

GK'S NOTES 3.0

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EDITION



VOLUME 3

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All cases, scenarios, clinical discussions, and teaching content in this book are **entirely original works** created independently by the author(s). They are:

- Based on common UK clinical practice scenarios and consultation structures
- Informed by publicly available NHS, NICE, BNF, and GMC Good Medical Practice guidelines
- Designed to teach clinical reasoning, communication skills, and management planning in a UK healthcare context
- Written using original phrasing and independently constructed case designs

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Users are strongly encouraged to consult official NHS, NICE, and BNF guidelines regularly, as clinical recommendations evolve over time.

Patient Scenarios

All patient cases are entirely fictional. Any resemblance to real persons, living or deceased, is purely coincidental. No real patient data or identifiable clinical encounters have been used.

For updates, revision tools, and additional resources, visit: www.gksplab2.com

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This textbook gives you the consultation scripts, the frameworks, and the exact words to say in every PLAB 2 station.

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- **OSCE Practice Stations** - Full exam-format stations with candidate briefs, marking schemes, actor scripts, and case notes that show you exactly where marks are won and lost. Practise each one as many times as you want.

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You know the drill. You post in the WhatsApp group: "Anyone free to practise tonight?" Three people say yes. One cancels. One doesn't show. The third wants to do a different system. By the time you actually practise, you've wasted a week.

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Free accounts get 9 sessions per day - 3 as Doctor, 6 as Patient. That's more daily practice than most candidates do in a week. Resets at midnight UK time, every day.

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PREPARE - Walk Into Every Station With Confidence

1. **Clinical Concept Refreshers**

Guidelines change between editions. Examiners don't tell you which ones. These refreshers keep your clinical knowledge aligned with current best practice for every system - so you never lose marks on something you could have looked up the night before.

Read the chapter in this textbook for how to consult. Use the refresher to make sure the clinical facts behind your consultation are still correct.

2. **Summary Notes - 500+ Cases On Your Phone**

The entire PLAB 2 syllabus condensed into high-yield notes across all 18 systems. Each one pulls the essentials from the corresponding GK's Notes chapter into something you can revise on the bus, in a queue, or in bed at midnight.

Not a replacement for reading. A replacement for flipping back through 1500 pages trying to find that one management step you can't quite remember.

PRACTICE - Because Reading About Consultations Doesn't Pass the Exam

3. **Practice Hub with 560+ OSCE Stations and patient scripts -**

Every station built to mirror the real PLAB 2 format. Candidate brief. Actor script. Case notes explaining precisely where marks are gained and where they're lost.

Stop wondering if you're ready. **Start knowing.**

4. **OSCE Evaluation Checklists - See Exactly Where Your Marks Go**

This isn't vague "practice questions." This is you sitting down, reading the brief, doing the case, then checking the marking scheme to see whether you'd have passed. Across all systems. Mapped directly to the cases in this textbook.

5. **AI Patient - An Examiner Who Never Sleeps***

You speak. The AI listens. It responds - naturally, in character, based on the clinical scenario. You have 8 minutes. The clock is running. There's no pause button, no hint, no "show me the answer." Just you, consulting, exactly like the real exam.

When time runs out, you get a **detailed feedback report** across all three PLAB 2 marking domains. Not generic encouragement - specific, actionable feedback on what you said, what you missed, and what you should have done differently.

Practise at 2 AM. The AI doesn't care. **Practise the same case six times.** It won't get tired of you. **Practise on the bus with earphones.** Nobody needs to know.

Your subscription includes 3 sessions.

Less than a cup of coffee per session. For feedback that used to require booking a tutor.

*Tech Preview - Full AI Practice packs and mocks coming soon.

6. **Unlimited Practice Partners - No Caps, No Excuses**

Premium removes the daily limit entirely. Practise 5 times. Practise 20 times. Morning, afternoon, midnight - as many sessions as you want, in any role, across any system.

The week before your exam, this is what makes the difference. The ability to just keep going.

7. **8-Minute Timer - Every System, Every Case**

The exam clock, available everywhere. Warning bell at 6 minutes. End bell at 8. Use it on every single case until you stop thinking about time - because the candidates who run out of time aren't the ones who know less. They're the ones who didn't train under the clock.

REVISE - The Part Where Everything Finally Sticks

8. **Rapid Review Notes - What You Actually Need to Remember**

You've read the chapter. You've practised the case. Now strip away everything except what you need to walk into the station knowing. Key points. Critical differentials. Management steps. Nothing else.

Open these the night before your exam. Refresh an entire system in minutes. This is the revision tool you'll wish you'd had for every exam you've ever taken.

9. **Visual Mindmaps - One Glance, One Entire System**

Every clinical system laid out as a single connected map - cases, differentials, management plans, all linked together. Scan it. Find the branch you can't recall. That's your revision target for the next hour.

Perfect for:

Refreshing an entire system in one sitting

Seeing how similar presentations differ (migraine vs. cluster vs. tension)

Discovering gaps you didn't know existed

10. **Management Flashcards - 570+ Cards That Refuse to Let You Forget**

Spaced repetition, done properly. Every major management plan in the PLAB 2 syllabus, tracked by an algorithm that learns what you know and what you don't. Cards you struggle with come back sooner. Cards you've mastered space out further.

This isn't re-reading your notes and hoping it sticks. This is **active recall** - the single most effective study technique research has ever identified - applied to every management plan you need to know. The app does the scheduling. You just show up and answer.

11. **AI Learning Trends - See What the Crowd Is Doing**

Which cases are trending this week? Which systems are getting the most practice? What are other candidates focusing on right now? Use real-time platform data to make sure you're not ignoring the topics everyone else is drilling.

12. **Medical Image Library - Train Your Eyes, Not Just Your Ears**

Clinical images - dermatological findings, clinical photographs - for the visual diagnoses that appear in PLAB 2 stations.

Use it until you can glance at an image and know. That's the standard.

The exam doesn't wait. Neither should you.

gksplab2.com

A Note Before You Begin

To every doctor reading this,

You already did something remarkable. You studied medicine, you qualified, and you chose one of the hardest paths a doctor can take - proving yourself all over again in a system that wasn't built with you in mind.

I won't sugarcoat what 2026 looks like for international medical graduates. The exam has changed - realigned to the MLA content map, demanding sharper clinical reasoning and deeper UK-specific thinking. PLAB 2 pass rates sit below 66%. Fees have risen. The validity window has tightened. And beyond the exam, the landscape has shifted dramatically. Over 47,000 doctors are now competing for roughly 13,000 specialty training posts. The UK Government has fast-tracked the Medical Training (Prioritisation) Bill - legislation that explicitly prioritises UK graduates for foundation and specialty training offers ahead of IMGs.

These are facts. You deserve to know them clearly.

But here's the other side of that story: over 138,000 internationally trained doctors are currently licensed and working in the UK - 42% of the entire medical workforce. The NHS doesn't just welcome international doctors. It depends on them. That hasn't changed, and it won't.

What sets you apart isn't where your degree is from. It's how you show up. The way you think through a consultation. The way you communicate with a patient. The way you safety-net, share decisions, and manage uncertainty. That's what this exam tests. And that's exactly what this book is built to teach you.

GK's Notes 3.0 is a complete rebuild from the ground up - every case, framework, and clinical discussion independently created, rooted in NHS, NICE, and GMC guidance, and designed to help you think the way this exam demands.

In the past eight months, over 4,000 candidates have used GK's PLAB 2 Study Centre to prepare - and passed. What started as a small project has grown into a community that spans countries, time zones, and exam cohorts. Doctors helping doctors. Strangers becoming study partners. People celebrating each other's passes like their own.

That community is you. And I owe you more than I can say.

To everyone who sent a message after passing, who recommended us to a friend, who showed up again after a setback - thank you. You built something far bigger than a set of notes.

Take your time with this edition. Read slowly. Think deeply. Practise out loud. And after every attempt, pause - not to judge yourself, but to learn.

The system may not be fair. But you can still be exceptional.

Trust the work. Trust yourself.

- GK

How to Use This Book

Let's get one thing out of the way.

DO NOT MEMORISE THESE NOTES.

If your plan is to highlight every line, cram fifty cases in a weekend, and walk into your station reciting someone else's words - this book isn't going to help you. Not because the content isn't good enough, but because that's not how PLAB 2 works.

This exam doesn't reward memory. It rewards thinking. It rewards doctors who can listen, respond, explain, and make decisions in real time - clearly, calmly, and with empathy. That's what this book is designed to train.

Every case is written in a natural, conversational style - not so you can repeat it word for word, but so you can absorb the rhythm of a safe, structured UK consultation and learn to speak in your own voice with confidence.

What This Book Is

This is a structured, station-by-station guide to PLAB 2. Every case is built around realistic clinical scenarios, aligned with current NHS, NICE, and GMC guidance, and designed to help you develop three things: clinical reasoning, consultation structure, and the language to tie them together. It's a resource that trains your logic, sharpens your communication, and prepares you to make sound decisions under time pressure.

What This Book Is Not

It is not a script bank. It is not a shortcut. It is not a rehash of academy slides or lecture transcripts. And it is not something to read cover to cover in silence the night before your exam.

How to Get the Most Out of It

- 1. Speak it out loud.** Every single time. Set a timer. Record yourself. Practise with a partner or solo - but never just read silently and move on. PLAB 2 is a spoken exam. Your preparation should be too.
- 2. Learn the structure, not the sentences.** Every case follows a logical consultation flow - opening, history, screening, ICE, explanation, plan, safety netting. These are your anchor points, not your script. Understand the steps, then express them in your own words.
- 3. Don't try to say everything.** The cases here are written in detail so you can understand the full picture. You are not expected to cover every point in an eight-minute station. In the exam, clear and focused communication will always beat trying to say it all. If you need a quicker revision pass before your exam, the **summary notes and rapid review notes on gksplab2.com** are built for exactly that - distilling each case down to what matters most.
- 4. Don't be overwhelmed by the size.** This is a comprehensive book - deliberately so. The detail exists to deepen your understanding, not to burden your memory. Take it one case at a time. Quality over quantity, always.
- 5. Repeat before you move on.** Master a few cases deeply. Then come back to them. Repetition builds fluency. Your goal isn't to finish the book - it's to learn from it.
- 6. Pair it with active revision tools.** Reading alone isn't enough. The most successful candidates combine spoken practice with visual and active recall methods. The **management flashcards, mind maps, and image library on gksplab2.com** are designed to work alongside this book - reinforcing key decisions, counselling phrases, and clinical patterns so they stick under exam pressure.

7. Test yourself with real station practice. Once you're comfortable with a case, try it under timed conditions. The **companion OSCE cases on gksplab2.com** give you a chance to simulate the exam experience - complete with candidate briefs and marking guidance - so you can identify gaps before exam day does it for you.

8. Use it however you study best. Whether you're attending a course, working with a study group, or preparing independently, these notes are built to give you a clean, solid foundation. They'll help you cut through the noise and focus on what actually matters in a station.

Staying Up to Date

PLAB 2 is a constantly evolving exam. Core stations reappear frequently, but new scenarios are introduced regularly - often with different angles, emotional tones, or ethical dimensions.

GK's Notes 3.0 is built to evolve with it.

This resource is updated multiple times a year, incorporating new case patterns, refined phrasing, and structural improvements. Always ensure you are working from the latest version. All updates, new cases, and the full suite of revision tools - including summary notes, rapid reviews, flashcards, mind maps, OSCE companions, and the image library - are available at www.gksplab2.com.

A Note on Accuracy

This book is the product of considerable time, care, and clinical attention - with the goal of helping as many candidates as possible prepare with confidence. Every case has been written with close attention to accuracy and alignment with current guidance.

That said, medicine evolves. Guidelines are updated. And despite every effort, no resource is immune to the occasional error.

If something seems unclear, outdated, or inconsistent - please verify it against trusted sources such as NICE, NHS CKS, or BNF. These should always be your primary reference for clinical reasoning and management decisions.

And if you do spot an error, I'd be genuinely grateful if you let me know directly. Every correction strengthens the next edition - and helps every candidate who comes after you. Email at gksplab2@gmail.com

Thank you for being part of making this resource better.

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Chapter 18: Counselling

A Note to Learners

The cases in this resource are written in a conversational style to help you become familiar with the natural flow of clinical consultations and the language commonly used in UK healthcare settings.

These dialogues are intended as a learning guide, not a script. Please do not attempt to memorise them verbatim. Examiners assess your ability to think and communicate authentically - not to recite rehearsed phrases.

Use this material to understand the underlying clinical reasoning, then practise in your own words until the consultation feels natural to you.

For Companion OSCE Cases, Practice Scripts, Evaluation Checklists, Summary Notes, Rapid Review Notes, Mindmaps, Management Flashcards and Image Library - visit <https://www.gksplab2.com>

Disclaimer

This material is independent educational content created to help candidates develop clinical reasoning and communication skills for UK medical practice.

All cases and clinical scenarios are based on common presentations encountered in UK primary care and emergency medicine, drawn from publicly available sources including NICE Clinical Knowledge Summaries (CKS), BNF, and other official NHS/UK healthcare guidelines.

No content in this resource is derived from, represents, or claims to replicate actual GMC PLAB 2 examination material.

Introduction to Counselling Stations

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

Patient scenario: Middle-aged adult requesting prophylactic antibiotics before international travel to South-East Asia. Has previously been prescribed antibiotics for travel to a tropical region but did not use them.

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:

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"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., *South-East Asia*
- "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?" → *Tropical 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 serious side effects** - the **MHRA (January 2024)** issued strengthened warnings that fluoroquinolones (including ciprofloxacin) must only be prescribed when other antibiotics are inappropriate, due to risk of disabling, potentially long-lasting or irreversible side effects including tendonitis, tendon rupture, neuropathy, and psychiatric effects.
- 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 inflammatory bowel disease, immunosuppression, or ileostomy).

Important nuance: Standby antibiotics **may** be considered for:

- Travellers with IBD, immunosuppression, or other conditions that increase risk of severe illness
- Those visiting **very remote areas** with limited healthcare access
- This decision should be made after specialist travel clinic assessment, not routine GP consultation

"So even though it may feel like a 'safety net,' it could actually do more harm than good - unless you have specific risk factors we should discuss."

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:

- Pack **oral rehydration sachets** (Dioralyte) for fluid replacement.
- Take **loperamide** (Imodium) for short-term symptom relief in case of mild diarrhoea.
- Buy from a pharmacy in advance - just in case.

B. What If You Do Get Ill?

- If symptoms are mild → Use rehydration and rest.
- If symptoms are severe (high fever, blood in stool, dehydration) → Seek local medical help.
- If needed, antibiotics can be prescribed there or on return.

C. Offer Leaflet or Link

"I can give you a leaflet from NHS Fit for Travel, or if you prefer, I can text you the link to check yourself. It has country-specific advice, including what vaccines are recommended."

5. Safety Netting

"If during or after your trip you develop symptoms like prolonged diarrhoea, blood in stool, fever, or dehydration - please see a doctor urgently."

"And if you're ever unsure during your trip, you can contact a local clinic or call NHS 111 on your return."

Close

"I hope that explains why I wouldn't recommend antibiotics this time - but I want you to feel safe and well-prepared. Shall I print you that leaflet, or is there anything else you'd like to ask?"

Obesity and Weight Management

Patient: Middle-aged woman calling to discuss weight management. Has struggled with weight since childhood, family history of obesity.

Opening & Introduction

"Hello, this is Dr [Name], one of the doctors at the practice. Am I speaking to [Patient Name]? Thank you - before we begin, could I just confirm your full name and age, please?"

"I understand you've called today to talk about weight concerns. Could you tell me more about what's been on your mind?"

C - Clarify the Concern

Explore what brought this up:

- "Has something happened recently that made you want to discuss this now?"
- "Have you been feeling differently about your weight or your health lately?"
- "Is this something you've been thinking about for a while?"

ICE:

- **Ideas:** "What do you think might be causing the weight gain - or what makes it hard to manage?"
- **Concerns:** "Is there anything in particular you're worried about?"
- **Expectations:** "What were you hoping I could help you with today?"

→ Patient is hoping to hear about medications or surgery options.

A - Assess the Background

1. Brief Medical History

- "Do you have any medical conditions - like diabetes, high blood pressure, thyroid problems, or joint issues?"
- "Are you taking any regular medications?"
- "Do you have any allergies?"

2. Family History

- "Is there a history of obesity, heart disease, or diabetes in your family?"

3. Lifestyle (DESA)

- **Diet:** "Could you describe what a typical day of eating looks like for you?"
- **Exercise:** "Do you manage any physical activity at the moment?"

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- **Smoking/Alcohol:** "Do you smoke or drink alcohol?"
- **Sleep:** "How's your sleep - any issues like snoring or daytime tiredness?"

4. Mood Check

- "How has your mood been lately?"
- "Do you ever feel low, anxious, or unmotivated?"

5. Menopause or Hormonal Factors (if relevant)

- "Have you gone through menopause, or are you experiencing any hormonal changes?"

R - Reassure

"Thank you for opening up about this - it's a really important conversation, and I'm glad you've reached out."

"The first thing I want to say is: obesity is recognised as a medical condition. It's not a personal failure. There are many factors that contribute to weight - including genetics, hormones, lifestyle, sleep, mood, and even things like menopause or certain medications."

"The fact that you've struggled since childhood and have a family history tells us that biology plays a significant role here. You're not alone, and there are things we can do to help."

E - Educate & Plan

Step 1: Understanding BMI

"Your BMI - that's your body mass index, a way we measure weight relative to height - is one of the tools we use to assess weight-related health risk."

"Based on what you've shared, it sounds like your BMI falls into a range where we'd want to offer support. I'd like to arrange some blood tests to make sure there are no underlying issues - like thyroid problems or diabetes - that might be contributing."

Note: It's also worth knowing that for people from South Asian, Chinese, other Asian, Middle Eastern, Black African or African-Caribbean backgrounds, we use slightly lower BMI thresholds because the health risks start at a lower weight.

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

"The first step we'd recommend is a structured weight management programme. This isn't just about 'eat less and exercise more' - it's a proper support service with dietitians, health coaches, and behavioural support."

"I can refer you to our local Tier 2 service, which is free on the NHS. They'll work with you on personalised goals, meal planning, and activity that suits your situation."

Step 3: Medications

"For medications, Orlistat can be started in primary care if your BMI is over 30, or over 28 with other health conditions. It works by reducing the amount of fat your body absorbs from food."

"For newer injectable medications like Semaglutide, Liraglutide, or Tirzepatide, these are only available through specialist weight management services - so if lifestyle changes aren't enough, I can refer you to a Tier 3 service where they can assess whether you'd be suitable for those options."

MHRA Safety Note: GLP-1 receptor agonists (including semaglutide, liraglutide, tirzepatide) have important safety considerations:

- Common GI side effects (nausea, vomiting, diarrhoea) - especially during dose titration

- Potential risk of hypoglycaemia in non-diabetic patients
- Women of childbearing potential should use effective contraception; semaglutide should be stopped at least 2 months before planned pregnancy
- Risk of pulmonary aspiration during general anaesthesia - inform anaesthetist before any surgery

Step 4: Bariatric Surgery (if appropriate)

"For people with a BMI over 40, or over 35 with complications, bariatric surgery can be considered - but only after other options have been properly tried. This would be assessed through a Tier 3 or Tier 4 specialist service."

Step 5: Mental Health and Support

"If mood or motivation is affecting your progress, we can also link you with counselling or psychological support."

Safety Netting & Follow-Up

"I'll arrange those blood tests and refer you to the weight management service. Let's speak again in 4–6 weeks to review how things are going."

"If you notice any changes in mood, energy, or new symptoms - or if you have any questions - please don't hesitate to get in touch."

Obesity Counselling - BMI 40

Patient: Perimenopausal woman presenting with concerns about progressive weight gain. BMI in Class III obesity range.

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 severe 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."

Note: For people from South Asian, Chinese, other Asian, Middle Eastern, Black African or African-Caribbean backgrounds, we use slightly lower BMI thresholds because the health risks start at a lower weight.

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 (can be considered alongside lifestyle support):

- "With a BMI of 40, we can consider medication **alongside** lifestyle support - you don't necessarily have to 'fail' lifestyle changes first. Current NICE guidance (NG246, 2025) recognises obesity as a chronic condition requiring a personalised approach."
- "Orlistat can be started in primary care - it helps reduce fat absorption from the food you eat."
- "For newer injectable medications like Semaglutide, Liraglutide, or Tirzepatide, these are NICE-recommended for eligible people, but access is usually via specialist weight management services and subject to **local commissioning criteria**, which vary by region. Given your BMI, I can refer you for assessment to discuss whether these might be suitable for you."

Orlistat continuation criteria: Therapy should only be continued beyond 12 weeks if at least 5% of initial body weight has been lost since starting treatment. For people with type 2 diabetes, slightly less strict goals (e.g., $\geq 3\%$) may be appropriate.

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."

MHRA Update: GLP-1 receptor agonists (including semaglutide, liraglutide, tirzepatide) have important safety considerations:

- Common GI side effects (nausea, vomiting, diarrhoea) - especially during dose titration
- Women of childbearing potential should use effective contraception; semaglutide should be stopped at least 2 months before planned pregnancy
- Risk of pulmonary aspiration during general anaesthesia - inform anaesthetist before any surgery

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:** Middle-aged woman with severe 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?"

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"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**. Many orthopaedic units have local policies about operating above certain BMI thresholds - not because of NICE guidelines specifically, but because evidence shows that operating at higher BMIs can increase the risk of complications."

"The **knee is a weight-bearing joint**. With a higher BMI, there are increased risks during and after surgery - such as the new joint loosening, wearing out earlier, infection, or blood clots. There's also a higher chance of wound healing problems."

"That said, I want to be honest with you: recent research, including a large NHS study from 2024, has shown that many patients with higher BMIs do well after knee replacement. The decision isn't black and white, and it's something we weigh up carefully for each person."

"The goal of weight reduction isn't to punish you - it's to give your surgery the best chance of success and to reduce the risk of needing a repeat operation down the line."

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 NG246):**

"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** in primary care:

"It reduces fat absorption in the gut."

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

Consider referral to **Tier 3 specialist service** for assessment for **Semaglutide or Tirzepatide** if 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 the local threshold** - 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; Tier 3 referral for injectable options

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 - Caring for Child

Setting: Primary Care **Role:** FY2 GP

Patient: Parent requesting time off work to care for their child who has chickenpox.

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."

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- "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 annual leave or emergency leave available?"
- "Would your employer allow unpaid compassionate leave?"

R - Reassure

"I completely understand how difficult this is - you're trying to care for your child while managing work pressures, and you're doing the right thing by being there for him."

"However, I need to explain something important about how sick notes work."

Explain the Boundary (Clear, Non-Judgmental):

"A sick note - which we now call a 'fit note' - is a medical document that certifies that **you** are unwell and unable to work. It's based on a clinical assessment of **your** health, not your circumstances at home."

"Because you're not currently unwell, I'm not able to issue a fit note in your name. If I did, it would be inaccurate - and could cause problems for both of us."

"I know that's not what you were hoping to hear, and I'm sorry I can't offer a simple fix."

Note for candidates: Since July 2022, fit notes can also be issued by nurses, occupational therapists, pharmacists, and physiotherapists - but the same principles apply: they must certify that the patient themselves is unfit for work.

E - Educate & Plan

Alternative Options to Explore:

"Here are some alternatives that might help:"

1. **Speak directly with your employer**
 - "Most employers understand childcare emergencies. You could request emergency dependant leave - this is a legal right in the UK under the Employment Rights Act 1996."
 - "You don't need a doctor's note for this - it's between you and your employer."
2. **Use annual leave or unpaid leave**
 - "If emergency leave isn't enough, some employers allow flexible or compassionate unpaid leave."
3. **Child's GP letter (if needed)**
 - "If your employer wants proof that your child is unwell, I can write a brief letter confirming that your child has chickenpox and is being cared for at home. That's factual and accurate."
4. **Contact HR or union**
 - "If you're unsure about your rights, your HR team or a union rep can advise you."

Safety Netting:

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"If **you** start to feel unwell - such as developing a fever, rash, or any other symptoms - please come back and we can reassess."

"And if your child's condition worsens - high fever, breathing problems, or signs of infection - bring him in or call 111."

Important clinical nuance: If the parent presents with their **own** symptoms of stress, anxiety, or low mood related to the caring situation, they may qualify for a Fit Note based on their **own** mental health condition. Ask: "How are **you** coping with all of this? How has your mood been?" If they disclose significant distress affecting their ability to function, this is a separate clinical presentation that can be assessed on its merits.

Close:

"I know this isn't the answer you were hoping for, but I hope the options I've explained are helpful. Is there anything else I can clarify?"

Sick Note Request - Childcare Issues During School Holidays

Setting: Primary Care **Role:** FY2 GP

Patient: Parent requesting a sick note to stay home during school holidays to care for children.

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

Setting: Primary Care **Role:** FY2 GP

Patient: Adult presenting after a road traffic accident, requesting a sick note for whiplash injury. Clinical assessment reveals no current injury.

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?"

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- "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. I want to support you and 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**."

"A Fit Note is a **legal document** that certifies a medical condition affecting your ability to work. Since your examination today is normal and you have no current symptoms, I am not able to legally certify you as unfit for work."

"However, I **can** write a **factual letter** confirming your attendance at A&E following the accident, and that you have consulted me today. This is accurate and may help explain the situation to your employer."

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?"

If Patient Requests You To 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

Setting: Emergency Department **Role:** FY2 Doctor

Patient: Adult with ankle pain after minor injury. X-ray normal. Later requests documentation be changed to support workplace compensation.

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1. Introduction

"Hello again. 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: Emergency Department **Role:** FY2 Doctor

Patient: Young adult with wrist pain after minor injury. X-ray normal. Requests records be changed to claim workplace injury for financial reasons.

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 Difficulty:

"I understand you're going through a difficult time, and I can see you're under a lot of pressure caring for your grandmother."

2. Explore Reason Without Judging:

"Can I just clarify - you're asking me to change the notes to say this injury happened at work, when it didn't?"

3. Clear, Firm Ethical Refusal:

"I have to be very clear with you: **I cannot do this, and I must explain why.**"

"What you're describing - changing medical records to state that an injury occurred at work when it didn't, in order to receive payment - would be **fraud**. This is a serious matter."

"Falsifying medical records to support a fraudulent claim would:

- Be a **criminal offence** (fraud by false representation)
- Breach **medical ethics** and could end my career
- Expose **you** to serious legal consequences if discovered
- Undermine trust in the medical system"

"I understand the situation is stressful, but I **cannot** help you pursue something that is illegal, even for sympathetic reasons. This isn't negotiable."

4. Maintain Integrity Without Escalating:

"This isn't about me being junior. No doctor - at any level - would change medical records in this way. It's simply not something we can do."

5. Redirect to Legitimate Support:

"If you're struggling financially because you need time off to care for your grandmother, there **are** legitimate options:

- Speak to your **employer** about compassionate leave or emergency dependant leave
- Contact **ACAS** (Advisory, Conciliation and Arbitration Service) about your employment rights
- If you're experiencing financial hardship, organisations like **Turn2us** or local councils can advise on benefits you may be entitled to"

"I'm happy to help with anything that's within my scope - but I can't be part of anything that involves falsifying records."

Note for candidates: This is a **firm boundary** situation. Do not soften the message by appearing to sympathise with the fraudulent request itself. You can acknowledge the difficult circumstances while being absolutely clear that fraud cannot be facilitated. Do NOT refer the patient to Citizens Advice or similar services specifically to help with a fraudulent claim.

Confidentiality - Parent Calls About Daughter with Depression

Setting: Primary Care (Telephone) **Role:** FY2 GP

Caller: Parent of an adult patient (>18 years) requesting information about their child's recent GP visit. Concerned about possible mental health issues.

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 **safety plan**, which includes emergency contacts and coping strategies 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."

"If you're finding this situation difficult yourself, organisations like Family Lives offer support for parents navigating these conversations with their children."

Confidentiality - Consultant Surgeon Requests Mother's CT Scan Result

Setting: Hospital Ward **Role:** FY2

Adult Child of Patient Seeking Medical Information. No Power of Attorney. Requesting Imaging Results.

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 X, consultant surgeon at [X] Trust. Y 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?"

"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."

"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."

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 want to make sure we get this right - protecting her privacy is something she'd expect from us. I'm sure you appreciate this from your own practice."

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 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."

"If your mother's condition changes urgently, please let us know immediately."

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?"

Confidentiality - Minor Requesting Contraception

Setting: Primary Care **Role:** FY2

Parent Concerned About Adolescent Daughter's Contraception. Requesting Access to Minor's Medical Records.

1. Clarify the Concern

Acknowledge concern warmly and elicit full background:

- "Can you please tell me exactly what you found and what made you concerned?"
- "Just to clarify, how old is your daughter?"
- "Have you had an opportunity to speak with your daughter about this?"
- "Are you asking for information about whether your daughter has been seen here recently, or something else in particular?"

2. Assess the Relevant Background

Listen carefully to the parent's initial concern. Focus on understanding exactly **why they are worried**.

If the parent only talks about the pills, acknowledge concern and move to explaining confidentiality.

If the parent hints at deeper worries (safety, older partner, STIs, religion, law), explore carefully:

Gently Explore By Saying...	
If Parent Mentions...	
Safety or "wrong crowd"	"Are you worried about her general safety or wellbeing?"
Partner being older	"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?"
Religious conflict	"I completely respect that. Would you like me to understand any particular family values that are important to you?"
Legal concerns	"Would you like me to clarify how the law works for young people in these situations?"

3. Reassure and Explain

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

"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."

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

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

"I know this isn't the answer you were hoping for, and I'm sorry. These confidentiality rules exist to protect all patients - including your daughter - but I understand it's frustrating when you're worried about her."

4. Educate - Fraser Guidelines

"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."

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?

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- Is there any concern about coercion or safeguarding?

Address Specific Concerns:

Parental Concern	Professional Response
Older Partner	CRITICAL SAFEGUARDING POINT: "We always ask about the partner's age. If there is a significant age gap (e.g., a 14-year-old with a partner aged 20+), this is a safeguarding emergency - potential Child Sexual Exploitation (CSE). This triggers a mandatory safeguarding referral, not a 'gentle conversation'. We must assess for grooming, coercion, and power imbalance."
STI Concern	"We advise on safe sex practices and encourage regular screening."
Religious Objections	"I absolutely respect your religious values. I can only offer health-based guidance here, but the religious or moral aspects might be something you could discuss with your daughter or your faith community."
Legal Concern	"The Sexual Offences Act 2003 recognises that while under-16 sex is technically unlawful, prosecution is not automatic - the law focuses on protecting young people from exploitation, not criminalising consensual relationships between peers of similar age."

SAFEGUARDING RED FLAGS - Mandatory Referral Required:

- Sexual activity with a child **under 13** - **ALWAYS** results in a child protection referral (no capacity to consent in law)
- Significant age gap with older partner (power imbalance)
- Signs of coercion, grooming, or exploitation
- Repeated presentations for STI treatment or termination of pregnancy
- Disclosure of abuse or concerning relationship dynamics

Note: Do NOT treat these as "gentle exploration points" - they require immediate safeguarding escalation.

Close

"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."

"Organisations like Family Lives offer support for parents navigating these conversations with teenagers."

Don't Tell My Mum She Has Cancer

Setting: Hospital or GP (Telephone/In-person) **Role:** FY2

Older Adult Female with New Cancer Diagnosis. Family Member Requests Non-Disclosure. Patient Has Capacity.

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."

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Step 2: 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 3: 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?"

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?"
- "Does she seem to suspect anything about her condition?"

3. Explore deeper emotional context

- "How are you coping with all of this?"
- "It must be hard supporting her while carrying these concerns."

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."

"I have a duty to her as her doctor - she has the right to know what's happening in her own body, and I need to respect that."

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?'"

"Some patients prefer not to know details - and if she tells us that, we'll respect it completely."

"If she says yes, we will explain everything gradually, kindly, and never in isolation."

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. 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."

"I'll document this conversation in her notes so the team is aware of your concerns and our plan."

Worried about Vascular Dementia

Setting: Primary Care **Role:** FY2

Patient presenting with concerns about vascular dementia risk following a relative's diagnosis.

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?"

"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."

A - Assess the Relevant Background**1. Understanding and Expectations**

- "What do you understand about vascular dementia so far?"
- "Is there anything specific you were hoping to find out today?"

2. Medical History

- "Do you have any long-term medical conditions?"
- "Any previous strokes, TIAs, or heart issues?"

3. Family History

- "Any other relatives with dementia or memory problems?"

4. Lifestyle Factors (DESA)

- **Diet:** "Would you say you mostly cook at home or eat out?"
- **Exercise:** "Do you do any regular physical activity?"
- **Smoking/Alcohol:** "Do you smoke or drink alcohol?"
- **BMI:** Measured in clinic
- **BP:** Check in clinic

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

"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."

3. Discuss Risk Categories

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

- Family history
- Age - dementia is more common after 65
- Past stroke or heart attack

Modifiable Risks (we can change) - *Updated per Lancet 2024:*

- High blood pressure
- Obesity
- Lack of exercise
- Poor diet
- Smoking, alcohol
- **Hearing loss** - untreated hearing problems increase dementia risk
- **Social isolation** - staying connected to others is protective
- **Depression** - if left untreated, it's a risk factor

4. Patient-Specific Advice

"Based on what you've told me, you do have a few modifiable risk factors we can work on."

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

- Monitor your blood pressure regularly
- Check cholesterol and blood sugar
- Offer support with weight management

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

- Cook more meals at home
- Reduce oily foods and red meat
- Aim for 30 minutes of exercise five times a week
- Stay socially active

Safety Netting & Follow-Up

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

"Would you like me to arrange an NHS Health Check to get a baseline of your cardiovascular risk?"

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

Diabetic Retinopathy

Setting: Primary Care **Role:** FY2 Doctor

Middle-Aged Adult with Type 2 Diabetes referred by Community Optician for Visual Changes.

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.

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?"

→ "I'm scared I might go blind."

Expectations - "Is there anything specific you were hoping I could do for you today?"

"That's completely understandable. Let's work through this together."

A - Assess the Relevant Background

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?"

Diabetes-Specific History

- "Was it type 1 or 2 diabetes?" → 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
- "Have you had diabetic eye checks before?" → Yes, but missed last one
- "Have you had your feet checked in the last year?" → No

MAFTOSA + Lifestyle

- **Medications:** None currently
- **Allergies:** No
- **Family history:** Sister has diabetes

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

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."

"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."

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."

"The decision about whether you need laser treatment or injections will be made by the ophthalmologist. In the meantime, I'll focus on getting your diabetes under better control - that's actually one of the most important things we can do to protect your eyes."

Note: NICE now recommends considering fenofibrate for people with non-proliferative retinopathy and type 2 diabetes to slow progression - your specialist may discuss this with you.

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."

FY2 Scope Note: Starting metformin for a patient with type 2 diabetes and a complication is within FY2 scope. The ophthalmology referral and specialist treatments (laser, injections, fenofibrate) are initiated by the eye team.

Blood Tests

- HbA1c - how your sugars have been over the past 3 months
- Kidney function, cholesterol, and other risk factors

Lifestyle Changes

- Support with reducing smoking and alcohol
- Dietician referral or diabetes support group
- Carer support options if needed

DVLA Notification

"Because the retinopathy is in both eyes, you'll need to notify the DVLA. They may ask for a visual field test and acuity check to decide whether you can continue driving. In the meantime, I'd advise not driving until your eye team has assessed your vision."

Note: DVLA rules require notification if retinopathy affects **both eyes** OR if visual standards are not met. For unilateral retinopathy with adequate vision in the other eye, you may be able to continue driving.

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."

"Once things are stable, you'll have annual eye screening through the national diabetic eye screening programme."

Close

"You've done the right thing coming in today. 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 (Prenatal Screening Counselling)

Setting: Primary Care **Role:** FY2 Doctor

Pregnant Person of Advanced Maternal Age. Concerned About Chromosomal Screening Options.

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?"
- "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?"

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- "Is the baby's father related to you by blood?"

E. Lifestyle & Psychosocial

- "Do you smoke, drink alcohol, or use any other substances?"
- "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 45, 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."

Maternal Age & Down Syndrome Risk (For Reference)

Age	Risk (approx.)
20	1 in 1,500
30	1 in 900
35	1 in 350
40	1 in 100
45	1 in 30

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. Non-Invasive Prenatal Testing (NIPT) - NHS pathway since June 2021

"Since 2021, there's a newer blood test called NIPT available on the NHS."

- Available following higher-chance combined/quadruple test result (risk between 1 in 2 and 1 in 150)
- Blood test from mother analysing fetal DNA
- Detection rate >99% for Down syndrome

- **No miscarriage risk**
- If NIPT shows higher chance, diagnostic test (CVS/amniocentesis) still needed to confirm

"This gives you a safer way to get more information before deciding whether to have an invasive test."

3. 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** ($\sim 0.5\%$)

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

4. 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."

"Antenatal Results and Choices (ARC) is a charity that offers support - their helpline is 020 7713 7486."

5. 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."

6. Follow-Up Plan

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

Sickle Cell Trait - Genetic Risk Counselling

Setting: Primary Care

Patient: Woman of Reproductive Age

Presenting Complaint: Pre-conception genetic counselling enquiry regarding family history of haemoglobinopathy

C - Clarify the Concern

"Hello, I'm one of the doctors here at the surgery. Before we start, could I just confirm your full name and age?"

"Thanks. I understand you've come in today to talk about some concerns around having children - could you tell me a bit more about what's on your mind?"

→ *Patient says:* "My maternal aunt had sickle cell disease, and I'm planning to get pregnant soon. I'm worried if it could affect my baby."

"That's a very thoughtful and important question, especially before pregnancy. You're doing the right thing by looking into this early. Would it be okay if I ask a few more questions, just to understand what you know and what support you need?"

"What do you understand so far about sickle cell disease and how it's inherited?"

"Has anyone ever offered you testing or spoken to you about your own genetic risk?"

"Are you mainly concerned about your own chances of being a carrier, or the chance of passing it to your child - or both?"

"Is there anything specific you were hoping I could help with today?"

A - Assess the Relevant Background

1. Family History

- "You mentioned your maternal aunt - does she have full sickle cell disease or is she a carrier?"

→ "She has the disease - she used to be admitted a lot as a child."

- "Has anyone else in the family been tested?"

→ "My mother got tested years ago and she was told she didn't carry anything."

- "Do you have any siblings, and have they ever been tested?"

→ "I have a brother, but I don't know if he's been tested."

2. Personal Testing History

- "Have you ever had any tests done yourself - perhaps during school, travel vaccinations, or blood donations?"

→ "No, I don't think I've been tested before."

3. Reproductive Context

- "Are you currently pregnant or just planning ahead?"

→ "Not pregnant yet - we're planning to start trying later this year."

- "Has your partner ever had any testing done - do you know his background or family origin?"

→ "He's from the Caribbean but hasn't been tested either."

R - Reassure

"Firstly, thank you for coming in and being so proactive - it's completely normal to feel a bit uncertain about these things when planning a family. The fact that your mother tested negative means she likely didn't carry the sickle cell gene, which *reduces* the chance that you inherited it from her side. But it doesn't rule it out completely - because you could still carry the gene if your father (or his side of the family) carries it. That's why we recommend offering the test to anyone with a family history or from an at-risk background, just to be sure. Being a carrier doesn't affect your own health - you wouldn't have any symptoms yourself. The reason we test is purely to understand what this might mean for a future pregnancy."

"The good news is - we have clear steps we can follow to give you more clarity and support."

E - Educate & Plan

1. What Is Sickle Cell Disease?

"Sickle cell disease is an inherited blood disorder where red blood cells become abnormally shaped, making it harder for blood to flow properly. It can lead to pain, anaemia, and organ damage."

"There's a difference between having the disease and being a carrier - if you're a carrier (what we call 'sickle cell trait'), you're usually healthy but can pass it on."

2. Inheritance - Autosomal Recessive Pattern

"Sickle cell is passed on through a *recessive gene*. This means both parents must carry the gene for a child to be affected."

(Use pen and paper to draw a Punnett square or diagram)

"If only one parent carries the gene, the child may be a healthy carrier like the parent. But if both parents carry it, each child has:

- 25% chance of being affected
- 50% chance of being a carrier
- 25% chance of being unaffected"

"Since your partner is from the Caribbean, he may have a higher chance of carrying the gene - even if there's no known family history. That's why if your test comes back positive, it's really important we test him too. Only if *both* of you carry the gene do we start worrying about the baby's risk - and even then, there are many supportive options available."

3. Testing and Screening

"We can arrange a simple blood test for you called a haemoglobin electrophoresis or sickle cell screen - it's done here at the surgery. Blood test results usually take 1-2 weeks. If you are found to be a carrier, we'll then test your partner too. If both of you are carriers, we'll refer you to a specialist genetic counselling team for further guidance and support in pregnancy planning."

4. Pregnancy & Future Planning

"If both partners are carriers, you will be offered options such as:

- Prenatal testing (CVS or amniocentesis) to check if the baby is affected
- Pre-implantation genetic diagnosis (PGD) with IVF for some couples

But again - these are only necessary if both parents carry the gene."

FY2 Note: The detailed discussion of prenatal testing options (CVS, amniocentesis, PGD) should be conducted by clinical genetics/haemoglobinopathy specialists. FY2 role is to explain basic inheritance, arrange screening, and refer appropriately. Refer to clinical genetics or haemoglobinopathy specialist for detailed counselling and prenatal testing discussions.

Reassurance & Leaflets

- "I'll give you an NHS leaflet about sickle cell trait and how it's passed on, so you can read through it at home."
- "You can also look up more at: nhs.uk/sicklecell"

Safety Net & Follow-Up

- "If you start trying and haven't had results yet - or if you have any more questions at any point - please don't hesitate to get in touch."
- "And if your partner needs support with testing or results, we can organise that together."

Close

"You've done the right thing by coming in before pregnancy. These conversations can feel a bit overwhelming, but you're making responsible and informed choices for your future child."

"You'll hear from us about the blood test results soon. We can take it one step at a time from there."

"Is there anything else on your mind today, or anything you'd like me to go over again before we finish?"

Note: Understanding Sickle Cell Inheritance

In PLAB 2 counselling cases involving **genetic conditions**, it's vital to understand and explain the inheritance pattern **accurately**, especially for **autosomal recessive** conditions like **sickle cell disease**.

Inheritance Pattern: Autosomal Recessive

- Sickle Cell Disease = ss
- Carrier (Sickle Cell Trait) = Ss
- Normal (No trait) = SS

To **have the disease**, a person must inherit **two faulty copies (ss)** - one from **each parent**.

To be a **carrier**, a person has **one normal (S)** and **one faulty gene (s)**.

If **both parents are carriers (Ss + Ss)**:

- 25% chance the child will have the disease (ss)
- 50% chance the child will be a carrier (Ss)
- 25% chance the child will be unaffected (SS)

Use a **Punnett square** to demonstrate this visually in the exam.

Family History Example - Maternal Aunt with Disease

- If a **maternal aunt** has sickle cell disease → the patient's **grandparents must both be carriers (Ss)**.
- That means the patient's **mother had a 50% chance of being a carrier (Ss)** and **25% chance of being unaffected (SS)**.
- So if the **mother tested negative (SS)**, the patient **cannot inherit the sickle gene from her**.

But this **only rules out the maternal side**. The patient **could still be a carrier via her father's side**, especially if they are from an at-risk background (e.g. African, Caribbean, Middle Eastern, Indian heritage).

Why We Still Offer Testing to the Patient

Even if the mother is not a carrier:

- The patient's **paternal background** may still pose a risk.
- The patient **may not know full family history** on one side.
- The patient's **partner's ethnicity** matters too:
If the partner is from a high-prevalence region (e.g. Caribbean), their chance of being a carrier is higher - about **1 in 10**.

That's why **NHS screening guidelines** recommend:

- Offering a **haemoglobinopathy screen** (blood test) to individuals with family history *or* at-risk ethnicity - **before or early in pregnancy**.

Huntington's Disease - Genetic Risk

Setting: Primary Care **Role:** FY2 Doctor

Adult with Recently Diagnosed Parent. Concerned About Inheritance Risk for Self and Children.

C - Clarify the Concern

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"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 recently, 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."

"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**. The uncertainty ends there."

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."

Important note: Predictive genetic testing is generally **not offered to asymptomatic minors** (your children) under current guidelines. The decision to be tested is usually deferred until they are adults and can make an informed choice themselves.

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."

"The Huntington's Disease Association has a helpline - their number is 0800 802 6262."

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?"

Post-MI Medication Adherence Counselling

Consultation Type: Telephone consultation **Role:** FY2 in GP

Patient discharged 4 weeks ago after STEMI + PCI + stent. Missing medications due to forgetfulness and fear of overdose.

Introduction

- "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

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- "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

DVLA Driving Guidance Post-MI:

- **Group 1 (car/motorcycle):** Can resume driving after **1 week** if successful PCI with no other disqualifying condition
- **Group 2 (HGV/bus):** Must notify DVLA; usually **6 weeks** off driving minimum; functional assessment may be required

"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, especially if you hold a Group 2 licence."

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: Primary Care **Role:** FY2

Patient discharged yesterday after STEMI + PCI. Seeking explanation of new medications and follow-up.

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

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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

Antiplatelet Therapy (NIC: After a heart attack with stent (PCI), you will be on **Dual Antiplatelet Therapy (DAPT)** - two blood thinners together - for **12 months**. After 12 months, your specialist will review and usually step you down to **one blood thinner for life** (typically aspirin or clopidogrel alone).

1. Aspirin 75 mg - once daily, morning

"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. Ticagrelor 90 mg twice daily OR Clopidogrel 75 mg once daily - for 12 months

"This is your second blood thinner - it works alongside aspirin to keep your stent open and reduce the risk of another heart attack."

"You will take two blood thinners for the first year. After 12 months, your heart specialist will decide whether to continue with one alone for life."

Side effects: Easy bruising, gum bleeding, heavier periods. Ticagrelor may also cause breathlessness (usually mild and transient)

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."

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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 - 80mg once daily (can be taken at any time that's convenient for you)

"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)

***Note:** Atorvastatin no longer needs to be taken at night - this was based on older short-acting statins. Atorvastatin has a long half-life and can be taken at any time. The standard dose for secondary prevention (after a heart attack) is 80mg.*

"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."

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."

Osteoporosis Medication Counselling

Setting: Orthopaedic Ward (Pre-Discharge) **Role:** FY2

Older Adult with Fragility Fracture. Newly Diagnosed Osteoporosis. Medication Counselling.

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. Living Situation

- Lives alone
- Home not single-level, kitchen not on same floor
- Difficulty with stairs

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. Think of it like a honeycomb - normally the holes are small and the structure is strong. With osteoporosis, those holes get bigger and the walls thinner, which makes the bone more likely to break."

"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."

"The goal now is to reduce the risk of any future fractures - and we're tackling it from all angles."

2. Medication Explanations

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)
- First thing in the morning, before any food or other tablets, with a full glass of plain tap water
- Then stay sitting or standing for 30 minutes - no lying down, no breakfast, no coffee during that time
- It sounds fiddly, but it's really important to protect your throat and stomach

Side effects:

- Heartburn or stomach pain if not taken correctly
- Rare: Jaw pain (osteonecrosis of the jaw), unusual thigh/hip/groin pain (atypical femoral fracture)
- **Please let any dentist know you're on alendronate BEFORE any dental work, especially extractions**

Treatment duration: "You'll typically take alendronate for at least 5 years. After that, we review whether to continue based on your bone density and fracture risk. For some patients, 10 years of treatment is recommended."

Note: If oral bisphosphonate is not tolerated, IV zoledronate is an alternative - particularly recommended following hip or vertebral fracture.

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

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
- Overdose can harm your liver, so please avoid doubling doses

Lisinopril (Reduced dose)

"This helps protect your heart and kidneys and also lowers blood pressure."

"We reduced your dose to avoid further drops in pressure, especially after your fall - sometimes standing up too quickly can make people dizzy on this medication."

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

E - Educate & Plan Together*Lifestyle Modifications*

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

- **Diet:** "Try adding more dairy, leafy greens, fish, and eggs - we can also connect you to a dietician if helpful."

- **Exercise:** "Start with light walking or chair-based physiotherapy after recovery - your physio team will guide you."
- **Alcohol:** 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
- New bone pain (especially thigh, hip, or groin)"

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

"I'll make sure everything we've discussed today is clearly documented in your notes."

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 Counselling

Setting: Primary Care **Role:** FY2

Adult Presenting as Close Contact of Meningitis Case. Requires Prophylaxis Counselling.

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."

Risk Context: "The risk of catching meningitis from a close contact is low - about 1 in 300 - but the antibiotics reduce this further."

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."
- "Public Health will be coordinating the contact tracing - they may also get in touch with you directly."

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."
- "Ideally this should be given within 24 hours of diagnosis of the index case."
- Alternatives: "If you're allergic to ciprofloxacin, we can consider **rifampicin** (twice daily for 2 days) or **ceftriaxone** as an injection."

FY2 Scope Note: Prescribing chemoprophylaxis for confirmed meningococcal contacts is within FY2 scope and should be done promptly. You do not need senior approval - time is critical. Public Health will coordinate wider contact tracing.

Dosing Reference:

- Adults: Ciprofloxacin 500mg single dose
- Children 5-11 years: 250mg
- Children 1-4 years: 125mg
- Infants <1 year: 30mg/kg (max 125mg)
- Rifampicin (if cipro contraindicated): Adults 600mg BD for 2 days; Children 10mg/kg BD (max 600mg)

Step 3: Vaccination Discussion

- "Depending on the type of meningitis confirmed, we might also recommend a vaccine booster - this gives you longer-term protection beyond the antibiotics."
- "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 (Motor Neurone Disease)

Setting: Primary Care **Role:** FY2

Adult with Motor Neurone Disease. Enquiring About Disease-Modifying Treatment Options.

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?"

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- "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 research shows it can slow the progression of ALS - on average by **2 to 3 months**. I know that might sound modest, but for some people that extra time is precious. And for others, riluzole may not be the right choice - it really depends on your priorities and how you're feeling about things."

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 - monthly for the first 3 months, then 3-monthly for the first year."
- "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."
- "At some point, your specialist may also want to discuss your wishes for future care - this is routine and doesn't mean anything has changed urgently."

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."

"The MND Association has a helpline and can connect you with local support - their number is 0808 802 6262."

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: Acute Medicine Ward (Pre-Discharge) **Role:** FY2

Older Adult with COPD Exacerbation. Smoking Cessation Discussion.

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?"

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- "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 "Smoking has played a big part in how your lungs are today. But here's the important thing - what you do from now on can still make a real difference."

"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** - "A prescription tablet that was unavailable for a few years is now back on the market. It's very effective and we can arrange this through the smoking cessation service if you're interested."
- **Bupropion** - Non-nicotine tablet option
- "They help reduce cravings and withdrawal. Usually started 1-2 weeks before quit date."

E-Cigarettes

- "Nicotine-containing e-cigarettes are also an option. They're not risk-free, but they're much less harmful than cigarettes and can help some people quit."

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: Primary Care **Role:** FY2

Postnatal Mother Who Is Breastfeeding. Requesting Smoking Cessation Support.

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?"

Postnatal Mental Health Check "How are you feeling in yourself? Some women find the early weeks overwhelming - there's support available if you need it."

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."

Address Guilt "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."

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."

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."
- "Quick-release options like sprays or gums work well if you time them after a feed - the nicotine level drops quite a bit before your next feed. It's much safer than continuing to smoke."
- "The amount of nicotine passed in breastmilk is small, and much less harmful than smoking itself."

2. Medications (if asked)

- "Varenicline and bupropion must not be offered to breastfeeding women. Varenicline is contraindicated as it passes into breast milk and may interfere with infant lung development. Although bupropion has slightly more safety data, NICE recommends against it in breastfeeding too."

- The recommended option is nicotine replacement therapy (NRT), used strategically after feeding."

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.

CRITICAL SAFETY MESSAGE - Co-sleeping and SIDS: "There's one very important thing I need to mention: **if you or your partner smoke, you must not share a bed with your baby.** Co-sleeping is much riskier for babies if a parent smokes - even if you never smoke in the bed itself. Smoking is one of the biggest risk factors for sudden infant death syndrome (SIDS), and this risk is significantly increased with bed-sharing."

"The safest place for your baby to sleep is in their own cot or Moses basket, in the same room as you, on their back."

(Lullaby Trust/NHS Safer Sleep Guidance)

Support Services

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

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

Setting: Cardiology Clinic **Role:** Doctor

Patient with Coronary Artery Disease Awaiting Intervention. Long Smoking History. Smoking Cessation Discussion.

1. Clarify the Concern

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"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:

- "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 a long time, 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:**
 - **Varenicline** - now available again (generic) and very effective
 - **Bupropion** - alternative option
 - "They help reduce cravings and withdrawal. Usually started 1-2 weeks before quit date."
- **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."

Handling Common Objections:

"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

Setting: GP Surgery / Telephone **Role:** FY2

Older Adult Male with NHS AAA Screening Result. Medium-Sized Aneurysm Detected.

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 says 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?"

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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. Think of it like a garden hose - normally it has a consistent width throughout. In some people, a part of it in the tummy area can start to bulge or balloon out - like a weak spot in the hose. 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."

FY2 Scope Note: Your role is to explain the screening result, arrange vascular referral, optimise cardiovascular risk factors (start/up-titrate statin, antihypertensive, smoking cessation), and provide safety netting. Decisions about surgical timing are made by the vascular team.

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?"

Note: AAA Size Categories and Management Reference

Aneurysm Size	Classification	Monitoring	Action / Management
< 3.0 cm	Normal	No follow-up needed	Reassure. No aneurysm.
3.0–4.4 cm	Small AAA	Yearly ultrasound	Lifestyle advice, smoking cessation, BP control
4.5–5.4 cm	Medium AAA	3-monthly ultrasound	Refer to vascular specialist. Continue monitoring.
≥ 5.5 cm	Large AAA	Surgical referral	Consider elective repair (open or EVAR)
Rapid growth	>1 cm/year	Urgent referral	May need surgery even if <5.5 cm

Additional Points:

- Emergency surgery required if aneurysm ruptures: sudden abdominal/back pain + collapse → 999
- **EVAR** (Endovascular repair): Minimally invasive, preferred in high-risk patients
- **Open repair:** For younger or anatomically unsuitable for EVAR
- Medical management includes: ACE inhibitors (e.g., ramipril), statins, smoking cessation

Valve Replacement Counselling

Setting: GP Clinic **Role:** FY2

Older Adult Male with Aortic Stenosis. Consultant Advised Valve Replacement. Has Concerns and Questions.

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?"

Assess the Relevant Background

"May I ask a few questions to get a fuller picture of your health?"

- "Do you have any other medical conditions, like diabetes, high blood pressure, or kidney problems?"
- "Are you on any regular medications?"
- "Have you ever had any heart surgery or procedures before?"
- "Do you smoke or drink alcohol?"
- "How has your breathing been recently - any chest pain or dizzy spells?"

Reassure & Explain

"I'm really sorry you've been left with so many unanswered questions. Let me go 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.

- **Mechanical valves** last longer but require lifelong blood thinners (warfarin)
- **Tissue (bioprosthetic) valves** may not need blood thinners but can wear out after 10-20 years

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 Baby

Setting: Primary Care (Telephone) **Role:** FY2

Parent Calling About 6 week old baby with Newly Detected Heart Murmur. Anxious About Diagnosis.

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."

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 - just a normal sound."

The referral is in place, and if anything changes between now and that appointment, don't hesitate to contact us.

Is there anything else you'd like to ask before we end the call?"

Varicose Veins Counselling

Setting: Primary Care **Role:** FY2

Adult with Symptomatic Varicose Veins. Requesting Information About Treatment Options.

C - Clarify the Concern

"Hello, I'm one of the doctors here at the practice. Could I confirm your full name and age please?"

"I understand you've come in today to talk about your leg veins. Could you tell me what's been bothering you?"

Explore the symptoms:

- "How long have you had these veins visible?"
- "Do they cause you any pain, aching, or heaviness?"
- "Do you notice swelling in your legs or ankles?"
- "Any skin changes - dryness, discolouration, or itching around the ankles?"
- "Have you ever had any ulcers or sores on your legs?"

ICE:

- *Ideas*: "What do you think is causing these problems?"
- *Concerns*: "Is there anything specific you're worried about?"
- *Expectations*: "Were you hoping for treatment or mainly advice today?"

A - Assess the Relevant Background**Risk Factors:**

- "Do you stand for long periods at work?"
- "Have you been pregnant before?" (if applicable)
- "Is there any family history of varicose veins?"
- "Do you have any history of blood clots in your legs?"

Medical History:

- "Do you have any other medical conditions?"
- "Are you on any regular medications?"
- "Any allergies?"

Impact on Life:

- "How much do these affect your daily activities or work?"
- "Do they bother you cosmetically, or is it mainly the symptoms?"

R - Reassure & Explain

"Thank you for sharing all that. Varicose veins are very common - they happen when the valves inside the veins don't work as well as they should, causing blood to pool and the veins to bulge."

"They're not usually dangerous, but they can cause symptoms like aching, heaviness, itching, and sometimes skin changes if left untreated for a long time."

E - Educate & Plan**Conservative Management (First-Line):**

"The first things we'd recommend are:

- **Compression stockings** - these help support the veins and reduce swelling
- **Regular walking** and avoiding standing still for long periods
- **Elevating your legs** when resting
- **Maintaining a healthy weight**"

"These measures can help symptoms a lot, and we'd usually try these for at least 3 months before considering other options."

When to Refer:

"We would refer you to a vascular specialist if:

- Conservative measures haven't helped after 3 months
- You're getting skin changes or discolouration around the ankles
- You've had a varicose vein bleed
- You've had or are at risk of leg ulcers"

Treatment Options (if referred):

"If you do need treatment, there are several options:

- **Endothermal ablation** - using heat (laser or radiofrequency) to seal the vein from inside
- **Foam sclerotherapy** - injecting a solution to close the vein
- **Surgery** - stripping or removing the vein, though this is less common now

The specialist will assess which option is best for you."

Safety Netting:

"Please come back or seek urgent help if:

- You develop a hard, painful area in your leg (could be a clot)
- A vein bleeds (apply pressure, elevate, and seek help)
- You notice skin breakdown or ulceration
- You develop sudden severe leg swelling"

Summary:

"So to summarise - your varicose veins are causing symptoms, which is understandable. Let's start with compression stockings and lifestyle measures. If things don't improve in 3 months, or if you develop any concerning changes, we can refer you for specialist assessment."

"Do you have any questions?"

Jehovah's Witness - Post-Surgical Anaemia

Setting: Hospital Ward **Role:** FY2

Adult Jehovah's Witness with Post-Surgical Anaemia. Declining Blood Transfusion. Capacity Assessment and Alternative Management.

Introduction

"Hello, my name is Dr [Name], one of the junior doctors on the ward. Could I confirm your full name and age please?"

"Thank you. I understand you had your surgery recently and the team has been monitoring your blood levels. I wanted to come and have a chat with you about where things stand and to make sure we're supporting you in the best way possible."

C - Clarify the Concern

"I've been told that you've expressed some wishes about blood transfusion. Before we go any further, would you be comfortable sharing your thoughts with me directly?"

→ Patient confirms they are a Jehovah's Witness and will not accept blood transfusion under any circumstances.

"Thank you for being so clear. I want to make sure I understand your position fully. Can I ask - is this an absolute decision, or are there any circumstances where you might reconsider?"

Explore specific beliefs:

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- "Are there any blood products you would be willing to accept - for example, some Jehovah's Witnesses accept certain fractions?"
- "Would you be open to treatments like iron infusions or other alternatives?"

A - Assess the Situation

Clinical Status: "I need to explain where things stand medically. After your surgery, you've lost quite a bit of blood. Your haemoglobin level - that's the part of your blood that carries oxygen around your body - is currently at 6. The normal range is around 12 to 15. At this level, your body is working harder to get oxygen to your organs, which is why you're feeling so exhausted."

Capacity Assessment (Document clearly):

"I need to make sure you fully understand the situation before we proceed. Can I ask you a few questions?"

1. "Can you tell me in your own words what I've just explained about your blood levels?"
2. "What do you understand about what might happen if your blood levels stay this low or drop further?"
3. "Can you tell me why you've made this decision?"
4. "Have you been able to think about this decision, or do you feel pressured in any way?"

Capacity Assessment Statement: "I can see you understand the situation clearly and are making this decision based on your beliefs - which I completely respect."

R - Reassure & Respect

"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."

"This is your decision to make, and we will honour it. Our job now is to explore every other option available to help you recover."

E - Educate & Engage in Shared Plan

Alternative Treatments:

"There are several things we can do to support your body without using blood transfusion:

1. **Intravenous iron** - this helps your body make new red blood cells faster
2. **Erythropoietin (EPO)** - an injection that stimulates your bone marrow to produce more blood cells
3. **Folic acid and vitamin B12** - essential for blood cell production
4. **Minimising blood loss** - we'll avoid unnecessary blood tests and use smaller tubes when we do need to take blood
5. **Oxygen therapy** - to help your body cope while your blood levels recover
6. **Keeping you well-hydrated** - with IV fluids as needed"

What We Cannot Do:

"I do need to be honest with you - these alternatives work more slowly than a transfusion. If your blood levels drop further, there is a risk that your heart and other organs could be affected. In the worst case, this could be life-threatening."

"I'm not saying this to scare you or to change your mind - but because I want you to have all the information."

Documentation and Advance Decision:

"I'll make sure everything we've discussed today is clearly documented in your notes, including your wishes about blood products."

"Do you have an Advance Decision document or card that specifies your wishes? If so, it would be helpful to have a copy for your records."

"We may also ask you to sign a consent form confirming your refusal of blood - this protects both you and the medical team."

Involving the Team:

"I'll speak with the consultant and the rest of the team to make sure everyone is aware of your wishes. We may also involve the haematology team to help optimise your treatment."

Safety Netting:

"If at any point you change your mind, or if you'd like to discuss this further, please let us know. This is your decision, and it can be revisited at any time."

"If you start to feel worse - more breathless, chest pain, or very dizzy - please tell the nurses immediately so we can act quickly."

Support:

"Is there anyone you'd like us to contact - family, friends, or a liaison from your congregation?"

"Would you like to speak to the hospital chaplain or any other support services?"

Close

"Thank you for being so open with me. I want you to know that whatever happens, we're here to care for you in a way that respects your beliefs. Please don't hesitate to ask questions or raise concerns at any time."

DKA Admission Refusal

Setting: Emergency Department **Role:** FY2

Young Adult Female. Acute Metabolic Emergency with Abdominal Symptoms. Patient Expressing Desire to Leave.

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)*

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- "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 - think of them like toxic waste products building up in your blood - 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 really need hospital supervision - we can't safely give them at home."

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:

"How does that sound to you? 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."

Paediatric DKA - Request for Discharge

Setting: Paediatric Ward **Role:** FY2

Child with First Episode DKA. Parent Requesting Early Discharge Due to Family Holiday.

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?"

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- "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."

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 significantly 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."
- "Once his blood results stabilise and he's able to eat and drink normally, we'll transition him to insulin injections and arrange discharge with proper training and support."

C. Explain Risks of Travel

- "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."

