (e.g., Ibuprofen)
- **Risk**: NSAIDs reduce Lithium clearance → **Lithium toxicity** (neuro, renal, cardiac)
- **DO NOT PRESCRIBE NSAIDs** if the patient is on Lithium
- **Action**:
    - Prescribe **Paracetamol** instead
    - Document clearly: "Avoid NSAIDs – on Lithium"

Clarithromycin + Statins (Atorvastatin, Simvastatin)
- **Risk**: Clarithromycin inhibits CYP3A4 → ↑ Statin levels → **Myopathy / Rhabdomyolysis**
- **Action**:
    - **STOP Statin** for the duration of Clarithromycin
    - Document: "Hold Atorvastatin while on Clarithromycin"

ACE Inhibitors (e.g., Ramipril) + Hyperkalemia
- **Risk**: ACE inhibitors reduce aldosterone → **↑ Potassium** → Hyperkalemia
- **Action**:
    - If **K^+ >5.0–5.5 mmol/L, STOP ACE inhibitor**
    - Document: "Stop due to hyperkalemia. Monitor K^+ and renal function"

ACE Inhibitors + UTI Antibiotics (Trimethoprim, Nitrofurantoin)
- **Risk**: All three can cause **hyperkalemia**, especially in CKD
- **Action**:
    - If patient is on Ramipril **and** needs Trimethoprim/Nitrofurantoin, **stop Ramipril**
    - Document: "Stop Ramipril. Monitor K^+ during antibiotic course"

Methotrexate + Infection or Trimethoprim
- **Risk**: Methotrexate + infection = ↓ immune function
    -
        - Trimethoprim = ↑ Methotrexate toxicity (shared renal excretion)
- **Action**:
    - **Hold Methotrexate** during infection (e.g., pyelonephritis)
    - Document: "Stop Methotrexate until antibiotic course completed"
    - Continue **Folic Acid** per usual schedule

Apixaban / Rivaroxaban + Aspirin or LMWH
- **Risk**: Additive anticoagulation → **↑ bleeding**
- **Action**:
    - **STOP Aspirin** unless specifically indicated (rare exceptions)
    - If **starting Apixaban**, ensure **Dalteparin is cancelled**
        - Cross out LMWH on drug chart, add initials and write: "Stop Dalteparin – Start Apixaban"

Cefalexin + Lithium (Paediatrics)

- **Risk**: Potential for **nephrotoxicity**
- **Action**:
  - Avoid Cefalexin in Lithium-treated children
  - Use **Co-amoxiclav** instead if safe

Apixaban + Elective Surgery

- **Risk**: Anticoagulant effect may increase **perioperative bleeding**
- **Action**:
  - **Hold Apixaban**:
    - 2 days before surgery
    - On the day of surgery
    - On the day after surgery
  - Document clearly: "Hold Apixaban for surgery – resume post-op"

Best Practice Reminders

- Always **document the STOP/HOLD action** on the drug chart
  - E.g., "Stop due to hyperkalemia" or "Hold for 1 week during antibiotic course"
- Communicate any major change to the **patient** and **multidisciplinary team**
- Check **renal function and electrolytes** when prescribing high-risk drugs (e.g., Methotrexate, ACE-I, Lithium)
- Always cross-check for **interacting drugs**, especially in elderly or polypharmacy cases

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Community Acquired Pneumonia (CAP) in Penicillin-Allergic Adult

Scenario: 55-year-old adult with cough, breathlessness, and fever. Diagnosed with CAP. Allergy to penicillin (rash). Takes Atorvastatin.
Prescriptions:

- **CLARITHROMYCIN 500mg PO BD** (09:00, 21:00) for 5 days
  → Indication: "CHEST INFECTION"
  → Start Date: e.g., 10/06/2025
  → Stop Date: e.g., 14/06/2025
  → Add: "Review in 48 hours"
- **STOP ATORVASTATIN** during Clarithromycin course (due to interaction risk of myopathy/rhabdomyolysis)

Key Notes:

- Ensure allergy to penicillin is clearly documented.
- If statin is co-prescribed, explicitly stop during antibiotic use.
- Duration and review date must be filled.

