Interview Preparation Document

Created by Pattaranit Krongboonying, Medical Student in 2022

Table Of Contents

Title of Topic	Page Number
Preface	3
Key Bodies You Should Know (UK Edition)	4-5
What's The Difference (Dive into PA vs MBBS vs HCA vs Nursing)	6-12
Values of the NHS	13-16
The Four Pillars of Medical Ethics	17-36
Consent to Treatment	37-46
Medical Ethics Concepts	47-49
The Doctrine of Double Effect	50-51
Medicine (The Types)	52-56
Reflection Techniques	57-79
Structure & Organisation of the NHS	80-81
Case Study 1: Surgeons & Ergonomics	82-88
Case Study 2: Returning to Surgical Training from Parental Leave	89-94
STARR Technique	95
SPIES Technique	96
Hierarchy of Doctors and Progression in the NHS	97-99
Patient Confidentiality	100-108
CAMP Technique	109-110
ICE Technique	111
Clinical Communication	112
Commonly Vaccinated Diseases	113-116
Hot Topics	117-179
List of Buzzwords	180-182
General Breakdown of Interview Types	183-199
Specific School Interview Questions & Breakdown	200-323
General Practice Questions + Model Responses	324-463

Drug Calculation Interview Questions	464-473
MMI / Scenario Practice Questions + Model Responses	474-525
Good Medical Practice (GMC) Domains	526-544

Preface

Hi everyone! If you are reading this document it means you have stumbled upon the "encyclopedia" that you have been looking for in terms of interview preparation. This is a preface by me, the person that created this document.
Originally I started this document as my own interview preparation, but over time it evolved into such a big project that I thought if I no longer need it, it could be of better use for those who were applying. I would just first like to establish that this document was mainly created by me, and I had the help of some of my friends (contributing about 5-10% of it), but the rest of it was done by me.

I would also like to establish that I did not write certain sections of this document such as Hot Topics and Reflection Techniques, what I did was to comb through websites and news articles to collate them into my document. **HOWEVER**, with that said, the rest of the document was written by me such as Values of the NHS, Specific School Interview Questions & Breakdown and all the responses to the interview question banks (General, MMI, Drug Calculation and Good Medical Practice). If I had to give a rough estimation, 80% was done by me, 15% was researched from other websites and 5% was by my friends.
With that out of the way, I just want to share some comments and feedback I would have liked to know before I actually sat for my interviews.

The first aspect would be that you don't actually need to know so much content for interviews (really ironic coming from me). Why I feel this is something I would like to establish is because after a while, you will come across as robotic and it will be quite difficult to correct it afterwards. Interviews are mainly looking for that personal touch, the aspect that your grades cannot represent and sounding robotic loses that personal touch. While I am not saying that you do not have to study at all, what I am trying to bring across is that studying in moderation is key for your interview preparation.

The second aspect would be that consistency is key. I made this whole document over the course of 5 months, which is an average of 100+ pages a month. I studied almost everyday for 3-4 hours (gap year things) and I felt that over time and continuous exposure to what I was writing, details started to stick and it became less difficult / tiresome to memorize certain things. For instance, my Why Medicine started off rough as the points felt really awkward to talk about, but after revising through it for months, it flowed naturally. You do not need to prepare for hours on end, but staying consistent (a little a day) will eventually pay off.
Lastly, the third aspect would be that things will work out. I just concluded my interviews a few days ago (as of writing this) and the amount of anxiety and pressure I felt finally lifted. While interview season is difficult and stressful, things will eventually pay off.

PREFACE (12th April 2026)
Hey everyone! I just wanted to let you know that this document would be around 4-5 years old by now. Things have definitely changed since then and I would hope that while most of it has remained relevant, there will definitely be bits that have evolved and changed since then. I would advise that you use this document as a support tool rather than your main way of preparing. Unfortunately I did not have the time to improve / revise this document but I hope it will still remain useful. Wishing you all the best 🙂

Key Bodies You Should Know

The GMC

The GMC (General Medical Council) has 4 main directives that they follow and you should know all 4 in depth:

- Keeping a register of all UK doctors in the UK. Ensure that no one is working without being registered in the UK
- Ensuring high quality of medical education and training. Mainly regarding medical schools in the UK and once you have graduated to work in certain specialities
- Dealing with doctors who are not up to standard. Includes striking them off the GMC register if necessary
- Upholding the standard of care offered by doctors. Ensure doctors follow Good Medical Practice (GMP), the modern day equivalent of the Hippocratic Oath and make sure doctors are frequently revalidated

Registration / membership is COMPULSORY.

The Royal Colleges

They are institutions charged with regulating the specialists or doctors who work within that field. You can only join them if you pass a certain number of examinations. There is a whole list of colleges but I will list a few in line with what I am interested in:

- Royal Colleges of Surgeons of England (RCS)
- Royal Colleges of Paediatrics and Child Health (RCPCH)
- College of Emergency Medicine (CEM)

Registration / membership is COMPULSORY.

The BMA

It is essentially a trade union for doctors. If you don't know what a trade union is, it is essentially an organized association of workers in a trade, group of trades, or profession, formed to protect and further their rights and interests.
The BMA helps to push for improvements and advancements for doctors such as pay increases (see NHS JDs strike for more information), and essentially look after the welfare of doctors in the UK.
Registration / membership is NOT COMPULSORY.

Medical Protection Society (MPS) / Medical Defence Union (MDU)

They are the two largest defence unions for doctors. They insure doctors against lawsuits and to represent them in court or in a GMC hearing. They also provide educational activities for their members.

Think of them as a safety net of sorts, where you can approach them for help if you need it and to defend you against potential lawsuits for whatever reason. They are your legal defence when things go wrong.

National Institute for Health and Care Excellence (NICE)

They are an independent organisation providing guidance on health promotion + the treatment and prevention of ill health. From my understanding they provide guidance in 4 areas:

- Health Technology. They look at which new medicine, equipment, procedures should be used within the NHS. They recommend it based on **BOTH EFFECTIVENESS AND COST**. They focus on the principle of "value for money" and hence play an important role in the rationing of drugs, treatments or investigations.
- Interventional Procedures. They assess the safety of the range of procedures + provide relevant information on their safety. They then determine the guidelines on how to use it. They mainly recommend, and do not prescribe / force the guidelines.
- Clinical Practice. They recommend which treatments are appropriate for which diseases or conditions, and also provide guidelines to improve the quality of care. It is evidence-based and are essentially "guidelines to follow unless there is a good reason not to"
- Public Health. They publish guidelines in nine areas such as obesity, diet and nutrition, sexual and mental health. They recommend strategies to tackle key issues

Care Quality Commission

They are the independent regulator of all health and social care services in England. They make sure all services meet national standards of quality and safety.
Think of it along the lines of your parents patrolling to make sure you do your homework. If you don't do it to a certain standard, you get scolded.

Monitor

They are a regulator looking after the health of finances of NHS trusts. It regularly assesses NHS trusts to ensure they are well led, in terms of quality and finances.

What's The Difference? Dive into PA vs MBBS vs HCA vs Nursing

I felt the need to make this section because I was starting to get confused between what is what, and especially because questions can ask you about these similar types of professions, I thought it would be extremely useful to break down the differences clearly and so you know the differences between them.

Profession	Physician Associate (PAs)	Doctor (MBBS)	Healthcare Assistants (HCAs)	Nurses
What can you do?	Taking medical histories from patients Performing physical examinations Diagnosing illnesses Seeing patients with long-term chronic conditions Performing diagnostic and therapeutic procedures Analysing test results Developing management plans Provide health promotion and disease prevention advice for patients	Addressing patient concerns about their health and well-being. Being on-call for emergencies and urgent care. Counseling patients on diet, hygiene, and preventive healthcare. Designing, implementing, and recommending treatment plans. Diagnosing and treating illnesses. Documenting and updating charts or patient information. Helping patients take care of their health. Interpreting medical tests. Ordering tests and	Looking after the physical comfort of patients, for example helping them to wash themselves and emptying bedpans Keeping departments clean and tidy, for example cleaning equipment and making and changing beds Taking and recording basic observations such as blood pressure and temperature Helping patients to eat and to move about, if they have mobility problems Listening and talking to patients Undertake new patient health checks Carry out baseline observations	Since nurses have like 4 main areas of specialisation, I picked 2 to focus on. **GP Nurse:** Obtaining blood samples Electrocardiograms (ECGs) Minor and complex wound management including leg ulcers Travel health advice and vaccinations Child immunisations and advice Family planning & women's health including cervical smears Men's health screening sexual health services Smoking cessation Screening and helping patients to manage long term conditions **Theatre Nurse:** Similar to GP nurses but a few more things to consider! **Preoperative phase** During the preoperative assessment, you'll make sure a patient is fully informed about the risks and benefits of the operation and that they are in a good state of health for surgery. You'll provide information about the operation and

		consultations for other physicians and other healthcare professionals. Performing physical exams. Prescribing medications. Reviewing test results and identifying standout findings. Taking patients' medical histories.	such as pulse oximetry, blood pressure, temperature, pulse rate, recording findings accurately Facilitate routine and 24-hour BP monitoring, advising patients accordingly Undertake wound care, dressings and other clinical tasks as required Support the practice nurse with the management of chronic disease clinics Carry out BMI checks as directed Act as a chaperone as required When trained, administer flu vaccinations Ensure specimens are recorded and ready for onward transportation Provide support during minor operations as required Ensure all clinical rooms are adequately stocked and prepared for each session	give the patient the opportunity to ask questions. This also reduces the risk of a late cancellation and resources being wasted. **Anaesthetic phase** During this phase, you'll primarily support the anaesthetist but also prepare any specialist equipment, devices and drugs. You'll also assess the patient immediately prior to the surgery. Surgical phase You'll be responsible for a number of roles during the surgical phase including: preparing all the necessary complex instruments and equipment including microscopes, lasers and endoscopes, working with the surgeon to provide instruments, needles, swabs and other materials as required responsibility for the surgical instruments, equipment and swabs act as a link between the surgical team and other parts of the theatre and hospital. **Recovery phase** Following the operation, you'll: offer the patient care and support upon arrival on the post anaesthetic care unit monitor the patient's health providing appropriate care and treatment until the patient has recovered from the effects of the anaesthesia and/or surgery

			Ensure fridges are cleaned routinely in accordance with extant guidance Ensure clinical waste is removed from clinical areas and sharps bins replaced in accordance with the practice IPC policy Deliver opportunistic health promotion where appropriate	assess the patient to ensure they can be discharged back to a ward assess the care given during each of the perioperative phases
What can you **NOT** do?	Prescribe medication or blood products Sign death certificates Request ionising radiation, such as a chest x-ray or CT scan Cannot specialise (yet)	Since we are comparing these professions against a doctor, there is almost nothing you cannot do since the doctor is the benchmark	It seems like HCAs are like support workers for nurses, aimed to help nursing duties and make it less strenuous on nurses. Some call them “budget nurses” which is untrue. In comparison with doctors, there is a lot HCAs cannot do so I will not list them all out.	Nurses cannot make prescriptions of medications (Generally true, but can do so under certain conditions) Nurses cannot conduct surgeries and other invasive procedures Nurses cannot certify death legally Nurses cannot provide medical diagnosis (**IMPORTANT NOTE**: There are apparently two types of diagnosis, clinical and nursing diagnosis. Nursing diagnosis is different as it covers the patient’s or family’s response to a health concern or ailment and may include such problems as a risk for falls or impaired mobility. Nurses cannot make final decisions for the patient’s care. Cannot make extensive referrals to specialists etc

Description of role	As a physician associate, you'll work within clearly defined boundaries, **under the supervision of a dedicated supervisor**. There will be specific tasks that you can do independently. **You could also provide cover so that trainee doctors and surgeons can attend training, clinics or theatre**		To **support the practice nursing team in the delivery of nursing services**, working as part of the practice multidisciplinary team, delivering care within their scope of practice to the entitled patient population. The healthcare assistant will **deliver and assist clinical staff** in the provision of treatment, preventative care, health promotion and patient education **Under the supervision and direction of qualified nursing staff**, healthcare assistants carry out a wide range of duties to care for, support, and provide information to patients and their families Important note: Report mainly to nursing staff!	The jobs of NHS nurses are to take care of the ill and injured persons in their homes or in the hospital. Typical daily duties may include recording and monitoring pulse rate, temperatures, respiration rate and blood pressure, preparing and administering drugs and injections and assisting physicians during surgeries and patient examinations

So what now?

So why do you need to know this? To be honest, it is quite unlikely that you will be asked to explain the differences between a nurse or a HCA compared to a doctor, but it can most definitely come out in certain questions such as:

- Why not nursing? Why not any other healthcare profession?
- Tell me more about the roles of the doctor and how different it is compared to other professions
- What is your view regarding PAs and how do they fit in with the healthcare team?
- Do you think that the introduction of roles such as HCAs or PAs would affect how doctors would be treated or function in a healthcare scenario?

While it would be good to remember all of the roles and responsibilities that HCAs / nurses / PAs carry out, it is honestly a lot and I think you have better use of your brain space than to memorize all this. With that said it is still really important to understand the differences and roles.

How to use in an interview scenario

This knowledge should be used to flex your knowledge and steps taken to consider the other professions. Personally I think it will be good to remember the “What you cannot do” section for HCAs, nurses and PAs since it is a great way to demonstrate your deeper understanding and motivations for Medicine. You can use this during your answers for “Why Medicine” etc.

Pros and Cons of being a Doctor

I thought it would be good to write this down as well because sometimes we get so tunnel-visioned regarding what we want to say that we fail to see other aspects / we fail to consider other things in our answer.
While it seems pretty common sense, it is good to revisit this before your interviews just to refresh your understanding and provide additional insights or talking points.

Pros	Cons
• Opportunity to use skills to treat others and make a difference • Dynamic subject with constant learning • CAMP opportunities such as teaching and managerial • Wide range of skills learnt and implemented at a high level • (Generally) respected by the public	• Can be stressful, particularly certain physical aspects and mental aspects • Can become too emotionally invested with patient care • Some aspects can be routine such as paperwork • Need to manage high quality of care with limited resources • Constantly under public scrutiny or exposed to danger of complaints • Potentially poor work-life balance • Personal and professional uncertainty • Patients may have unreasonable expectations

Values of the NHS

It is important to take note of the work values that guide doctors in our everyday work, and these are the core principles to note when preparing for the interviews. One should understand these principles, be able to defend them / raise examples of when these values will come into play and be able to follow / abide by them.
The values are as followed:

- **working together for patients**. Patients come first in everything we do
- **respect and dignity**. We value every person – whether patient, their families or carers, or staff – as an individual, respect their aspirations and commitments in life, and seek to understand their priorities, needs, abilities and limits
- **commitment to quality of care**. We earn the trust placed in us by insisting on quality and striving to get the basics of quality of care – safety, effectiveness and patient experience right every time
- **compassion**. We ensure that compassion is central to the care we provide and respond with humanity and kindness to each person's pain, distress, anxiety or need
- **improving lives**. We strive to improve health and wellbeing and people's experiences of the NHS
- **everyone counts**. We maximise our resources for the benefit of the whole community, and make sure nobody is excluded, discriminated against or left behind.

Now let's break down each value accordingly, with examples on when such values would come into play.

Working together for patients

In a hospital setting it is common for doctors, nurses and other healthcare staff from all departments to work together on a patient, especially complex cases where doctors from varying fields need to come together to confer on how a patient is treated. From the administrative team to the nurses and even the cleaners (is that the right word), everyone has a role to play. However, at the core of the profession, the patients' safety and interests are of utmost importance.
An example would be when considering treatment for a patient. As the doctors go through the diagnosis procedure, there are numerous, different possible treatment methods to suggest to the patient. However, one should remember that the patient comes first, and that whichever method is recommended to the patient should have the patient at heart.

Another example could be when there are conflicting interests or factors at play. If for example, there happens to be a complication regarding the doctor-patient relationship, while it is important to maintain the relationship and resolve any friction, the patient should be at the forefront of any decision made. As such, it would be more appropriate to look for a method that resolves any issue faced by the patient first, and improve upon the relationship at another time.

Respect and Dignity

Respect and dignity. Dignity primarily refers to self-respect, and this concept is applied to everyone, from the patient to their families or relatives, to the healthcare staff such as

doctors, nurses and other staff in the hospital. As for respect, it is to give due regards to the feelings, wishes, or rights of others (regardless of whoever they may be). It is crucial to understand that these values should be a given, and practiced at all times.

Moving on, an example of where this would come in would be just like how SJT presents their questions to us. The doctor and patient (or patient's family) have conflicting opinions on what should be the next option taken. However, instead of taking offense at the patient for going against what you think may be best, one should take the time to understand the motivations behind why they may choose to do it that way, what are some of the considerations they have (be it monetary, social, religious, ethical), and even if you disagree with it, you should respect that they made their decision consciously.

As for dignity, this could apply in a variety of scenarios. From a personal standpoint, if you are uncomfortable with how you are being treated (if someone is being racist, xenophobic, rude or threatening, or even talking down on you), one should have enough self-respect to stand up for yourself (or others) and maintain one's dignity. Dignity is similar to respect but has subtle differences. Another example could be treating the dead with dignity, where you respect the life they have had and how they are as a person, not making condescending or inappropriate comments about them. This also applies to treatment where one should not make the patient feel humiliated whenever possible.