Note: If Parent Insists on Discharge:

DKA in a child is a LIFE-THREATENING EMERGENCY. If a parent insists on removing a child against medical advice when the child remains unstable:

1. **This is NOT a negotiation scenario.** The child's life is at immediate risk.
2. **You must be firm and clear:**
 - "I have to be completely honest with you: if you try to take your child now, **he could die**. This is a life-threatening emergency."
 - "As a doctor, I have a **legal and ethical duty** to protect your child's life. I cannot allow you to remove him in this condition."
3. **Escalate immediately:**
 - Inform senior clinician and paediatric consultant
 - Contact hospital safeguarding team
 - Contact social services for emergency assessment
4. **Police Protection Powers (Section 46, Children Act 1989):**
 - If the parent attempts to physically remove the child, the police can be called to invoke **Police Protection Powers**
 - This allows police to **prevent removal of a child from hospital** where there is imminent risk of significant harm
 - Hospital security should also be alerted
5. **Document everything:** Record the conversation, your warnings, the parent's response, and all escalation steps

Key message: In this scenario, "negotiation" is inappropriate. **Protection of the child is paramount.** Do not soften the message or try to preserve rapport at the expense of the child's safety.

Hypoglycaemia with Recurrent Seizures - Refusal to Stay

Setting: Acute Medicine Ward **Role:** FY2

Young Adult Male with Type 1 Diabetes. Recurrent Hypoglycaemic Seizures. Wants to Leave for Work.

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

DVLA Advice (Important):

"I also need to mention something about driving. After a hypoglycaemic seizure, you'll need to stop driving and inform the DVLA. For Group 1 licences, you must stop driving for at least 6 months from the date of the seizure - and 12 months if there's impaired hypoglycaemia. You'll need to notify the DVLA. Group 2 drivers must stop driving immediately and notify DVLA. Relicensing requires specialist confirmation of adequate hypo awareness, no severe episodes for 12 months, and regular monitoring."

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: Primary Care **Role:** FY2

Older Adult Female with Dysplastic Polyps Found on Sigmoidoscopy. Refusing Recommended Colonoscopy.

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 higher up."

B. What the Results Mean

- "The polyps they found are called **adenomatous polyps with dysplasia**."
- "Dysplasia means the cells are starting to behave abnormally - they're not cancer yet, but they could become cancer if left unchecked."
- "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

Setting: Primary Care **Role:** FY2

Middle-Aged Male with Group 2 Driving Licence. Recent TIA with Ongoing Non-Compliance with Driving Restriction. Safety Counselling Required.

NOTE: This case involves a **Group 2 licence holder**. The driving restriction for TIA is **12 months (1 year)**

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 a period of time. However, I've been told that you've been seen 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. I'm glad you're feeling better - that's encouraging. But I do want to explain a few things so we're on the same page."

A - Assess the Background

- "Can you tell me what happened when you had the TIA?"
- "What symptoms did you experience at the time?"
- "Have you had any symptoms since then - even briefly?"
- "How has your mood been? Any stress or worry about your job?"
- "Are you taking your medications as prescribed?"
- "Have you made any lifestyle changes since the TIA - smoking, diet, exercise?"

R - Reassure & Explain

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 trying to frighten you - but I do need to be honest with you. 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**, the driving restrictions after a TIA depend on your licence type:

- For **Group 1 licences** (private car/motorcycle): you must stop driving for **1 month** after a single TIA.
- For **Group 2 licences** (taxi, HGV, bus drivers): the restriction is **at least 12 months (1 year)**, and you'll need medical clearance before driving again."

"This is because Group 2 drivers spend more time on the road, carry passengers, and need to meet higher medical standards."

"If you drive during this period and something happens, it could mean losing your licence permanently, facing legal consequences, or - and I have to be frank - harming yourself or someone else."

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 - which for Group 2 licence holders is typically after 12 months with no further events."

2. Financial Options "I understand your financial concerns - losing your income as a taxi driver must be incredibly stressful."

"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** (if applicable)
- Help reduce alcohol intake (if applicable)
- Refer to a **dietician or lifestyle coach**
- Book a **review in 1 month** to monitor your blood pressure and TIA recovery
- Ensure your medications are optimised"

4. Safety Netting "If you develop any new symptoms - such as weakness, speech problems, visual changes, confusion, or severe headache - please call 999 immediately. Don't wait."

5. Documentation "I'll document today's discussion in your notes. If you have any questions later or want to talk things through again, please come back."

Follow-Up

- Regular GP review to monitor cardiovascular risk factors
- Confirm DVLA notification has been made
- Support with secondary prevention medications
- Consider referral to occupational health or vocational rehabilitation

Worried About Prostate Cancer

Setting: Primary Care **Role:** FY2

Middle-Aged Male. Family History Concern Regarding Prostate Cancer. Counselling and Risk Assessment.

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 - I know your dad's diagnosis must be worrying, and it's completely natural to wonder what it means for you. 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?"

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- "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 prostate cancer at your age is really quite uncommon - the risk increases as men get older, usually after 50."

"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, Prostate Cancer UK, 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?"

Requesting PSA Test

Setting: Primary Care **Role:** FY2

Middle-Aged Male without Urinary Symptoms. Requesting PSA Blood Test. Shared Decision-Making Discussion.

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?"

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- "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 there's no urgent medical reason to do this test right now - but that doesn't mean you can't have it if you want to."

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:

- "If your PSA is raised, about 3 out of 4 men who go on to have a biopsy do not have cancer. Conversely, about 1 in 7 men with prostate cancer may have a normal PSA level - so a normal result doesn't completely rule it out."
- "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 in an appropriate age group to consider it. So, having heard all that - what are your thoughts? Would you like to go ahead, or would you prefer some time to think it over?"

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?"

Worried About Testicular Cancer

Setting: Primary Care **Role:** FY2

Young Adult Male. Anxiety Regarding Testicular Health. Reassurance and Education.

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 takes courage to come in and ask about something like this - you've done exactly the right thing. 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?

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- 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 had a really careful feel, 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."

"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?"

Vasectomy Request

Setting: Primary Care **Role:** FY2

Young Adult Male. Requesting Permanent Contraception. Counselling and Shared Decision-Making.

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?"

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?"

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- "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?"

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."

Important: "You'll need to use other contraception until a **semen test at 12 weeks** (or after 20+ ejaculations) confirms the vasectomy has been successful."

"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."

"We do know that younger men, particularly those without children, are more likely to change their mind down the line - and that's not a criticism, it's just something to be aware of."

"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."

Risks to mention:

- "Most men recover quickly with minimal discomfort"
- "A small number of men (about 1-2%) experience **ongoing testicular discomfort** after the procedure - this is called chronic post-vasectomy pain"
- "Other risks include bruising, infection, or sperm granuloma, but these are uncommon"

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."

"Ultimately, this is your body and your decision - I just want to make sure you have all the information you need."

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."

Follow-up Plan:

- Follow-up in 1 month to revisit decision
 - Offer of counselling services
 - If proceeding: referral to vasectomy service with clear information about post-procedure semen analysis
-

Refused Tonsillectomy Referral

Setting: Primary Care **Role:** FY2

Parent Consultation. Child with Recurrent Tonsillitis - Referral Declined by Secondary Care. Addressing Parental Concerns and Explaining Criteria.

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?"
- "Were these spread over one year, or multiple years?"
- "Were they all confirmed as tonsillitis by a doctor, or some managed at home?"

Key point: "The key is having these episodes **recorded in medical notes** - if they weren't seen by a doctor at the time, they're harder to count towards the criteria."

Severity & Treatment:

- "What symptoms does he get during each episode?"
- "Has he needed antibiotics each time?"
- "Has he ever been hospitalised for tonsillitis?"

Impact on Daily Life:

- "How much school has he missed because of this?"
- "How is it affecting his eating, sleep, or general wellbeing?"

R - Reassure & Explain

Why the referral was declined:

"I can absolutely understand why you might wonder if this is about cost - but honestly, that's not what's driving this decision."

"The NHS has criteria for tonsillectomy that help make sure surgery is offered to children who will benefit the most. These are called the **Paradise Criteria**."

Paradise Criteria (explain clearly):

"To qualify for surgery, a child typically needs to have had:

- **7 or more** documented episodes of tonsillitis in **1 year**, OR
- **5 or more** episodes per year for **2 consecutive years**, OR
- **3 or more** episodes per year for **3 consecutive years**"

"And each episode needs to be significant enough to affect normal daily life - things like missing school, needing antibiotics, or having a high fever."

"Based on the records we have, your son hasn't quite met those thresholds yet - and that's likely why the referral wasn't accepted."

Why these criteria exist:

"The reason for these criteria isn't to be difficult - it's because tonsillectomy is a surgery with real risks, including bleeding and infection. We want to make sure the benefits clearly outweigh those risks."

"The good news is that for lots of children, these infections become less frequent as they get older - sometimes the problem just fades away on its own."

E - Engage in Shared Plan

1. Documentation going forward:

"From now on, let's make sure every episode is properly documented. Each time he gets tonsillitis, please bring him in or call us so we can record it. That way, if the pattern continues, we'll have the evidence to re-refer."

2. Supportive management:

"In the meantime, we can help manage his symptoms:

- Pain relief with paracetamol or ibuprofen
- Adequate fluids and soft foods during episodes
- Antibiotics when genuinely needed (not for every sore throat)"

3. Re-referral if criteria met:

"If he does meet the criteria over the next year or two, we can absolutely refer again - and this time it's likely to be accepted."

4. Consider second opinion:

"If you feel strongly that he needs surgery, you could also ask for a second opinion or discuss private options - I'm happy to help with that if you'd like."

Safety Netting

"If he develops any of the following, please seek urgent help:

- Difficulty breathing or swallowing
- Inability to open his mouth (could suggest quinsy/abscess)
- Signs of severe dehydration
- Prolonged high fever despite treatment"

Closure

"I know this isn't the answer you were hoping for, and I'm sorry the situation is so frustrating. But we're absolutely on your side, and we'll work together to make sure your son gets the best care - whether that's surgery in the future or managing things well in the meantime."

"Is there anything else you'd like to ask or talk through?"

Recurrent Infections in a Child

Setting: Primary Care **Role:** FY2

Preschool Child. Parent Concerned About Recurrent Childhood Illnesses and Possible Immune Deficiency.

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:

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- "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 to eight 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."

"How does that sound to you?"

8-Week Vaccination Counselling

Setting: Primary Care (Telephone or Face-to-Face) **Role:** FY2

Parent of Young Baby Seeking Information on Upcoming 8-Week Vaccinations.

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?"

Explore Understanding:

- "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 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?" (none given before 8 weeks in UK)
- **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)

"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 (MenB)

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.

***Note on Schedule Changes (July 2025):** The vaccination schedule has been updated. MenB is now given at 8 weeks and 12 weeks (previously 8 and 16 weeks). PCV (pneumococcal vaccine) has moved from 12 weeks to 16 weeks. Your practice nurse can confirm the exact schedule for your baby.*

Paracetamol Advice for MenB:

"Because the MenB vaccine can sometimes cause a higher temperature than other vaccines, we recommend giving your baby a dose of infant paracetamol at the time of vaccination, then two more doses 4-6 hours apart. The nurse will explain the exact dosing."

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

"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?"

"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: Primary Care (Telephone Consultation) **Role:** FY2

Parent of Young Child. Counselling Regarding Flu Vaccination with Parental Concerns.

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:

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"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

- "Has your child had any illnesses or fevers recently?"
- "Any known allergies - particularly to previous vaccines?"

Important clarification: "Egg allergy is actually **not a problem** for the nasal spray flu vaccine. This is a common misconception, but the nasal spray can be safely given to children with egg allergy."

- "Is your child on any regular medications?"
- "Any history of asthma or wheezing?"

Educate:

What is the Flu Vaccine?

"The flu vaccine helps protect your child against influenza - a viral infection that can cause high fever, muscle aches, severe fatigue, and sometimes serious complications like pneumonia or ear infections."

"For children aged 2-17, we use a **nasal spray vaccine** called Fluenz. It's given as a quick spray up each nostril - no injection needed."

How Does It Work?

"The nasal spray does contain a weakened live virus, but it's been specially designed so it can only work in the cooler temperatures inside your nose - it can't survive in warmer parts of the body to cause proper flu."

"It triggers your child's immune system to build protection against flu strains."

Common Side Effects

"Most children have no side effects at all. Some may experience:

- A runny or blocked nose for a day or two
- Mild tiredness
- Occasionally a low-grade fever"

"These are mild and settle quickly."

Addressing Specific Concerns

"Can my child get flu from the vaccine?" "No - the weakened virus in the nasal spray cannot cause actual flu. Some children may feel a bit under the weather briefly, but this is the immune system responding, not flu illness."

"My neighbour's child had a febrile convulsion after a vaccine" "Febrile convulsions can happen with any fever, including fevers from actual flu infection - and flu infection causes much higher fevers than the vaccine. The vaccine actually reduces the risk by preventing flu itself."

"Is it really necessary?" "Flu can be much more serious in children than a common cold. It causes thousands of hospitalisations each year. The vaccine significantly reduces this risk and also helps protect vulnerable family members."

Safety Netting

"If your child develops any concerning symptoms after the vaccine - difficulty breathing, widespread rash, or seems very unwell - seek medical advice. Serious reactions are extremely rare."

"You can call us or 111 if you have any concerns."

MMR Vaccine Counselling

Setting: Primary Care **Role:** FY2

Parent of Infant Approaching First Birthday. Pre-MMR Vaccination Counselling with Parental Questions About Safety.

C - Clarify the Concern

"Thank you for coming in today. I understand your baby is due for her MMR vaccination soon. Before we begin, could I ask - are there any specific concerns or questions you have about this vaccine?"

Explore Understanding:

- "What have you heard about the MMR vaccine?"
- "Is there anything in particular that's made you worried or hesitant?"

Common Concerns to Listen For:

- Autism link
- Too many vaccines at once
- Side effects
- Request for separate vaccines

A - Assess the Background

- "Has your baby been well recently?"
- "Any known allergies?"
- "Any history of seizures or neurological conditions?"
- "Is your baby on any medications?"
- "Any family history of reactions to vaccines?"

R - Reassure

"I can completely understand wanting to know everything before making decisions about your child's health. Let me explain what MMR is and address any concerns you have."

E - Educate

What is MMR?

"MMR stands for Measles, Mumps, and Rubella. It's a combined vaccine that protects against three serious viral infections:

Measles:

- Causes high fever, rash, and can lead to pneumonia, brain inflammation (encephalitis), and even death
- Highly contagious - one of the most infectious diseases known

Mumps:

- Causes painful swelling of the salivary glands
- Can lead to meningitis, hearing loss, and in boys, inflammation of the testicles which can affect fertility

Rubella (German Measles):

- Usually mild in children
- But if a pregnant woman catches it, it can cause serious birth defects (deafness, blindness, heart problems)"

When is it given?

"The first dose is given at 12 months of age."

Schedule Update (July 2025): "The timing of the second dose has recently changed. For children born on or after 1 July 2024, the second dose is now given at **18 months** instead of 3-4 years old. This is because evidence shows better vaccine uptake when the second dose is offered earlier. From January 2026, children are also receiving **MMRV** - which includes chickenpox protection as well. The nurse can confirm exactly which schedule applies to your child."

The Autism Question

"I want to address the autism concern directly, as I know this worries many parents."

"There is **no link between MMR and autism**. This has been studied extensively - involving millions of children worldwide - and the evidence is absolutely clear."

"The original study that suggested a link was published in 1998 by a doctor who was later struck off the medical register. The study was found to be fraudulent and was retracted."

"The signs of autism typically appear around the same time as the vaccine is given - which causes confusion - but this is coincidental timing, not cause and effect."

"Millions of children have received MMR safely over the last 50+ years."

Can You Give Separate Vaccines?

"I understand why some parents ask about this. However, separate vaccines are not recommended and are not routinely available on the NHS."

"Giving separate vaccines would mean more injections, more appointments, and importantly, would leave your child unprotected for longer - during which time they could catch one of these diseases."

Common Side Effects

"Most children have no problems. Some may develop:

- A mild fever and rash about 7-10 days after (this is the immune system responding)
- Mild swelling of the glands
- Very rarely, a temporary reduction in platelets (blood clotting cells)

These are all much milder than the actual diseases themselves."

Egg Allergy

"You don't need to worry about egg allergy - MMR can be safely given to children with egg allergy."

Shared Decision-Making

"You don't have to decide right now. It's important that you feel comfortable with your decision. I can give you written information to take home, and we can speak again if you have more questions."

"However, I would strongly encourage vaccination. Measles in particular is making a comeback, and unvaccinated children are at real risk."

Safety Netting

"After the vaccine, if your child develops a high fever that doesn't respond to paracetamol, a widespread rash, or seems very unwell - contact us or call 111."

Worried About Miscarriage

Setting: Antenatal Clinic **Role:** FY2

Woman with Early Pregnancy. History of Pregnancy Loss Causing Current Anxiety.

C - Clarify the Concern

"Hello, thank you for coming in today. I understand this is your first antenatal visit with this pregnancy. How are you feeling about everything?"

Explore the Concern:

- "I can see from your notes that you've had some difficult experiences with previous pregnancies. Would you feel comfortable telling me a bit about what happened?"
- "How are you feeling emotionally about this pregnancy?"
- "Is there anything specific you're worried about?"

Acknowledge and Validate:

"I can completely understand why you're feeling anxious. Having been through pregnancy loss before, it's natural to feel worried about this pregnancy. You're not alone in feeling this way."

A - Assess the Background

Current Pregnancy:

- "When was your last period?"
- "How many weeks pregnant do you think you are?"
- "Have you had any bleeding or pain so far?"
- "Any nausea, breast tenderness, or tiredness?"
- "Have you had any scans or blood tests yet?"

Previous Pregnancy History:

- "How many pregnancies have you had?"
- "Can you tell me about each one - how far along were you, and what happened?"
- "Were any investigations done after your miscarriages?"
- "Were you given any reasons for the losses?"

Medical History:

- "Do you have any medical conditions?"
- "Are you taking any medications?"
- "Do you take folic acid?"
- "Any history of clotting problems, thyroid issues, or autoimmune conditions?"

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Lifestyle:

- "Do you smoke or drink alcohol?"
- "How is your diet and general health?"

R - Reassure

"Thank you for sharing all of that - I know it's not easy to talk about."

"I want to reassure you that many women who have had miscarriages go on to have healthy pregnancies. Miscarriage is unfortunately common - about 1 in 5 pregnancies end in miscarriage, most in the first 12 weeks - but having one or even two miscarriages doesn't mean you can't have a successful pregnancy."

"Most miscarriages happen because of a one-off chromosomal abnormality in the embryo - something that happens by chance and isn't caused by anything you did or didn't do."

E - Educate and Plan**What We Can Do:**

"Based on your history, here's what I'd recommend:

1. **Early Pregnancy Scan** - We can arrange an early scan at around 7-8 weeks to confirm the pregnancy is developing normally and to check for a heartbeat. This may help with your anxiety.
2. **Progesterone Support** - For women with a history of miscarriage who are currently bleeding, progesterone can be offered. Since you're not currently bleeding, we'll monitor you closely but can start progesterone if any bleeding occurs.
3. **Regular Monitoring** - We can arrange more frequent appointments if that would help reassure you.
4. **Aspirin** - If you've had 3 or more miscarriages, you may benefit from low-dose aspirin. We can discuss this further or refer you to a recurrent miscarriage clinic."

Investigations (if applicable):

"If you've had 3 or more miscarriages, there are some tests we can do to look for underlying causes:

- Blood clotting tests (antiphospholipid syndrome)
- Thyroid function
- Uterine anatomy scan

But many women don't have an identifiable cause, and most still go on to have healthy pregnancies with supportive care."

What You Can Do:

- Continue taking folic acid (400mcg daily)
- Avoid smoking and alcohol
- Rest when you need to
- Try to reduce stress where possible

Support:

"If you're feeling very anxious, please don't struggle alone. We have counselling services available, and organisations like the Miscarriage Association offer support for women in your situation."

Safety Netting

"If you experience any bleeding, severe pain, or feel something isn't right - please contact us immediately or go to the Early Pregnancy Unit. Don't wait."

"We're here to support you through this pregnancy."

Pregnancy Planning on Captopril

Setting: Primary Care **Role:** FY2

Woman Planning Pregnancy. Currently on ACE Inhibitor for Hypertension.

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?"

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?"

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."

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R - Reassure

"I completely understand why you're asking - and it's great that you're thinking ahead."

"Trying for a baby later in life can carry some challenges, but many women in your situation do have successful pregnancies. What matters is that you're planning early and seeking the right support."

"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 belongs to a group of blood pressure medicines called **ACE inhibitors**. While it works well for blood pressure, unfortunately, it's **not safe during pregnancy**.

It can cause **serious harm to the baby**, including problems with how the baby develops, kidney issues in the baby, and reduced fluid around the baby."

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."

C. Referral to Specialist

"I'll refer you to a **pre-conception hypertension specialist or maternal medicine clinic**. They'll help us answer:

- 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, please come back to us **immediately**. We'll need to **stop Captopril straight away** and start a pregnancy-safe medicine."

FY2 Scope Note: If a woman on an ACE inhibitor presents with an unexpected pregnancy, an FY2 CAN and SHOULD act immediately: stop the ACE inhibitor, start labetalol (100mg BD is a common starting dose), and arrange urgent referral to maternal medicine. Do not wait for specialist advice before stopping the teratogenic medication.

F. Lifestyle Optimisation

"While waiting for review:

- Keep your blood pressure well-controlled
- Eat a heart-healthy, low-salt diet
- Stay physically active
- Start taking **Folic Acid** - The standard folic acid dose is 400 micrograms daily. A higher dose of 5mg may be recommended if you have certain risk factors such as BMI over 30, diabetes, or a history of neural tube defects - but hypertension alone doesn't require the higher dose.
- Maintain a healthy weight"

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."

Surgical Abortion Counselling

Setting: Primary Care **Role:** FY2

Adult Woman. Early Pregnancy. Requesting Information About Planned Surgical Termination.

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?"

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?"

2. Medical and Psychosocial History

- "Do you have any medical conditions?"
- "Any allergies?"
- "Do you feel emotionally supported at home or in your relationship?"

3. Understanding the Decision

- "What's led you to consider an abortion at this time?"
- "Is your partner aware of the pregnancy - and are they generally supportive?"

R - Respond with Clear Explanation

1. Preparation

"Because you're in early pregnancy, this is usually a straightforward day procedure."

"Before the procedure, you'll be given medicine to soften the cervix - either Misoprostol or Mifepristone."

2. Anaesthetic and Pain Relief

"You'll usually be awake but will be given local anaesthesia. Stronger pain relief or sedation 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."

4. Aftercare

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"You'll stay in the clinic for observation for a few hours and then go home the same day. You may have bleeding like a period for up to 2 weeks."

E - Empower with Support, Safety Netting, and Reassurance

1. Future Fertility

"This procedure doesn't affect your ability to have children in the future."

2. Emotional Support

"Emotionally, many women feel fine afterwards. Some may feel sad or unsure - that's completely normal. There are services like **NUPAS** that offer confidential support."

3. Signs to Watch For

"If you develop heavy bleeding, fever, foul-smelling discharge, or severe pain - please contact the clinic or your GP immediately."

4. 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."

Gender Preference Counselling

Setting: GP / Primary Care

Patient: Mother of multiple same-sex children

Presenting Issue: Request for information about influencing baby's sex in a future pregnancy (timing, positions, and gender-based abortion)

Introduction & Consent

"Hello, I'm one of the doctors here today. I understand you wanted to discuss future pregnancy planning. Before we start, is it okay if we talk about this in detail now? Everything we discuss is confidential."

C - Clarify the Concern

"Can you tell me a bit more about what brought you in today?"

Patient expresses:

- Desire for a **male child**
- Asks about possibility of abortion if the baby is a girl

Acknowledge & normalise emotions (without validating the belief):

"Thank you for being open with me. I can see that this is very important to you, and it's okay to talk about these thoughts openly."

Explore motivation and pressure (key scoring area):

- "Can I ask, is there a particular reason you're hoping for a boy this time?"
- "Is this something you personally want, or do you feel pressure from your partner, family, or community?"
- "How is your partner feeling about this?"
- "How have you felt emotionally after your previous pregnancies?"

Explore ICE explicitly:

- **Ideas:** “What do you think determines the baby’s sex?”
- **Concerns:** “What worries you most about having another girl?”
- **Expectations:** “What were you hoping I could help you with today?”

A - Assess Relevant Background & Risk**Obstetric & Gynaecological History**

- Number of previous pregnancies and deliveries
- Any complications (e.g. GDM, pre-eclampsia, operative deliveries)
- Current parity and spacing between pregnancies

Menstrual & Contraceptive History

- Regularity of cycles
- Current contraception
- Time trying to conceive (if applicable)

Fertility & Relationship Context

- Any known fertility issues (self or partner)
- Stability of relationship
- Partner involvement in decision-making

Psychosocial & Safeguarding Check (very important)

- Cultural or family pressure
- Fear of rejection, abuse, or coercion if baby is female
- Emotional wellbeing and mental health

(If any suggestion of coercion or harm → acknowledge and offer support pathways)

R - Reassure with Facts & Empathy**Clear, factual explanation (non-judgemental)**

“I want to give you clear and honest information.”

- “In humans, the baby’s sex is determined **at the moment of conception**, based on whether the sperm carries an X or Y chromosome.”
- “There is **no proven medical, natural, or lifestyle method** - including timing, diet, or sexual positions - that can reliably influence a baby’s sex.”
- “Online advice or traditional methods are unfortunately myths and not scientifically accurate.”

Legal and ethical clarification (UK-specific, calm tone)

“In the UK, abortion is **not permitted for gender selection**. Termination is only allowed if specific legal medical grounds are met, and choosing a baby’s sex is not one of them.”

Emotional reframing without moralising

“I also want to be honest that even with another pregnancy, there is always a chance the baby could be a girl again. That can be difficult to accept, especially if there has been disappointment before.”

(Pause, allow response)

“Every child, regardless of gender, has equal value - and your wellbeing as a mother matters just as much as the outcome.”

E - Educate & Engage in a Shared Plan

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1. Pre-conception & Pregnancy Planning Advice

If planning a future pregnancy:

- **Folic acid 400 micrograms daily** (start pre-conception)
- Review of:
 - BMI and healthy weight
 - Smoking, alcohol, and substance use
- Ensure:
 - Cervical smear is up to date
 - Any long-term conditions are optimally controlled
- Offer:
 - Pre-conception blood tests if indicated
 - Referral to GP or midwife-led pre-pregnancy clinic if appropriate

2. Emotional Support & Ethical Discussion

"It's normal to hope for a certain outcome, but pregnancy and parenthood are not fully controllable."

"If you ever feel pressured, distressed, or unsupported - especially if expectations are coming from others - please speak to us. We are here to support **you**, not judge you."

"If you'd like, we can also arrange:

- Further counselling
- A follow-up appointment with your partner present
- Referral for emotional or psychological support"

Safety Netting & Follow-Up

- "If your feelings about this become overwhelming, or if you feel unsafe or under pressure at home, please seek help urgently."
- "We can arrange a follow-up appointment to continue this discussion, especially if you are planning a pregnancy."

Closing the Consultation

"Before we finish, is there anything you were hoping I'd explain again, or anything you're still unsure about?"

"Thank you for speaking so openly today."

Lesbian Fertility Counselling

Setting: Primary Care **Role:** FY2

Adult Woman in Same-Sex Relationship. Requesting Information About Fertility Options.

C - Clarify the Concern

"Thank you for sharing that. Just to confirm, you'd like to explore fertility options for starting a family - is that right?"

A - Assess the Background

1. Relationship and Living Situation:

- "Are you currently in a relationship?"
- "How long have you been together?"
- "Are you living together?"

NHS requires a **stable relationship (usually >2 years)**.

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2. Reproductive History:

- "Have you or your partner ever been pregnant before?"
- "Any history of miscarriages or living children?"

3. General Health and Lifestyle:

- Health conditions, medications
- Smoking, alcohol
- BMI (should ideally be 19–30 kg/m²)

R - Reassure and Explain

"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:

"The NHS fertility pathway for same-sex couples varies by area. Some areas offer NHS-funded IUI; others require self-funded IUI cycles (usually 6) before considering NHS-funded IVF. I'd recommend checking your local ICB's fertility policy."

Eligibility Requirements:

- Stable same-sex relationship (usually 2+ years)
- No living children from either partner
- BMI 19–30 kg/m²
- Must be non-smoker
- STI screening completed

Important note: "Eligibility criteria can vary slightly between different NHS regions, so the fertility clinic will confirm exactly what applies in your area."

E - Educate and Empower**Immediate Next Steps:**

- Referral to local NHS fertility clinic
- Tests including AMH levels, ultrasound, STI screening

Lifestyle Optimisation:

- Healthy BMI, avoid smoking
- Start folic acid 400 mcg daily

Donor Sperm Options:

- Anonymous donor through NHS or regulated sperm banks

Emotional Support:

- Support groups and counselling available

Contraception Counselling

Setting: Primary Care **Role:** FY2

Adult Woman with History of DVT. Requesting Contraception Advice.

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C - Clarify the Concern

"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."

A - Assess the Relevant Background

1. Past Contraceptive Use

- "Have you used contraception in the past?" → "I used to be on the combined pill but was told to stop it after I had a clot."

2. Medical History & Contraindications

- "You mentioned a clot - was that a DVT?" → "Yes, DVT in the leg, two years ago."

3. Sexual & STI Risk History

- "Have you ever had an STI screen before?" → "No."
- "Have you had unprotected sex with this new partner?" → "Yes."

R - Reassure

"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."

"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

Options that are safe for you include:

1. Progestogen-Only Pill (POP)

- 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
- Effectiveness: >99% if taken correctly

2. Progestogen-Only Injection (Depo-Provera)

- One injection every 12 weeks
- Very effective, no clot risk

3. Progestogen Implant (Nexplanon)

- Lasts up to 3 years
- Can be removed anytime

4. Copper IUD (Non-hormonal)

- Lasts 5-10 years
- No hormones at all

5. Hormonal IUS (Mirena/Kyleena)

- Lasts upto 8 years
- Safe after DVT

6. Condoms

- No hormones, protects against STIs

Recommendation:

"Given your history of DVT and preference for something short-term, the **progestogen-only pill** sounds like a good option."

"I'd also recommend having an **STI screen** since you've had unprotected sex with a new partner."

Safety Netting

"If you experience any unusual symptoms - leg swelling, chest pain, unusual bleeding - please come back straight away."

Mammogram Request

Setting: Primary Care **Role:** FY2

Adult Woman. Requesting Breast Screening Due to Personal or Family Concerns.

C - Clarify the Concern

Greet and confirm identity:

"Hello, I'm Dr. [Name]. 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?"

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)

Scenario 1: Middle-Aged Patient (Around 50)

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."

Breast awareness:

"In the meantime, get to know how your breasts normally look and feel, so you can notice any changes. There's no special technique needed - just be aware of what's normal for you."

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."

Scenario 2: Mammogram Request in Younger Patient (Around 30s)

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."

Family history referral criteria:

"If you have one first-degree relative diagnosed under 40, or multiple relatives affected, that would warrant a specialist review - we can arrange that referral."

Current advice:

- No immediate mammogram
- Encourage **breast awareness** (being familiar with your normal breasts)

Explain breast awareness:

"Get to know how your breasts normally look and feel. You don't need a specific technique - just be aware of what's normal for you and report any changes promptly."

Screening:

"Routine mammograms through the NHS screening program start at age 50. If any symptoms appear before then, you should return immediately."

Leaflet:

- 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

Setting: Primary Care **Role:** FY2

Adult Woman in Same-Sex Relationship. Received Cervical Screening Invitation Letter. Questioning Need for Screening.

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?

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- 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 cervical screening 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 everyone aged 25 to 64 who has a cervix, based on NHS records - not on your individual circumstances."

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 cervical screening?**

"Cervical screening looks for early changes in the cells of the cervix and for HPV infection - the main cause of cervical cancer."

Who needs cervical screening?

"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 is passed through skin-to-skin genital contact, which can happen during sexual activity between women too - it doesn't require penetration."

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 (Updated July 2025):

"Since July 2025, if your HPV test is negative, you'll be invited every **5 years** regardless of your age - this is because we now know that HPV-negative women have a very low risk of cervical cancer.

If HPV is found, you'll be monitored more closely.

Screening continues until age 64.

Early changes picked up by screening can prevent cervical cancer."

Important clarification: The 5-yearly interval change is **not applied retrospectively**. It only applies to samples taken **on or after 1 July 2025**. If someone was screened before July 2025 and was HPV-negative, they remain on 3-yearly recall until their next test. Additionally, if someone's previous test (within 5 years) was HPV-positive, they stay on 3-yearly monitoring even if their latest test is HPV-negative.

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."

Cervical Screening for a Transgender Man

Setting: Primary Care **Role:** FY2

Transgender Man Assigned Female at Birth. Enquiring About Cervical Screening Eligibility.

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 cervical screening test?"

"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 cervical screening 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?"
- "Would you feel comfortable telling me a bit about the types of sexual contact you have - for example, does it involve genital contact?"
- "Do you usually use protection, like condoms or barriers?"
- "Have you ever been screened for STIs or had the HPV vaccine?"

(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 cervical screening 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:

"Cervical screening 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 for anyone aged 25 to 64 who still has a cervix - regardless of gender identity."

"If your HPV test is negative, you'll be invited every **5 years**. If HPV is found, you'll be monitored more closely."

"It's not based on how you identify or which hormones you take, but simply whether your cervix is still present."

Important note for trans men:

"Trans men who are registered as male with their GP may not receive automatic screening invitations - so it's important to request screening yourself or ask us to flag your records."

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 screening is so important: it helps 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 screening, 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 cervical screening 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."

Persistent Acne - Request for Isotretinoin

Setting: Primary Care **Role:** FY2

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Young Adult with Persistent Acne. Requesting Isotretinoin. No Prior Treatment Tried.

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, has seen online success stories about isotretinoin, and wants something 'stronger' that works.

2. Assess the Relevant Background

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?"
- "Any other medications?"
- "Have you noticed any link with your cycle, stress, or certain foods?"

Social Impact:

- "How is the acne affecting you day-to-day?"
- "Is it affecting your confidence or mood?"

3. Reassure the Patient

Anchor Phrase: *"Let me explain why this is happening and what we can do."*

About acne persistence:

"First, I want to say - it's completely normal to still have acne at your age. 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."

Note: For women of childbearing potential, isotretinoin requires participation in the **Pregnancy**

Prevention Programme with strict contraception requirements - the dermatologist will explain this in detail if referral is needed.

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."

4. Engage in a Shared Plan

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."

Pregnancy safety: Before prescribing, confirm pregnancy status if relevant. Adapalene is a topical retinoid and is **contraindicated during pregnancy and when planning a pregnancy** due to theoretical teratogenic risk. Advise effective contraception while using, or offer an alternative (e.g., azelaic acid or benzoyl peroxide monotherapy) for women who may become pregnant.

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."

Discharge Discussion with Relative

Setting: Acute Medical Unit **Role:** FY2

Discussion with Adult Child of Elderly Patient. Patient Medically Fit for Discharge. Relative Concerned About Safety and Requesting Nursing Home Placement.

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 the right choice when someone genuinely can't manage safely at home even with full support - and that's not where your mum 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 ask her GP to check on her at home in the next few 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 frustrating it feels to hear she's leaving when you've only just arrived. If you'd like, you could stay with her for the first day or two at home to see how she manages."

"What if she falls again?"

"Falls are always a concern in older adults, but we can't prevent every risk - what we can do is reduce the risk as much as possible. The physio team has assessed her mobility, and carers will be visiting regularly. We'll also refer her to a falls clinic for a full assessment."

Closing

"I know this isn't easy, and I can see how much you care. But based on everything we've seen, she's safe to go home with support - and that's what she wants."

"We'll make sure there's a clear plan in place, and you'll have numbers to call if anything changes."

"Is there anything else I can help explain or arrange before she leaves?"

Worried About Stroke

Setting: Primary Care

Patient: Middle-aged Adult

Concern: Anxiety about stroke risk following borderline blood pressure reading

C - Clarify the Concern

Open: "Hello, I'm Dr _____. I understand you wanted to see me today - how can I help?"

Patient: "Doctor, I am worried about stroke. My BP was borderline, and I saw an advert saying over 50 or family history means risk."

Clarify:

"What do you understand about stroke?"

"What exactly is worrying you most?"

"What are you hoping I can do for you today?"

Empathy: "I can see why you are concerned. It's good you came - let's go through your risks properly and see what we can do."

A - Assess Relevant Background

Risk Factor Screening

Family history: Stroke or heart disease in relatives? At what age?

Medical history: Diabetes, hypertension, cholesterol, atrial fibrillation, TIA/stroke/MI.

Medications: Any current tablets?

Blood pressure: Nurse said "borderline" → will recheck in clinic.

Lifestyle:

Smoking? If yes, how much/how long.

Alcohol intake (units/week).

Diet (spicy/oily/processed foods vs fruit, veg, wholegrains).

Exercise (regular activity, stairs vs lifts).

Stress (NHS managerial role, long hours, coping?).

Ethnicity: Black or South Asian background?

Other symptoms: Weakness, speech problems, visual loss (to exclude TIA/stroke).

Examination (if time)

Repeat BP, pulse, BMI/waist circumference, cardiovascular exam.

R - Reassure & Explain**Stroke Basics**

"A stroke happens when blood supply to part of the brain is blocked or bursts. This causes sudden weakness, speech problems, or even paralysis. It is always a medical emergency."

FAST Rule

Teach: **Face droop, Arm weakness, Speech difficulty, Time to call 999.**

Offer leaflet.

Risk Factors

Non-modifiable: Age, family history, ethnicity.

Modifiable: High BP, diabetes, cholesterol, smoking, alcohol, diet, lack of exercise, obesity, stress, AF.

Borderline BP

"Borderline means your blood pressure is a bit higher than we'd like - not high enough that we'd usually recommend tablets right away, but high enough that we should pay attention to it. The good news is, lifestyle changes can make a real difference at this stage."

BP Thresholds:

"Stage 1 hypertension (140-159/90-99): Offer lifestyle advice; consider treatment if target organ damage, CVD, renal disease, diabetes, or QRISK3 $\geq 10\%$ "

E - Engage in Shared Plan**Investigations**

Blood tests: HbA1c, lipid profile, U&E, FBC, LFT.

BP monitoring: Ambulatory or home BP to confirm.

QRISK3 score: Calculate 10-year risk of heart attack/stroke.

***Note:** QRISK4 is now available and includes additional risk factors (COPD, learning disability, certain cancers) but may not yet be integrated into all GP systems.*

***Note:** NICE updated the NG238 pathway in October 2025 to remove the link to the online QRISK3 calculator, as it should not be used for direct patient care by healthcare professionals. QRISK3 remains the recommended CVD risk assessment tool - use the version integrated into your GP clinical system*

ECG if irregular pulse (rule out AF).

Lifestyle Changes (first-line, NICE CKS)

Stop smoking → NHS support, nicotine replacement.

Reduce alcohol (<14 units/week).

Healthier diet → cut salt, fried/oily foods; increase fruit, veg, fibre, oily fish.

Exercise → 150 min/week (brisk walking, stairs instead of lifts).

Weight reduction if overweight.

Stress management → sleep hygiene, relaxation, mindfulness, GP support.

Medications (if indicated after risk calculation)

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Statin: Offer atorvastatin 20 mg if QRISK3 $\geq 10\%$. For QRISK3 $< 10\%$, do not rule out treatment - discuss individualised risk-benefit, especially using QRISK3-lifetime for younger patients with modifiable risk factors.

Antihypertensive if sustained BP $\geq 140/90$ despite lifestyle changes (age < 55 : ACE/ARB; ≥ 55 or Black ethnicity: CCB first line).

Anticoagulation if AF present.

Safety Netting

If sudden weakness, facial droop, or speech problem → **999 immediately**.

If chest pain or collapse → urgent help.

Return if new or worrying symptoms.

Follow-Up

Review in 2–4 weeks with BP and blood test results.

Discuss QRISK3 and treatment plan at that visit.

Ongoing annual review for cardiovascular risk.

Patient Resources

Provide NHS leaflet on FAST and stroke prevention.

Signpost to NHS website for lifestyle and smoking cessation resources.

Antenatal Counselling - Amniocentesis

Setting: Antenatal Clinic

Patient: Pregnant Woman (First/Second Trimester)

C - Clarify the Concern

Open: "Hello, I'm Dr _____. I understand you'd like to discuss a test called amniocentesis. Could you tell me what you already know about it and what concerns you most?"

Explore ICE:

"What do you understand about why this test is being offered to you?"

"What are your main worries - about your baby's health, or about the procedure itself?"

"What are you hoping to get out of today's consultation?"

Empathy: "I can see this feels overwhelming. My aim is to explain how the test is done, what it can show, the risks and alternatives, so you can make the decision that feels right for you."

A - Assess Relevant Background

Pregnancy & Obstetric History

"How many weeks pregnant are you now?" (Patient: 14 weeks).

"How has the pregnancy been so far - any bleeding, pain, or complications?"

"Have you had your dating scan and combined screening test? What results were you given?"

"Any previous pregnancies, miscarriages, or babies with health conditions?"

Medical & Family Background

"Do you have any medical conditions such as diabetes, high blood pressure, or problems with clotting?"

"Do you take any regular medications?"

"Any allergies - latex, antiseptics?"

"Is there any family history of chromosomal conditions or inherited diseases, such as cystic fibrosis or muscular dystrophy?"

Social & Support

"Is your partner or family aware of this appointment?"

"How are you coping emotionally with the news that there may be a higher chance?"

R - Reassure & Explain

What is Amniocentesis?

"Amniocentesis is a test done in pregnancy where we take a small sample of the fluid around your baby. This fluid has the baby's cells, and by testing them we can check the baby's chromosomes directly.

It gives a **definite diagnosis** for conditions such as **Down's syndrome (Trisomy 21)**, **Edwards' syndrome (Trisomy 18)**, and **Patau's syndrome (Trisomy 13)**."

"It can also check for **other chromosomal problems** such as sex chromosome conditions (like Turner's or Klinefelter's syndrome).

If there is a known family condition, it can sometimes test for **single-gene disorders** such as cystic fibrosis or spinal muscular atrophy."

When is it Done?

"It is usually offered between **15 and 20 weeks of pregnancy**. It is safest after 15 weeks, as doing it earlier carries higher risks."

"Since you are 14 weeks, if you go ahead, it would be arranged in the next week or two."

How is it Done (Step by Step)?

"The procedure is done in hospital and guided by ultrasound:

An ultrasound scan checks the baby's position.

The skin of your tummy is cleaned.

A very fine needle is passed through the tummy into the womb, under ultrasound guidance.

A small amount of amniotic fluid is taken.

The baby's heartbeat is checked again afterwards.

It usually takes about **10–15 minutes**, and you can go home the same day."

Risks

"The procedure-related risk of miscarriage is approximately 0.1-0.5% (around 1 in 200 to 1 in 1000). In experienced centres, the risk may be lower. This means that for every 200-1000 amniocentesis procedures, one may lead to miscarriage that would not otherwise have occurred. In experienced centres, the risk is at the lower end of this range.

Other possible effects:

Mild tummy cramps or discomfort for a day or two,

Light vaginal bleeding or small fluid leak,

Very rarely, infection or injury to the baby."

Results

"QF-PCR (rapid) results are available within 3 working days; full karyotype takes 2-3 weeks."

"The test does not check for everything - only the main chromosomal conditions and specific ones we test for."

Alternatives

Chorionic Villus Sampling (CVS):

Done earlier (11–14 weeks).

Slightly higher miscarriage risk (approximately 1%).

Non-Invasive Prenatal Testing (NIPT):

"If your combined screening showed a chance between 1 in 2 and 1 in 150, you'll be offered NIPT first. NIPT is a blood test from your arm - it's very accurate but not 100% diagnostic. If NIPT shows a higher chance, or if you prefer, you can proceed to amniocentesis for definite confirmation."

No further testing:

Some women prefer not to have invasive tests and continue with standard antenatal care.

"There is no pressure - we will support whatever decision you make."

E - Engage in Shared Plan

Next Steps

Since you are 14 weeks:

We can discuss whether you want NIPT first, or to proceed with amniocentesis once you reach 15 weeks.

If you opt for amniocentesis, we will arrange it in the antenatal clinic.

If Results Show Abnormality

Referral to **fetal medicine specialists** and **genetic counselling**.

Discussion of options in a **non-directive way**: continuation of pregnancy with support, or considering termination.

Safety Netting (after procedure)

"After the procedure, mild cramp is common.

But if you develop **heavy bleeding, leaking of fluid, severe pain, or fever**, call the hospital straight away."

Follow-Up

Clinic review when results are available.

Emotional support and counselling as needed.

Resources

Provide NHS leaflet on amniocentesis.

Signpost to **ARC (Antenatal Results & Choices)** for support.

Terminology Note:

Throughout this consultation, use "higher chance" rather than "high risk" - this is the terminology recommended by NHS Fetal Anomaly Screening Programme (NHS FASP).

Narcolepsy - Driving Restriction Concern

Setting: Primary Care

Patient: Adult with recent sleep disorder diagnosis

Presenting concern: Occupational and driving implications of diagnosis

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Clarify the Concern

Opening statement: "Hello, I'm Dr [Name], one of the GPs here. I understand you wanted to talk about something your nurse mentioned about driving?"

Patient response: "Yes doctor, she told me I shouldn't drive because I was diagnosed with narcolepsy, but driving is part of my job - I might lose it."

Clarifying the situation & exploring ICE:

"I can really hear how worried you are about this - your job and your independence are important, and I want to help you navigate this. Can I check - what exactly did the nurse tell you?"

"What's your understanding of why you've been advised not to drive?"

"How long have you had this diagnosis?"

"What kind of driving do you do - is it personal, or part of your job?"

"Are you currently still driving?"

"What worries you most - losing your licence, your job, or not knowing what comes next?"

"What were you hoping I could help you with today?"

Assess the Relevant Background**A. Focused History - Symptom control & diagnosis**

"When were you diagnosed with narcolepsy?"

"Was it confirmed by a neurologist or sleep specialist?"

"What kind of symptoms led to the diagnosis?"

"Do you have sudden uncontrollable episodes of sleep during the day?"

"How long do these attacks last, and how often do they happen?"

"Have you ever had one while driving or in a risky situation?"

"Do you experience any sudden weakness in your body, like knees giving way when you laugh or get excited (cataplexy)?"

"Any episodes of vivid dreaming or sleep paralysis?"

"How is your sleep at night - restful or disturbed?"

"Are you taking any medicines such as modafinil or solriamfetol? Any side effects?"

B. Occupational and safety background

"Can you tell me about your job - does it mainly involve driving or machinery?"

"Do you have any previous accidents or near misses while driving?"

"Has your employer been informed of your condition yet?"

"Are you under pressure to continue driving despite the advice?"

C. Medical and social background

"Any other medical problems like epilepsy, diabetes, heart disease?"

"Any other medications - especially anything that makes you drowsy?"

"Do you consume alcohol, caffeine, or energy drinks?"

"Do you smoke or use recreational drugs?"

"How are you coping emotionally since the diagnosis?"

"Any family or social support?"

Summary to patient: "Thank you, that gives me a good picture. You've recently been diagnosed with narcolepsy, and though you've been told to stop driving, you're understandably anxious because your work depends on it."

Examiner notes:

Demonstrates safe history taking: explores **symptoms, driving risk, and legal responsibility**.

Screens for exacerbating factors (medications, alcohol, sleep hygiene).

Identifies **functional and emotional impact** - crucial for empathy marks.

Reassure & Explain

A. Explain the condition (in layman terms): "Narcolepsy is a long-term neurological condition where the brain's control over sleep and wakefulness doesn't work properly. So people may suddenly feel very sleepy or fall asleep during normal activities. Some may even lose muscle control when laughing or feel paralysis or vivid dreams on waking. It's not your fault - it's a recognised medical condition caused by changes in certain brain chemicals."

B. Why driving is restricted: "The main concern is safety. Because narcolepsy can cause sudden sleep episodes, there's a high risk of losing control while driving. So by law, people diagnosed with narcolepsy must **stop driving immediately** and **notify the DVLA (Driver and Vehicle Licensing Agency)**. This isn't a personal rule from the nurse - it's a national legal requirement to protect both you and others on the road."

C. Who decides and for how long: "The DVLA, not your GP or nurse, will assess your case. They contact your neurologist, review your treatment and symptom control, and then decide when it's safe for you to drive again. Once your symptoms are stable and well-controlled, you can usually reapply for your licence. Many people with narcolepsy do go back to driving once things are under control."

D. Address the concern about job loss: "I understand your worry about work. While you mustn't drive until cleared, your employer is legally obliged to consider alternative duties or adjustments under the Equality Act. You can discuss temporary non-driving roles or other supportive measures with Occupational Health. I can help you with documentation or a fit note to explain the situation."

E. Reassurance points:

"This doesn't mean you'll never drive again - it's temporary."

"Once your treatment is working well and your specialist confirms stability, your licence can be reinstated."

"I'll support you through the DVLA process and help liaise with your workplace."

Engage in Shared Plan + Specific Management

A. Legal / Immediate actions

Stop driving immediately until cleared by DVLA.

Notify DVLA (using the SL1 form or online service).

GP to document in notes: "Advised patient to cease driving due to narcolepsy and notify DVLA."

Group 2 (HGV/bus) licence holders: The restrictions are **significantly stricter** than for Group 1 licences, and relicensing is **more difficult** (though not impossible with well-controlled symptoms,

specialist follow-up, and on-road assessments). Discuss this specifically with the DVLA and your specialist.

Insurance warning: Driving against medical advice or without notifying the DVLA may **invalidate your motor insurance**, leaving you personally liable for any accidents.

B. Clinical management

Continue follow-up with neurologist or sleep clinic.

Optimise treatment (e.g. modafinil, solriamfetol) as per NICE guidance.

Review for medication side effects and adherence.

Reinforce **sleep hygiene**: consistent sleep schedule, avoid caffeine after noon, avoid heavy meals or alcohol before bed.

Encourage power naps at work if advised by specialist.

Monitor for comorbid depression or anxiety; offer mental health support if needed.

C. Occupational & psychosocial management

Discuss informing employer or occupational health for temporary adjustments.

Provide a **fit note (sick note)** explaining medical restriction from driving.

Refer to **Occupational Health** for workplace accommodations.

Offer contact to **Citizens Advice** or **Disability Employment Adviser** for guidance on income protection and job rights.

Give **NHS leaflet** or **Narcolepsy UK resources** for education and peer support.

D. Safety net

"Do not drive or operate heavy machinery until DVLA gives you written clearance."

"If you have a sudden worsening of daytime sleepiness or any new episodes, contact us or your specialist immediately."

"Let me know if your work puts you under pressure to drive despite restrictions - we can provide a medical letter if required."

E. Follow-up plan

GP review in **4–6 weeks** to check on DVLA progress, symptom control, and work adjustment.

Neurologist to provide updates on treatment and symptom diary.

Ongoing support until clearance granted.

Closure: "I know this feels difficult right now, but it's about keeping you and others safe. This restriction is usually temporary, and once your symptoms are well controlled, you'll be able to drive again. I'll help with your DVLA paperwork and any letters for your employer. Does that sound okay to you?"

Alcohol Counselling

Station ID

Setting: Primary Care

Patient: Adult

Presenting: Voluntary consultation - lifestyle concerns emerge during history

1) Introduction & Consent

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Greet, confirm identity and age; introduce yourself as the GP.

Ask preferred form of address.

Confidentiality reassurance: "What we discuss is confidential unless I'm worried about your or someone else's safety."

Agenda: "Is it okay if I ask a few questions to understand what brought you in today, then we'll make a plan together?" Obtain consent.

2) Clarify the Concern - CARE: Clarify

Open questions:

"What brings you in today?"

"Tell me a bit more about what made you decide to see me now?"

Emerge details:

She's noticed drinking more since a promotion; mostly weekends; wants advice on cutting down.

Explore:

"When did you first notice this change?"

"What made you notice?"

"Has anyone else commented?" → Husband and mother concerned.

"How do you feel about it yourself?"

"What would you hope we achieve today?"

3) Assess the Relevant Background - CARE: Assess

A) Screening first: AUDIT-C (primary UK tool)

Frequency: "How often do you drink alcohol?" → Weekends, 3 days/week.

Typical quantity per drinking day? → Specify exact glasses/bottles.

Six units or more on one occasion? → Most weekends.

Result: High AUDIT-C risk → proceed to dependence screen and brief intervention.

B) Dependence screen: CAGE

Cut down? → Yes, that's why she came.

Annoyed by others' criticism? → Husband/mother mentioned it (not hostile).

Guilty? → No, more surprised at the total.

Eye-opener? → No.

Interpretation: No dependence features.

C) Pattern, Quantity, and Unit Calculation

Targeted questions:

Exact types: wine (% ABV), champagne (% ABV).

Exact volumes: number of glasses and size (125/175/250 ml), bottles (750 ml).

Days: Fri/Sat/Sun; any weekday use?

Context: social vs alone; triggers (celebrations, stress, disposable income).

Worked example to match her report of about 39 units/week:

Suppose over Fri-Sun she had:

10 large (250 ml) glasses of 12% wine → 10×3 units = **30 units**

Plus 1 × 750 ml bottle of 12% champagne → **9 units**

Total ≈ **39 units/week**.

Say it to the patient: "Adding up what you've told me, that comes to about thirty-nine units this week, which is almost three times the UK recommended maximum of fourteen units."

Note rounding and variation by brand; adjust to her exact amounts if the examiner gives volumes.

D) Harms / Impact / Risk

Work, family, relationships, arguments or tension.

Missed responsibilities, accidents/injuries, falls, blackouts.

Driving after drinking or next-day impairment.

Findings (scenario): family concern only; no harms disclosed; no drink-driving.

E) Physical Health Review (subtle alcohol-related features)

GI: dyspepsia, nausea, appetite change, bowel changes, haematemesis/melaena.

Neuro: tingling in feet/hands, poor concentration, memory lapses.

CV: palpitations, chest discomfort.

General: weight change, night sweats, fevers.

PMH: liver disease, ulcers, HTN, pancreatitis.

Medications/supplements; interactions.

Pregnancy or plans.

Findings: none disclosed; not pregnant; no meds.

F) Mental Health Screen (brief, validated)

PHQ-2: anhedonia, low mood.

GAD-2: nervous/anxious/on edge.

Findings: mild work-related stress only; no red flags.

G) Red Flags

No withdrawal symptoms (tremor, sweats, morning drinking).

No self-harm ideation.

No acute GI bleed features.

Not pregnant.

4) Reassure & Explain - CARE: Reassure & Explain

Acknowledge:

"You've done the right thing catching this early and coming in. That first step is often the most important."

Safe limits:

"In the UK the low-risk guidance is **≤14 units per week**, spread over 3 or more days, with several alcohol-free days."

Why it matters:

Sustained intake at this level increases risk of liver disease, hypertension, certain cancers, mood/sleep problems, accidents.

Pattern risk:

"Concentrated weekend intake is **binge drinking**; even if only a few days, the sudden high dose strains the heart and liver and raises accident risk."

Classification:

"You do not have signs of dependence, which is good. Your drinking is at a level that increases health risks over time, even though you may not notice any problems yet."

Reassure:

"You don't need to stop completely unless you prefer; most people do well with structured cutting-down."

5) Engage in Shared Plan - CARE: Engage in Shared Plan + Specific Management

A) Brief Intervention (core)

Motivational interviewing prompts:

"On a scale of 0–10, how ready are you to cut down?"

"What would be the biggest benefit if you reduced?"

"What might get in the way, and how could we handle that?"

Agree **SMART** goals (collaboratively):

Target ≤ 14 units/week over the next 4–6 weeks.

Plan at least 2–3 alcohol-free days weekly.

Avoid bingeing; pace drinks; eat before and during.

Choose lower-strength options; alternate alcoholic with soft drinks; smaller glasses.

Keep a drink diary or app-based tracker.

B) Information, Tools, and Support

NHS Live Well alcohol advice and unit calculator.

Specific tools many patients find helpful:

Drinkaware website and unit calculator.

NHS "Drink Free Days" app for goals, reminders, tracking.

Explain and offer referral to **Alcohol Brief Intervention / Community Alcohol Service**: routine for hazardous drinking, not a judgment of addiction; provides structured coaching and accountability.

Offer **Social Prescribing** / Wellbeing Coach for stress, sleep, exercise, budgeting alternative leisure activities.

C) Investigations and Opportunistic Checks

Baseline bloods: **LFT, FBC (including MCV - macrocytosis is a marker of chronic alcohol excess), GGT**; consider HbA1c/lipids if risk factors.

Consider oral thiamine supplementation if high alcohol intake combined with poor dietary intake (Wernicke-Korsakoff prevention).

BP and **BMI** today or at first follow-up.

Consider full **AUDIT (10-item)** if you want a more granular baseline.

D) Pharmacological

Not indicated: no dependence, no withdrawal risk.

6) Safety Netting

"If you experience withdrawal symptoms like tremor, sweating, agitation, or if you feel you cannot cut down, seek help urgently."

"Seek urgent care for vomiting blood, black stools, jaundice, or severe abdominal pain."

"If low mood worsens or you develop suicidal thoughts, contact us urgently or attend emergency services."

"If cutting down proves difficult, return earlier; we can escalate support."

7) Follow-Up Plan

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Review in **2–4 weeks**: drink diary/app data, progress against SMART goals, BP/BMI, blood results.
If little progress, increase support intensity via community alcohol services.

8) Leaflet & Final Check

Provide NHS alcohol booklet, unit calculator link, Drinkaware resources, "Drink Free Days" app details.
Check understanding and agreement: "How does this plan sound?" "Any questions or concerns before we close?"

Differentials (and why)

Hazardous drinking - most likely: high weekly units, binge pattern, no dependence or harm.

Harmful drinking - less likely now; no health or social consequences elicited.

Alcohol dependence - unlikely: CAGE negative, no withdrawal, no morning drinking.

Adjustment-related anxiety/stress - mild; addressed via social prescribing if needed.

Note : Alcohol Unit Calculation

Use the UK formula during history and say it aloud.

Units = (ABV% × volume in ml) ÷ 1000

Examples for 12% ABV:

125 ml wine (small) ≈ 1.5 units

175 ml wine (standard) ≈ 2.1 units

250 ml wine (large) ≈ 3.0 units

750 ml bottle of wine/champagne ≈ 9 units

Beer/cider examples:

Pint (568 ml) at 4% ≈ 2.3 units; at 5% ≈ 2.8 units

Spirits:

25 ml single at 40% ≈ 1 unit; 35 ml ≈ 1.4 units

When the patient provides their exact volumes, total them using the formula and compare directly to the **14-unit** weekly guidance.

Chapter 19: Abuse and Safeguarding

A Note to Learners

The cases in this resource are written in a conversational style to help you become familiar with the natural flow of clinical consultations and the language commonly used in UK healthcare settings.

These dialogues are intended as a learning guide, not a script. Please do not attempt to memorise them verbatim. Examiners assess your ability to think and communicate authentically - not to recite rehearsed phrases.

Use this material to understand the underlying clinical reasoning, then practise in your own words until the consultation feels natural to you.

For Companion OSCE Cases, Practice Scripts, Evaluation Checklists, Summary Notes, Rapid Review Notes, Mindmaps, Management Flashcards and Image Library - visit <https://www.gksplab2.com>

Disclaimer

This material is independent educational content created to help candidates develop clinical reasoning and communication skills for UK medical practice.

All cases and clinical scenarios are based on common presentations encountered in UK primary care and emergency medicine, drawn from publicly available sources including NICE Clinical Knowledge Summaries (CKS), BNF, and other official NHS/UK healthcare guidelines.

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Introduction

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.
6. **Risk Assess:** For domestic abuse cases, complete a **DASH risk assessment**. High-risk cases (DASH score ≥ 14 , escalation, or professional judgement) should be referred to **MARAC** and linked to an **IDVA**.

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):

- **Explore** what happened (what, when, who, how, where?)
- **Support:** "Have you been able to speak to anyone about this?"
- **Impact:** "How has this been affecting you physically, emotionally, or at home?"
- **Social history:** relationships, children, finances, home situation
- **Medical 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 follow-up based on risk: within **24–72 hours** if high-risk (pregnancy, children at home, escalation, strangulation, weapons, recent assault); within **1 week** if ongoing concern; **1–2 weeks** only if standard risk and stable

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: Setting: Acute Medical Ward | Role: FY2 Doctor | Patient: Older Adult Female | Presenting Complaint: Fall with Multiple Bruises of Varying Ages | Key Features: Mild Cognitive Impairment with Retained Capacity | Task: Speak with Family Member (Patient Consented)

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 something we need to take seriously as a potential harm, even though I can see it wasn't intentional."
- "I'm not here to judge-I want to make sure your mother is safe and that 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 examine and manage your mother's bruises appropriately.
 - Under the **Care Act 2014**, the local authority has a duty to make enquiries where there is concern about an adult with care and support needs. We'll refer her to social services to explore care options and support.
 - Social services will need to speak with your mother privately first to assess her needs and wishes. They will also discuss with you how you are coping, but our priority right now is ensuring the immediate safety of the home environment."

10. Addressing Concerns

Daughter: "Are they going to take my mum away?"

You:

- "That's a fair question. Social services aren't there to punish anyone-their main goal is to find ways to support families and keep everyone safe. 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."

Note: 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

Scenario: Setting: Paediatric Ward | Role: FY2 Doctor | Patient: Pre-school Child | Presenting Complaint: Limb Swelling | Key Finding: Long Bone Fracture with Concerning Mechanism | Task: History from Parent, Safeguarding Assessment Required

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.)

Important Note on Mobility Assessment: For any child presenting with unexplained bruising or fractures, always assess and document their developmental stage and mobility-whether they can roll, crawl, cruise, or walk independently. "Non-mobile" means children who cannot crawl, cruise, or bottom-shuffle, with particular attention to children who cannot roll over.

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. Whenever we see an injury like this without a clear explanation, we have a duty to make sure we understand how it happened-to protect your child."

"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

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"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
- I will discuss with the consultant paediatrician whether a skeletal survey is required to check for any other injuries-this is standard practice in cases like this.

Note: Per RCR/RCPCH guidance, a skeletal survey is generally indicated for children under 2 years presenting with fractures where NAI is suspected

- 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. The goal is always to understand the situation and offer support. Separation from family is only ever a last resort when absolutely necessary for the child's safety."

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 discussed with consultant paediatrician, senior informed*
- **Avoid interpretation** - stick to facts and observations
- Document emotional state of caregiver if relevant
- Follow local multi-agency safeguarding arrangements

Note: 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

Scenario: Setting: Emergency Department | Role: FY2 Doctor | Patient: Pregnant Adult Female | Presenting Complaint: Vaginal Bleeding | Key Findings: Reassuring Scan, Unexplained Bruising | Task: Safety Assessment and Discharge Planning

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."

Note: Asking about domestic abuse is part of routine antenatal care. This type of enquiry should feel natural in the pregnancy context.

4. Detailed History – Domestic Violence Assessment

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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."
- "I'm going to arrange an **immediate referral to our Safeguarding Midwife** here in the hospital- she specialises in supporting women in your situation."
- "I'd also like to refer you to an **Independent Domestic Violence Advocate (IDVA)**-they work one-on-one with you to develop a safety plan and can support you through this."