Acute Exacerbation of COPD with Dual Allergy

Scenario: Adult patient with COPD exacerbation. Allergic to penicillin and macrolides (e.g., Clarithromycin).
Prescriptions:

- **DOXYCYCLINE 200mg PO STAT** (Once Only section)
- **DOXYCYCLINE 100mg PO OD** for 4 more days (Regular/Antibiotics section)
  → Indication: "COPD EXACERBATION"
  → Total Duration: 5 days

→ Start Date: e.g., 10/06/2025
→ Stop Date: e.g., 14/06/2025

Additional Prescriptions:

- **PREDNISOLONE 30mg PO OD** for 5 days
- **SALBUTAMOL 100–200 micrograms INH QDS PRN** (max 8 puffs/day)
  → Indication: Breathlessness
- **Continue SERETIDE** or regular inhaler if listed in stem

Key Notes:

- Choose Doxycycline in penicillin + macrolide allergy.
- Add both once-only and regular antibiotic doses.
- Always include oral steroids for COPD exacerbation.

CAP with Oxygen Requirement

Scenario: Adult with CAP, breathless and hypoxic. No allergy.
Prescriptions:

- **AMOXICILLIN 500mg PO TDS** × 5 days (if no allergy)
- OR CLARITHROMYCIN (if allergic) as in Case 2.1.1
- **OXYGEN** prescription:
  - Target Saturation: 94–98% (if normal patient) or 88–92% (if COPD)
  - Delivery: Venturi Mask or Nasal Cannulae
  - Flow Rate: 2–4 L/min (per stem)

Key Notes:

- Tick box: "Check here if target saturation is not indicated" if unsure
- Tailor antibiotic based on allergy and severity

Uncomplicated UTI in a 30-Year-Old Female

Scenario: 30-year-old woman with burning micturition. No comorbidities, not pregnant, normal renal function (eGFR >45).
Prescription:

- **NITROFURANTOIN 100mg PO BD for 3 days**
  → Indication: "UTI"
  → Start Date: e.g., 10/06/2025
  → Stop Date: e.g., 12/06/2025

Key Notes:

- Nitrofurantoin is first-line in women with uncomplicated UTI.
- Short 3-day course is appropriate.
- Confirm eGFR >30 before prescribing.

UTI in Male Patient

Scenario: 40-year-old male with classic UTI symptoms. Normal renal function.
Prescription:

- **NITROFURANTOIN 100mg PO BD for 7 days**
  → Indication: "UTI"

→ Start: e.g., 10/06/2025
→ Stop: e.g., 16/06/2025

Key Notes:
- Males require a longer 7-day course.
- Confirm absence of complications (e.g., prostatitis) unless otherwise stated.

UTI in Pregnancy
Scenario: Pregnant woman (e.g., 28 weeks gestation) with urinary symptoms. eGFR >45, no allergy.
Prescription:
- **NITROFURANTOIN 100mg PO BD for 7 days**
  → Indication: "UTI in pregnancy"
  → Start and Stop Dates clearly mentioned

Key Notes:
- Avoid Nitrofurantoin at term due to risk of neonatal haemolysis.
- Safe if used before 36 weeks with normal renal function.

UTI with Renal Impairment (eGFR 27)
Scenario: Older adult with UTI symptoms. eGFR = 27. Not pregnant. No known allergies.
Prescription:
- **TRIMETHOPRIM 200mg PO BD for 3 days (female) / 7 days (male)**
  → Indication: "UTI"
  → Start and Stop Dates per course

Key Notes:
- Avoid Nitrofurantoin if eGFR <30.
- Trimethoprim is acceptable with caution—check for hyperkalaemia risk.

UTI with Hyperkalaemia on Ramipril
Scenario: 68-year-old with UTI and serum K^+ = 5.5 mmol/L. Currently on **Ramipril**. eGFR = 38. Plan to give Nitrofurantoin.
Prescriptions:
- **NITROFURANTOIN 100mg PO BD for 3 days**
  → Indication: "UTI"
- **STOP RAMIPRIL** – Document clearly on prescription notes or medication chart:
  → "Stop temporarily due to K^+>5.5, review and monitor K^+"

Key Notes:
- Both Nitrofurantoin and Trimethoprim can exacerbate hyperkalaemia.
- Always stop ACE inhibitors temporarily in this setting.
- Reassess potassium levels before restarting.