Commitment to quality of care

It is important to understand that every patient in the NHS should be given the basics of healthcare and more importantly, the highest quality of care should always be provided whenever possible. As mentioned above in the document, we must place quality first, that we do the basics right before we attempt anything else that may be more complicated.

One example of this could be that when there are many patients admitted to the hospital, for example due to Covid complications increasing. While it can cause the healthcare staff on hand to feel and become overwhelmed by the increasing number of cases, all patients should at least receive the bare essentials, such as safety where they are placed in an environment where they can be attended to. In terms of patient experience, it could be that we provide a professional experience, catering to patients' needs as much as possible. Or when it comes to effectiveness, we aim to give patients the most effective method of treatment that could resolve what they face, reducing the time necessary for them to be treated. One example of this is that we aim to have effective registration systems, allowing for the shortest possible time between visits.

Compassion

Compassion. Essentially the crux of what every doctor should have. As per Google's definition, compassion refers to having sympathetic pity and concerns for the misfortunes or sufferings of others. A doctor MUST be able to be sympathetic towards those who are suffering, placing themselves in the shoes of the patient that they are treating, feel what the patient does and look for methods together to relieve pain.

One example of compassion is when doctors conduct ward rounds and ask the patient how they are doing. A simple question, definitely. But it shows that the doctor is trying to keep the patient in mind and show sympathy to their situation, that while we are not physically in the same situation as them, we are trying to emotionally connect with them. It is even clearer

when the doctors ask explicitly where they are hurting and if there is anything that can be done to relieve aforementioned pain, clearly showcasing sympathy for others.

It is also compassionate to not discount someone's feelings and how they are reacting to something. Clearly doctors do not accuse patients of faking the pain, or say that even though patients are feeling this way, their opinions do not matter. What compassionate individuals would do is to look for a way to resolve or help the patients feel more comfortable, such as the above example. While there are many attributes necessary to be a doctor, compassion is definitely at the forefront.

Improving Lives

As mentioned by the NHS, we aim to improve the health and well-being of the patients, as well as their experiences. Transparently speaking, most patients that we see are inflicted with some sort of illness, and we aim to treat them to help them recover from the said illnesses. That is the face value of what "improving health" could mean and as for "improving well-being", it could range from emotional to physical health-being depending on how or what the patient is affected in.

One example of this could be when the patient has kidney stones present, having a lot of physical pain and perhaps emotionally distraught because he is in constant agony. By having the NHS intervene via an operation to remove the said stones, the patient, while still experiencing some level of post-op pain, feels much better. This would already hence improve the physical well-being of the patient, and through therapy or compassion from the healthcare team supporting him, it could improve his emotional state and he could feel less anxious / better rested, improving his emotional health.
There are a lot of different scenarios possible to give as an example, and even some that are perhaps out of our scope (such as helping the less fortunate improve their living conditions). However, the aim or even guiding mission that we have is to help those around us and improve upon any aspect possible compared to before they came to us.

Everyone Counts

Understandably, this may seem as a no-brainer to those around us, especially those who are leaders in teams, that we always account for everyone around us. However, in developed settings, it is easy for us to forget that there are always people who are left behind when advancements are made due to many reasons. While the ideal scenario is to help everyone possible make advancements in their situation, in reality it is not possible. As such, it falls on us as doctors to try to help keep everyone in this loop to help them improve, and prevent discrimination or intentional exclusion wherever possible.

One example of this could be when doctors are about to treat a group of patients that were brought in, perhaps due to an accident. In the chaos of it all, it could be easy to overlook the elderly patient at the side who had come in earlier for a consultation, the young child who looked sick in the corner. However, it is our duty to ensure no one is excluded from the care they deserve, and maximise our resources (such as manpower) for everyone in the community, so by sending a doctor to overlook these two patients that could have been unintentionally excluded. Another instance could be racism, where a patient is discriminated against due to their skin colour. As a doctor in the NHS, it is our responsibility to provide the necessary treatment for them just like anyone else, and not discriminate based on factors that were or were not in their control.

Ultimately, as a doctor, we would inevitably end up in a position where we could be handling a small or large team of professionals to overlook / take care of those who come to us for help. We have to make sure we efficiently utilize the said resources and take special attention to monitor and care for those around us, including everyone.

The Four Pillars of Medical Ethics

In this segment, we will break down the four pillars of Medical Ethics. This serves as a set of guidelines that influences us as doctors, how we behave and approach patients, as well as a reminder of what we as doctors should exemplify to those around us. Again doctors are seen as the “leaders” in a hospital setting (more on that in a bit), and we are “role models” to those around us. It is good to bring this up during interviews wherever possible, so as to show relevance to the NHS and provide a solid answer to best show our understanding / knowledge of what is going on around us.

The breakdown is: Autonomy, Beneficence, Justice and Nonmaleficence.
We would go into further detail about each pillar in this segment.

Autonomy

As the name suggests, it refers to the principle where every patient has the right to self-determination without external influence. Patients have the right to choose how they want to be treated, what treatment and to what extent they want to be treated, as well as most importantly - be able to choose if they want to refuse treatment. While this may seem quite counterproductive, such as why would a patient deliberately choose to forgo treatment, it is important to understand that such patients have their reasons and human right to do so, and we should respect that they have given it thought and careful consideration before making such a decision.

Some implications which could affect this would be that information must be fully and truthfully transparent. As doctors we have a duty to deliver information in a concise, clear and easy to understand manner for others to digest it, and in such a profession, it is of utmost importance that we give all the necessary information while also withholding personal bias to the patients so that they can make an **INFORMED** decision (more on this in a bit). Without such transparent information, the patient could be making a decision in the dark, not having complete understanding of what they are up against and what they can choose to do, which would affect the “Nonmaleficence” pillar for Medical Ethics.

Another implication is that the patient must show evident and clear competency. I am sure that most of us have seen cases where the patient is unable to think straight for a few reasons such as having a concussion, or having a mental breakdown where they start to panic and can no longer think for themselves. In this case, we refer to the patient having a lack of **CAPACITY**. Capacity is crucial especially when it comes to crucial issues such as refusal of treatment, and as doctors it is very important for us to check capacity as thoroughly and as precisely as possible. Additionally, there are many rules and regulations for doctors to abide by, checks that must be done, hence showing the importance of the situation.
Another implication could be that there should be no external influence, if at all when a decision of such nature is made. Understandably, with most patients, they may have family or relatives who do not share the same views or opinions as them, they may pressure the patient to make a decision that the patient does not desire or want to. This includes pressuring them to accept certain treatment options, or forcing them to continue in a state where they do not want to (such as vegatative state, Alzheimer's). This is a morally complex situation which requires extensive detailed exploration of options and scenarios before a decision of such scale is made, and in this document, we will attempt to break down as detailed as possible to best illustrate this concept.
SCENARIO: There is a patient being admitted to the hospital with a terminal illness, where if treatment is not pursued, there is a high possibility that it will deteriorate and lead to death.

However, treatment options are not high and it could lead to a possibly worse quality of life for the patient. The patient needs to make a decision on this matter.

SITUATION 1: The patient is of legal age, and has capacity to make decisions.
This is the ideal scenario. While the legal age is **HIGHLY** dependent on the situation, generally it is 18 years old. For this, we will assume that it is 18 just to avoid complicating things unnecessarily. Since the patient can make decisions of a sound mind, and is of legal age, he is an adult and his decision will be respected by the medical professionals handling the case. In this case, family and relatives are unable to intervene with his decisions as he has already made his decision clearly.

SITUATION 2: The patient is not of legal age, but has capacity to make decisions.
This situation will be slightly more complicated. In the event that someone is not of legal age, it will then come down to the Fraser Guidelines and Gillick competency. The Fraser Guidelines are more specifically targeted towards contraception and sexual health, but the Gillick Decision is more general, but still has a hold in contraception and sexual health. If deemed that the patient is "Gillick Competent", they are allowed to undergo the desired treatment mentioned without requiring parental consent or knowledge. However, this is also **HIGHLY** dependent on the course of treatment suggested, where not all treatments are allowed to grant such "Gillick Decision". The understanding required for varied treatments vary, and capacity can also fluctuate. Hence, each individual decision requires assessment of competence. Assuming that the patient is granted "Gillick Competent", and other factors are addressed (such as the treatment being granted), the patient can undergo such treatment, and family and relatives cannot intervene in the process.

SITUATION 3: The patient is not of legal age, and has no capacity to make decisions.
This situation is slightly less complicated. Since the patient is not of legal age, it will then fall on the next legal guardian or the next lasting Power of Attorney (POA) to make the decision in the best interests of the patient. For context, POA just refers to the legally appointed member (family or could be anyone appointed by the individual) who can make decisions in the best interests of the patient. This could range from anyone such as the next of kin to friends, and are given the legal authority to make such decisions. Exemptions to this exist, and this will be further covered down the line.

SITUATION 4: The patient is of legal age, but has no capacity to make decisions.
This is a similar situation to situation 3. The patient is unable to make decisions in their best interests and this would lead to the responsibility falling on the next legal guardian or the POA to make the necessary decision for them. This individual usually will make the decision in the best interests for the patient. However, there are also exemptions to this, and will be further covered down after this segment.

EXCEPTIONS!
It is important to note that this list of exemptions is non-exhaustive and there are plenty more scenarios that can occur, especially in the real world. We will aim to cover the most common ones in this segment.
SITUATION 1: Who gets to decide who is the POA or the legal guardian?
Questions are no doubt raised when there are many individual members involved in such a situation. When the next of kin is referred to, does it mean the parents, and which parent (the dad of the mom)? What about the spouse? What about the kids that could be grown up? Who should be given this responsibility?

Well, the next of kin is **USUALLY** the family members before the spouse. So the immediate members that are related by blood get to make the decision first. However, like all cases, there are exceptions. Which will be covered in Situation 3.

SITUATION 2: What if the patient loses capacity before he can appoint a POA or pick the person to best represent his interests?
This situation occurs more frequently than expected as due to worsening conditions, it is possible for a patient to deteriorate so quickly that they may not be able to appoint someone legally to take over their responsibilities. Doctors do actively encourage patients to make early decisions to prevent messy situations such as this. However, the situation would be similar to Situation 1 where the next of kin is given the responsibility to care for the patient and act in their best interests.
SITUATION 3: What happens if there is a conflict of interests / if there is reason to believe that the appointed individual is not acting for the patient's best interests?
This is where the situation can get really messy. Doctors tend to remain professional and do not interfere unless there are clear reasons that the individual is not acting on behalf of the patient in the best interests. This is for example, but not limited to demanding certain drugs / procedures to be done when it is not done, turning down treatment that the patient would have wanted. This would then lead to doctors stepping in in order to best protect the patients' interests at heart.
We will dive into another example as shown in this image.

What are some considerations that we need to take into account before deciding on what to do?

- Does the patient have clear, concise and truthful information regarding his actions and what the implications can be
- Is intervention really for the patient's best interest?
- Check for any agreements patient have signed, when was it signed and if there is any long standing agreements that we are not aware of
- Is there any way we can trace the family members to help in this decision?
- Is the patient of sound mind and capacity to make such decisions?

While certainly non-exhaustive, as the list can still go on in terms of the considerations given the complexity of the situation, this list serves as a guide for us to be able to best determine a course of action for the patient on hand. As mentioned, this type of scenario is very morally complex and requires extensive exploration of scenarios. As a doctor, your main aim is to keep the patient's best interests in heart, while also providing all and relevant information to the patient to make an **INFORMED** decision about their health. By doing so, it would be relevant to the "Autonomy" ethical pillar as patients have the ability to make decisions for themselves without external influence.

EXTENSION OF AUTONOMY

We will do a deep dive into the toolkit and the relevant segments. In this deep dive, we will not completely address everything (as we might as well have copied the whole document if we wanted to do that), but instead focus on the minority of the content while diving deep into certain principles or relevant important things. If you are interested, the link is here as such: https://www.bma.org.uk/media/1850/bma-best-interests-toolkit-2019.pdf
Now let us begin our deep dive into this BMA toolkit.
Decisions for adults who lack the capacity to consent to medical treatment in England and Wales are governed by the Mental Capacity Act 2005 (MCA). The MCA specifies that, any act done, or decision made, for a person who lacks capacity must be made in their best interests.
The MCA does not define best interests. Instead, it sets out a process to be followed when making a decision. In most circumstances it will be clear where the individual's best interests lie, and a decision as to care or treatment will not be challenging or time-consuming – but this is not always the case. Whether to provide analgesics for someone in pain is likely to be

a straightforward question; a decision about whether to continue providing life-sustaining treatment is less so.
There are 5 statutory principles set out in the MCA; where we will break down each principle for better understanding.

1. Presume capacity
2. Provide support
3. Unwise decisions
4. Best interests
5. The less restrictive option

Presume Capacity
The patient must be presumed to possess capacity unless it has been proven otherwise. The person challenging this should be the one who looks for evidence to prove that the patient lacks capacity.
Provide Support
A person should be given all relevant support to make a decision (as practical and realistic as possible) and all options should be exhausted before exploring that the patient may not have capacity. This includes but is not limited to: Providing a translator, checking if medication or other factors have a role to play
Unwise Decisions
A person should not be deemed to be unable to make a decision just because the decision seems unwise or irrational. It is important to note that everyone has different views as to why they might want to do something, and you might have different opinions on how something should be done.
Best Decisions
Any act or decision made for, or on behalf, must have the patient's interests at heart.
Less Restrictive Option
Before anything is done, it is important that regard is given to whether it can be done in a way without restricting the rights and freedom of the individual.
What are some ways to make decisions?
In short, there are 5 methods:

1. Advance decisions to refuse treatment (ADRTs)
2. Lasting Power of Attorney
3. Court-Appointed Deputies
4. Court of Protection
5. Clinician-led decision making

Let us break down each method.
Advance Decisions to refuse treatment (ADRTs)
Sometimes patients would have already made an ADRT that applies to their situation. Although ADRTs can be made orally or in writing, an advanced refusal will only apply to life-sustaining treatment when it is in writing, is signed and witnessed, and contains a statement that it is to apply even where life is at risk. You should give these ADRTs the "utmost care, attention and scrutiny" and make sure you ask to see a copy of the ADRT, rather than relying on a summary of it.

It should be assumed that the person had capacity at the time they made the ADRT. If there is any doubt as to this, or about its validity or applicability, legal advice should be sought and, if necessary, the Court of Protection may be asked whether the ADRT can be relied upon
Lasting Power of Attorney (LPA)
Some people have made a lasting power of attorney (LPA) appointing a health and welfare attorney. Where this person has the appropriate powers (including, in the context of decisions about life-sustaining treatment, the power to consent to or refuse such treatment), and the LPA has been registered with the Office of the Public Guardian (OPG), the health and welfare attorney is the lawful decision-maker.

They must, however, follow the principles of the MCA. If there is genuine doubt or uncertainty that the attorney is acting in the best interests of the person, or there are concerns about an attorney, one should contact the OPG. If doubt or disagreement persists, the Court of Protection should be involved.
It is important that one asks to see the original LPA document (embossed with "validated – OPG" at the bottom of each page) and check that it does indeed confer the appropriate powers required for the decision.
Attorneys cannot be compelled to make a decision. In some circumstances, they may feel unable to draw a clear picture of what would be in the person's best interests, or unable to make the decision required. If an attorney chooses to exempt themselves from the decision-making process, responsibility will fall to the relevant clinician to carry out a best interests assessment.

Court-appointed Deputies

The Court of Protection could have appointed a deputy to make such decisions. If there is a deputy, they are the only decision-maker, and can only make decisions approved by courts, and they cannot consent or refuse any life-sustaining treatment.
It is important that you see the official documentation appointing the deputy and check the powers that have been conferred on them.

Court of Protection

The COP makes decisions when there is no other way to resolve disputes regarding such matters, being established by the MCA. This occurs if the matter is serious enough, or if the circumstances of such a case are important enough.

Clinician-led Decision Making

In all other cases, decisions must be made by the clinical team on the patient's behalf, based on his or her best interests.

What are "best interests" and what should be considered when making decisions?

"Best interests" are not defined in the MCA. This was a deliberate decision by those drafting the Act. It would be impossible to specify in advance what would be in every individual's best interests, and such decisions will be taken by a range of professionals, in a variety of settings and circumstances.
As for what should be considered, below would be a checklist.

(1) In determining for the purposes of this Act what is in a person's best interests, the person making the determination must not make it merely on the basis of –
a. the person's age or appearance, or
b. a condition of his, or an aspect of his behaviour, which might lead others to make unjustified assumptions about what might be in his best interests.
(2) The person making the determination must consider all the relevant circumstances and, in particular, take the following steps.
(3) He must consider:
a. whether it is likely that the person will at some time have capacity in relation to the matter in question, and
b. if it appears likely that he will, when that is likely to be.
(4) He must, so far as is reasonably practicable, permit and encourage the person to participate or to improve his ability to participate, as fully as possible in any act done for him and any decision affecting him.
(5) Where the determination relates to life-sustaining treatment he must not, in considering whether treatment is in the best interests of the person concerned, be motivated by a desire to bring about his death.
(6) He must consider, so far as is reasonably ascertainable:
a. the person's past and present wishes and feelings (and in particular, any relevant written statement made by him when he had capacity),
b. the beliefs and values that would be likely to influence his decision if he had capacity, and
c. the other factors that he would be likely to consider if he were able to do so.