- "If you prefer to go home, we will arrange for your **GP or community midwife to follow up** with you within **2-3 days**-pregnancy is a time when we need to keep a close eye on your safety."
- "Because this affects your safety and your baby's well-being, I'd like to involve social services- they're there to support you and make sure you and your baby are safe. Their role is to help, not to judge or separate families. This is part of what's called a **pre-birth assessment**, which helps ensure the right support is in place before your baby arrives."
- "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** - 0808 2000 247 - 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** when prompted (this is called Silent Solution) to alert the police
- **Text SHOUT to 85258** for free crisis text support
- **Live chat** is available at nationaldahelpline.org.uk"

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 within **2-3 days** - either with your GP, community midwife, or through the IDVA service - so we can check on your health, safety, and the progress of your pregnancy. Pregnancy is a high-risk time, so we want to keep in close contact. Please do your best to attend, and if anything changes before then, come back immediately or call 999."

Note: 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

Scenario: Setting: Primary Care | Role: FY2 Doctor | Patient: Adult Female | Presenting Complaint: Recent-Onset Insomnia | Key Features: Anxious Affect, Guarded History | Task: Explore Underlying Cause, Address Safeguarding Concerns

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. What you've described-the pushing, the fear, the control-that's 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 **press 55** if you can't speak (Silent Solution)
- **Text SHOUT to 85258** for free crisis text support
- **Live chat** is available at nationaldahelpline.org.uk
- 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 can discuss with my senior colleague whether a very short course of sleeping tablets might be appropriate for you-usually just a few nights to help you get some rest. However, I need to be cautious because these medications can make you drowsy, and in your situation, you may need to be alert if you need to respond quickly or leave in an emergency. If we do prescribe them, we'd need to make sure you have a safety plan in place first.
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"

Note: 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

Scenario: Setting: Primary Care | Role: FY2 Doctor | Patient: Adult Female | Presenting Complaint: Request to Change Mental Health Provider | Key Features: Vague Initial Presentation, Professional Boundary Concern | Task: Explore Reason for Request, Address Safeguarding

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."

"What happened should never have happened. As healthcare professionals, we have strict rules about boundaries-and he crossed a line that should never be crossed. I need to take this seriously-I'll be discussing this with senior staff to 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."
- "We will need to report this to the appropriate professional body. For counsellors, this would typically be the BACP (British Association for Counselling and Psychotherapy) or the relevant professional register they are on."

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 isn't something that can stay private-when a professional crosses that line, it has to be reported. It's not about punishment-it's about safety and making sure 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"

Note: 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/BACP standards and a safeguarding violation, it required escalation, structured support, and mental health follow-up.

Workplace Harassment – LGBT Discrimination

Scenario: Setting: *Primary Care* | Role: *FY2 Doctor* | Patient: *Young Adult* | Presenting Complaint: *Unspecified – "I want to speak to a doctor"* | Key Features: *Anxious Presentation, Eventual Disclosure of Workplace Distress* | Task: *Explore Concerns, Provide Support*

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 why you've turned to alcohol-it makes complete sense that you'd want something to take the edge off. Let's think together about some other ways to cope that won't hurt you in the long run."

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**."
- "**Galop** - 0800 999 5428 - is a specialist LGBTQ+ anti-abuse charity that can also help."
- "There may be **free legal aid** available if needed."

C. What I Will Do as Your Doctor

- "First, I need to check your physical health today-I'd like to listen to your heart, check your blood pressure, and do some basic tests. Palpitations combined with daily alcohol use can sometimes have a physical cause that we need to rule out."
- "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. Given the amount you're drinking, I'd recommend we refer you to our **alcohol support services** for specialist advice-they can provide proper support. In the meantime, some strategies that might help include exercise, breathing techniques, or reconnecting with friends or hobbies. I'll continue to see you here as well."

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."

Note: 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

Scenario: Setting: Primary Care | Role: FY2 Doctor | Patient: Young Adult (Student) | Presenting Complaint: Request for Medical Certificate | Key Features: Anxious Affect, Avoidant Behaviour | Task: Explore Underlying Concern, Provide Support

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?"

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- "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've told me about is sexual assault. I want to be clear-what happened to you was wrong, and it was a crime. None of this is your fault. 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 - forensic evidence collection is most effective within the first **72 hours** (3 days), but it's still worth attending even **7 days or more** after-speak to the SARC for advice

- Screen and treat for sexually transmitted infections
- Offer professional counselling and mental health support
- Connect you with an **Independent Sexual Violence Advisor (ISVA)** who can support you through the process
- 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. Discuss HIV Post-Exposure Prophylaxis (PEP)

"There's something important I need to discuss with you. Can I ask when this happened?"

(If within 72 hours): "Because this happened recently, there's medication we can offer to help reduce the risk of HIV infection-it's called PEP, or post-exposure prophylaxis. It works best when started as soon as possible, ideally within **24 hours**, but it can still be effective up to **72 hours** after the incident. This involves taking tablets for 28 days. I'd like to arrange for you to be seen urgently today-either here, at a sexual health clinic, or at A&E-to discuss whether this is right for you. Would that be okay?"

(If more than 72 hours): "Because it's been more than 72 hours, PEP medication is unlikely to be effective now. However, I'd still recommend STI screening, which the SARC can provide, and we can arrange testing for HIV at 6 weeks and 12 weeks."

10. Discuss Emergency Contraception (if applicable)

(For female patients where there is risk of pregnancy from the assault):

"I need to ask whether there's any possibility you could become pregnant from what happened. If so, we can offer emergency contraception to prevent pregnancy."

Options include:

Ulipristal (EllaOne) - oral option, effective up to 120 hours (5 days), often preferred after sexual assault

Levonorgestrel - oral option, most effective within 72 hours (3 days)

Copper IUD - most effective EC overall, can be fitted up to 5 days, but use after sexual assault requires consideration of STI risk; prophylactic antibiotics should be given if an IUD is fitted in this context

"The SARC can help arrange this, or we can refer you to a sexual health clinic today if you prefer."

11. Offer Hepatitis B Vaccination

"We also recommend hepatitis B vaccination after sexual assault-this protects against a viral liver infection that can be transmitted through bodily fluids."

- First dose should ideally be given as soon as possible, within 24 hours of the assault
- Follow-up doses arranged through SARC or GP - typically at 1 month and 6 months (standard schedule), or an accelerated schedule may be used depending on clinical assessment
- If the assailant is known to be Hepatitis B positive, **Hepatitis B Immunoglobulin (HBIG)** may also be offered alongside the vaccine

"I can arrange for this to be given here today by our practice nurse, or the SARC can provide it when you attend. Would you like me to arrange that?"

12. 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."

13. 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."

14. 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."

Note on Diagnosis

This is a case of sexual assault disclosed by a young adult 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

Scenario: Setting: Emergency Department | Role: FY2 Doctor | Patient: Adult | Presenting Complaint: Ankle Injury Following Fall | Key Features: Previous Attendances with Self-Discharge, Vague Injury History | Task: Injury Management, Explore Safeguarding Concerns

1. Introduction

"Hello, I'm Dr [Your Name], one of the doctors here in A&E. I understand you've come in with some pain in your ankle-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 you've been to A&E a few times recently-I hope you don't mind me asking, but I wanted to check everything is okay?"

→ *(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.

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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?"

6. 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

7. 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

8. 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

9. Provisional Diagnosis

- Ankle sprain, likely mechanical
- Underlying safeguarding concern: suspected ongoing intimate partner violence (IPV) in a same-sex relationship

10. 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

11. 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 Advice Line (Respect)** - 0808 8010 327 - for male victims of domestic abuse
 - **Galop UK** - 0800 999 5428 - specialist LGBT+ domestic violence services
- "I can refer you to an **Independent Domestic Violence Advocate (IDVA)** who can work with you one-on-one to develop a safety plan. If we assess the risk as very high using a formal risk assessment called DASH, we may need to discuss your case at a **multi-agency meeting (MARAC)** to coordinate support from different services to help keep you safe-but this is a professional meeting, and you wouldn't need to attend."
- "Domestic violence affects people in all types of relationships. Your gender or sexuality does not make what is happening to you acceptable, and the services I've mentioned are experienced in supporting people in same-sex relationships."
- 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

12. 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

Note: 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

A Note to Learners

The cases in this resource are written in a conversational style to help you become familiar with the natural flow of clinical consultations and the language commonly used in UK healthcare settings.

These dialogues are intended as a learning guide, not a script. Please do not attempt to memorise them verbatim. Examiners assess your ability to think and communicate authentically - not to recite rehearsed phrases.

Use this material to understand the underlying clinical reasoning, then practise in your own words until the consultation feels natural to you.

For Companion OSCE Cases, Practice Scripts, Evaluation Checklists, Summary Notes, Rapid Review Notes, Mindmaps, Management Flashcards and Image Library - visit <https://www.gksplab2.com>

Disclaimer

This material is independent educational content created to help candidates develop clinical reasoning and communication skills for UK medical practice.

All cases and clinical scenarios are based on common presentations encountered in UK primary care and emergency medicine, drawn from publicly available sources including NICE Clinical Knowledge Summaries (CKS), BNF, and other official NHS/UK healthcare guidelines.

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Gender Dysphoria in a 16-year-old

Station ID: Primary Care Setting | Adolescent Patient | First Presentation of Gender Identity Concerns | Unaccompanied Consultation

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

Note: This framework provides comprehensive coverage but should be adapted to the consultation flow - not recited as a checklist. In an 8-minute station, integrate questions naturally based on what the patient shares. Focus on exploration and understanding rather than rushing through all categories. The Cass Review emphasises neutral, exploratory care - avoid appearing to push toward any particular pathway.

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 young people's mental health team - sometimes called CAMHS - or the paediatric team."

- "Unfortunately, wait times can be quite long at the moment, but we'll support you throughout."
- "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 new regional NHS gender services for young people - there are now services in London, the North West, Bristol, and more opening across England - 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

- "There are support organisations that work with young people and families exploring gender identity."
- "You can also access NHS-aligned resources through the new regional service websites once your referral is in progress."

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 an adolescent with no prior medical or psychological input. Following the Cass Review (April 2024), NHS guidance requires referral through

NHS secondary care services (CAMHS or paediatrics) who will coordinate with the new regional Children and Young People's Gender Services. GIDS at the Tavistock closed in March 2024 and has been replaced by new regional centres. The primary focus is on holistic psychosocial support, with currently only being used as part of a specific clinical research trial called the Pathways trial, and hormone treatments not routinely initiated before age 18. No GP direct referral. Focus is on psychological support and safety-netting.

Variation: The Patient Asks About Bottom Surgery

During the consultation, the 16-year-old says:

"I've been reading about it online... I want to have bottom surgery. When can I get it?"

This is a critical moment in the consultation. The candidate must respond in a way that is **validating, honest, age-appropriate, and clinically accurate** - without dismissing the patient's feelings or making promises that cannot be kept.

Step 1 - Acknowledge and Validate

Do NOT shut the conversation down. Do NOT look shocked or uncomfortable. The patient has trusted you with something important.

"Thank you for telling me that - I can see this is something you've been thinking about seriously."

"It's completely okay to talk about this. Lots of young people with gender dysphoria have questions about surgery, and it's a really important topic."

"Can I ask - what do you already know about bottom surgery? Where have you been getting your information?"

[Note: Many young people get information from social media, forums, or peers. Acknowledging their research shows respect. It also helps you understand - and gently correct - any misconceptions.]

Step 2 - Explore What They Mean

"Bottom surgery" can mean different things to different people. Clarify sensitively:

"When you say 'bottom surgery' - do you have a specific procedure in mind, or is it more of a general feeling that you want your body to match how you feel?"

"Is it the appearance that bothers you most, or is it more about how it feels day-to-day - things like clothing, using the toilet, or intimacy?"

"How much distress is this causing you right now?"

[Note: Understanding the underlying distress is more important than the specific surgical request. The distress may be manageable with psychological support and social transition, or it may be severe enough to warrant urgent mental health input.]

Step 3 - Be Honest About the Pathway

"I really appreciate you being so open with me. I want to be completely honest with you about where things stand.

Bottom surgery is not available for under-18s on the NHS. This isn't because your feelings aren't valid - they absolutely are. It's because genital surgery is irreversible, and the NHS pathway is designed to make sure that by the time someone has surgery, they've had enough time, support, and assessment to be confident it's the right decision for them.

Here's what the current pathway looks like:"

For under-18s:

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The first step is referral to the **NHS Children and Young People's Gender Service** - these are the new regional centres that replaced the old GIDS at the Tavistock

The focus at your age is on **psychological support, exploration, and holistic wellbeing** - not medical or surgical intervention

Puberty blockers are currently only available through approved research protocols, not as routine treatment (per NHS England interim policy, March 2024)

Cross-sex hormones are generally not initiated before age 16, and only through specialist services with very careful assessment

Surgery is an adult pathway - typically considered only after the age of 18, after sustained hormone therapy (usually 12+ months), and with full assessment through an adult Gender Identity Clinic (GIC)

"So right now, surgery isn't something we can arrange. But what I can do is make sure you get the right support and that when you're old enough, you're in the best position to access the care you want."

Step 4 - Address the Emotional Response

The patient may be upset, angry, or feel dismissed. Anticipate this:

If the patient is upset:

"I can see this isn't what you were hoping to hear, and I'm sorry about that."

"Your feelings are completely valid. Wanting your body to match who you are is a really understandable thing."

"Just because surgery isn't available right now doesn't mean nothing can be done. There are things we can do now to support you."

If the patient says "But I can't wait that long":

"I hear you - and I understand how difficult it must be to feel like you're stuck waiting."

"The time between now and when you're older doesn't have to be wasted time. We can use it to get you the right psychological support, connect you with other young people going through similar things, and make sure you're as prepared as possible."

"How are you coping with these feelings day-to-day? Is there anything that helps?"

If the patient mentions self-harm or distress related to their body:

Take this seriously - screen for self-harm and suicidal ideation

"Sometimes when people feel very distressed about their body, they can feel very low or even think about hurting themselves. Has that ever happened to you?"

If yes → urgent mental health input, safety plan, consider CAMHS referral

If no → continue with supportive approach

Step 5 - What CAN Be Done Now

"While surgery isn't an option right now, here's what we can do to help you:"

Referral to the NHS CYP Gender Service - if not already referred, this is the priority. They provide specialist assessment and psychological support

Psychological support - CAMHS referral for gender-related distress; some areas have specialist gender-affirming therapists

Social transition support - if the patient wants to change name, pronouns, or presentation at school, the GP can write to the school to support this

Peer support - organisations like **Mermaids** (helpline: 0808 801 0400) or **Gendered Intelligence** provide support for young transgender people

Family support - if the family is struggling, signpost to family support services or Mermaids' parent helpline

Body dysphoria management - practical strategies such as binding (safely), tucking, clothing choices; signpost to safe resources

Planning for the future - "When you turn 18, you can be referred to an adult GIC. If you've been through the CYP service, they can help make that transition smooth."

Step 6 - Safety Netting (Specific to This Variation)

"I want to make sure you know where to get help if things feel really tough:"

If you're in crisis or having thoughts of self-harm → Childline: 0800 1111 | Samaritans: 116 123 | 999 in an emergency

If you need someone who understands gender stuff → Mermaids helpline: 0808 801 0400

If things get worse before your next appointment → come back and see us - you don't need to wait
"And I want you to know - we're on your side. We'll keep working with you on this."

UTI in a Transgender Male (Post-Transition)

Station ID: Primary Care Setting | Young Adult | Transgender Patient (Post-Transition) | Dysuria

Scenario Context: A young adult transgender male (assigned female at birth, has completed gender-affirming transition) presents with painful urination.

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?"

- **Pregnancy screen (CRITICAL - do not omit):**
 - "I know this might seem like a standard question, but because testosterone isn't a contraceptive, I need to check - is there any chance you could be pregnant?"
 - (*Testosterone suppresses ovulation but is NOT reliable contraception. Up to 30% of pregnancies in trans men are unplanned. Abdominal pain + urinary symptoms could mask ectopic pregnancy. Testosterone is teratogenic.*)
- **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?"
- **Urogenital atrophy:** "Have you noticed any dryness, irritation, or discomfort in that area - separate from the burning when you pass urine?"

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 or if there's reduced fluid intake."

"It's also worth knowing that testosterone can sometimes cause thinning of the tissues in this area - similar to what happens after menopause. This can make the area feel irritated or like an infection, even when it isn't one. If your symptoms don't settle with antibiotics or keep coming back, we might need to look into that as a possibility."

"The good news is, both conditions are very treatable."

10. Management Plan

Antibiotic Treatment

- "I'll prescribe a short course of antibiotics - usually **nitrofurantoin** or **trimethoprim** taken for **three days**. Nitrofurantoin is often preferred if you've had trimethoprim recently, as bacteria can become resistant to it. Have you taken any antibiotics in the last few months?"
- "Most people feel significantly better within 48 hours."

Urine Sample for Culture (MSU)

- "I'd also like to send a urine sample to the lab for culture. This tells us exactly which bacteria is causing the infection and confirms the antibiotics will work."

FY2 Note: Send MSU if:

- *Pregnant or risk of pregnancy*
- *Recurrent UTI (≥ 2 in 6 months or ≥ 3 in 12 months)*
- *Symptoms not improving after 48 hours of antibiotics*
- *Atypical symptoms or diagnostic uncertainty*
- *Catheter-associated or post-surgical anatomy*
- *In transgender patients with altered anatomy, MSU is advisable to guide treatment*

Hydration Advice

- "Drink plenty of fluids - about 6 to 8 glasses of water a day helps flush out the bacteria."

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."
- "These could be signs the infection has spread to your kidneys, which would need stronger treatment."

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 or three in twelve months - we may need to check for other causes."
- "You're welcome to come back for review if symptoms persist."

When to Refer (FY2 Knowledge):

Refer to urology or seek specialist advice if:

- Recurrent UTIs despite prophylaxis
- Structural abnormality suspected (especially post gender-affirming surgery)
- Haematuria persisting after infection treated
- Male anatomy with UTI (per NICE - though consider patient's surgical history)

If recurrent symptoms with negative cultures - consider GSM/urogenital atrophy:

- Topical vaginal estrogen may be appropriate but discuss with patient's gender service or endocrinologist first
- Some patients may decline estrogen due to dysphoria - respect this and explore alternatives

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 young adult 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.

CRITICAL: Pregnancy screening is mandatory. Testosterone is NOT a reliable contraceptive - up to 25% of pregnancies in trans men are unplanned. Testosterone is teratogenic. Always ask about pregnancy possibility if the patient has a uterus and is sexually active with sperm-producing partners.

Differential diagnosis must include Genitourinary Syndrome of Menopause (GSM) / urogenital atrophy. Trans men on testosterone experience estrogen suppression, causing vaginal and urethral atrophy identical to postmenopausal changes. This presents with dysuria, frequency, and irritation - mimicking UTI. If dipstick is negative, cultures return negative, or symptoms are recurrent despite antibiotics, consider topical vaginal estrogen as treatment - but discuss with gender service first as some patients may decline due to dysphoria.

FY2 Management Summary:

- First-line antibiotics: nitrofurantoin 100mg MR BD for 3 days OR trimethoprim 200mg BD for 3 days (NICE NG109)
- Send MSU in transgender patients, recurrent UTI, treatment failure, or diagnostic uncertainty
- Referral triggers: recurrent UTI despite prophylaxis, suspected structural abnormality, persistent haematuria
- For patients with surgical alteration of urethra - seek specialist advice
- If recurrent negative-culture symptoms → suspect GSM, liaise with gender service re: topical estrogen

Reassurance, psychological sensitivity, and clear safety netting are essential. If patient is sexually active and wishes to avoid pregnancy, offer contraception counselling - all methods are safe to use alongside testosterone.

Pulmonary Embolism in a Transgender Patient on Oestrogen Therapy

Station ID: Primary Care or Emergency Setting | Young Adult | Patient on Hormone Therapy | Acute Chest Pain and Breathlessness

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 see from your notes that you're receiving hormone therapy as part of your 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."

"We use a scoring system called the Wells Score to assess how likely it is you have a clot, and your symptoms put you in a higher risk category."

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.

It's also worth knowing that the way oestrogen is taken makes a difference - tablets carry a higher risk of clots compared to patches or gels that go through the skin. When you're recovered, your specialist might discuss switching to a safer form if you want to continue hormone therapy."

11. Management Plan

Immediate Actions

If haemodynamically unstable (hypotension, severe hypoxia, altered consciousness):

- "This is a medical emergency. I'm calling 999 for an emergency ambulance."
- *Activate crash team if in hospital setting*

If stable but PE suspected:

- "You'll need urgent hospital tests and treatment today. I'll arrange for you to be transferred right away." (*If in GP*)

Immediate Supportive Care:

- **Oxygen:** "I'm going to give you some oxygen to help your breathing" - target SpO₂ 94-98%
- **IV access:** Establish if possible
- **Monitor:** Continuous pulse oximetry, regular observations

Interim Anticoagulation:

If diagnostic tests will be delayed >4 hours, start treatment-dose anticoagulation:

- "While we're waiting for the scan, I'm going to start you on a blood-thinning injection to prevent the clot getting worse."
- **Options:** DOAC (apixaban or rivaroxaban - can be continued if PE confirmed) as preferred interim treatment, OR treatment-dose LMWH (e.g., dalteparin, enoxaparin weight-based) if DOAC not suitable
- *Do not wait for confirmation if high clinical suspicion and transfer delayed*

Hospital Investigations:

- "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 (CTPA)**."

Treatment (Once Confirmed)

- "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."
- "You'll usually need to take these for at least 3 months, sometimes longer."

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."

"We don't know yet whether it was the extra doses or your normal dose that caused this, but we do know that oral oestrogen - especially at higher doses - carries more risk than forms that go through the skin."

"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, switch to transdermal preparations which may be safer, or consider surgical options."

"At this stage, 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

Young adult 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.

FY2 Management Summary:

- **Haemodynamically unstable** (hypotension, severe hypoxia, syncope) → 999, crash call, thrombolysis may be needed
- **Stable but PE suspected** → urgent same-day transfer to hospital
- **Immediate care:** Oxygen (target SpO₂ 94-98%), IV access, continuous monitoring
- **Interim anticoagulation:** If transfer/CTPA delayed >4 hours, start treatment-dose LMWH (NICE NG158) - do NOT wait for confirmation if high clinical suspicion
- **Investigations:** D-dimer (may skip if PE likely on Wells >4), CTPA (gold standard), CXR, ECG, ABG if hypoxic
- **Confirmed PE treatment:** DOAC (apixaban/rivaroxaban) first-line for most patients; minimum 3 months
- **Hormone therapy:** Pause pending haematology/specialist review; transdermal preparations have lower VTE risk than oral - discuss switching post-recovery

Hormonal therapy to be paused pending specialist review. Awareness of Wells Score expected for PLAB 2. Important to note that transdermal oestrogen has lower VTE risk than oral preparations - this should be discussed as a potential safer alternative post-recovery. Smoking increases VTE risk with oestrogen (2-fold increase, 9-fold if also obese). Empathy and shared planning are essential.

Nosebleeds in Transgender Patient Self-Medicating with Testosterone

Station ID: Primary Care Setting | Young Adult | Patient Awaiting Gender Service Assessment | Headache and Epistaxis

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 honest about the medication. 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

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- Focused:
 - **Nasal examination** → Small clot visible, no active bleeding
 - **Blood pressure** → 169/XX (elevated systolic) - "Your blood pressure is 169 - the top number should normally be below 140"
 - 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**. But there's another important effect I need to explain."

"Testosterone can also cause your blood to thicken - it does this by increasing the number of red blood cells. This is called **polycythaemia**. When the blood gets too thick, it puts strain on your blood vessels and heart, pushes up your blood pressure, and increases your risk of blood clots and stroke. This is the specific reason why high blood pressure combined with nosebleeds and testosterone use is concerning - it suggests your blood may have thickened."

"Buying medication online is risky because the dose may not be what it says, and the product might not even contain what it's supposed to - sometimes these products are contaminated or fake."

10. Management Plan

Assess Severity First:

- Accelerated hypertension: BP $\geq 180/120$ with signs of papilloedema, retinal haemorrhage, or life-threatening symptoms → same-day specialist assessment.
- Severe hypertension without end-organ damage (BP $\geq 180/120$): investigate for target organ damage, review within 7 days.
- Signs of end-organ damage (papilloedema, encephalopathy, AKI, cardiac ischaemia)
- *In this case: BP 169 systolic with headache and epistaxis - not quite emergency threshold but needs close monitoring*

If BP $\geq 180/120$ with severe symptoms or end-organ damage → same-day senior review or medical admission

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."
- "I strongly advise you to **stop the testosterone** you're taking for now - especially because it hasn't been prescribed or monitored. Your blood pressure is at a level where there's a real risk of stroke."

If patient expresses difficulty stopping:

- "I understand this is really hard. If you feel you absolutely cannot stop, then at the very least we need to monitor you closely - checking your blood thickness (haematocrit) and liver function regularly so you know the immediate risks. But I want to be clear: the safest thing is to stop until we can get you on a properly monitored, prescribed regimen."

Investigations to Order:

- "I'd like to arrange some blood tests today:"
 - **FBC** - "To check if your blood has thickened (polycythaemia) - haematocrit above 0.50 (50%) warrants close monitoring and is a relative contraindication to initiating testosterone; above 0.54 (54%) requires intervention (dose reduction, withholding testosterone, consider venesection, and referral to haematology if not improving)"
 - **U&Es** - "To check your kidney function, as high blood pressure can affect the kidneys"
 - **Lipid profile** - "Testosterone can affect cholesterol levels"
 - **LFTs** - "To check your liver, especially with unregulated medication"
 - **HbA1c** - "To check for diabetes as part of cardiovascular risk"

Consider if symptoms paroxysmal: 24-hour urinary metanephrines to exclude pheochromocytoma (rare but important secondary cause)

Onward Steps

- "I'll arrange a review of your blood pressure in a few days to see if it settles after stopping the testosterone."
- "If it remains elevated after 1-2 weeks off testosterone, we may need to discuss starting blood pressure medication and investigate further for other causes."

[Note for candidate - When to Start Antihypertensives:]

- *If BP remains $\geq 140/90$ (confirmed on ABPM/HBPM) after removing causative factor and lifestyle modification $\rightarrow$ consider starting antihypertensive per NICE NG136 step 1 (ACE inhibitor or ARB for patient <55 years)*
- *First-line for young patient: ACE inhibitor (e.g., ramipril) or ARB*
- *Seek senior input or refer to hypertension clinic if secondary cause suspected or resistant to treatment*

Transgender Clinic Referral

- "Your referral is already in progress. As an adult, you'll be seen by an adult gender service. There's currently an NHS review of adult services underway, and wait times remain significant."
- "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 - and if your blood tests are normal and BP settles, there may be safer ways to access monitored hormone therapy while you wait."

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

Young adult 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.

FY2 Management Summary:

- **Hypertensive emergency** (BP $\geq 180/120$ + end-organ damage: papilloedema, encephalopathy, AKI, cardiac ischaemia) → same-day medical admission
- **Hypertensive urgency** (BP $\geq 180/120$ + symptoms but no end-organ damage) → same-day senior review, consider admission
- **This case:** BP 169 systolic with symptoms - close monitoring, not emergency threshold but needs action
- **Investigations:** FBC (polycythaemia - haematocrit >0.52 concerning), U&Es, LFTs, lipids, HbA1c; consider urinary metanephrines if paroxysmal symptoms
- **Management:** Stop unregulated testosterone, repeat BP in days; if persists $\geq 140/90$ after 1-2 weeks off testosterone → lifestyle then medication
- **Antihypertensives if needed:** ACE inhibitor/ARB first-line in young patient; seek senior input if secondary cause suspected
- **Polycythaemia:** If haematocrit elevated, urgent haematology advice - may need venesection

No red flags requiring immediate hospital admission in this case. Patient education, hormone cessation, BP monitoring, and counselling offered. Post-Cass Review, the adult gender service pathway is also under review. Wait times are acknowledged to be lengthy. Counsel against self-medication while supporting patient through appropriate channels. Transgender-sensitive, non-judgmental approach essential.

Sexuality Concerns

Station ID: Primary Care Setting | Adolescent Patient | Personal Concern Discussion | Undisclosed Initial Complaint

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? And just so you know, it's okay if you don't know - these things can take time to figure out."
- "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*)
- "Is this someone you know in real life from school, or did you meet online?" (*If met online, screen for grooming: "How did you first start talking? Has he ever asked you to keep your conversations secret? Has he asked for photos or to meet up alone?"*)

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?"
- "What's your sense of how your family feels about these kinds of relationships?" (*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

Independent educational content based on publicly available UK clinical guidelines.

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GK's PLAB 2 Preparation WhatsApp Channel - <https://tinyurl.com/gksplab2>

- "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. Supportive Exploration (NOT Diagnosis)

[Note for candidate: Do NOT offer sexuality as a "diagnosis" or present options like a medical assessment. Sexuality is for the patient to explore and define in their own time.]

Exploratory approach:

- "It sounds like you're exploring your feelings and trying to understand what they mean for you. That's completely normal and healthy."
- "You don't need to pick a label like 'gay' or 'bisexual' right now - or ever, unless you want to. Many people your age have these feelings and take time to figure out what fits them best."
- "Some people find they're attracted to one gender, some to more than one, and for some it changes over time. All of that is okay."

Normalising information:

"In the UK, studies show that around 3-4% of people identify as gay, lesbian, or bisexual - and among young people your age, it's even more common, around 8%. You're 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

Adolescent patient 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. Statistics updated to ONS Census 2021 data (approximately 3.2% of adults identify as LGB+, rising to 8% among 16-24 year olds). Confidentiality, support, and optional counselling offered. Patient reassured, no pressure applied regarding disclosure. School support should only be accessed with explicit consent.

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. Following the Cass Review and restructuring of NHS gender services, be aware that regional services have replaced GIDS, and wait times remain significant. 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.

Important distinction - Exploratory Therapy vs. Conversion Therapy:

- **Exploratory therapy** (neutral, curious questioning of gender distress and its origins) is the recommended standard per the Cass Review. This is good clinical practice.
- Conversion therapy (attempting to change someone's gender identity or sexual orientation) is unethical and condemned by all major UK medical bodies. While some conversion practices may already be illegal under existing criminal law (e.g., where they involve violence or coercion), comprehensive standalone legislation banning all conversion practices has not yet been enacted in the UK, though it is expected
- Psychological support should NOT be viewed as conversion therapy. Candidates must walk the line of being neutral and curious - not immediately affirming medical pathways, but also not denying or challenging identity.

If you accidentally misgender a patient:

- Apologise briefly and move on: "Sorry, he..." and continue.
- Do NOT over-apologise ("Oh my god, I'm so sorry, I didn't mean to offend you") - this places the emotional burden on the patient to comfort you and wastes consultation time.

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.
- Consider brief screening for online safety if the patient met the person of interest online.

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, polycythaemia, 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**.
- For patients on oestrogen therapy, be aware that transdermal preparations have lower VTE risk than oral oestrogen - this is important counselling information.

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

A Note to Learners

The cases in this resource are written in a conversational style to help you become familiar with the natural flow of clinical consultations and the language commonly used in UK healthcare settings.

These dialogues are intended as a learning guide, not a script. Please do not attempt to memorise them verbatim. Examiners assess your ability to think and communicate authentically - not to recite rehearsed phrases.

Use this material to understand the underlying clinical reasoning, then practise in your own words until the consultation feels natural to you.

For Companion OSCE Cases, Practice Scripts, Evaluation Checklists, Summary Notes, Rapid Review Notes, Mindmaps, Management Flashcards and Image Library - visit <https://www.gksplab2.com>

Disclaimer

This material is independent educational content created to help candidates develop clinical reasoning and communication skills for UK medical practice.

All cases and clinical scenarios are based on common presentations encountered in UK primary care and emergency medicine, drawn from publicly available sources including NICE Clinical Knowledge Summaries (CKS), BNF, and other official NHS/UK healthcare guidelines.

No content in this resource is derived from, represents, or claims to replicate actual GMC PLAB 2 examination material.

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

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.**

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

Station ID: Hospital Ward Setting | Middle-Aged Female Patient | Post-Antibiotic Gastrointestinal Complication | Communication and Complaint Management

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."

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."

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?"

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?"

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.

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."

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."

Explore the Solution

What We're Doing Now

"You're already receiving treatment - we've started you on *vancomycin*, which is an antibiotic specifically targeted at *C. diff*. It's given by mouth and works directly in the gut where the infection is."

"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 (WCC >15 or rising creatinine may indicate severe infection requiring escalation)
- Stool: *C. diff* toxin testing (GDH + toxin EIA or NAAT)

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."

"If you develop severe abdominal pain, a swollen tummy, high fevers, or become very unwell, we would involve the senior team immediately - and in rare cases, the surgeons may need to be involved."

Senior/MDT Input

"We work closely with our microbiology team who advise on antibiotic choices, especially if the infection doesn't respond to initial treatment. The infection control team has also been notified, which is standard for all confirmed *C. diff* cases."

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?"

Candidate Note: Per NICE NG199, first-line treatment for *C. difficile* infection is oral *vancomycin* 125mg four times daily for 10 days. *Metronidazole* is no longer first-line and should only be used if *vancomycin*/*fidaxomicin* are unavailable. *Fidaxomicin* is second-line if *vancomycin* fails.

C. Diff Ward Transfer

Station ID: Phone Call Setting | Medical Ward | Relative of Older Adult Male | Concern About Ward Transfer Following Antibiotic-Related Infection

Who: Son of a patient admitted for chest infection, now transferred to C. diff ward

Concern: "Did my dad get food poisoning from hospital food? Why was he moved?"

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

Station ID: Paediatric Emergency Setting | Young Child | Post-Antibiotic Skin Reaction | Parent-Initiated Complaint

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."

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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 can happen after antibiotics like amoxicillin."

"Now, I should explain that rashes during antibiotic treatment in children aren't always true allergies. Many are actually related to the underlying viral infection rather than the antibiotic itself - studies show over 95% of children labelled 'penicillin allergic' can actually tolerate the medication safely when properly tested."

"However, because we can't tell the difference without formal testing, we'll record this as a *possible* penicillin allergy for now, switch to a safe alternative, and refer her to an allergy clinic. They can do proper testing to clarify whether this is a true allergy or not - this is really important because being incorrectly labelled as allergic can limit future antibiotic choices."

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. **Switch to an appropriate non-penicillin alternative** - if she still needs antibiotics to complete her course, we'll choose a suitable alternative based on what infection she's being treated for (commonly clarithromycin or a cephalosporin depending on local guidance)
3. **Give cetirizine** (a non-sedating antihistamine to relieve the rash and itching)
4. **Add the allergy to her official NHS record**
5. **Observe for 1 hour** - since this is urticaria only (skin rash without breathing problems, swelling, or low blood pressure), a shorter observation period is reasonable. If she had any systemic symptoms like wheeze, throat swelling, vomiting, or dizziness, we would need to observe for at least 4-6 hours.
6. **Referral to paediatric allergy clinic** - this is important because many children labelled as "penicillin allergic" after viral rashes can actually tolerate penicillin safely. Allergy testing can clarify this and prevent unnecessary antibiotic restrictions in future.

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

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"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."

Senior Review

"Before she goes home, I'll discuss her case with my senior colleague or the paediatric registrar, just to make sure we haven't missed anything and the plan is right."

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

Station ID: Emergency Department Setting | Adolescent Patient with Neurodevelopmental Condition
| Father Accompanying | Follow-Up Complaint About Previous Care

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 in the areas the Ottawa Rules specifically check - and he's able to bear weight and take a few steps, which is reassuring. This 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. We use validated clinical decision tools like the **Ottawa Ankle Rules** to determine when x-rays are needed. When there's no bony tenderness in the specific areas these rules identify, 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 with paracetamol. Ibuprofen can be considered after the first 48 hours if needed for swelling, but paracetamol is preferred initially
- Cold compress and leg elevation
- There are a few things that can help this heal at home: protect the ankle from further injury, keep it elevated, use a compression bandage, and apply ice for 15-20 minutes at a time. Paracetamol can help with the pain. We'd suggest avoiding ibuprofen for the first couple of days as some evidence suggests anti-inflammatories may slow the early healing process.

Further reassurance:

"I'll document my examination findings very clearly today, including the specific areas I've checked and the fact that he can bear weight."

"If there's no improvement in a few more days, or if things worsen - we'll absolutely re-review and consider imaging then."

"If you'd still feel more reassured with an X-ray today, I can discuss this with my senior colleague - but based on the clinical assessment, I don't think it's necessary at this point."

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

Station ID: Hospital Respiratory Ward | Older Adult Female | Relative Concerned About Delayed Diagnosis | Communication About Prior Care

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

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"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."
- "Part of this review will check whether she met the national criteria for urgent cancer referral - for example, certain symptoms like coughing up blood should trigger a fast-track referral."
- "If they feel something might have been missed, a more formal investigation may be started under our **Duty of Candour** - this is a legal requirement for healthcare organisations to be open and honest when things go wrong."
- "If any issues are found, it may be reviewed by regulatory bodies like the GMC."

[Note for candidates: NICE NG12 criteria for lung cancer referral - unexplained haemoptysis (40+) triggers direct 2WW referral; persistent cough in ever-smoker warrants urgent CXR within 2 weeks, then referral if suspicious. Know these criteria but don't quote guideline numbers to patients.]

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 - or whether she met the NICE criteria for urgent cancer referral at the point she was seen."

"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

Station ID: Primary Care Setting | Older Adult Female on Long-Term Medication | Family Member Concerned About Communication

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?"

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(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 and Legal Authority

"Can I just check - does your mother currently make her own medical decisions, or do you hold Power of Attorney for her health?"

(This is critical: If the patient HAS capacity, confidentiality rules apply and we need her consent to share information with family. If she LACKS capacity, we must verify whether the daughter holds a registered Lasting Power of Attorney for Health and Welfare before committing to share medical information.)

"Are you her next of kin?"

"Is anyone legally appointed as her lasting power of attorney for health and welfare - and if so, is it registered with the Office of the Public Guardian?"

"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 mention this to one of the senior partners so they're aware of the concern.
- I'll recommend that her next medication review is flagged for discussion with family in advance."

"I should be honest though - I can't guarantee that every doctor will see this flag, which is why it's helpful if you also mention this arrangement when you're in contact with us."

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

Station ID: Paediatric Ward Setting | Infant Patient | Parent Concerned About Basic Care Standards

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

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(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 and ensure she's cleaned and comfortable."

"For the feeding tube, I'll ask the paediatric registrar or one of the senior nurses to check it and make sure it's repositioned safely."

[Note for candidates: NG tube repositioning in infants should be verified by experienced staff. Don't attempt complex procedures beyond your competence - appropriate escalation is good practice.]

"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 we'll also complete an incident report - we call it a Datix - which means this will be formally reviewed so we can learn from it and prevent it happening again."

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

Station ID: Acute Medical Ward | Older Adult Female | Cardiac Investigation | Relative Frustrated with Communication

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, it can put extra pressure on other organs, including the kidneys."

There can be various causes for blood in the urine - sometimes it's related to changes in blood flow and pressure from the heart condition, but it's important that we investigate it separately to make sure nothing else is going on. We'll be running some tests to look into that."

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

Station ID: Emergency Department | Middle-Aged Male | Post-Operative Wound Complication | Confrontational Opening

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."

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- "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. **Check your observations and sepsis screen** - we'll assess whether the infection has spread beyond the wound, as this would need urgent treatment
2. **Admission to Surgical Ward** - they'll take over your care as this is related to your previous operation
3. **Examine and clean the wound**
4. **Take a wound swab** to identify the bacteria causing infection
5. **Start intravenous antibiotics** - the choice will be guided by our local protocol and microbiology advice
6. **Order blood tests** to check infection markers and kidney function
7. **Ensure pain control and wound dressing protocol**
8. **Once things begin improving**, we'll switch to oral antibiotics and plan for safe discharge

Next Steps

"I'll start the initial treatment now and refer you to the surgical team - they'll take over your care once you're admitted, as they're the specialists in managing wound complications after hernia surgery."

"I'll speak to them straight away so they can see you as soon as possible. We'll also make sure your pain is managed in the meantime."

[Note for candidates: As an FY2 in A&E, your role is to stabilise, investigate, and refer appropriately. The surgical team will lead ongoing management of post-operative wound infections.]

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

Station ID: Surgical Ward | Adult Patient | Post-Operative Wound Infection | Discharge Discussion

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."

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"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."

"Your GP can review the wound in about a week - I'd recommend booking an appointment so they can check it's healing properly."

"You may also receive a follow-up appointment from us 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. Here's the ward contact number in case you need it."

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

Station ID: Hospital Ward | Older Adult Male | Terminal Illness | Family Member Concerned About DNACPR Decision

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, the consultant and senior team made this decision. It's not about giving up. It's about avoiding harm."

"If your father had capacity, we would've absolutely spoken to him first - the law is clear on this. The Tracey v Cambridge case established that patients must be involved in DNACPR decisions wherever possible."

"If he lacked capacity, we follow the Mental Capacity Act - making a decision in his best interest while consulting those close to him, like family members. No one is forced - and we do not make these decisions lightly."

"Some hospitals now use a document called ReSPECT (Recommended Summary Plan for Emergency Care and Treatment), which is a broader care plan that includes the DNACPR decision but also records other preferences about emergency care."

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. Under the Tracey ruling, we have a legal duty to involve the patient in DNACPR decisions wherever possible. If the patient lacks capacity, the Mental Capacity Act requires us to consult family members as part of determining best interests - which is what should have happened here. 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."

"If you'd like to discuss changing the decision or have further questions about the reasoning, I can arrange for you to speak directly with the consultant - they made the decision and can explain their thinking in more detail."

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

Station ID: Medical Ward | Junior Doctor | Middle-Aged Male, Admitted with Respiratory Condition, MRSA Nasal Colonisation Detected | Spouse (concerned about isolation precautions) | Relative Communication + Infection Control Counselling

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 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?"

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- "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.

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** - which stands for Methicillin-Resistant Staphylococcus Aureus, but don't worry about the name - in his nose. This is called **colonisation** - which just means the bacteria are sitting on his skin, like a passenger, not causing any trouble."

"I want to be clear: having MRSA does not mean he is 'dirty' or has poor hygiene. Roughly 1 in 30 people carry these bacteria naturally - it's very common, and most people never know they have it."

"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 five-day decolonisation regimen following our hospital's infection control protocol:

- **Nasal treatment:** Mupirocin 2% nasal ointment (Bactroban Nasal), applied to both nostrils twice daily for 5 days
- **Body wash:** Chlorhexidine 4% (Hibiscrub), used daily for 5 days - including washing hair at least twice during the treatment period

If mupirocin-resistant or unavailable: We may use Naseptin (neomycin/chlorhexidine) four times daily for 10 days as an alternative.

Note: Naseptin was historically contraindicated in peanut allergy because it contained arachis (peanut) oil. The formulation was updated in 2023 to remove this, but caution should still be exercised in patients with peanut or soya allergy, and you should check the specific product label.

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 would prefer to finish the treatment here in hospital, 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."

Infection Control Team

"Our infection control team oversees all MRSA cases. If the standard treatment doesn't work, or if he needs repeated courses, they'll advise on alternative approaches. They're the specialists in this area."

"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: Mupirocin 2% twice daily OR Naseptin 4x daily to both nostrils + chlorhexidine 4% body wash daily - both for 5 days.
- Re-screen 2 days after completing treatment; requires 3 negative swabs 48-72 hours apart to confirm clearance.
- 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

A Note to Learners

The cases in this resource are written in a conversational style to help you become familiar with the natural flow of clinical consultations and the language commonly used in UK healthcare settings.

These dialogues are intended as a learning guide, not a script. Please do not attempt to memorise them verbatim. Examiners assess your ability to think and communicate authentically - not to recite rehearsed phrases.

Use this material to understand the underlying clinical reasoning, then practise in your own words until the consultation feels natural to you.

For Companion OSCE Cases, Practice Scripts, Evaluation Checklists, Summary Notes, Rapid Review Notes, Mindmaps, Management Flashcards and Image Library - visit <https://www.gksplab2.com>

Disclaimer

This material is independent educational content created to help candidates develop clinical reasoning and communication skills for UK medical practice.

All cases and clinical scenarios are based on common presentations encountered in UK primary care and emergency medicine, drawn from publicly available sources including NICE Clinical Knowledge Summaries (CKS), BNF, and other official NHS/UK healthcare guidelines.

No content in this resource is derived from, represents, or claims to replicate actual GMC PLAB 2 examination material.

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 - Duty of Candour

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:** "If you'd like to speak to someone impartial about this, I can help you contact the Patient Advice and Liaison Service - PALS. They can provide support, answer questions, and help resolve concerns. If you wish to make a formal complaint, they can signpost you to the hospital's Complaints Department, who will guide you through that process."

Don't wait for the patient to ask about PALS. Always offer it voluntarily.

Note: PALS resolves concerns informally and provides support. Formal complaints are handled separately by the Complaints Department - PALS can signpost patients to this service if needed.

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 Clinic | **Role:** Junior Doctor | **Patient:** Young Adult Male, Awaiting Results of Recent Kidney Biopsy | **Task:** Explain Medical Error and Discuss Repeat Procedure

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 unfortunately, the biopsy sample wasn't received by the laboratory and 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?")

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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 kidney specialist was concerned there might be inflammation in your kidneys - a condition we call glomerulonephritis. You were initially referred by your GP after some blood and urine tests showed changes that needed further investigation."

"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 about ensuring you're as comfortable as possible. We can arrange for sedation to help you feel more relaxed, and we'll make sure a senior operator performs the procedure."

"We'll do everything possible to make this experience better than the first." "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** - "If you'd like to speak to someone impartial about this, I can put you in touch with the Patient Advice and Liaison Service - PALS. They can provide support and help resolve concerns. If you wish to make a formal complaint, they can guide you through that process."

Written Summary (Statutory Requirement): "As part of our formal duty of candour process, I will be writing to you with a summary of everything we've discussed today, along with updates on the investigation as they become available."

If asked "Where is my sample now?": "I'm really sorry, but at this point, we don't know exactly where it is. That's part of what makes this such a serious breach of our protocols, and it's something the investigation will try to establish."

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

"[Name], I just want to say again - I'm so sorry that this has happened." "We'll do everything possible 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 | **Format:** Telephone Consultation | **Role:** Junior Doctor | **Patient:** Middle-Aged Male, Scheduled for Elective Orthopaedic Surgery | **Task:** Explain Blood Sample Error and Arrange Repeat

1. Telephone Opening & Identification

"Good morning. Am I speaking to [Patient's name]?" "Hi, [Patient's name] - 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?"

[Note: These questions establish surgical risk factors and why the blood sample matters clinically.]

3. Warning Shot - Prepare for Disclosure

"Thanks for that, [Patient's name]. 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 unfortunately, the sample wasn't labelled correctly - and because of that, they weren't able to process it." "Unfortunately, for safety reasons, when a sample isn't labelled correctly, the lab can't process it - it has to be discarded to prevent any mix-ups." "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?"

[Note: This demonstrates flexibility, patient-centred 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, [Patient's name]." "Thank you so much for your patience - we truly appreciate your understanding, and we'll make sure the process is smoother this time."

12. PALS and Written Summary

"If you have any concerns about how this was handled, I can help you contact the Patient Advice and Liaison Service - PALS. They can provide support and answer any questions. If you wish to make a formal complaint, they can guide you through that process."

Written Summary (Statutory Requirement): "As part of our duty of candour, I will also be sending you a written summary of this conversation for your records."

13. 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 Clinic | **Role:** Junior Doctor | **Patient:** Middle-Aged Male, Recent Admission for Respiratory Infection | **Task:** Explain Radiological Mix-up and Duty of Candour Disclosure

1. Professional Introduction & Agenda Setting

"Good morning, [Patient's name]. 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?"

[Note: 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 - unfortunately, the report we received was for a different patient's x-ray - not yours." "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

"You mentioned having diarrhoea after the antibiotics - is that still ongoing, or has it settled now?"

If still ongoing: "I'd like to arrange a stool sample just to make sure there's no infection that's developed - sometimes antibiotics can cause an infection called C. difficile. We'll check that to be safe."

If resolved: "I'm glad that's settled. That side effect usually resolves once the course is finished."

"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."

Written Summary (Statutory Requirement): "As part of our formal duty of candour process, I will be writing to you with a summary of everything we've discussed today, along with updates on the investigation."

11. Offer PALS - Right to Support and Complain

"[Patient's name], if you'd like to speak to someone impartial about this, I can help you contact the Patient Advice and Liaison Service - PALS." "They can provide support and help resolve any concerns. If you wish to make a formal complaint, they can guide you through that process."

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?" "I want to reassure you that we've already identified the patient whose X-ray was actually abnormal, and they have been contacted to ensure they receive appropriate care." "That will have been followed up as a priority."

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: Cardiology Ward | **Role:** Junior Doctor | **Patient:** Adult Male, Currently Admitted for Cardiac Treatment | **Context:** Previous Emergency Presentation with Chest Pain - Diagnosis Missed at Initial Visit | **Task:** Duty of Candour Disclosure for Missed Diagnosis

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 the tests from that first visit actually showed you were having a heart attack - and unfortunately, this wasn't picked up at the time." "The ECG showed signs of a heart attack, and the blood test - a troponin test, which is a specific marker for heart damage - was also raised, which we unfortunately didn't check before you were discharged."

(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. Address Questions About Earlier Treatment (If Asked)

"I understand why you might ask if things could have been different." "While the initial event had already started by the time you came to us - which is why the blood test was positive - recognising it earlier would have allowed us to start treatment sooner." "Earlier treatment can help protect the heart muscle and reduce any additional strain or damage." "That's why we're now monitoring you closely to ensure there haven't been any complications from the delay."

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."

Written Summary (Statutory Requirement): "As part of our formal duty of candour process, I will be writing to you with a summary of everything we've discussed today, along with updates on the investigation."

11. Offer PALS - Support and Complaint Option

"Mr. [Surname], if you'd like to speak to someone impartial about this, I can help you contact the Patient Advice and Liaison Service - PALS." "They can provide support and help resolve concerns. If you wish to make a formal complaint, they can guide you through that process."

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:** Junior Doctor | **Patient:** Young Child with Recent ED Attendance for Foreign Body Concern | **Task:** Urgent Recall Following X-ray Review Error

1. Telephone Opening & Identification

"Hello, am I speaking to Mrs. [Name]?" "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?"

[Note: This ensures you cover the clinical picture fully before breaking bad news, despite prior consultation.]

3. Warning Shot - Prepare for Disclosure

"Thank you, Mrs. [Name]. 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 Transport Triage

If Button Battery in Oesophagus: "Before you set off - can I ask how far away you are from the hospital right now?" "With a button battery in the food pipe, time is absolutely critical - damage can occur within two hours. If you're not nearby, we may need to arrange an ambulance to get her here as quickly as possible." (If close by: "Please come straight in - we'll have everything ready for her arrival.")

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." "Depending on where it is, we may need to arrange transfer to a specialist team who can remove the object safely - this usually involves a procedure called endoscopy if it's in the food pipe, or bronchoscopy if it's in the airway." "She'll be carefully monitored throughout and treated by specialists experienced in these procedures."

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." "If you'd like to speak to someone impartial, I can help you contact the Patient Advice and Liaison Service - PALS. They can provide support, and if you wish to make a formal complaint, they can guide you through that process."

Written Summary (Statutory Requirement): "As part of our duty of candour, I will also be sending you a written summary of this conversation."

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. [Name], 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 with Parent and Child | **Role:** Junior Doctor | **Patient:** Paediatric Patient with Recent ED Attendance Following Injury | **Task:** Explain Radiological Review Finding and Arrange 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?"

[Note: This 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." "Most childhood fractures do heal very well. However, because children are still growing, we need the orthopaedic team to review the X-ray carefully to check whether it affects the growth area of the bone - what we call the growth plate." "If it's a simple hairline fracture away from the growth plate, the outlook is very good and he should make a full recovery." "We'll know more once the specialists have reviewed the images, and they'll be able to give you more specific reassurance."

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."

Written Summary (Statutory Requirement): "As part of our duty of candour, I will also be sending you a written summary of this conversation."

10. Offer PALS - Right to Support and Complain

"If you'd like to speak to someone impartial, I can help you get in touch with the Patient Advice and Liaison Service - PALS." "They can provide support, and if you wish to make a formal complaint, they can guide you through that process."

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." "This has been an important learning experience. In future, we'll make sure to get a second opinion straight away whenever there's any uncertainty." "We'll also make sure the whole department is aware of this, so that similar issues are discussed and prevented."

Safeguarding Check (Document in Notes): "Just to be thorough for our records, can you remind me exactly how he fell and what part of his body hit the ground?"

Note: In all paediatric injury presentations, ensure mechanism is consistent with injury pattern and document safeguarding assessment.

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 in Wound

Setting: Emergency Department | **Format:** Telephone Consultation | **Role:** Junior Doctor | **Patient:** Paediatric Patient with Recent ED Attendance for Soft Tissue Injury | **Task:** Urgent Recall Following X-ray Review Finding

1. Telephone Opening & Identification

"Hello, am I speaking to Mr. [Name]?" "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. [Name], 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

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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, a senior doctor will assess the wound and decide on the best approach to remove the glass safely." "Depending on how deep it is, this may be done in the department under local anaesthetic, or it may need a minor procedure in theatre." "We'll assess the wound carefully - if there are any signs of infection developing, like redness, swelling, or discharge, we may need to give antibiotics. But if the wound looks clean, we'll focus on removing the glass safely and ensuring the area heals well." "Because this wound had a foreign body in it, we'll check his vaccination records carefully. If his tetanus protection isn't up to date, we may need to give him a booster - and depending on the wound, possibly an additional injection to boost his immunity straight away." "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." "If you'd like to speak to someone impartial, I can help you contact the Patient Advice and Liaison Service - PALS. They can provide support, and if you wish to make a formal complaint, they can guide you through that process."

Written Summary (Statutory Requirement): "As part of our duty of candour, I will also be sending you a written summary of this conversation."

11. If Asked: "How did this happen?" / "Why wasn't it seen yesterday?"

"Glass doesn't always show up clearly on X-rays, especially if it's small or 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. [Name], 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: Orthopaedic Ward | **Format:** Face-to-face with Relative | **Role:** Junior Doctor | **Patient:** Elderly Female Nursing Home Resident, Post-Fall | **Relative:** Family Member with LPA (Concerned) | **Task:** Duty of Candour Disclosure for Missed Fracture Diagnosis

1. Professional Introduction & Acknowledge Concern

"Hello Mr. [Name], 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 for health and welfare, is that correct?"

"Just so I understand the situation correctly - has your mother been assessed as lacking capacity to make decisions about her care? This is important because, under the law, we must formally assess a person's ability to make their own decisions before anyone else can make decisions on their behalf - even if they hold a Lasting Power of Attorney.

If she's able to understand and participate in decisions, we would ideally involve her directly in this conversation. But if she lacks capacity, then you would be the appropriate person to discuss her care with."

- "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?"

[Note: Health and Welfare LPA only becomes active when the patient lacks capacity. "Next of Kin" has no legal standing in healthcare decision-making - LPA is what matters.]

[Note: 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."

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- "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." "I'm particularly sorry that your mother was asked to do physiotherapy and to walk on her hip when it was broken. I realise that must have caused her a great deal of pain, and I can imagine how distressing that is for you to witness." "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'd like to speak to someone impartial, I can help you contact the Patient Advice and Liaison Service - PALS. They can provide support, and if you wish to make a formal complaint, they can guide you through that process."

Written Summary (Statutory Requirement): "As part of our formal duty of candour process, I will be writing to you with a summary of everything we've discussed today, along with updates on the investigation."

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 will be decided by our orthopaedic team. For this type of fracture, surgery is usually the recommended treatment - and ideally this would be done within a day or two of admission. The type of surgery depends on the exact fracture pattern and her overall health. In some cases where surgery may not be suitable, we would discuss alternative approaches - but the orthopaedic team will explain all the options to you clearly."

"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 fracture was present on the original X-ray but unfortunately wasn't identified at the time." "We're investigating exactly how this happened as part of our formal review process." "I want to be transparent with you - once the investigation is complete, we'll be able to give you a clearer picture of what went wrong and what steps are being taken."

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

A Note to Learners

The cases in this resource are written in a conversational style to help you become familiar with the natural flow of clinical consultations and the language commonly used in UK healthcare settings.

These dialogues are intended as a learning guide, not a script. Please do not attempt to memorise them verbatim. Examiners assess your ability to think and communicate authentically - not to recite rehearsed phrases.

Use this material to understand the underlying clinical reasoning, then practise in your own words until the consultation feels natural to you.

For Companion OSCE Cases, Practice Scripts, Evaluation Checklists, Summary Notes, Rapid Review Notes, Mindmaps, Management Flashcards and Image Library - visit <https://www.gksplab2.com>

Disclaimer

This material is independent educational content created to help candidates develop clinical reasoning and communication skills for UK medical practice.

All cases and clinical scenarios are based on common presentations encountered in UK primary care and emergency medicine, drawn from publicly available sources including NICE Clinical Knowledge Summaries (CKS), BNF, and other official NHS/UK healthcare guidelines.

No content in this resource is derived from, represents, or claims to replicate actual GMC PLAB 2 examination material.

Colleague-Related Scenarios– 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

Key GMC Updates for Colleague Scenarios:

Under Good Medical Practice 2024, doctors have specific new duties regarding workplace culture:

- You must help create a culture that is **respectful, fair, supportive and compassionate**
- You **must not abuse, discriminate against, bully, or harass** anyone based on their personal characteristics or for any other reason
- You **must not act in a sexual way towards colleagues** with the effect or purpose of causing offence, embarrassment, humiliation or distress (this includes verbal/written comments, displaying or sharing images, and physical contact)
- If you witness such behaviour, you **should act** - speak to the person affected, challenge the behaviour, or report it
- Those in **leadership or management roles must ensure** such behaviour is adequately addressed and concerns are dealt with promptly

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 appropriately** – match your escalation to the level of risk (for advice on grey areas; for immediate safety action on patient safety issues)

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 matters (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: Surgical Department | **Role:** Junior Doctor | **Colleague:** Senior Medical Student with Persistent Lateness | **Task:** Address Professional Concern About Punctuality Using Supportive Framework

S – Set the Stage

"Hi there - are you one of the final-year medical students on this rotation? Thanks for taking a few minutes. I'm one of the FY2s here - I think we've worked together briefly during handover. 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 final 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 final 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 final year can be. I just want to explain why even seemingly small issues like timing can be significant - especially now that you are preparing for provisional registration and your Foundation training."

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?"

If lateness persists despite this conversation: If the issue continues after your initial discussion, you should escalate formally to the educational supervisor. At that point, it becomes a pattern that needs structured intervention, not just peer support.

Colleague Smelling of Alcohol and Coming Late

Setting: Surgical Department | **Role:** Junior Doctor | **Colleague:** Junior Doctor with Alcohol Concern
| **Task:** Address Observed Impairment Concerns and Ensure Patient Safety

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):

- "I can smell alcohol on you now. Have you had a drink today, or is this from last night?"
- "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 think it's important that you **don't continue seeing patients today** - just to be on the safe side."
- "I will speak to the Consultant immediately to arrange cover. 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:

- "I need to inform the Consultant immediately because this is a patient safety issue. My priority is ensuring no patients are harmed and that you get support - but we cannot keep this between us. The Consultant will arrange cover and ensure everything is handled properly."

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 step away from clinical duties now - and rest.

- I'll speak with the Consultant immediately so they can arrange cover and ensure patients are looked after. The patients you saw today should be reviewed as well.
- The Consultant will help us 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: Surgical Department | **Role:** Junior Doctor | **Colleague:** Junior Doctor (More Junior) with Acute Alcohol Concern | **Task:** Immediate Assessment and Patient Safety Management

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?"

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- "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 need to step away from clinical duties for the rest of the day."
- "I'll help hand over your patient list and ensure anything urgent is followed up."
- "I need to inform the on-call consultant immediately because this is a patient safety issue. They need to be aware so they can arrange proper cover and ensure all patients you've seen today are reviewed."

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. There are also confidential services specifically for doctors - like the BMA Wellbeing Service or the NHS Practitioner Health Programme - which specialise in supporting doctors through exactly this kind of situation."
- "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: Surgical Department | **Role:** Junior Doctor | **Colleague:** Senior Medical Student with Suspected Substance Misuse | **Task:** Address Observed Drug Use and Professional Implications

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 a recreational drug. 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?"
- "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 that substance, 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 future doctors, we're held to a very high professional standard. Recreational drug use - whether during work or in your private life - is considered a serious professional concern, because it can raise questions about your fitness to practise and public trust in the profession."
- "Drug use is a **Fitness to Practise concern**. The medical school will need to be involved to ensure you are safe to continue on the course."
- "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."
- "If this were to be formally investigated through the Fitness to Practise process, it could affect your eligibility to qualify as a doctor."
- "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 do need to speak to the consultant leading the team today. Because this is a Fitness to Practise concern, it will need to be escalated through proper channels - likely to the medical

school. I know that sounds serious, but it's actually better for you to engage with this process early and honestly."

- "You've been on the ward, and it's important that the team knows so we can ensure everything is handled professionally and you get the right support."

Offer follow-up:

- "I'm happy to check in with you again next week to see how you're getting on - but the medical school and your educational supervisor will take the lead on supporting you through the formal process."

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."

"Because you're a medical student, this will be handled through the medical school's fitness to practise process rather than the GMC - since you're not yet registered. Medical schools do have supportive mechanisms and often focus on remediation when you engage early and honestly. But it's important to take this seriously - the standards are the same as for registered doctors, and in serious cases, students can be removed from their course."

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: Hospital Department | **Role:** Junior Doctor | **Concern:** Colleague's Social Media Activity Potentially Breaching Professional Standards | **Task:** Address Social Media Professionalism Using Supportive Framework

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."
- "It's also worth remembering that even posts in private groups aren't truly private - they can be screenshotted and shared. The GMC guidance is clear that messages in private groups may become public - others can screenshot and share communications beyond their intended audience."
- "It's also worth remembering that sharing or forwarding inappropriate content can carry similar professional consequences to posting it - the GMC expects the same professional standards regardless of how content is communicated or distributed."

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 - 'Using social media as a medical professional' - it's a clear and practical document about what's expected of us online."

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?"

- "Removing the post stops the immediate harm, which is the most important first step. However, because patient confidentiality may have been breached, we may need to discuss this with a supervisor to see if the patient needs to be informed under the Duty of Candour. It's not about getting anyone in trouble - it's about handling this properly and learning from it."

If asked about anonymity:

- "I understand you'd prefer to stay out of it. The focus is on supporting our colleague to do the right thing - but if there's been a potential confidentiality breach, we do need to involve a supervisor to ensure it's handled appropriately."

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: Surgical Department | **Role:** Junior Doctor | **Concern Raised By:** Nursing Staff | **About:** Junior Doctor Allegedly Adding Patients on Social Media and Accepting Gifts | **Task:** Assess and Address Professional Boundary Concerns

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:

- "The GMC advises against connecting with patients via personal social media - it can blur professional boundaries and create ethical difficulties, 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."
- "It's not just about the value - it's about the **perception of favouritism**. All gifts should be declared to the team or supervisor to ensure transparency."
- "Most Trusts have a Declaring Interests policy - the NHS England standard is that gifts from patients over →£50 should not be accepted in a personal capacity, and gifts under →£50 should be declared. However, the GMC standard is stricter: doctors should generally refuse gifts, and may only accept gifts of 'minimal value' (such as flowers or sweets) if refusing would cause deep

offence or embarrassment. Always check your specific trust's policy, and when in doubt, decline and explain why."