Diabetic Foot Cellulitis with Penicillin Allergy
Scenario: 50-year-old diabetic patient presents with a swollen, red, warm foot. Penicillin allergy noted (rash).
Prescriptions:

- **CO-TRIMOXAZOLE 960mg PO BD × 7 days**
  → Indication: "CELLULITIS"
- **METRONIDAZOLE 400mg PO TDS × 7 days**
  → Indication: "ANAEROBIC COVERAGE – DIABETIC FOOT"

Alternative (if IV route required):

- **GENTAMICIN 450mg IV OD** (if 90kg, adjust per weight: 5–7mg/kg/day)

Key Notes:

- Use combination therapy for polymicrobial coverage.
- Adjust Gentamicin dose by weight.
- Oral route preferred if patient is stable and tolerating.

Confirmed MRSA Infection (eGFR 50, 80kg, Penicillin Allergy)
Scenario: 82-year-old with confirmed MRSA infection. Rash with penicillin. Weight 80kg, eGFR 50.
Prescriptions:

- **VANCOMYCIN 1.5g IV loading dose** in 500mL 0.9% NaCl over 180 minutes (on Vancomycin chart)
- **VANCOMYCIN 500mg IV BD** in 250mL 0.9% NaCl over 60 minutes (maintenance dose) → Indication: "MRSA INFECTION"
- **Add: "Check plasma Vancomycin before 3rd dose"**

Key Notes:

- Use the Vancomycin chart (supersedes BNF).
- Monitor trough levels before 3rd BD dose.
- Watch for nephrotoxicity. Check renal function.

MRSA Decolonisation
Scenario: Patient colonised with MRSA but no active infection.
Prescription:

- **MUPIROCIN 2% OINTMENT BD × 5 days** (apply to both nostrils)
  → Indication: "ERADICATION"

Key Notes:

- Used only for colonisation, not infection.
- Write BD nasal application explicitly.

Acute Pancreatitis (Pre-op Antibiotic Prophylaxis)
Scenario: 55-year-old with acute pancreatitis, planned cholecystectomy in 2 days. History of DVT and asthma. Penicillin allergy (rash). Weight 65kg.
Prescriptions:

- **HARTMANN'S SOLUTION IV 2000mL/24h (83mL/hr)** with 15mmol KCl per bag
  → Route: IV via maintenance
  → Indication: "MAINTENANCE FLUID"
- **GENTAMICIN 1.5mg/kg IV STAT** (approx. 97.5mg) + **METRONIDAZOLE 500mg IV STAT**
  → Route: IV via 'Once Only' section
  → Timing: Administer 30 mins pre-op
  → Indication: "PRE-OP PROPHYLAXIS – CHOLECYSTECTOMY"

Additional:

- **STOP APIXABAN** 2 days prior to surgery, on day of procedure, and the day after

Key Notes:

- Do not use Meropenem in biliary surgery unless clearly instructed.
- Timing and combination are key for prophylaxis.
- Adjust Gentamicin dose per weight.

Common Palliative Care Scenarios & Prescriptions:

- **Palliative Care 1 (metastatic pancreatic cancer, cannot eat/drink):**
  - **MORPHINE:** For pain (dose provided or calculated for breakthrough). E.g., Morphine 5mg S/C every 4 hours PRN, max 30mg/24 hours.
  - **CYCLIZINE:** 50mg S/C every 8 hours (TDS) PRN for nausea/vomiting (max 150mg/24 hours).
  - **HYOSCINE BROMIDE:** 400 micrograms S/C every 4 hours PRN for secretions (max 2.4mg/24 hours).
  - Omit PARACETAMOL and ATORVASTATIN if previously prescribed orally.
- **Palliative Care 2 (Similar to Palliative Care 1, but Diamorphine used):**
  - **DIAMORPHINE:** E.g., 3.3mg S/C every 4 hours PRN for pain (max 20mg/24 hours).
  - CYCLIZINE and HYOSCINE BROMIDE as above.
  - Omit PARACETAMOL and ATORVASTATIN.
- **Palliative Care 3 (Morphine Syringe Driver):**
  - **Syringe Driver: MORPHINE** 30mg S/C via syringe driver over 24 hours (written on syringe driver chart or regular chart). Diluent: Water for Injection.
  - **Breakthrough MORPHINE:** 5mg S/C PRN (calculated as 30 mg÷6). Add note "Refer to syringe driver sheet" if applicable.
  - **CYCLIZINE** and **HYOSCINE BROMIDE** PRN S/C as per task.
  - Omit oral PARACETAMOL/ATORVASTATIN.
- **Palliative Care 4 (Diamorphine Syringe Driver):**
  - **Syringe Driver: DIAMORPHINE** 20mg S/C via syringe driver over 24 hours. Diluent: Water for Injection.
  - **Breakthrough DIAMORPHINE:** 3.3mg S/C PRN (calculated as 20 mg÷6).
  - Cyclizine and Hyoscine Bromide PRN S/C as per task.
- **Palliative Care 5 (MORPHINE PRN given, calculate DIAMORPHINE Syringe Driver):**
  - Given: **MORPHINE** 5mg S/C 4 hourly PRN for breakthrough pain (max 30mg/24 hours).
  - Calculate Max DIAMORPHINE Syringe Driver: Max MORPHINE dose is 30mg. DIAMORPHINE dose = 30 mg÷1.5=20 mg.
  - **Syringe Driver: DIAMORPHINE** 20mg S/C via syringe driver over 24 hours.
  - **Breakthrough MORPHINE:** 5mg S/C 4 hourly PRN (as given in task).
  - **CYCLIZINE** and **HYOSCINE BROMIDE** PRN S/C as per task.
- **Palliative Care 6 (Review and Adjust: MORPHINE to DIAMORPHINE Syringe Driver & Breakthrough):**
  - Given: Patient on MORPHINE 45mg S/C via syringe driver, pain ongoing.
  - Convert to DIAMORPHINE Syringe Driver: 45 mg MORPHINE÷1.5=30 mg DIAMORPHINE.
  - **Syringe Driver: DIAMORPHINE** 30mg S/C via syringe driver over 24 hours.
  - Calculate Breakthrough DIAMORPHINE: 30 mg (Diamorphine syringe driver dose)÷6=5 mg.
  - **Breakthrough DIAMORPHINE:** 5mg S/C PRN.
  - Other PRNs (**CYCLIZINE, MIDAZOLAM, HYOSCINE BROMIDE**) as per task.
- **Palliative Care 7 (Review and Adjust: Pain not controlled, increase DIAMORPHINE):**

- Given: Patient on DIAMORPHINE syringe driver 5mg/day S/C, pain not controlled. Yesterday received total 6mg DIAMORPHINE for pain.
- Task: Review and adjust. The new total 24-hour dose is 6mg.
- **Syringe Driver: DIAMORPHINE** 6mg S/C via syringe driver over 24 hours.
- Calculate Breakthrough **DIAMORPHINE**: 6 mg (new syringe driver dose)÷6=1 mg.
- **Breakthrough DIAMORPHINE:** 1mg S/C every 4 hours PRN (max 6mg/day).
- Other PRNs (**CYCLIZINE, MIDAZOLAM, HYOSCINE BROMIDE**) as per task.

Postnatal VTE Prophylaxis (Intermediate Risk)
Scenario: 42-year-old postnatal woman, parity 4, 1200mL PPH, weight 60kg.
Prescription:

- **DALTEPARIN 5000 units S/C OD × 10 days** → Indication: "VTE Prophylaxis – Intermediate Risk" → Additional: "Review after 10 days" → Time: 08:00

Key Notes:

- Tick "VTE risk assessment form completed"
- Write "units" in full

VTE Prophylaxis After Fall (Medical Admission)
Scenario: 63-year-old admitted post-fall, no fracture, weight 60kg.
Prescription:

- **DALTEPARIN 5000 units S/C OD × 7 days** → Indication: "VTE Prophylaxis – Medical" → Additional: "Review after 7 days"

Apixaban for PE
Scenario: 60-year-old post-flight PE, eGFR 87, no bleeding risk.