(7) He must take into account, if it is practicable and appropriate to consult them, the views of:
a. anyone named by the person as someone to be consulted on the matter in question or on matters of that kind,
b. anyone engaged in caring for that person or interested in his welfare,
c. any donee of a lasting power of attorney granted by the person, and
d. any deputy appointed for the person by the court, as to what would be in the person's best interests and, in particular, as to the matters mentioned in subsection (6).

TLDR: One should avoid discrimination, take into account relevant circumstances and whether it is possible for the patient to regain capacity, encourage patient participation, find out the patient's views while consulting others, all while not being motivated to bring about the person's death.

Who is the decision maker and who should be consulted?

A collaborative approach is necessary, where the approach is multi-disciplinary, seeking to involve and hear from all those who were involved in the care of the patient.

Since delays can occur if a decision-maker is not established, if it involves provision of medical treatment, the healthcare professional responsible for the provision of treatment is the decision maker. However, if there are **POTENTIAL SERIOUS CONSEQUENCES**, the most senior clinician with overall responsibility is the decision maker.

What about family members and next of kin?

It is important that "next of kin" does **NOT** grant any legal right for decision-making unless they have been formally appointed or are deputies.

Who should be involved in decision-making?

There are 4 main groups:

1. Anyone named by the patient to be consulted
2. Anyone engaged in caring or interested in the patient's welfare
3. Court-appointed duties
4. The person themself

Anyone named by the patient to be consulted

Where the person has named one or more people to be consulted but has not formally appointed them as health and welfare attorney, their views about the person's best interests should be sought. This could include, for example, someone named in medical records as someone to be involved in decision-making or, where the person is able to express a view currently, anyone named by them when asked.

When making an ADRT, people are sometimes asked to name someone as a "proxy" decision-maker. This does not mean that that person has been granted decision-making powers. Legally, a proxy decision-maker can only be appointed by granting lasting power of attorney, or if the Court of Protection appoints someone as a deputy. Someone named as a "proxy" in an ADRT should be involved in consultation but does not have decision-making authority and cannot overrule the decision a person has made in their ADRT.

Anyone engaged in caring or interested in the patient's welfare

For the most part, this will normally include family members – which includes immediate relatives, adoptive families, families of choice, as well as spouses (whether by marriage or civil union), partners, and people with close personal relationships (whether or not these are legally recognised).

Where someone has no family, or where it is appropriate to consult more widely, you may wish to consult a wider network of relatives or speak to close friends or others who are part of the person's wider social circle or community. They may be aware of the person's views and values or have relevant information to share.

This category also covers members of the healthcare team and anyone else involved in caring for the person, including carers, whether paid or unpaid. The views of care staff at all levels can be helpful and relevant in assessing what decision the person would judge to be in his or her best interests – particularly those who have spent a considerable period of time with the person and those close to them.

Court-appointed deputies

In some cases, the Court of Protection may have appointed a deputy to make ongoing healthcare decisions on behalf of the person. Where deputies have been authorised to make a particular decision by the court, they are the decision-maker (with the important exception that deputies cannot consent to or refuse life-sustaining treatment).
Where their powers do not cover the decision in question, they must still be specifically consulted as part of the best interests decision.

The person themself

Wherever possible, the person who lacks capacity to make a decision should still be involved in the decision-making process.17 They may have views on matters affecting the decision or on what outcome would be preferred, however these views may be demonstrated, articulated, or indicated by their actions, behaviour, or responses (whether verbal or non-verbal).
Consulting the person involved may take some time. It is important to allow sufficient time to explain what is happening, why a decision needs to be made, and to hear from the person involved. You may wish to consider:

- Using simple language and/ or illustrations to help the person understand the decisions and their options;
- Asking them about the decision at a time and in a location where the person feels most relaxed and at ease;
- Using specialist interpreters for speech and language therapists to aid communication;
- Involving trusted relatives or friends,or carers or advocates who may be able to
  help the person express a wish or to indicate a preference between options; and
- Any non-verbal behaviours or responses which might indicate how a person feels about a particular treatment or intervention.

What does "practical and appropriate" mean?

Decision-makers must show that they have thought carefully about who to speak to. If it is practical and appropriate to speak to someone, you must do so and take their views into account. If you do not speak to a particular person, you must be able to explain why you chose not to do so, and the reasons for this should be recorded in the patient's notes.

What is "practical and appropriate" will vary in different cases, but you must be able to justify a decision not to consult someone. Even in an emergency situation there may still be an opportunity to communicate with or contact those close to the patient.

What is the IMCA?

The Independent Mental Capacity Advocate (IMCA), which was created by the MCA to provide independent safeguards for people who lack capacity and, at the time the decision needs to be made, either have no-one else to support or represent them, or where it would be inappropriate to consult them.
The role of the IMCA is to support and represent the person in the decision- making process. Their role is to advocate for the person, not to make the best interests decision itself.
IMCAs are only available to people who:

- lack capacity to make a specific decision about serious medical treatment or long-term accommodation;
- have no family members and/or others who are available and appropriate to support or represent them apart from professionals or paid workers providing care or treatment; and
- have not previously named someone who could help with a decision; and
- have not made a lasting power of attorney

IMCAs are not necessary only in situations where an **URGENT** decision is needed.

What counts as "wishes, feelings, beliefs and values" ?

These categories cover a broad range of information, and you might like to consider the following questions in carrying out and reasonably ascertain your assessment:

- What was the person like before becoming ill?
- What Was Their Job? Did They Have Any Hobbies Or Interests?
- What Did They like or dislike?What parts of their life were particularly important to them?
- Did they ever say or do anything which indicates how they might feel about their current situation?
- Did they ever write anything down which might indicate their views–for example, in emails, on social media, or in an advance statement or advance care plan?
- Do they have any religious, spiritual or ethical beliefs that might impact on their view of their current situation?
- Are there any other aspects of the person's personality that might be relevant to understanding what their views might be?

How expansive your consideration of wishes, feelings, beliefs and values is will depend on the nature and consequences of the decision being made.
"Reasonably ascertainable" means considering all possible information in the time available.

How should I balance and weigh different factors?

There may be other more complex competing factors which need to be weighed against one another. In these cases, it may be useful to use a balance sheet approach to decision-making.
The balance sheet approach involves setting out the potential risks and benefits of each option side-by-side. This is not a purely numerical exercise: it is not the case that the side with the most factors on it will be determinative.
It is the weight of the arguments that is important. Each factor must be appropriately weighed, and the reasons for weighing them in this way provided. Simply listing them as pros and cons without attributing any importance to them will not be helpful.
In carrying out this exercise, it may become clear that although there are many risks and benefits, in some cases, one risk or benefit may be of overriding importance, and so have a decisive influence. These are often called "factors of magnetic importance".

How do I decide between previously and currently expressed wishes, feelings etc?

It all varies depending on the situation, but the situation that clearly shows the patient making the decision **WITH CAPACITY** should be given more weightage as it highlights the patient's wishes.

Reviewing Best Interests Decisions

Capacity is decision-specific: it focuses on the specific decision that needs to be made at the time the decision is required. It is not a single one-off event, but one that needs to be regularly assessed in relation to each decision required. For this reason, it is important for capacity to be regularly reviewed.

Similarly, what is in a person's best interests may change over time. This means that even where similar actions need to be taken repeatedly in connection with the person's care or treatment, the person's best interests should also be regularly reviewed.

Who is the decision-maker for life-sustaining treatment?

There are various ways in which decisions can be taken for or in relation to persons who lack capacity, and it is worth restating them here in the specific context of life-sustaining treatment.

- If the person has made a valid and applicable advance decision to refuse treatment (ADRT), that applies in the person's clinical situation, the person has already decided to decline a certain treatment, and that decision must be respected.
- If the person has made a lasting power of attorney (LPA) appointing a health and welfare attorney, with the power to consent to, or refuse, life-sustaining treatment, and the LPA has been registered with the Office of the Public Guardian, the LPA is the decision-maker. LPAs must follow the principles of

the Mental Capacity Act 2005 (MCA) when making decisions and act in the best interests of the person.
- When a decision about life-sustaining treatment is needed and the person has neither an ADRT nor an LPA, it must be made by the clinical team on the person's behalf, based on his or her best interests. Where a person has nobody to represent them or no one who it is appropriate to consult, an IMCA must be instructed.
- In cases where there is disagreement about the person's best interests, or the decision is finely balanced, the Court of Protection is the ultimate decision-maker and should be asked to decide.

It is important to note that a court-appointed deputy does not have, and cannot receive, the power to refuse consent to the carrying out or continuation of life-sustaining treatment.

What are some additional considerations to note?

There is a strong legal presumption in favour of prolonging life, and decision- makers must start from this premise. This presumption can be rebutted, however, where:

- There is clear evidence that the person would not want the treatment in question in the circumstances that have arisen;
- The treatment itself would be overly burdensome for the person – in relation to what is known about the person's wishes for care and treatment; or
- There is no prospect that the treatment would return the person to a quality of life that would be acceptable to them. It is crucial to emphasise that quality of life must be viewed through the lens of what the person would view as worthwhile, not what the healthcare team or family members might view as worthwhile.

This decision must be reached, as with all other best interests decisions, following careful consideration and assessment of the person's wishes, feelings, beliefs and values. Due to the serious consequences of a decision not to provide life-sustaining treatment for a person who could, with it, potentially live for a long time, it is likely that an extensive and rigorous consultation and assessment process would be required.

Beneficence

Beneficence as defined by Google, is defined as an act of charity, mercy, and kindness with a strong connotation of doing good to others including moral obligation. All professionals have the foundational moral imperative of doing right.

All medical practitioners have a moral duty to promote the course of action that they believe is in the best interests of the patient. As per the Hippocratic Oath, we swear to "first do no harm" and while in today's context, we no longer heavily abide by the Oath, instead taking bits and pieces from it to form the values that we know today. However, it still remains as the core idea of the profession, that we aim to help others.

Breaking down beneficence, we have two main groups of beneficence and as a doctor, we should be able to display both groups as and when the situation requires us to be able to. The two groups are "weak obligatory beneficence" and "strong obligatory beneficence". Weak obligatory beneficence could refer to everyday actions such as opening a door for a stranger who is disabled, and offering to carry groceries for a struggling elderly. Strong obligatory beneficence on the other hand could refer to rescuing a stranger from danger, or risking our own personal safety for the betterment of others (aka going above and beyond). As a doctor, we need to be able to demonstrate both groups as and when required, but mainly the strong obligatory beneficence. While not in the same context as the examples, we should be giving everything we possibly can to help those around us.

Some considerations we should keep in mind is whether the option suggested and problem suggested are proportionate in terms of scale. Now this admittedly would be a little confusing so we will attempt to break it down with an example. An example would be that a patient

comes in with stomach pain. We have two options of either bringing her in for surgery to operate and look for a cause, or to do a simple diagnosis before making a decision on what to do. Yes, a surgery **COULD** resolve the stomach pain faced by the patient, but it is quite disproportionate to the problem faced. Instead opting for the simple diagnosis before making a decision is much more proportionate to the problem faced. It is important for us to keep in mind that not all solutions are **APPROPRIATE** despite them being feasible.
Another consideration would be the individual circumstances faced. Every patient is unique, and they all have different backgrounds or circumstances that influence who they are and how they came to be in the situation that they are in. As such, we should approach each patient with an open mind and aim to support them as best we can in whatever capacity we should be able to.
Another consideration would be if the options suggested for the patient are considered to be exceptions? As previously mentioned, every patient is unique and are different from other patients. As such treatment options that are suggested could be exclusive to certain patients, but in line with Beneficence, we should also explore and consider that the options suggested could perhaps be a possible suggestion for future patients that may suffer the same illness as the current patient.
Now let us take a look at this example below:

Breaking down the example, we have two treatment options that differ in terms of scale. One option seems more extreme and carries a potential risk to the patient, while the alternative option is less extreme and could resolve the problem faced by the patient, but may not be very effective. If the second method does not succeed, the first option would need to be carried out.

As a doctor, we have to look beyond the treatment and look into the wishes of the patient as a consideration as well. In this context, the female is a soprano singer, and is scared of going under the knife (aka scared of the operation). It would not be extreme to suggest that the patient would perhaps want to continue with her singing interest / passion / potential career, and would like to keep her voice intact as much as possible. The patient is also scared of an operation, and while the mental capacity of this patient is assumed to be intact and can make her own decisions, she may opt to avoid the operation.

In this case, we should consider all the relevant information presented to us before making a decision. In line with the “Beneficence” pillar, we aim to do good for the patient as much as feasibly possible. As such our aim is to help maintain the overall voice of the patient as much as possible, while respecting her wishes. Since she does not want to take the operation, our first step should be to make sure all options are explored and presented to her in a clear, concise manner that is easy to understand.

Next, assuming these are the only 2 options, we would suggest the anti-inflammatory drugs first in line with her wishes, as the suggested treatment option **WHILE** also making it clear to her that the option of the surgery would need to be undertaken if there is no improvement for her condition. We should reassure her as well that we will take all preventive measures to ensure that the potential risks are minimised as much as possible, and prevent the damaging of the nerve. We will stop short of promising her that it will not happen, since we are unable to predict or guarantee anything during the operation. While yes, it could help her feel much more reassured and less afraid of the operation, however, we should not make misleading or false promises, to maintain the professionalism required for the profession.
Let us take another look into an example suggested by @jintei. For this, we will first have to understand the Jehovah’s Witness beliefs. A very important belief that they have is that it is against God's will to receive blood and, therefore, they refuse blood transfusions, often even if it is their own blood. The willing acceptance of blood transfusions by Jehovah's Witnesses has in some cases led to expulsion from and ostracisation by their religious community. This will be the main belief that will come into play for this scenario.

SCENARIO: A competent adult patient loses a massive amount of blood from a blood vessel bleeding in an acute duodenal ulcer. The best chance of saving his life is an urgent blood transfusion along with operative intervention to arrest the bleeding. The patient refuses blood but asks for treatment instead with the best available non-blood products, and surgery, accept- ing the substantial risk that surgery without blood transfusion is much less likely to save his life than surgery with blood transfusion. The healthcare team has to make a decision now to save the patient's life.
What should be done? According to the medical pillar of "Beneficence", we should do good for others and take every step possible to save the patient's life. However, the patient has religious beliefs that should be respected and will want alternative methods to be explored to save their life. However, in our goal to "do no harm" if we were to explore other alternatives, and seek to save the patient, we would be going against the aim of beneficence. But again, we do not have much time as the situation is critical.

As such the consensus / approach is as such: We would let the patient know that they are at significant risk if they were to pursue other methods given the critical nature of the situation, and provide all relevant information for them to make a clear and informed decision. If they understand and are able to accept that the risks they are undertaking are manageable, and that it is not worth going against their religious beliefs, then we would proceed to pursue other forms of treatment in line with the patient's wishes.

In certain cases, the healthcare team may aim to attain a legal opinion on the spot from the court via the hospital's lawyer, to overturn the decisions from the patient if necessary. The doctor concludes, if he cannot obtain parental consent to save the child's life, is morally right (and probably legally right) to override their refusal and administer a blood transfusion on the grounds that the child does not fall within the scope of the principle of respect for autonomy, and that the parents' authority to decide on medical treatment for their child morally should not and legally does not extend to imposing severe and probably fatal harm on their child in the pursuit of their own religious beliefs rather than in what their society, though not their religion, regards as the child's best interests. In doing so, the doctor still abides by the pillar of "Beneficence", to do good for the patient.

Non-maleficence

Non-maleficence refers to the obligation of a physician not to harm the patient. This simply stated principle supports several moral rules – do not kill, do not cause pain or suffering, do not incapacitate, do not cause offense, and do not deprive others of the goods of life.
The physician weighs the benefits against burdens of all interventions and treatments, to eschew those that are inappropriately burdensome, and to choose the best course of action for the patient. This is particularly important in difficult end-of-life care decisions on withholding and withdrawing life-sustaining treatment, medically administered nutrition and hydration, and in pain and other symptom control.
A physician's obligation and intention to relieve the suffering (e.g., refractory pain or dyspnea) of a patient by the use of appropriate drugs including opioids override the foreseen but unintended harmful effects or outcome (doctrine of double effect)
Some considerations that are important to note are that there are some harms that are foreseeable, and all feasible action should be taken to address and reduce the risks. An example of this could be in a surgical setting, the operating surgeon notices that one of the nurses on bedside duty has a tear in her surgical gloves. The surgeon knows that this can cause the operating environment to no longer be sterile and can cause infection. Along the pillar of non-maleficence, the surgeon should alert the nurse as soon as possible, taking the step to reduce the risk of infection by getting the nurse to change gloves.

However, another consideration is also important that while some harms are foreseeable, they may also be acceptable if they are connected to a significant health benefit, where the harm is unavoidable. One clear example of this is when a patient has to undergo chemotherapy to address advanced cancer. We are well aware of the risks and harms that chemotherapy possesses, such as fatigue, increased risks of infection, memory - concentration - sleep issues. However, the benefit of chemotherapy is that the cancer can be completely eradicated, potentially saving the life of the patient to allow them to make a full recovery. In a way, it is a question on whether the “means justify the ends”, and in line with this medical ethic, we should weigh all possible factors as evenly as possible.