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."

When to escalate further:

- "If the concerns are more serious - for example, if there's any suggestion of an inappropriate relationship developing, significant or frequent gifts, or if any patients have raised concerns - I would need to involve a supervisor or clinical lead. That's not something I could handle just as a peer conversation."

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."

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"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: Emergency Department | **Role:** Junior Doctor | **Colleague:** Junior Doctor Who Posted Potentially Identifiable Patient Information with Mocking Language | **Task:** Address Immediate Confidentiality and Professionalism Breach

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 - 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:

- "Using stigmatising language about mental health conditions is particularly concerning - it conflicts with the profession's commitment to treating all patients with dignity and respect, regardless of their condition."
- "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 Guidance** - 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 light-hearted, 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 support with appropriate honesty:

- "My first priority is helping you address this quickly. Depending on whether patient confidentiality was actually breached - for example, if the patient could be identified from the post - we may need to discuss this with a supervisor. But let's focus on removing the post first, and then we can work out what else needs to happen."

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?"

"I appreciate you listening. I want to ensure you understand that addressing this properly protects your registration as much as it protects patient dignity. This is a learning moment, not a punishment."

Delay in Discharge Summary

Setting: Medical Ward | **Role:** Junior Doctor | **Context:** Complaint Following Discharge Delay Due to Administrative Oversight | **Task:** Supportive Check-in with Junior Colleague Following Complaint

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."

"It's worth remembering that discharge delays often reflect systems pressures - not just individual oversight. Things like competing demands, interrupted workflow, and unclear prioritisation can all contribute."

"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."

WhatsApp Task Dumping by Colleague

Setting: Hospital Department | **Role:** Junior Doctor | **Colleague:** Junior Doctor Experiencing Workplace Pressure/Boundary Concerns | **Task:** Support Colleague and Advise on Escalation Pathways

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."

"The GMC's updated Good Medical Practice (2024) is clear that doctors must not bully, harass, or discriminate against colleagues - and those in leadership positions have a responsibility to act when they witness such behaviour."

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 Written Log

"I'd strongly recommend keeping a **dated written log** of these incidents - note down the date, time, what was requested, and how it affected your work. This is standard advice in NHS workplace disputes and will be helpful if you need to escalate later."

3. Escalation Channels

"The Freedom to Speak Up Guardian is an excellent first point of contact if you're unsure how to proceed - they maintain confidentiality wherever possible, and they're specifically there for this sort of situation. They can advise you on next steps without it necessarily becoming formal."

"You can also speak to your **clinical supervisor** or **educational supervisor** if it continues or starts affecting your performance. They'll take it seriously."

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 their records are kept separately from clinical records. They can offer confidential support to help you through this."

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 in the immediate conversation - routine testing is not part of UK clinical practice for colleagues. If testing becomes necessary, it would be arranged later through Occupational Health as part of a formal process.
- 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

A Note to Learners

The cases in this resource are written in a conversational style to help you become familiar with the natural flow of clinical consultations and the language commonly used in UK healthcare settings.

These dialogues are intended as a learning guide, not a script. Please do not attempt to memorise them verbatim. Examiners assess your ability to think and communicate authentically - not to recite rehearsed phrases.

Use this material to understand the underlying clinical reasoning, then practise in your own words until the consultation feels natural to you.

For Companion OSCE Cases, Practice Scripts, Evaluation Checklists, Summary Notes, Rapid Review Notes, Mindmaps, Management Flashcards and Image Library - visit <https://www.gksplab2.com>

Disclaimer

This material is independent educational content created to help candidates develop clinical reasoning and communication skills for UK medical practice.

All cases and clinical scenarios are based on common presentations encountered in UK primary care and emergency medicine, drawn from publicly available sources including NICE Clinical Knowledge Summaries (CKS), BNF, and other official NHS/UK healthcare guidelines.

No content in this resource is derived from, represents, or claims to replicate actual GMC PLAB 2 examination material.

Introduction: How to Break Bad News

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** will be provided. Regarding fluids/hydration: explain that this is **individualised** - *"We'll review whether a drip would help with comfort, because in some situations it can help and in others it can cause problems. We'll decide this together based on what keeps them most comfortable."*
- 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 **older 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. Explain Care Plan and Next Steps

Once they've had time to process, explain what happens now - focusing on comfort, dignity, and support.

Step	Example Phrase
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 **Role:** FY2 Doctor **Patient:** Older Adult with Sudden Collapse and Reduced Consciousness **Relative:** Next of Kin (In-Person or Telephone) **Task:** Take collateral history, explain investigation findings, deliver difficult news sensitively, discuss prognosis and comfort-focused care

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 the scans and assessments, 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. If you'd like to discuss this further with another member of the team, I can arrange that."

"**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 your [relative] ever share any thoughts about where they'd want to be looked after if they became very unwell? 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?**" "We'll work closely with a team who specialise in comfort care - they'll help make decisions about things like fluids together with you. Every decision we make from here will be guided by one thing - keeping them comfortable and at peace."

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

"We can arrange contact with the palliative care or chaplaincy team if you'd like." "Could you help me clarify who is the official next of kin for documentation?" "Please feel free to ask questions at any time." "We can offer you privacy or a quiet room if needed." "At some point, it may be helpful to discuss what would happen if their heart were to stop - this is something we can talk about when you're ready."

***Note for Candidates (Organ Donation - NICE CG135):** In cases of fatal brain injury/ICH, particularly in younger patients, the medical team will liaise with the Specialist Nurse for Organ Donation (SN-OD) as part of standard protocol. This is typically a consultant-led discussion, but awareness is important. If the family raises organ*

donation, an appropriate response would be: "Thank you for mentioning that. The senior team will be able to discuss this with you properly - we have specialist nurses who can sensitively explore this with you when the time is right."

Document the conversation clearly and escalate any requests (e.g., home discharge)

Bilateral Stroke

Setting: Acute Medical Unit **Role:** FY2 Doctor **Patient:** Older Adult with Previous Stroke, Now Unresponsive Following Further Cerebrovascular Event **Relative:** Next of Kin (In-Person) **Task:** Gather collateral history, deliver bad news, explain prognosis and palliative care approach

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 further, could you tell me what happened from your point of view? What have you been told so far?"

History - Clinical Background and Hospital Course

"Can I ask a few questions about their medical history?"

- "I understand they've had a stroke before - do you remember when that was?"
- "How much were they affected by the first stroke? Were they able to walk, talk, or care for themselves?"
- "Have they been on any medications like blood thinners or tablets for blood pressure?"
- "Were they managing well at home before this happened?"
- "Has there been any recent illness - chest infections, falls, or confusion?"

Warning Shot

"I'm afraid I have some difficult news to share with you."

Deliver - Clear and Compassionate

"I'm really sorry to tell you that the CT scan has shown your relative has had another stroke - and this time, it has affected **both sides of the brain**. This is what we call a bilateral stroke, and unfortunately, the damage is very serious. 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. We'll also review whether giving fluids through a drip would help with comfort - sometimes it does, and sometimes it can actually

cause problems like fluid building up. We'll make that decision together based on what keeps them most comfortable."

Address Common Questions and Concerns

"**Are you giving up on them?**" "I can completely understand why it might feel like that. What we're doing is changing the focus of our care - instead of trying to fix something that sadly can't be fixed, we're putting all our energy into making sure they're peaceful and comfortable."

"**Can you delay their death?**" "Unfortunately, the damage that's happened is something we can't reverse or slow down - but what we can do is make sure their remaining time is spent peacefully."

"**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?**" "If an infection develops, we'll consider antibiotics only if they're likely to improve their comfort - for example, if an infection is causing distressing symptoms. If they won't help or would add burden, we'll focus on symptom relief instead."

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: Acute Medical Unit **Role:** FY2 Doctor **Patient:** Older Adult with Large Territory Stroke, Persistent Reduced Consciousness Despite Treatment **Relative:** Next of Kin (In-Person) **Task:** Gather collateral history, explain imaging findings, deliver prognosis, discuss transition to comfort-focused care

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:

*Independent educational content based on publicly available UK clinical guidelines.
Not affiliated with or derived from GMC PLAB 2 examination material.
GK's PLAB 2 Preparation WhatsApp Channel - <https://tinyurl.com/gksplab2>*

- "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?"

Narrate - Build Clinical Context

"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 about making sure someone is comfortable and supported - we focus on things like pain, breathlessness, or anxiety, so that whatever time they have is spent as peacefully as possible. 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 so long to tell us this?**" "I'm really sorry it's taken this long to get a clear picture. We were all hoping to see some improvement, and we wanted to give your [relative] every chance. 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 active treatment would not help and might even cause more harm. The decision to shift to comfort-focused care was made because it's no longer in your relative's best interest to continue life-prolonging interventions."

"**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."

Note: *Withdrawal of futile treatment is lawful in the UK and distinct from euthanasia (which remains illegal). This is supported by GMC guidance 'Treatment and care towards the end of life'.*

"**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 **Role:** FY2 Doctor **Patient:** Adult Following Major Vascular Surgery with Post-Operative Complication **Relative:** Next of Kin (In-Person) **Task:** Gather relevant history, explain complication, deliver difficult news, provide support and outline next steps

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. Could you tell me what you know about the operation they were having?"

Clarify Pre-Operative Status

- "Were they well before surgery?"
- "Did they understand the risks involved?"
- "Were they generally fit and active before this?"
- "Were there any concerns the surgical team raised with you beforehand?"

Check Understanding

"Has anyone spoken to you about how the surgery went?" "Would you like to sit down somewhere quiet before we talk?"

Invite - Ensure They're Ready

"I've been asked to speak with you about what's happening now. 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 involved repairing a narrowed blood vessel in the leg that was causing circulation problems. The surgery itself was completed, and they were transferred to recovery as planned. As part of our routine post-operative care, we monitor patients closely for any signs of complications. Unfortunately, during monitoring, we noticed some concerning signs."

Warning Shot

"I'm afraid we've run into a complication."

Deliver - Clear and Honest Explanation

"I'm really sorry to tell you that your [relative] has developed **bleeding inside the abdomen** after the surgery. This is a serious complication, and they are now being prepared to **return to the operating theatre** so the surgical team can find and stop the source of the bleeding. They've already needed a **significant blood transfusion** - six units so far - which indicates this is a major haemorrhage. This is a

life-threatening situation. The team is doing everything possible to stabilise them and take them back to surgery urgently."

(Pause. Stay quiet and let the news sink in.)

Address Reaction - Emotional Support

"I'm so sorry. This must be incredibly frightening. I know that must be a really difficult thing to take in right now. Please take your time - I'm here with you."

Explain What Happens Next

"The surgical team is preparing the theatre now. Your [relative] will be taken back for emergency surgery, which is likely to take several hours - possibly 5-6 hours or more. The aim is to stop the bleeding and stabilise them. Once we know more, someone will come and update you. In the meantime, we'll do everything we can to keep you informed."

Address Common Questions

"Is this a mistake?" "I can absolutely understand why you'd ask that. Right now, we haven't found anything that went wrong - this is unfortunately a known risk with this type of surgery, even when everything is done as carefully as possible. But please know we take your concern seriously and will look into everything thoroughly."

"Will they survive?" "It's very difficult to say right now. This is a critical situation. We are doing everything we can, and we'll keep you informed every step of the way."

"Should I call my children abroad?" "I know that must be a really difficult thing to think about right now. Yes, I think it would be wise to inform close family. The situation is serious."

"Can I see them before surgery?" "The team is working very quickly to prepare them, but if there's time, we'll try to arrange a brief moment. Let me check for you."

Reassure Ongoing Support

"Please know we're not leaving you alone. A member of staff will stay in touch with you and bring updates. If there's anything you need - a quiet room, a chaplain, someone to talk to - just ask."

Next Steps

- Provide a quiet waiting area
- Ensure regular updates are given during surgery
- Offer contact with PALS or patient liaison if needed
- Document the discussion and family's understanding

Post-Operative Stroke

Setting: Neurosurgical Ward **Role:** FY2 Doctor **Patient:** Older Adult with Neurological Deficit Following Intracranial Surgery **Relative:** Next of Kin (In-Person) **Task:** Gather relevant history, explain post-operative event, deliver bad news, discuss ongoing management

Introduction & Identity Confirmation

"Hello, I'm one of the doctors involved in your [relative]'s care. Could I confirm your name please? And just to check, how are you related to the patient? Do you know their age?"

Establish Understanding

"I understand your [relative] had brain surgery recently. Has anyone spoken to you about how things have been going since then? What have you been told so far?"

Clarify Pre-Operative Baseline

- "Before the surgery, how was your [relative] doing?"
- "Were they able to walk, talk, and look after themselves?"
- "Were there any medical problems like high blood pressure, diabetes, or heart conditions?"
- "Did the surgeons discuss the risks of the operation with you?"

Invite - Prepare for Conversation

"I've been asked to give you an update about your [relative]'s condition. Before I continue, are you okay to talk now? 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 older patients and may not be directly caused by the surgery, but we're waiting for the specialist to review the full picture."

"Are they going to die?" "Right now, the situation is serious. It's difficult to say how things will unfold. They've been through a lot - first the surgery, and now this stroke on top of it. I know this must be incredibly hard to hear. But they are receiving treatment, and we're doing everything possible to support them. Let's stay hopeful, and we'll know more once the specialists complete their review."

"Will they recover? Will they walk again?" "I wish I could give you a clear answer right now. What I can tell you is that we're doing everything possible, and we'll have a much better idea once the stroke team has fully assessed them. 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."

"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

"They're being looked after very closely by a team of specialists. We'll monitor them 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: Primary Care **Role:** FY2 Doctor **Patient:** Young Adult with Persistent Bone Pain, Attending for Investigation Results **Task:** Deliver abnormal imaging result, explain suspected diagnosis, address concerns, arrange urgent specialist referral

Introduction

"Hello, I'm one of the doctors here at the practice. Could I confirm-are you [Patient's name]? 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?"

Ideas, Concerns, Expectations 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

Urgent referral: "Because of the X-ray findings and your age, I'm going to arrange an **urgent suspected cancer referral** to the sarcoma team. For young people like yourself, this is treated as **very urgent** - we aim for you to be seen within 48 hours, and we'll try to make it even sooner if possible."

Note for candidates: NICE NG12 specifies different pathways:

- *Children and young people (under 25): Very urgent referral - appointment within 48 hours*
- *Adults (25+): Suspected cancer pathway referral - appointment within 2 weeks In practice, young people aged 16-24 may use either pathway depending on local arrangements.*

Further investigations: "They'll likely do a **CT scan or MRI** to see the extent of the lesion and surrounding structures. They may use those scans to guide treatment directly."

Treatment: "If confirmed, treatment usually involves **surgery to remove the tumour** - often they can save the limb rather than amputate. **Chemotherapy** may also be part of the plan, either before or after surgery. The specialist team will explain all of this properly once they've assessed you."

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?" "I know how important football is to you, and I'm really sorry that this might change things. Honestly, returning to high-impact sports like football is unlikely because the bone will be weaker after treatment and the risk of fracture would be too high. But we'll focus on helping you regain your mobility and independence, and the physio team will work with you on what activities you can still enjoy. The specialist team will be able to give you more specific guidance once they've assessed you."

"Can I delay my referral? I have an exam coming up." "I can hear how important your exam is to you, and I really do understand that. 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 appointment at 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 (DCIS)

Setting: Primary Care or Breast Clinic **Role:** FY2 Doctor **Patient:** Adult Female Attending for Breast Biopsy Results **Task:** Gather relevant history, deliver biopsy result, explain diagnosis and management pathway, address concerns

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 through the suspected cancer pathway, which means you should be seen by the specialist breast team within two weeks. You'll receive a letter shortly with your appointment details. 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 what's right for you."

Sentinel lymph node biopsy: "If you need a mastectomy, the surgeons will also check some lymph nodes under your arm at the same time - this helps make sure we haven't missed anything. If you have breast-conserving surgery, this isn't usually needed unless there are specific concerns."

Other treatments: "Depending on your individual situation, the team may also discuss **radiotherapy** or **hormonal therapy** to reduce the risk of the cancer coming back. These are decisions the specialist team will make with you based on all the test results."

Support: "You'll be assigned a **breast care nurse specialist** who will be your main point of contact throughout this process. She can answer questions, support you emotionally, and help you navigate the system. You'll also be offered written information and details of support groups."

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. It's actually a really good thing that this was found before you could feel anything - it means we've caught it at a very early stage when treatment is most effective."

"Why would the whole breast need to be removed?" "That's a really important question, and I completely understand why you'd want to know. 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." "If you'd like, we can arrange for you to speak to another specialist - sometimes hearing things from a different doctor can help."

Dementia

Setting: Hospital Ward **Role:** FY2 Doctor **Patient:** Older Adult Admitted with Significant Weight Loss, Background of Progressive Cognitive Decline **Relative:** Adult Child **Task:** Gather relevant history, explain current situation and prognosis, discuss comfort-focused care approach

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:

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- "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?"

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 significant 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 can hear how much you want to do something to help - that's completely natural. But I have to be honest with you - the medical team, including the consultants, have reviewed her case carefully and at this stage, tube feeding wouldn't be beneficial and could actually cause more distress than help. In someone with advanced dementia, there's a real risk she might pull it out or accidentally inhale the food, which can cause serious complications. 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 recognise 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. Please try to remember - even if she doesn't recognise you in the way she used to, your presence is still comforting to her. Being there still matters."

"Has your mother ever talked about what she'd want at this stage of her life, or did she make any written wishes?" *(Add this question to explore advance care planning)*

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 **Patient:** Adult with Terminal Malignancy and Current Infection, Requesting Discharge Against Medical Advice **Task:** Explore patient's wishes, assess understanding of prognosis, discuss treatment options including discharge planning, provide supportive care

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. Before we talk about the cannula, I'd really like to understand how you're feeling about everything. How has your stay been?"

Acknowledge the Concern

"I hear you're saying you'd like to go home. That's a really important thing to share with me. I respect that completely-and I want to understand more about what you're thinking and feeling."

Explore the Request

- "Can you tell me more about what's on your mind?"
- "You said you don't have much time-how are you feeling about that?"
- "Is there something specific making you want to leave today?"
- "How are things at home-with your wife, your support?"

Clarify Understanding of Prognosis

- "What have the doctors told you about your cancer?"
- "Do you understand that your condition is terminal?"
- "Have you and your wife had a chance to talk about what comes next?"

Ideas, Concerns, Expectations

- **Ideas:** "What do you think would happen if we let you go home today?"
- **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?"

Respecting Autonomy While Explaining Options

"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. *This is delivered through a service called OPAT (Outpatient Parenteral Antimicrobial Therapy), where nurses visit daily to administer IV antibiotics 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 absolutely sure you have everything you need - good pain relief, support at home, and a way to reach us if anything changes."

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: Primary Care (Telephone Consultation) **Role:** FY2 Doctor **Patient:** Adult Female with Recent Early-Stage Breast Cancer Diagnosis Declining Treatment **Task:** Explore reasons for treatment refusal, address concerns, provide balanced information, offer ongoing support

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

It's important to let her speak without jumping in to correct or reassure - sometimes people just need to feel heard first.

- Allow the patient to speak without interruption
- 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
- Concerns about information sources (from online research)
- 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 services available, and the NHS also has information about wigs and headwear."

Breast Loss: "If surgery is needed, reconstruction options are available, often done at the same time as removal. This is something you can discuss fully with the specialist team."

Concerns about information sources: "I understand - the internet can be overwhelming, and it's hard to know what to trust. Would it be helpful if I pointed you towards some sources that I know are reliable?"

Autonomy and Reassurance

"I want you to know-whatever you decide, we're here for you. This is ultimately your choice, and I respect that completely. But I also want to make sure you have all the facts before making a final decision."

"You're not alone in this. We have nurses, counsellors, and support groups who've helped many others through similar feelings."

Offering Support Services

- Macmillan cancer support nurse
- Breast care nurse specialist
- Talking therapy / CBT referral
- Written information about DCIS and treatment options

Second Opinion

"If you'd like, we can arrange for you to speak to another specialist - sometimes hearing things from a different doctor can help."

Safety Netting

"If you change your mind at any point, or just want to talk things through again, please call us. We're here to support you-whatever you decide."

Refusal of Prostate Cancer Treatment

Setting: Primary Care (Face-to-Face or Telephone Consultation) | **Role:** FY2 Doctor | **Patient:** Adult Male with Recent Localised Prostate Cancer Diagnosis Declining Treatment

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Introduction

"Hello, I'm one of the doctors at the practice. Before we start, can I just confirm your full name and date of birth, please?"

Thank you. I understand you wanted to speak to us today - how can I help?"

Clarification and Empathy

Patient: "I don't want the treatment for my prostate."

Doctor: "Thank you for telling me that. Can I just check - are you talking about the treatment for the prostate cancer that was recently diagnosed?"

Patient: "Yes. I've decided I'm not going through with it."

Doctor: "I appreciate you being upfront with me. This must be a really difficult time. Before we talk about anything else, can I ask - what's made you feel this way?"

Active Listening Phase

- Allow the patient to speak without interruption
- Do not rush to correct, reassure, or provide medical facts
- Show genuine interest in understanding his perspective
- Reflect back key phrases to show you've heard him

Patient Concerns

Fear of incontinence - "I don't want to end up wearing pads for the rest of my life"

Fear of erectile dysfunction - "I'd rather die than lose that part of my life"

Impact on masculinity and identity - feeling less of a man, embarrassment, shame

Impact on relationship/partner - worried about burdening partner, intimacy changes

Belief that the cancer is slow-growing - "I've read that prostate cancer is slow and I'll probably die of something else first"

Bad experience with someone else's treatment - "My friend had the surgery and was never the same"

Distrust of medical intervention - prefers to "let nature take its course"

Mental health - low mood, anxiety, feeling overwhelmed since diagnosis

Information sources - read things online or heard anecdotal stories

Acknowledging and Thanking the Patient

"Thank you for sharing all of that. I can hear how much thought you've given this, and I respect that enormously. These are real, valid concerns - and you're not the first person to feel this way. I want to make sure you have all the information you need before making a final decision."

Gentle Exploration

"Can I ask a few questions to help me understand your situation better?"

"Has anyone explained what stage and grade your cancer is?"

"Do you know what your PSA level was, and your Gleason score?"

"Have the specialists explained the different treatment options available to you?"

"Who do you have at home supporting you - partner, family, friends?"

"How have you been feeling in yourself - your mood, your sleep?"

ICE

Ideas: "What do you think will happen if you don't have any treatment?" **Concerns:** "What is your biggest worry about the treatment itself?" **Expectations:** "What were you hoping we could help with today?"

Explanation: Balanced Information

"Let me explain what we know about your cancer and the options available - and then we can talk it through together."

If Localised / Early-Stage Prostate Cancer:

"Your cancer has been caught at an early stage, which is very encouraging. At this stage, there are actually several options - and not all of them involve surgery or aggressive treatment."

Treatment options (per NICE NG131):

Active surveillance - regular PSA monitoring, MRI scans, and repeat biopsies. No treatment unless the cancer shows signs of progressing. This is recommended for many men with low-risk localised prostate cancer and avoids the side effects of treatment entirely.

Radical prostatectomy - surgical removal of the prostate. Very effective for localised disease. Main risks: urinary incontinence (most men recover bladder control over months), erectile dysfunction (nerve-sparing techniques can preserve function in many cases).

Radical radiotherapy - external beam radiotherapy or brachytherapy. Alternative to surgery with similar outcomes. Side effects include bowel and urinary irritation, and erectile dysfunction over time.

Watchful waiting - for men who choose not to have curative treatment. Focuses on symptom management rather than cure. More appropriate for older men or those with significant comorbidities.

[Per NICE NG131: Offer a choice of active surveillance, radical prostatectomy, or radical radiotherapy to men with localised prostate cancer who are suitable for all options. Discuss the benefits and risks of each.]

"You mentioned you're worried about incontinence and the impact on your intimate life. Those are completely valid concerns. But I want you to know that many men who have treatment - particularly with modern techniques - recover well. And active surveillance may mean you don't need any treatment at all, at least for now."

Addressing Specific Concerns with Practical Solutions

Incontinence: "After surgery, most men experience some leakage initially, but for the majority, bladder control improves significantly within 6–12 months. Pelvic floor exercises before and after surgery can make a real difference. We also have specialist continence nurses who provide ongoing support."

Erectile dysfunction: "This is one of the most common concerns. With nerve-sparing surgery, many men retain some erectile function. If difficulties arise, there are effective treatments - medications like sildenafil, vacuum devices, or other options. The specialist team will support you through this."

Masculinity and identity: "I hear you. Many men feel this way. But having treatment - or even choosing surveillance - doesn't change who you are. There are support groups with other men who've been through the same thing, and many find it really helpful to talk to someone who understands."

Partner/relationship: "Would it help if we involved your partner in the conversation? Many couples find it easier to make decisions together, and your partner may have their own questions too."

"It's slow-growing, I'll die of something else": "You're right that many prostate cancers are slow-growing - and that's exactly why active surveillance is an option. But it depends on the grade and stage. Some prostate cancers can become more aggressive over time. The monitoring we do with active surveillance is specifically designed to catch that early, so we can act before it becomes a problem."

Mental health: "You mentioned feeling low and not sleeping well. That's very common after a cancer diagnosis. We can refer you for talking therapy - such as CBT - and there are cancer-specific counselling services available. Your mental health matters just as much as your physical health."

Online information: "The internet can be overwhelming, and not everything you read will apply to your specific situation. I'd recommend Prostate Cancer UK and the NHS website - they have reliable, up-to-date information. I can also give you some written information to take away."

Autonomy and Reassurance

"I want to be really clear - this is your decision, and I respect that completely. Nobody is going to force you into anything. But my job is to make sure you have all the facts before you make a final choice. If you'd like more time to think, that's absolutely fine. And if you change your mind at any point - whether that's next week or next year - the door is always open."

Offering Support Services

Prostate Cancer UK helpline - specialist nurses available

Prostate cancer specialist nurse at the hospital

Macmillan cancer support

Talking therapy / CBT referral for low mood and anxiety

Support groups - local and online, with other men who've been through the same

Partner/family counselling - if the partner is also struggling

Written information - about prostate cancer, active surveillance, and treatment options

Second Opinion

"If you'd like, we can arrange for you to see a different specialist - sometimes hearing things from another doctor can help you feel more confident in your decision, whichever way you go."

Safety Netting

"If you notice any new symptoms - such as difficulty passing urine, blood in your urine, new back pain, or unexplained weight loss - please come in straight away so we can check things out."

"And if you change your mind about treatment, or just want to talk things through again, please call us. We're here to support you - whatever you decide."

Post MI Medication Refusal

Setting: Primary Care - Routine Chronic Disease Review **Role:** FY2 Doctor **Patient:** Older Adult Female with Cardiovascular History and Well-Controlled Metabolic Conditions **Task:** Address request to discontinue medication, explore underlying concerns, assess mood and capacity, discuss advance care planning

Introduction

"Hello, I'm Dr [Your Name], one of the doctors at the practice. Is it alright if I sit down? I understand you're here for your routine review today. Before we begin, could I confirm your name and age, please? Thank you for coming in. How have you been since your last visit?"

C - Clarify the Concern

Patient mentions she wants to stop her medications.

"Thank you for telling me that. Can I ask what's brought this up today? I'd really like to understand what you're thinking and feeling."

(Allow space. She may reveal emotional exhaustion, sense of futility, or feelings about mortality.)

A - Assess the Background

Medical Review:

- "Can I go over your health history briefly? I understand you had a heart attack some time ago?"
- "Have things been stable since then?"
- "How are you managing with your diabetes, blood pressure, and cholesterol?"
- "Are you experiencing any new symptoms-chest pain, breathlessness, swelling?"

Medication Review:

- "Could you tell me which medications you're currently taking?"
- "How do you feel about taking them every day?"
- "Are there any side effects that are troubling you?"

Psychosocial Assessment:

- "You've mentioned wanting to stop treatment. Can I ask-how have you been feeling emotionally lately?"
- "Have you been sleeping okay?"
- "Do you still enjoy the things you used to?"
- "Have you had any thoughts that life isn't worth living, or about harming yourself?"

(Important: If she expresses hopelessness or existential fatigue, assess suicide risk sensitively.)

"Sometimes when people feel they've had enough, they might have thoughts about harming themselves or ending their life. Have you ever had any thoughts like that?"

Ideas, Concerns, Expectations

- "What do you think would happen if you stopped your medication?"
- "Is there anything in particular that's worrying you about continuing treatment?"
- "What do you feel would make things better for you right now?"

R - Reassure and Validate

"Thank you for sharing that with me. That must be incredibly difficult to carry. I can only imagine how tiring it must feel to take tablets every day, especially if you feel like you've already lived a good life. You're not alone in thinking that-many people in your situation feel the same way."

E - Educate Gently

A. Explain 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, DNACPR, and support at home. We can arrange for a nurse or someone from the palliative team to speak with you as well."

DNACPR Discussion (If Patient Raises It)

"I know that's quite a clinical term, so let me explain what it means in practical terms..."

DNACPR stands for **Do Not Attempt Cardiopulmonary Resuscitation**. It means that if your heart were to stop, we would not attempt 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 DNACPR 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."

"Note: The ReSPECT (Recommended Summary Plan for Emergency Care and Treatment) process is progressively replacing standalone DNACPR forms across England (adopted in approximately 70% of areas by 2024).

ReSPECT is a more holistic approach that records the patient's values, treatment preferences, and CPR decision in a single form. Candidates should be aware of both DNACPR and ReSPECT, as the form used varies by local trust."

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: "Not because I think there's anything wrong with how you're feeling - but because having someone independent to talk to can sometimes help when you're navigating big decisions like this."
- **If DNACPR is requested:** Complete the DNACPR form and ensure it's documented in their records. Inform the senior GP/consultant as per local protocol.

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 together, in a way that respects what matters most to you while making sure you're supported. And whatever you decide, we'll be here."

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 + DNACPR Request - Elderly Male

Setting: Primary Care **Role:** FY2 Doctor **Patient:** Older Adult Male with Cardiovascular and Metabolic History, Living Alone **Presenting Concern:** Requests to discontinue all medications, expresses fatigue with ongoing treatment, requests DNACPR documentation **Task:** Explore reasoning, assess capacity and mood, facilitate advance care planning

Note: Cases 11 and 12 are variations on the same theme - practise both to see different presentations.

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?"

A - Assess

Living Situation:

- "You mentioned living alone-how are you managing day to day?"
- "Do you have family or friends who visit regularly?"
- "Is there anyone who helps with shopping, meals, or medication?"

Mood & Meaning:

- "How have you been feeling in yourself lately?"
- "Sometimes when people feel tired of treatment, there are deeper feelings underneath-have you been feeling low or hopeless?"
- "Do you still find enjoyment in small things-reading, television, visits from family?"
- "Have you had any thoughts of harming yourself or ending your life?"

Medication Understanding:

- "Do you understand what each of your medications is doing?"
- "Is there something specific about them that bothers you-side effects, the number of tablets, or something else?"

Capacity Check:

- "Can you explain back to me what might happen if you stopped your medications?"
- "Are you able to weigh up the pros and cons of this decision?"

(Patient demonstrates understanding, retention, ability to weigh information, and can communicate a clear choice - has capacity.)

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."

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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. DNACPR - What It Means

"You also mentioned wanting a **DNACPR** form - that stands for *Do Not Attempt Cardiopulmonary 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 DNACPR 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. DNACPR Discussion and Documentation

- Complete DNACPR documentation after confirming patient has capacity and understands the decision
- Inform the senior GP/consultant as per local protocol
- Add to GP records, summary care record, and ambulance database (per local policy)
- Provide printed copy for patient to keep at home

2. Medication Review

- Go through current medications with patient
- Discuss potential deprescribing of non-essential medications
- 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 there's anything wrong with how you're feeling - but because having someone independent to talk to can sometimes help when you're navigating big decisions like this."

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. And whatever you decide, we'll be here."

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: Medical Ward **Role:** FY2 Doctor **Patient:** Older Adult Male with Respiratory Infection and Multiple Comorbidities **Presenting Concern:** Refusing IV access and treatment, requesting discharge **Task:** Explore reasons for refusal, assess capacity, discuss implications, explore end-of-life care preferences if appropriate

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 what's behind your decision today. Can you help me understand what's been going through your mind?"

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 Social Background

Use your preferred history framework (PMAFTOSA or similar):

- "Do you have any other medical conditions apart from your heart problems and this infection?"
- "Are you taking many regular medications at the moment?"

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- "Any allergies?"
- "Can you manage your basic activities like dressing or washing on your own?"
- "Any recent trips to hospital or surgeries apart from this one?"
- "Any past serious infections or breathing problems?"
- "Are you sleeping or eating okay?"
- "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

- "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.

Ideas, Concerns, Expectations

- **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."

"Without the antibiotics, there's a real possibility that the infection could get worse, and I have to be honest with you - it could become life-threatening."

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."

DNACPR and LPA Clarification

- "Would you like to talk about DNACPR, which means *Do Not Attempt Cardiopulmonary 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."
- "A DNACPR only applies to that one situation - if your heart stops."
- "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: Emergency Department **Role:** FY2 Doctor **Patient:** Older Adult Male from Care Home with Acute Respiratory Symptoms and Reduced Oxygen Saturations **Situation:** Declining Hospital Admission **Task:** Assess clinical status, explore reasons for refusal, assess capacity, ensure informed decision-making, arrange safe discharge if appropriate

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?"

Presenting Complaint - Focused Symptom History

Initial Sepsis Risk Assessment (NICE NG253): Before taking history, note the patient's observations:

- Check NEWS2 score (respiratory rate, oxygen saturations, temperature, BP, heart rate, consciousness level)

- NEWS2 ≥ 5 = moderate risk; NEWS2 ≥ 7 = high risk requiring urgent senior clinical review and consideration of sepsis. A single parameter score of 3 (e.g., SpO₂ <92% on air) should prompt urgent clinical assessment regardless of total NEWS2.
- Low oxygen saturations in the context of infection = RED FLAG for potential sepsis
- "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?"

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?"

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?"

Explore Refusal - Ideas, Concerns, Expectations

- "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?"

Capacity Check - Respectful & Structured

Important: Hypoxia can impair capacity. If oxygen saturations are low (<92%), be vigilant for subtle cognitive changes (confusion, agitation, poor concentration) that may affect decision-making ability. Document that you have considered this.

- "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?"
- "I just want to make sure that your breathing difficulties aren't affecting your thinking at all - sometimes when oxygen levels are low, it can make it harder to concentrate."
- "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. Document that capacity was assessed with consideration of potential hypoxic effects.*)

Provisional Diagnosis + Lay Explanation

Diagnosis: Likely *community-acquired pneumonia* in a high-risk patient

"Based on your symptoms and observations, this infection is moderate in severity, which is why we'd normally recommend hospital treatment. Let me explain what we're concerned about..."

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."

Risks of Refusing Admission - Clear, Honest, Non-Threatening

This is a critical safety conversation. Be explicit about the risk of death.

"I need to be very honest with you about what could happen if we don't treat this in hospital - and I know this might sound frightening, but I think you deserve to know the full picture.

Your oxygen levels are lower than they should be, and with an infection like this, we're concerned about something called **sepsis** - which is when the infection spreads and the body starts to struggle.

I need to be completely straight with you: with your oxygen levels this low and an active chest infection, there is a real risk that if you go home, you could become more confused, fall into a deep sleep, and not wake up. There is a genuine risk of dying overnight if this isn't treated.

I'm not saying this to frighten you - but I would feel I hadn't done my job properly if I didn't tell you how serious this is."

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?"

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."

Safety Netting & Emergency Advice

Critical: In potential sepsis, safety net must emphasize 999, not GP.

"If you do decide to go home, I need you and the nursing home staff to watch very carefully for these warning signs:

- **Worsening breathlessness or struggling to breathe**
- **Becoming more sleepy, confused, or harder to rouse** - this is especially important
- High fever or feeling cold and clammy
- Chest pain or not being able to eat or drink

- Skin looking mottled, pale, or bluish

If any of those happen - do NOT wait for the GP. Call 999 immediately. This is an emergency situation.

I'll personally make sure the nursing home staff know exactly what to look out for, and I'll provide clear written instructions. I'll also contact your GP so everyone is on the same page - but I want to be clear: if you deteriorate, it's 999, not the GP surgery."

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
- **Document the discussion clearly, including capacity assessment, risks explained, and patient's understanding**

Key Learning Points

1. **Capacity assessment is decision-specific** - someone may have capacity for one decision but not another
 2. **DNACPR only covers cardiac arrest** - always clarify that other treatments continue
 3. **Respecting refusal ≠ abandoning the patient** - offer alternatives, follow-up, and support
 4. **"Warning shots" are essential** - prepare patients/families before delivering difficult news
 5. **Silence is therapeutic** - pause after delivering bad news; don't rush to fill the space
 6. **Know your FY2 scope:**
 - **You CAN:** Deliver bad news, explain diagnoses and prognosis, formulate management plans, complete DNACPR (with senior notification), initiate referrals, assess capacity, make clinical decisions within your competence
 - **Escalate when:** You're uncertain, the family requests it, there's conflict about treatment decisions, complex ethical situations, or when you need senior input for specific decisions
 - **Don't over-defer:** Constantly saying "I'll ask my senior" suggests lack of confidence - be decisive within your scope while knowing when to escalate
-

Chapter 25: Miscellaneous Cases

A Note to Learners

The cases in this resource are written in a conversational style to help you become familiar with the natural flow of clinical consultations and the language commonly used in UK healthcare settings.

These dialogues are intended as a learning guide, not a script. Please do not attempt to memorise them verbatim. Examiners assess your ability to think and communicate authentically - not to recite rehearsed phrases.

Use this material to understand the underlying clinical reasoning, then practise in your own words until the consultation feels natural to you.

For Companion OSCE Cases, Practice Scripts, Evaluation Checklists, Summary Notes, Rapid Review Notes, Mindmaps, Management Flashcards and Image Library - visit <https://www.gksplab2.com>

Disclaimer

This material is independent educational content created to help candidates develop clinical reasoning and communication skills for UK medical practice.

All cases and clinical scenarios are based on common presentations encountered in UK primary care and emergency medicine, drawn from publicly available sources including NICE Clinical Knowledge Summaries (CKS), BNF, and other official NHS/UK healthcare guidelines.

No content in this resource is derived from, represents, or claims to replicate actual GMC PLAB 2 examination material.

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.
 - **Ask about a "Hospital Passport"** (or "This is me" document) - this is a standard UK document in LD care that summarizes the patient's needs, communication preferences, and important health information. Asking for it demonstrates excellent system awareness.
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.
 - Use concrete analogies: instead of "side effect," say "unwanted feeling" or "bad reaction"; instead of "blood pressure," say "the pushing force of blood in your tubes."
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.
- **Mental Capacity Act (2005)**
 - For patients who may lack capacity to consent, be familiar with the Mental Capacity Act framework for decision-making.
- **Communication aids**
 - Some patients may use Makaton or other communication aids - ask if they have any preferred way of communicating.

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:** Middle-Aged Adult Male with Learning Disability **Condition:** DVT Follow-Up - Medication Adherence Concerns

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?"
- "Do you have anyone who helps you at home - maybe with cooking, shopping, or remembering 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, **with your evening meal** - this helps the body absorb it properly. For example, can we pick 6 o'clock in the evening?"

(Note: The food requirement applies to 15mg and 20mg doses. If the patient is on 10mg or 2.5mg maintenance dose, food is not required for absorption, though taking with food is still fine.)

- "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?"

Practical support:

- "Would a weekly pill box help? We can arrange one for you."
- "You could ask someone you trust - a family member, carer, or the district nurse - to help remind 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. **Tell them you are on blood thinners immediately** - this is very important."

"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 Diabetes Clinic **Patient:** Young Adult Male with Learning Disability **Condition:** Type 1 Diabetes Review - Recent Hospital Admission for Diabetic Emergency

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

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

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- "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. We aim for your sugar to be between 4 and 7 before meals."

"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**."

"Take this insulin just before you eat - within about 15 minutes. If you take it and don't eat, your sugar could drop too low."

"This is your *daytime insulin*. It may come with an orange or yellow label - like the sun."

Important: "The colours may vary depending on the brand, so always check the name on your insulin pen."

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, hungry, confused, or notice tingling around your lips."

"If this happens, have **15 grams of fast-acting sugar** - like **3-4 glucose tablets**, **150ml of fruit juice** (orange juice works well), or **GlucoJuice**. Then wait 15 minutes and check your sugar again. Chocolate is not ideal because the fat slows down sugar absorption."

(Note: Avoid recommending "regular cola" - due to the UK Soft Drinks Industry Levy, many cola brands have reduced sugar content and may not effectively treat hypoglycaemia. Glucose tablets, GlucoJuice, or fruit juice are reliable options.)

"Always carry glucose tablets or a small carton of juice with you - in your bag or pocket. These work faster than chocolate."

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."

Safe Sharps Disposal:

- "Do you have a **yellow bin** for your used needles? It's called a sharps bin."
- "Never put used needles in the regular bin - they could hurt someone."
- "If you don't have one, we can arrange for you to get a sharps bin from the pharmacy."

"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: Emergency Department **Patient:** Young Adult Male with Learning Disability **Presentation:** Painful Swollen Leg - Confirmed Venous Thrombosis

1. Introduction

"Hello, I'm one of the doctors here in the Emergency Department. 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?"

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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

FY2 Role in ED: You can initiate investigations and start anticoagulation for confirmed DVT. Discuss with your senior/registrar if there are concerns about PE, haemodynamic instability, or if the patient has contraindications to anticoagulation.

"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** to check your general health and help us understand why this happened"

Note on cancer screening: For unprovoked DVT, NICE no longer recommends routine CT scanning for cancer. Instead:

- Review medical history and baseline blood tests (FBC, calcium, liver function, renal function)
- Offer a physical examination
- Only investigate further for cancer if the patient has relevant clinical symptoms or signs
- Do NOT offer routine abdomino-pelvic CT or extensive cancer screening

Note on compression stockings: Graduated compression stockings are no longer routinely recommended to prevent post-thrombotic syndrome.

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 (unprovoked), you'll need to take the medicine for **at least 3 months**, then we'll review whether to continue - many people need longer or even lifelong treatment."
- "If we find a clear reason, like a long journey or surgery, you might need it for **3 months** if the risk factor is no longer present."

"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

"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

Setting: Primary Care - Same-Day Appointment **Patient:** Adult Patient **Presentation:** Facial Swelling - Medication Side Effect Query

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 a typical allergic reaction - it works through a different pathway - but it's still a reaction to the medicine that we need to take seriously."

"This type of swelling is caused by a chemical called bradykinin, not histamine. That's why antihistamines and steroids may have limited effect, but we give them anyway to help settle things down."

"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 medicines ending in '-pril' again - like ramipril, lisinopril, or enalapril. I'll add this as a drug allergy to your records."

2. Change to Safer BP Medication

- "We usually avoid ARBs (like losartan) as well, because there's a small chance (about 2-17%) they could cause similar swelling."
- "We'll use a calcium channel blocker like Amlodipine instead - this does not cause this kind of swelling."

Supportive Medications

*Note: Because this type of angioedema is caused by bradykinin - not histamine - standard allergy treatments like antihistamines and steroids are **not effective** here. Instead, the key treatment is: stopping the ACE inhibitor permanently, switching to a safe alternative, and monitoring. In severe or refractory cases (e.g., airway compromise not responding to stopping the drug), specialist treatments such as icatibant (a bradykinin B2 receptor antagonist), C1-inhibitor concentrate, or fresh frozen plasma may be considered in the emergency setting.*

*Note: Adrenaline works in allergic (histamine-mediated) angioedema but is **not effective** in bradykinin-mediated angioedema like this. If the cause of angioedema is uncertain and there's airway compromise, adrenaline may be given as a precaution while the team assesses further.*

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."

"If swelling happens again even on the new medication, seek help immediately."

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

"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 (bradykinin-mediated). Medication was stopped, supportive therapy given, and safe long-term antihypertensive planned (CCB preferred over ARB due to cross-reactivity risk). 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

Setting: Primary Care **Patient:** Young Adult Male **Presentation:** New-Onset Acne - Possible Medication/Supplement-Related

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?"

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- "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?"

F. Mental Health Impact

- "Acne can really affect how you feel about yourself. Has this been affecting your mood or confidence at all?"

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 affect your liver, your natural hormone levels, and your cholesterol - so stopping them is good for your overall health, not just your skin."
- (*IPS tip - appeal to vanity*): "Steroids can actually shrink your testicles and cause breast growth (gynecomastia) - which might be the opposite of the look you're aiming for."

B. Investigations

- **Liver Function Tests (LFTs)** → due to liver toxicity risk
- **Hormonal Profile:** Testosterone, LH, FSH → check for hypogonadotropic hypogonadism (shut-down of natural testosterone production)

- **Lipid Profile** → steroids can elevate cholesterol
- **FBC/U&E** if oral treatment is planned

C. Medical Management - Based on Severity (NICE NG198)

If Mild to Moderate Acne (non-scarring):

First-line: Fixed-combination topical products for 12 weeks:

- **Adapalene + benzoyl peroxide** (e.g., Epiduo), OR
- **Tretinoin + clindamycin + benzoyl peroxide** (e.g., Twyneo)

If Moderate to Severe Acne:

- Add oral antibiotics as part of combination therapy (not as monotherapy):
 - **Doxycycline** or **Lymecycline** (preferred)
 - **Avoid minocycline** - associated with lupus-like syndromes and other adverse effects
 - We try to avoid using antibiotics alone for acne. The initial course is 12 weeks (3 months), after which we reassess. If acne is not fully clear, the course can be extended up to a maximum of 6 months total, but no longer. Antibiotics should be stopped as soon as the skin is completely clear, and topical therapy continued alone.
 - Review at 6-8 weeks

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."
- "Please come back urgently if you notice yellowing of your skin or eyes, very dark urine, severe tiredness, or chest pain - these could be signs of liver problems."

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 using NICE NG198 combination therapy recommendations. Antibiotic stewardship emphasized (max 3 months). Mental health impact explored. Follow-up planned, lifestyle and safety netting advice provided. Patient education and support offered using NHS resources.

Post-operative Constipation After Hip Surgery

Setting: Orthopaedic Ward **Patient:** Older Adult Female **Presentation:** Post-Operative Constipation - Day 5 Following Joint Surgery

Vitals: Haemodynamically stable, no systemic red flags

1. Introduction

"Hello, 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

Independent educational content based on publicly available UK clinical guidelines.
Not affiliated with or derived from GMC PLAB 2 examination material.

GK's PLAB 2 Preparation WhatsApp Channel - <https://tinyurl.com/gksplab2>

- "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

"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."

Important principle: "Whenever we prescribe strong painkillers like codeine, we should also prescribe a laxative from the start to prevent this."

10. Management Plan

1. Stop or Switch Offending Medication

- "We'll stop your co-codamol and switch to **paracetamol** instead."

- "We may add **ibuprofen** if appropriate - though some surgeons prefer to avoid it after joint surgery due to theoretical concerns about bone healing. We'll check with the team."
- "We'll monitor your pain and adjust if needed - we won't let you be in pain."

2. Start Laxatives

First-line Treatment:

- **Macrogol (Laxido/Movicol) or Lactulose 15 ml BD** (Osmotic laxative):

"It draws water into your bowel, which softens the stool and makes it easier to pass - 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 liquid medicine given through your bottom - it usually works within a few hours and helps empty the lower bowel."

- **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 **laxative 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)

Setting: Primary Care **Patient:** Middle-Aged Adult Female **Presentation:** Hair Loss - Immunosuppressant Medication Query

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, hair thinning is something we know can happen with tacrolimus - it's not common, but you're not alone in experiencing this."

"This is a known side effect of tacrolimus - the immunosuppressant you take after your kidney transplant. 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."

"We'll also check your tacrolimus levels are in the right range - sometimes adjusting the dose can help without compromising your transplant."

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."
- "If you'd find it helpful, we can arrange information about wigs - the NHS can sometimes help with the cost."

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."
- **Important:** "Biotin supplements can interfere with some blood tests, so please let us know if you start taking them."

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."

"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

Middle-aged 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 including NHS wig service information. Biotin blood test interference warning given. Dermatology input considered if hair loss progresses or affects wellbeing.

Oxybutynin Side Effects

Setting: Primary Care - Follow-Up Review **Patient:** Older Adult Male **Presentation:** Confusion and New Symptoms - Urinary Frequency - Medication Side Effect Query

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:

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- "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 problems, and - especially in some people - it can affect memory and concentration. This doesn't mean anything is permanently wrong."

"Medicines like oxybutynin belong to a group called anticholinergics that can add up to cause confusion, especially as we get older. We try to avoid stacking too many of these together."

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 have other options."

Important clarification:

- **For overactive bladder (OAB):** Consider **mirabegron** - a beta-3 agonist with fewer cognitive effects. "If your urinary symptoms return, we could try a different type of medicine called mirabegron, which works differently and has fewer effects on memory."
- **For prostatic symptoms/LUTS (obstruction):** Alpha-blockers like **tamsulosin** are appropriate.

Note: Tamsulosin is for prostate/LUTS, not for OAB - ensure correct indication.

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

Student Note: How the Diagnosis and Plan Were Made

This was a follow-up consultation for urinary frequency in an older adult male 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 (mirabegron for OAB, or tamsulosin if prostatic symptoms present). Anticholinergic burden awareness emphasized. Cognitive screening was included to address patient concerns sensitively.

Lithium Toxicity

Setting: Emergency Department **Patient:** Older Adult (Accompanied by Family Member) **Presentation:** Tremor and Unsteadiness - On Long-Term Psychiatric Medication

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."

"Because lithium is removed through the kidneys, we always check kidney function when someone has these symptoms."

"This doesn't mean it's permanent or untreatable, but we need to act quickly to bring the level down."

6. Structured Management Plan

FY2 Role: Recognise lithium toxicity, initiate immediate management, and **escalate early to senior/registrar**. If level >2.0 mmol/L or severe symptoms (seizures, arrhythmia, reduced GCS), **involve ITU/critical care immediately**.

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**
- **Inform medical registrar** - lithium toxicity requires senior oversight

B. Target Lithium Range (Updated per NICE 2025)

- Therapeutic target: **0.6 – 0.8 mmol/L** (Levels above 0.8 are linked to more side effects)
- Toxic: **>1.5 mmol/L**
- **>2.0 mmol/L** → discuss with toxicology/renal
- **>2.5 mmol/L** or severe symptoms → **dialysis** (requires ITU/renal input)

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 medicine that directly reverses lithium - but we can bring the levels down by stopping the tablet and giving fluids through a drip. 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 - this includes lithium levels and kidney function. Thyroid function should be checked at least every 6 months. These tests should continue for as long as he takes lithium."

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

Older adult 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. Updated therapeutic range (0.6-0.8 mmol/L per NICE 2025) noted. Psychiatric input was planned for long-term treatment review. Family concerns were addressed with clear education and safety netting.

Medication-induced Galactorrhoea

Setting: Primary Care

Patient: Middle-aged Adult Female

Background: Hypertension, on long-term antipsychotic medication

1. Introduction & Consent

- "Hello, my name is Dr _____. I'm one of the doctors here in the clinic today."
- "I understand you've noticed some discharge from your breast - is that right?"
- "Would it be alright if I ask you a few questions to understand this better and examine you if needed?"

2. Presenting Complaint - Detailed History

A. Characterisation of Nipple Discharge

- "When did you first notice the discharge?"
- "Is it from one or both breasts?"
- "What does it look like - is it milky, clear, yellow, green or bloody?" → Milky
- "Does it come out by itself or only when you press the area?"
- "How often is it happening?"
- "Any change in colour or amount over time?"

B. Associated Breast Symptoms

- "Have you noticed any lumps in your breast or underarms?"
- "Any pain, redness, swelling, or warmth in the breast?"
- "Any skin changes around the nipple - like flaking, thickening, or inversion?"

3. Systemic & Red Flag Screening

- **Pituitary symptoms:** "Do you get any headaches?" → No
- "Any changes in your vision or blurred vision?" → No

- "Any nausea or vomiting recently?"
- **Endocrine symptoms:**
 - "Any recent weight gain or loss?"
 - "Have your periods been regular?"
 - "Any hot flashes or dryness?" (if perimenopausal)
- **Pregnancy screening:** "Any chance you might be pregnant?"

4. Past Medical, Drug, and Psychosocial History

- **Past medical history:** "Do you have any medical conditions?" → *Hypertension, psychosis*
- **Medication history:** "Are you on any regular medications?"
 - *Risperidone likely cause*
 - *Check dose, duration, and compliance*
- "Have there been any recent changes to your medications?"
- "Do you take any herbal or over-the-counter remedies?"
- **Family history:** Breast cancer, pituitary tumours?
- **Lifestyle:** Smoking, alcohol, caffeine use
- **Allergies**

5. ICE

- **Idea:** "Do you have any idea what might be causing this?"
- **Concern:** "I'm worried about why it's happening. I want to know what's going on."
- **Expectation:** "I want to know what can be done."

6. Examination

- **General:** Vital signs, hydration, weight
- **Breasts:** No masses, skin changes, or tenderness. Discharge may be expressed
- **Neurological:** Normal
- **Visual field:** Normal by confrontation

7. Explanation

- "Thanks for patiently answering my questions. From everything you've told me, this discharge looks like something called **galactorrhoea** - which means a milky discharge not related to breastfeeding."
- "The most likely cause in your case is your medication - **Risperidone**. This can raise the level of a hormone called **prolactin**, which sometimes makes the body act as if it's preparing to produce milk."
- "This isn't dangerous or a sign of cancer - and it's something we see quite commonly with this type of medication."
- "We'll do some blood tests to confirm this is the reason, and then we can decide the next steps together."
- "I understand you feel well on your medication, so don't worry - we're not going to change anything straight away."

8. Management Plan

Initial Blood Tests:

- **Serum prolactin** - to confirm hyperprolactinaemia
- **TSH and FT4** - to rule out hypothyroidism (common secondary cause)

- **U&Es, LFTs** - to rule out other metabolic causes
- **βhCG** - pregnancy test if relevant

If prolactin is elevated:

- Review **drug history**: Confirm that antipsychotic is likely the cause
- **MRI pituitary** if any of the following:
 - Prolactin significantly elevated (>5000 mU/L or >235 ng/mL - at these levels, macroprolactinoma is likely)
 - Visual symptoms or persistent headache
 - No identifiable drug cause
 - Neurological signs
 - Rapidly rising prolactin or level disproportionate to drug dose

Note: Some local protocols use lower thresholds (e.g., >2000 mU/L). Always follow your local trust guideline.

Monitoring Advice:

"Recommend annual prolactin monitoring for patients on prolactin-raising antipsychotics (risperidone, amisulpride, sulpiride, typical antipsychotics)"

Medication Review

- Involve psychiatry/mental health team - "We can discuss your medication with the mental health team to see if there's an alternative that suits you better"
- If prolactin significantly raised or symptoms troublesome, **consider**:
 - Dose reduction
 - Switching to a prolactin-sparing antipsychotic (e.g., **Aripiprazole**)
- Decision to change medication should **only be made with psychiatric input**
- Do **not stop** antipsychotic abruptly

Bone Health Consideration:

"If amenorrhoea present for ≥12 months, consider DEXA scan to assess bone mineral density. Long-term hyperprolactinaemia can lead to hypogonadism and osteoporosis risk. Offer contraception advice and consider HRT or COC for bone protection in hypoestrogenic women."

When to refer to Breast Clinic:

- Unilateral, spontaneous, **bloody** discharge
- Associated **lump**, nipple change, or skin abnormality
- Over age 50 with persistent symptoms
- Not applicable in this case (normal breast exam, bilateral milky discharge)

9. Reassurance & Shared Decision Making

- "The discharge is most likely a side effect of your current medication."
- "We'll confirm it with a few tests. If your hormone levels are high, I'll speak to your mental health team before any changes are made."
- "In many cases, prolactin levels can settle even without major medication changes. And if needed, a small tweak in your medication can help - but only if you're comfortable and it's safe."

10. Safety Netting

- "If you notice any of the following, please come back urgently:"
 - Blood in the discharge
 - A new lump or breast pain
 - Headaches or vision problems
 - Symptoms getting worse or more frequent

11. Follow-Up Plan

- Arrange bloods today (prolactin, TSH, U&Es, LFTs, β -hCG)
- Review results in 1 week
- Discuss with psychiatry team if hyperprolactinaemia confirmed
- Plan further tests (e.g. MRI) or referral if needed

12. Leaflet + Final Check

- Offer leaflet on **medication side effects and galactorrhoea**
- "Is there anything else on your mind you'd like to ask?"
- "Would it be okay if I contact your mental health team once results are back?"

Risperidone-Induced Weight Gain

Setting: Primary Care **Patient:** Young Adult Female (e.g., 28 years old) **Background:** Known history of psychosis/schizophrenia, on Risperidone. Presents complaining of significant weight gain since starting the medication. Psychiatrically stable.

1. Introduction & Consent

"Hello, my name is Dr _____. I'm one of the doctors here at the practice today."

"I understand you've come in with some concerns - would you like to tell me what's been troubling you?"

"Would it be alright if I ask you a few questions so I can understand the situation better?"

2. Presenting Complaint - Detailed History

A. Characterisation of Weight Gain

"When did you first notice the weight gain?"

"How much weight do you think you've gained, roughly?"

"Over what time period has this happened?"

"Did the weight gain start around the time you began your medication?"

"Has it been gradual or quite rapid?"

"Have you noticed where the weight has gone - around your tummy, face, all over?"

B. Dietary and Lifestyle Assessment

"Can you talk me through what a typical day looks like for eating - breakfast, lunch, dinner, snacks?"

"Have you noticed any change in your appetite since starting the medication - are you eating more, craving certain foods?"

"What about fizzy drinks, sugary snacks, takeaways?"

"How much water do you drink in a day?"

"Do you do any physical activity or exercise at the moment?"

"How are you sleeping - getting enough rest?"

C. Associated Metabolic Symptoms

"Have you noticed being more thirsty than usual or passing urine more often?" (screen for diabetes)

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"Any skin changes - dark patches around your neck or underarms?" (*acanthosis nigricans*)

"Any changes to your periods - irregular, absent?" (*screen for hormonal disruption*)

"Any breast discharge?" (*screen for hyperprolactinaemia - links to the Galactorrhoea case*)

"Any swelling in your legs or feet?"

"Any shortness of breath or chest pain on exertion?"

D. Mental Health Assessment

"How is your mental health at the moment - are you feeling stable?"

"Any return of symptoms - hearing things, feeling paranoid or anxious?"

"How is your mood - feeling low, hopeless, or lacking motivation?"

"How is the weight gain making you feel about yourself?"

"Is it affecting your confidence, social life, or relationships?"

"Are you having any thoughts of harming yourself?"

[Note: This is critical - the weight gain may be causing significant distress and impacting self-esteem, which can worsen mental health. Screen sensitively but thoroughly.]

3. Past Medical, Drug, and Psychosocial History

Past medical history:

Psychosis/schizophrenia - when diagnosed, number of episodes, hospital admissions?

Any other conditions - thyroid problems, PCOS, diabetes, cardiovascular disease?

Medication history:

Risperidone - dose, duration, compliance

"Have there been any recent dose changes?"

"Have you tried other antipsychotics before? Which ones? Why were they changed?"

Any other medications - contraception, antidepressants, mood stabilisers?

OTC remedies, herbal supplements?

Family history:

Diabetes, cardiovascular disease, obesity, thyroid problems?

Social history:

Smoking, alcohol, recreational drug use?

Living situation, employment, support network?

Impact on daily functioning and quality of life?

Allergies

4. ICE

Ideas: "Do you have any thoughts about what might be causing the weight gain?" **Concerns:** "What is your biggest worry about this?" → "I feel like the medication is making me fat and I want to stop it"

Expectations: "What were you hoping we could do about it today?"

5. Examination

Weight, height, BMI - compare with baseline (pre-antipsychotic if available)

Waist circumference - central obesity is a key metabolic risk factor

Blood pressure and pulse

General inspection - acanthosis nigricans (neck, axillae), signs of Cushing's, thyroid

Cardiovascular - heart sounds if indicated

Abdominal examination - if clinically indicated

6. Investigations

Baseline metabolic screen (if not already done or overdue):

Fasting blood glucose and HbA1c - screen for diabetes/pre-diabetes

Fasting lipid profile - total cholesterol, LDL, HDL, triglycerides

U&Es, LFTs - renal and hepatic function

TFTs - rule out hypothyroidism as a contributing cause

Prolactin - risperidone commonly raises prolactin; check if not done recently

FBC - general health screen

ECG - if cardiovascular risk factors present or per SPC

Monitoring schedule (per NICE CG178 / Lester Tool):

Parameter	Baseline	1 month	3 months	6 months	12 months	Annually
Weight/BMI	✓	✓ weekly for first 6 weeks	✓	✓	✓	✓
Waist circumference	✓		✓		✓	✓
Blood pressure	✓		✓		✓	✓
Fasting glucose/HbA1c	✓		✓		✓	✓
Fasting lipids	✓		✓		✓	✓
Prolactin	✓				✓	✓

[Per NICE CG178: Monitor weight weekly for the first 6 weeks of a new antipsychotic. Rapid early weight gain (3–4 kg in the first 4 weeks) predicts severe long-term weight gain.]

7. Explanation

"Thank you for telling me all of this. I can completely understand how frustrating and upsetting the weight gain must be.

From what you've told me, the most likely cause of your weight gain is your medication - Risperidone.

This is a well-known side effect of this type of medication. It can increase your appetite and change the way your body processes sugars and fats, which leads to weight gain.

Risperidone is considered a **medium-risk** antipsychotic for weight gain - not the highest risk, but it can still cause significant changes, especially in the first few months of treatment.

I want to reassure you that this is something we take seriously. Weight gain isn't just cosmetic - it can increase your risk of developing diabetes, high cholesterol, and heart problems over time. So we need to address it properly.

The good news is there are several things we can do - and we don't necessarily have to stop your medication to improve things."

8. Management Plan

A. Lifestyle Interventions (First-Line)

Healthy eating programme:

Referral to a dietitian or NHS weight management service

Practical dietary advice - reduce sugary drinks, processed foods, increase fruit/vegetables, regular meals

"Small, sustainable changes work better than crash diets"

Physical activity programme:

Recommend 150 minutes of moderate activity per week (*per NICE PH53*)
 Suggest walking, swimming, cycling - whatever is enjoyable and sustainable
 Consider referral to exercise on prescription or local community programmes

Behavioural support:

Consider referral to the NHS Diabetes Prevention Programme if pre-diabetic
 Support groups for people on long-term mental health medication

B. Medication Review - Discuss with Psychiatry

Do NOT stop or change the antipsychotic in primary care without psychiatric input.

"I'd like to discuss your medication with your mental health team. We won't change anything without their guidance and your agreement."

Options the psychiatry team may consider (*per NICE CG178 1.3.6.3*):

Dose reduction - if clinically appropriate and symptoms remain controlled

Switching to a lower-risk antipsychotic - e.g., **aripiprazole** (considered weight-neutral and prolactin-sparing) or **lurasidone**

Switching should be done gradually with psychiatric supervision - never stop abruptly

[Note per NICE CG178: If the medication has distressing side effects, a different antipsychotic should be offered. A person should not be on more than one antipsychotic at a time except temporarily during a switch.]