Prescription:

- **APIXABAN 10mg PO BD × 7 days**, then
- **APIXABAN 5mg PO BD ongoing** → Indication: "Pulmonary Embolism"

Key Notes:

- Stop any co-prescribed Aspirin

Apixaban for AF (Dose Reduction)
Scenario: 81-year-old with AF, Cr 135 µmol/L, weight 63kg, eGFR ~40.
Prescription:

- **APIXABAN 2.5mg PO BD** → Indication: "Atrial Fibrillation – Stroke Prevention"
- **ATENOLOL 50mg PO OD** (eGFR adjusted)

Important Action:

- If chart contains prefilled Dalteparin, draw a line through it, write: "Stop Dalteparin. Start Apixaban." Add initials + GMC number.

Rivaroxaban for DVT
Scenario: 50-year-old with confirmed DVT.
Prescription:

- **RIVAROXABAN 15mg PO BD × 21 days**, then
- **RIVAROXABAN 20mg PO OD** → Indication: "Deep Vein Thrombosis"

Key Notes:

- Stop Aspirin if co-prescribed

Methotrexate Hold During Infection
Scenario: 80-year-old on Methotrexate for RA. Now presents with pyelonephritis. eGFR 40.
Prescription Adjustments:

- **Hold Methotrexate**: Rewrite it and annotate – "Stop for one week until Ciprofloxacin course complete"
- **Continue Folic Acid**: Write "Daily (except Methotrexate day)"
- **CIPROFLOXACIN 500mg PO BD × 7 days** → Indication: "Pyelonephritis"

Lithium with Safe Analgesia (Avoid NSAIDs)
Scenario: 50-year-old with Lithium therapy presents with ankle pain. Nurse suggests Ibuprofen.
Prescription:

- **PARACETAMOL 1g PO QDS PRN**, max 4g/24h → Indication: "Pain"

Key Notes:

- DO NOT prescribe Ibuprofen.
- Continue Lithium per stem, no changes unless specified.

PROM with Penicillin Allergy
Scenario: 30-year-old at 34 weeks, PROM. Rash with penicillin.
Prescription:

- **ERYTHROMYCIN 250mg PO QDS × 10 days**
  → Indication: "PROM – Prophylaxis"
- **DEXAMETHASONE 12mg IM OD × 2 days**
  → Indication: "Fetal Lung Maturation"
  → Section: Regular Medications

Key Notes:

- RCOG guidance overrides BNF/NICE.
- Clarify any missing frequency/dose using BNF only if not stated.

Elderly Male with CAP and Polypharmacy
Scenario: 82-year-old male with fever, cough, SOB. PMH: HTN, T2DM, osteoarthritis. On Ramipril, Metformin, Atorvastatin, Paracetamol, and Ibuprofen. Penicillin allergy (rash). eGFR = 45. K^+ = 5.3 mmol/L.
Prescriptions:

- **CLARITHROMYCIN 500mg PO BD × 5–7 days** → Indication: "CAP"
- **OXYGEN**: Nasal cannula 2–4 L/min, target saturation 94–98%
- **DALTEPARIN 5000 units S/C OD** → Indication: "VTE Prophylaxis" → Additional: "Review after 7 days"

Regular Medications:

- **STOP RAMIPRIL** → "Stop due to hyperkalemia and eGFR. Monitor K^+."
- **REVIEW METFORMIN** → "Consider dose reduction to 500mg BD due to eGFR 45."
- **STOP ATORVASTATIN** → "Hold during Clarithromycin course."
- **PARACETAMOL 1g PO QDS PRN** → Indication: "Pain/Fever"
- **STOP IBUPROFEN** (Do not prescribe)

Postnatal Mother with VTE Risk and Pain
Scenario: 38-year-old postnatal (day 1) after 3rd delivery. PPH 1000ml. Breastfeeding. Weight: 85kg. NKA.
Prescriptions:

- **VTE RISK: Intermediate** (age >35, parity ≥3, PPH ≥1L)

- **ENOXAPARIN 40mg S/C OD × 10 days** → Indication: "Postnatal VTE Prophylaxis" → Additional: "Review after 10 days"

PRN Analgesia:

- **PARACETAMOL 1g PO QDS PRN** → Indication: "Pain"
- **IBUPROFEN 400mg PO TDS PRN** → Indication: "Pain"

Bipolar Patient on Lithium + Acute Pain

Scenario: 45-year-old male on **Lithium Carbonate 400mg BD**. Presents with ankle sprain. Nurse suggests Naproxen.