Lastly, an important thing to note is that in desperate situations, risky treatments are justified as the risk of not treating is equally or more likely to do harm to the patient. In a hypothetical scenario, where the patient is potentially at risk of dying due to injuries, the surgeon decides to carry out a surgery to attempt to save the patient’s life. However, the surgery bears risks such as a lower postoperative quality of life (QOL) or could lead to health implications in the long run. However, if the surgery is not undertaken, the patient is most likely to pass on from the severity of his injuries. The doctor, after weighing the pros and cons, determines that the pros outweigh the cons, and justify the operation to take place. This would be in line with the pillar of “Non-maleficence” as the doctor did no harm by not withholding treatment.

Let us look at an example to understand how this concept is used:

SCENARIO: A 52-year-old man collapses in the street complaining of severe acute pain in his right abdomen. A surgeon happens to be passing and examines the man, suspecting that he is on the brink of rupturing his appendix. The surgeon decides the best course of action is to remove the appendix in situ, using his trusty pen-knife.

What should be undertaken in this scenario? According to the Ethical Pillar of “Non-maleficence”, we should operate on the patient who is clearly in severe pain, and for us to choose not to operate, would leave the man in severe pain and in potential danger as the situation can worsen from there. In line with “doing no harm”, we should take the appropriate actions to help the man whenever possible to relieve his pain.

However, we should consider certain factors. Firstly, this would be an external setting, where it would hardly be considered sterile compared to the operating room. If the operation to remove the appendix goes forward, we could be exposing the patient to potential infections, which in turn leads to even more complications down the line. Additionally, there are multiple instruments needed for a successful operation to go smoothly, such as retractors, and a pen-knife would hardly be able to carry out all the necessary functions needed.

Lastly, in line with providing solutions with the appropriate scale / proportion, this action would hardly be proportionate to the issue unless there was no hospital around for the patient to be transported to the appropriate environment. It would be immensely disproportionate to operate in such a setting if there was a nearby hospital where some of the risks can be addressed, reducing any further complications down the line.

Ultimately, the question would be whether intervention via roadside operation does more or less harm towards the patient. Yes, by not operating, the patient could be in severe risk of further complications, however this may not be as life-threatening given the situation As such, by choosing to operate, it could lead to even greater harm to the patient, hence doing “more” harm as compared to not intervening. As such, just like any medical ethic, there are more considerations to make than just the “apparent” or “obvious” one and that sometimes the straightforward approach is not the best approach when other factors come into play.

Justice

Justice in a medical / ethical setting refers to the principle that when weighing up if something is ethical or not, we have to think about whether it's compatible with the law, the patient's rights, and if it's fair and balanced. It also means that we must ensure no one is unfairly disadvantaged when it comes to access to healthcare. In short, it is the need to treat all equally in healthcare settings, regardless of factors such as age, gender, social status etc.
There are a few considerations to make in regards to this ethical pillar. One of such would be is this action legal, and does it unfairly contradict someone's human rights? One example that could help us understand better would be the detainment of an individual to give them medical treatment, forceful detainment or otherwise. Every human has a basic right to freedom and to not be enslaved to anyone / anything, so would such detainment be considered legal? If we have to confine them in a setting that they cannot escape from via the use of restraints for example, does that unfairly infringe upon the human right of freedom? However, as we know, there are still some such cases where patients are held in place via restraints, so in what setting would then such detainment be acceptable?

Another consideration that should be explored would be does this action prioritize a group over another? As per our understanding, justice determines that we weigh up if the action is fair and balanced. However, if one group is advantaged over the other, would that be considered an infringement of the medical ethic? There are many settings to consider but one example would be that if a group of patients (aged over 65) are given priority treatment over youths (age ranged 14-18). This clearly shows a bias and priority given to a certain group of patients, and is there a justifiable reason for this? Do the elderly need to be prioritized over youths, and would this be considered a fair reason?

Lastly, one consideration would be in a hypothetical scenario, if it does prioritize one group over another, can that prioritisation be justified in terms of overall net benefit to society or does it agree with moral conventions? I will raise the example of the equality movement, where there is increasing support for women to be treated the same as men. Let us raise this in a hypothetical scenario, where due to increased support for such movements, women are given priority over men when it comes to any form of medical treatment. As mentioned, can this prioritization be justified in the overall net benefit to society or was it more of a consequence due to moral conventions? Was this treatment a result of scientifically proven results that by prioritizing women over men, society benefits to a larger extent, or was it a consequence of social pressures? If it was the latter, clearly does that mean that justice has not been achieved in this setting, since the decision is not fair and balanced?
This concept can be tested in almost any setting, and would be considered as universal as the other pillars of medical ethics. Popular questions could include testing you on your stance towards certain topics such as abortion, euthanasia or even pay scales for the different professionals on the healthcare team.
Now let us take a look at an example to better understand this ethical principle:
SCENARIO: Patients suspected of having cancer are prioritised within the NHS, with the maximum waiting time for referral being two weeks (as opposed to 18 weeks for non-urgent referrals). Patients diagnosed with cancer are entitled to a range of treatments including radiotherapy and chemotherapy. These treatments are expensive and treat a small, but significant proportion of patients.
On first glance, it may be easy for us to immediately assume that this action is in line with the ethical pillar of "Justice", since based on the definition given above, it complies with the law, the patients' rights are still being respected in the given situation, and that it is fair and

balanced since patients suspected of having cancer may be more disadvantaged when they are seeking treatment since they are not inflicted with the disease yet, and may not be taken seriously. Additionally, early intervention for cancer is crucial, as the disease can run rampant quickly and in the later stages, it can pose an extremely high risk of death. Through early intervention we would be able to prevent further progression of the disease, saving the lives of those affected. While small in terms of numbers, it is still a significant proportion of the patients and hence has a beneficial impact for these patients.

However, if we take a step back and look at it, there are a few glaring issues to be addressed. First off, prioritising cancer patients means you're limiting the ability of other patients to access healthcare. That would not necessarily be just and fair as you are somewhat limiting other people who may need it more as compared to other individuals. Next, it is also important to know that it will be difficult to determine non-urgent referrals (aka what classifies as urgent and what is not), hence it could lead to even greater waste of resources, which could worsen the situation if resources are already scarce.

Another point to note is that spending public money on radio and chemotherapy on a smaller group of people is taking the budget away from less expensive treatments that would benefit a greater number of people – for example, an increase in stations for those at risk of cardiovascular disease. This would then violate the "fair and balanced" definition since the benefit to society is less than the benefit to one group.

Consent to Treatment

Overview

Consent to treatment means a person must give permission before they receive any type of medical treatment, test or examination.
This must be done on the basis of an explanation by a clinician.
Consent from a patient is needed regardless of the procedure, whether it's a physical examination or something else.
The principle of consent is an important part of medical ethics and international human rights law.

Defining consent

For consent to be valid, it must be **voluntary and informed, and the person consenting must have the capacity to make the decision**.
The meaning of these terms are:

- voluntary – the decision to either consent or not to consent to treatment must be made by the person, and must not be influenced by pressure from medical staff, friends or family
- informed – the person must be given all of the information about what the treatment involves, including the benefits and risks, whether there are reasonable alternative treatments, and what will happen if treatment does not go ahead
- capacity – the person must be capable of giving consent, which means they understand the information given to them and can use it to make an informed decision

If an adult has the capacity to make a voluntary and informed decision to consent to or refuse a particular treatment, their decision must be respected.
This is still the case even if refusing treatment would result in their death, or the death of their unborn child.

If a person does not have the capacity to make a decision about their treatment and they have not appointed a lasting power of attorney (LPA), the healthcare

professionals treating them can go ahead and give treatment if they believe it's in the person's best interests.
But clinicians must take reasonable steps to discuss the situation with the person's friends or relatives before making these decisions.
Read more about assessing the capacity to consent, which explains what someone can do if they know their capacity to consent may be affected in the future.

How consent is given

Consent can be given:

- verbally – for example, a person saying they're happy to have an X-ray
- in writing – for example, signing a consent form for surgery

Someone could also give non-verbal consent, as long as they understand the treatment or examination about to take place – for example, holding out an arm for a blood test.
Consent should be given to the healthcare professional responsible for the person's treatment.
This could be a:

- nurse arranging a blood test
- GP prescribing new medication
- surgeon planning an operation

If someone's going to have a major procedure, such as an operation, their consent should be secured well in advance so they have plenty of time to understand the procedure and ask questions.
If they change their mind at any point before the procedure, they're entitled to withdraw their previous consent.

Consent from children and young people

If they're able to, consent is usually given by patients themselves.
But someone with parental responsibility may need to give consent for a child up to the age of 16 to have treatment.

When consent is not needed

There are some exceptions when treatment may be able to go ahead without the person's consent, even if they're capable of giving their permission.
It may not be necessary to obtain consent if a person:

- needs emergency treatment to save their life, but they're incapacitated (for example, they're unconscious) – the reasons why treatment was necessary should be fully explained once they have recovered
- immediately needs an additional emergency procedure during an operation – there has to be a clear medical reason why it would be unsafe to wait to obtain consent
- with a severe mental health condition, such as schizophrenia, bipolar disorder or dementia, lacks the capacity to consent to the treatment of their mental health (under the Mental Health Act) – in these cases, treatment for unrelated physical conditions still requires consent, which the patient may be able to provide, despite their mental health condition
- needs hospital treatment for a severe mental health condition, but self-harmed or attempted suicide while competent and is refusing treatment (under the Mental Health Act) – the person's nearest relative or an approved social worker must make an application for the person to be forcibly kept in hospital, and 2 doctors must assess the person's condition
- is severely ill and living in unhygienic conditions (under the National Assistance Act 1948) – a person who's severely ill or infirm and living in unsanitary conditions can be taken to a place of care without their consent

Consent and life support

A person may be being kept alive with supportive treatments, such as lung ventilation, without having made an advance decision, which outlines the care they'd refuse to receive.

In these cases, a decision about continuing or stopping treatment needs to be made based on what that person's best interests are believed to be.
To help reach a decision, healthcare professionals should discuss the issue with the relatives and friends of the person receiving the treatment.
They should consider:

- what the person's quality of life will be if treatment is continued
- how long the person may live if treatment is continued
- whether there's any chance of the person recovering

Treatment can be stopped if there's an agreement that continuing treatment is not in the person's best interests.
The case will be referred to the courts before further action is taken if:

- an agreement cannot be reached
- a decision has to be made on whether to stop treatment for someone who's been in a state of impaired consciousness for a long time (usually at least 12 months)

It's important to note the difference between stopping a person's life support and taking a deliberate action to make them die.

Assessing Capacity

All adults are presumed to have sufficient capacity to decide on their own medical treatment, unless there's significant evidence to suggest otherwise.
What is capacity?
Capacity means the ability to use and understand information to make a decision, and communicate any decision made.
A person lacks capacity if their mind is impaired or disturbed in some way, which means they're unable to make a decision at that time.
Examples of how a person's brain or mind may be impaired include:

- mental health conditions – such as schizophrenia or bipolar disorder
- dementia
- severe learning disabilities
- brain damage – for example, from a stroke or other brain injury
- physical or mental conditions that cause confusion, drowsiness or a loss of consciousness
- intoxication caused by drugs or alcohol misuse

Someone with such an impairment is thought to be unable to make a decision if they cannot:

- understand information about the decision
- remember that information
- use that information to make a decision
- communicate their decision by talking, using sign language or any other means

How capacity is assessed
As capacity can sometimes change over time, it should be assessed at the time that consent is required.
This will usually be done by an appropriately trained and experienced healthcare professional who's either:

- recommending the treatment or investigation
- involved in carrying it out

If the healthcare professional feels you have the capacity to give your consent, your decision will be accepted and your wishes will continue to be respected, even if you lose capacity at a later stage.
If the healthcare professional feels you do not currently have the capacity to give consent and you have not made an advance decision or formally appointed anyone to make

decisions for you, they'll need to carefully consider what's in your best interests before making a decision.

Respecting personal beliefs

If someone makes a decision about treatment that other people would consider to be irrational, it does not necessarily mean they have a lack of capacity, as long as they understand the reality of their situation.

For example, a person who refuses to have a blood transfusion because it's against their religious beliefs would not be thought to lack capacity.

They still understand the reality of their situation and the consequences of their actions.

But someone with anorexia who's severely malnourished and rejects treatment because they refuse to accept there's anything wrong with them would be considered incapable.

This is because they're regarded as not fully understanding the reality of their situation or their consequences.

Determining a person's best interests

If an adult lacks the capacity to give consent, a decision about whether to go ahead with the treatment will need to be made by the healthcare professionals treating them.

To make a decision, the person's best interests must be considered.

There are many important elements involved in trying to determine what a person's best interests are.

These include:

- considering whether it's safe to wait until the person can give consent if it's likely they could regain capacity at a later stage
- involving the person in the decision as much as possible
- trying to identify any issues the person would take into account if they were making the decision themselves, including religious or moral beliefs – these would be based on views the person expressed previously, as well as any insight close relatives or friends can offer

If a person is felt to lack capacity and there's nobody suitable to help make decisions about medical treatment, such as family members or friends, an independent mental capacity advocate (IMCA) must be consulted.

Involving the Court of Protection

In situations where there's serious doubt or dispute about what's in an incapacitated person's best interests, healthcare professionals can refer the case to the Court of Protection for a ruling.

This is the legal body that oversees the operation of the Mental Capacity Act (2005).

Situations that must always be referred to the courts include:

- **sterilisation for contraceptive purposes**
- **donation of organs or regenerative tissue, such as bone marrow**
- **withdrawal of nutrition and hydration from a person who's in a permanent vegetative state or minimally conscious state**

Changes in capacity

A person's capacity to consent can change. For example, they may have the capacity to make some decisions but not others, or their capacity may come and go.

In some cases, people can be considered capable of deciding some aspects of their treatment but not others.

For example, a person with severe learning difficulties may be capable of deciding on their day-to-day treatment, but incapable of understanding the complexities of their long-term treatment.

Some people with certain health conditions may have periods when they're capable and periods when they're incapable.

For example, a person with schizophrenia may have psychotic episodes when they cannot distinguish between reality and fantasy, during which they may not be capable of making certain decisions.

A person's capacity can also be temporarily affected by:

- shock

- panic
- extreme tiredness (fatigue)
- medication

Advance decisions and power of attorney
If a person knows their capacity to consent may be affected in the future, they can choose to draw up a legally binding advance decision, also known as a living will.
This sets out the procedures and treatments that a person refuses to undergo.
You can also choose to formally arrange for someone, often a close family member, to have lasting power of attorney (LPA) if you wish to anticipate your loss of capacity to make important decisions at a later stage.
Someone with LPA can make decisions about your health on your behalf, although you can choose to specify in advance certain treatments you'd like them to refuse.

Children and Young People

People aged 16 or over are entitled to consent to their own treatment. This can only be overruled in exceptional circumstances.
Like adults, young people (aged 16 or 17) are presumed to have sufficient capacity to decide on their own medical treatment, unless there's significant evidence to suggest otherwise.
Children under the age of 16 can consent to their own treatment if they're believed to have enough intelligence, competence and understanding to fully appreciate what's involved in their treatment. **This is known as being Gillick competent**.
Otherwise, someone with parental responsibility can consent for them.
This could be:

- the child's mother or father
- the child's legally appointed guardian
- a person with a residence order concerning the child
- a local authority designated to care for the child
- a local authority or person with an emergency protection order for the child

Parental responsibility
A person with parental responsibility must have the capacity to give consent.
If a parent refuses to give consent to a particular treatment, this decision can be overruled by the courts if treatment is thought to be in the best interests of the child.
By law, healthcare professionals **only need 1 person with parental responsibility** to give consent for them to provide treatment.
In cases where 1 parent disagrees with the treatment, doctors are often unwilling to go against their wishes and will try to gain agreement.
If agreement about a particular treatment or what's in the child's best interests cannot be reached, the courts can make a decision.
In an emergency, where treatment is vital and waiting for parental consent would place the child at risk, treatment can proceed without consent.
When consent can be overruled
If a young person refuses treatment, which may lead to their death or a severe permanent injury, their decision can be overruled by the Court of Protection.
This is the legal body that oversees the operation of the Mental Capacity Act.

Health Power of Attorney

A health power of attorney is a legal document that lets you give someone you trust the power to make decisions for you. The legal name is lasting power of attorney (LPA) for health and welfare.
Information:
Making a health power of attorney keeps you in control if you lose the ability (you lack mental capacity) to make decisions or speak for yourself because of an accident or illness.

A health power of attorney allows someone to make decisions about:

- where you live and are cared for
- your daily routine and diet
- medical care and treatment options
- people you see and spend time with

IMPORTANT NOTE: Your relatives have no legal right to make decisions for you if you have not made them a health power of attorney.

Why people make a health power of attorney

You might lose the ability to make decisions or speak for yourself because of an accident or illness. If this happens and a decision needs to be made about your treatment or care your family should be involved, but they will not have the final say.
Some people decide to make a health power of attorney because they:

- want to stay in control
- have seen relatives left out of important decisions
- want to make things easier for their family
- are getting older and want to be prepared
- have been diagnosed with a serious illness

By making a health power of attorney you can make sure that the people who know you best are involved in your care and can make important decisions for you.