C. Pharmacological Adjuncts (If Lifestyle Alone Insufficient)

Metformin - consider as adjunct for antipsychotic-induced weight gain:

Recommended when prescribing risperidone to patients with BMI >25 or ≥1 cardiometabolic risk factor

Also recommended if >3% body weight gain in the first year on any antipsychotic

Evidence shows average weight reduction of ~3 kg (range 2.5–4 kg) as add-on therapy

Starting dose: 500 mg OD, titrate to 500 mg BD–TDS as tolerated

Monitor renal function (eGFR) before starting and annually

[Note: Metformin for AIWG is off-label but supported by emerging UK and international consensus guidelines. Discuss with psychiatry/metabolic team.]

GLP-1 receptor agonists (e.g., liraglutide, semaglutide) - emerging evidence for antipsychotic-induced weight gain; currently not in routine UK guidelines for this indication but may be considered by specialists in obesity medicine

D. Managing Cardiovascular Risk

[Per NICE CG181 - Cardiovascular Disease Risk Assessment]

Calculate QRISK if aged ≥40 (or earlier if significant risk factors)

If dyslipidaemia identified - manage per NICE CG181 (consider statin therapy if 10-year QRISK ≥10%)

If pre-diabetes/diabetes - manage per NICE NG28 (Type 2 Diabetes)

If hypertension - manage per NICE NG136

9. Addressing the Patient's Concern

"I want to stop the medication"

"I completely understand why you feel that way - the weight gain is really affecting you, and that's valid. But I need to be honest with you: stopping your antipsychotic suddenly could be dangerous. It could cause your symptoms to return, and that could lead to a relapse or hospital admission."

What I'd like to do is work with your mental health team to find a solution that protects both your physical and mental health. That might mean adjusting the dose, or trying a different medication that's less likely to cause weight gain - like aripiprazole, which is considered more weight-neutral.

In the meantime, the lifestyle changes and possibly adding metformin can make a real difference. You don't have to choose between your mental health and your physical health - we can work on both."

10. Safety Netting

"If you notice any of the following, please come back or contact us urgently:"

Excessive thirst or passing urine very frequently (*diabetes symptoms*)

Chest pain, palpitations, or shortness of breath

Sudden worsening of mood - feeling very low, hopeless, or having thoughts of self-harm

Return of psychotic symptoms - hearing voices, feeling paranoid, unusual thoughts

Any new or worsening side effects from your medication

11. Follow-Up Plan

Bloods today: Fasting glucose, HbA1c, fasting lipids, TFTs, prolactin, U&Es, LFTs, FBC

Review results in 1-2 weeks

Refer to/discuss with psychiatry team regarding medication review

Refer to dietitian / NHS weight management programme

Weigh monthly for the next 3 months, then at least every 6 months

Repeat metabolic bloods at 3 months and then annually (*per Lester Tool*)

If metformin started - review in 4 weeks for tolerability and renal function

12. Leaflet + Final Check

Offer written information on antipsychotic side effects and healthy lifestyle

"Is there anything else on your mind you'd like to ask?"

"Would it be okay if I contact your mental health team to discuss your medication?"

Cat Bite - Animal Bite Sustained Abroad

Setting: Primary Care or Emergency Department **Patient:** Adult Patient **Presentation:** Animal Bite Sustained Abroad - Infection and Rabies Risk Assessment

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?"
- "Which country were you in when this happened?"
- "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?"

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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 history (to rabies-endemic area)
- **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, the country where this happened has rabies in animals - this is called a 'rabies-endemic area.'"

"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**
- **Do NOT suture animal bites** (risk of anaerobic infection) - leave wound open to heal by secondary intention
 - *Exception:* Facial wounds may be closed by specialists for cosmetic reasons after thorough debridement
- Dress the wound loosely
- Monitor for signs of local infection

B. Antibiotics

- **Co-amoxiclav 625 mg TDS**
 - **Prophylaxis (uninfected bite):** 3 days
 - **Treatment (infected bite):** 5 days
 - **Extend to 7 days** only if significant tissue destruction or penetration of bone/joint/tendon/vascular structures
- If penicillin allergy: **Doxycycline + Metronidazole**
 - *Note: Check pregnancy status before prescribing doxycycline*

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)

- RIgS: Rabies and Immunoglobulin Service (RIgS)

If **no prior rabies vaccination**:

1. **Human Rabies Immunoglobulin (HRIG)** - infiltrated around wound
 - *Note: June 2025 interim HRIG guidance issued - Monoclonal Antibodies (mAbs) are increasingly preferred over HRIG due to supply/safety. Contact RIgS to determine appropriate treatment.*
2. **Rabies Vaccine** - IM into deltoid at:
 - **Day 0, 3, 7, and 21** (4 doses for immunocompetent - UK schedule)

If **previous rabies pre-exposure vaccine**:

- No HRIG needed
- Give **Rabies Vaccine on Day 0 and Day 3** only

If **immunocompromised**:

- May need 5 doses (Day 0, 3, 7, 14, 28-30) + HRIG
- "If you have any conditions affecting your immune system, please let us know as we may need to give you an extra vaccine dose."

9. Public Health Notification

- **Inform UKHSA** 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"

"Please stay nearby for 15–30 minutes after the injection. If you feel faint, dizzy, or unwell, let us know straight away."

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 a rabies-endemic area. 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. Note made of June 2025 interim HRIG guidance and immunocompromised patient schedule. Public health authorities were informed, and follow-up arranged. Full patient education, safety netting, and documentation provided.

Antibiotic-Associated Diarrhoea After Dog Bite

Setting: Primary Care / Urgent Care **Patient:** Adult **Presentation:** Antibiotic-Associated Gastrointestinal Symptoms Following Animal Bite Treatment

1. Introduction & Consent

"Hello, I'm 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."
- "I'm sorry if that information wasn't shared clearly - it's something that should be mentioned when prescribing these antibiotics."

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? (Review NSAIDs, ACE inhibitors, diuretics - may need stopping if dehydrated)
- **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 allergic reaction - it's a **known side effect** that can happen because antibiotics don't just kill the harmful bacteria, they can also disrupt the friendly bacteria in your gut. The imbalance 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
- **Hydration Advice:**
 - Drink plenty of fluids and consider **oral rehydration salts**
 - Eat light, bland meals (e.g. bananas, toast, rice)
- **Important - Do NOT use anti-motility drugs:**

- "We won't give you anything to stop the diarrhoea like loperamide - these can make things worse in antibiotic-associated diarrhoea."
- **Probiotics guidance:**
 - "You might have heard about probiotics - current evidence doesn't support using them to prevent or treat this type of diarrhoea, so we don't recommend them."
- **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
- **Review and stop other medications if dehydrated** (NSAIDs, ACE inhibitors, diuretics)
- **Seek microbiology/ID input** for further antibiotic guidance
- **Start oral vancomycin 125 mg QDS for 10 days** - per NICE NG199:
 - If C. difficile **confirmed**: start vancomycin (first-line)
 - If C. difficile **strongly suspected AND patient unwell**: discuss urgently with microbiology/ID and **consider starting treatment before confirmation**
- **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?" "I'm sorry if that information wasn't shared clearly - it's something that should be mentioned when prescribing these antibiotics."
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."

Student Note: Adult patient presented with watery diarrhoea following co-amoxiclav for dog bite. No red flags or signs of severe infection. Diagnosis: antibiotic-associated diarrhoea. Management per NICE NG199: hydration, stool sample, avoid anti-motility drugs (loperamide contraindicated), probiotics not recommended. If *C. difficile* confirmed or strongly suspected (and patient unwell), oral vancomycin is first-line - treatment can be started before confirmation after discussion with microbiology/ID. Medication review emphasized (stop NSAIDs/ACE-I/diuretics if dehydrated). Patient education, infection control advice, and safety netting provided.

Citalopram-Induced Hyponatraemia

Setting: Primary Care **Station Type:** Test Result Discussion **Patient:** Older Adult **Presentation:** Fatigue with Abnormal Blood Results (Electrolyte Disturbance) Following Recent Antidepressant Initiation

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 older adults, those on diuretics, and in the first few weeks of treatment."

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 give you fluids through a drip to gently raise your sodium levels."
- "The hospital will correct your sodium slowly - We aim to raise sodium by no more than 10 mmol/L in the first 24 hours and no more than 8 mmol/L in each subsequent 24-hour period - going faster risks serious brain damage (osmotic demyelination syndrome)."
- "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 change your antidepressant to one that's safer for your sodium levels - the good news is there are several good alternatives."
- "A common choice is **mirtazapine**, which is often well-tolerated in older adults, or we can discuss other options like nortriptyline - we'll discuss which suits you best."

Note: TCAs like amitriptyline have significant anticholinergic burden in elderly (confusion, falls, constipation, urinary retention) - mirtazapine often preferred as first alternative.

Note: Important MHRA Safety Note: Citalopram causes dose-dependent QT interval prolongation. The MHRA restricts the maximum dose to 20mg/day in patients over 65 years of age (and those with hepatic impairment).

Before starting citalopram in elderly patients, consider baseline ECG. When switching to an alternative antidepressant, check that the original citalopram dose was within the MHRA limit.

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: Older adult patient was started on Citalopram 6 weeks ago for depression. She presented with fatigue and was found to have **moderate hyponatraemia ($\text{Na}^+ 128$)**. 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 (max 8-10 mmol/L/24hr to avoid osmotic demyelination). Alternative antidepressant: **mirtazapine preferred** over amitriptyline due to lower anticholinergic burden in elderly. Follow-up and safety netting arranged.

Chronic Fatigue Syndrome

Setting: Primary Care **Patient:** Adult **Presentation:** Persistent Fatigue Unrelieved by Rest

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 these symptoms have lasted more than **3 months**, aren't relieved by rest, and actually get worse after activity - this may be a condition called **Chronic Fatigue Syndrome**, also known as **Myalgic Encephalomyelitis** or **ME**."

"For a diagnosis of ME/CFS, we look for four key features: **debilitating fatigue**, **symptoms that get worse after physical or mental effort** (called post-exertional malaise), **sleep that doesn't refresh you**, and **difficulty with concentration or memory**."

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."

"It's often triggered after an infection - many patients describe feeling like they never fully recovered from a virus."

"It's what we call a **functional condition** - which means it's absolutely real and can be very disabling, even though standard scans and blood tests often come back normal."

"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 ME/CFS team** who can confirm the diagnosis and guide your treatment plan."

Note: Referral should be to ME/CFS specialist team, not specifically rheumatology (per NICE NG206).

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 to support management, not as treatment or cure - per NICE NG206)

Important: Graded Exercise Therapy (GET) should NOT be offered (per NICE NG206).

D. Vitamins

"Some people ask about vitamin supplements or special diets - there's no evidence these help ME/CFS specifically, though we'll check your vitamin levels aren't low. If we do find a deficiency and correcting it resolves your 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 ME/CFS team."
- "In the meantime, if you'd like to read more, I'll give you a leaflet and a reliable website."

Student Note: Patient presents with >3 months of fatigue (NICE NG206 reduced the diagnostic threshold from 4 months under the previous CG53 guideline to 3 months) not relieved by rest, worsened by exercise (post-exertional malaise is mandatory criterion), 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 ME/CFS team** (not rheumatologist), and **supportive therapy**. GET not offered per NICE NG206. Vitamin deficiencies will be tested, not presumed.

Vitamin D Deficiency - Test Result

Setting: Primary Care **Station Type:** Test Result Discussion **Patient:** Middle-Aged Adult **Presentation:** Fatigue and Constipation with Family History of Thyroid Disease **Test Results:** Available at Station

1. Introduction & Consent

"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 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."

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?"
- "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?"

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:** 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 quite low - it's 14 nmol/L**, which is well below the normal level of 50 or above. This is what we'd call **severely deficient**."

Note: NICE CKS uses <25 nmol/L for deficiency, 25-50 nmol/L for insufficiency, >50 nmol/L for sufficiency.

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. This is a prescription dose - much higher than what you'd buy in a shop - but it's safe and needed to bring your levels up quickly."

A. Vitamin D Supplementation

- "You'll take **50,000 units once a week for 6 weeks** - this is the high loading dose."
- "After that, you can continue with an **over-the-counter vitamin D supplement** - 800 to 2000 units daily - which is available from pharmacies or supermarkets."

B. Lifestyle Advice

- "Try to get **10-15 minutes of safe sunlight exposure per day** when possible, especially in summer."
- "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."

"We don't routinely need to retest if your symptoms improve. However, for severe deficiency like yours, we may recheck at around 3 months to confirm your levels have risen. If symptoms persist, we will definitely retest."

***Student Note:** 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 nmol/L - NICE defines <25 as deficient). 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 800-2000 IU maintenance** (can be purchased OTC). Routine retesting not needed per NICE CKS unless symptoms persist. Safety netting and follow-up arranged.*

Septic Arthritis

Setting: Primary Care / Urgent Care **Patient:** Older Adult with Diabetes **Presentation:** Acute Monoarthritis with Systemic Features **History:** Previous Crystal Arthropathy in Different Joint **Observations:** Tachycardia, Pyrexia (Provided at Station)

Introduction

Independent educational content based on publicly available UK clinical guidelines.
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"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."

- Site - Is the pain located in just one knee or does it affect both?
- Onset - When did the pain start? Was it sudden or gradual?
- Character - How would you describe the pain - sharp, throbbing, constant?
- Radiation - Does the pain move anywhere else?
- Associated symptoms - Any swelling, redness, warmth, stiffness, or fever?
- Timing - Is the pain always there or does it come and go?
- Exacerbating/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

"I know this might feel unexpected, but I want to be honest with you about what I'm seeing."

"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

FY2 Role in Primary Care/Urgent Care: Your job is to **recognise this emergency and arrange urgent transfer** - do NOT delay by attempting aspiration or starting antibiotics in the community. Call ahead to the hospital so they are prepared.

"Joint infections are a medical emergency - but the good news is, when we catch them early and treat them quickly, people usually do very well. Here's what we need to do:"

- **Urgent hospital admission** (same-day, ideally within hours)
 - "You'll need to go to hospital straight away so they can confirm the diagnosis and start treatment."
 - **Phone the medical/orthopaedic registrar** to handover directly
- **Joint aspiration** (in hospital - NOT in primary care)
 - "It's really important that the hospital takes fluid from your joint before starting antibiotics - this helps us identify the exact germ and choose the right treatment."
 - Also to check for crystals (to rule out gout or pseudogout)
 - *Aspiration should be performed by orthopaedics or experienced medical team*
- **Baseline imaging**
 - "They'll likely do an X-ray of your knee as a baseline, and possibly a scan if they need more detail."
- **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:

"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."

"Joint infections can be very serious if not treated quickly - that's why we're sending you straight to hospital today."

"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
- Baseline X-ray mentioned per BSR guidelines
- Hospital referral is mandatory
- 11% case fatality rate emphasizes urgency

Frontotemporal Dementia (FTD)

Setting: Primary Care / Memory Clinic **Patient:** Older Adult (Present) **Accompanying:** Family Member/Carer **Presentation:** Gradual Personality and Behavioural Changes **Station Focus:** Collateral History and Initial Management Discussion

Introduction & Rapport Building

- Greet the caregiver respectfully and introduce yourself: "Hello, I'm 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, mixing 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."
- (*IPS tip for relatives who confuse with Alzheimer's*): "This type of dementia **changes who he is** before it **changes what he knows**."
- "These changes are caused by the illness affecting their brain - they're not choosing to behave this way, and it's not about being difficult or not trying."
- "Caring for someone with this condition can be incredibly hard - both emotionally and practically - and it's completely understandable if you're feeling overwhelmed."
- "There isn't a specific medication to slow down this type of dementia, but there's a lot we can do to support both your [family member] and you through this."

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

Note: NICE cautions against antipsychotics in dementia unless significant distress or risk is present.

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** - "It's important to think about advance planning while your [family member] still has capacity to make decisions about their future care."
- **Driving status - MUST notify DVLA**: "You must inform the DVLA about this diagnosis - this is a legal requirement. The DVLA will then decide whether driving can continue, usually based on a medical assessment. In some cases, the licence may be revoked, but in early-stage dementia, a person may retain their licence subject to annual review. However, with FTD specifically, impaired impulse control and judgement often make driving particularly unsafe, and many patients will need to stop driving soon after diagnosis."
- 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)

Setting: Primary Care **Patient:** Adult **Presentation:** Repetitive Behaviours Causing Distress **Station**

Focus: Mental Health Assessment and Management Discussion

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 getting out of the house, work, 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?"

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 - family or friends?
- **H** - Any history of hallucinations or feeling paranoid?

6. MAFTOSA + LMP

- **Allergies:** Any known allergies?
- **Function:** Current daily activities and responsibilities
- **Travel:** Any recent travel?
- **Occupation:** Current work or role?
- **Smoking/Alcohol:** Habits?
- **LMP:** "When was your last period?" (if applicable - 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 life?"
- "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."

"It's more common than you might think - about 1 in 50 people experience OCD at some point - and there are very effective treatments available."

10. Management Plan

Stepped Care Model (per NICE CG31)

Step 1 - Guided Self-Help (First-Line for Mild to Moderate)

- "We usually start with **guided self-help** - using workbooks or online programs with support from a therapist - and if that's not enough, we move to more intensive therapy."
- "For mild to moderate OCD, guided self-help uses CBT principles but in a less intensive format."

Step 2 - Cognitive Behavioural Therapy with ERP

- "If guided self-help isn't effective after about 4 weeks, 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 - fluoxetine, fluvoxamine, paroxetine, sertraline, or citalopram."
- "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."
- "If we do use medication, we sometimes need higher doses than we'd use for depression - we'd start low and increase gradually."

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:** 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 supported by history and impact on function, per NICE OCD diagnostic framework. Management follows NICE CG31 stepped care model with guided self-help as first-line option.*

Confusion in Elderly - Hyponatraemia & Suspected Renal Failure

Setting: Acute Medical Unit **Patient:** Older Adult **Accompanying:** Family Member **Presentation:** Acute Confusion **Pre-Station Data:** Abnormal Blood Results (Electrolyte and Renal Function Abnormalities) **Background:** Long-term Antihypertensive Medication

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 his blood pressure medication?"

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 the level of sodium - one of the important salts in the blood - is too low. The brain is very sensitive to sodium levels, which is why your father has become confused."

"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

FY2 Role on AMU: Initiate workup and management as below, but **discuss with medical registrar on admission** - hyponatraemia with AKI requires senior oversight for safe sodium correction and medication management.

Hospital Admission

- "We're going to admit him to monitor and treat him closely."

Correcting Sodium

- "We'll treat the low sodium with controlled IV fluids - in some cases a special concentrated salt solution through a drip - but we do this very gradually and carefully."
- **Correction rate limits:**
 - First 24 hours: ≤ 10 mmol/L
 - Each subsequent 24 hours: ≤ 8 mmol/L
 - *More conservative targets in high-risk patients (chronic hyponatraemia, malnutrition, alcoholism, hypokalaemia)*
- "We'll check sodium levels every 4–6 hours while correcting, to make sure we're not going too fast."
- *If severe (<120 mmol/L) or symptomatic (seizures, reduced GCS): escalate to registrar/ITU*

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."
- **Check potassium urgently** - hyperkalaemia is a rapid killer in ACE-I + AKI patients
- *If $K^+ > 6.5$ or ECG changes: treat as emergency and escalate immediately*

Sick Day Rules (for future) - "SADMANS"

- "For future reference: if your father becomes unwell with vomiting, diarrhoea, or fever, he should temporarily stop these medications and contact his GP:"
 - **S** - SGLT2 inhibitors (e.g., dapagliflozin, empagliflozin) - risk of euglycaemic DKA
 - **A** - ACE inhibitors (e.g., ramipril, enalapril) - risk of AKI
 - **D** - Diuretics (e.g., furosemide, bendroflumethiazide) - risk of AKI
 - **M** - Metformin - risk of lactic acidosis
 - **A** - ARBs (e.g., losartan, candesartan) - risk of AKI
 - **N** - NSAIDs (e.g., ibuprofen, naproxen) - risk of AKI
 - **S** - Sulfonylureas (e.g., gliclazide) - risk of hypoglycaemia

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?"

***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 explains the altered mental status. Sodium correction rate limited to **8-10 mmol/L/24hr** to prevent osmotic demyelination. Further nephrology input essential to determine reversibility, assess CKD stage, and rule out obstructive or secondary causes.*

Hyponatraemia due to SIADH (Suspected Lung Cancer)

Setting: Primary Care **Station Type:** Test Result Discussion **Patient:** Older Adult with Chronic Respiratory Disease **Risk Factors:** Current Smoker **Presentation:** Fatigue **Results:** Available at Station (Severe Electrolyte Abnormality)

1. Introduction & Consent

"Hello, I'm 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 recently?"
- "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.

Warning Shot:

"I'm afraid I have some concerning news from your blood tests that I need to discuss with you. Is it okay if we talk through this together?"

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

FY2 Role in Primary Care: This patient requires **same-day hospital admission**. Discuss with your GP supervisor/senior partner before the patient leaves - this is a potential lung cancer presentation with dangerous hyponatraemia. Do not manage in the community.

Hospital Referral (Urgent - Same Day)

- "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."
- **Phone the medical registrar** to arrange direct admission - do not send via A&E if avoidable

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 PET scan or a biopsy
 - Blood and sputum tests"
- "Given your symptoms and smoking history, I'd like to arrange an urgent chest X-ray - ideally within the next two weeks."
- **Initiate 2WW lung cancer referral** if not already admitted
- "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

Student Note: Older adult 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**. Warning shot provided before delivering concerning diagnosis. Urgent hospital referral and 2WW pathway initiated.

Bulimia Nervosa - Electrolyte Disturbance - Test Results

Setting: Primary Care Station **Type:** Test Result Discussion **Patient:** Young Adult **Presentation:** Fatigue with Abnormal Electrolyte Results **Background:** To Be Explored During Consultation

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?"

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- "Have you ever noticed any blood in the vomit?" (Screens for Mallory-Weiss tear - important safety question)
- "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 Sick because you feel uncomfortably full?"
- "Do you feel you lose Control over how much you eat?"
- "Have you lost more than One stone (14 pounds) in a 3-month period?"
- "Do you believe yourself to be Fat 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)

3. 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)

4. 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?"

5. Clear Result Disclosure

"Thank you for being honest with me about what's been happening - I know that wasn't easy to share."

"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."

6. Lay Explanation of the Condition

"Based on what you've shared - especially about inducing vomiting to manage your weight - this may point to a condition called **bulimia nervosa**."

"Bulimia is an eating disorder that involves cycles of eating and then trying to prevent weight gain - it's more common than people realize, and it's absolutely treatable."

"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."

7. 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**."

- "We usually start with **bulimia-focused guided self-help** - working through a structured program with support from a therapist."
- "If that's not enough after 4 weeks or so, you'll be offered **Cognitive Behavioural Therapy** specifically designed for eating disorders (CBT-ED) - typically up to 20 sessions over 20 weeks."
- "They can also provide advice from dietitians and a safe space to talk through your experience."

Physical Health Monitoring

- "We'll need to monitor your bloods regularly while you're in treatment."
- **ECG required** - hypokalaemia can cause dangerous heart rhythm changes
- **Urgent admission criteria:** severe hypokalaemia (<2.5 mmol/L), syncope, palpitations/arrhythmia, significant dehydration, or abnormal ECG

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."

Dental Health Advice

"Vomiting can damage your teeth over time because of the acid. Here's some important advice:

- **See your dentist regularly** - let them know about this so they can monitor your enamel
- **Do NOT brush your teeth immediately after vomiting** - the enamel is soft and will strip away
- Instead, **rinse with water or fluoride mouthwash** and wait at least 30 minutes before brushing"

8. 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."

9. 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"

10. 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?"

"I can also give you details for **Beat**, which is a charity that supports people with eating disorders."

"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: 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. Management follows NICE NG69 stepped care: guided self-help first, then CBT-ED if needed. Insight present, no current suicidality.

SIADH Secondary to Infection - Elderly Confusion

Setting: Acute Medical Ward **Patient:** Older Adult (Present) **Accompanying:** Family Member (Concerned) **Presentation:** Acute Confusion with Abnormal Blood Results **Background:** Recent Viral Illness, Current Medications Include Antidepressant and Diuretic **Investigations:** CT Head Normal, Inflammatory Markers Elevated, Electrolyte Abnormality (Results Provided)

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 the scan was normal - she's not having a stroke, and there's no bleeding or other acute problem in her brain."

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"

Critical - Sodium Correction Rate

"We aim to raise her sodium by no more than **8-10 points per day** - going faster can cause serious damage to the brain's protective covering, a condition called osmotic demyelination syndrome. That's why we're so careful about the speed of correction."

"We'll check her sodium levels **every 4-6 hours** while correcting, to make sure we're not going too fast."

Fluid Restriction

"We may also need to restrict how much fluid she drinks to help her sodium levels recover - this is a standard part of treating this condition."

Medication Review

"We'll review her regular medications as well:

- **Change her antidepressant** to one that's less likely to affect sodium. Options include **mirtazapine** - which is often well tolerated in older adults - or possibly a low-dose tricyclic, depending on her other medical conditions. The hospital team will discuss the best choice.
- **Stop the thiazide diuretic** - which can contribute to low sodium - and switch to a different type of blood pressure medication that doesn't affect sodium levels, such as **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"

Discharge Planning

"Before she goes home, we'll make sure her new medications are sorted and she has a follow-up appointment. We'll also send a letter to her GP explaining the changes."

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: Older adult 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**. SIADH diagnosis requires: euvoemia (no signs of dehydration or fluid overload), serum osmolality <275 mOsm/kg, urine osmolality >100 mOsm/kg (inappropriately concentrated), urine sodium >30 mmol/L, and normal thyroid and adrenal function.

Sodium correction initiated with strict rate limits: **≤ 10 mmol/L in first 24hr, then ≤ 8 mmol/L per 24hr thereafter** (more conservative in high-risk patients) to prevent osmotic demyelination syndrome. Sodium checked every 4-6 hours during correction. Fluid restriction may be required.

Medication review: switch citalopram to **mirtazapine** (preferred in elderly due to lower anticholinergic burden compared to TCAs like amitriptyline); switch thiazide to **amlodipine** (CCB doesn't affect sodium).

Buprenorphine Patch Refill Request

Setting: Primary Care

Patient: Middle-aged Adult

Presenting Complaint: Request for continuation of opioid analgesia for chronic back pain with no acute pain

1. Introduction

"Hello, I'm Dr _____, one of the GPs here today. Can I just confirm your full name and age, please?"

"I understand you've come in because the pharmacy couldn't issue your back pain patch - is that right?"

"Thank you. Would it be okay if I ask you a few questions to understand what's going on, and then we'll decide together what to do next?"

2. Focused History

A. Background of Condition

- "Can you tell me more about your back problem - when did it start?"
- "Was it due to an injury or accident?"
- "Were you seen by a specialist or had any scans?"

Patient confirms traumatic disc prolapse 3 years ago, reviewed by specialist. No surgery needed.

B. Previous and Current Treatment

- "What medicines were tried first?"

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- "Who prescribed the patch - was it your GP or hospital team?"
- "How often do you use the patch?"
- "Is it helping you now?"

Initially on naproxen (ineffective), switched to buprenorphine patch with good relief.

C. Current Symptoms

- "Do you have any back pain currently?"
- "Any numbness, tingling, or weakness in your legs?"
- "Any difficulty passing urine or opening bowels?"
- "Any issues walking or doing your daily tasks?"
- "Any fevers, weight loss, or night sweats?"

Patient is completely asymptomatic.

D. Usage Pattern

- "Do you follow the patch schedule exactly as prescribed?"
- "Have you needed to change them more frequently?"
- "Do you have any patches left now?"

Unclear - possibility of early refill suspected.

E. Side Effects or Dependence

- "Any drowsiness, confusion, or skin issues from the patch?"
- "Do you feel like you rely on it or fear stopping it?"

ICE

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

Patient believes he still needs the patch and expects repeat to be issued.

Examination

"I would like to examine your back and check for any signs of nerve pressure - would that be alright?"
(If examiner declines, proceed.)

Diagnosis

Resolved traumatic disc prolapse with no current symptoms

Patient is requesting ongoing **opioid patch** despite being pain-free

Explanation

"So, from what you've told me, you had a slipped disc in your lower back some time ago - that means one of the soft cushions between your back bones moved out of place and pressed on a nerve, causing pain.

The patch you're using - buprenorphine - is a strong painkiller. It sticks on the skin and slowly releases medicine to block pain signals going to the brain.

It's great that it worked well and you've been pain-free for a while.

But because it's a strong medicine, if used for too long, the body can get used to it. That means it might stop working as well, or you might need higher doses, and it can also lead to dependence over time.

That's why, now that you're better, we usually review whether you still need it - and if not, we plan to slowly reduce and stop it safely."

Buprenorphine-Specific Information:

"Buprenorphine patches have a lower risk of misuse compared to other strong opioids and cause less physical dependence, making them easier to withdraw from. However, like all opioids, they should be regularly reviewed for continued benefit."

Management Plan

A. If Patch Use is On Time (No Overuse)

- **Issue repeat prescription - short-term only** (e.g., 1 week's supply)
- Update EMIS prescription schedule to match correct interval (e.g., 7-day supply, no early repeats)
- **Book opioid medication review** within 4 weeks to assess need for continuation

IMPORTANT - Brand Prescribing: Buprenorphine patches should be prescribed by brand name (e.g., BuTrans, Butec, Hapoctasin) as different brands have different durations of action (72-hour, 96-hour, or 7-day).

B. If Early Refill or Misuse Suspected

- **Do not prescribe immediately**
- Explain:

"The pharmacy noticed this prescription came through a bit earlier than expected. I'm not assuming anything is wrong - there could be a good reason - but I want to make sure we're using this medication safely. Can we have a chat about how things have been going?"

- Book review in 1-2 weeks and explore:
 - Whether patch can be tapered
 - Whether the patient is dependent

C. Long-Term Strategy

- Arrange **opioid reduction plan** if patient is now asymptomatic
Gradual reduction: e.g., lower dose patch or increase duration between changes (10% reduction every 1-4 weeks per FPM guidance)

FY2 Note: Opioid prescribing decisions should be discussed with GP supervisor. Complex opioid tapering requires pain management team guidance - do not undertake unsupervised.

- Offer referral to **pain management team** if complex withdrawal or long-term needs
- Offer safer alternatives (if any pain returns):
 - Short NSAID course (if tolerated)
 - Simple analgesics (e.g., paracetamol)
 - **Back exercise programs**, posture therapy
- Encourage **activity-based recovery** per NICE guidance

Heat Warning: "Avoid applying heat (hot water bottles, electric blankets) over the patch - heat increases drug absorption and can cause overdose."

Safety Netting

"If you develop any new pain, numbness, leg weakness, or changes in your bladder or bowel habits, please contact us urgently or go to A&E.

Also, let us know if you experience any side effects from the patch like confusion, drowsiness, or trouble breathing."

Follow-Up Plan

- GP review in **4 weeks** (or sooner if concerns)
- Monitor EMIS record for pattern of early refill
- If opioid continuation is still requested:
 - Justify ongoing need
 - Refer to pain team for shared care
 - Begin taper if appropriate

Leaflet & Final Check

- Offer NHS leaflet:
 - "Managing Long-Term Pain Without Opioids"
 - "Buprenorphine Patch - Safe Use Guide"
- Final check:

"Does everything I've said make sense?"

"Do you have any questions or anything you'd like me to go over again?"

Hypercalcaemia - Non-PTH - Test Result Discussion

Companion to Volume 1: Chapter 8 case - Primary Hyperparathyroidism (Scenario 1 = raised PTH).

This is Scenario 2 = normal PTH.

Setting: Primary Care | 60-Year-Old Female | Follow-Up Blood Results Consultation | Hypercalcaemia with Normal PTH

Patient: 60-year-old lady. GP follow-up for blood results.

Key Information:

Corrected Ca: 3.0 mmol/L (raised)

PTH: Normal (or not done yet)

PC: Tiredness for months

Associated symptoms: Muscle/joint pain, polyuria, dyspepsia

PMH: Takes Vitamin D tablets, calcium tablets, and drinks a lot of milk

Concerns: "Is the milk causing this?"

1. Introduction & Consent

"Good morning. I'm one of the doctors here at the surgery. Before we start, could I just confirm your full name and date of birth, please?"

Thanks for confirming. I understand you've come in today to go over the blood tests we arranged. If it's alright with you, I'll first ask a few follow-up questions about how you've been feeling, and then I'll explain what we found and what we'll do next. Does that sound okay?"

2. Focused History - Data Gathering

Presenting complaint: "Can I ask - what prompted us to arrange these blood tests?" → Patient: "I've been feeling tired for months."

Explore the tiredness (ODIPARA):

"When did the tiredness start? Has it been getting worse?"

"Does it affect your work, home life, or daily activities?"

"Is it there all the time, or does it come and go?"

Screen for classical features of hypercalcaemia - Bones, Stones, Groans, Thrones, Moans:

Bones: "Have you had any bone or joint pain? Any muscle weakness?"

Stones: "Have you ever had kidney stones? Any loin pain or blood in your urine?"

Groans: "Any abdominal pain, nausea, vomiting, or constipation?"

Thrones: "Have you been passing urine more often than usual? Are you more thirsty than normal?"

Moans: "Have you felt low in mood, anxious, or confused? Any difficulty concentrating or memory problems?"

Additional symptoms:

"Any loss of appetite or unintentional weight loss?"

"Any dyspepsia or heartburn?" (*patient has dyspepsia*)

Closed questions - confirm key features:

Corrected Ca: 3.0 ✓

PTH: Normal ✓

Vitamin D supplements ✓

Calcium supplements ✓

High dairy intake (lots of milk) ✓

General questions:

"Do you take any other medications regularly?" (*check for thiazide diuretics, lithium, ACE inhibitors*)

"Any past medical history - including thyroid problems?"

"Any recent blood tests or illnesses?"

"Does anyone in your family have calcium or hormone problems?"

"Do you smoke or drink alcohol?"

Impact on life:

"How is this affecting your work?"

"How is it affecting your home life and relationships?"

"How has your mood been overall?"

3. Explore ICE

Ideas: "Have you had any thoughts about what might be causing these symptoms?" Concerns: "Is there anything specific you're worried about?" → "*Is the milk causing this?*" Expectations: "Were you hoping the blood tests would explain your tiredness?"

4. Examination

Vitals: HR, BP, temperature

Abdomen: tenderness, masses

Limbs: bone tenderness, muscle weakness

General: hydration status, mental state

5. Investigations

Corrected calcium - already done: 3.0 mmol/L (raised)

PTH - already done or to be arranged: normal → this rules out primary hyperparathyroidism

Vitamin D levels - to assess if excess supplementation is contributing

Phosphate - typically low in PTH-mediated, may be normal/high in non-PTH causes

U&E, eGFR - assess renal function (hypercalcaemia can cause renal impairment)

LFTs, albumin - to confirm corrected calcium calculation

FBC - screen for haematological malignancy

Thyroid function - hyperthyroidism can cause hypercalcaemia

Myeloma screen - serum protein electrophoresis, Bence Jones protein (urine)

24-hour urinary calcium - to rule out familial hypocalciuric hypercalcaemia (FHH)

CXR - if malignancy or sarcoidosis suspected

ECG - hypercalcaemia can cause shortened QT interval, arrhythmias

[Note: With normal PTH and raised calcium, the main differential is: Vitamin D/calcium supplement excess (milk-alkali syndrome), malignancy (PTHrP-secreting tumours), sarcoidosis/granulomatous disease, thyrotoxicosis, or myeloma.]

6. Patient Explanation

If Ca <3.0 mmol/L and No Symptoms:

"Your blood test shows that the level of calcium in your blood is higher than the recommended range.

This can be caused by the extra Vitamin D and calcium tablets you are taking, and the large amount of milk in your diet.

Because you're not feeling particularly unwell and your calcium is only mildly raised, what I'd like to do is:

Stop the Vitamin D and calcium supplements for now

Ask you to drink 2–3 litres of water a day to help flush the calcium out

Recheck your levels in a few weeks to see if they return to normal

If your symptoms persist or your calcium remains high, we'll investigate further."

If Ca ≥3.0 and Symptomatic (This Patient):

"Your blood test confirms that your calcium level is 3.0, which is high. Because you are already feeling very tired and unwell, we cannot treat this safely at home.

High calcium can cause dehydration and affect your heart. I need to refer you to the hospital today so they can give you fluids through a drip to bring the level down safely."

If Ca >3.5 or Severe Symptoms (Confusion, Vomiting):

"Your calcium level is dangerously high. This needs emergency treatment in hospital with intravenous fluids and further assessment. I will arrange an emergency admission now."

[Per Society for Endocrinology Emergency Guidance: Ca >3.5 mmol/L = significant risk of cardiac arrest → urgent correction required.]

7. Management - By Severity

A. If Ca ≥3.0 and Symptomatic (This Patient)

What the patient can do:

Hydration: Aim to drink 2–3 litres of water a day to help flush the calcium out

What the doctor can offer - Hospital Management:

Urgent same-day referral to the Medical Assessment Unit (MAU)

IV rehydration: Hospital will start 0.9% Normal Saline (usually 3–4 litres in 24 hours)

IV bisphosphonate therapy (e.g., IV zoledronic acid 4 mg over 15 minutes, or IV pamidronate) - once rehydrated

Medication cessation: Advise the hospital team to hold thiazide diuretics (if on any) and stop Vitamin D and calcium supplements

Monitoring: ECG monitoring because $\text{Ca} \geq 3.0$ risks arrhythmias

[Per NICE CKS: Corrected calcium ≥ 3.0 mmol/L with symptoms → prompt hospital admission for IV fluids and IV bisphosphonate. Rehydration is always the first step before bisphosphonates.]

B. If $\text{Ca} > 2.6$ but < 3.0 and No Symptoms

Make a full clinical assessment and arrange initial investigations to establish the probable cause

Stop calcium and Vitamin D supplements

Refer to the appropriate specialist depending on the clinical picture - unless a correctable cause is found (e.g., stopping supplements normalises calcium)

Prompt treatment with the appropriate specialist will usually be required

C. If $\text{Ca} > 3.5$ or Severe Symptoms

Emergency hospital admission - arrange emergency ambulance

IV fluids and IV bisphosphonate therapy in hospital

Further specialist assessment and management such as IV calcitonin if refractory

8. Addressing the Patient's Concern

"Is it because of the milk?"

"That's a really good question. It's not immediately dangerous, but it's important we investigate further.

Your bones, kidneys, and energy levels - they all depend on calcium staying in the right range.

The good news is it's very treatable. The calcium and Vitamin D supplements you are taking, combined with the large amount of milk, could well be the main cause - this is sometimes called 'milk-alkali syndrome.' However, we need to rule out other causes first with some further tests.

The raised parathyroid hormone is the key here - and because yours is normal, it usually means one of the glands is NOT overactive. This actually points more towards something like excess intake or another cause, which is why we need to investigate."

9. Safety Netting

"If you start feeling more unwell - for example, if you feel very confused, develop severe tummy pain, can't keep fluids down, or feel your heart racing - please call 999 immediately or go straight to A&E, as very high calcium can be dangerous."

"If your levels remain high after stopping supplements, or if new symptoms develop, we will investigate further - including ruling out other causes."

10. Follow-Up & Patient Support

Follow-up: You will need a repeat calcium, PTH, and Vitamin D level in 2 weeks after stopping supplements

Cardiac monitoring: Continue ECG monitoring because Ca level is 3.0

Safety netting: If you feel dizzy, develop chest pain, or vomit before you reach the hospital, call 999 immediately

If levels remain high (> 2.6) or symptoms worsen despite stopping supplements → hospital admission for IV fluids may be needed

Leaflet/resources: NHS leaflet on hypercalcaemia. Follow-up in 2 weeks.

How This Differs from Volume 1 Chapter 8 - Primary Hyperparathyroidism

Feature	Volume 1: Primary Hyperparathyroidism	This Case: Non-PTH Hypercalcaemia
PTH level	Raised	Normal (or not done yet)
Cause	Overactive parathyroid gland	Excess Vit D + calcium supplements + high dairy (milk-alkali syndrome), or malignancy, sarcoidosis, myeloma
Key investigation	Neck USS/sestamibi scan, DEXA	Myeloma screen, CXR, Vit D levels, 24-hr urinary calcium
Definitive treatment	Parathyroidectomy	Stop supplements, hydration, treat underlying cause
Medical treatment	Cinacalcet (if surgery unsuitable)	IV fluids + IV bisphosphonate (if severe)
Specialist referral	Endocrinology	Depends on cause - endocrinology, oncology, or haematology
Patient concern	"How long will I feel like this?"	"Is the milk causing this?"
Prognosis	Excellent post-surgery	Depends on underlying cause - if supplement-related, resolves after stopping

Chapter 26: Teaching

A Note to Learners

The cases in this resource are written in a conversational style to help you become familiar with the natural flow of clinical consultations and the language commonly used in UK healthcare settings.

These dialogues are intended as a learning guide, not a script. Please do not attempt to memorise them verbatim. Examiners assess your ability to think and communicate authentically - not to recite rehearsed phrases.

Use this material to understand the underlying clinical reasoning, then practise in your own words until the consultation feels natural to you.

For Companion OSCE Cases, Practice Scripts, Evaluation Checklists, Summary Notes, Rapid Review Notes, Mindmaps, Management Flashcards and Image Library - visit <https://www.gksplab2.com>

Disclaimer

This material is independent educational content created to help candidates develop clinical reasoning and communication skills for UK medical practice.

All cases and clinical scenarios are based on common presentations encountered in UK primary care and emergency medicine, drawn from publicly available sources including NICE Clinical Knowledge Summaries (CKS), BNF, and other official NHS/UK healthcare guidelines.

No content in this resource is derived from, represents, or claims to replicate actual GMC PLAB 2 examination material.

Introduction to 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

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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

Scenario: Primary Care Setting | Parent of Young Child | EpiPen Training Following Recent Anaphylactic Episode

Professional, Warm Introduction

"Good morning, I'm [First Name], one of the FY2 doctors here."

"Before we begin, can 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
- Feeling dizzy, clammy, faint, or confused
- 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 the time stated on your device** - for EpiPen this is 3 seconds; for Emerade it is 5 seconds; and for Jext it is 10 seconds. Count slowly: *"1 elephant, 2 elephant, 3 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 - or symptoms are getting worse - use the second EpiPen if available. Do not delay the second dose beyond 5 minutes in a patient with severe symptoms.
- Once at hospital, doctors will **observe him for at least 6 to 12 hours**. This is because sometimes symptoms can return after seeming to improve - this is called a 'biphasic reaction' and happens in about 1 in 20 cases.

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 - don't wait longer than 15 minutes."

"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.

Your son has also been referred to the specialist allergy clinic, where they'll do some tests to confirm exactly what triggered the reaction and discuss long-term management options."

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

- **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

Scenario: Hospital Ward Setting | Medical Student | Teaching Urine Dipstick Test Interpretation and Technique

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?"

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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 - make sure all the coloured squares are covered by the urine.
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)."

Important Limitation in Elderly Patients

"One really important thing to remember - and this often comes up in exams - is that **urine dipsticks are unreliable in patients over 65**. This is because a significant proportion of older adults can have bacteria in their urine without actually having an infection - this is called asymptomatic bacteriuria, and it can affect up to half of care-home residents over 80.

So if you do a dipstick on an 80-year-old who's a bit confused, and it shows leukocytes or nitrites - that doesn't mean they have a UTI. You need to look for actual urinary symptoms like dysuria, frequency, or suprapubic pain. The UK Health Security Agency (UKHSA, formerly Public Health England) actually recommends **not using dipsticks** for suspected UTI in the over-65s - diagnosis should be based on clinical assessment instead."

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

Scenario: Hospital Ward Setting | Medical Student | Teaching Subcutaneous Injection Technique

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** - that's a blood-thinning injection like 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."

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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."

Common Student Questions

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."

ECG Teaching

Scenario: Cardiology Department Setting | Medical Student | Teaching Basic ECG Interpretation 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?"

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- "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: $300 \div \text{number of squares} = \text{bpm}$ 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:

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- 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."

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)

Scenario: Emergency Department Setting | Medical Student | Teaching Adult Basic Life Support 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

Important Note on Recognition: "Recognising cardiac arrest can sometimes be challenging - if you're unsure whether someone is breathing normally, start CPR. The ambulance service call handler can help guide you if needed."

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."

Practical tip: "Put your phone on **speakerphone** so you can keep your hands free for compressions while talking to the dispatcher. They can guide you through CPR if needed."

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

Use of an AED

"Anyone can use an automated external defibrillator (AED) - no training is needed, and the device will guide you through the process with voice prompts. If an AED is available, use it as soon as possible. Early defibrillation significantly improves survival rates."

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
- Use an AED as soon as one is available
- Continue until advanced help arrives or signs of life return"

"The Resuscitation Council UK released updated 2025 guidelines in October this year - I'll make sure you get the latest version of the BLS Adult Guide."

Final Encouragement & Open Invitation

"You've done brilliantly today. This is a lifesaving skill - and it's something you'll carry with you throughout your career."

"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)

Scenario: Paediatric Department Setting | Medical Student | Teaching Paediatric Basic Life Support 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 Resuscitation Council UK 2025 Guidelines)

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 - for example, after a fall or road traffic collision - 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:** Two-thumb encircling technique (preferred) - place both thumbs on the lower sternum while your hands wrap around the infant's chest. If this technique doesn't allow for effective compressions, use the two-finger technique.
- **Children (1-puberty):** 1 hand (or 2 if needed for depth)

Rate: 100-120 per minute **Depth:** About $\frac{1}{3}$ 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

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."

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: two-thumb encircling (preferred) 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

"The Resuscitation Council UK released updated 2025 paediatric guidelines in October - I'll make sure you get the latest version of the paediatric algorithm."

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

Scenario: Outpatient Clinic Setting | Medical Student | Teaching Speculum and Pelvic 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:

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- 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."

Speculum Examination (Perform Before Bimanual)**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 female genital mutilation (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) - if asked or indicated**Steps:**

1. Use cyto-brush (or verbalise if not available)
2. Insert brush into **external os**

3. Rotate the brush 360° (one full turn) clockwise, or as per your local trust protocol, to collect an adequate sample
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.

Note: The NHS cervical screening programme uses HPV primary screening. The sample is first tested for high-risk HPV. Only if HPV is detected is the sample examined for cell changes (cytology). From July 2025, screening intervals were extended to 5 years (ages 25–49) for those who test HPV-negative

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."

Bimanual Examination

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."

Note: The recommended order in UK clinical guidance is speculum examination FIRST, followed by bimanual examination. Performing bimanual before speculum can introduce lubricant into the vaginal canal, potentially contaminating cervical specimens and making speculum insertion more difficult.

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

Scenario: Surgical Outpatient Setting | Medical Student | Teaching Inguinoscrotal 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."

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."

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:

*Independent educational content based on publicly available UK clinical guidelines.
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"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):

Drawing a quick diagram of the inguinal region can really help students visualise the anatomy.

- "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

Scenario: Primary Care/Hospital Setting | Medical Student | Teaching Cancer Referral Pathway and Communication

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 **Urgent Suspected Cancer (USC)** pathway - often still called the '2-week wait' - for patients with symptoms suggestive of cancer. The goal is now measured by the **Faster Diagnosis Standard**: patients should have cancer ruled out or receive a diagnosis within 28 days. If confirmed, treatment should ideally begin within 62 days of referral."

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

- Fever (unexplained)
- Loss of weight (unintentional)
- Appetite loss
- Weakness/fatigue
- Sweating at night

"Obviously, we don't use 'FLAWS' with patients - it's just a quick memory aid for us."

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 Urgent Suspected Cancer (USC) / 2WW Pathway

- GP or hospital doctors can initiate the referral via the Urgent Suspected Cancer pathway. The key performance measure is the Faster Diagnosis Standard: patients should have cancer diagnosed or ruled out within 28 days of referral. The previous '2-week wait' (14-day first appointment) metric has been retired as a standalone standard, though the term is still commonly used.
- If cancer is confirmed, start treatment within 31 days of the decision to treat
- Covers patients presenting with symptoms suggestive of cancer.

Note: patients identified through NHS screening programmes (cervical, bowel, breast) are referred through separate dedicated screening pathways.

"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 Suspected Cancer pathway (often called the 2-week wait)."

- 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. Setting - private, quiet, seated
2. Perception - "What do you understand about your symptoms so far?"
3. Invitation - "Would you like me to explain all the results now?"
4. Knowledge - Break bad news gently: "I'm afraid the results do show cancer..."
5. Emotion - Pause. Let them react. Offer tissues, space, empathy
6. Strategy - "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

Scenario: Paediatric Clinic Setting | Medical Student | Teaching Toddler Developmental Assessment

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

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- **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 (speech and language therapy), 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

Scenario: Hospital Setting | Medical Student | Teaching Principles of 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."

The Montgomery Ruling (2015)

"It's also important to remember the Montgomery ruling - we must tell patients about any risk that a reasonable person in their position would want to know, not just what we think is relevant. This is about respecting patient autonomy and helping them make their own informed decision."

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."

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 High Court (under its inherent jurisdiction)

Important distinction: **Gillick competence** applies to any medical treatment - it's the general test of whether a child can understand and consent. **Fraser guidelines** are specifically for contraception and sexual health advice. Don't use these terms interchangeably in exams.

Emergencies

- If unconscious or incapacitated → treat in **best interest**
- **Document your rationale** clearly
- **Explain later** once the patient recovers

Mental Health Act (MHA) Scenarios

- You can treat mental illness without consent under the **MHA** - that's the Mental Health Act
- 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

Scenario: Paediatric/Primary Care Setting | Medical Student | Teaching NHS Childhood Vaccination 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 paed 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

Here's a simple way to remember it: "8-12-16 weeks, 1 year, 18 months (from Jan 2026), preschool, teens"

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
	Meningococcal group B (MenB) - 2nd dose	MenB
	Rotavirus gastroenteritis	Rotavirus

16 weeks	Diphtheria, tetanus, pertussis, polio, Hib, hepatitis B	DTaP/IPV/Hib/HepB
	Pneumococcal (PCV13) - 1st dose	PCV
1 year (on or after the child's first birthday)	Pneumococcal booster	PCV booster
	Measles, mumps, rubella, VARICELLA (chickenpox) - 1st dose	MMRV*
	Meningococcal group B (MenB) booster	MenB
18 months (FROM JAN 2026)	Diphtheria, tetanus, pertussis, polio, Hib, hepatitis B (4th dose)	DTaP/IPV/Hib/HepB
	Measles, mumps, rubella, varicella (2nd dose)	MMRV*
2–3 years	Influenza (each year from September)	Live attenuated influenza vaccine (LAIV)
3 years 4 months	Diphtheria, tetanus, pertussis, polio	dTaP/IPV
12–13 years	Human papillomavirus (HPV)	HPV (1 dose)
14 years (school Year 9)	Tetanus, diphtheria, polio	Td/IPV
	Meningococcal groups A, C, W, Y	MenACWY

*MMRV eligibility depends on date of birth - children born on or after 1 January 2025 receive two doses of MMRV (at 12 months and 18 months). Children born between 1 July 2024 and 31 December 2024 also receive two doses of MMRV but at 18 months and 3 years 4 months. Older children born 1 September 2022 to 30 June 2024 receive one dose at 3 years 4 months. A catch-up programme for children born 1 January 2020 to 31 August 2022 begins November 2026.

HPV Vaccine Update (September 2023): The UK has moved to a **single-dose HPV schedule** for healthy adolescents under 25. Two or three doses are only required for immunocompromised individuals. This is based on JCVI evidence that one dose provides equivalent protection.

IMPORTANT FOR EXAM CANDIDATES: This schedule reflects changes active from **January 2026** (including universal chickenpox/MMRV and the new 18-month appointment).

Important Updates from January 2026:

- **MMRV (Measles, Mumps, Rubella, Varicella/Chickenpox)** will replace MMR for eligible children. This means the NHS is now offering routine chickenpox vaccination for the first time.
- **New 18-month appointment** - children will receive:
 - A 4th dose of the 6-in-1 vaccine (DTaP/IPV/Hib/HepB)
 - The 2nd dose of MMRV (bringing MMR 2nd dose forward from 3 years 4 months)
- **Why the change?** Moving the second MMR dose earlier has been shown to improve vaccine uptake - evidence from London outbreaks showed coverage increased by about 3.3% when the second dose was offered at 18 months.
- **Hib/MenC (Menitorix) discontinued** - this vaccine is no longer being manufactured. Children born on or after 1 July 2024 won't receive this vaccine. Protection against Hib continues through the hexavalent vaccine, and MenC protection comes from the adolescent MenACWY programme.

Why It Matters

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- **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

Scenario: Primary Care Setting | Medical Student | Teaching Management of Parental Vaccine 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)

First, validate their intent - before jumping into education:

"I can see you've thought about this carefully, and it shows how much you want to protect your child. Can we look at the specific worries you have about safety?"

This reduces defensiveness and opens the door to a productive conversation. Educating straight away can feel like lecturing.

Then 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)

Scenario: Hospital Setting | Medical Student | Teaching Digital Rectal Examination

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

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- "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

Scenario: Outpatient/Breast Clinic Setting | Medical Student | 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

Scenario: Hospital Ward Setting | Medical Student | 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 - ODIPARA stands for Onset, Duration, Intermittent/constant, Progression, Associated symptoms, Relieving/aggravating factors, and Attitude of patient)
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

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- 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

Scenario: Orthopaedic/MSK Clinic Setting | Medical Student | Teaching Elbow Examination

Professional Introduction & Rapport

"Hi, I'm [First 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.

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"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

Scenario: Hospital Ward Setting | Medical Student | Teaching Female Urethral Catheterisation

Professional, Warm Introduction

"Hi Tony - I'm [First 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. Instillagel - lidocaine 2% with chlorhexidine 0.25%)
- 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: "Monitor vital signs for 30 minutes post-catheterisation. Although clinically significant hypotension from rapid bladder decompression is uncommon, mild BP changes may occur, particularly in elderly or hypovolaemic patients."

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)

Scenario: Hospital Ward Setting | Medical Student | Teaching Phlebotomy Technique

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."

Order of Draw (Important for Multiple Tubes):

"If you're taking multiple samples, you must follow the **Order of Draw** to prevent cross-contamination of additives between tubes:

1. **Blood cultures** (if needed) - always first
2. **Light blue** (citrate - for coagulation)
3. **Yellow/Red** (serum - for biochemistry)
4. **Green** (lithium heparin)
5. **Purple/Lavender** (EDTA - for FBC)
6. **Grey** (fluoride oxalate - for glucose)

Getting this wrong can give you false results - for example, EDTA contains potassium, so if it contaminates a biochemistry tube, you'll get a falsely elevated potassium level."

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."

Zero Tolerance Policy: "In the NHS, there's a strict zero tolerance policy for sample labelling. You **must** label the tube at the patient's bedside while looking at their wristband. If you label it away from the patient - even just at the nurses' station - the lab will reject it immediately. This is a patient safety issue to prevent wrong-blood-in-tube errors."

- 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."

Teaching Thyroid Examination

Station ID

Setting: Clinical Teaching Environment

Task: Teach a medical student to perform thyroid examination

1. Professional Introduction

Introduce yourself using only your first name, maintaining a calm and supportive tone.

"Hello, I'm [First Name], one of the FY2s here today. You must be [Student Name]. I understand you wanted to revise the **thyroid examination**. I'm happy to take you through it step by step."

Aim: establish professionalism, rapport and psychological safety for learning.

2. Build Rapport

Ask brief, supportive questions to ease the student into the interaction:

"How is the rotation going so far?"

"Have you had the chance to observe or practise a thyroid exam before?"

"Any assessments coming up?"

Keep this short and professional. You are a senior colleague, not a peer.

3. Set the Agenda

State expectations clearly and concisely:

"Let's keep this as a relaxed, interactive session. Please feel free to stop me if you'd like me to repeat a step or slow down. If we get interrupted, I'll ensure you still receive the full explanation. Shall we begin?"

Purpose: clarifies structure, demonstrates time awareness, and invites collaboration.

4. Assess Learning Needs (The 4 Ws)

Tailor the content to the student's needs:

"What do you already know about the thyroid examination?"

"Which parts are you keen to focus on today?"

"Why is this topic important to you at the moment-have you seen a relevant case?"

"When is this examination typically performed in clinical practice?"

Use the student's response to prioritise depth (e.g., spend more time on palpation if identified as a weak area).

5. Teaching the Skill

Teach calmly and logically. Demonstrate on the simulated patient while explaining rationale throughout.

General Inspection

"From the end of the bed, begin with the overall clinical picture rather than the neck. Look for restlessness or agitation, which suggest hyperthyroidism, or slowed, fatigued movements suggesting hypothyroidism. Body habitus can also give clues, such as weight loss or gain."

Hands: "Next, move to the hands. The temperature and moisture provide early metabolic clues: warm and sweaty in hyperthyroidism; cold and dry in hypothyroidism. A fine tremor can be assessed by placing a sheet of paper on outstretched hands. The pulse is checked for rate and rhythm, as atrial fibrillation is a classic sign."

Eyes: "A brief look at the eyes can be very revealing. Lid lag, lid retraction, exophthalmos, or conjunctival injection all point towards **Graves' disease**, rather than general hyperthyroidism."

Inspection of the Neck: "Turning attention to the neck, note any swelling, asymmetry, scars, or visible pulsation. Ask the patient to swallow - the thyroid rises with swallowing. Ask the patient to protrude the tongue - a thyroglossal cyst rises with the tongue."

Posterior Palpation Technique: "The most accurate palpation is performed from behind the patient. The thyroid cartilage is located first, followed by the cricoid cartilage. Just below the cricoid lies the isthmus of the thyroid."

"Using the pads of the fingers, the isthmus is assessed, followed by each lobe. During palpation, evaluate size, symmetry, surface texture, consistency, tenderness, nodules, and movement during swallowing. This is the highest-yield portion of the examination."

Cervical Lymph Nodes: "The cervical lymph node chains are then swept systematically: submental, submandibular, anterior cervical, posterior cervical, and supraclavicular nodes. Hard, fixed nodes raise concern for malignancy."

Retrosternal Assessment

"If the thyroid enlargement is significant, retrosternal extension must be assessed."

"Pemberton's test involves lifting both arms above the head for up to a minute. Facial flushing, neck vein engorgement, or breathlessness indicate thoracic inlet obstruction. **Important:** If the patient becomes dizzy or breathless during the test, **stop immediately** and lower their arms."

"Percussion over the manubrium is also useful. Normal findings are resonant; dullness may indicate retrosternal spread."

Auscultation

"The thyroid is auscultated using the bell of the stethoscope. A bruit indicates increased vascularity, typically associated with Graves' disease."

Reflexes: "Finally, systemic completion includes neuromuscular assessment. Proximal muscle weakness may be present. Most importantly, the ankle reflex is checked, as delayed relaxation is a classic sign of hypothyroidism."

6. Involve the Student Throughout

Encourage active participation:

"Is this pace comfortable?"

"Would you like me to repeat the palpation technique?"

"Would you like to practise locating the isthmus yourself?"

This demonstrates listening, facilitation, and tailored teaching.

7. CLOSURE

Summary: "To summarise the structure: general inspection, hands and eyes, neck inspection, posterior palpation with anatomical landmarks, lymph nodes, special tests including Pemberton's and manubrial percussion, auscultation, and systemic features such as reflex delay."

"The key principles to remember are: **Look, Feel, Move, Listen**, and always assess both **thyroid dysfunction** and **local structural effects**."

Offer a resource: "I'll send you a YouTube link you can review later."

8. Final Encouragement

"You've engaged very well today. With practice, this sequence becomes intuitive. If you ever want to revise another clinical exam or run through this again before your OSCE, feel free to ask."

Chapter 27: Procedures

A Note to Learners

The cases in this resource are written in a conversational style to help you become familiar with the natural flow of clinical consultations and the language commonly used in UK healthcare settings.

These dialogues are intended as a learning guide, not a script. Please do not attempt to memorise them verbatim. Examiners assess your ability to think and communicate authentically - not to recite rehearsed phrases.

Use this material to understand the underlying clinical reasoning, then practise in your own words until the consultation feels natural to you.

For Companion OSCE Cases, Practice Scripts, Evaluation Checklists, Summary Notes, Rapid Review Notes, Mindmaps, Management Flashcards and Image Library - visit <https://www.gksplab2.com>

Disclaimer

This material is independent educational content created to help candidates develop clinical reasoning and communication skills for UK medical practice.

All cases and clinical scenarios are based on common presentations encountered in UK primary care and emergency medicine, drawn from publicly available sources including NICE Clinical Knowledge Summaries (CKS), BNF, and other official NHS/UK healthcare guidelines.

No content in this resource is derived from, represents, or claims to replicate actual GMC PLAB 2 examination material.

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 - including to latex, chlorhexidine (the skin cleaning solution), or any local anaesthetics?
- 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 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?"

[Note: Marking domains - 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 2% chlorhexidine in 70% 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

Scenario: Emergency Department | Young Adult Male | Intentional Overdose - Blood Sampling Required

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 senior colleague 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
 - *Note: Specific bottle colour may vary by trust - use what's available and label appropriately*
 - 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 helps us decide if treatment is needed."

Explain Next Steps

- "You'll be staying in our observation area while we wait for the result."
- "Once we have your blood level, we'll plot it on a treatment chart to see if you need the antidote."
- "If the level is high, we'll start a medicine called NAC - that stands for N-acetylcysteine - which helps protect your liver. This is given through a drip, usually over about 12 hours. It's very effective when started early."
- "Once the treatment is finished and your blood tests show your liver is safe, the mental health liaison team will come to see you before you go home."

FY2 Note: If staggered overdose (ingestion over >1 hour) or uncertain timing - start NAC regardless of paracetamol level, as the treatment nomogram is unreliable in these cases. Discuss with senior/toxicology for ongoing management

Important: The blood sample for paracetamol levels should be taken at least 4 hours after the overdose - earlier samples can underestimate the level and mislead treatment decisions

Safety Netting While on the Ward

- "While you're with us receiving treatment, if you feel any nausea, flushing, itching, or a rash, let the nurse know immediately - these can sometimes happen with the NAC drip and we can manage them easily."
- "Also let us know if you feel drowsy, confused, or have any tummy pain."

Red Flag Safety Netting (for discharge)

- "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, nausea or vomiting, 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: Surgical Ward | Post-Operative Patient | Pyrexia - Blood Culture Required

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 surgery a few days ago, and your temperature has been a bit high today. Before we start any antibiotics, I need to take the blood cultures - this gives us the best chance of finding out exactly which bacteria might be causing the infection."

2. Early Rapport & Soft Screening

"How are you feeling overall today?" "Have you noticed any pain or discharge from your surgical site?"

[Note: 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. I'll use a fresh needle stick for this - we don't take blood cultures from existing cannulas as it increases the risk of contamination."
- **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

Independent educational content based on publicly available UK clinical guidelines.

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GK's PLAB 2 Preparation WhatsApp Channel - <https://tinyurl.com/gksplab2>

- 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

- Use bevel up
- Hold needle securely at all times
- Once flashback seen, **loosen tourniquet**
- I'll need to collect about 8-10 millilitres into each bottle - this gives the best chance of detecting any bacteria
- **CRITICAL - Order of Draw with Butterfly Needle:** Fill the **AEROBIC bottle FIRST** to expel the air from the butterfly tubing, then fill the **ANAEROBIC bottle**. This prevents air contaminating the anaerobic environment.
 - *"Because I'm using a butterfly needle, I'll fill the aerobic bottle first to displace the air in the tubing, then the anaerobic bottle."*
- 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. Documentation

"I'll document in the notes: time taken, site used, and bottles sent."