Prescriptions:

- **CONTINUE LITHIUM 400mg PO BD** → Indication: "Bipolar Disorder"
- **PARACETAMOL 1g PO QDS PRN** → Indication: "Ankle Pain"
- **CODEINE PHOSPHATE 30mg PO QDS PRN** (if needed) → Indication: "Severe Pain"

DO NOT PRESCRIBE NSAIDs

→ Document rationale if communication is part of the scenario.

Child with Acute Tonsillitis + Unable to Swallow

Scenario: 5-year-old, 18kg, unable to swallow. Diagnosis: Acute bacterial tonsillitis. IV access secured.

Prescriptions:

- **BENZYLPENICILLIN 50mg/kg IV QDS** (900mg per dose; verify vial size)
  → Indication: "Acute Tonsillitis" → Duration: 7 days
- **FLUIDS**: 0.9% NaCl + 5% Dextrose + 10 mmol KCl per 500ml
  → Rate: 56ml/hr (4-2-1 rule) → Indication: "Maintenance"
- **PARACETAMOL 15mg/kg IV QDS PRN** (270mg/dose)
  → Indication: "Fever" → Max: 60mg/kg/day

If Penicillin Allergy: Consider **IV Clindamycin** or **Macrolide** (check BNF-C).

Common Antibiotic Regimens (Adult & Pediatric)

Condition	*First-line/Common Antibiotic (No Allergy)*	*Common Alternative (e.g., Penicillin Allergy)*	*Dose*	*Route*	*Frequency*	*Typical Duration*
Adult Infections						
Community Acquired Pneumonia	Amoxicillin	Clarithromycin	500 mg	PO	BD	5 days
		Doxycycline (if macrolide allergy also)	200 mg loading, then 100 mg OD	PO	OD	5 days total
COPD Exacerbation	Amoxicillin/Doxycycline/Clarithromycin	Doxycycline	200 mg loading, then 100 mg OD	PO	OD	5 days total
UTI (Uncomplicated, Female)	Nitrofurantoin	Trimethoprim (if eGFR <30 for Nitro)	100 mg (Nitro) / 200 mg (Trimeth)	PO	BD	3 days

UTI (Male or Complicated)	Trimethoprim / Nitrofurantoin		200 mg (Trimeth) / 100 mg (Nitro)	PO	BD	7 days
Pyelonephritis (Adult)	Ciprofloxacin / Co-amoxiclav	Ciprofloxacin / Cefalexin	500 mg (Cipro/Cefalexin)	PO	BD	7 days
Cellulitis (Pen. Allergy)	Flucloxacillin	Co-trimoxazole +/- Metronidazole +/- Gentamicin	960 mg (Co-trimox) / 400 mg (Metro) / 5–7 mg/kg (Gent)	PO/ IV	BD/TDS/OD	7 days
MRSA Infection	Vancomycin	Vancomycin	1.5 g load; 500 mg maint. (per chart)	IV	BD (maint)	e.g., 10 days
PROM (Pen. Allergy)	Benzylpenicillin	Erythromycin	250 mg	PO	QDS	10 days
Pre-op Prophylaxis (Cholecystectomy, Pen. Anaphylaxis)	Co-amoxiclav	Metronidazole + Gentamicin	500 mg (Metro) + 1.5 mg/kg (Gent)	IV	Once Only	Single Dose
Pediatric Infections						
Quinsy (Difficulty Swallowing)	Benzylpenicillin + Metronidazole	Benzylpenicillin + Metronidazole	25mg/kg (Benzpen) + 7.5mg/kg (Metro)	IV	QDS/TDS	7 days
Quinsy (Oral Tolerated)	Phenoxymethylpenicillin + Metronidazole	Phenoxymethylpenicillin + Metronidazole	250 mg (Phenoxy) + 7.5mg/kg (Metro)	PO	QDS/TDS	7 days
LRTI	Amoxicillin	Cefuroxime	20mg/kg	IV	TDS	3-5 days
Pyelonephritis (Child, no Lithium)	Co-amoxiclav / Cefalexin	Cefalexin	125 mg	PO	TDS	7 days
Pyelonephritis (Child, on Lithium)	Co-amoxiclav	Co-amoxiclav (avoid Cefalexin)	250/125 mg	PO	TDS	7 days