Making a health power of attorney

Anyone over the age of 18 with mental capacity can make a health power of attorney. To make one you need to:

1. Choose one or more people you trust (known as attorneys)
2. Complete the form
3. Register the form with the Office of the Public Guardian (it takes up to 20 weeks if there are no mistakes in the application)
4. Tell your relatives, GP and others involved in your care

In England and Wales you can make a power of attorney yourself using the GOV.UK website.
It costs about 82 pounds to make one, sometimes even more expensive through a solicitor (who uses the exact same form, but people use their services for a peace of mind). While reduction in prices or exemptions are possible, it is **NOT A GIVEN**. (More on this later)

Can I have a health power of attorney and a living will?

Yes, you can have both a health power of attorney and a living will, they work well together. If you make a health power of attorney it is important that you tell your attorney what you do and do not want to happen to you. This will help the person you choose as your attorney to make important decisions, and will prove to doctors and care staff that they are acting in your best interests.
You should make an advance statement to say what care you want, and a living will (advance decision) if there are specific treatments that you do not want. You can say that your attorney must follow your advance statement and living will in section 7 of the health power of attorney form.
There are a few things you can do in advance to tell people what treatment and care you want in the future.

- Living will (advance decision) – used to refuse any medical treatments that you do not want to be given in the future

- Advance statement – used to say what care you do want, for example where you want to live and be cared for
- DNR form – a form you can only get from your doctor which is used to prevent people being given CPR inappropriately

The role of a health power of attorney

It is important that whoever you choose as your attorney is aware of the responsibilities and will act according to your wishes.

Responsibilities of an attorney

If you lack capacity to make decisions for yourself, then your attorney will be able to make any decisions about your treatment and care. They must act in your best interests.

These decisions might include:

- where you live and are cared for
- your daily routine and diet
- medical care and treatment options
- people you see and spend time with

You can add any instructions that your attorney must follow, or any preferences that you'd like them to take into account in section 7 of the health power of attorney form.

IMPORTANT NOTE: You will need to choose if your attorney has the right to make decisions about life-sustaining treatment (for example CPR or artificial ventilation) in section 5 of the health power of attorney form.

If you do not give them this right it will be left to the doctor in charge of your care to decide what is best for you, if a decision about life-sustaining treatment needs to be made.

Health power of attorney and living will (advance decision)

A health power of attorney lets you give someone you trust the power to make decisions for you if you cannot make decisions for yourself. It covers any decision about treatment and care, for example where you live, your daily routine and treatment decisions.

A living will is a form written by you to refuse medical treatments in advance. It only covers decisions about refusing specific medical treatments.

They are both legally binding, and cannot be used unless you lose the ability to make decisions or speak for yourself because of an accident or illness.

If you need support deciding which form is right for you contact us:

- phone on 0800 999 2434
- email at info@compassionindying.org.uk

How to choose an attorney

Your attorney can be anyone over the age of 18 including a friend or relative.

It is important to think about whether the person:

- understands and respects your wishes
- will stand up for what you want, even if a doctor disagrees
- has the time to support you and be involved in your long-term care

You can choose one or more attorneys. If you have more than one, you will need to decide how they make decisions together in section 3 of the health power of attorney form.

Rights of an attorney

If you are the attorney for someone who no longer has capacity to make care and treatment decisions you should let their care team know about your role (you should show them the form). The treatment and care options available should be explained to you so you can make

an informed decision on the person's behalf. You cannot demand treatments on their behalf (for example, you cannot demand CPR is given if a doctor decides it is not medically appropriate). You have the right to access medical records if needed.
If someone (for example a doctor or care home manager) thinks you are not acting in the person's best interests they can challenge your decision. If this happens you can ask for a best interests meeting. At this meeting you will need to explain why you think the decision is in the person's best interests and may need to provide evidence (for example an advance statement or living will).
If after this meeting you have still not reached an agreement you can:

- ask for a second opinion
- involve an advocate
- apply to the Court of Protection to make a decision
- make a formal complaint to the hospital or care provider

Medical Ethics Concepts

Truthfully speaking, I did not know this was a thing until I heard about it in the R/UCAT server (which is another reason to join if you have not joined already) and upon looking it up more, I realised it is just the naming of certain concepts which I knew about. I found 3 concepts here which are good for you to know and I will try to break it down in a simplified manner. I am sure that there are more but these 3 are a good start. If I can find more, I will include them in this segment down below.

Consequentialism

Consequentialism is an ethical ideology that states the morality of an action is dependent purely on its consequences. A simpler way to phrase this would be that the "ends justify the means". If your action has an overall benefit, then it does not matter about the action itself. Consequentialism is an attractive ethical approach because it provides clear and practical guidance – at least in situations where outcomes are easy to predict. The theory is also impartial. By asking us to maximize benefit for the largest number of people (or, for Peter Singer and other preference utilitarians, creatures who have preferences), we set aside our personal biases and self-interest to benefit others.
One problem with the theory is that it can be hard to measure different benefits to decide which one is morally preferable. Is it better to give my money to charity or spend it studying medicine so I can save lives? Many forms of consequentialism have been proposed that attempt to deal with the issue of comparing moral values.
The other concern people express is the tendency of consequentialism to use 'ends justify the means' logic. If all we are concerned with is getting good outcomes, this can seem to justify harming some people in order to benefit others. Is it ethical to allow some people to suffer so more people can live well?

Example: Your patient has a terminal illness and is not likely to survive the operation she is about to undertake. Just as she is about to be anaesthetised, she asks you: "Doctor, will I be okay?" A consequentialist ideology supports that lying in this circumstance is acceptable, even though lying itself is not a moral action. By lying, the benefit or the ends that you are trying to achieve would be to reassure the patient and make them at ease, and while the means is immoral since you are lying, it does not quite matter since you have a good intention.

Utilitarianism

Utilitarianism says the best action is that one that brings about the best increase in utility (benefit). Utility is generally considered on a broad scale, often taking into consideration

wider society and not just the patient in question. It's a form of consequentialism.

Utilitarianism holds that the most ethical choice is the one that will produce the greatest good for the greatest number. It is the only moral framework that can be used to justify military force or war. It is also the most common approach to moral reasoning used in business because of the way in which it accounts for costs and benefits.
However, because we cannot predict the future, it's difficult to know with certainty whether the consequences of our actions will be good or bad. This is one of the limitations of utilitarianism.
Utilitarianism also has trouble accounting for values such as justice and individual rights. For example, assume a hospital has four people whose lives depend upon receiving organ transplants: a heart, lungs, a kidney, and a liver. If a healthy person wanders into the hospital, his organs could be harvested to save four lives at the expense of one life. This would arguably produce the greatest good for the greatest number. But few would consider it an acceptable course of action, let alone the most ethical one.
Example: You have a sum of money to either fund a very expensive treatment for one patient with a rare disease or five patients with a very common and easy-to-treat disease. Utilitarian ethics dictates that treating the five patients is morally superior as a greater overall benefit is achieved.
In summary, utilitarianism is essentially "For the greater good".

Deontology

Deontology is also known as "duty-based ethics". This ideology states that the correct course of action is dependent on what your duties and obligations are. It means that the morality of an action is based on whether you followed the rules, rather than what the consequence of following them was.
This is in direct contrast with consequentialism. It is an ethical theory that says actions are good or bad according to a clear set of rules.
We should do our duty for no other reason than because it's the right thing to do.
Obeying the rules for self-interest, because it will lead to better consequences or even because it makes us happy is not, for deontologists, an ethical reason for acting. **We should be motivated by our respect for the moral law itself**.
Deontologists require us to follow universal rules we give to ourselves. These rules must be in accordance with reason – in particular, they must be logically consistent and not give rise to contradictions.
It's worth mentioning that deontology is often seen as being strongly opposed to consequentialism. This is because in emphasising the intention to act in accordance with our duties, deontology believes the consequences of our actions have no ethical relevance at all – a similar sentiment to that captured in the phrase "Let justice be done, though the heavens may fall".
The appeal of deontology lies in its consistency. By applying ethical duties to all people in all situations the theory is readily applied to most practical situations. By focussing on a person's intentions, it also places ethics entirely within our control – we can't always control or predict the outcomes of our actions, but we are in complete control of our intentions.
Others criticise deontology for being inflexible. By ignoring what's at stake in terms of consequences, some say it misses a serious element of ethical decision-making.
Example: If your terminally ill patient asks if they'll be ok after a surgery they're unlikely to survive, a deontological approach would suggest you don't lie to comfort them. That's because according to this concept, lying isn't morally acceptable because it's our obligation not to lie – no matter the consequences.
In summary, deontology refers to the strict following of rules or duties, and that good and bad is determined by the rules and duties we have.

The Doctrine of Double Effect

This doctrine says that if doing something morally good has a morally bad side-effect it's ethically OK to do it providing the bad side-effect wasn't intended. This is true even if you foresaw that the bad effect would probably happen.
The principle is used to justify the case where a doctor gives drugs to a patient to relieve distressing symptoms even though he knows doing this may shorten the patient's life.
This is because the doctor is not aiming directly at killing the patient - the bad result of the patient's death is a side-effect of the good result of reducing the patient's pain.
Many doctors use this doctrine to justify the use of high doses of drugs such as morphine for the purpose of relieving suffering in terminally-ill patients even though they know the drugs are likely to cause the patient to die sooner.

Factors involved in the doctrine of double effect

- The good result must be achieved independently of the bad one: For the doctrine to apply, the bad result must not be the means of achieving the good one. So if the only way the drug relieves the patient's pain is by killing him, the doctrine of double effect doesn't apply.
- The action must be proportional to the cause: If I give a patient a dose of drugs so large that it is certain to kill them, and that is also far greater than the dose needed to control their pain, I can't use the Doctrine of Double Effect to say that what I did was right.
- The action must be appropriate (a): I also have to give the patient the right medicine. If I give the patient a fatal dose of pain-killing drugs, it's no use saying that my intention was to relieve their symptoms of vomiting if the drug doesn't have any effect on vomiting.
- The action must be appropriate (b): I also have to give the patient the right medicine for their symptoms. If I give the patient a fatal dose of pain-killing drugs, it's no use saying that my intention was to relieve their symptoms of pain if the patient wasn't suffering from pain but from breathlessness.
- The patient must be in a terminal condition: If I give the patient a fatal dose of pain-killing drugs and they would have recovered from their disease or injury if I hadn't given them the drugs, it's no use saying that my intention was to relieve their pain. And that applies even if there was no other way of controlling their pain.

Problems with the doctrine of double effect

Some philosophers think this argument is too clever for its own good.

- We are responsible for all the anticipated consequences of our actions: If we can foresee the two effects of our action we have to take the moral responsibility for both effects - we can't get out of trouble by deciding to intend only the effect that suits us.
- Intention is irrelevant: Some people take the view that it's sloppy morality to decide the rightness or wrongness of an act by looking at the intention of the doctor. They think that some acts are objectively right or wrong, and that the intention of the person who does them is irrelevant. But most legal systems regard the intention of a person as a vital element in deciding whether they have committed a crime, and how serious a crime, in cases of causing death.
- Death is not always bad - so double effect is irrelevant:Other philosophers say that the Doctrine of Double Effect assumes that we think that death is always bad. They say that if continued life holds nothing for the patient but the

negative things of pain and suffering, then death is a good thing, and we don't need to use the doctrine of double effect.

- Double effect can produce an unexpected moral result: If you do think that a quicker death is better than a slower one then the Doctrine of Double Effect shows that a doctor who intended to kill the patient is morally superior to a doctor who merely intended to relieve pain.

If you would like to read more regarding this, you can either Google it or click on this link to be redirected to the Wiki page.
https://en.wikipedia.org/wiki/Principle_of_double_effect

Why is this so important?

It is important as a possible answer to certain interview questions that may be posed to you such as the MMI questions or even panel interview questions.
We will break down the concept and use it to answer one of the questions below using a mock question.
EXAMPLE: You are a Junior Doctor who is attending to a patient that has just come into the A & E as a result of a terrible accident. He is currently in severe pain given the extent of his injuries, and as a result of his adrenaline, it is very difficult to control the patient in order to administer the relevant treatment. You realise that the provision of morphine would help to ease the pain he is suffering from and could allow the healthcare team to continue treatment. However, you also know that there is a chance this dose of morphine could possibly kill him given the large dosage.
Additionally, if you were to not provide him the dose of morphine, he would most likely die from the extent of his injuries. You have no time to explore other options, and have to act now. What do you do?
ANSWER: In this case, you would be justified in giving him the dose of morphine as the doctrine of double effect applies in this situation. It is proportional to the cause, with the medication matching the causes and symptoms, all while the patient is in a terminal condition where he would probably not have survived without the dose of morphine. While you knew / had a feeling that the dose could kill him, your intentions were not to kill him but instead relieve him of his pain + allow the team to treat his injuries to save his life.

Medicine (The Types)

I was reading through the ISC Medical Book and chanced upon a question talking about holistic medicine. I thought about it and decided to write down the different types of Medicine practiced and just a quick breakdown in the event you need to explain what they are.

Holistic Medicine

Holistic medicine means that we treat the patient as a whole. This not only includes the physical aspect but also taking into account the social, psychological and spiritual issue. We do not look at the patient based on just the physical symptoms presented, we consider their emotional needs and other possible factors that could play into why they are sick.
Some examples would be:

- A patient has a rash. While the physical treatment would just be an ointment, a holistic treatment could be determining if the rash has a psychological origin or due to a stressful lifestyle for example. On top of treating the rash, the doctor also studied how the rash and treatment affects the person's life etc, and take steps to minimise negative implications
- A patient is struggling with mental health complications. The clinical treatment may just be providing antidepressants or medication to manage the emotions, but a holistic treatment could be more of figuring out what aspects of their life

may be causing these complications and how to manage them. The doctor would also find ways to help the patient live a normal social life or work life etc

Now let us take a look at the pros and cons of holistic medicine:

Pros	Cons
• Ensures complete support and comprehensive care in all aspects of the patient's health (Can link to how important mental health / other aspects are in the recovery and healing phase) • Leaves no stone unturned and ensures that prevention is also carried out, preventing the possibility of the patient suffering from the same illness again • Shows dedication on the end of the doctor, which can reassure and make the trust in the profession to be even stronger (Talk about the benefits of a strong doctor-patient relationship)	• Potentially underappreciated by patients, especially those who are less educated about the importance of prevention (They may not take the advice of prevention seriously) • Time consuming to find treatments and provide specific advice in depth to every patient (Can link to even bigger strain on the healthcare workforce and puts a bigger strain on resources than ideal) • May be unaffordable to some patients, especially those on the lower end of the spectrum in earning power. For example, if the patient needs to eat a specific sort of food to regulate the side effects of the medication, they may not be able to afford it on a consistent basis

Scientific / Traditional Medicine

Conventional medicine is science-based medicine. When you have a sore throat, and you go see your primary care physician at a doctor's office, you are partaking in scientific medicine. This type of medicine uses scientific observations in order to understand and treat the human body.

Your doctor is most likely an M.D. Professionals holding this Medical Doctor title have studied and earned a degree in science-based medicine. According to the American Medical Association, **the key difference between scientific medicine and all other forms of medicine is the educational qualification of practitioners to a particular scientific standard**.

So, you show up for your appointment with your sore throat. Your doctor takes a look inside your throat and swabs it in order to collect organisms. The swab will be processed in a lab. The results will let the doctor know whether or not you have an infection, like strep throat or the flu. Let's say the results show that you have strep throat. The doctor will then prescribe an antibiotic drug designed to eliminate strep infections.

This scientific process is a newer type of medicine. It was developed over the last few centuries, but only became what we now know as conventional medicine, or modern medicine, in the 19th and 20th centuries. That was due to discoveries and advances relating to germs, infectious diseases, and medicines. The first true antibiotic wasn't discovered until 1928 and wasn't widely used until the late 1940s. Other important advances include microscopes, stethoscopes, and x-ray machines.

Scientific medicine is based on documentation. Throughout the 19th century, medical researchers utilized the numerical method. This method analyzed specific treatments through statistics in order to determine effectiveness. For this reason, **scientific medicine is also sometimes referred to as evidence-based medicine (EBM)**. Though research methods are drastically modernized, this type of clinical research is still central to scientific medicine.

Evidence-based medicine relies on the scientific method of gathering credible data and formulating logical hypotheses and theories. Medicine is ultimately always applied on an individual basis, accounting for unique variables, but the foundation of evidence-based medicine is what we know objectively to be true.