4. 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
- "We'll also check a blood gas for your lactate level - this helps us see how serious the infection is"
- "We'll start antibiotics through a drip to fight the infection while we wait for the results"
- Send off full septic screen if required (lactate is part of Sepsis Six)
- "Once the lab tells us exactly which bacteria is causing the infection, we can make sure you're on the best antibiotic"

FY2 Note: Start empirical antibiotics as per trust protocol. Inform surgical team (post-op patient). If not responding to treatment or patient deteriorating - escalate to senior/critical care outreach.

Anchor Phrase: "Early cultures help tailor the treatment - we don't want to delay starting the right antibiotics."

IV Cannulation

Scenario: Surgical Ward | Post-Operative Patient | Cannula Replacement for Intravenous Therapy

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 surgery a few days ago - I hope you're feeling a bit more settled now?"

[Note: Observe non-verbal cues - pain, fatigue, concern.]

2. Reframe Purpose

"Your nurse mentioned that your cannula isn't working properly, and my senior colleague has asked me to replace it so we can continue giving you your medications and fluids safely - especially your pain medication."

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

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- **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
- 2% chlorhexidine in 70% alcohol swabs
- 5-10 mL 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 **2% chlorhexidine in 70% 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?" "Is your pain manageable at the moment?" "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: **Cyclizine 50mg slow IV** (caution in severe heart failure - may reduce cardiac output) or **Ondansetron 4mg IV**

Metoclopramide: NOT recommended for routine post-operative nausea (ineffective at licensed doses for PONV per current UK guidance). Only consider if nausea is specifically due to gastric stasis. MHRA restrictions: max 5 days use, max 30 mg/24 hours, risk of acute dystonic reactions (especially in young adults and children).

- If fever present: **Paracetamol**
- Document cannula change, site, and saline flush in notes
- Reassess in 15 minutes if pain persists
- "The nurses will check your cannula regularly using the VIP score - that's a standard assessment to spot any early signs of irritation or infection. We'll also review daily whether you still need it."

FY2 Note: If difficult IV access after 2 attempts - ask senior for help. If pain uncontrolled or new post-op concerns - inform surgical team.

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)

Scenario: Emergency Department | Middle-Aged Adult with Respiratory Condition | Acute Breathlessness - ABG Required

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 a respiratory condition. Is that right?"

Purpose & Framing

"My senior colleague 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 working and how much oxygen is getting into 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."

Offer of Local Anaesthetic

"Some patients find this quite uncomfortable. If you'd prefer, I can use some local anaesthetic to numb the area first - it just takes an extra minute or two. Would you like me to do that?"

Safety Questions (Check Before You Start)

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- "Are you on any blood thinners like warfarin, aspirin or apixaban?"
- "Are you allergic to any local anaesthetics or numbing creams?"
- "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
- Local anaesthetic (if patient requests)

Perform Allen's Test (Collateral Circulation Check)

"Before I go ahead, I'll just check the blood supply to your hand - I'm checking for collateral flow from the ulnar artery, which ensures safe blood supply to your hand if the radial artery were to spasm."

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

Clinical Note: Evidence suggests Allen's test has limited predictive value for ischemic complications (sensitivity ~77%, specificity ~93%) and is not considered "standard of care" for ABG sampling. However, it remains standard practice in UK OSCEs. In clinical practice, if concerns exist about collateral flow (vascular disease, previous radial procedures), consider Doppler assessment or use an alternative site.

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. Administer Local Anaesthetic (if requested)

- If patient requested LA: "I'll inject a small bleb of local anaesthetic now."
- Inject subcutaneously over the artery site
- **Wait at least 60 seconds** (ideally 2 minutes) for full effect
- "I'll just wait a minute for that to take effect before I continue."

3. Prepare Syringe & Warn Patient

- Loosen cap on syringe
- "You'll feel a sharp scratch now." (or "You may feel some pressure" if LA given)
- Insert needle at approximately 45° angle, bevel up, like a pen

4. Collect the Sample

- Blood should **self-fill** due to arterial pressure (do not pull the plunger)
- Collect ~ 1-3 mL (standard ~ 2 mL; minimum 0.3 mL for basic analysis)

5. 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

6. 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 get this analysed straight away - we should have results in just a few minutes."

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."

FY2 Note: If severe hypoxia, rising CO₂, or patient deteriorating - escalate to senior. May need NIV or ICU review.

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 FiO ₂ (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
Local Anaesthetic	Offer per BTS guidelines - "Would you like me to numb the area first?"

Male Urethral Catheterisation

Scenario: Emergency Department | Adult Male | Acute Urinary Retention - Catheterisation Required

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?" "Are you allergic to any local anaesthetics or numbing creams?" "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 some numbing gel first to make it more comfortable."

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
- Sterile normal saline for meatal cleaning (antiseptic if local policy requires)
- Anaesthetic gel syringe (2% lidocaine, e.g., Instillagel)
- Sterile 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

- "I'm going to use some numbing gel now to make this more comfortable."
- Instil the full contents of the gel syringe (11 mL Instillagel or equivalent)
- Hold the glans closed to retain the gel
- **Wait at least 5 minutes** (ideally 5–10 minutes for full anaesthetic effect and sphincter relaxation)
- Verbalise: "I'll hold this closed and wait 5 minutes for the gel to work properly - this helps relax the sphincter and makes the procedure much more comfortable."

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

- **CRITICAL: Reposition foreskin** (if applicable) - failure to do so causes paraphimosis (urological emergency)
- 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

Catheter Passport

"You'll be given a catheter passport - a small card that has all the details about your catheter. Keep this with you, as it helps other healthcare staff know what type you have and when it might need changing."

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

FY2 Note: Refer to urology for assessment and TWOC planning. If catheter won't pass - DO NOT FORCE - stop and call urology for help.

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

Scenario: Emergency Department | Adult Female | Acute Urinary Retention - Catheterisation Required

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

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"Do you have any known kidney issues?" "Any recent procedures involving your urinary tract?"

Pregnancy Consideration (*for women of childbearing age*)

"Is there any chance you could be pregnant?"

Medication, Allergy, Bleeding Risk

"Are you on any blood thinners like warfarin or aspirin?" "Any allergies - particularly to latex or medications?" "Are you allergic to any local anaesthetics or numbing creams?" "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 some numbing gel to make it more comfortable.

To perform this properly, I'll need you to lie flat with your knees bent and let your legs fall gently apart.

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 2%)
- 10 mL syringe with sterile water
- Sterile normal saline for meatal cleaning (antiseptic if local policy requires)
- 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."

*Clinical Note: Standard-length catheters are safe for all patients. Female-length catheters are shorter and more comfortable for females but **MUST NEVER** be used in males (too short - risk of balloon inflation in the urethra causing trauma).*

PERFORM - Step-by-Step Catheter Insertion

Patient Positioning

"Ensure the patient is lying supine with knees bent and legs falling gently apart. 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 use some numbing gel to make this more comfortable."
 - Gently insert the nozzle into the urethral opening
 - Instil 3-5 mL of 2% lidocaine gel (use female-size syringe if available, typically 6 mL)
 - **Wait at least 5 minutes** (verbalise this)

Anchor phrase: "Always wait - don't rush past the gel step. Five minutes allows for full anaesthetic effect."

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

Catheter Passport

"You'll be given a catheter passport - a small card that has all the details about your catheter. Keep this with you, as it helps other healthcare staff know what type you have and when it might need changing."

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

FY2 Note: Refer to urology for assessment. If catheter won't pass - DO NOT FORCE - stop and call urology/senior for help.

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

A Note to Learners

The cases in this resource are written in a conversational style to help you become familiar with the natural flow of clinical consultations and the language commonly used in UK healthcare settings.

These dialogues are intended as a learning guide, not a script. Please do not attempt to memorise them verbatim. Examiners assess your ability to think and communicate authentically - not to recite rehearsed phrases.

Use this material to understand the underlying clinical reasoning, then practise in your own words until the consultation feels natural to you.

For Companion OSCE Cases, Practice Scripts, Evaluation Checklists, Summary Notes, Rapid Review Notes, Mindmaps, Management Flashcards and Image Library - visit <https://www.gksplab2.com>

Disclaimer

This material is independent educational content created to help candidates develop clinical reasoning and communication skills for UK medical practice.

All cases and clinical scenarios are based on common presentations encountered in UK primary care and emergency medicine, drawn from publicly available sources including NICE Clinical Knowledge Summaries (CKS), BNF, and other official NHS/UK healthcare guidelines.

No content in this resource is derived from, represents, or claims to replicate actual GMC PLAB 2 examination material.

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. The station focuses on safe, structured care - critical errors that would harm a real patient will be penalised. 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 Ischaemia)

- 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
- **Listen to the examiner**: While you should direct all clinical communication to the patient/mannequin, the examiner may act as a "Voice of God" to provide findings you cannot physically assess on the mannequin (e.g., "The abdomen feels rigid," "The pupils are pinpoint," "There is blood in the mouth"). If you ignore these cues, you will miss critical clinical signs.
- **Use signposting summaries**: Instead of narrating every thought constantly, use structured summaries to show clear thinking. For example: *"I have completed my A and B assessment. I am satisfied the airway is safe and breathing is supported. I am now moving to Circulation."*

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 [XXXXXX]."*
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 (ACVPU or GCS) - (Alert, new Confusion, responds to Voice, Pain, Unresponsive). Note: New confusion scores 3 points on NEWS2.
- **+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:

Antibiotic Timing Based on NEWS2 (per NICE 2024):

- NEWS2 ≥ 7 (High Risk): IV antibiotics within **60 minutes**
- NEWS2 5-6 (Moderate Risk): IV antibiotics within **3 hours**

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 SpO₂ 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, SpO₂, Mental status
 - Whether the patient is on oxygen
2. **Calculate the NEWS score once you've completed ABCDE**

"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:** SpO₂

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 SpO₂ 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/ACVPU 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, SpO₂, 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.
Important: In known or suspected COPD, use air-driven nebuliser to avoid worsening CO₂ retention
- **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, SpO₂
- *"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."*

D – DISABILITY

Goal: Assess neurological status and correct metabolic disturbances

Assessment

- ACVPU (Alert, new Confusion, responds to Voice, Pain, Unresponsive)
- Say: *"I'm assessing the patient's level of consciousness using the ACVPU 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 ACVPU = P/U, airway is at risk. Escalate for possible intubation now.

Immediate Interventions

- If hypoglycaemia: **Administer 100 mL of 20% glucose 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 ACVPU
- *"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, SpO₂, any interventions given].
- **Circulation** – [BP, HR, cap refill, IV access, fluids given].
- **Disability** – [GCS or ACVPU, blood glucose, pupils].
- **Exposure** – [Temperature, any rashes, wounds, bleeding, other findings].

Example: "Airway is patent. Breathing: RR 28, SpO₂ 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 SpO₂ 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

Scenario: Emergency Department | Young Adult Male | Acute Breathlessness with Known Asthma and Abnormal Observations

Monitor findings:

- SpO₂: 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

Initial Steps

1. Knock and enter
2. Greet examiner: "Hello, I'm Dr [Name], GMC number [XXXXXX]. 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: "I can see you're really struggling to breathe right now. I'm going to help you straight away."

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, targeting SpO₂ 94-98%."

[Note: Target SpO₂ 94-98% per BTS guidelines for acute asthma. This should be verbalised as the target but you wouldn't say "per BTS" to the patient.]

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."
- "The medication I'm giving you through this mask should start to help within a few minutes."
- "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, SpO₂ 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 the patient can swallow, oral prednisolone 40-50mg is equally effective and is the preferred route."

"If no response, I'll escalate for intravenous magnesium sulphate 1.2-2g IV over 20 minutes 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 young adult 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, SpO₂ 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

Scenario: Emergency Department | Middle-Aged Male | Acute Breathlessness with Known COPD

Monitor findings:

Independent educational content based on publicly available UK clinical guidelines.

Not affiliated with or derived from GMC PLAB 2 examination material.

GK's PLAB 2 Preparation WhatsApp Channel - <https://tinyurl.com/gksplab2>

- SpO₂: 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 SpO₂ between 88 and 92 percent."

B – Breathing

- "RR is 20. SpO₂ 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 CO₂ 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 SpO₂ 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 middle-aged 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, SpO₂ 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. If ABG shows pH <7.35 with PaCO₂ >6 kPa despite initial treatment, initiate non-invasive ventilation (BiPAP). Escalate to senior/ICU if no improvement within 1-2 hours."

Refer to respiratory clinic. Review inhaler technique and arrange smoking cessation support. Provide safety netting and discharge plan after improvement."

Infective Exacerbation of COPD

Scenario: Emergency Department | Middle-Aged Male | Difficulty Breathing with Fever - Known COPD on Inhalers, Now Septic

Vitals: SpO₂: 85%, BP: 100/60 mmHg, HR: 120 bpm, RR: 24, Temp: 39°C, Lead II: Sinus Rhythm

Background: 50-year-old male presenting to A&E feeling unwell. History of COPD on inhalers. Now has difficulty breathing and fever. No other associated symptoms.

Key Feature: This case combines a COPD exacerbation with an infective trigger and sepsis. The critical distinction from a standard COPD exacerbation is the presence of fever, hypotension, and tachycardia - requiring initiation of sepsis management alongside bronchodilator therapy. The oxygen target must remain 88-92% (not 94-98%) because of the COPD history - this is commonly tested.

Initial Steps

Knock and enter

Greet examiner: "Hello, I'm Dr [Name], GMC number [XXXXXX]. I've taken universal precautions and ensured the scene is safe."

Greet patient and confirm identity: "Hello, I'm one of the doctors here. Could I confirm your full name and date of birth?"

Acknowledge situation: "I can see you're struggling to breathe and feeling very unwell. I'm going to help you straight away."

Focused History

If the patient can speak in full sentences - take history early:

Independent educational content based on publicly available UK clinical guidelines.

Not affiliated with or derived from GMC PLAB 2 examination material.

GK's PLAB 2 Preparation WhatsApp Channel - <https://tinyurl.com/gksplab2>

Onset: "When did the breathing difficulty start? When did the fever begin?"

Associated symptoms: cough, sputum (volume, colour, blood?), chest pain, wheeze, leg swelling

Infective symptoms: sore throat, runny nose, urinary symptoms, diarrhoea

Past medical history: COPD - how long? Previous admissions? ICU? NIV?

Medications: which inhalers? Compliance? Home nebulisers? Home oxygen?

Allergies: any known?

Smoking history: pack-years, current or ex-smoker?

If the patient is too breathless to talk:

"You're too breathless to talk right now. I'll start treatment first and come back to questions later."

Differential Diagnosis to Consider: Infective COPD exacerbation, pneumonia, pulmonary embolism, pneumothorax, heart failure

ABCDE Assessment & Management

A – Airway

Check for visible or audible obstruction - patient vocalising, airway patent.

SpO₂ 85% - critically low.

"Starting oxygen via Venturi mask at 24%, 2–3 litres per minute, targeting SpO₂ 88–92%."

[Per BTS 2017 Guidelines and NICE NG115: In COPD patients, target SpO₂ 88–92%. Start with 24% Venturi mask at 2–3 L/min (or 28% Venturi at 4 L/min if 24% unavailable). Do NOT give 15L via NRM - over-oxygenation risks hypercapnic respiratory failure. Per NICE NG253: Target 88–92% for those at risk of hypercapnic respiratory failure.]

Reassess: "SpO₂ improving to 90% - within target range."

B – Breathing

"Respiratory rate is 24. Accessory muscles may be in use."

Inspect for barrel chest, hyperinflation.

Palpate trachea - central. Chest expansion - may be reduced bilaterally.

Percuss - may be hyperresonant.

Auscultate: wheeze AND unilateral coarse crackles (key finding - wheeze from COPD + crackles from infection).

"Starting nebulised salbutamol 5 milligrams AND ipratropium bromide 500 micrograms via air-driven nebuliser."

[Per BTS Guidelines: Use compressed air to drive nebulisers in COPD patients, NOT oxygen-driven. If compressed air unavailable, limit oxygen-driven nebulisers to 6 minutes maximum. If supplemental O₂ needed during nebulisation, give via nasal cannula at 2 L/min alongside the air-driven neb.]

"Requesting a chest X-ray."

"Performing an arterial blood gas including glucose and lactate."

C – Circulation

"Pulse is 120 beats per minute. Blood pressure is 100 over 60. Capillary refill is greater than 2 seconds."

"This patient has signs of infection with haemodynamic compromise. I am calculating the NEWS2 score - with these observations, the NEWS2 is likely ≥7, placing them at high risk of severe illness or death from sepsis."

[Per NICE NG253 (Nov 2025): NEWS2 ≥7 = high risk. Broad-spectrum IV antibiotics within 1 hour. IV fluid bolus without delay.]

Immediate Sepsis Management (per NICE NG253):

Take:

Blood gas including glucose and lactate - lactate ≥ 2 mmol/L confirms high risk

Blood cultures - take before giving antibiotics

Send bloods: FBC, U&E, LFTs, CRP, clotting

Insert **2 wide-bore cannulas**

Give:

IV broad-spectrum antibiotics - within 1 hour of NEWS2 calculation

For IECOPD with sepsis (*per NICE NG114 + local formulary*): **IV co-amoxiclav 1.2 g TDS** or **IV piperacillin-tazobactam 4.5 g TDS** (if severe or high risk of treatment failure)

If penicillin allergy: **IV clarithromycin 500 mg BD** or per local formulary

Review at 48 hours - step down to oral when possible

IV fluid resuscitation - give an initial bolus of **250 mL isotonic crystalloid (Hartmann's solution preferred, or 0.9% saline)** over 10–15 minutes. Reassess after each bolus. Give further 250 mL boluses if needed, up to **1,000 mL total**.

Oxygen - already started via Venturi mask, targeting 88–92%

[*CRITICAL UPDATE - NICE NG253 (Nov 2025): IV fluid boluses are now 250 mL (not 500 mL). Use balanced crystalloid (Hartmann's) as first choice. Maximum 1,000 mL before senior escalation.*]

Insert **urinary catheter** and send urine for culture.

Request 12-lead ECG.

Reassess after each fluid bolus:

"BP still borderline - giving further 250 mL bolus and reassessing."

Reassess after 1,000 mL total:

"If the patient has not improved enough, I will get advice from a senior clinical decision maker and discuss with critical care." (*per NICE NG253 1.8.9*)

D – Disability

"Patient is alert. GCS assessed."

"Pupils are equal and reactive."

"Blood glucose - checked on blood gas."

"Temperature 39°C - administering IV paracetamol 1 gram."

E – Exposure

"Examining abdomen - soft, non-tender."

"Checking limbs for oedema, cellulitis, DVT."

"Checking private areas."

"No additional findings. Re-covering patient to maintain warmth and dignity."

Management Plan

Escalate to seniors - registrar and consultant.

Complete sepsis management as per NICE NG253.

Continue bronchodilators - repeat nebulisers via air-driven nebuliser as needed.

Corticosteroids (*per NICE NG115*): Oral prednisolone **30 mg once daily for 5 days** (or IV hydrocortisone 100 mg if unable to swallow).

Antibiotic duration (*per NICE NG114*): **5 days**. Review IV at 48 hours and step down to oral:

Oral step-down options: Amoxicillin 500 mg TDS, or doxycycline 200 mg day 1 then 100 mg OD, or clarithromycin 500 mg BD - all for 5-day total course

Recalculate NEWS2 every 30 minutes for high-risk patients (*per NICE NG253*).

Escalate to critical care (*per NICE NG253*): If no response within 1 hour of any intervention, ensure senior clinical decision maker attends in person. Discuss vasopressors with critical care team.

Consider NIV if ABG shows type 2 respiratory failure (pH <7.35, PaCO₂ >6 kPa) despite initial treatment (*per NICE NG115*).

Review CXR - look for consolidation, pneumothorax, or pleural effusion.

[Note: *Per NICE NG114, if a person is on prophylactic azithromycin, it does NOT need to be stopped during an acute exacerbation - but treatment antibiotics should be from a different class.*]

Explanation to the Patient

"Mr X, your breathing difficulty has flared up because you've developed an infection on top of your COPD - we call this an infective exacerbation. The infection has also caused your body to react very strongly, which is why your blood pressure dropped and your heart rate went up. This is called sepsis. We've started you on oxygen to help your breathing, inhalers through a nebuliser to open your airways, strong antibiotics through a drip to fight the infection, and fluids to support your blood pressure. We've also taken blood samples to find out exactly which bug is causing the infection.

We're monitoring you closely and will involve the intensive care team if needed. Once the infection is under control, we'll review your regular inhalers and make sure you have the right treatment going forward."

SBAR Handover

S – Situation: "This is a 50-year-old male with known COPD presenting with acute breathlessness and fever. He is septic with hypotension and tachycardia - likely infective exacerbation of COPD. NEWS2 ≥7 - high risk."

B – Background: "Known COPD on inhalers. No allergies reported. Presented feeling unwell with difficulty breathing and pyrexia."

A – Assessment: "Airway patent. Breathing: RR 24, SpO₂ 85% - now 90% on Venturi 24%, targeting 88–92%. Auscultation: wheeze and unilateral coarse crackles. Nebulised salbutamol and ipratropium via air-driven nebuliser. Circulation: HR 120, BP 100/60, CRT >2s. Sepsis management per NICE NG253: 2 cannulas, bloods and cultures sent, IV co-amoxiclav given within 1 hour, 250 mL Hartmann's boluses given - reassessing after each. Catheterised. Disability: alert, temp 39°C - IV paracetamol given. ABG with lactate requested. Exposure: no other source."

R – Recommendation: "Needs urgent senior review. Recalculate NEWS2 every 30 minutes. Continue fluid resuscitation - escalate to senior decision maker if no improvement after 1,000 mL total. Prednisolone 30 mg OD for 5 days for COPD component. Review ABG - if type 2 respiratory failure, consider NIV. Antibiotics for 5 days per NICE NG114 - review IV at 48 hours. Discuss critical care if no response within 1 hour."

Student Note: How This Differs from a Standard Acute Exacerbation of COPD

Feature	Acute Exacerbation of COPD	Infective Exacerbation of COPD (IECOPD)
Trigger	May be non-infective (pollution, cold air, non-compliance)	Infective cause - bacterial or viral
Fever	Usually absent or low-grade	Present - pyrexia (e.g., 39°C) is a key feature

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Haemodynamics	Usually stable (normal BP, HR)	Hypotension + tachycardia → sepsis picture
Auscultation	Wheeze predominantly	Wheeze AND coarse crackles (infection + obstruction)
Sepsis pathway	Not required	Required - NEWS2 scoring, IV antibiotics within 1 hour, IV fluid resuscitation per NICE NG253
Antibiotics	Only if purulent sputum or clinical signs of infection (per NICE NG114)	Always required - IV broad-spectrum initially, step down at 48 hours
IV fluids	Not typically needed	250 mL Hartmann's boluses, up to 1,000 mL (per NICE NG253)
Blood cultures	Not routine	Mandatory - take before antibiotics
Urinary catheter	Not routine	Insert for urine output monitoring + urine culture
Lactate	Not routine	Mandatory on ABG - lactate ≥ 2 confirms high risk
Escalation	May be managed on ward or even at home	Senior review, ITU discussion if no response within 1 hour
Steroids	Prednisolone 30 mg OD × 5 days	Same - but given alongside sepsis management
Nebulisers	Salbutamol ± ipratropium via air-driven neb	Same - but ensure air-driven while also managing O ₂ for sepsis
Oxygen target	88–92% (same)	88–92% (same - do NOT switch to 15L NRM despite sepsis)

The bottom line: In a standard COPD exacerbation, the focus is on bronchodilators, steroids, and controlled oxygen. In IECOPD with sepsis, you must layer the full sepsis protocol on top - IV antibiotics within 1 hour, fluid resuscitation, blood cultures, lactate, catheterisation, and early escalation - while still maintaining the COPD-specific oxygen target of 88–92% and using air-driven nebulisers. The oxygen target is the most commonly tested pitfall: even though this patient is septic, you must NOT give 15L via NRM.

Anaphylaxis

Scenario: Emergency Department (Post-Operative) | Older Adult Male | Acute Breathlessness and Hypotension Following Blood Transfusion

Monitor findings:

- SpO₂: 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 recently **Position:** Patient is in a semi-sitting position

Initial Steps

1. Knock and enter
2. Greet examiner: "Hello, I'm Dr [Name], GMC number [XXXXXX]. 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. SpO₂ 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 crystalloid (preferably Hartmann's solution or Plasma-Lyte; 0.9% saline is an alternative), **500-1000 mL rapid bolus**, reassessing after each bolus and repeating as needed. Large volumes may be required in anaphylactic shock."
- "Requesting bloods: FBC, U&E, CRP, clotting, LFTs, and ECG."
- "Taking blood samples for **serum tryptase** - ideally within 1-2 hours of symptom onset, and a baseline sample at 24 hours or follow-up."

D – Disability

- "Patient is alert. Blood glucose is 6.0. Pupils equal and reactive."
- "Rechecking BP. If still low, administering another 500-1000 mL IV fluid bolus."

E – Exposure

- "Examining abdomen, limbs, and catheter site. Widespread urticarial rash noted."
- "Once the patient is stabilised, I may consider a non-sedating oral antihistamine such as cetirizine, but this is not part of the initial emergency treatment."
- "Re-covering the patient to maintain warmth and dignity."

Patient Explanation (After Stabilisation)

"Mr. X, you've had a very serious allergic reaction - what we call anaphylaxis - 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, and fluids to stabilise you. You're doing better now, but we'll be admitting you to a higher level of care for observation.

All patients with anaphylaxis should be observed for a minimum of 6 hours following the reaction. Admission for 12-24 hours should be considered for severe reactions or if adrenaline was required. 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 "Older adult post-op male developed acute shortness of breath and hypotension shortly 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: SpO₂ 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 - minimum 6-hour observation. 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)

Scenario: Emergency Department | Older Adult Male | Acute Breathlessness with Palpitations, Dizziness and AF on Monitor

Monitor findings:

- SpO₂: 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, SpO₂ 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 very distressed despite initial treatment:* "If the patient appears very distressed despite initial treatment, I may consider **low-dose IV morphine (1-2.5mg) with extreme caution**, although this is no longer routinely recommended due to limited evidence of benefit and risk of respiratory depression."
- 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 an older adult male 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: SpO₂ 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, GTN. Bloods sent, chest X-ray and ABG done. Catheter inserted."

R – Recommendation "Admit under medical team. Request transthoracic echocardiogram. Discuss rate control with cardiology. **First-line options include beta-blockers (e.g., bisoprolol) or rate-limiting calcium channel blockers (e.g., diltiazem)** - avoid beta-blockers if decompensated heart failure, and avoid diltiazem if heart failure with reduced ejection fraction.

Digoxin may be considered as add-on or alternative. Start anticoagulation depending on stroke risk (e.g., CHA₂DS₂-VASc). Continue monitoring fluid output and oxygenation. Provide safety netting and explain further management to patient."

Heart Failure (Chronic, Referred by GP)

Scenario: Emergency Department (GP Referral) | Older Adult Male | Progressive Breathlessness with Known Valvular Heart Disease and AF on Monitor

Monitor findings:

- SpO₂: 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, SpO₂ 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 "Older adult 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, SpO₂ 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. X, 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

Scenario: Gastroenterology Ward | Middle-Aged Male | Acute Upper GI Bleeding with Haemodynamic Instability and Recent Endoscopy

Monitor findings:

- SpO₂: 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 recently

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

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"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 high-flow oxygen at 15 L/min via non-rebreather mask, targeting SpO₂ 94-98%."
- "Explaining to patient: 'You're losing blood quickly - I'm giving you oxygen to help your body cope.'"

B – Breathing

- "RR is 30. SpO₂ 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."
- "I will calculate the **Glasgow-Blatchford Score** to assess risk and guide management decisions."
- "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."
- "If **variceal bleeding is suspected** (e.g., known liver disease, liver stigmata, splenomegaly), I will immediately start **terlipressin** [(dose based on weight: <50kg → 1mg; 50-70kg → 1.5mg; >70kg → 2mg), then 1-2mg every 4-6 hours for up to 5 days], and **prophylactic antibiotics** (per local protocol). **Do NOT give PPI before endoscopy** - urgent endoscopy is the priority."
- "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 "Middle-aged male presenting with acute haematemesis and haemodynamic instability."

B – Background "Had an upper GI endoscopy recently - unclear indication or findings. Now vomiting fresh blood. No known comorbidities yet identified."

A – Assessment "Airway patent with blood in mouth. Breathing: RR 30, SpO₂ 90%, equal chest sounds. Circulation: HR 120, BP 80/55, CRT delayed. Two IV lines in. Fluids started. Major haemorrhage protocol activated. Glasgow-Blatchford Score calculated. 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. If variceal bleeding suspected: terlipressin and prophylactic antibiotics already started; PPI is NOT indicated pre-endoscopy per NICE CG141. 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

Scenario: Obstetrics Ward | Adult Female (Multiparous) | Major Postpartum Haemorrhage with Haemodynamic Compromise

Monitor:

- SpO₂: 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:** Multiparous, placenta delivered, no medical conditions

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."
- "SpO₂ 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 5 IU by slow intravenous injection** (may repeat). *Note: 10 IU IV bolus carries risk of cardiovascular collapse; 5 IU slow IV is the recommended maximum IV bolus per RCOG/NICE.*
 - **Begin uterine massage immediately**
 - **Administer tranexamic acid 1 gram IV over 10 minutes.** If bleeding continues after 30 minutes, or restarts within 24 hours, give a second 1g IV over 10 minutes

- If bleeding continues despite oxytocin and massage, consider:
 - Ergometrine 500mcg IM (contraindicated in hypertension, pre-eclampsia, cardiac disease)
 - Carboprost (Hemabate) 250mcg IM (contraindicated in asthma)
 - Misoprostol 1000mcg rectally (less effective than oxytocin but useful when ergometrine and carboprost are contraindicated)
- "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 multiparous woman, Mrs. X, who is post-vaginal delivery and now experiencing heavy vaginal bleeding."

B – Background "This was a multiparous delivery. Placenta was delivered completely. No medical conditions. No history of bleeding disorders or allergies."

A – Assessment "Airway is patent. Breathing: RR 30, SpO₂ 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, 5 IU IV oxytocin (slow injection), 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 to oxytocin, consider ergometrine or carboprost (checking contraindications). If still bleeding, 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

Scenario: Gynaecology Ward (Post-Operative) | Middle-Aged to Older Adult Female | Acute Deterioration with Hypotension and Desaturation Following Major Abdominal Surgery

Independent educational content based on publicly available UK clinical guidelines.

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Monitor Observations

- **SpO₂**: 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

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 SpO₂** 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 SpO₂** 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 middle-aged to older adult female patient who is hypotensive and desaturating post-hysterectomy."

B – Background: "Surgery was completed recently. Nurse noted a sudden drop in BP and called for review. No significant past medical history."

A – Assessment: "Airway: patent. Breathing: RR 30, SpO₂ 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. O₂ and crystalloid started."

R – Recommendation: "Request **urgent obstetric/gynaecology 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 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

Scenario: Emergency Department | Young Adult Male | Major Lower GI Bleeding with Anticoagulation and Haemodynamic Instability

Setting: Patient alert, pale, in bed with pad soaked in fresh blood

*Independent educational content based on publicly available UK clinical guidelines.
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Monitor:

- SpO₂: 89%
- BP: 80/55 mmHg
- HR: 110 bpm
- RR: 30
- Temp: 36°C
- Lead II: Atrial Fibrillation (AF)

Note: A young adult with AF on warfarin is uncommon - clinical context may involve early-onset AF or other underlying conditions.

Initial Steps

1. Knock and enter
2. Greet examiner: "Hello, I'm Dr [Name], GMC number [XXXXXX]. 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 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**: → "Have you had any recent procedures like colonoscopy?"
- **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."
- "SpO₂ is low - starting **100% oxygen via non-rebreather mask at 15 L/min.**"
- **Reassess SpO₂** 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) 25-50 units/kg** (dose per INR/weight and local protocol) immediately. Recheck INR 15-30 minutes after PCC administration."
- "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 young adult male with major PR bleeding on warfarin, now hypotensive and desaturating."

B – Background: "He is on warfarin for atrial fibrillation. Recent colonoscopy showed diverticular disease. No known allergies."

A – Assessment: "Airway: patent. Breathing: RR 30, SpO₂ 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

"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)

Scenario: Emergency Department | Middle-Aged Male | Acute Severe Limb Pain with AF on Monitor - Suspected Vascular Emergency

Monitor:

- SpO₂: 99%
- BP: 120/80 mmHg
- HR: 110 bpm
- RR: 24
- Temp: 36°C
- Lead II: Atrial Fibrillation (AF)

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're in a lot of pain in your 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."
- "SpO₂ is 99% - oxygen is not required at this stage. I will ensure supplemental oxygen is readily available if the patient deteriorates."

Note: High-flow oxygen is not routinely indicated when SpO₂ is normal, but in the exam context, demonstrating an emergency mindset by 'erring on the side of caution' with oxygen is unlikely to be penalised.

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 affected 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."
- "**IMMEDIATE urgent vascular surgery referral** - any delay risks limb loss, especially with sensorimotor impairment."
- "Inserting **2 large-bore IV cannulas**."
- "Sending urgent bloods: **FBC, U&E, LFT, CRP, clotting, glucose, lactate, group and save**."
- "Administering:
 - **Unfractionated Heparin IV bolus - 5000 IU** (or weight-based: 70-100 IU/kg) **to prevent clot propagation**. Follow with continuous infusion at 18 IU/kg/hour, adjusted to APTT 2-2.5x control.
 - **IV Morphine 5 mg** for pain
 - **12-lead ECG** to assess ongoing AF or cardiac strain"
- "Keep limb **warm** (avoid external compression or heat), lower foot of bed if possible, and document **neurovascular status** repeatedly."
- **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 affected 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 - affected leg pale, cold, pulseless; other leg warm and pink."

SBAR Handover (if requested)

S – Situation: "I'm Dr [Name], managing a middle-aged male presenting with sudden onset of severe 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, SpO₂ 99%. No distal pulses in affected 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

Scenario: Obstetric Ward (Post-Operative) | Adult Female | Postoperative Pain Following Elective Caesarean Section

Monitor:

- SpO₂: 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 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."
- "SpO₂ 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."
- "I will also check whether the patient received intrathecal morphine or has a wound catheter for local anaesthetic, which may still be providing background analgesia."
- "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."
- "If pain persists and there are no contraindications, I would consider **oral or rectal diclofenac 50-100mg** or **ibuprofen 400mg**, which are safe during breastfeeding and effective for post-surgical pain."
- "If the pain continues or worsens despite these measures, 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."

Note: Important safety note: Codeine is CONTRAINDICATED in breastfeeding women (MHRA 2013). Due to variable CYP2D6 metabolism, some mothers convert codeine to morphine at dangerously high rates, which passes into breast milk and can cause neonatal respiratory depression, sedation, and apnoea.

Patient Explanation – if needed

"Mrs X, 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 paracetamol alone isn't enough, we can add an anti-inflammatory medication which is also safe while breastfeeding.

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: Emergency Department | Young Adult Male | Unconscious Patient - Suspected Metabolic Emergency

Vitals: SpO₂ 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."
- *SpO₂ 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 100 ml of 20% glucose IV over 15 minutes." (*alternative: 200 ml of 10% glucose*)
- **If IV access is not available**, administer **Glucagon 1mg IM** (note: less effective in patients who are malnourished or have liver disease).
- **If history suggests alcohol use: To prevent Wernicke's encephalopathy, I'll give 2 vials of IV Pabrinex alongside the glucose** (or immediately after), as thiamine deficiency is a concern in this patient. However, **DO NOT** delay glucose correction - hypoglycaemia must be treated immediately.

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: shakiness, sweating, dizziness, confusion, hunger, trembling, palpitations, difficulty concentrating
- 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 young adult 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, cardiovascularly 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

Scenario: Emergency Department | Young Adult Male | Unconscious Patient with Hypoglycaemia on ABG - IV Access Established

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 100 ml of 20% glucose IV over 15 minutes." (Alternative: 200 ml of 10% 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

- SpO₂ = 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

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- 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, a young adult male, 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."

Note: Cases 12 and 13 are similar in management. The key differentiating factors are:

- **Case 12:** Focus on unknown diabetic status - IV access needs to be established
- **Case 13:** Focus on confirmed hypoglycaemia with pre-existing IV access - more rapid treatment initiation

Hypoglycaemia - Post-Fall Elderly Woman

Scenario: Hospital Ward (Physiotherapy) | Older Adult Female | Acute Collapse with Reduced Consciousness - Recent Inpatient Following Fall

Monitor: SpO₂ 98%, BP 120/80, HR 80, RR 16, Temp 36°C **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 wristband to confirm her full name and age."

4. **Acknowledge Situation**

"This is an older adult female 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 100 mL of 20% glucose IV over 15 minutes." (If IV access not available or glucose not available, give Glucagon 1 mg IM - note: less effective in malnourished patients or those with liver disease.)

ABCDE Assessment

A – Airway

- Check for obstruction.
- Confirm airway is patent.
- SpO₂ 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, hunger, trembling, palpitations, difficulty concentrating.
 - 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, an older adult female, 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

Scenario: Acute Medical Unit | Older Adult Male (Care Home Resident) | Acute Deterioration with New Respiratory Symptoms and Sepsis Features - Hospital-Acquired Infection

Vitals: SpO₂ 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:**

"Mr X, you've developed a chest infection while in hospital, which has made you quite unwell. We're giving you oxygen, fluids, and strong antibiotics to fight the infection. We're monitoring you very closely and will involve the intensive care team if needed."

"This patient is showing signs of clinical deterioration - I will assess and manage him urgently."

"With SpO₂ 87%, HR 120, RR 24, BP 88/50 - this patient's NEWS2 is likely **≥7 (High Risk)**. IV antibiotics should be administered **within 60 minutes**."

[Note: Per NICE 2024, NEWS2 ≥7 requires IV antibiotics within 60 minutes; NEWS2 5-6 within 3 hours.]

ABCDE Assessment & Management

A – Airway

- Check for any visible or audible obstruction.
- Patient is responsive to voice - airway patent.
- **SpO₂ 87% on room air → Start 15L O₂ via non-rebreather mask immediately.**
- Reassess:

"SpO₂ improving to 94% after oxygen administration."

B – Breathing

- Inspect 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 O₂ 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) - **within 60 minutes for NEWS2 ≥7**
5. **500 mL IV crystalloid (e.g., 0.9% saline or Hartmann's) bolus over less than 15 minutes.**
Reassess after each bolus and repeat as needed.

[Note: Per NICE NG51, 500mL is standard; reduce to 250mL boluses if known heart failure or fluid overload risk.]

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 another 500 mL bolus and reassess."

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.
- I will review the current antibiotic choice and consider **broadening or changing** based on clinical response and culture results.
- 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, an older adult care home resident admitted recently 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: "SpO₂ was 87%, improved with 15L O₂. Crackles on one side, ABG awaited, temp 39°C, hypotension 88/50. NEWS2 ≥7 - high risk. Sepsis 6 initiated within 60 minutes: antibiotics, fluids (500mL boluses), blood cultures, catheterisation. Paracetamol given."

R – Recommendation: "Patient needs urgent senior review. Escalate to ITU if no improvement after fluid resuscitation. Continue sepsis protocol, monitor urine output, adjust antibiotics after sensitivities return."

Community Acquired Pneumonia

Scenario: Emergency Department | Young Adult Male | Acute Fever and Confusion - No Past Medical History, Brought in by Friend

Vitals: SpO₂: 94%, BP: 100/60 mmHg, HR: 120 bpm, RR: 24, Temp: 39°C, Lead II: Sinus Rhythm

Background: 18-year-old male university student brought to the emergency department by his flatmate due to fever and confusion. No past medical history, no regular medications.

Key Feature: Patient is NOT confused at presentation and CAN give history. This is a young, previously well patient presenting with sepsis secondary to community-acquired pneumonia - a high-acuity case requiring early recognition of sepsis and prompt initiation of treatment. The combination of youth, no PMH, and rapid deterioration makes this high-yield.

Initial Steps

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Knock and enter

Greet examiner: "Hello, I'm Dr [Name], GMC number [XXXXXX]. I've taken universal precautions and ensured the scene is safe."

Greet patient and confirm identity: "Hello, I'm one of the doctors in the emergency department. Can I confirm your full name and date of birth?"

Acknowledge situation: "I can see you're quite unwell. I'm going to assess you quickly and start treatment straight away."

Focused History (Patient Can Give History)

"I'll ask a few quick questions while I begin my assessment."

Onset: "When did you start feeling unwell? The fever - when did that begin?"

Associated symptoms:

"Any shortness of breath, cough, or chest pain?" - denies

"Any urinary symptoms - burning, frequency?" - denies

"Any nausea, vomiting, diarrhoea, or abdominal pain?"

"Any headache, neck stiffness, or sensitivity to light?" (*rule out meningitis*)

"Any rash?"

Past medical history: none

Medications: none

Allergies: none

Social history: university student, any recent travel, sick contacts?

Differential Diagnosis to Consider: Community-acquired pneumonia, meningitis, urosepsis, viral illness, infective endocarditis

CURB-65 Severity Assessment

[Per NICE NG250: Use CURB-65 to assess severity in adults presenting to hospital with CAP.]

Criterion	This Patient
Confusion (AMT ≤ 8)	No = 0
Urea > 7 mmol/L	Awaiting bloods
Respiratory rate ≥ 30	No (RR 24) = 0
BP systolic < 90 or diastolic ≤ 60	Diastolic 60 = 1
Age ≥ 65	No (age 18) = 0

Provisional CURB-65 score: 1 (low risk) - BUT clinical picture suggests sepsis (tachycardia, hypotension, fever), so clinical judgement overrides the score and this patient should be managed as **moderate-to-high severity** with a sepsis approach.

[Per NICE NG250: Use clinical judgement together with the CURB-65 score. Consider intensive care assessment for CURB-65 ≥ 3 or clinical concern.]

ABCDE Assessment & Management

A – Airway

Check for any obstruction - airway patent, patient is speaking.

SpO₂ 94% - at lower limit of target.

"Starting oxygen at 15 litres per minute via non-rebreather mask, targeting SpO₂ 94–98%."

[Per NICE NG253 and BTS Guidelines: Target SpO₂ 94–98% in patients without COPD.]

B – Breathing

"Respiratory rate is 24."

Inspect for chest deformity, accessory muscle use.

Palpate trachea and chest expansion.

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Percuss lung fields.

Auscultate: unilateral coarse crackles (key finding - suggestive of consolidation).

"Requesting a chest X-ray - should be done within 4 hours of presentation."

"Performing an arterial blood gas including glucose and lactate."

[Per NICE NG250: Chest X-ray within 4 hours of presentation to hospital. Per NICE NG253: Blood gas including lactate is a mandatory venous blood test in suspected sepsis.]

C – Circulation

"Pulse is 120 beats per minute. Blood pressure is 100 over 60. Capillary refill is greater than 2 seconds."

"This patient has clinical features of infection with haemodynamic compromise. I am calculating the NEWS2 score - with HR 120, RR 24, SpO₂ 94%, BP 100/60, temp 39°C, this patient's NEWS2 is likely ≥ 7 , placing them at high risk of severe illness or death from sepsis."

[Per NICE NG253 (Nov 2025): NEWS2 ≥ 7 = high risk. Broad-spectrum IV antibiotics within 1 hour. IV fluid bolus without delay (within 1 hour of identifying high risk).]

Immediate Sepsis Management (per NICE NG253):

Take:

Blood gas including glucose and lactate - lactate ≥ 2 mmol/L confirms high risk

Blood cultures - take before giving antibiotics

Send bloods: FBC, U&E, LFTs, CRP, clotting

Insert **2 wide-bore cannulas**

Give:

IV broad-spectrum antibiotics - within 1 hour of NEWS2 calculation

For high-severity CAP (per NICE NG250): **IV co-amoxiclav 1.2 g TDS PLUS IV or oral clarithromycin 500 mg BD**

If penicillin allergy: **Levofloxacin 500 mg BD** (per NICE NG250)

Use agreed local formulary (per NICE NG253)

IV fluid resuscitation - give an initial bolus of **250 mL isotonic crystalloid (Hartmann's solution preferred, or 0.9% saline)** over 10–15 minutes. Reassess after each bolus. Give further 250 mL boluses if needed, up to **1,000 mL total**.

Oxygen - already started at 15L via NRM, targeting 94–98%

[CRITICAL UPDATE - NICE NG253 (Nov 2025): IV fluid boluses are now 250 mL (not 500 mL). Use balanced crystalloid (Hartmann's) as first choice. Maximum 1,000 mL before senior escalation. This replaces the old NG51 guidance of 500 mL boluses.]

Insert **urinary catheter** and send urine for culture.

Request 12-lead ECG.

Reassess after first fluid bolus:

"BP still low - giving a further 250 mL bolus and reassessing after each."

Reassess after 1,000 mL total:

"If the patient has not improved enough after 1,000 mL, I will get advice from a senior clinical decision maker." (per NICE NG253 1.8.9)

D – Disability

"Patient is alert but appears unwell. GCS 15."

"Pupils are equal and reactive."

"Blood glucose - checked on blood gas."

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"Temperature 39°C - administering IV paracetamol 1 gram."

E – Exposure

"Examining abdomen - soft, non-tender."

"Checking limbs for rash, cellulitis, DVT."

"Checking private areas."

"No additional findings. Re-covering to maintain dignity and warmth."

Management Plan

Escalate to seniors - registrar and consultant.

Complete sepsis management as per NICE NG253.

Antibiotic duration (*per NICE NG250*): Stop after **5 days** unless microbiological results suggest a longer course is needed, or the person is not clinically stable (e.g., fever in the past 48 hours).

Review IV antibiotics at 48 hours and consider stepping down to oral:

Oral step-down: Amoxicillin 500 mg TDS ± clarithromycin 500 mg BD

Monitor urine output - target >0.5 mL/kg/hour.

Escalate to critical care (*per NICE NG253*): If no response within 1 hour of any intervention, ensure senior clinical decision maker attends in person, and refer to or discuss with critical care team. Discuss whether vasopressors should be given.

Recalculate NEWS2 every 30 minutes for high-risk patients (*per NICE NG253*).

Investigations (*per NICE NG250*): Consider blood cultures, sputum culture, pneumococcal urinary antigen test, and legionella urinary antigen test if risk factors present.

Explanation to the Patient

"Mr X, your blood tests and examination suggest you've developed a chest infection called pneumonia. Because your body is reacting very strongly to this infection - with a high temperature, fast heart rate, and low blood pressure - we believe you have developed sepsis, which is a serious condition that needs urgent treatment.

We've started you on strong antibiotics through a drip, given you fluids to support your blood pressure, and oxygen to help your breathing. We've taken blood samples and are closely monitoring how you respond.

We're keeping a very close eye on you. If needed, we'll involve the intensive care team to give you additional support. Do you have any questions?"

SBAR Handover

S – Situation: "This is an 18-year-old male university student brought in by his flatmate with fever and confusion. He is showing signs of sepsis secondary to community-acquired pneumonia. NEWS2 score ≥ 7 - high risk."

B – Background: "No past medical history, no regular medications, no allergies. Previously fit and well."

A – Assessment: "Airway patent. Breathing: RR 24, SpO₂ 94% - now on 15L O₂ via NRM, targeting 94–98%. Unilateral coarse crackles on auscultation. CXR requested. Circulation: HR 120, BP 100/60, CRT >2 seconds. Sepsis management initiated per NICE NG253: 2 cannulas inserted, bloods and cultures sent, IV co-amoxiclav and clarithromycin given within 1 hour, 250 mL Hartmann's boluses given - reassessing after each. Catheter inserted. Disability: GCS 15, temp 39°C - IV paracetamol given. ABG with lactate requested. Exposure: no other source found."

R – Recommendation: "Needs senior review. Recalculate NEWS2 every 30 minutes. If no improvement after 1,000 mL fluid, escalate to senior decision maker and discuss critical care referral."

Await CXR, ABG lactate, and culture results. Review antibiotics at 48 hours - step down to oral if improving. Stop antibiotics after 5 days per NICE NG250 if clinically stable."

Catheter-Associated Urinary Tract Infection - Sepsis

Scenario: Emergency Department | Older Adult Male | Acute Confusion with Fever and Urinary Symptoms - Post-Urological Procedure with Indwelling Catheter

Vitals: SpO₂ 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
- **SpO₂ 90% on room air** → Start **15L O₂ via non-rebreather mask**
- Reassess:

"SpO₂ 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 crystalloid 500 mL bolus over less than 15 minutes**, reassess BP.

[Note: Per NICE NG51, 500mL is standard; reduce to 250mL if known heart failure or fluid overload risk.] 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:

"BP after 500 mL now 105/65 - continue monitoring and reassess need for further boluses."

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*)

"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.

You're in safe hands and we're keeping a very close eye on everything."

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S – Situation: "This is Mr X, an older adult male, brought in with confusion and fever. He had urological surgery recently and has had a catheter in place since."

B – Background: "His wife reported burning urine and fever for a couple of days. Now tachycardic, febrile, hypotensive. This is likely catheter-associated UTI leading to sepsis."

A – Assessment: "SpO₂ 90%, BP 100/60, HR 120, Temp 39. Given O₂, IV fluids (500mL boluses), 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

Scenario: Medical Ward | Elderly Male | Acute Deterioration with Confusion - Known UTI on Treatment, Now Septic with AF

Vitals: SpO₂: 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:**

"I'll check the patient's wristband to confirm identity."

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**
- **SpO₂ 88% on room air** → Give **15L O₂ via non-rebreather mask**
- Reassess:

"SpO₂ 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

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- 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 crystalloid 500 mL bolus over less than 15 minutes.

[Note: Per NICE NG51, 500mL is standard; reduce to 250mL if known heart failure or fluid overload risk.] 5.

Insert urinary catheter, send urine sample for culture 6. Monitor urine output hourly

- I will review the current antibiotic choice and consider broadening or changing based on clinical response and culture results.
- Request 12-lead ECG → AF noted
- Reassess after 500 mL bolus:

"BP now 92/55 - will give further 500mL boluses as needed, reassessing after each."

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, an elderly male, admitted yesterday with UTI, now acutely deteriorating with confusion, hypotension, and fever."

B – Background: "On antibiotics for UTI. Nurse noted sudden confusion and worsening vitals. AF on ECG."

A – Assessment: "SpO₂ 88% (now improving with O₂), BP 85/50, HR 120, RR 24, Temp 39°C. ECG shows AF. Started Sepsis 6: O₂, fluids (500mL boluses), antibiotics, cultures, catheterised and monitored output."

R – Recommendation: "Needs urgent senior review. May require escalation to ITU depending on response. Awaiting bloods and cultures. Will review antibiotic choice based on clinical response and culture results. **I will also check if the patient has a ReSPECT form or DNACPR decision in place and discuss escalation limits with the senior.**"

Sepsis of Unknown Source

Scenario: Emergency Department | Young Adult Male | Acute Fever with Hypotension and Tachycardia - No Clear Source of Infection, Brought by Flatmate

Vitals: SpO₂: 94% on air, BP: 80/55 mmHg, HR: 120 bpm, RR: 26, Temp: 38.9°C

Background: 30-year-old male who developed a fever overnight. His flatmate called an ambulance. No past medical history provided initially.

Key Feature: This is a sepsis case where the source of infection is NOT immediately obvious. The examiner expects you to systematically search for a source through history and examination while simultaneously initiating resuscitation and sepsis management per NICE NG253. You must demonstrate that you do not delay treatment while waiting to identify the source - "treat first, investigate in parallel."

Initial Steps

Knock and enter

Greet examiner: "Hello, I'm Dr [Name], GMC number [XXXXX]. I've taken universal precautions and ensured the scene is safe."

Greet patient and confirm identity: "Hello, I'm one of the doctors in the emergency department. Can I confirm your full name and date of birth?"

Acknowledge situation: "I can see you're very unwell with a high temperature and your blood pressure is quite low. I'm going to assess you urgently and start treatment straight away."

Focused History - Data Gathering**Explore the fever (ODIPARA):**

Onset, Duration, Intermittent/continuous, Precipitating factors, Aggravating/relieving factors, Associated symptoms

Systematically explore for a source - ask about:

Respiratory: cough, sputum, shortness of breath, chest pain

Urinary: dysuria, frequency, urgency, haematuria, loin pain

GI: abdominal pain, nausea, vomiting, diarrhoea

ENT: sore throat, runny nose, ear pain

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GK's PLAB 2 Preparation WhatsApp Channel - <https://tinyurl.com/gksplab2>

Skin: rash, wound, recent bites or cuts, IV drug use

Neurological/Red Flags: neck stiffness, photophobia, headache (*rule out meningitis*)

Musculoskeletal: joint pain or swelling (*septic arthritis*)

Past medical history: any chronic conditions, immunosuppression, recent surgery, recent travel?

Medications: any regular medications, recent antibiotics? **Allergies:** any known? **Social history:** occupation, living situation, travel, sexual history, IV drug use?

Differential Diagnosis to Consider: Pneumonia, urosepsis, meningitis, intra-abdominal sepsis, cellulitis/skin source, endocarditis, viral illness with secondary bacterial infection

NEWS2 Score and Risk Stratification

[Per NICE NG253 (Nov 2025): Use NEWS2 to stratify risk in adults aged 16+ with suspected infection.]

With HR 120, RR 26, SpO₂ 94%, BP 80/55, temp 38.9°C - **this patient's NEWS2 is ≥7, placing them at high risk of severe illness or death from sepsis.**

Red flag criteria present (per NICE NG253):

SBP <90 mmHg ✓

HR >130 - borderline (120)

RR >25 ✓

Lactate - awaiting ABG

ABCDE Assessment & Management

A – Airway

Check for any obstruction - patient vocalising, airway patent.

SpO₂ 94% on room air - at lower limit of target.

"Starting oxygen at 15 litres per minute via non-rebreather mask, targeting SpO₂ 94–98%."

[Per NICE NG253 and BTS Guidelines: Target SpO₂ 94–98% in patients without COPD. No history of COPD, so standard targets apply.]

B – Breathing

"Respiratory rate is 26 - tachypnoeic."

Inspect for chest deformity, accessory muscle use.

Palpate trachea and chest expansion.

Percuss lung fields.

Auscultate: crackles in both lower zones (possible respiratory source, but could also be secondary to fluid redistribution in sepsis).

"Requesting a chest X-ray."

"Performing an arterial blood gas including glucose and lactate."

"Requesting an ECG."

C – Circulation

"Pulse is 120 beats per minute. Blood pressure is 80 over 55. Capillary refill is greater than 3 seconds."

"This patient is febrile, hypotensive, and tachycardic with bilateral crackles. NEWS2 ≥7 - high risk of severe illness or death from sepsis. I am initiating immediate sepsis management."

Immediate Sepsis Management (per NICE NG253):

Take:

Blood gas including glucose and lactate - lactate ≥2 mmol/L confirms high risk

Blood cultures - take from two separate sites, before giving antibiotics

Send bloods: FBC, U&E, LFTs, CRP, clotting, procalcitonin if available

Insert **2 wide-bore cannulas**

Give:

IV broad-spectrum antibiotics - within 1 hour of calculating NEWS2 score

Use IV antimicrobial from the agreed local formulary (*per NICE NG253*)

Typical empiric choice for sepsis of unknown source: **IV piperacillin-tazobactam 4.5 g TDS** or per local protocol

If penicillin allergy: per local formulary (e.g., meropenem may be considered in severe cases)

If meningitis suspected (neck stiffness, photophobia, rash): add **IV ceftriaxone 2 g** immediately

IV fluid resuscitation - give an initial bolus of **250 mL isotonic crystalloid (Hartmann's solution preferred, or 0.9% saline)** over 10–15 minutes. Reassess after each bolus. Give further 250 mL boluses if needed, up to **1,000 mL total**.

Oxygen - already started at 15L via NRM, targeting 94–98%

[CRITICAL UPDATE - NICE NG253 (Nov 2025): IV fluid boluses are now 250 mL (not 500 mL as per old NG51). Use balanced crystalloid (Hartmann's) as first choice. Maximum 1,000 mL before senior escalation.

Antibiotics within 1 hour for NEWS2 ≥ 7 .]

Insert **urinary catheter** and send urine for culture.

Request 12-lead ECG.

Reassess after first fluid bolus:

"BP still 85/58 - giving another 250 mL bolus and reassessing."

Reassess after 1,000 mL total:

"If the patient has not improved enough after 1,000 mL, I will get advice from a senior clinical decision maker." (*per NICE NG253 1.8.9*)

D – Disability

"Assessing GCS - patient is alert but looks unwell."

"Pupils are equal and reactive."

"Blood glucose - checked on blood gas."

"Temperature 38.9°C - administering IV paracetamol 1 gram."

E – Exposure

This is the critical step for unknown source sepsis - thorough examination is essential:

"Examining the skin - checking for rash (*petechial/purpuric rash = meningococcal sepsis - if found, give IV ceftriaxone 2 g immediately*), cellulitis, wound infections, injection sites."

"Examining the abdomen - checking for tenderness, guarding, rigidity."

"Checking the legs - looking for DVT, cellulitis, joint swelling."

"Checking private areas - any signs of perineal or genital infection."

"Checking the back - any spinal tenderness, pressure sores."

"Checking neck stiffness - if positive, consider meningitis."

"No obvious source identified on examination - will continue broad-spectrum treatment and await investigation results."

Management Plan

Escalate to seniors - registrar and consultant.

Complete sepsis management as per NICE NG253.

Recalculate NEWS2 every 30 minutes for high-risk patients (*per NICE NG253*).

Escalate to critical care (*per NICE NG253*): If no response within 1 hour of any intervention, ensure senior clinical decision maker attends in person, and refer to or discuss with critical care specialist. Discuss whether vasopressors should be given.

Monitor urine output - target >0.5 mL/kg/hour.

Review antibiotic choice when culture and sensitivity results return - narrow to targeted therapy.

Investigate for source:

CXR - pneumonia?

Urine culture - UTI/urosepsis?

Blood cultures - bacteraemia?

Consider CT abdomen/pelvis if no source found and patient not improving

Consider lumbar puncture if meningitis suspected (after CT head if indicated)

Consider echocardiography if endocarditis suspected

Review antibiotics at 48 hours - step down to oral and narrow spectrum when cultures available.

Repeat bloods at 6 hours to assess response (lactate trend, CRP, WCC).

Explanation to the Patient

"Mr X, your blood tests and examination show that your body is fighting a serious infection - we call this sepsis. At the moment, we haven't been able to pinpoint exactly where the infection started, but we've found some crackles in your chest which may suggest a chest infection.

We've already started you on strong antibiotics through a drip, given you fluids to bring your blood pressure up, and oxygen to support your breathing. We've taken blood and urine samples and ordered a chest X-ray to help us find the exact cause.

We're monitoring you very closely. Once we know which bug is causing the infection, we'll adjust your antibiotics to target it specifically. If your condition doesn't improve quickly, we'll involve the intensive care team for extra support. Do you have any questions?"

SBAR Handover

S – Situation: "This is a 30-year-old male brought in by ambulance with fever since last night. He is hypotensive, tachycardic, and febrile - clinical picture consistent with sepsis of unknown source. NEWS2 ≥ 7 - high risk."

B – Background: "No known past medical history, no regular medications, no allergies. Flatmate called the ambulance after he developed a high fever overnight."

A – Assessment: "Airway patent. Breathing: RR 26, SpO₂ 94% - now on 15L O₂ via NRM, targeting 94–98%. Crackles in both lower zones on auscultation. Circulation: HR 120, BP 80/55, CRT >3 seconds. Sepsis management initiated per NICE NG253: 2 cannulas, bloods and cultures sent, IV broad-spectrum antibiotics given within 1 hour, 250 mL Hartmann's boluses given - reassessing after each. Catheterised. Disability: alert, temp 38.9°C - IV paracetamol given. ABG with lactate requested. Exposure: no rash, no obvious skin or abdominal source. Bilateral lower zone crackles may suggest respiratory source."

R – Recommendation: "Needs urgent senior review. Recalculate NEWS2 every 30 minutes. Continue fluid resuscitation - escalate to senior decision maker if no improvement after 1,000 mL total. Discuss critical care referral if no response within 1 hour. Await CXR, ABG, cultures. Review antibiotics when

sensitivities return. If no source identified and patient not improving, consider CT abdomen/pelvis and broader investigation."

Morphine Toxicity

Scenario: Emergency Department | Elderly Male with Chronic Kidney Disease | Acute Drowsiness and Respiratory Depression - Recent Opioid Prescription

Vitals: SpO₂: 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. This is likely **accidental opioid toxicity** rather than deliberate overdose. Given the patient is opioid-naïve with CKD, I will use a **low-dose naloxone regimen** to avoid precipitating severe withdrawal or acute pain. 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**
- **SpO₂ is 88% → Administer 15L oxygen via non-rebreather mask**
- **Reassess SpO₂** after oxygen:

"SpO₂ 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
- **Low-dose naloxone regimen:** Starting with **IV Naloxone 100-200mcg** titrated to respiratory reversal (target RR >10, SpO₂ >92%), NOT full reversal of consciousness. Repeat doses every 2-3 minutes as needed.
- Request **ABG** and **chest X-ray** to assess gas exchange and exclude aspiration
- **Reassess RR and GCS after 2-3 minutes:**

"Checking response - RR improving slightly. Will titrate further if needed."

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 naloxone doses:

"If RR not improving to >10, administer another 100-200mcg naloxone IV and reassess."

D – Disability

- Check **GCS, blood glucose, and temperature**
- Blood glucose normal
- Continue titrating naloxone to respiratory reversal
- **Target:** RR >10, SpO₂ >92% - NOT full consciousness
- If repeated boluses are required, consider starting a **naloxone infusion** - typically 60% of the total dose required for reversal, given over 1 hour.

"After titrated doses, RR improving to 12/min and SpO₂ now 96%. Patient becoming more rousable."

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)

Observation Period

Per RCEM 2024: "Observe for at least **4 hours after the last dose of naloxone** AND at least **6 hours after the suspected time of opioid use**."

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)

"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. We used a carefully titrated approach to restore your breathing without causing pain or distress. 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, an elderly male with CKD stage 4, presented drowsy and bradypnoeic after recent morphine prescription."

B – Background: "Came recently with back pain after a fall and was prescribed morphine. Wife reports increasing drowsiness. Today found with RR 6, SpO₂ 88%, BP 90/60."

A – Assessment: "Suspected accidental opioid toxicity - pinpoint pupils, low RR. Used low-dose naloxone regimen: 100-200mcg IV doses titrated to respiratory reversal. Patient now rousable with RR 12, SpO₂ 96%. Target was respiratory reversal (RR >10, SpO₂ >92%), not full consciousness. ABG and chest X-ray pending. ECG SR."

R – Recommendation: "Needs admission with observation for at least 4 hours post-naloxone AND 6 hours post-opioid. Morphine to be stopped, switch to safer analgesia. Consider naloxone infusion if further doses needed. Involve renal and pain teams."