Vancomycin Dosing and Monitoring Quick Guide

Parameter	*Loading Dose*	*Maintenance Dose*	*Target Trough Level*	*Key Monitoring*
Basis for Dose	Actual Body Weight	eGFR		Plasma Vancomycin levels (trough), Renal function (U&Es, Creatinine, eGFR)
Example (80kg, eGFR 50)	1.5 g IV in 500 mL NaCl over 180 mins	500 mg IV in 250 mL NaCl over 60 mins, every 12 hours	10–20 mg/L	Check level before 3rd or 4th dose. Monitor renal function throughout.
Example (eGFR 30-39)	(Weight-based)	750 mg IV, every 24 hours	10–20 mg/L	Check level before 2nd or 3rd dose (for

			OD). Monitor renal function.
Dilution	Reconstitute, then further dilute in NaCl or Glucose 5%. Final conc. not > 5 mg/mL.	Reconstitute, then further dilute in NaCl or Glucose 5%. Final conc. not > 5 mg/mL.	
Administration Rate	Not exceeding 10 mg/minute.	Not exceeding 10 mg/minute.	
Chart Authority	Vancomycin Chart supersedes BNF.	Vancomycin Chart supersedes BNF.	Follow chart instructions precisely.

Summary of Critical Drug Interactions and Management in PLAB2

Interacting Drugs (Drug A + Drug B)	***Potential Consequence***	***Action Required in PLAB2***
Lithium + NSAIDs (e.g., Ibuprofen)	Lithium toxicity (due to reduced renal clearance of Lithium)	**AVOID** concurrent use. Prescribe Paracetamol for analgesia.
Clarithromycin + Statins (e.g., Atorvastatin, Simvastatin)	Increased risk of myopathy and rhabdomyolysis	**STOP** statin for the duration of the Clarithromycin course.
ACE Inhibitors (e.g., Ramipril) + Hyperkalemia	Worsening of hyperkalemia	**STOP** ACE inhibitor if significant hyperkalemia is present. Monitor potassium levels.
ACE Inhibitors + K+-sparing UTI Antibiotics (Nitrofurantoin, Trimethoprim)	Increased risk of hyperkalemia	**CAUTION**. If hyperkalemia present/develops, stop ACE inhibitor. Monitor potassium.
Methotrexate + Acute Severe Infection	Impaired immune response, worsening of infection	**STOP/HOLD** Methotrexate during the acute infection and antibiotic course.
Apixaban/Rivaroxaban + Aspirin	Increased bleeding risk	**STOP/HOLD** Aspirin (unless very specific indication for dual therapy by specialist).
Apixaban/Rivaroxaban + Other Anticoagulants (e.g., Dalteparin)	Significantly increased bleeding risk	**STOP** one of the anticoagulants. If transitioning, clearly cancel the discontinued anticoagulant on the prescription chart.
Cefalexin + Lithium (Pediatrics)	Potential increased risk of nephrotoxicity	**AVOID**. Consider alternative antibiotic (e.g., Co-amoxiclav for pyelonephritis if child is on Lithium).
Apixaban + Elective Surgery	Increased perioperative bleeding risk	**HOLD** Apixaban for a specified period before surgery (e.g., 48 hours, depending on surgical risk and renal function).