Now let us take a look at the pros and cons of scientific medicine:

Pros	Cons
• Provides a certain level of safety and reassurance that whatever method is proposed is actually safe, and definitely allows for increased use • We can better analyze these symptoms and pinpoint the start of the flu season well before it becomes obvious. As the USC Keck School of Medicine points out in their article on technology and public health: by using geographic mapping, as well as massive collected evidence from previous flu (or other) outbreaks, we can assess and treat our patients more accurately with the help of technology. • With the help of Evidence-based medicine, nurses and doctors can keep track of a patient's pattern of admission when they have been brought in with tell-tale health indicators. It's as simple as keeping notes on similar symptoms; doctors should notice patterns and will be able to fully assess a patient. For travel nurses, this is especially helpful. We can use the past EHRs of new-to-us patients to catch recurring symptoms, and then use the best possible options within EBM to help that patient find relief	• There are some scenarios for which a doctor has no evidence base to rely on. Sometimes it is a disease or combination of factors so rare that there simply haven't been any studies done on it. Or it could be that there's no funding to study a particular thing. • Evidence based medicine is statistical and ignores specific cases. As a result, it is blind to many cures - because cures are individual. • Vulnerable to selective publication. Not all research studies gain enough traction to be recognized and validated, potentially missing out certain possible treatments • The pharmaceutical industry funds the majority of research, and therefore it also shapes the current research agenda. This leads to a bias of research focus on commercially viable interventions, where there is an anticipated beneficial outcome rather than harmful outcomes, and on products where there is likely to be a ready market. Consequently, there is not much research funding for drugs for neglected diseases affecting populations in low-income countries, where financial returns on research

• Can keep up-to-date on the best treatments and further our understanding of new and emerging illnesses as they happen • EBM has proven to lower costs for not just patients (they have fewer and faster visits) but for hospitals too. So much of our medical spending is wasted on redundant tests and screenings, as well as on readmitting patients for treatable conditions or illnesses	investments would be limited.

Which is better?

It is then common after understanding the different ways of medicine practiced, that the question pops up which way of practice is better. In this section I will present some points of view before concluding with my view on this matter.

POV 1: Developing Countries / Developed Countries

In a country that is still considered to be developing, or in previous terminology a “3rd World Country”, they are plagued by diseases that are waterborne or insect-borne, which are diseases that are not commonly seen in developed countries such as malaria or cholera. This is often because developed countries have developed infrastructure such as water filtration systems or vaccines that have been made compulsory, which limits the spread and hence impact on the individuals around the population.
As such, in a way clinical / traditional medicine would only be able to treat the “symptoms” of the issue, as the root causes of the issue would be the lack of infrastructure to provide cleanliness and proper access to basic necessities. Hence the logical solution would be to adopt holistic medicine where not only do we treat the “symptoms”, we can also treat the root causes.but we can also take adoptive measures to tackle the other aspects such as their access to basic necessities.
Consideration: While holistic medicine in theory can address all aspects of the issue, in practice it is quite unlikely to be able to make any more difference compared to clinical medicine. Looking at developing countries, many areas lack access to resources to build such infrastructure and maintain those structures or systems to the standard required to prevent such diseases from running rampant. As such, even by trying to take steps to improve other aspects of their life, we are limited by the resources present to carry out said actions.
However in developed countries it becomes less of a resource issue and perhaps more of a “political will” issue. For those who do not know, political will mainly refers to how willing politicians or policy makers are willing to carry out actions. Even if a country has a lot of resources, if they lack political will to carry out said actions, no infrastructure or actions will be taken which causes the issues to continue running rampant.

POV 2: Appearance of New Diseases

Let us look back at a relatively recent global pandemic, as we all know it to be COVID-19. While we were somewhat fortunate to have some previous events such as SARS to go based on and look back at those events to glimpse certain lessons and strategies, just imagine for a moment that a new disease has appeared in our life, and it is completely new. It acts in ways that we have never seen before and have never experienced in our long history, our evidence from past diseases are useless.
Evidence based medicine (EBM) in this case is rendered completely useless since it is completely new and we have never experienced this once, in a way we are moving blind and acting completely independently. Looking at holistic medicine on the other hand, it can be a possible way of treatment and could help alleviate the symptoms currently experienced or perhaps mitigate the impacts it has first.
By looking at the symptoms presented, we can compare and contrast the possible socio-economic factors, personal factors that the patients have in common and look for a treatment that way. We would also be able to look at the symptoms presented and take active steps to deal with them. For example if patients experience physical pain when eating certain types of food, we could adjust their diet for them to reduce the amount of pain experienced. Or another example could be if they feel cold in certain environments, we could tailor said environment so that they no longer feel cold by introducing more heaters etc. This in turn would allow them to rest better and could experience better mental health.

Conclusion

You might now start to see that both types of medicine have their pros and cons, and would be effective in different types of scenarios (one would be more effective in the other in Scenario A, but the other would be more effective in Scenario B). And you would be right in thinking that.
The conclusion that you should have arrived at is that **both types of medicine are effective in their own right and that at the end of the day, both should be incorporated as and when possible**. It is really important for doctors to try and practice both types of medicine, especially preventive medicine given the state of the world now and the increased need for education on how to care for their own health.
If ever asked in an interview setting / question, I think it is really important for you to provide a balanced view (mention both sides and the pros + cons) and if you want, you can interject with your personal opinion at the end.

Reflection Techniques

The 5R Framework

This model lends itself well to structuring both the thinking process and the write-up of a reflection. To get the full benefit of this model you will have to know the characteristics of each of the 5 R's. Being able to recognise the language that is relevant for each step will also benefit you if using the model for academic reflection.
The 'Reporting' and 'Responding' can sometimes interlink and be presented as one level. This highlights the fact that while there is a natural progression through the stages, when producing written reflections you might want to write more freely without a clear boundary between the areas.
A number of helpful questions as well as key components are outlined below for each of the stages. You don't have to answer all of them, but they can guide you to what sort of things

make sense to include in that stage. You might have others questions that work better for you.

Reporting

Here you can present the context with little or no comment or interpretation of the experience.

What to do	What's included	Helpful questions
A brief description of the experience/problem or issue	The key elements of the situation that are essential for you to communicate the context to the reader.	• What happened? • What are the key aspects of this situation? • Who was involved? • What did I do?

Key language points: You are reporting on an event that happened so use the past tense. Helpful phrases are 'I saw…', 'I noticed…', 'I/they said…', 'I had…' and words indicating time such as yesterday, last week, etc.

Example of Reporting
Yesterday, I had a meeting with my supervisor to discuss my final project. I requested the meeting as I had a series of concerns about the next steps for my methods section of my report. During the meeting we got side-tracked, spending 30 minutes talking about my literature review, which did not leave us enough time to discuss what I needed. As a result, I left with no answers to my concerns.

Responding

Here you can present your reaction or response to the situation. This can be thoughts, feelings, and observations.

What to do	What's included	Helpful questions
Provide your personal response to the situation.	Your feelings and thoughts about the experience, as well as any observations and potential questions you have.	• How did what happened make me feel? • What did I think? • What made me think and

		feel this way?

Key language points: You are writing about thoughts and feelings that happened, so use the past tense. Helpful phrases are ‘I felt…’, ‘I thought…’, ‘I believe…’, ‘I think…’. It can be useful to use transitional language to connect experiences with feelings and thoughts, for example ‘next’, ’subsequently’, ‘afterwards’, ‘finally’, ‘leading to’ etc.

Example of Responding
When I came out of the meeting I remember thinking that I had wasted our time, leading me to feel really frustrated. I think I felt that way because I was hesitant to say to my supervisor that the conversation on the literature review was not what I wanted to discuss. The reason I was hesitant is that my supervisor has so much more experience than me, so if they wanted to spend time on the literature review that was probably the right thing to do. However, given I believe we wasted our time I realised afterwards that it was probably not the right thing to do.

Relating

Here you can relate your experience of the reported situation with your knowledge and skills from outside of the situation.

What to do	What’s included	Helpful questions
Provide your understanding of how the situation relates to your own knowledge and past experiences.	Your connections between past experiences, your skills, knowledge, your understanding and the situation.	• Have I seen this before? • What was similar/different then? • Do I have skills and knowledge to deal with this?

Key language points: You are commenting on an experience from the past but in the present so you should consider writing in the present tense. Helpful phrases are ‘This reminds me of…’, ‘This is like when…’. It can be useful to use comparative language as ‘previously’, ‘similarly’, ‘unlike’, etc.

Example of Relating

I realise that similar things have happened before when I am in meetings with people who have more experience than I and I don't have a clear plan. This reminds me of my meeting at work, where I had a concern I wanted to raise with my boss but we never got around to it. I think the common factor in these situations is that I feel that people with more expertise than I always make better decisions than I do.

Reasoning

Here you can make sense of the situation in terms of significant factors and, if relevant (for example if requested in assessments), the theoretical literature relevant to your experience.

What to do	What's included	Helpful questions
Explore and explain the situation or experience.	Significant factors within the situation and how they are important to understanding what happened.	• What is the most important aspect of this situation and why? • Is there any theoretical literature that can help me make sense of the situation? • How do different perspectives (for example personal, as a student or professional) affect the way I understand the situation? • How would someone who is knowledgeable about these types of situations respond?

Key language points: These are your current thoughts so write in the present tense. Helpful phrases are 'I understand that…', 'I realise', 'For me the most significant aspect...'. It can be useful to use analytical language as 'critically', 'imply', 'support' (as in supporting evidence), etc.

Example of reasoning

The most significant thing about the meeting situation is what happens when I am going in with a vague plan of what I want. I have realised that I do not get the things I need from the meeting. This is especially problematic when the person I am meeting with has more experience than me. My previous experience with my boss would support this idea. I think if I address them like peers and not superiors, I can be differently prepared. I imagine that if I was an expert at leading meetings I would have a clear plan, which I would state at the beginning of the meeting so that we both know what we need to discuss. I think what has been holding me back is being afraid of looking bossy. However, if I look at it from their perspective and see that I am actually saving them time by only meeting once, I would actually be coming across as professional rather than bossy.

Reconstructing

Here you make a conclusion about your future plans based on the previous four sections.

What to do	What's included	Helpful questions
Reframe or reconstruct future practice by drawing conclusions from the four previous stages. Use this to develop an action plan for what to do next.	Your deeper understanding and summary of the learning. You will also have to include an action plan, arguing for why it will work. That can be based on literature included in the previous stage or from the new knowledge gained from the Relating and Reasoning stages.	• How would I need to do this differently in the future? • What might work and why? • Are there different options? • Are my ideas supported by theory? • Can I make changes to benefit others? • What might happen if…?

Key language points: These are your current thoughts about what you want to do in the future so use the present or future tense. Helpful phrases are 'I will now…', 'I realise', 'I have learned that…', 'As a next step, I need to...'. It can be useful to use words indicating future as 'will', 'may', 'could', etc.

Example of reconstructing
Based on the previous reflection stages, I have learned that I need to write an agenda before going into a meeting. I realise that by taking 10 minutes before a meeting to prepare what I need from it, I can save time for both myself and the person I am meeting with. Firstly in the meeting, I will share the agenda so the objectives are clear from the start to enable the outcome I want. Alternatively, I could email the person beforehand telling them what I need from the meeting so they can prepare. I think the latter will work at university, but maybe not at my work where there is no email culture. I think if I do this, my meetings will be shorter and I can get what I need from them.

How this is useful

This is especially useful when it comes to certain questions that could be asked regarding a previous experience and how you would like to improve, and would most likely be used in questions pertaining to your academics or work experience.
Some questions that come to my mind would be:

- Tell me about your work experience and how you would like to improve upon the experience if you were able to do it again
- What were some learning points regarding your A levels and if you were to take your A levels again, what would you have liked to have done better?
- What are some things you would like to tell your past self of 5 years ago?

While this may seem a bit of an odd approach given the unconventionality of the approach, it is actually a good way to summarize and answer as many factors to give a detailed, comprehensive answer to the question.
EXAMPLE: Tell me about your work experience and some things you would have liked to improve upon if you could do it again.
Reporting: I was given the opportunity to observe an operation in the OT together with the head surgeon and the healthcare team in charge of the patient. The head surgeon offered me a chance to help out during the operation but decided against it in the end.
Responding: It made me feel upset and misled that the surgeon offered me the chance but yet went back on his offer during the operation itself. I think I felt this way as I was really excited and looking forward to actually doing my part.
Relating: I realized that this actually has occurred before in different situations where I did not voice out my feelings about something and end up feeling disappointed when something did not go the way I would have liked it to go.
Reasoning: This particular incident really allowed me to notice that not everyone would be able to read my mind and know what or how I wanted something to be done, and it came down to me to be vocal about it, explaining it clearly so that others are made aware of my opinions and views. Additionally, the surgeon may not have realized before the operation that there may be certain complexities that would limit my ability to actually help during the operation, and as such decided against asking me to help out during the operation to maintain patient safety as the first priority + to make sure the operation was a success.
Reconstructing: Based on this incident, I realized it would be best for me to take the initiative to ask if I can help out during certain scenarios while keeping in mind the strict regulations and rules within the OR. Additionally it would be good for me to plan ahead, and find an appropriate time to talk to the surgeon before the actual operation, and agree on a predetermined time for me to step in and help (within my abilities). As such, in the future if I were to get the chance to do so again, I would like to do what I had mentioned as to get a better learning experience and practice the skills that have been demonstrated to me.

CARL Framework

This model, unlike a fair amount of other reflection models, does not explicitly require further planned actions. This is not essential for reflection, as identifying new learning is an extremely valuable process and will in many cases affect practice on its own. The model is **frequently seen in interviews without the 'learning' stage**, however it is important to include this stage in reflection as it allows you to critically extract knowledge and learning from the situation.
One potential challenge with using this model is that it encourages you to describe throughout - that is to describe the context, the actions, and results and only think about implications in learning. While there can be benefits from solely describing as it can make you aware of the consequences of your actions, describing is not the same as being critically reflective. To ensure that you remain reflective throughout, keep asking yourself the question why – 'why did I do what I did?' etc.

For other models there is a natural place where you introduce and think about relevant theoretical literature. In this model each step can benefit from literature, as it can help explain your motivations, for example in actions you might want to use a particular theory to explain why you chose a specific action above another.
A number of helpful questions are outlined below for each of the sections. You don't have to answer all of them, but they can guide you to what sort of things make sense to include in that section. You might have other questions that work better for you.

Context

Here you will set the context for yourself or the reader. Describe what is essential to understand the situation.
Helpful questions:

- What was the context of the situation?
- What was the situation?
- Where was it?
- Who was there?
- What am I hoping to accomplish?

Depending on whether you are presenting the reflection, for example as an interview answer, or using the model as a helpful framework for your own reflective process, you may wish to tailor how extensive you are.

If doing it for yourself, it can be very helpful to understand a full comprehensive context, whereas when presenting it to others you may wish to only include enough that the audience understands the context.
Examples of Context
The examples below show how the reflective process can happen at an overarching process level and a specific experience level. Both will tackle the same scenario, but their conclusions can be different. Reflecting both levels can be helpful.

Developing public speaking as a skill over time	Public speaking individual experience
I am currently working on improving my public speaking as a part of my ongoing professional development. I could specifically take opportunities within my role as class representative, where I will have to stand in front of an entire course.	I was given the opportunity to give a presentation about my subject to high school students who might be interested in applying to study it. I had 20 minutes and could spend them as I wished. There were 30 students present in the auditorium at the high school where I gave my talk.

Action

Here you can describe what your actions were in relation to the context specified above. To critically engage with the reflection it is important not only to describe your actions, but think about why you did these actions and not something else.
Helpful questions:

- What did I do?
- What else happened (other actions)?
- Why did I choose this action?

- What other actions could I have chosen? (not necessarily giving you the same result)

Examples of Action

Developing public speaking as a skill over time	Public speaking individual experience
Within the class representative network I was made aware of an opportunity to go and present our course to high school students who might be interested in taking the course. I signed up despite being slightly time pressured, as I wanted to give myself the chance to practise. I prepared the presentation and the public speaking part went well, however I feel that I might have structured my presentation poorly for the students to gain the most from it.	I chose to do a PowerPoint presentation with a lot of practical information on it. It wasn't a particularly nice PowerPoint, I generally don't like them with a lot of text, but I didn't prioritise the preparation enough so I needed to create something quickly. I could have spent more time actually making a nicer PowerPoint communicating the value of my course more than the practical aspects.

Results

Here you can discuss the results that came from your actions and what the implications are of the results.

Helpful questions:

- Did I accomplish what I wanted?
- Did my actions accomplish what I wanted in the way I expected?
- What are the implications of my actions on myself/others/similar situations in the future?
- Could different actions have given me the same result?
- Is there a way I could improve my results or actions?

Examples of Results

Developing public speaking as a skill over time	Public speaking individual experience
I gave myself a chance to practise my public speaking and I am feeling more comfortable standing in front of a group of people now, just because I have practised. As mentioned above, I could have structured the presentation differently. Having a well-structured presentation would have given me the same feeling of success in terms of public speaking and had a better impact on the students. However, from this experience I now know I can spend less time stressing about the public speaking element of it, and spend more time on the actual presentation.	I could see that the students were desperately trying to write down everything I said and what was on the slides. However I felt confident in my delivery of the content, I didn't feel a loss of breath or anything, which suggests I'm feeling more confident with public speaking itself. That said, I didn't feel like they were actually getting any value from the presentation. They didn't seem excited, and no one asked questions or anything. I think they would have gotten more from why they should study this course, rather than how to apply. I think equally if I had allowed time for their questions they would have gotten much more value from the situation.

Learning

Here you have a chance to conclude using the insights gained from the three sections above. While not explicitly suggested by the model, if you want to include an action plan this is a natural place to do so.
Helpful questions:

- What did I learn from the experience?
- Would I do the same thing again or would I change something?
- What should I do next time I'm in a similar experience?
- Should I change anything about the way I do things? What?