Atrial Fibrillation

Scenario: Emergency Department | Older Adult | Acute Palpitations and Dizziness with Tachycardia - AF on ECG

Vitals: SpO₂: 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 SpO₂ <94%, administer **15L O₂ via non-rebreather mask**

"SpO₂ 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:**
 - **First-line options include beta-blockers** (e.g., bisoprolol 2.5-5mg) or **rate-limiting calcium channel blockers** (e.g., diltiazem SR 90-120mg)
 - Avoid beta-blockers if decompensated heart failure or asthma
 - Digoxin may be considered as add-on or alternative
- "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

"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], an older adult, presented with dizziness and palpitations. Vitals show HR 140 irregular, BP 110/80, SpO₂ 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 (first-line). 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."

COPD Exacerbation with NEWS Chart

Scenario: Emergency Department | Middle-Aged Male | Acute Breathlessness with Known COPD - NEWS Chart Provided

Monitor: SpO₂ 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

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. X."
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
- SpO₂ 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 nebuliser**
Note: Use air-driven nebuliser (not oxygen-driven) in COPD to avoid worsening CO₂ retention. If the patient also needs supplemental oxygen, deliver it via nasal cannula simultaneously. If ABG shows pH <7.35 with PaCO₂ >6 kPa despite initial treatment, initiate non-invasive ventilation and escalate to senior/ICU.
- Order **Chest X-ray**

- Perform **ABG** to assess for CO₂ 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
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 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**

S – Mr. X, a middle-aged 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: SpO₂ 97%, HR 95, RR 23. NEWS score 3 (low risk). 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.

Chronic Bronchitis

Scenario: Emergency Department | Middle-Aged Male | Acute Breathlessness with Known Chronic Bronchitis and Normal Observations

Vitals: SpO₂: 98%, BP: 120/70 mmHg, HR: 80 bpm, RR: 15, Temp: 37°C

Background: 45-year-old male with known chronic bronchitis. Uses a blue (salbutamol) inhaler. Has not been taking his inhalers for the past few days. Presenting complaint: breathlessness and cough. No known allergies. Non-smoker.

Key Feature: Patient can speak in full sentences without breathlessness - this is a stable presentation, not a life-threatening emergency. However, you must still perform a full ABCDE assessment and demonstrate structured management.

Initial Steps

Knock and enter

Greet examiner: "Hello, I'm Dr [Name], GMC number [XXXXXX]. I've taken universal precautions and ensured the scene is safe."

Greet patient and confirm identity: "Hello, I'm one of the doctors here today. Could I confirm your full name and date of birth?"

Acknowledge situation: "I can see you've come in feeling breathless. I'm going to assess you thoroughly and get things started straight away."

Focused History (Patient Can Speak - Take History Early)

"Since you're able to talk comfortably, I'll ask a few quick questions while I assess you."

Onset and duration: "When did the breathlessness start? Has it been getting worse?"

Associated symptoms: cough (productive?), sputum colour/volume change, fever, chest pain, wheeze, leg swelling

Triggers: cold air, exercise, infection, missed inhalers

Past medical history: chronic bronchitis - any previous admissions, ICU stays, NIV?

Medications: blue inhaler (salbutamol) - any preventer inhaler? Compliance?

Allergies: none

Smoking history: non-smoker, any passive exposure?

Differential Diagnosis to Consider: Acute exacerbation of chronic bronchitis, asthma, COPD exacerbation, pulmonary embolism, heart failure

ABCDE Assessment & Management

A – Airway

"The patient is speaking in full sentences, so the airway is patent."

"Checking the oral cavity: no obstruction or secretions."

SpO₂ 98% on room air - no immediate oxygen required.

"As this patient has a history of chronic bronchitis, I will target SpO₂ 88–92% if oxygen is needed, to avoid the risk of hypercapnic respiratory failure."

[Per BTS 2017 Guidelines and NICE NG115: Target SpO₂ 88–92% in patients with COPD/chronic bronchitis. If ABG confirms no hypercapnia, target can be adjusted to 94–98%.]

B – Breathing

"Respiratory rate is 15. Oxygen saturation is 98 percent."

Inspect for chest deformity, accessory muscle use - none expected.

Palpate trachea position and chest expansion - central trachea, symmetrical expansion.

Percuss lung fields - resonant bilaterally.

Auscultate: may hear scattered wheeze or rhonchi bilaterally.

"As the patient has a history of chronic bronchitis and is dyspnoeic, I'm administering nebulised salbutamol 5 milligrams via **air-driven** nebuliser."

[Per BTS Guidelines: Use compressed air to drive nebulisers in COPD/chronic bronchitis patients (with nasal O₂ at 2 L/min if oxygen is needed). If compressed air is unavailable, limit oxygen-driven nebulisers to 6 minutes maximum.]

"Requesting a chest X-ray and performing an arterial blood gas."

C – Circulation

"Pulse is 80 beats per minute, regular. Blood pressure is 120 over 70. Capillary refill is under 2 seconds."

"Inserting an intravenous cannula."

"Sending bloods: full blood count, urea and electrolytes, liver function tests, CRP."

"Requesting a 12-lead ECG."

D – Disability

"Patient is alert and orientated. GCS 15."

"Blood glucose is within normal range."

"Temperature is 37 degrees - no pyrexia."

"Pupils are equal and reactive."

E – Exposure

"Inspecting chest, abdomen, back, limbs, and private areas."

"No rashes, oedema, or signs of DVT."

"Re-covering the patient to maintain warmth and dignity."

Management Plan

Admit for observation and further investigation.

Involve seniors - discuss with registrar or consultant.

Consider antibiotics only if signs of bacterial infection are present (*per NICE NG114*):

Pyrexia

Increase in sputum volume or purulence

Change in sputum colour (green/yellow)

Raised inflammatory markers (CRP, WCC)

Abnormal chest X-ray (consolidation or new changes)

If antibiotics are indicated (*per NICE NG114*):

First-line oral: Amoxicillin 500 mg three times daily for 5 days

Alternative oral (if penicillin allergy): Doxycycline 200 mg on day 1, then 100 mg once daily for 5 days;
OR Clarithromycin 500 mg twice daily for 5 days

If higher risk of treatment failure (repeated courses, resistant organisms): Co-amoxiclav 500/125 mg three times daily for 5 days

If IV needed (unable to take oral, or severe illness): IV amoxicillin 500 mg TDS, or IV co-amoxiclav 1.2 g TDS, or IV clarithromycin 500 mg BD - review at 48 hours and step down to oral

Continue nebulised bronchodilators as needed.

Review ABG and CXR results when available.

Consider oral prednisolone 30 mg once daily for 5 days (*per NICE NG115*) if significant airflow obstruction.

[Note: Per NICE NG114, many exacerbations - including some severe ones - are not caused by bacterial infections and will not respond to antibiotics. Do not prescribe antibiotics routinely.]

Patient Advice

"Mr X, your breathing difficulty is likely because your chronic bronchitis has flared up - possibly because you've missed your inhalers recently."

"It's really important to use your inhalers regularly, even when you feel well, to keep your airways open and prevent flare-ups."

Advise on:

Regular inhaler use - compliance is key

Maintaining a trigger diary - to identify what worsens symptoms

Avoiding secondary smoking and other irritants

Annual flu and pneumococcal vaccination (*per NICE NG115*)

Pulmonary rehabilitation referral if recurrent episodes

Self-management/rescue pack: Consider providing a short course of oral corticosteroids and antibiotics to keep at home if they have had an exacerbation within the last year (*per NICE NG114*)

Safety Netting

"If your breathing gets worse, you develop a high fever, or you notice blood in your sputum, please come back to the emergency department or call 999 immediately."

"We'll monitor you here and review your test results. If everything looks stable, we'll plan for a safe discharge with follow-up."

SBAR Handover

S – Situation: "This is a 45-year-old male with known chronic bronchitis presenting with acute breathlessness after stopping his inhalers."

B – Background: "He has a diagnosis of chronic bronchitis, uses a salbutamol inhaler but has been non-compliant for several days. Non-smoker, no allergies."

A – Assessment: "Airway is patent. Breathing: RR 15, SpO₂ 98%, scattered wheeze on auscultation. Nebulised salbutamol given via air-driven nebuliser. Circulation: HR 80, BP 120/70, stable. Disability: Alert, GCS 15, normoglycaemic, afebrile. Exposure: No abnormalities. CXR and ABG requested."

R – Recommendation: "Admit for monitoring. Review CXR and bloods. Consider antibiotics if infection markers are raised - first-line amoxicillin 500 mg TDS for 5 days. Reinforce inhaler compliance. Consider rescue pack on discharge. Arrange respiratory follow-up if recurrent presentations."

Chapter 29: Prescriptions

A Note to Learners

The cases in this resource are written in a conversational style to help you become familiar with the natural flow of clinical consultations and the language commonly used in UK healthcare settings.

These dialogues are intended as a learning guide, not a script. Please do not attempt to memorise them verbatim. Examiners assess your ability to think and communicate authentically - not to recite rehearsed phrases.

Use this material to understand the underlying clinical reasoning, then practise in your own words until the consultation feels natural to you.

For Companion OSCE Cases, Practice Scripts, Evaluation Checklists, Summary Notes, Rapid Review Notes, Mindmaps, Management Flashcards and Image Library - visit <https://www.gksplab2.com>

Disclaimer

This material is independent educational content created to help candidates develop clinical reasoning and communication skills for UK medical practice.

All cases and clinical scenarios are based on common presentations encountered in UK primary care and emergency medicine, drawn from publicly available sources including NICE Clinical Knowledge Summaries (CKS), BNF, and other official NHS/UK healthcare guidelines.

No content in this resource is derived from, represents, or claims to replicate actual GMC PLAB 2 examination material.

Introduction

Prescription stations are a core component of the PLAB 2 examination. Unlike communication stations where you interact with patients, prescription stations test your ability to accurately and safely complete drug charts under time pressure. This chapter provides everything you need to confidently approach any prescription scenario.

Key Principles for Success

Task Priority: Always complete the main task first. If the station asks you to prescribe an antibiotic, that prescription must be your priority. Failing to prescribe the requested medication will significantly impact your score, regardless of how well you complete other elements.

Use the BNF: The BNF is available in the station. Opening it demonstrates good practice and can earn marks. Use it for antibiotics, new medications, and anticoagulants unless all doses are provided in the task.

Verify Patient Details: Always cross-check the patient sticker against the task information. Mismatched details are a deliberate examiner trap that can cost significant marks.

Check for Interactions: Before prescribing, review the patient's regular medications. Common interactions (Lithium + NSAIDs, Statins + Clarithromycin, Anticoagulants + Aspirin) are frequently tested.

Adjust for Renal Function: Always note the eGFR. Key thresholds include: Nitrofurantoin contraindicated if eGFR <30, Vancomycin frequency reduced if eGFR <50.

CRITICAL EXAM TIP: Complete all boxes for every prescription. Missing elements (duration, signature, beep number) lose marks even if the drug choice and dose are correct.

How to Use This Chapter

For Learning: Read through Sections 1-3 to understand the fundamentals, then work through condition-specific sections (4-11) systematically.

For Revision: Use Section 12 (Quick Reference Tables) for rapid review. Focus on the boxes marked "MEMORIZE" throughout the chapter.

For Practice: Work through Section 13 (Practice Cases) under timed conditions. Each case includes a detailed answer key to help identify gaps in your knowledge.

Section 1: Prescription Chart Anatomy

1.1 Chart Sections Overview

The PLAB 2 prescription chart contains multiple distinct sections that must be completed correctly. Understanding the layout is essential for efficient and accurate prescribing.

Chart Layout Summary

Section	Location	Purpose

Demographics	Top left	Ward, Hospital, Consultant, Admission Date, Weight, Height
Patient Sticker	Top right (Pages 1 & 3)	Patient identification - MUST verify against task
Prescriber Details	First page header	Your full name + GMC number
Allergy Box	Upper section	Drug allergies + reaction type, or "NKA"
Once Only Medications	Upper-middle	Stat doses, loading doses, one-time medications
Oxygen Section	Dedicated area	Target saturations, device, flow rate
Antibiotic Section	Middle	Antibiotics with indication and review date
Regular Medications	Middle-lower	Scheduled regular medications
As Required (PRN)	Lower section	PRN medications with max doses

Demographics Section (Top Left)

Complete this section FIRST. Required fields:

- **Ward:** Copy from task information
- **Hospital:** Copy from task information
- **Consultant:** Write in CAPITAL LETTERS
- **Date of Admission:** Use DD/MM/YYYY format
- **Weight:** In kg (critical for dosing calculations)
- **Height:** In cm or m
- **Date Written:** Today's date (exam date)

Patient Sticker Section (Top Right)

CRITICAL WARNING: The patient sticker appears on Pages 1 and 3 of the drug chart. You MUST verify that the information on the sticker matches the task information. An incorrect sticker is a costly mistake that will lose marks.

Check the following match:

- Patient name
- Date of birth
- Hospital/NHS number
- Any other identifiers

Prescriber Details Section

On the first page header, write:

- Your FULL NAME in capitals
- Your GMC number
- This information should be consistent throughout the chart

Allergy Box

If allergies present:

- Write drug name in CAPITALS
- Document reaction type (e.g., "Rash", "Anaphylaxis", "Photosensitivity")
- Sign and date

If no known allergies:

- Write "NKA" (No Known Allergies)

- Sign and date

IMPORTANT: Never leave the allergy box blank. This is an examiner checkpoint.

1.2 Abbreviations Reference Tables

Dosage Abbreviations

Preferred	Acceptable	AVOID
nanograms	-	ng
micrograms	-	mcg, µg, ug
mg	-	-
grams, g	-	-
mL	ml	-
L	l	-
mmol	-	-
mol	-	-
tablet(s), tab(s)	-	T
units	-	U, IU
puffs	-	-

MEMORIZE: Never abbreviate "micrograms" or "units" - write them out in full.

Route Abbreviations

Preferred	Acceptable	AVOID
IM	intramuscular	-
INH	inhaled	-
IV	intravenous	-
NEB	nebulised	-
Oral	PO (per os)	O
PEG, NG	by enteral tube	-
PR	rectal	-
SC	subcutaneous	-
SL	sublingual	-
PV	vaginal	-
TOP	topical	-

Fluid Abbreviations

Preferred	Acceptable	AVOID
0.9% sodium chloride	0.9% NaCl, 0.9% saline	Normal saline, N. saline
5% glucose	5% Dextrose®	-
Compound sodium lactate	Hartmann's solution	CSL
Potassium chloride	KCl	-

Frequency Abbreviations

Abbreviation	Meaning	Times (24-hour)
OD	Once daily	08:00
BD	Twice daily	08:00, 20:00
TDS	Three times daily	08:00, 16:00, 00:00
QDS	Four times daily	06:00, 12:00, 18:00, 00:00

Mane	Morning	08:00
Nocte	At night	22:00
PRN	As required	Variable
STAT	Immediately	Single dose

1.3 Writing Conventions

Capital Letters Rule

Use CAPITAL LETTERS for:

- Your name
- Consultant's name
- Patient demographics
- **All medication names**
- Routes of administration

Tip: If your handwriting is difficult to read, write the ENTIRE prescription in capitals.

Quantity Writing Rules

Quantity	Write As	NOT
≥1 gram	1 g, 1.5 g	1000 mg
<1 gram	500 mg	0.5 g
<1 mg	100 micrograms	0.1 mg

Decimal Rules

Rule	Correct	Incorrect
Avoid unnecessary decimals	3 mg	3.0 mg
Zero before decimal point	0.5 mL	.5 mL
Ranges with decimals	0.5 to 1 g	0.5-1g

Volume Rules

- Use mL (capital L preferred)
- **NEVER** use cc or cm³

Units Rule

CRITICAL: Always write "units" in full. Never abbreviate to "U" or "IU".

Example:

- ✓ Correct: Heparin 5000 units SC
- X Wrong: Heparin 5000 U SC

Section 1 Quick Reference Card

Before Starting Any Prescription

1. ☐ Black pen only
2. ☐ Check patient sticker matches task
3. ☐ Complete demographics FIRST
4. ☐ Document allergies (or NKA)
5. ☐ Write all drug names in CAPITALS
6. ☐ Never abbreviate "micrograms" or "units"
7. ☐ Use 24-hour clock for all times

Common Mistakes to Avoid

- Leaving allergy box blank
- Not verifying patient sticker against task
- Using "normal saline" instead of "0.9% sodium chloride"
- Abbreviating units as "U"
- Writing ".5" instead of "0.5"
- Not signing and dating each entry

Section 2: Step-by-Step Workflow

2.1 Seven-Step Completion Order

CRITICAL PRINCIPLE: The task is always the priority. If the task asks for a new medication or antibiotic, write these FIRST. Failing to prescribe the requested medication is a costly mistake that will significantly impact your score.

Priority Order for Completing the Drug Chart

Step	Action	Section of Chart
1	Fill demographics	Top left section
2	Complete allergy box	Allergy section
3	Write emergency/urgent drugs (if applicable)	Once Only section
4	Write antibiotics → Open the BNF	Antibiotic section
5	Write new medications → Open the BNF	Appropriate section
6	Write anticoagulants → Open the BNF	Regular/Once Only section
7	Write regular and PRN medications	Regular/PRN sections

Step-by-Step Breakdown

Step 1: Demographics (30 seconds)

Fill in the top left section:

- Ward
- Hospital
- Consultant (CAPITALS)
- Date of admission
- Weight (kg)
- Height
- Date written (today's date)

Then immediately: Verify patient sticker on Pages 1 and 3 matches task information.

Step 2: Allergies (15 seconds)

In the allergy box:

- If allergies stated → Drug name + Reaction type → Sign + Date
- If no allergies → "NKA" → Sign + Date

Step 3: Emergency Drugs (if applicable)

If the scenario involves:

- Anaphylaxis
- Cardiac arrest
- Status epilepticus

- Acute severe asthma
- Septic shock

Write these drugs FIRST in the Once Only section.

Step 4: Antibiotics

Always open the BNF for antibiotic prescribing unless all doses are given in the task.

In the Antibiotic section, include:

- Drug name (CAPITALS)
- Dose
- Route
- Frequency
- Start date
- Stop/Review date
- **Indication box:** Write the condition (e.g., "CAP", "UTI")
- **Additional info:** "Review in 48 hours"

Step 5: New Medications

Prescribe any new medications requested in the task. Use the BNF to confirm:

- Correct dose
- Correct route
- Any dose adjustments (renal function, age, weight)

Step 6: Anticoagulants

If prescribing anticoagulants:

- Loading doses → Once Only section
- Maintenance doses → Regular section (or Antibiotic section for VTE treatment)
- Always document indication

Step 7: Regular and PRN Medications

Transcribe regular medications from the task:

- Drug name (CAPITALS)
- Dose
- Route
- Frequency
- Tick appropriate timing boxes
- Sign, date, and add bleep number

For PRN medications:

- Include indication
- Include frequency as HOURLY intervals (not BD/TDS/QDS)
- Include maximum 24-hour dose
- Sign and add bleep

2.2 Timing Conventions (24-Hour Format)

All times on the prescription chart must be written in 24-hour format.

Standard Timing for Frequencies

Frequency	Number of Doses	Times to Write

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OD (once daily)	1	08:00
BD (twice daily)	2	08:00, 20:00
TDS (three times daily)	3	08:00, 16:00, 00:00
QDS (four times daily)	4	06:00, 12:00, 18:00, 00:00
Mane (morning)	1	08:00
Nocte (at night)	1	22:00

Regular Medication Tick Box Mapping

When prescribing regular medications, tick the appropriate boxes:

Boxes to Tick	
Frequency	
Mane / OD	Morning only ☐
BD	Morning ☐ + Evening ☐
TDS	Morning ☐ + Midday ☐ + Evening ☐
QDS	Morning ☐ + Midday ☐ + Evening ☐ + Bedtime ☐
Nocte	Bedtime only ☐

Antibiotic Timing

For the antibiotic section, write specific times:

Frequency	Write These Times
6-hourly (QDS)	06:00, 12:00, 18:00, 00:00
8-hourly (TDS)	08:00, 16:00, 00:00
12-hourly (BD)	08:00, 20:00
24-hourly (OD)	08:00

PRN Frequency

For PRN medications, write frequency as hourly intervals:

- ✓ Correct: "Q4h PRN" or "4-hourly PRN"
- ✗ Wrong: "TDS PRN" or "QDS PRN"

2.3 Error Correction Protocol

Mistakes happen. The key is correcting them properly without using correction fluid.

How to Correct an Error

1. Draw a single line through the incorrect entry
2. Sign and date beside the crossed-out entry
3. Write the correct prescription in a new medication box below
4. Complete all fields in the new box

What NOT to Do

Incorrect Method	Why It's Wrong
Using correction fluid (Tipp-Ex)	Against hospital policy; raises fraud concerns
Scribbling over the error	Makes original unreadable; unprofessional
Writing over the mistake	Creates confusion about the intended prescription
Leaving error uncorrected	Patient safety risk

Example of Proper Correction

Incorrect entry:

AMOXICILLIN 250 mg PO TDS × 5 days [crossed out with single line] Dr. X 15/01/25

Corrected entry (new box):

AMOXICILLIN 500 mg PO TDS × 5 days

Start: 15/01/25 Stop: 19/01/25

Dr. X Bleep: 1234

Crossing Out Morning Dose for Loading Doses

When prescribing a loading dose followed by maintenance:

Example: Vancomycin

1. Loading dose in Once Only section: Vancomycin 1.5 g IV STAT
2. Maintenance dose in Antibiotic section: Vancomycin 500 mg IV BD
Note: Maintenance dose shown assumes eGFR ≥50; adjust frequency per renal function (see Section 6.5)
3. **Cross out the morning dose** on Day 1 (as loading dose replaces it)

Section 2 Quick Reference Card

The 7-Step Order (MEMORIZE)

1. Demographics → Top left
2. Allergies → Allergy box
3. Emergency drugs → Once Only (if needed)
4. Antibiotics → Open BNF
5. New medications → Open BNF
6. Anticoagulants → Open BNF
7. Regular + PRN meds → Last

Timing Quick Reference

Frequency	Times
OD	08:00
BD	08:00, 20:00
TDS	08:00, 16:00, 00:00
QDS	06:00, 12:00, 18:00, 00:00

Error Correction Checklist

- ☐ Single line through error
- ☐ Sign and date the correction
- ☐ Write new entry in fresh box
- ☐ Complete ALL fields in new entry
- ☐ NEVER use correction fluid

Critical Reminders

- **Task priority:** Always write requested medications FIRST
- **BNF:** Open it for antibiotics, new meds, and anticoagulants
- **Patient sticker:** Verify it matches task information
- **Signature:** Use the same signature throughout
- **Bleep number:** Include from handover information

Section 3: Marking Criteria

Understanding how prescription stations are marked helps you prioritize your actions and avoid common pitfalls. PLAB 2 prescription stations are marked across three domains: Interpersonal Skills (IPS), Data Gathering, and Management.

3.1 Interpersonal Skills (IPS) Marks

IPS marks assess your professional conduct during the station. Even though you're completing paperwork, examiners observe your demeanor and approach.

How to Maximise IPS Marks

Behaviour	How to Demonstrate
Confident entry	Walk in calmly, make eye contact with examiner
Professional greeting	"Good morning, I'm Dr. [Name], FY2"
Calm demeanor	Don't appear flustered even if task seems complex
Organised approach	Work through the chart systematically
Tidy workspace	Keep materials organized as you work
Professional exit	Before leaving: close BNF, return charts to place, close pen
Thank the examiner	Say "Thank you" before leaving the station

Clear Handwriting

- Write legibly - examiners must be able to read your prescription
- Use CAPITALS for drug names and important fields
- Don't crowd entries together
- Stay within designated boxes
- **Don't write in other staff's boxes** (e.g., pharmacy check boxes, nursing administration boxes)

Handling Mistakes Professionally

- If you make a mistake, correct it calmly using proper technique
- Don't panic or cross out repeatedly
- Single line through error → sign → date → rewrite in new box

IPS Checkpoint Summary

Do	Don't
Enter confidently	Rush in looking flustered
Greet the examiner	Ignore the examiner
Work systematically	Jump around the chart randomly
Keep workspace tidy	Leave papers scattered
Close BNF before leaving	Leave BNF open on the desk
Thank examiner on exit	Walk out silently

3.2 Data Gathering Marks

Data Gathering marks assess whether you've correctly captured and verified all relevant patient information.

Key Data Gathering Points

Element	What Examiners Check
Patient demographics	Correctly transcribed from task

Hospital/Ward details	Accurately recorded
Consultant name	Written in capitals
Weight	Recorded (essential for dose calculations)
Allergies	Documented with reaction type, or "NKA"
Patient sticker verification	Cross-checked against task information

Critical Data Gathering Rule

ALWAYS cross-check the patient information on the sticker/affix label with the task information.

In some stations, the sticker may contain deliberately incorrect information. If you fail to identify this mismatch, you will lose significant marks.

What to Verify on Patient Sticker

- Patient name matches task
- Date of birth matches task
- Hospital number matches task (if provided)
- NHS number matches task (if provided)

If sticker information doesn't match the task: Alert the examiner that you've noticed a discrepancy. In the real exam, you would seek clarification before prescribing.

Allergy Documentation

Scenario	What to Write	Action
Allergy stated in task	Drug name + Reaction type	Sign + Date
Multiple allergies	Each drug + Each reaction	Sign + Date
No allergies mentioned	"NKA" (No Known Allergies)	Sign + Date
Allergy box already filled	Verify it matches task	Add if missing

Data Gathering Checklist

- ☐ Ward name transcribed correctly
- ☐ Hospital name transcribed correctly
- ☐ Consultant name in CAPITALS
- ☐ Date of admission recorded
- ☐ Patient weight recorded
- ☐ Patient sticker verified against task
- ☐ Allergies documented (or NKA)
- ☐ Allergy box signed and dated
- ☐ Your name and GMC number on chart

3.3 Management Marks

Management marks assess the accuracy and completeness of your prescriptions. This is where most marks are allocated.

Core Management Criteria

Element	What Examiners Check
Correct drug	Appropriate for the condition and patient
Correct dose	Adjusted for age, weight, renal function
Correct route	Appropriate for clinical situation

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Correct frequency	Standard dosing interval
Correct duration	Appropriate course length
All boxes completed	No blank fields

Using the BNF

When to open the BNF:

- Prescribing antibiotics
- Prescribing new medications
- Prescribing anticoagulants
- When dose not specified in task
- When unsure about renal adjustments

When you don't need the BNF:

- All doses clearly provided in the task
- Transcribing regular medications with doses given

IMPORTANT: Opening the BNF demonstrates good practice and can earn marks, even if you know the dose. However, don't waste time looking up every medication if doses are provided.

Section-Specific Completion Requirements

Once Only Section

- Date
- Time
- Drug name (CAPITALS)
- Route
- Dose
- Prescriber signature
- Bleep number

Oxygen Section

- Circle target saturation (94-98% OR 88-92%)
- Device type
- Flow rate (L/min or %)
- PRN or Continuous (circle one)
- Name
- Signature
- Bleep
- Start date

Antibiotic Section

- Drug name (CAPITALS)
- Dose
- Route
- Frequency with times
- Start date
- Stop date (or review date)
- **Indication box** - e.g., "CAP", "UTI", "MRSA"

- **Additional information** - "Review in 48 hours"
- Signature
- Bleep

Regular Section

- Drug name (CAPITALS)
- Dose
- Route
- Start date
- Stop date (if applicable)
- **Tick timing boxes** (Morning/Midday/Evening/Bedtime)
- Name
- Signature
- Bleep

PRN Section

- Drug name (CAPITALS)
- **Indication** - when to give the medication
- Dose
- Route
- **Frequency as HOURLY intervals** - e.g., "Q4h PRN"
- **Maximum 24-hour dose**
- Name
- Signature
- Bleep

Common Management Mistakes

Mistake	Consequence	Prevention
Wrong dose	Critical error	Use BNF; adjust for renal function
Missing duration	Incomplete prescription	Always write start and stop dates
Wrong route	Medication won't work/harmful	Check BNF for available routes
Missing indication	Unclear why antibiotic given	Always complete indication box
No review date	Poor antibiotic stewardship	Write "Review in 48 hours"
Blank signature	Prescription invalid	Sign every entry
Missing bleep	Can't contact prescriber	Add bleep from handover

Marking Criteria Summary

Quick Point Allocation Guide

Domain	Focus Areas	Tips
IPS	Professionalism, organisation	Confident entry, tidy exit, thank examiner
Data Gathering	Accuracy of patient details	Verify sticker, document allergies
Management	Correct prescriptions	Right dose, route, duration; use BNF

The Most Common Mark-Losing Errors

1. **Not verifying patient sticker** - loses Data Gathering marks
2. **Wrong dose for renal impairment** - loses Management marks
3. **Missing indication/review date for antibiotics** - loses Management marks
4. **Leaving boxes blank** - loses Management marks

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5. Not prescribing the main task medication - loses most Management marks
6. Messy corrections using scribbles - loses IPS marks

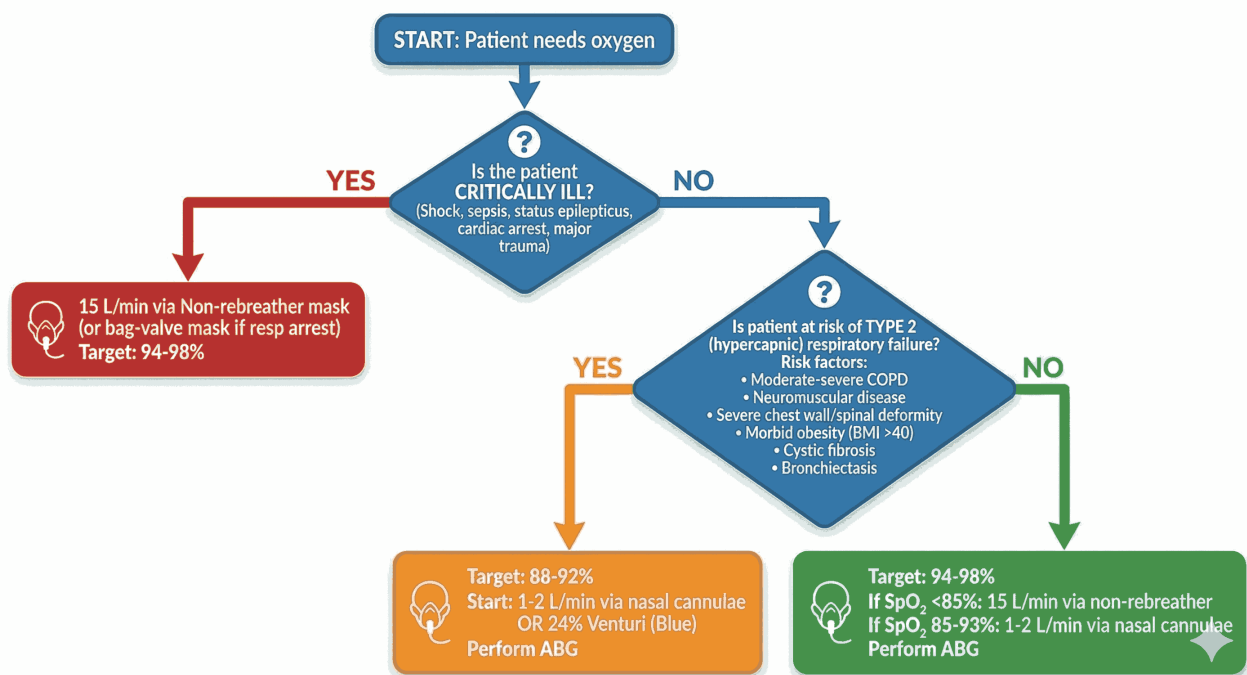
Final Checklist Before Leaving Station

- ☐ Main task completed (antibiotic, new drug, etc.)
- ☐ All medications have complete entries
- ☐ Allergies documented
- ☐ Patient sticker verified
- ☐ All entries signed
- ☐ Bleep number included
- ☐ BNF closed
- ☐ Workspace tidy
- ☐ Thank the examiner

Section 4: Oxygen Prescribing

Oxygen is a drug and must be prescribed. The key decision is determining the appropriate target saturation based on the patient's clinical status and risk of Type 2 respiratory failure.

4.1 Oxygen Prescribing Algorithm Decision Flowchart



4.2 Target Saturations

Two Target Ranges

Patient Group	Target SpO ₂	Rationale
Standard patients	94-98%	Ensures adequate oxygenation
At risk of Type 2 respiratory failure	88-92%	Prevents CO ₂ retention

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Who Gets 88-92% Target?**MEMORIZE these conditions:**

Condition	Why at Risk
Moderate-severe COPD	Chronic CO ₂ retention, hypoxic drive
Neuromuscular disease	Weak respiratory muscles, poor ventilation
Severe kyphoscoliosis	Restricted chest expansion
Morbid obesity (BMI >40)	Obesity hypoventilation syndrome
Cystic fibrosis	Chronic lung disease
Bronchiectasis (with fixed airflow obstruction)	Chronic suppurative lung disease

Critical Illness Override

If patient is critically ill, **ALWAYS** give high-flow oxygen first (15 L/min via non-rebreather), regardless of COPD status.

Critical illness includes:

- Shock (any cause)
- Sepsis with hypotension
- Status epilepticus
- Cardiac arrest
- Major trauma
- Anaphylaxis
- Near-drowning

Rationale: Hypoxia kills faster than hypercapnia. Stabilise the patient first, then adjust oxygen based on ABG results.

4.3 Oxygen Delivery Devices**Device Selection Guide**

Device	Flow Rate	FiO ₂ Delivered	When to Use
Nasal cannulae	1-4 L/min	~24-40%	Mild hypoxia, stable patients, Type 2 risk
Simple face mask	5-10 L/min	~40-60%	Moderate hypoxia
Venturi mask	Variable	Fixed %	Precise FiO ₂ needed, COPD patients
Non-rebreather mask	15 L/min	~85-90%	Severe hypoxia, critical illness
Bag-valve mask	15 L/min + reservoir	~100%	Respiratory arrest, need to ventilate

Venturi Mask Colour Coding

Colour	FiO ₂	Flow Rate
Blue	24%	2-4 L/min
White	28%	4-6 L/min
Yellow	35%	8-10 L/min
Red	40%	10-12 L/min
Green	60%	12-15 L/min

For COPD/Type 2 risk: Start with Blue Venturi (24%) or nasal cannulae at 1-2 L/min

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Starting Oxygen by Clinical Scenario

Scenario	Starting Device	Target
COPD exacerbation, SpO ₂ 88%	Nasal cannulae 1-2 L/min OR 24% Venturi	88-92%
CAP, no COPD, SpO ₂ 90%	Nasal cannulae 2-4 L/min	94-98%
Severe CAP, SpO ₂ 82%	Non-rebreather 15 L/min	94-98%
Septic shock	Non-rebreather 15 L/min	94-98%
COPD with septic shock	Non-rebreather 15 L/min (critical illness)	Initially 94-98%, reassess with ABG

4.4 Completing the Oxygen Section**Required Fields**

When prescribing oxygen, complete ALL of the following:

Field	What to Write
Target saturation	Circle either "94-98%" or "88-92%"
Device	e.g., "Nasal cannulae", "Venturi 24%", "Non-rebreather"
Flow rate	e.g., "2 L/min", "15 L/min"
PRN or Continuous	Circle appropriate option
Name	Your name
Signature	Your signature
Bleep	Your bleep number
Start date	Today's date

Example Oxygen Prescriptions**Example 1: COPD Exacerbation**

TARGET SATURATION: [88-92%] circled

Device: Nasal cannulae

Flow rate: 2 L/min

☐ PRN ☒ Continuous

Start date: 15/01/2025

Name: DR A SMITH

Signature: [signature]

Bleep: 1234

Example 2: CAP with Hypoxia (No COPD)

TARGET SATURATION: [94-98%] circled

Device: Simple face mask

Flow rate: 6 L/min

☐ PRN ☒ Continuous

Start date: 15/01/2025

Name: DR A SMITH

Signature: [signature]

Bleep: 1234

Example 3: Critical Illness

TARGET SATURATION: [94-98%] circled

Device: Non-rebreather mask

Flow rate: 15 L/min

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☐ PRN ☒ Continuous

Start date: 15/01/2025

Name: DR A SMITH

Signature: [signature]

Bleep: 1234

4.5 Common Oxygen Prescribing Scenarios

Scenario Decision Table

Clinical Situation	Target	Device	Flow Rate
COPD exacerbation, SpO ₂ 89%	88-92%	Nasal cannulae	1-2 L/min
COPD exacerbation, SpO ₂ 85%	88-92%	24% Venturi	2-4 L/min
CAP, otherwise healthy	94-98%	Nasal cannulae or simple mask	2-6 L/min
Severe pneumonia, SpO ₂ 80%	94-98%	Non-rebreather	15 L/min
Asthma exacerbation	94-98%	Nasal cannulae or simple mask	2-6 L/min
PE with hypoxia	94-98%	Adjust to maintain target	Variable
Morbid obesity, chest infection	88-92%	Nasal cannulae or 24% Venturi	1-2 L/min

Section 4 Quick Reference

Target Saturation Decision

Question	Answer
Does patient have COPD, neuromuscular disease, morbid obesity, or severe chest wall deformity?	
YES → Target 88-92%	
NO → Target 94-98%	
CRITICALLY ILL → Start with 15 L/min non-rebreather regardless	

Device Quick Pick

Starting SpO ₂	No Type 2 Risk	Type 2 Risk
>93%	May not need O ₂	May not need O ₂
85-93%	Nasal cannulae 2-4 L/min	Nasal cannulae 1-2 L/min
<85%	Non-rebreather 15 L/min	24-28% Venturi (unless critical)
Critical illness	Non-rebreather 15 L/min	Non-rebreather 15 L/min

Key Points to Remember

- ☐ Oxygen is a drug - it must be prescribed
- ☐ Two targets only: 94-98% (standard) or 88-92% (Type 2 risk)
- ☐ COPD = 88-92% target (unless critically ill)
- ☐ Critically ill = 15 L/min non-rebreather first
- Always request ABG when starting oxygen. Recheck ABG at 30-60 minutes in patients at risk of Type 2 respiratory failure. (Not applicable to prescriptions – general note)
- ☐ Complete ALL fields in oxygen section
- ☐ Circle (don't tick) the target saturation

Section 5: IV Fluid Prescribing

IV fluid prescribing requires understanding different requirements for adults and children. The calculations, fluid choices, and monitoring requirements differ significantly between these groups.

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5.1 Adult Maintenance Fluids

The 30 ml/kg/day Formula

MEMORIZE: Adult maintenance fluid requirement = 30 ml/kg/day

Calculation Method

Step 1: Total daily requirement = Weight (kg) × 30 ml

Step 2: Hourly rate = Total daily requirement ÷ 24 hours

Step 3: Select appropriate bag sizes to deliver over 24 hours

Worked Example: 65 kg Adult

Step 1: 65 kg × 30 ml = 1,950 ml/day

Step 2: 1,950 ÷ 24 = 81.25 ml/hour (round to 80 ml/hour)

Step 3: Prescribe 2 × 1L bags over 24 hours

- 1L over 12 hours (83 ml/hr)
- 1L over 12 hours (83 ml/hr)

Worked Example: 80 kg Adult

Step 1: 80 kg × 30 ml = 2,400 ml/day

Step 2: 2,400 ÷ 24 = 100 ml/hour

Step 3: Prescribe 3 × 1L bags over 24 hours

- 1L over 8 hours (125 ml/hr)
- 1L over 8 hours (125 ml/hr)
- 1L over 8 hours (125 ml/hr)

Adult Fluid Choice

For routine maintenance in adults:

- **0.9% Sodium Chloride** (preferred)
- **Hartmann's Solution** (Compound Sodium Lactate)

IMPORTANT: In adults, do NOT routinely add dextrose or potassium unless:

- Specifically requested in the task
- Patient is hypoglycaemic (add dextrose)
- Patient is hypokalaemic (add KCl)

***Clinical Note (NICE CG174):** NICE CG174 recommends routine glucose (50–100 g/day) and potassium (1 mmol/kg/day) in adult maintenance fluids. However, in PLAB 2 exam stations where U&Es are not provided, the safest approach is plain 0.9% NaCl unless otherwise directed. Be aware that in real clinical practice, glucose and potassium are standard components of maintenance fluid prescriptions.*

Fluid Prescribing for Acute Pancreatitis

For acute pancreatitis requiring IV fluids:

- Use **0.9% Sodium Chloride** or **Hartmann's Solution** as specified
- Aggressive fluid resuscitation may be needed
- Follow specific guidance in the task

5.2 Paediatric Maintenance Fluids

The Holliday-Segar Formula (4-2-1 Rule)

MEMORIZE the 4-2-1 Rule:

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Weight Range	Rate
First 10 kg	4 ml/kg/hour
10-20 kg	+ 2 ml/kg/hour
>20 kg	+ 1 ml/kg/hour

Calculating Paediatric Maintenance Rate

Example 1: 8 kg child

First 10 kg: $8 \times 4 = 32$ ml/hour

Total: 32 ml/hour

Example 2: 15 kg child

First 10 kg: $10 \times 4 = 40$ ml/hour

Next 5 kg: $5 \times 2 = 10$ ml/hour

Total: 50 ml/hour

Example 3: 25 kg child

First 10 kg: $10 \times 4 = 40$ ml/hour

Next 10 kg: $10 \times 2 = 20$ ml/hour

Next 5 kg: $5 \times 1 = 5$ ml/hour

Total: 65 ml/hour

Quick Reference Table: Paediatric Maintenance Rates

Weight (kg)	Hourly Rate (ml/hr)	Daily Volume
5	20	480 ml
8	32	768 ml
10	40	960 ml
12	44	1,056 ml
15	50	1,200 ml
20	60	1,440 ml
25	65	1,560 ml
30	70	1,680 ml
35	75	1,800 ml
40	80	1,920 ml

5.3 Paediatric Fluid Selection

The Standard Paediatric Fluid

CRITICAL: The standard maintenance fluid for children is:

0.9% Sodium Chloride + 5% Dextrose + 10 mmol KCl per 500 ml bag

Written as: 0.9% NaCl + 5% Glucose + KCl 10 mmol/500 ml

Why This Combination?

Component	Reason
0.9% NaCl	Isotonic - prevents hyponatraemia
5% Dextrose	Provides glucose - children have high metabolic needs
KCl	Most children need potassium supplementation

Note: Important Paediatric Fluid Rule

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For maintenance fluids in children, always use 0.9% NaCl + 5% Glucose (+ KCl) - never Hartmann's alone, as maintenance fluids must contain glucose. Hartmann's can be used for fluid resuscitation boluses in children, where glucose-free crystalloid is recommended.

Hartmann's does not contain glucose, and children need glucose in their maintenance fluids.

Paediatric Fluid Resuscitation Bolus: Give 10 ml/kg of glucose-free crystalloid (sodium 131–154 mmol/L) over less than 10 minutes. Reassess and repeat if needed. (Note: this was changed from the previous 20 ml/kg recommendation.)

When to Omit or Adjust Components

Situation	Adjustment
High blood glucose (severe infection, brain injury)	Reduce or omit glucose component
Hyperkalaemia	Omit KCl
Hypokalaemia	May increase KCl (guided by results)

5.4 Electrolyte Replacement

Potassium Chloride (KCl) Supplementation

Standard addition in paediatric fluids:

- 20 mmol KCl per 1L bag
- 10 mmol KCl per 500 ml bag

Adjust based on:

- Serum potassium levels
- Clinical condition
- Urine output

KCl Safety Rules

Rule	Rationale
Never give undiluted KCl	Fatal arrhythmias
Maximum concentration: 40 mmol/L via peripheral line	Higher concentrations cause phlebitis
Maximum rate: 10-20 mmol/hour (adults)	Rapid infusion causes cardiac arrest
Always check serum K ⁺ before adding KCl	Avoid hyperkalaemia

5.5 Monitoring Requirements for IV Fluids in Children

Essential Monitoring

Parameter	Frequency	Rationale
Plasma electrolytes	On starting fluids, then at least every 24 hours	Detect hyponatraemia early
Blood glucose	With electrolytes	Guide glucose component
Weight	Before starting, then daily	Detect fluid overload
Fluid balance	Daily	Ensure adequate output

Warning Signs Requiring Immediate Action

Stop fluids and check electrolytes if the child develops:

- Nausea or vomiting
- Headache
- Irritability
- Altered consciousness
- Seizure
- Apnoea

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These may indicate hyponatraemia - call for senior help immediately.

5.6 Completing the IV Fluid Prescription

Required Fields

Field	What to Write
Fluid	e.g., "0.9% Sodium Chloride"
Volume	e.g., "1000 ml"
Additives	e.g., "+ KCl 20 mmol"
Rate/Duration	e.g., "Over 8 hours" or "125 ml/hr"
Route	"IV"
Date	Start date
Signature	Your signature
Bleep	Your bleep number

Example Adult IV Fluid Prescription

65 kg adult with acute pancreatitis:

FLUID: 0.9% SODIUM CHLORIDE

Volume: 1000 ml

Additives: None

Rate: Over 8 hours (125 ml/hr)

Route: IV

Date: 15/01/2025

Signature: [signature]

Bleep: 1234

FLUID: 0.9% SODIUM CHLORIDE

Volume: 1000 ml

Additives: None

Rate: Over 8 hours (125 ml/hr)

Route: IV

Date: 15/01/2025

Signature: [signature]

Bleep: 1234

Example Paediatric IV Fluid Prescription

15 kg child requiring maintenance fluids:

Calculation: 50 ml/hour → 500 ml over 10 hours

FLUID: 0.9% SODIUM CHLORIDE + 5% GLUCOSE

Volume: 500 ml

Additives: + KCl 10 mmol

Rate: Over 10 hours (50 ml/hr)

Route: IV

Date: 15/01/2025

Signature: [signature]

Bleep: 1234

Additional instructions:

- Measure electrolytes on starting and every 24 hours
- Daily weight
- Accurate fluid balance chart

Section 5 Quick Reference

Adult Fluids

Parameter	Value
Formula	30 ml/kg/day
Fluid choice	0.9% NaCl or Hartmann's
Additives	Not routine unless indicated

Paediatric Fluids (4-2-1 Rule)

Weight	Calculation
First 10 kg	4 ml/kg/hour
10-20 kg	+ 2 ml/kg/hour
>20 kg	+ 1 ml/kg/hour

| Fluid | 0.9% NaCl + 5% Glucose + KCl 10 mmol/500 ml |

Quick Calculation Examples

Patient	Weight	Hourly Rate
Adult	70 kg	$70 \times 30 \div 24 = 87.5$ ml/hr
Child	8 kg	$8 \times 4 = 32$ ml/hr
Child	15 kg	$(10 \times 4) + (5 \times 2) = 50$ ml/hr
Child	25 kg	$(10 \times 4) + (10 \times 2) + (5 \times 1) = 65$ ml/hr

Critical Reminders

- ☐ Adults: 30 ml/kg/day
- ☐ Children: 4-2-1 rule
- ☐ Children ALWAYS need glucose in maintenance fluids
- ☐ Standard paediatric fluid: 0.9% NaCl + 5% Glucose + KCl
- ☐ Monitor electrolytes on starting and every 24 hours (children)
- ☐ Weigh children daily when on IV fluids
- ☐ Stop fluids if signs of hyponatraemia develop

Section 6: Antibiotic Prescribing

Antibiotic prescribing requires attention to allergy status, renal function, route of administration, and appropriate duration. Always include an indication and review date.

6.1 CAP and COPD Exacerbation

Community-Acquired Pneumonia (CAP)

IMPORTANT: CAP treatment is based on disease severity (NICE NG250). Assess severity using:

- CRB65 (Primary care): Confusion, Respiratory rate ≥ 30 , BP < 90 systolic or ≤ 60 diastolic, Age ≥ 65
- CURB65 (Hospital): As above + Urea > 7 mmol/L

CAP Severity-Based Treatment (NICE NG250)**Low-Severity CAP (CRB65 = 0, CURB65 = 0-1)**

Allergy Status	Antibiotic	Dose	Route	Duration
No allergies	Amoxicillin	1 g TDS	PO	3 days (extendable to 5 days if not clinically improving)
Penicillin allergy	Doxycycline	200 mg Day 1, then 100 mg OD	PO	5 days
Penicillin allergy (alternative)	Clarithromycin	500 mg BD	PO	5 days
Penicillin allergy (pregnancy)	Erythromycin	500 mg QDS	PO	5 days

Moderate-Severity CAP (CRB65 = 1-2, CURB65 = 2)

Allergy Status	Antibiotic	Dose	Route	Duration
No allergies	Amoxicillin	500 mg TDS	PO	5 days
No allergies + atypical suspected	Amoxicillin + Clarithromycin	500 mg TDS + 500 mg BD	PO	5 days
Penicillin allergy	Doxycycline	200 mg Day 1, then 100 mg OD	PO	5 days
Penicillin allergy (alternative)	Clarithromycin	500 mg BD	PO	5 days

MEMORIZE: If atypical pathogens suspected (e.g., Mycoplasma, Legionella) → ADD a macrolide

High-Severity CAP (CRB65 = 3-4, CURB65 = 3-5)

Allergy Status	Antibiotic	Dose	Route	Duration
No allergies	Co-amoxiclav + Clarithromycin	1.2 g TDS + 500 mg BD	IV	5 days
Penicillin allergy	Levofloxacin	500 mg BD	IV/PO	5 days

CRITICAL: High-severity CAP requires DUAL THERAPY with Co-amoxiclav AND Clarithromycin (per NICE NG250)

Note: Levofloxacin IV must be given over at least 60 minutes. See MHRA warnings on fluoroquinolone side effects.

CRITICAL: Clarithromycin and Azithromycin are BOTH MACROLIDES. If a patient is allergic to one, they are allergic to both.

Paediatric CAP**For children aged 3 months to 11 years with NON-SEVERE CAP:**

Allergy Status	Antibiotic	Dose	Route	Duration
No allergies	Amoxicillin	See BNFC for weight	PO	3 days
Penicillin allergy	Clarithromycin	See BNFC for weight	PO	3 days
Penicillin allergy (alternative)	Erythromycin	See BNFC for weight	PO	3 days

For children aged 12-17 years OR severe CAP at any age:

- Use 5 days duration (as per adult guidance)
- Severe CAP requires hospital admission and IV antibiotics

IMPORTANT: Extend beyond 3 days if child is NOT clinically stable (e.g., respiratory distress, oxygen saturations not improving)

COPD Exacerbation

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The same antibiotic regimen applies as for low-severity CAP:

Allergy Status	Antibiotic	Dose	Route	Duration
No allergies	Amoxicillin	1 g TDS	PO	3 days
Penicillin allergy	Clarithromycin	500 mg BD	PO or IV	5 days
Penicillin + Macrolide allergy	Doxycycline	200 mg STAT then 100 mg OD	PO	5 days total

Prescribing Doxycycline (Loading Dose Pattern)

When prescribing Doxycycline:

1. **Day 1:** 200 mg STAT (Once Only section)
2. **Days 2-5:** 100 mg OD (Regular section)
3. Total duration: 5 days

6.2 Urinary Tract Infection (UTI)

Key Principles

- Treatment duration differs by gender: **Women 3 days, Men 7 days**
- Adjust dose based on eGFR
- Two first-line options: **Nitrofurantoin** or **Trimethoprim**

Nitrofurantoin Dosing

eGFR	Women	Men
≥45	100 mg MR PO BD × 3 days	100 mg MR PO BD × 7 days
30-44	100 mg MR PO BD × 3 days	100 mg MR PO BD × 7 days
<30	CONTRAINDICATED	CONTRAINDICATED

Why contraindicated if eGFR <30? Nitrofurantoin requires adequate renal function to achieve therapeutic concentrations in urine. Note: modified-release (MR) formulation to be used.

Trimethoprim Dosing

eGFR	Women	Men
≥45	200 mg PO BD × 3 days	200 mg PO BD × 7 days
30-44	200 mg PO BD × 3 days	200 mg PO BD × 7 days
15-29	200 mg BD × 3 days, consider reducing to 100 mg BD	200 mg BD × 7 days (or 100 mg BD)
<15	200 mg PO BD × 3 days	200 mg PO BD × 7 days

UTI Decision Algorithm

UTI diagnosed

|



Check eGFR

|

├── eGFR ≥30 → Either Nitrofurantoin OR Trimethoprim

|

└── eGFR <30 → Use TRIMETHOPRIM (Nitrofurantoin contraindicated in most patients with eGFR <45). Nitrofurantoin may be used with caution at eGFR 30-44 only for multidrug-resistant organisms

Important UTI Prescribing Notes

- Always check renal function before prescribing
- Document why a particular antibiotic was chosen if there are allergies
- If UTI with hyperkalaemia ($K^+ >5.5$): consider interaction with ACE inhibitors (see Section 10)

6.3 Acute Pyelonephritis**Adult Pyelonephritis****First-line:**

Drug	Dose	Route	Frequency	Duration
Cefalexin	500 mg	PO	BD	7-10 days

If severe or unable to take orally:

- Cefuroxime IV or other IV antibiotic as per local guidelines

Paediatric Pyelonephritis (3 months to 17 years)**Oral First-line: Cefalexin**

Age	Dose	Frequency	Duration
3-11 months	12.5 mg/kg BD (or 125 mg TDS)	BD or TDS	7-10 days
1-4 years	12.5 mg/kg BD (or 125 mg TDS)	BD or TDS	7-10 days
5-11 years	12.5 mg/kg BD (or 250 mg TDS)	BD or TDS	7-10 days
12-17 years	500 mg	2-3 times daily	7-10 days

IV First-line: Cefotaxime or Ceftriaxone (if severely unwell or unable to take oral antibiotics)

Antibiotic	Dose	Frequency	Max Dose
Ceftriaxone	50-80 mg/kg	Once daily IV	4g/day
Cefotaxime	50 mg/kg	Q6-8h	12g/day

6.4 Cellulitis**Standard Cellulitis****First-line:**

- Flucloxacillin 500 mg - 1 g PO QDS × 5-7 days

Penicillin allergy:

- Clarithromycin 500 mg PO BD × 5-7 days, OR
- Doxycycline 200 mg STAT then 100 mg OD × 5-7 days

Diabetic Foot Cellulitis (More Severe)

Diabetic foot infections require broader spectrum cover due to polymicrobial flora.

Standard treatment:

- Flucloxacillin + Metronidazole, OR
- Co-amoxiclav

If Penicillin + Doxycycline allergy:

Option 1	Option 2
Co-trimoxazole 960 mg PO BD × 7 days	Clarithromycin 500 mg PO BD × 7 days + Metronidazole 400 mg PO TDS × 7 days

Metronidazole provides anaerobic cover essential for diabetic foot infections.

6.5 MRSA (Vancomycin Prescribing)

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Vancomycin Prescribing Principles

- **Loading dose:** Based on actual body weight
- **Maintenance dose:** Adjusted by eGFR
- **Administration:** Always as IV infusion, NEVER bolus
- **Monitoring:** Check pre-dose (trough) levels before 4th dose

Loading Dose (Based on Body Weight)

Body Weight	Loading Dose	Volume	Infusion Duration
60-90 kg	1.5 g	500 ml 0.9% NaCl	Over 2 hours

Write loading dose in **Once Only** section.

Maintenance Dose (Based on eGFR)

eGFR	Dose	Frequency	Volume	Infusion Duration
≥50	500 mg	BD (every 12 hours)	250 ml 0.9% NaCl	Over 1 hour
35-49	500 mg	OD (every 24 hours)	250 ml 0.9% NaCl	Over 1 hour
<35	Specialist advice	-	-	-

Write maintenance dose in **Antibiotic** section.

Timing the Maintenance Dose

- Start maintenance dose **12-24 hours after loading dose** (depending on eGFR)
- **Cross out the morning dose** on Day 1 if loading dose was given in the morning
- Example: Loading at 08:00 → First maintenance at 20:00 (if BD) or 08:00 next day (if OD)

Mupirocin for MRSA Nasal Decolonisation

In addition to IV Vancomycin, prescribe:

Drug	Dose	Route	Frequency	Duration
Mupirocin 2% nasal ointment	Apply to each nostril	TOP (nasal)	BD	5 days

Example MRSA Prescription (70 kg patient, eGFR 50)**Once Only Section:**

VANCOMYCIN 1.5 G

In 500 ml 0.9% NaCl, IV over 2 hours

Date: 15/01/25 Time: 08:00

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Antibiotic Section:

VANCOMYCIN 500 MG

In 250 ml 0.9% NaCl, IV over 1 hour

BD (08:00, 20:00)

Start: 15/01/25 Stop: 20/01/25

Indication: MRSA

Review in 48 hours

Check pre-dose level before 4th dose

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[Cross out 08:00 on Day 1 as loading dose given]

PRN/Regular Section:

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MUPIROCIN 2% NASAL OINTMENT

Apply to both nostrils

TOP, BD × 5 days

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6.6 Quinsy (Peritonsillar Abscess)**Key Decision: Oral Tolerance**

The choice between oral and IV antibiotics depends on whether the patient can swallow.

If Patient Can Tolerate Oral Intake

Allergy Status	Antibiotic	Dose	Route	Duration
No allergies	Phenoxymethylpenicillin	250-500 mg	PO	6-hourly × 7 days
Penicillin allergy	Clarithromycin	Per BNF	PO	× 7 days
Penicillin allergy	Erythromycin	Per BNF	PO	× 7 days

If Patient Cannot Tolerate Oral Intake

Allergy Status	Antibiotic	Dose	Route	Duration
No allergies	Benzylpenicillin Sodium	25 mg/kg	IV	6-hourly × 7 days
Penicillin allergy	Erythromycin	Per BNF	IV	× 7 days

IMPORTANT:

- There is NO IV formulation of Phenoxymethylpenicillin
- There is NO oral formulation of Benzylpenicillin Sodium
- IV Clarithromycin is NOT licensed for children under 12 years

Paediatric Quinsy: Phenoxymethylpenicillin Dosing

Age	Dose	Frequency	Duration
6-11 years	250 mg	6-hourly (QDS)	7 days

Metronidazole Addition (if advised)

If the task specifies adding Metronidazole:

Route	Dose	Frequency	Duration
PO	7.5 mg/kg	8-hourly (TDS)	5 days
IV	7.5 mg/kg	8-hourly (TDS)	5 days

Dexamethasone for Quinsy**Single dose steroid for symptom relief:**

- 10 mg IV/IM as a single dose (standard published dose)
- Or 6.6-10 mg depending on local protocol

Note: Some UK hospitals use 3.3 mg/mL vials (3 mL = 9.9 mg). If the station specifies a vial strength, calculate accordingly. Otherwise, use 10 mg.

Can prescribe in Once Only section.

6.7 PROM (Premature Rupture of Membranes)**Antibiotic Regimen**

Drug	Dose	Route	Frequency	Duration
Erythromycin	250 mg	PO	QDS	10 days

Additional information to write: "Review in 48 hours"

Antenatal Corticosteroids for Fetal Lung Maturity

Standard regimens (RCOG/ACOG):

Drug	Dose	Route	Frequency	Total
Dexamethasone	6 mg	IM	Q12h × 4 doses	24 mg
OR Betamethasone	12 mg	IM	Q24h × 2 doses	24 mg

Note: Maximum benefit obtained 24 hours to 7 days post-administration. Given to women at risk of preterm birth between 24-34 weeks.

Section 6 Quick Reference Tables**Antibiotic Duration Summary**

Condition	Standard Duration
CAP (adults)	5 days
CAP (children 3mo-11y, non-severe)	3 days (NICE NG250)
CAP (children 12-17y or severe)	5 days
COPD exacerbation	5 days
UTI (women)	3 days
UTI (men)	7 days
Pyelonephritis	7-10 days
Cellulitis	5-7 days
MRSA (Vancomycin)	As specified (often 5-7 days)
Quinsy	7 days
PROM (Erythromycin)	10 days

Allergy Cascade

No Allergy	Penicillin Allergy	Penicillin + Macrolide Allergy
Amoxicillin	Clarithromycin	Doxycycline
Flucloxacillin	Clarithromycin	Doxycycline
Co-amoxiclav	Clarithromycin	Co-trimoxazole

eGFR Adjustment Quick Reference

Drug	eGFR Threshold	Adjustment
Nitrofurantoin	<30	CONTRAINDICATED
Trimethoprim	15-30	Consider reducing to 100 mg BD
Vancomycin	<50	Reduce frequency (OD instead of BD)

Key Reminders

- ☐ Always include indication in antibiotic section
- ☐ Always write "Review in 48 hours"
- ☐ Check eGFR before prescribing Nitrofurantoin or Vancomycin
- ☐ Clarithromycin and Azithromycin are BOTH macrolides
- ☐ UTI: Women 3 days, Men 7 days
- ☐ Quinsy: Check oral tolerance before choosing PO vs IV
- ☐ MRSA: Loading dose + renal-adjusted maintenance + Mupirocin

Section 7: Anticoagulation

Anticoagulation prescribing requires understanding the different indications, dosing regimens, and important interactions. This section covers DVT/PE treatment, AF stroke prophylaxis, and VTE prophylaxis.

7.1 DVT/PE Treatment

Overview

For treatment of DVT or PE, DOACs (Direct Oral Anticoagulants) are preferred:

- Apixaban
- Rivaroxaban

*Note: If a patient is incidentally taking aspirin (e.g., for primary prevention), **review and stop** aspirin when starting anticoagulation for VTE, as concomitant use increases bleeding risk without additional VTE benefit. However, if aspirin is prescribed for a specific cardiac indication (recent ACS, coronary stent), seek senior/cardiology advice before stopping.*

Apixaban Regimen for DVT/PE

Two-phase dosing (MEMORIZE):

Phase	Dose	Frequency	Duration
Initial	10 mg	BD	7 days
Maintenance	5 mg	BD	As specified (usually 3-6 months)

Rivaroxaban Regimen for DVT/PE

Two-phase dosing (MEMORIZE):

Phase	Dose	Frequency	Duration
Initial	15 mg	BD (with food)	21 days
Maintenance	20 mg	OD (with food)	As specified (usually 3-6 months)

Note: Rivaroxaban must be taken with food to ensure adequate absorption.

How to Prescribe DVT/PE Treatment

Option 1: Using Once Only + Regular sections

Once Only section:

APIXABAN 10 MG

PO, STAT

Date: 15/01/25 Time: 08:00

Regular section:

APIXABAN 10 MG

PO, BD × 7 days

Then: 5 mg BD ongoing

Option 2: Using Regular section only (with clear dates)

APIXABAN 10 MG

PO, BD

Start: 15/01/25 Stop: 21/01/25

APIXABAN 5 MG

PO, BD

Start: 22/01/25 Stop: [As specified]

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DVT/PE Treatment Comparison

Feature	Apixaban	Rivaroxaban
Initial phase	10 mg BD × 7 days	15 mg BD × 21 days
Maintenance	5 mg BD	20 mg OD
Food requirement	No	Yes (with food)
Total initial phase	7 days	21 days

7.2 AF Stroke Prophylaxis**Standard Dosing**

For stroke prevention in non-valvular atrial fibrillation:

Drug	Standard Dose	Frequency
Apixaban	5 mg	BD
Rivaroxaban	20 mg	OD (with food)

Apixaban Reduced Dose Criteria

Reduce Apixaban to 2.5 mg BD if the patient has ≥2 of the following:

Criterion	Threshold
Age	≥80 years
Body weight	≤60 kg
Serum creatinine	≥133 micromol/L

Additional criteria:

- eGFR 15-29 ml/min → Consider 2.5 mg BD

Reduced Dose Decision Table

Patient Characteristics	Dose
Age 75, weight 65 kg, creatinine 100	5 mg BD (0 criteria)
Age 82, weight 70 kg, creatinine 120	5 mg BD (1 criterion: age)
Age 82, weight 55 kg, creatinine 120	2.5 mg BD (2 criteria: age + weight)
Age 85, weight 58 kg, creatinine 140	2.5 mg BD (3 criteria: age + weight + creatinine)

Rivaroxaban in Renal Impairment

eGFR	Dose
≥50	20 mg OD
15-49	15 mg OD
<15	Avoid

Atenolol Dosing in AF (if rate control needed)

eGFR	Dose
≥15	50 mg OD
<15	25 mg OD
Unknown/not specified	50 mg OD (starting dose)

7.3 VTE Prophylaxis**Post-Natal VTE Prophylaxis**

Risk Assessment: RCOG uses a weighted risk scoring system. **Intermediate risk** (e.g., 2–3 factors): LMWH for minimum 10 days post-delivery. **High risk** (e.g., 4+ factors or previous VTE): LMWH for 6 weeks post-delivery. All women post-caesarean + any additional risk factor warrant ≥ 10 days minimum.