Appendix: Layman Terms for Medical Specialties in PLAB 2

In PLAB 2, it's important to use **language patients understand**. Avoid using specialty names like "ENT" or "rheumatology" when speaking to patients — these are **clinical terms**, not patient-friendly. Instead, use **clear and simple explanations** that describe what the doctor or clinic does.
Below is a guide to help you describe most medical specialties in lay terms:

Medical Specialties and Their Lay Terms

Specialty	*Layman Description to Use in Exam*
Cardiology	*Heart specialist*
Respiratory / Pulmonology	*Lung specialist*
Gastroenterology	*Digestive system or stomach and bowel specialist*
Neurology	*Brain and nerve specialist*
Endocrinology	*Hormone or gland specialist*
Rheumatology	*Joint and immune system specialist*
Nephrology	*Kidney specialist*
Urology	*Urinary and bladder specialist (sometimes also deals with men's health)*
Gynaecology	*Women's health specialist*
Obstetrics	*Pregnancy and childbirth specialist*
Paediatrics	*Children's doctor*
Dermatology	*Skin specialist*
ENT (Otorhinolaryngology)	*Ear, nose and throat specialist*
Ophthalmology	*Eye specialist*
Psychiatry	*Mental health specialist*
Geriatrics	*Older adult or elderly care specialist*
Oncology	*Cancer specialist*
Haematology	*Blood specialist*
Infectious Diseases	*Specialist in infections or serious long-term infections*
General Surgery	*Surgical team or doctor who may perform an operation if needed*
Orthopaedics	*Bone and joint specialist (especially after injuries)*
Plastic Surgery	*Specialist for rebuilding or repairing the body after injury/surgery*
Maxillofacial Surgery	*Specialist for jaw, face, or mouth surgery*
Vascular Surgery	*Specialist for blood vessels and circulation*
Palliative Care	*Specialist in symptom relief and support for serious or long-term illnesses*
Sexual Health / GU Medicine	*Clinic that deals with sexual health and infections*
A&E / Emergency Medicine	*Emergency team / hospital emergency department*
Anaesthetics / Pain Medicine	*Specialist who helps with pain relief or during operations*
Public Health / Screening	*Team that focuses on prevention and health checks*
Genetic Counselling / Genomics	*Specialist who deals with inherited or genetic conditions*

Tips for Using These Terms in PLAB 2

- Don't say: *"I'll refer you to ENT."*
  Say: *"I'll refer you to a specialist who deals with the ear, nose, and throat."*
- You can also say: *"We'll involve a team that deals with..."* if you're unsure.

This small change improves your **communication score** — and shows the examiner that you can **explain things clearly to a patient** without using jargon.

What Next?

If you've made it this far — well done. But here's the truth:
It's not great notes that make you pass PLAB 2. It's how much you practise.
These notes are here to give you structure, confidence, and clarity — but **they are not a script**. They are a guide.
And your job now is to **bring them to life**.

Practice Like It's the Real Exam

- Practice **out loud**, not silently.
- Practice **with a partner**, or even **in front of a mirror**.
- **Use a timer** — always. Your brain must learn to think and speak in 8-minute blocks.
- Try **random case recall** — don't just practise the same 10 stations again and again.

Mock Exams: Your Best Mirror

- Attend at least one **good-quality mock** with a **reputed provider**.
- Don't just chase high scores — chase **honest feedback**.
- Use the feedback to **adjust your approach**, not your personality.

Add Layers to Your Learning

To truly build clinical fluency:

- Use **flashcards** for rapid recall of management plans.
- Use **revision packs** to review cases efficiently.
- Listen to **audio cases** while driving or walking — get used to the sound of good communication.
- Try **AI tools** or apps to simulate patient dialogue if practising alone.

What About PLAB 2 Academies?

PLAB 2 academies and online courses can offer:

- Structured guidance
- Case walkthroughs
- Peer practice networks

They can absolutely **add value** — especially if you need direction or motivation. But remember:
No tutor or course can pass the exam **for** you.
What matters is **how much you practise**, **how honestly you reflect**, and **how clearly you speak**.

Final Note: Don't Memorise This Book

Please don't study *GK's Notes 2.0* like a script. That's not how PLAB 2 works.
Instead:

- **Understand** the reason behind each question.
- **Say things in your own words.**
- **Keep it simple, keep it human.**

"Use your own words. Patients don't want textbook language — they want to understand you."
You don't need to sound smart.
You need to sound **clear**, **kind**, and **confident**.

Now go practise. Again. And again. And again.
That's how you pass.

Stay Connected — Get More Than Just Notes

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www.gksplab2.com

✉️ **Email:**
gksplab2@gmail.com

Scan the above QR code to join my WhatsApp group

Let's make PLAB 2 simpler, smarter, and more strategic—together.