Examples of Learning

Developing public speaking as a skill over time	Public speaking individual experience
I have learned that I get better at public speaking when I give myself the opportunity to practise in front of people. I will therefore continue to seek out challenges including public speaking. However, I have also realised that while I get similar benefits to my own development in terms of confidence through standing in front of others, I can practise the most effective way of delivering the content. In the future I have to give myself more time to prepare.	I have realised if I had spent more time thinking about what information the students needed and how to present it, it would have been a more impactful experience. The way I presented is an example of passive learning (people just sitting and receiving information) which has been shown to be less effective than active learning (people participating in the activity; e.g. Michel et al, 2009) Therefore, I think using group participation and allowing them to guide the discussion by asking questions and following their interests would have been better. I will ensure I incorporate interactive activities in my future presentations.

How this is useful

This is especially useful when it comes to certain questions that could be asked regarding a previous experience and how you would like to improve, and would most likely be used in questions pertaining to your academics or work experience.
Some questions that come to my mind would be:

- Tell me about a time when you exhibited teamwork and what you learnt from that experience
- Think back to a certain scenario where you had to demonstrate leadership and what you learnt or took away from that experience
- Recall a time when you exhibited good communication skills and your takeaways

EXAMPLE: Tell me about a time when you thought you had demonstrated good leadership of the team, but did not do as well as you thought. Highlight your takeaways from that experience.
Context: I distinctly recall the time when I was given the task of planning a cohort wide camp where we were supposed to spread the message of anti-bullying and how to stand up to it. I was in charge of a team of 5, and back then I held the position of Vice-chairperson in the entire board of members. I still remember thinking to myself that it would be an easy event and I could pretty much handle it on my own since the event was relatively small compared to the other projects I had undertaken before.
Action: As such, I delegated the work that I felt was necessary to do to the rest of my team, without giving much thought about the event and the possible constraints, resources or the amount of considerations necessary for the event to be a success. In my head I felt that I

handled the task well since I had done all I had to and I involved my team in the running of the operation just like how a good leader should do so.
Results: However, what had actually occurred was that the team had no clear direction from me and hence did not manage to plan the event well as everyone had different views on how the event should be carried out. Additionally, the event was underplanned, with the necessary resources such as banners, decorations lacking significantly, causing the event as a whole to become a laughing stock in school. This in turn ruined the message that we were planning to deliver since the event was poorly organised, and hurt the reputation of our board.
Learning: This was a big wake up call for me as it made me realize that given my position, it has a lot of authority and responsibility to deliver on what was intended. As such, it was the turning point in my leadership journey and ever since, I have experienced an increase in maturity and how I approach any tasks that I am given the responsibility to handle. It was also a very important learning experience for me to finally understand that a leader has to provide **PURPOSE & IDENTITY** for the team to follow after, and that without it, the team would not be able to execute tasks ideally.

The Four F's of Active Reviewing

This model can be used to think and reflect on a situation and can help to structure written reflections. The model is easy to remember and goes over the main aspects of what is helpful to consider when reviewing an experience.
In the original model there is little to no emphasis on thoughts you had during the event. This might work well for you. However, to get the most out of the reflection you might want to revisit the thoughts you had at the time. If you choose to include them, they will fit best in either Facts or Feelings. Both Findings and Future will include current and more analytical thinking about the event looking back. Give the model a try and see what works for you.
For each of the sections a number of helpful questions are outlined below. You don't have to answer all of them, but they can guide you about what sort of things make sense to include in that section. You might have other prompts that work better for you.

Facts

The first F represents hard facts. Here you can examine the sequence of events and key moments. If you are working through the model with other people, it can be interesting to see if you agree on the facts. Be wary that facts do not turn into opinions, for example 'Then X did the wrong thing', rather say 'X did this and it had this effect'.
Helpful questions:

- Make a short news report covering: What? Who? Where? When? [Save Why? and How? for 'Findings'.]
- Did anything unexpected happen? Any surprises?
- Did anything very predictable happen?
- What was most memorable/different/interesting?
- What were the turning points or critical moments?
- What happened next? What happened just before?
- What most influenced your attitude and behaviour?
- What didn't happen that you thought/hoped would happen?

Examples of 'Facts'

Success	Mistake

A customer came into work today around 4pm and I was alone as my manager was on her break. The customer was complaining about an item she bought, which had broken before the warranty ran out. The customer was quite loud and yelled at me. Even though I haven't done any returns before, I have seen how it's done. I spoke calmly to the customer and said I would deal with it. And I did!	When working at the restaurant last night it got really busy, and I was waiting on five big tables. While taking orders I thought I could remember them all in my head, because I usually can do that when I'm less busy. Unexpectedly, I forgot the drinks that one table ordered and I only realised it when they called me over 20 minutes later to remind me. I decided to give the table the drinks for free, which my boss was not happy with

Feelings

Here is where you can describe the feelings in the situation. Feelings can guide you to fully understanding the situation and so your learning is better grounded in the experience.
It is possible to start accidently evaluating and judging in this section, however try to stay with your feelings. Be cautious that you do not use 'felt' as a judgement, for example 'I felt they were wrong', or 'my feeling was that it was a good choice'. The latter can be rewritten as 'I felt confident while making the choice.
Helpful questions:

- What are some of the feelings you experienced?
- At what point did you feel most or least involved?
- What other feelings were present in the situation?
- At what points were you most aware of controlling/expressing your feelings?
- What were your personal highs and lows?

Examples of 'Feelings'

Success	Mistake
I was actually a little bit scared when the customer was clearly angry and started yelling. I'm new and I felt uneasy as I didn't know what to do. I really tried to hold back my reaction, because my natural response would have been to become angry and yell at the customer. But I held back and managed to solve the problem. That made me really proud. I didn't know I could do it and then I rose to the challenge and did it.	I was really angry with myself. I don't usually forget things. I was also embarrassed when the guests called me out on forgetting the drinks. They seemed quite hesitant to remind me, and it seemed they were uncomfortable reminding me which made me feel guilty. I offered them the drinks for free to make me feel less guilty and it helped.

Findings

Here you can start investigating and interpreting the situation to find meaning and make judgements. The main questions are 'how' and 'why'.
Helpful questions:

- Why … did or didn't it work? …did you take on that role? …did you do what you did? …did you not do something else? etc.
- How … did your feelings influence what you said and did? …did you get the outcome that happened? etc.
- Were there any missed opportunities or regrets?

- What would you like to have done differently / more of / less of?
- What was most / least valuable?
- Was there any feedback / appraisal?
- What have you found out?

Examples of 'Findings'

Success	Mistake
I think the main reason it worked so well was because I didn't become angry with the customer. I almost did, but I remembered to take a deep breath first. This gave me time to think before responding. Moreover it allowed me to think through the steps of doing a return. Focusing on my breath really helped. I'm finding it extremely empowering that I now know I can remain calm in a stressful situation like this.	I think the reason why I forgot the order was because I relied on habit more than on what was needed in the situation. I have always felt proud that I didn't need to take notes, but in reality there is nothing wrong with that. I regret that I didn't know that before. My manager also told me just to use a notepad. I have learned that relying too much on habit can cause negative emotions and consequences for me and others.

Future

Here you take your findings and consider how to implement them in the future.
Helpful questions:

- How do you imagine using what you have learned?
- What has already changed?
- What choices do you have?
- How does it look to use the findings?
- What plan can you make for the future?

Examples of 'Future'

Success	Mistake
I think there are two things I can take away from this. For one, I can keep this as an example that I can do things that I'm not certain about. This will give me confidence in new situations. Secondly, taking a deep breath gave me time to think before acting. I will practise this when I get stressed. For instance this may be when I am fighting with my partner. Maybe taking a breath will make me less likely to yell. I want to try that and see how it goes.	In the future, I will have to be much better at doing what is needed in the situation. I now know that there are situations where I cannot remember everything. Therefore, I will have to start using a notepad to take orders when we are busy. I think the first step is to have it in my apron because currently I don't have one. To practise using it, I will then start always taking notes on Friday and Saturday evenings, whether or not there are lots of customers. Those are the nights we tend to be busy. The other nights I will base it on how many customers there are.

How this is useful

This is especially useful when it comes to certain questions that could be asked regarding a previous experience and how you would like to improve, and would most likely be used in questions pertaining to your academics or work experience.
Some questions that come to my mind would be:

- Tell me about a time when you were confronted by someone and how you responded to the situation
- Tell me a time when you had to react quickly with little to no information, and how things turned out from there
- Recall an incident you had and how you responded, and how it influenced your personal growth

EXAMPLE: Tell me about a time when things were heated, and how you responded as well as how you grew from that experience.
Facts: There was an incident when I was working as a childhood caregiver, and was in charge of taking care of students aged 7-10. My job scope was primarily to make sure their homework was done correctly, that they were given proper and healthy food to eat, and essentially babysit them until their parents came to pick them up to return home after work. That day, I was babysitting a bunch of 10 year olds and I was busy helping others with their homework, as a result I did not notice a bunch of them who slipped away from the classroom. Suddenly, I felt a sharp pain across my back and spinning my head around, I noticed that the bunch of them were holding a cane and had hit me across the back with it as they thought it was funny.
Feelings: Immediately I felt a sense of anger and definitely pain as I was hit unfairly by the kids who had a twisted view on what was okay to do in such a setting. I remember seething and fuming at them as it could have gone much worse than what had actually occurred. However, I remember that these kids were not as mature as I was given the age gap, and would not have understood what actions were socially acceptable. Admittedly it was incredibly difficult to calm myself down given the amount of pain I was experiencing, but I took a deep breath and told them strongly but firmly to put the cane down. Immediately they could tell that I was not happy about their actions and immediately obliged.
Findings: One reason why I felt that what I did was so effective was because I remained calm throughout the entire situation, and did not show the emotions that they were looking to get out of me. Additionally, given that I was typically a joyful and happy-go-lucky individual, the fact that I was not as cheery as I would imparted a strong impression that I was upset and unhappy with their actions. Focusing on controlling my emotions instead of flaring up really helped me maintain some semblance of control in that situation.
Future: There are two things that I feel like were really important takeaways for me. The first would be that by maintaining a calm approach and regulating my emotions, allow me to deal with situations in a more mature manner. Additionally, I learnt that what I know may not be the same as others, and that socially acceptable behavior takes time to learn and nurture in the youth, and the best way to teach them is to guide them in the process of learning.

The Integrated Reflective Cycle

The model is inspired by a range of other frameworks, including Gibbs' reflective cycle and shares some characteristics with it. In contrast to Gibb's reflective cycle, the integrated reflective cycle contains fewer steps which may make it simpler to work through, while still being able to bring out the same realisations and learning.
The 'Reflection on Action' step contains what some models would break up into feelings, results and evaluation.
A number of helpful questions are outlined below for each of the sections. You don't have to answer all of them, but they can guide you to what sort of things make sense to include in that section. You might have other questions that work better for you.

An example of using this model is also provided below. This example is specific to a field, but still demonstrates well how you can use thoughts and theory to make informed decisions about your practice. To make it more relevant, you can ask yourself if there is anything from the example that resonates with you.

The Experience

Here you should describe the situation in as much detail as you find necessary. Think about whether it is for yourself or for someone else to read. If it is for someone else, it is important you define the context clearly.
Helpful questions

- What happened?
- What were the contributing factors?
- Who else was there?
- What did I/others do?

Example of 'The Experience'

Consultation with patient
During a medical placement I was doing my first supervised consultation with a patient. I needed to run a medical interview and learn about their symptoms and signs to potentially come up with a diagnosis and a treatment plan. We have been taught the Calgary-Cambridge framework to run a consultation (Kurtz SM, Silverman JD, Draper J, 1998). While engaging with the patient I kept checking my notes to ensure I got the process right. In the end I got confused and kept asking the same questions and the patient looked uneasy. Then the supervisor stepped in and finished the consultation.

Reflection on Action

Here is where you start to make sense of what happened. You should question yourself and your assumptions to understand what led you to your actions – this will allow you to challenge the status quo of your actions and assumptions.
Helpful questions

- What was I trying to achieve?
- Why did I act as I did?
- What assumptions did I make?
- What were the consequences for me and the other people involved?
- How did I feel?
- How did the other people feel and how could I tell?

Example of 'Reflection on Action'

Consultation with patient

I was trying to go through a good patient consultation, making sure that I got the right information and ensuring that I built a relationship and provided structure to the consultation. I think I went through the interview framework too rigidly; I assumed that by asking each question on the list in the order they were displayed I would conduct a good interview. That's why I kept checking my notes – I felt afraid that I would miss something despite having learned and practised the framework with my course friends. Overall, I was really nervous and afraid of making mistakes. This made me uncertain and that's why I wanted to stick fully to the template. I could see that the constant checking of my notes made the patient uneasy; they kept looking to the supervisor and would hesitantly answer my questions. In the end, when the supervisor took over I felt a bit ashamed but also relieved. My supervisor then gave me feedback. She told me that while my intention of getting all the questions of the Calgary-Cambridge framework correct was good, I need to treat each consultation as an individual case and use the framework to inform my decisions.

Theory

Here you can conclude on your learnings. You can use both your own realisations and theoretical literature to make sense of the experience. It can be useful to discuss how your experience has influenced your understanding of your professional or theoretical knowledge.
Helpful questions

- What has this experience contributed to my professional or theoretical knowledge?
- What have I learned that I can apply to a similar situation in the future?
- What have I learned in general?

Example of 'Theory'

Consultation with patient
I have learned that I need to relax better in new situations. I went into the consultation being extremely nervous, and I realised that it was my nervousness and not my ability that made me stumble over my questions. I will need to work on my nervousness. Secondly, I now see how theory is a tool that should be applied to, but not dictate, every step in practice. Of course, all of my decisions need to be informed by theory, but the theory gives a general overview and it's my job to apply the specifics. In this case, I have updated my knowledge of the Calgary-Cambridge model. I know that I need to touch on all the different aspects but it's not a checklist that I need to complete. I need to apply the parts which are relevant to the individual – building a relationship with the patient and providing structure to the consultation is important to make the patient feel safe and confident before I start asking questions. This will look different for each patient and once I get more confident with the model I am sure this will come more naturally to me.

Preparation

Here you can take all of the things that you have discovered in the previous sections to create a plan for how to become better prepared for the future.
Helpful questions

- What will I do next time in a similar situation?
- How could I do better next time?

- What will I now consider for next time?
- What other strategies could I adopt to move forward?

Example of 'preparation'

Consultation with patient
Next time I will be calmer going into a supervised consultation. I will do this in two ways. Firstly, knowing that my supervisor can always step in and help me, and knowing that I don't have to use the interview framework exactly as it is written, will allow me to go with the flow of the consultation much better. Secondly, before starting the consultation I will take as many deep breaths as I need to calm down. Moreover, I will ask my supervisor specifically to give me feedback on my use of the model to make sure I am using it in an effective way. I will start out by making sure the patient is comfortable by introducing myself and getting their name from them, rather than the records. While I'm doing the first steps of the initiation, I will not look at my notes, but keep eye contact and use responsive body language.

How this is useful

This is especially useful when it comes to certain questions that could be asked regarding a previous experience and how you would like to improve, and would most likely be used in questions pertaining to your academics or work experience.
Some questions that come to my mind would be:

- Explore a previous time when you had done your work experience, and how it would be useful for future events such as placements in Medical School?
- Having done your work experience, what would you improve / do differently from the doctors you have shadowed?
- Explore potential areas of improvements in regards to what you have observed in a professional environment.

EXAMPLE: Having done your work experience, what would you improve / do differently from the doctors you have shadowed?
The Experience: I remember the time when I got to shadow in a regional hospital, in particular the Surgery Department where there were ongoing operations daily from morning till the late afternoon. I was fortunate to be allowed to scrub in and stand in the operating room to witness up close the operations being undertaken. Being given such an opportunity allowed me to pick up on the physical actions such as the surgical skills demonstrated, as well as the non-physical aspects such as communication and teamwork. One thing that I picked up upon was the communication between the healthcare professionals where the surgeons were at times rude and insensitive towards the nurses.
Reflection on Action: What occurred at times was when the doctors had asked for a certain tool or equipment, there would be times where it was not available and the nurses had to get it from the store room. The doctors, potentially frustrated, would lash out at them and say certain things that demean or mock them, which is simply unprofessional behavior. Often the nurses would look stunned or shocked but would carry on quickly to prevent further backlash.
Theory: This was a particularly eye-opening experience for me as I did not quite expect to see such behavior in a professional setting. I understand that at times, people have their bad days or moments, and could be stressed out over certain things that lead to their actions. However, I felt it was really unfair for the nurses to take the brunt of it, and instead the surgeons should have managed their emotions better. As such, this experience resonated with my personal mission to always treat everyone with respect, and taught me that while there will be occasions that I am not feeling the best, I should work on communicating it to those around me and find healthier ways to cope with my emotions.

Preparation: Some ways that I have been practicing this goal of mine is to always take deep breaths when I am experiencing a bad day, and to always consciously think of what I am about to say before I say it. As such it allows me to stop myself from commenting on anything that could hurt others, and regulate my emotions that I feel. Additionally I choose to take a breather whenever I feel overwhelmed so as to allow me to stay in control of the situation. With all these methods, it has allowed me to follow through my intentions.