Common risk factors:

- Age >35
- Parity >3 (≥ 3 previous births)
- BMI >30
- Caesarean section
- Immobility
- Pre-eclampsia
- Postpartum haemorrhage (PPH) >1 litre
- Extended surgery

LMWH Selection for Post-Natal Prophylaxis

CRITICAL: If the patient is **breastfeeding**, prescribe **ENOXAPARIN** (safest option).

LMWH	Prophylactic Dose	Route	Frequency
Enoxaparin	40 mg	SC	Once daily
Dalteparin	5000 units	SC	Once daily
Tinzaparin	4500 units	SC	Once daily

Dosing by weight (Enoxaparin example):

Weight	Dose
<50 kg	20 mg SC OD
50-90 kg	40 mg SC OD
91-130 kg	60 mg SC OD (or 40 mg BD)
>130 kg	40 mg BD

Duration: Minimum 10 days, continue until fully mobile.

VTE Prophylaxis Post-Fall (Medical Patients)

For hospitalised patients at risk of VTE following a fall or immobility:

Drug	Dose	Route	Frequency	Duration
Dalteparin	5000 units	SC	Every 24 hours	Until mobile

Additional instruction: "Re-assess the need for continuation"

Surgical VTE Prophylaxis

For pre-operative prophylaxis (e.g., before cholecystectomy):

If patient is on Penicillin/Beta-lactam allergy pathway:

- Gentamicin 1.5 mg/kg IV once (over ≥ 3 min, 30 min before procedure)
- Metronidazole 500 mg IV once (30 min before procedure)

Note: Meropenem is a beta-lactam antibiotic - avoid if penicillin allergy.

7.4 LMWH Selection and Dosing

LMWH Comparison Table

LMWH	Prophylactic Dose	Treatment Dose
Enoxaparin	40 mg SC OD	1.5 mg/kg SC OD or 1 mg/kg SC BD

Dalteparin	5000 units SC OD	200 units/kg SC OD (max 18,000 units)
Tinzaparin	4500 units SC OD	175 units/kg SC OD

When to Use LMWH vs DOAC

Scenario	Preferred Agent
VTE prophylaxis (post-natal)	LMWH (Enoxaparin if breastfeeding)
VTE prophylaxis (medical)	LMWH
VTE treatment (DVT/PE)	DOAC (Apixaban or Rivaroxaban)
AF stroke prevention	DOAC
Cancer-associated VTE	LMWH or DOAC per guidelines
Pregnancy	LMWH only (DOACs contraindicated)

LMWH Administration Notes

- **Route:** Always subcutaneous (SC)
- **Site:** Rotate injection sites
- **Timing:** Usually evening (for prophylaxis)
- **Splitting doses:** "May be given in 2 divided doses" means you can split (e.g., 30 mg BD instead of 60 mg OD)

7.5 Key Anticoagulation Rules

The "STOP ASPIRIN" Rule

When starting anticoagulation for VTE (DVT/PE):

If a patient is incidentally taking aspirin (e.g., for primary prevention), **review and stop** aspirin when starting anticoagulation for VTE, as concomitant use increases bleeding risk without additional VTE benefit. However, if aspirin is prescribed for a specific cardiac indication (recent ACS, coronary stent), seek senior/cardiology advice before stopping.

Contraindications to Anticoagulation

Consider before prescribing:

- Active bleeding
- Recent major surgery (check timing)
- Severe thrombocytopenia
- Severe liver disease
- Known bleeding disorders

Monitoring Requirements

Agent	Monitoring
LMWH	Anti-Xa levels if renal impairment or extremes of weight
Warfarin	INR
DOACs	Renal function (baseline and periodically)

Section 7 Quick Reference

DVT/PE Treatment

Drug	Initial	Duration	Maintenance
Apixaban	10 mg BD	7 days	5 mg BD
Rivaroxaban	15 mg BD	21 days	20 mg OD

AF Stroke Prevention

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Drug	Standard	Reduced
Apixaban	5 mg BD	2.5 mg BD (≥ 2 criteria)
Rivaroxaban	20 mg OD	15 mg OD (eGFR 15-49)

Apixaban reduction criteria (≥ 2 of): Age ≥ 80 , Weight ≤ 60 kg, Creatinine ≥ 133

VTE Prophylaxis

Situation	Drug	Dose
Post-natal (breastfeeding)	Enoxaparin	40 mg SC OD
Post-natal (not breastfeeding)	Any LMWH	As per weight
Post-fall/immobility	Dalteparin	5000 units SC OD

Critical Reminders

- ☐ STOP aspirin when starting DOAC for VTE
- ☐ Apixaban reduced dose if ≥ 2 criteria met
- ☐ Breastfeeding = use Enoxaparin
- ☐ Rivaroxaban must be taken WITH FOOD
- ☐ Apixaban: 7-day initial phase
- ☐ Rivaroxaban: 21-day initial phase
- ☐ Post-natal VTE prophylaxis: minimum 10 days

Section 8: Pain Management

Pain management in the PLAB 2 prescription station commonly involves hip fractures, paediatric analgesia, and prescribing considerations when there are drug interactions. This section covers the key scenarios.

8.1 Hip Fracture Analgesia

Key Assessment Questions

Before prescribing analgesia for hip fracture:

- Can the patient eat and drink? → Determines PO vs IV route
- What is the patient's age? → Determines dose (Adult vs Elderly)

Morphine Dosing by Age and Route

Route	Age Group	Dose	Frequency	Max 24-hour Dose
PO	Adult (19-64 years)	10 mg	Q4h PRN	60 mg
PO	Elderly (≥ 65 years)	5 mg	Q4h PRN	30 mg
IV	Adult or Elderly	5 mg	Q4h PRN	30 mg

Key Points:

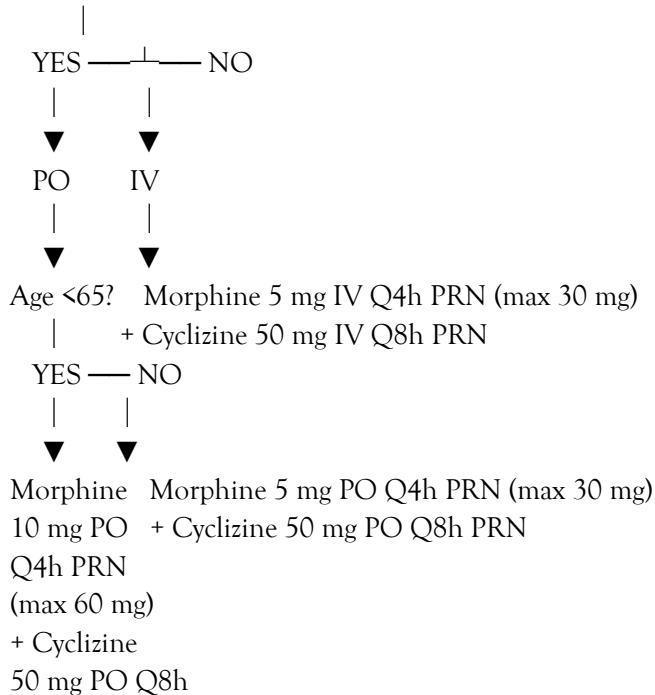
- Elderly patients receive HALF the oral dose compared to younger adults
- IV morphine: Start at **1–2 mg IV** (elderly) or **2–5 mg IV** (younger adults), titrated every 5–15 minutes to effect. Do not use a fixed dose for all patients - individualise based on weight, age, and opioid tolerance.
- Exam tip: **5 mg IV PRN** is an acceptable simplified answer, but in clinical practice, titrate to effect.
- Always prescribe as PRN (as required) with maximum 24-hour dose

Anti-emetic with Opioid Analgesia**Always prescribe an anti-emetic when prescribing morphine:**

Drug	Dose	Route	Frequency	Max 24-hour Dose
Cyclizine	50 mg	PO, IV, or IM	Q8h PRN	150 mg

Same dose for all adults (including elderly)**Route Selection Algorithm**

Can patient eat and drink?

**Example Hip Fracture Prescription****75-year-old patient, able to eat and drink:**

PRN Section:

MORPHINE SULFATE 5 MG

PO, Q4h PRN

Max 24h dose: 30 mg

Indication: Pain (hip fracture)

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CYCLIZINE 50 MG

PO, Q8h PRN

Max 24h dose: 150 mg

Indication: Nausea/vomiting

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55-year-old patient, nil by mouth:

PRN Section:

MORPHINE SULFATE 5 MG

IV, Q4h PRN

Max 24h dose: 30 mg

Indication: Pain (hip fracture)

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 CYCLIZINE 50 MG
 IV, Q8h PRN
 Max 24h dose: 150 mg
 Indication: Nausea/vomiting
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8.2 Paediatric Analgesia

Paracetamol Dosing (MEMORIZE Key Ages)

Oral Paracetamol Dosing by Age:

Age	Dose	Frequency	Max Doses/Day
1-2 months	30-60 mg	Q8h PRN	3
3-5 months	60 mg	Q6h	4
6-23 months	120 mg	Q6h	4
2-3 years ★	180 mg	Q6h	4
4-5 years	240 mg	Q6h	4
6-7 years ★	240-250 mg	Q6h	4
8-9 years	360-375 mg	Q6h	4
10-11 years	480-500 mg	Q6h	4
12-15 years ★	480-750 mg	Q6h	4
16-17 years	500 mg - 1 g	Q6h	4

★ = Key ages frequently tested

IV Paracetamol Dosing:

Weight/Age	Dose	Frequency	Duration
<10 kg	10 mg/kg	Q6h	Over 15 minutes
10-50 kg ★	15 mg/kg	Q6h	Over 15 minutes
≥50 kg	1 g	Q6h	Over 15 minutes

When to Prescribe Paracetamol

Only prescribe Paracetamol if:

- Pain is mentioned in the scenario
- Fever is mentioned in the scenario
- Specifically advised to prescribe analgesia

Do not prescribe Paracetamol if there is no indication for it in the task.

Ibuprofen Dosing (if no contraindications)

Age	Dose	Frequency
3-5 months	50 mg	Q8h (max 30 mg/kg/day)
6 months - 1 year	50 mg	Q6-8h
1-3 years	100 mg	TDS
4-6 years	150 mg	TDS
7-9 years	200 mg	TDS
10-11 years	300 mg	TDS
12-17 years	200-400 mg	TDS-QDS (max 2.4 g/day)

Contraindications to Ibuprofen:

- History of GI bleeding or peptic ulcer
- Renal impairment
- Asthma (NSAID-sensitive)
- Taking anticoagulants
- **Lithium therapy** (see Section 8.3)

8.3 Analgesic Prescribing with Lithium

The Lithium-NSAID Interaction

CRITICAL: NSAIDs (including Ibuprofen) increase serum Lithium levels, risking Lithium toxicity.

If a patient is on Lithium and needs analgesia:

- Use **PARACETAMOL** instead of Ibuprofen
- Paracetamol can be prescribed in either Regular or PRN section

Adult Paracetamol Dosing

Dose	Frequency	Max 24-hour Dose
500 mg - 1 g	Q4-6h	4 g

Example: Patient on Lithium Needing Analgesia

Task: Prescribe analgesia for a patient with chronic back pain who takes Lithium.

DO NOT prescribe Ibuprofen

Instead, prescribe in Regular or PRN section:

PARACETAMOL 1 G

PO, Q6h PRN

Max 24h dose: 4 g

Indication: Pain

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Lithium Carbonate - Continue as Prescribed

If the patient is on Lithium Carbonate, continue their usual dose unless specifically told otherwise:

LITHIUM CARBONATE 300 MG

PO, OD (or as specified in task)

Indication: Mood stabilisation

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Other Medications to Continue

When prescribing for a patient on Lithium, also continue:

- **Salbutamol inhaler** (if prescribed for asthma) - no indication to stop
- Other regular medications as specified in the task

Section 8 Quick Reference

Hip Fracture Analgesia Quick Table

Age	Route	Morphine Dose	Cyclizine Dose
19-64	PO	10 mg Q4h (max 60 mg)	50 mg Q8h (max 150 mg)
≥65	PO	5 mg Q4h (max 30 mg)	50 mg Q8h (max 150 mg)
Any adult	IV	5 mg Q4h (max 30 mg)	50 mg Q8h (max 150 mg)

Paediatric Paracetamol (Key Ages)

Age	Oral Dose	IV Dose (if weight known)

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2-3 years	180 mg Q6h	15 mg/kg Q6h
6-7 years	240-250 mg Q6h	15 mg/kg Q6h
12-15 years	480-750 mg Q6h	15 mg/kg Q6h

Lithium and Analgesia

If Patient on Lithium	Prescribe	Avoid
Needs analgesia	Paracetamol	Ibuprofen (and all NSAIDs)

Key Reminders

- ☐ Elderly (≥ 65) get half the oral morphine dose
- ☐ IV morphine dose is the same for all adults (5 mg)
- ☐ Always prescribe Cyclizine with Morphine
- ☐ Paediatric Paracetamol: MEMORIZE key ages (2-3, 6-7, 12-15)
- ☐ IV Paracetamol: 15 mg/kg for children 10-50 kg
- ☐ Lithium + NSAID = toxicity risk → use Paracetamol
- ☐ Only prescribe analgesia if indication present in task

Section 9: Palliative Care

Palliative care prescribing requires understanding opioid conversions, syringe driver calculations, and PRN (breakthrough) dosing. These calculations are frequently tested in PLAB 2.

9.1 General Principles

Key Principles of Palliative Prescribing

1. **Stop all oral medications** when transitioning to end-of-life care
2. **Switch to subcutaneous (S/C) route** via syringe driver
3. **Always prescribe breakthrough (PRN) doses** alongside continuous infusion
4. **Syringe driver** delivers medications continuously over 24 hours
5. **Anticipatory prescribing:** PRN medications should be ready before needed

Medications to Prescribe

Symptom	Drug	Route
Pain	Morphine, Diamorphine, or Oxycodone	S/C
Respiratory secretions	Hyoscine Hydrobromide or Hyoscine Butylbromide	S/C
Nausea/Vomiting	Cyclizine	S/C
Agitation/Restlessness	Midazolam	S/C

9.2 Opioid Calculations

The Key Formula (MEMORIZE)

BREAKTHROUGH DOSE = SYRINGE DRIVER DOSE $\div$ 6

SYRINGE DRIVER DOSE = BREAKTHROUGH DOSE $\times$ 6

Worked Examples

Example 1: Finding Breakthrough Dose

- Syringe driver dose: 30 mg Morphine over 24 hours
- Breakthrough dose = $30 \div 6 = 5$ mg PRN

Example 2: Finding Breakthrough Dose

- Syringe driver dose: 18 mg Diamorphine over 24 hours
- Breakthrough dose = $18 \div 6 = 3 \text{ mg PRN}$

Example 3: Finding Syringe Driver Dose

- Breakthrough dose: 10 mg Morphine PRN
- Syringe driver dose = $10 \times 6 = 60 \text{ mg over 24 hours}$

9.3 Opioid Conversion**Morphine ↔ Diamorphine Conversion (S/C Route)****MEMORIZE these conversions:****S/C MORPHINE to S/C DIAMORPHINE: Divide by 1.5****S/C DIAMORPHINE to S/C MORPHINE: Multiply by 1.5****Conversion Examples****Example 1: Morphine → Diamorphine**

- Current: Morphine syringe driver 45 mg/24h
- Convert to Diamorphine: $45 \div 1.5 = 30 \text{ mg Diamorphine/24h}$
- Breakthrough: $30 \div 6 = 5 \text{ mg Diamorphine PRN}$

Example 2: Morphine → Diamorphine

- Current: Morphine syringe driver 30 mg/24h
- Convert to Diamorphine: $30 \div 1.5 = 20 \text{ mg Diamorphine/24h}$
- Breakthrough: $20 \div 6 = 3.3 \text{ mg} \rightarrow \text{round to } 3 \text{ mg Diamorphine PRN}$

Example 3: Diamorphine → Morphine

- Current: Diamorphine syringe driver 20 mg/24h
- Convert to Morphine: $20 \times 1.5 = 30 \text{ mg Morphine/24h}$
- Breakthrough: $30 \div 6 = 5 \text{ mg Morphine PRN}$

Quick Conversion Table

Morphine S/C (24h)	Diamorphine S/C (24h)	Breakthrough ($\div 6$)
15 mg	10 mg	Morphine 2.5 mg / Diamorphine 1.5-2 mg
30 mg	20 mg	Morphine 5 mg / Diamorphine 3 mg
45 mg	30 mg	Morphine 7.5 mg / Diamorphine 5 mg
60 mg	40 mg	Morphine 10 mg / Diamorphine 6-7 mg
90 mg	60 mg	Morphine 15 mg / Diamorphine 10 mg

9.4 Syringe Driver Prescribing**Where to Prescribe Syringe Driver Medications**

Situation	Prescribe Syringe Driver In	Prescribe PRN In
Separate syringe driver chart available	Syringe driver chart	Main chart PRN section
No syringe driver chart	Main chart Regular section	Main chart PRN section

IMPORTANT: If you use a syringe driver chart, write "Refer to syringe driver chart" on the main prescription.

Example Syringe Driver Prescription

Scenario: Patient on Diamorphine 30 mg syringe driver, also needs PRN medications

Syringe Driver Chart (or Regular section):

DIAMORPHINE HYDROCHLORIDE 30 MG

S/C via syringe driver over 24 hours

Start date: 15/01/25

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Main Chart - PRN Section:**DIAMORPHINE HYDROCHLORIDE 5 MG**

S/C, Q4h PRN

Indication: Breakthrough pain

Max 24h: 30 mg (or 6 doses)

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9.5 PRN Medications and Max Dose Rules**Standard PRN Palliative Medications**

Drug	Indication	Route	Frequency	Max 24h
Morphine Sulfate	Pain	S/C	Q4h PRN	Calculated
Diamorphine Hydrochloride	Pain	S/C	Q4h PRN	Calculated
Oxycodone Hydrochloride	Pain	S/C	Q4h PRN	Calculated
Hyoscine Hydrobromide	Secretions	S/C	Q4h PRN	1.2-2.4 mg
Hyoscine Butylbromide	Secretions	S/C	Q4h PRN	120 mg
Cyclizine	Nausea	S/C	Q8h PRN	150 mg
Midazolam	Agitation	S/C	Q4h PRN	Variable

Max Dose Rules: Stated vs Calculated**CRITICAL:** When there's a discrepancy between stated and calculated max doses:**Calculated max** = Single dose × Number of times per day**Rule 1: If stated max > calculated max → Use stated max**

- The frequency prevents overdose
- Example: Midazolam 2.5 mg Q4h → Calculated max = $2.5 \times 6 = 15$ mg/day
- If scenario says "max 20 mg" → Use 20 mg (stated allows extra if needed)

Rule 2: If stated max < calculated max → Use stated max

- Respects clinical safety limits
- Example: Hyoscine Hydrobromide 400 mcg Q4h → Calculated max = $400 \times 6 = 2.4$ mg/day
- If scenario says "max 1.2 mg" → Use 1.2 mg (stricter limit applies)

PRN Frequency for Palliative Medications**Always write frequency as HOURLY intervals:**

- ✓ Correct: "Q4h PRN"
- ✗ Wrong: "QDS PRN"

Q4h = every 4 hours = maximum 6 doses in 24 hours**9.6 Dose Adjustment Based on Breakthrough Usage****When to Adjust Syringe Driver Dose**

If a patient requires multiple breakthrough doses, the syringe driver dose should be increased.

Calculation Method*Independent educational content based on publicly available UK clinical guidelines.**Not affiliated with or derived from GMC PLAB 2 examination material.***GK's PLAB 2 Preparation WhatsApp Channel - <https://tinyurl.com/gksplab2>**

New syringe driver dose = Previous syringe driver dose + Total breakthrough used

Then calculate new breakthrough dose: New syringe driver dose $\div$ 6

Worked Example

Scenario: Patient on Diamorphine 5 mg/24h syringe driver. Yesterday, they needed 6 mg total breakthrough doses.

Calculation:

1. Total opioid requirement yesterday = 5 mg (syringe driver) + 6 mg (breakthrough) = 11 mg
2. New syringe driver dose = 11 mg (can round to 10 or 12 mg for practicality)
3. New breakthrough dose = $11 \div 6 = 1.8 \text{ mg} \rightarrow$ round to 2 mg PRN

Or alternative method:

1. New syringe driver = Total breakthrough yesterday $\times 6 \div 6 = 6 \text{ mg}$ (simplified)
2. This calculation assumes breakthroughs represent actual need

More accurate calculation:

New syringe driver = Total 24h opioid use = Syringe driver + All breakthrough doses

New breakthrough = New syringe driver $\div$ 6

Example Prescription After Adjustment

Before adjustment:

- Syringe driver: Diamorphine 5 mg/24h
- PRN: Diamorphine 0.8 mg Q4h PRN

After adjustment (total requirement was 11 mg):

Syringe Driver Chart:

DIAMORPHINE HYDROCHLORIDE 12 MG

S/C via syringe driver over 24 hours

Start date: 16/01/25

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PRN Section:

DIAMORPHINE HYDROCHLORIDE 2 MG

S/C, Q4h PRN

Indication: Breakthrough pain

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9.7 Prescribing All Three Opioid Options

Morphine Sulfate

Setting	Dose	Route	Frequency
Syringe driver	As calculated	S/C over 24h	Continuous
Breakthrough	Syringe driver $\div$ 6	S/C	Q4h PRN

Diamorphine Hydrochloride

Setting	Dose	Route	Frequency
Syringe driver	As calculated	S/C over 24h	Continuous
Breakthrough	Syringe driver $\div$ 6	S/C	Q4h PRN

Conversion from Morphine: Divide by 1.5

Oxycodone Hydrochloride

Setting	Dose	Route	Frequency
Syringe driver	As calculated	S/C over 24h	Continuous
Breakthrough	Syringe driver ÷ 6	S/C	Q4h PRN

Note: Oxycodone is approximately **1.5–2 times more potent** than oral morphine. Conversion: oral morphine to oral oxycodone = divide by **1.5 to 2** (e.g., morphine 30 mg/24h ≈ oxycodone 15–20 mg/24h). Always use the lowest estimate and titrate.

Section 9 Quick Reference

The Two Key Formulas

Formula	Use
Breakthrough = Syringe Driver ÷ 6	Calculate PRN dose
S/C Morphine → S/C Diamorphine = ÷ 1.5	Convert between opioids

Quick Calculation Aid

Syringe Driver	÷ 6 = Breakthrough
6 mg	1 mg
12 mg	2 mg
18 mg	3 mg
24 mg	4 mg
30 mg	5 mg
36 mg	6 mg
60 mg	10 mg

PRN Medications Summary

Drug	Indication	Frequency
Opioid	Pain	Q4h PRN
Hyoscine Hydrobromide	Secretions	Q4h PRN
Hyoscine Butylbromide	Secretions	Q4h PRN
Cyclizine	Nausea	Q8h PRN
Midazolam	Agitation	Q4h PRN

Key Reminders

- ☐ Breakthrough dose = Syringe driver ÷ 6
- ☐ Morphine → Diamorphine: divide by 1.5
- ☐ Always prescribe breakthrough alongside syringe driver
- ☐ Use Q4h PRN (not TDS/QDS) for PRN frequency
- ☐ Adjust syringe driver based on total opioid use
- ☐ Write "Refer to syringe driver chart" on main prescription if applicable
- ☐ Stop oral medications when starting syringe driver

Section 10: Drug Interactions

Drug interactions are commonly tested in PLAB 2 prescription stations. Recognising these interactions and taking appropriate action is essential for patient safety and exam success.

10.1 Lithium Interactions

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Lithium + NSAIDs

Interaction	Severity	Mechanism
Lithium + Ibuprofen	SIGNIFICANT	NSAIDs reduce renal excretion of Lithium → increased serum Lithium levels → toxicity risk

Clinical Features of Lithium Toxicity:

- Tremor
- Nausea/vomiting
- Diarrhoea
- Confusion
- Seizures

Action Required:

- **DO NOT** prescribe Ibuprofen (or any NSAID) for patients on Lithium
- Prescribe PARACETAMOL instead

Patient on Lithium Needs	Prescribe	Avoid
Analgesia for pain	Paracetamol 500 mg - 1 g Q4-6h (max 4 g/day)	Ibuprofen, Naproxen, Diclofenac, all NSAIDs

10.2 Statin + Clarithromycin

Interaction	Severity	Mechanism
Statins + Clarithromycin	SIGNIFICANT	Clarithromycin inhibits CYP3A4 → increased statin levels → rhabdomyolysis risk

Affected Statins:

- Simvastatin (most significant)
- Atorvastatin
- Lovastatin
- Simvastatin: STOP during clarithromycin course. Atorvastatin: reduce to max 20 mg/day or stop temporarily. Fluvastatin/Pravastatin: can continue safely (no significant interaction)

Action Required:

- **STOP** the statin temporarily while on Clarithromycin
- Resume statin after completing antibiotic course

Patient on Statin Needs Clarithromycin	Action
CAP with penicillin allergy	Prescribe Clarithromycin, OMIT statin from prescription
COPD exacerbation, penicillin allergy	Prescribe Clarithromycin, OMIT statin from prescription

Alternative Approach (if statin cannot be stopped):

- Use Doxycycline instead of Clarithromycin (if appropriate for the infection)
- Doxycycline has no significant interaction with statins

Example Prescription

Task: Patient on Simvastatin and Amlodipine needs antibiotics for CAP (penicillin allergy).

Prescription:

CLARITHROMYCIN 500 MG

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PO, BD × 5 days

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AMLODIPINE 10 MG

PO, OD

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[Do NOT prescribe Simvastatin - interaction with Clarithromycin]

10.3 ACE Inhibitors + Hyperkalaemia

Interaction	Severity	Mechanism
ACE Inhibitor + High K ⁺	SIGNIFICANT	ACE inhibitors cause potassium retention → worsening hyperkalaemia → cardiac arrhythmias

Action Required:

- If patient has hyperkalaemia (K⁺ >5.5 mmol/L), consider withholding ACE inhibitor temporarily
- Seek senior advice before making permanent changes

Serum K ⁺	ACE Inhibitor Action
<5.5 mmol/L	Continue as prescribed
5.5-6.0 mmol/L	Consider withholding, seek advice
>6.0 mmol/L	Withhold, treat hyperkalaemia urgently

Common ACE Inhibitors

- Ramipril
- Lisinopril
- Enalapril
- Perindopril

Example Scenario

Task: Patient with UTI and K⁺ 5.8 mmol/L, on Ramipril 5 mg OD.

Consideration:

- UTI treatment: Trimethoprim or Nitrofurantoin (check eGFR)
- Ramipril: Consider omitting due to hyperkalaemia
- If task does not specifically address this, you may prescribe the antibiotic and note the elevated K⁺

10.4 Anticoagulant + Antiplatelet Warning

Interaction	Severity	Mechanism
Anticoagulant + Antiplatelet	SIGNIFICANT	Combined use increases bleeding risk substantially

Common Combinations to Avoid:

Anticoagulant	+	Antiplatelet	Risk
Apixaban	+	Aspirin	Major bleeding
Rivaroxaban	+	Aspirin	Major bleeding
Warfarin	+	Aspirin	Major bleeding
Any DOAC	+	Clopidogrel	Major bleeding

Action Required:

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- When starting anticoagulation for DVT/PE, **STOP aspirin** unless there is a specific cardiac indication
- If task shows patient on aspirin, **omit it** from your prescription when starting a DOAC

Example Prescription for DVT

Task: Patient on Aspirin 75 mg OD, Atorvastatin 40 mg OD, now diagnosed with DVT. Start Apixaban.

Prescription:

APIXABAN 10 MG

PO, BD × 7 days, then 5 mg BD

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ATORVASTATIN 40 MG

PO, OD (Nocte)

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[Do NOT prescribe Aspirin - risk of bleeding with anticoagulant]

10.5 Methotrexate + Infection

Interaction	Severity	Mechanism
Methotrexate + Infection/Antibiotics	VARIABLE	Methotrexate is immunosuppressive; some antibiotics increase methotrexate toxicity

Key Rules:

Scenario	Action
Patient on Methotrexate develops infection	May need to hold Methotrexate temporarily
Co-trimoxazole + Methotrexate	AVOID (severe interaction - bone marrow suppression)
Penicillins + Methotrexate	Generally safe

Folic Acid and Methotrexate

- Patients on Methotrexate often take **Folic Acid** to reduce side effects
- Folic Acid is typically taken **NOT on the same day as Methotrexate**
- Follow the regimen given in the task

Example:

- Methotrexate 15 mg once weekly (Monday)
- Folic Acid 5 mg once weekly (NOT Monday)

10.6 Complete Drug Interaction Table

Drug 1	Drug 2	Interaction	Action
Lithium	NSAIDs (Ibuprofen)	Increased Lithium levels	Use Paracetamol instead
Statins	Clarithromycin	Rhabdomyolysis risk	Stop statin temporarily
ACE Inhibitors	Hyperkalaemia	Worsening K ⁺	Consider withholding ACE-I

Anticoagulants	Antiplatelets	Bleeding risk	Stop antiplatelet when starting anticoagulant for VTE
Methotrexate	Co-trimoxazole	Bone marrow suppression	Avoid combination
Methotrexate	Folic Acid	Reduced efficacy	Don't give on same day

10.7 Quick Recognition Guide

Red Flags for Interactions

When you see these combinations, STOP and think:

See This	Think This
Lithium + "needs analgesia"	Paracetamol, NOT Ibuprofen
Statin + "penicillin allergy + infection"	May need Clarithromycin → stop statin
K ⁺ >5.5 + ACE inhibitor	Consider withholding ACE-I
Aspirin + "start anticoagulation for VTE"	Stop aspirin
Methotrexate + infection	Consider holding MTX; avoid Co-trimoxazole

Section 10 Quick Reference

Must-Know Interactions

Interaction	Alternative/Action
Lithium + NSAID	Prescribe Paracetamol
Statin + Clarithromycin	Stop statin
Anticoagulant + Aspirin (for VTE)	Stop aspirin
ACE-I + High K ⁺	Consider withholding

Key Reminders

- ☐ Always check regular medications for potential interactions
- ☐ Lithium patients: no NSAIDs
- ☐ When in doubt, check BNF interactions section
- ☐ Document your reasoning if omitting a regular medication
- ☐ Don't automatically transcribe all regular meds without checking for interactions
- ☐ STOP aspirin when starting DOAC for VTE

Section 11: Paediatric Prescribing

Paediatric prescribing requires careful attention to age and weight-based dosing. This section consolidates the key paediatric doses tested in PLAB 2.

11.1 Paracetamol Dosing (Complete Table)

Oral Paracetamol

Age	Dose	Frequency	Max Doses/24h
Neonate 28-32 weeks	20 mg/kg loading, then 10-15 mg/kg	Q8-12h	Max 30 mg/kg/day
Neonate ≥32 weeks	20 mg/kg loading, then 10-15 mg/kg	Q6-8h	Max 60 mg/kg/day
1-2 months	30-60 mg	Q8h PRN	3 doses
3-5 months	60 mg	Q6h	4 doses
6-23 months	120 mg	Q6h	4 doses
2-3 years ★	180 mg	Q6h	4 doses
4-5 years	240 mg	Q6h	4 doses

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6-7 years ★	240-250 mg	Q6h	4 doses
8-9 years	360-375 mg	Q6h	4 doses
10-11 years	480-500 mg	Q6h	4 doses
12-15 years ★	480-750 mg	Q6h	4 doses
16-17 years	500 mg - 1 g	Q6h	4 doses

★ = MEMORIZE these key age groups

IV Paracetamol

Weight/Age	Dose	Frequency	Max Daily	Infusion Duration
Neonate ≥32 weeks	7.5 mg/kg	Q8h	-	Over 15 minutes
Term neonate	10 mg/kg	Q4-6h	-	Over 15 minutes
<10 kg	10 mg/kg	Q6h	-	Over 15 minutes
10-50 kg ★	15 mg/kg	Q6h	Max 60 mg/kg or 2 g	Over 15 minutes
≥50 kg	1 g	Q6h	Max 4 g	Over 15 minutes

★ = MEMORIZE this key weight range

When to Prescribe Paracetamol

Only prescribe if the scenario mentions:

- Pain
- Fever
- Specific instruction to prescribe analgesia

11.2 Antibiotic Dosing by Age/Weight

Cefalexin (Oral) - Pyelonephritis

Age	Dose	Frequency	Duration
3-11 months	12.5 mg/kg BD or 125 mg TDS	BD or TDS	7-10 days
1-4 years	12.5 mg/kg BD or 125 mg TDS	BD or TDS	7-10 days
5-11 years	12.5 mg/kg BD or 250 mg TDS	BD or TDS	7-10 days
12-17 years	500 mg	2-3 times daily	7-10 days

IMPORTANT: If child is on Lithium → Use **Co-amoxiclav** instead

Cefuroxime (IV) - Severe Pyelonephritis

Age	Dose	Frequency	Max Single Dose
3 months - 15 years	20 mg/kg	Q8h (TDS)	750 mg
16-17 years	750 mg - 1.5 g	Q6-8h	-

Phenoxymethylpenicillin (Oral) - Quinsy

Age	Dose	Frequency	Duration
6-11 years	250 mg	6-hourly (QDS)	7 days

REMEMBER:

- No IV formulation of Phenoxymethylpenicillin
- If cannot tolerate oral → Use Benzylpenicillin Sodium IV

Benzylpenicillin Sodium (IV) - Quinsy

Age	Dose	Frequency	Duration
Child	25 mg/kg	6-hourly (QDS)	7 days

Metronidazole - Additional Cover for Quinsy

Route	Dose	Frequency	Duration
PO	7.5 mg/kg	8-hourly (TDS)	5 days
IV	7.5 mg/kg	8-hourly (TDS)	5 days

Amoxicillin - Respiratory Infections

Age	Dose	Frequency
1-11 months	125 mg	TDS
1-4 years	250 mg	TDS
5-17 years	500 mg	TDS

Co-amoxiclav - Alternative

Dose based on weight/age per BNF. Use when:

- Broader spectrum needed
- Penicillin allergy not present

11.3 IV Fluid Calculations**The 4-2-1 Rule (Holliday-Segar)**

Weight Range	Rate
First 10 kg	4 ml/kg/hour
10-20 kg	+ 2 ml/kg/hour
>20 kg	+ 1 ml/kg/hour

Quick Calculation Examples

Weight	Calculation	Hourly Rate
5 kg	$5 \times 4 = 20$	20 ml/hr
8 kg	$8 \times 4 = 32$	32 ml/hr
10 kg	$10 \times 4 = 40$	40 ml/hr
15 kg	$(10 \times 4) + (5 \times 2) = 40 + 10$	50 ml/hr
20 kg	$(10 \times 4) + (10 \times 2) = 40 + 20$	60 ml/hr
25 kg	$(10 \times 4) + (10 \times 2) + (5 \times 1) = 40 + 20 + 5$	65 ml/hr
30 kg	$(10 \times 4) + (10 \times 2) + (10 \times 1) = 40 + 20 + 10$	70 ml/hr

Standard Paediatric IV Fluid

CRITICAL: The standard maintenance fluid for children is:

0.9% Sodium Chloride + 5% Glucose + KCl 10 mmol per 500 ml bag

Even if the scenario suggests Hartmann's, prescribe 0.9% NaCl + 5% Glucose for children

IV Fluid Prescription Example

12 kg child requiring maintenance fluids:

Calculation: $(10 \times 4) + (2 \times 2) = 40 + 4 = 44$ ml/hr

FLUID: 0.9% SODIUM CHLORIDE + 5% GLUCOSE

Volume: 500 ml

Additives: + KCl 10 mmol

Rate: 44 ml/hr

Route: IV

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Date: 15/01/25

Additional: Monitor electrolytes on starting and every 24h

Daily weight

Dr A Smith Bleep: 1234

11.4 Special Considerations

Weight-Based vs Fixed Dosing

Drug	Dosing Method
Paracetamol (PO)	Fixed by age band
Paracetamol (IV)	Weight-based (mg/kg)
Cefuroxime (IV)	Weight-based (mg/kg)
Cefalexin (PO)	Weight-based OR fixed by age
Metronidazole	Weight-based (mg/kg)

Always Document Weight

- Record the child's weight in the demographics section
- Weight is essential for calculating doses
- If weight not provided, use age-based dosing from tables

Children on Lithium

If prescribing antibiotics for a child on Lithium:

- Avoid Cefalexin (nephrotoxicity risk)
- Use Co-amoxiclav instead

Children with Regular Medications

Transcribe regular medications as specified in the task:

- Sodium Valproate (epilepsy)
- Lansoprazole/Omeprazole (gastritis)
- Inhalers (asthma)
- Follow doses given in the task

Maximum Doses

Always check maximum doses don't exceed:

- Maximum single dose
- Maximum daily dose
- Maximum doses per day (usually 4 for Paracetamol)

11.5 Paediatric Dosing Quick Reference Card

Paracetamol (MEMORIZE)

Age/Weight	Oral	IV
2-3 years	180 mg Q6h	-
6-7 years	240-250 mg Q6h	-
12-15 years	480-750 mg Q6h	-
10-50 kg	-	15 mg/kg Q6h
≥50 kg	-	1 g Q6h

Cefuroxime IV

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Age	Dose	Max
3 months - 15 years	20 mg/kg Q8h	750 mg/dose

IV Fluids (4-2-1)

First 10 kg	10-20 kg	>20 kg
4 ml/kg/hr	+2 ml/kg/hr	+1 ml/kg/hr

Key Reminders

- ☐ Always record weight
- ☐ Check maximum single and daily doses
- ☐ Children need glucose in IV fluids
- ☐ Use 0.9% NaCl + 5% Glucose + KCl for maintenance
- ☐ Monitor electrolytes when on IV fluids
- ☐ Daily weight while on IV fluids
- ☐ Lithium patients: avoid NSAIDs → use Paracetamol
- ☐ Only prescribe Paracetamol if indicated (pain/fever in scenario)

Section 12: Quick Reference Tables

This section consolidates key information into rapid-reference tables for exam preparation.

12.1 Common Doses Quick Reference

Antibiotics - Adult Doses

Condition	First-Line	Dose	Duration
CAP (low severity)	Amoxicillin	1 g PO TDS	3 days
CAP (moderate, atypical)	Amoxicillin + Clarithromycin	500 mg TDS + 500 mg BD PO	5 days
CAP (high severity)	Co-amoxiclav + Clarithromycin	1.2 g TDS + 500 mg BD IV	5 days
CAP (penicillin allergy)	Doxycycline	200 mg STAT then 100 mg OD	5 days
CAP (high severity, penicillin allergy)	Levofloxacin	500 mg IV BD	5 days
COPD exacerbation	Amoxicillin	1 g PO TDS	3 days
UTI (women)	Nitrofurantoin	100 mg PO BD	3 days
UTI (men)	Nitrofurantoin	100 mg PO BD	7 days
UTI (eGFR <30)	Trimethoprim	200 mg PO BD	3 or 7 days
Pyelonephritis	Cefalexin	500 mg PO BD	7-10 days
Cellulitis	Flucloxacillin	500 mg - 1 g PO QDS	5-7 days
Quinsy (oral)	Phenoxymethylpenicillin	250-500 mg PO 6-hourly	7 days
PROM	Erythromycin	250 mg PO QDS	10 days

Anticoagulation

Indication	Drug	Initial	Maintenance
DVT/PE	Apixaban	10 mg BD × 7 days	5 mg BD

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DVT/PE	Rivaroxaban	15 mg BD × 21 days	20 mg OD
AF (standard)	Apixaban	-	5 mg BD
AF (reduced dose)	Apixaban	-	2.5 mg BD
VTE prophylaxis	Enoxaparin	40 mg SC OD	-
VTE prophylaxis	Dalteparin	5000 units SC OD	-

Analgesia

Setting	Drug	Dose	Route	Frequency	Max 24h
Hip fracture (adult <65)	Morphine	10 mg	PO	Q4h PRN	60 mg
Hip fracture (≥65)	Morphine	5 mg	PO	Q4h PRN	30 mg
Hip fracture (IV)	Morphine	5 mg	IV	Q4h PRN	30 mg
With morphine	Cyclizine	50 mg	PO/IV	Q8h PRN	150 mg
Lithium patient	Paracetamol	1 g	PO	Q4-6h PRN	4 g

MRSA (Vancomycin)

Phase	eGFR	Dose	Frequency
Loading (60-90 kg)	Any	1.5 g IV	STAT
Maintenance	≥50	500 mg IV	BD (12-hourly)
Maintenance	35-49	500 mg IV	OD (24-hourly)
Nasal	-	Mupirocin 2%	BD × 5 days

Oxygen

Patient Type	Target SpO ₂	Starting Device
Standard	94-98%	Nasal cannulae 2-4 L/min
COPD/Type 2 risk	88-92%	Nasal cannulae 1-2 L/min or 24% Venturi
Critical illness	94-98%	Non-rebreather 15 L/min

12.2 eGFR Adjustment Summary

Drugs Requiring Renal Adjustment

Drug	eGFR Threshold	Action
Nitrofurantoin	<45	CONTRAINDICATED
Trimethoprim	15-30	Consider reducing to 100 mg BD
Vancomycin	<50	Reduce frequency (OD instead of BD)
Vancomycin	<35	OD dosing, consider dose reduction
Rivaroxaban	15-49	Reduce to 15 mg OD (for AF)
Rivaroxaban	<15	Avoid
Apixaban (AF)	15-29	Consider 2.5 mg BD
Atenolol	<15	Reduce to 25 mg OD

eGFR Quick Decision Tool

Patient needs UTI antibiotic:

- └— eGFR ≥30 → Nitrofurantoin OR Trimethoprim
- └— eGFR <30 → Trimethoprim ONLY (Nitrofurantoin contraindicated)

Patient needs Vancomycin:

- └— eGFR ≥50 → 500 mg BD
- └— eGFR 35-49 → 500 mg OD
- └— eGFR <35 → Specialist advice

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12.3 Paediatric Dosing by Age

Paracetamol Oral (Key Ages)

Age	Dose	Frequency
2-3 years	180 mg	Q6h
6-7 years	240-250 mg	Q6h
12-15 years	480-750 mg	Q6h

Paracetamol IV (Key Weights)

Weight	Dose	Frequency
<10 kg	10 mg/kg	Q6h
10-50 kg	15 mg/kg	Q6h
≥50 kg	1 g	Q6h

IV Fluid Rates (4-2-1 Rule)

Weight	Hourly Rate
5 kg	20 ml/hr
10 kg	40 ml/hr
15 kg	50 ml/hr
20 kg	60 ml/hr
25 kg	65 ml/hr
30 kg	70 ml/hr

Cefuroxime IV (Paediatric)

Age	Dose	Frequency	Max
3 months - 15 years	20 mg/kg	Q8h	750 mg

12.4 Antibiotic Duration Summary

Condition	Standard Duration
CAP (adults)	5 days
CAP (paediatric 3mo-11y, non-severe)	3 days
CAP (paediatric 12-17y or severe)	5 days
COPD exacerbation	5 days
UTI (women)	3 days
UTI (men)	7 days
Pyelonephritis	7-10 days
Cellulitis	5-7 days
Quinsy	7 days
PROM (Erythromycin)	10 days
MRSA (Vancomycin)	As specified (typically 5-7 days)

12.5 Drug Interaction Quick Reference

If Patient Is On	And Needs	Use	Avoid
Lithium	Analgesia	Paracetamol	NSAIDs
Statin	Macrolide for infection	Stop statin temporarily	-
Aspirin	Anticoagulation for VTE	-	Stop aspirin
ACE inhibitor	-(K ⁺ >5.5)	Consider stopping	-
Methotrexate	Antibiotic	-	Co-trimoxazole

12.6 Palliative Care Calculations

Key Formulas

Formula	Purpose
Breakthrough = Syringe Driver $\div$ 6	Calculate PRN dose
Morphine $\rightarrow$ Diamorphine = $\div$ 1.5	Convert S/C Morphine to S/C Diamorphine
Diamorphine $\rightarrow$ Morphine = $\times$ 1.5	Convert S/C Diamorphine to S/C Morphine

Quick Calculation Table

Syringe Driver	$\div$ 6 = Breakthrough
12 mg	2 mg
18 mg	3 mg
24 mg	4 mg
30 mg	5 mg
36 mg	6 mg
60 mg	10 mg

Morphine ↔ Diamorphine Conversion

Morphine (S/C)	Diamorphine (S/C)
15 mg	10 mg
30 mg	20 mg
45 mg	30 mg
60 mg	40 mg
90 mg	60 mg

12.7 Apixaban Reduced Dose Criteria

Reduce to 2.5 mg BD if ≥ 2 of:

Criterion	Threshold
Age	≥ 80 years
Weight	≤ 60 kg
Serum Creatinine	≥ 133 micromol/L

12.8 Timing Quick Reference

24-Hour Format

Frequency	Times
OD	08:00
BD	08:00, 20:00
TDS	08:00, 16:00, 00:00
QDS	06:00, 12:00, 18:00, 00:00

Tick Boxes

Frequency	Boxes to Tick
OD	Morning
BD	Morning + Evening
TDS	Morning + Midday + Evening
QDS	Morning + Midday + Evening + Bedtime

12.9 Abbreviations Cheat Sheet

Safe Abbreviations

Use	For
mg	milligrams
g	grams
mL	millilitres
IV	intravenous
IM	intramuscular
SC	subcutaneous
PO	by mouth
PR	per rectum
NEB	nebulised
TOP	topical
BD, TDS, QDS	twice, three times, four times daily
PRN	as required

Never Abbreviate

Write in Full	Never Write
micrograms	mcg, µg
units	U, IU
0.9% sodium chloride	normal saline

12.10 Critical Numbers to Memorize

Parameter	Value
Adult IV fluid	30 ml/kg/day
Paediatric IV fluid first 10 kg	4 ml/kg/hr
Palliative breakthrough	Syringe driver ÷ 6
Morphine to Diamorphine	÷ 1.5
Nitrofurantoin contraindicated	eGFR <30
Apixaban initial (DVT/PE)	10 mg BD × 7 days
Rivaroxaban initial (DVT/PE)	15 mg BD × 21 days
UTI duration (women)	3 days
UTI duration (men)	7 days
Elderly morphine (PO)	5 mg (half the adult dose)
Oxygen target (COPD)	88-92%
Oxygen target (standard)	94-98%

Section 13: Practice Cases

These original practice scenarios cover the key station types you may encounter. Work through each case, then check your answers against the answer key.

How to Use These Cases

1. Read the scenario carefully
2. Identify the key tasks
3. Note any allergies, renal function, or drug interactions
4. Write your prescription (on paper if practicing)
5. Check against the answer key

6. Review any errors using the relevant section of this chapter

Case 1: MRSA with Renal Impairment

Scenario

A 68-year-old woman is admitted with an MRSA wound infection. She weighs 72 kg and her eGFR is 42 ml/min.

Task: Prescribe Vancomycin treatment for 5 days. Include nasal decolonisation.

Allergies: NKDA

Regular medications: Amlodipine 5 mg OD, Metformin 500 mg BD

Answer Key - Case 1

Once Only Section:

VANCOMYCIN 1.5 G

In 500 ml 0.9% NaCl, IV over 2 hours

Date: [Today] Time: 08:00

Antibiotic Section:

VANCOMYCIN 500 MG

In 250 ml 0.9% NaCl, IV over 1 hour

OD (24-hourly) - eGFR 35-49

Start: [Today] Stop: [+5 days]

Indication: MRSA

Check pre-dose level before 4th dose

[Cross out morning dose on Day 1]

Regular Section:

MUPIROCIN 2% NASAL OINTMENT

Apply to both nostrils

TOP, BD × 5 days

AMLODIPINE 5 MG - PO, OD

METFORMIN 500 MG - PO, BD

Key Points:

- eGFR 42 = OD dosing (not BD)
- Loading dose based on weight (60-90 kg = 1.5 g)
- Include Mupirocin for nasal decolonisation
- Continue regular medications

Case 2: UTI with Drug Interaction

Scenario

A 45-year-old woman presents with lower urinary tract infection symptoms. She takes Lithium Carbonate 400 mg OD for bipolar disorder. Her eGFR is 55 ml/min.

Task: Prescribe appropriate antibiotic treatment. She also requests pain relief.

Allergies: Penicillin (rash)

Answer Key - Case 2

Antibiotic Section:

NITROFURANTOIN 100 MG

PO, BD × 3 days

Indication: UTI

(Note: **Trimethoprim + ACE Inhibitor/ARB** - Trimethoprim causes potassium retention by blocking sodium channels in the distal nephron. Combined with ACEi/ARB, this increases hyperkalaemia risk approximately **7-fold**. **Action:** Avoid trimethoprim in patients on ACEi/ARB where possible; use nitrofurantoin instead (if eGFR ≥ 45). If trimethoprim must be used, **monitor potassium closely** within 3–5 days of starting.)

Regular Section:

LITHIUM CARBONATE 400 MG

PO, OD

PRN Section:

PARACETAMOL 1 G

PO, Q4-6h PRN

Max 24h: 4 g

Indication: Pain

Key Points:

- UTI in women = 3 days treatment
- eGFR 55 = Nitrofurantoin is fine (contraindicated only if <45)
- Patient on Lithium = NO NSAIDs → Paracetamol for analgesia
- Continue Lithium at prescribed dose

Case 3: Palliative Care Opioid Calculation

Scenario

A 72-year-old man with metastatic lung cancer is being started on a syringe driver for end-of-life care. The palliative care team recommends Morphine Sulfate 24 mg via syringe driver over 24 hours.

Task: Prescribe the syringe driver medication and appropriate PRN breakthrough analgesia.

Answer Key - Case 3

Syringe Driver Chart (or Regular Section):

MORPHINE SULFATE 24 MG

S/C via syringe driver over 24 hours

Start: [Today]

PRN Section:

MORPHINE SULFATE 4 MG

S/C, Q4h PRN

Indication: Breakthrough pain

Calculation:

- Breakthrough dose = $24 \div 6 = 4$ mg

Key Points:

- Breakthrough = Syringe driver $\div 6$
- Both continuous and PRN must be prescribed
- Route is S/C for both
- PRN frequency is Q4h (not TDS/QDS)

Case 4: Post-Natal VTE Assessment

Scenario

A 37-year-old woman (Parity 4) delivered by emergency caesarean section 6 hours ago. She had a postpartum haemorrhage of 1.2 litres. She is breastfeeding. Her BMI is 33. She weighs 85 kg.

Task: Assess VTE risk and prescribe prophylaxis if indicated.

Answer Key - Case 4**VTE Risk Factors Present:**

- Age >35 ✓
- Parity >3 ✓
- Caesarean section ✓
- PPH >1 litre ✓
- BMI >30 ✓

Multiple risk factors → VTE prophylaxis indicated

Regular Section (or PRN):

ENOXAPARIN 40 MG

S/C, OD (evening)

Duration: Minimum 10 days

Key Points:

- ≥2 risk factors = intermediate risk = LMWH required
- Breastfeeding = ENOXAPARIN (safest option)
- Duration: minimum 10 days
- 85 kg falls in 50-90 kg range = 40 mg dose

Case 5: CAP with Multiple Allergies**Scenario**

A 58-year-old man presents with community-acquired pneumonia. He is able to eat and drink. His observations are stable.

Task: Prescribe appropriate antibiotic treatment.

Allergies:

- Penicillin (anaphylaxis)
- Azithromycin (rash)

Regular medications: Atorvastatin 40 mg OD, Ramipril 5 mg OD

Answer Key - Case 5**Once Only Section:**

DOXYCYCLINE 200 MG

PO, STAT

Date: [Today]

Regular Section:

DOXYCYCLINE 100 MG

PO, OD × 4 days

Start: [Tomorrow]

Indication: CAP

RAMIPRIL 5 MG - PO, OD

ATORVASTATIN 40 MG - PO, OD (Nocte)

Key Points:

- Penicillin allergy = cannot use Amoxicillin
- Azithromycin allergy = cannot use Clarithromycin (both macrolides)
- Third-line = Doxycycline (200 mg loading then 100 mg OD)
- Total treatment = 5 days (Day 1 loading + 4 days maintenance)

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- Atorvastatin can continue (no interaction with Doxycycline)

Case 6: Paediatric Pyelonephritis**Scenario**

A 4-year-old girl (weight 16 kg) presents with fever, vomiting, and positive urine dip. She is diagnosed with acute pyelonephritis. She can tolerate oral medications.

Task: Prescribe appropriate antibiotic and analgesia.

Allergies: NKDA

Regular medications: None

Answer Key - Case 6**Antibiotic Section:**

CEFALEXIN 125 MG

PO, TDS × 7 days

(Alternative: 12.5 mg/kg BD = 200 mg BD)

Indication: Pyelonephritis

PRN Section:

PARACETAMOL 240 MG

PO, Q6h PRN

Max: 4 doses/24h

Indication: Pain/Fever

Key Points:

- Age 4 years = Cefalexin 125 mg TDS (or 12.5 mg/kg BD)
- Duration: 7-10 days for pyelonephritis
- Paracetamol 4-5 years = 240 mg Q6h
- Can tolerate oral = PO route

Case 7: DVT Treatment with Aspirin**Scenario**

A 62-year-old man is diagnosed with a proximal DVT. He has been advised to start anticoagulation with Apixaban.

Task: Prescribe DVT treatment.

Allergies: NKDA

Regular medications: Aspirin 75 mg OD, Lisinopril 10 mg OD, Omeprazole 20 mg OD

Answer Key - Case 7**Regular Section:**

APIXABAN 10 MG

PO, BD × 7 days

Start: [Today] Stop: [+7 days]

Then: APIXABAN 5 MG PO BD ongoing

LISINOPRIL 10 MG - PO, OD

OMEPRAZOLE 20 MG - PO, OD

DO NOT prescribe Aspirin (anticoagulant + antiplatelet = bleeding risk)

Key Points:

- Apixaban for DVT: 10 mg BD × 7 days → 5 mg BD maintenance

- STOP ASPIRIN when starting anticoagulation for VTE
- Continue other regular medications

Case 8: Hip Fracture in Elderly Patient**Scenario**

An 82-year-old woman is admitted with a fractured neck of femur. She is able to eat and drink but is in significant pain.

Task: Prescribe appropriate analgesia.

Allergies: Codeine (nausea)

Regular medications: Amlodipine 10 mg OD

Answer Key - Case 8**PRN Section:**

MORPHINE SULFATE 5 MG

PO, Q4h PRN

Max 24h: 30 mg

Indication: Pain

CYCLIZINE 50 MG

PO, Q8h PRN

Max 24h: 150 mg

Indication: Nausea/vomiting

Regular Section:

AMLODIPINE 10 MG - PO, OD

Key Points:

- Age ≥ 65 = HALF the adult oral morphine dose (5 mg, not 10 mg)
- Max 24h = 30 mg (not 60 mg)
- Always prescribe anti-emetic with morphine
- Cyclizine dose same for all adults

Case 9: COPD Exacerbation with Oxygen**Scenario**

A 71-year-old man with known severe COPD presents with an infective exacerbation. His SpO₂ is 87% on air. He is not critically ill.

Task: Prescribe antibiotic and oxygen therapy.

Allergies: NKDA

Regular medications: Salbutamol inhaler PRN, Seretide 250 1 puff BD

Answer Key - Case 9**Antibiotic Section:**

AMOXICILLIN 1G

PO, TDS $\times$ 3 days

Indication: COPD exacerbation

Review in 48 hours

Oxygen Section:

TARGET: [88-92%] - circle this

Device: Nasal cannulae

Flow rate: 1-2 L/min

Continuous

Start: [Today]

Regular Section:

SALBUTAMOL INHALER - 2 puffs, INH, PRN

SERETIDE 250 - 1 puff, INH, BD

Key Points:

- Severe COPD = Target 88-92% (not 94-98%)
- Start with low-flow oxygen (1-2 L/min)
- Amoxicillin first-line for infective exacerbation
- Continue inhalers

Case 10: Palliative Care - Morphine to Diamorphine Conversion

Scenario

A 68-year-old woman with end-stage breast cancer is currently on Morphine 45 mg via syringe driver over 24 hours. The team wants to convert her to Diamorphine.

Task: Calculate and prescribe the equivalent Diamorphine syringe driver and breakthrough dose.

Answer Key - Case 10

Conversion Calculation:

- S/C Morphine → S/C Diamorphine = divide by 1.5
- 45 mg ÷ 1.5 = 30 mg Diamorphine

Breakthrough Calculation:

- 30 mg ÷ 6 = 5 mg

Syringe Driver Chart:

DIAMORPHINE HYDROCHLORIDE 30 MG

S/C via syringe driver over 24 hours

Start: [Today]

PRN Section:

DIAMORPHINE HYDROCHLORIDE 5 MG

S/C, Q4h PRN

Indication: Breakthrough pain

Key Points:

- Morphine to Diamorphine (S/C) = ÷ 1.5
- Then calculate breakthrough = New dose ÷ 6

Case 11: AF with Reduced Dose Criteria

Scenario

An 84-year-old woman (weight 52 kg) is diagnosed with non-valvular atrial fibrillation. Her serum creatinine is 145 micromol/L.

Task: Prescribe stroke prophylaxis with Apixaban.

Allergies: NKDA

Answer Key - Case 11

Assessment for reduced dose:

- Age ≥80 ✓
- Weight ≤60 kg ✓

- Creatinine ≥ 133 ✓

3 out of 3 criteria met → Use REDUCED DOSE

Regular Section:

APIXABAN 2.5 MG

PO, BD

Indication: AF stroke prophylaxis

Key Points:

- ≥ 2 of: Age ≥ 80 , Weight ≤ 60 kg, Creatinine ≥ 133 = reduced dose
- Reduced dose = 2.5 mg BD (not 5 mg BD)

Case 12: Paediatric IV Fluids

Scenario

A 3-year-old boy (weight 14 kg) is admitted with gastroenteritis and is unable to tolerate oral fluids. He requires IV maintenance fluids.

Task: Calculate and prescribe appropriate IV fluids.

Answer Key - Case 12

Calculation (4-2-1 Rule):

- First 10 kg: $10 \times 4 = 40$ ml/hr
- Next 4 kg: $4 \times 2 = 8$ ml/hr
- Total: 48 ml/hr

IV Fluids Section:

FLUID: 0.9% SODIUM CHLORIDE + 5% GLUCOSE

Volume: 500 ml

Additives: + KCl 10 mmol

Rate: 48 ml/hr (or over ~ 10 hours)

Route: IV

Additional instructions:

- Check electrolytes on starting and every 24h
- Daily weight
- Accurate fluid balance

Key Points:

- Use 4-2-1 rule for paediatric maintenance
- Standard fluid = 0.9% NaCl + 5% Glucose + KCl
- Must include monitoring instructions

Case 13: Cellulitis in Diabetic Foot

Scenario

A 65-year-old man with Type 2 diabetes presents with cellulitis of his right foot.

Task: Prescribe appropriate antibiotic therapy.

Allergies:

- Penicillin (rash)
- Doxycycline (photosensitivity)

Regular medications: Metformin 500 mg TDS, Gliclazide 80 mg BD

Answer Key - Case 13

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Antibiotic Section (choose one option):**Option 1:**

CO-TRIMOXAZOLE 960 MG

PO, BD × 7 days

Indication: Diabetic foot cellulitis

Option 2:

CLARITHROMYCIN 500 MG

PO, BD × 7 days

METRONIDAZOLE 400 MG

PO, TDS × 7 days

Indication: Diabetic foot cellulitis

Regular Section:

METFORMIN 500 MG - PO, TDS

GLICLAZIDE 80 MG - PO, BD

Key Points:

- Penicillin allergy = cannot use Flucloxacillin or Co-amoxiclav
- Doxycycline allergy = cannot use Doxycycline
- Options: Co-trimoxazole OR Clarithromycin + Metronidazole
- Continue diabetes medications

Case 14: Quinsy in a Child**Scenario**

A 7-year-old girl (weight 24 kg) presents with peritonsillar abscess (quinsy). She is unable to swallow due to pain and trismus.

Task: Prescribe appropriate antibiotic therapy.

Allergies: NKDA

Answer Key - Case 14**Antibiotic Section:**

BENZYL PENICILLIN SODIUM

Dose: 25 mg/kg = 600 mg

IV, 6-hourly (QDS) × 7 days

Indication: Quinsy

PRN Section:

PARACETAMOL 240-250 MG

PO (when able to swallow) or IV

Q6h PRN

Max: 4 doses/24h

Indication: Pain/Fever

Key Points:

- Cannot swallow = IV antibiotics required
- IV for quinsy = Benzylpenicillin Sodium 25 mg/kg 6-hourly
- No IV Phenoxymethylpenicillin exists
- Paracetamol 6-7 years = 240-250 mg Q6h

Case 15: Acute Pancreatitis with IV Fluids**Scenario**

A 55-year-old man (weight 78 kg) is admitted with acute pancreatitis. He requires IV fluid resuscitation.

Task: Prescribe 24-hour maintenance IV fluids.

Allergies: NKDA

Answer Key - Case 15**Calculation:**

- $78 \text{ kg} \times 30 \text{ ml/kg/day} = 2,340 \text{ ml/day}$
- Approximately 2.5 L over 24 hours
- Can prescribe as $3 \times 1\text{L}$ bags or similar

IV Fluids Section:

FLUID: 0.9% SODIUM CHLORIDE

Volume: 1000 ml

Rate: Over 8 hours

Route: IV

[Repeat $\times 3$ bags for 24 hours]

Key Points:

- Adult maintenance = 30 ml/kg/day
- Acute pancreatitis = 0.9% NaCl or Hartmann's (as specified)
- Adults do not routinely need dextrose or KCl added
- May need more aggressive resuscitation initially (follow clinical guidance)

Summary Checklist for All Cases

Before submitting any prescription, verify:

- ☐ Demographics completed
- ☐ Allergies documented (or NKA)
- ☐ Main task medication prescribed FIRST
- ☐ Correct dose (adjusted for age/weight/renal function)
- ☐ Correct route
- ☐ Correct frequency
- ☐ Correct duration
- ☐ Indication included (for antibiotics)
- ☐ "Review in 48 hours" (for antibiotics)
- ☐ Regular medications continued (unless contraindicated)
- ☐ Drug interactions addressed
- ☐ All entries signed with bleep number

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