Gibb's Reflective Cycle

This model is a good way to work through an experience. This can be either a stand-alone experience or a situation you go through frequently, for example meetings with a team you have to collaborate with. Gibbs originally advocated its use in repeated situations, but the stages and principles apply equally well for single experiences too. If done with a stand-alone experience, the action plan may become more general and look at how you can apply your conclusions in the future.

For each of the stages of the model a number of helpful questions are outlined below. You don't have to answer all of them but they can guide you about what sort of things make sense to include in that stage. You might have other prompts that work better for you.

Description

Here you have a chance to describe the situation in detail. The main points to include here concern what happened. Your feelings and conclusions will come later.
Helpful questions:

- What happened?
- When and where did it happen?
- Who was present?
- What did you and the other people do?
- What was the outcome of the situation?
- Why were you there?
- What did you want to happen?

Example of 'Description'

Group work assignment
For an assessed written group-work assignment, my group (3 others from my course) and I decided to divide the different sections between us so that we only had to research one element each. We expected we could just piece the assignment together in the afternoon the day before the deadline, meaning that we didn't have to schedule time to sit and write it together. However, when we sat down it was clear the sections weren't written in the same writing style. We therefore had to rewrite most of the assignment to make it a coherent piece of work. We had given ourselves enough time before the deadline to individually write our own sections, however we did not plan a great deal of time to rewrite if something were to go wrong. Therefore, two members of the group had to drop their plans that evening so the assignment would be finished in time for the deadline.

Feelings

Here you can explore any feelings or thoughts that you had during the experience and how they may have impacted the experience.
Helpful questions:

- What were you feeling during the situation?
- What were you feeling before and after the situation?
- What do you think other people were feeling about the situation?
- What do you think other people feel about the situation now?
- What were you thinking during the situation?
- What do you think about the situation now?

Example of 'Feelings'

Group work assignment
Before we came together and realised we still had a lot of work to do, I was quite happy and thought we had been smart when we divided the work between us. When we realised we couldn't hand in the assignment like it was, I got quite frustrated. I was certain it was going to work, and therefore I had little motivation to actually do the rewriting. Given that a couple of people from the group had to cancel their plans I ended up feeling quite guilty, which actually helped me to work harder in the evening and get the work done faster. Looking back, I'm feeling satisfied that we decided to put in the work.

Evaluation

Here you have a chance to evaluate what worked and what didn't work in the situation. Try to be as objective and honest as possible. To get the most out of your reflection, focus on both the positive and the negative aspects of the situation, even if it was primarily one or the other.
Helpful questions:

- What was good and bad about the experience?
- What went well?
- What didn't go so well?
- What did you and other people contribute to the situation (positively or negatively)?

Example of 'Evaluation'

Group work assignment
The things that were good and worked well was the fact that each group member produced good quality work for the agreed deadline. Moreover, the fact that two people from the group cancelled plans motivated us to work harder in the evening. That contributed positively to the group's work ethic. The things that clearly didn't work was that we assumed we wrote in the same way, and therefore the overall time plan of the group failed.

Analysis

The analysis step is where you have a chance to make sense of what happened. Up until now you have focused on details around what happened in the situation. Now you have a chance to extract meaning from it. You want to target the different aspects that went well or poorly and ask yourself why. If you are looking to include academic literature, this is the natural place to include it.
Helpful questions:

- Why did things go well?
- Why didn't it go well?
- What sense can I make of the situation?
- What knowledge – my own or others (for example academic literature) can help me understand the situation?

Example of 'Analysis'

Group work assignment
I think the reason that our initial division of work went well was because each person had a say in what part of the assignment they wanted to work on, and we divided according to people's self-identified strengths. I have experienced working this way before and discovered when I'm working by myself I enjoy working in areas that match my strengths. It seems natural to me that this is also the case in groups. I think we thought that this approach would save us time when piecing together the sections in the end, and therefore we didn't think it through. In reality, it ended up costing us far more time than expected and we also had to stress and rush through the rewrite. I think the fact we hadn't planned how we were writing and structuring the sections led us to this situation. I searched through some literature on group work and found two things that help me understand the situation. Belbin's (e.g. 2010) team roles suggests that each person has certain strengths and weaknesses they bring to a group. While we didn't think about our team members in the same way Belbin does, effective team work and work delegation seems to come from using people's different strengths, which we did. Another theory that might help explain why we didn't predict the plan wouldn't work is 'Groupthink' (e.g. Janis, 1991). Groupthink is where people in a group won't raise different opinions to a dominant opinion or decision, because they don't want to seem like an outsider. I think if we had challenged our assumptions about our plan - by actually being critical, we would probably have foreseen that it wouldn't work. Some characteristics of groupthink that were in our group were: 'collective rationalisation' – we kept telling each other that it would work; and probably 'illusion of invulnerability' – we are all good students, so of course we couldn't do anything wrong. I think being aware of groupthink in the future will be helpful in group work, when trying to make decisions.

Conclusions

In this section you can make conclusions about what happened. This is where you summarise your learning and highlight what changes to your actions could improve the outcome in the future. It should be a natural response to the previous sections.
Helpful questions:

- What did I learn from this situation?
- How could this have been a more positive situation for everyone involved?
- What skills do I need to develop for me to handle a situation like this better?

- What else could I have done?

Example of a 'Conclusion'

Group work assignment
I learned that when a group wants to divide work, we must plan how we want each section to look and feel – having done this would likely have made it possible to put the sections together and submit without much or any rewriting. Moreover, I will continue to have people self-identify their strengths and possibly even suggest using the ‘Belbin team roles’-framework with longer projects. Lastly, I learned that we sometimes have to challenge the decisions we seem to agree on in the group to ensure that we are not agreeing just because of groupthink.

Action plan

At this step you plan for what you would do differently in a similar or related situation in the future. It can also be extremely helpful to think about how you will help yourself to act differently – such that you don’t only plan what you will do differently, but also how you will make sure it happens. Sometimes just the realisation is enough, but other times reminders might be helpful.

Helpful questions:

- If I had to do the same thing again, what would I do differently?
- How will I develop the required skills I need?
- How can I make sure that I can act differently next time?

Example of 'Action Plan'

Group work assignment
When I’m working with a group next time, I will talk to them about what strengths they have. This is easy to do and remember in a first meeting, and also potentially works as an ice-breaker if we don’t know each other well. Next, if we decide to divide work, I will insist that we plan out what we expect from it beforehand. Potentially I would suggest writing the introduction or first section together first, so that we have a reference for when we are writing our own parts. I’m confident this current experience will be enough to remind me to suggest this if anyone says we should divide up the work in the future. Lastly, I will ask if we can challenge our initial decisions so that we are confident we are making informed decisions to avoid groupthink. If I have any concerns, I will tell the group. I think by remembering I want the best result possible will make me be able to disagree even when it feels uncomfortable.

How this is useful

Depending on the context you are doing the reflection in, you might want to use different levels of details. Here is the same scenario, which was used in the example above, however it is presented much more briefly.

Short example of Gibbs’ reflective cycle:

Describe:
In a group work assignment, we divided sections according to people's strengths. When we tried to piece the assignment together it was written in different styles and therefore we had to spend time rewriting it.

Feelings:
I thought our plan would work and felt good about it. When we had to rewrite it, I felt frustrated.

Evaluation:
The process of dividing sections went well. However, it didn't work not having foreseen/planned rewriting the sections for coherence and writing styles.

Analysis:
Dividing work according to individual strengths is useful. Belbin's team roles (2010) would suggest something similar. I have done it before and it seems to work well.
The reason piecing work together didn't work was we had no plan for what it needed to look like. We were so focused on finishing quickly that no one would raise a concern. The last part can be explained by 'groupthink' (e.g. Jarvis, 1991), where members of a group make a suboptimal decision because individuals are afraid of challenging the consensus.

Conclusion:
I learned that using people's strengths is efficient. Moreover, planning how we want the work to look, before we go off on our own is helpful. Lastly, I will remember the dangers of groupthink, and what the theory suggests to look out for.

Action plan:
I will use Belbin's team roles to divide group work in the future. Moreover, I will suggest writing one section together before we do our own work, so we can mirror that in our own writing. Finally, I will speak my mind when I have concerns, by remembering it can benefit the outcome.

Structure & Organisation of the NHS

The NHS in each country of the United Kingdom oversees healthcare and is independent to the government, although the Department for Health is responsible for funding and healthcare policy. This means that the NHS relies on the government allocation for its budget, but it can then make its own decisions about how to spend this money.
Within the NHS, local healthcare services are divided up into Clinical Commissioning Groups (CCGs). These are run by healthcare professionals (including nurses, GPs and hospital consultants) who are responsible for assigning the budget to services that are needed in their area.

NHS Foundation Trusts are commissioned by the CCGs to provide care. The NHS is devolved so that each country of the United Kingdom is responsible for running their own healthcare service. It is very important that you are aware of the structure of the NHS in the country of the medical school you are interviewing at.
Make sure you are aware of particular challenges that the healthcare service may face in the local area, as this is where you would receive your clinical training.
The advantage of devolution is that healthcare services can be tailored to the local population, with the hope this will improve wellbeing. An economic argument is that local areas will become more productive if people have fewer sick days and retire at an older age. However, there are concerns that devolved healthcare services would be more vulnerable to local financial difficulties, and that it may be unwise to attempt such a large-scale reorganisation of the NHS in the midst of increasingly stretched budgets. The NHS, as the world's fifth largest employer, already has hugely complex operations and decreasing the amount of centralised control may only add to these pressures.
For a quick video introduction for NHS England, do watch this video:
How does the NHS in England work? An alternative guide - YouTube (May be relatively outdated)
In the beginning of 2019, the NHS published its new long term plan which details how the service will run over the next decade and what its ambitions are for this time period. It builds on from the Five-Year Forward View, which in 2014 prioritised preventative care and gave power to GPs to make decisions about funding by the creation of Clinical Commissioning Groups (CCGs).
The goals of the long-term plan can be summarised as: ● To base care on individual's needs ● Improve the quality of community healthcare services ● Make services more accessible, including bringing them closer to people's homes and providing online GP consultations ● A focus on cancer, particularly preventing deaths by earlier diagnosis ● Supporting patients to self-manage their long-term health conditions ● Focus on preventing illness to reduce the demand for treatment in the future ● Address the issue of short staffing by training more new healthcare professionals
The Department of Health and Social Care in England planned to spend £140 billion this year (2019/20). 95% of this is allocated to the daily running of healthcare services, e.g. the costs of medications and staffing. The rest (£7.1 billion) is for investments into the future, e.g. buildings and new technology. In the aftermath of the 2009 recession, there has been only 1% growth in the NHS budget year on year.
This austerity funding came at a time when the NHS needed to expand its services to support an ageing population and improve the quality of care for all patients. The King's Fund, an independent healthcare think tank, has suggested that the NHS actually requires a budget increase of 4% per year. More healthcare spending in the future has been promised. The Prime Minister declared that by 2023/24 the spending on NHS England would increase by £33.9 billion compared to 2018/19. However, **when inflation is taken into account, this is still not enough to allow the NHS to deliver better care**.
NOTE: CCGs have been replaced by ICBs (Integrated Care Board)

Case Study 1: Surgeons & Ergonomics

Link to original article: https://publishing.rcseng.ac.uk/doi/epdf/10.1308/bull.2022.104.issue-8
Surgeons face many additional physical concerns due to poorly fitting protective clothing and awkward equipment. Erin Dean explores whether we can develop better solutions for the 'one-size-fits-all' tools and offer relief to surgeons.

Ergonomics refers to the study of people's efficiency in their working environment.
A growing body of research is looking at the physical impact of carrying out surgery. Its findings suggest that Ms Bowbrick's experience is far from unique, with surgeons' bodies buckling under the pressure of operating.

A study by Tran et al of more than 600 surgeons in the US noted that just over half reported an injury related to operating. The neck, lower back and shoulders were the areas that caused the most problem, with the prevalence significantly higher among women. These musculoskeletal problems **were having a serious impact on those involved: more than a quarter (26%) had had to have surgery to repair injuries caused by operating, and a similar proportion (24%) said their injuries affected the quality and duration of operations they could carry out**.

In addition, a systematic review from 2018 found that surgeons and interventionalists had a prevalence of work related musculoskeletal disorders at a similar level to that of labourers. Worryingly, these studies suggest a serious issue regarding both the health and wellbeing of surgeons, and their ability to work at Worryingly, these studies suggest a serious issue regarding both the health and wellbeing of surgeons, and their ability to work at their best over long careers.

Many surgeons say that a critical part of the problem is **the equipment they use in theatre, including the table, instruments and personal protective equipment (PPE), which can fit poorly.** Those working in minimally invasive surgery seem to fare particularly badly, with higher rates of pain in the neck, arm, shoulder, hands and legs, and higher odds of fatigue and numbness.

Equipment still being designed on the assumption that surgeons are male is an issue that has been championed by a number of UK surgeons. Roshana Mehdian, the British Orthopaedic Association (BOA) diversity and inclusion working group representative, wrote to equipment manufacturers in March, together with Deborah Eastwood (then vice-president but now the president of the BOA), appealing for help to address this issue.

This detailed the long-term pain and damage to which female surgeons are being exposed. Ms Mehdian wrote in the letter that she and many colleagues 'had experienced frequent niggling problems using orthopaedic tools such as drills, arthroscopic instruments and screwdrivers'. They **simply are not designed for women**, she wrote. 'Our **hands and wrists suffer due to the design mismatch in weight and handspan needed to operate these tools with optimal control**,' the letter said.

The BOA appealed for help from the manufacturers to join a collaboration to carry out more research and to commit to designing inclusive tools. Ms Mehdian told the Bulletin that they had a positive response from a number of companies and had had constructive meetings with a number of large businesses keen to implement change. 'We can make change more quickly working with industry,' she points out. 'This is not just for women; it is for smaller men, surgeons with disabilities, anyone who isn't a 70kg male.'

Part of the problem is that as women often take longer to train (owing to maternity leave), they can be overlooked by companies in their search for experienced surgeons to work with on development. 'I have asked that a woman or diverse surgeon is put on each design, education and research panel, and that they are represented in all areas of the industry's work,' says Ms Mehdian.

Another issue that affects women disproportionately is the fit of PPE. This was a particularly critical issue for some surgeons during the COVID-19 pandemic, when poorly fitting kits put doctors' health (and potentially their lives) at risk. The Women in Global Health group found that **only 14% of women in over 50 countries used PPE that was fitted to them, leaving female health workers feeling expendable**. Concern about these dangers during the first wave of the pandemic prompted a collaboration between Cambridge University Hospitals NHS Foundation Trust and the Centre for Engineering Better Care at the University of Cambridge to look further into the fit of masks for surgeons.

Ambika Chadha, a fellow in cleft lip and palate surgery in Cambridge who is undertaking a PhD degree in three-dimensional facial analysis, co-led a survey with Kanwalraj Moar, a cleft consultant, in 2020.Their detailed study (the largest ever global survey of doctors on PPE, with over 1,500 participants) showed that **one in four doctors felt that their FFP3 masks did not provide them with a sense of safety**. 'The collaboration was inspired by hearing surgeons say their PPE didn't fit optimally, that it was uncomfortable and ultimately, that it

was difficult to do the job in theatre,' Ms Chadha says. 'I certainly found this. My FFP3 mask was not compatible with loupes or a headlight unless I removed my visor.'

Ms Chadha recalled comments in the survey of **surgeons putting themselves at risk while operating in emergency situations without their masks or with poorly fitting ones as they could not tolerate them or wear them together with the other equipment they needed**: 'Surgeons were **having to take more frequent breaks in surgery due to discomfort of PPE and they were very anxious when operating** during the first wave. Personally, I found it hard to focus when at the back of your mind you're thinking: "Is this mask doing its job and who will look after my kids if I die of COVID?"'

Chadha's study demonstrated that women and people from some ethnic minorities, in particular, felt that masks did not fit their face shape well enough to offer a good protective seal. Medical engineers across the globe have since developed prototypes of a reusable and more adaptable FFP3 mask that will fit different face shapes and sizes better (especially smaller ones) to increase safety. Ms Chadha hopes that a commercial and academic collaboration could help put these into production soon for NHS staff (and the wider public) to access.The suitability of PPE for women also became a hot topic at the 2022 BOA annual congress. **A poster presented at the conference suggested that the large arm holes on protective vests not designed for women could be behind higher rates of breast cancer in orthopaedic surgeons**. Women should be issued immediately with radiation protection designed for them, the poster authors said.

Research has highlighted that **rates of discomfort and pain are higher among women, and pieces of equipment (particularly in laparoscopy) are harder to use.** A study looking at four disposable laparoscopic instruments in the US found that women reported that the stapler, the Harmonic® scalpel (Ethicon, Somerville, NJ, US) and the LigaSure™ (Valleylab, Boulder, CO, US) were more awkward to use than their male counterparts. **Women were more likely to use two hands and to describe these devices as 'always awkward'**. As glove size increased (regardless of sex), doctors were more likely to describe these devices as easy to use and used these devices with only one hand. Wing-Sum Lao, a neurosurgery registrar at South Tees Hospitals NHS Foundation Trust, says that **being a relatively small woman, she has struggled to find equipment that fits well**. 'If there is a big height discrepancy between me and the consultant, that can create a real problem,' she explains. 'I will generally use a step to stand on in that case but even then it can be hard to see properly.

We use a microscope a lot in neurosurgery, and sometimes it is literally above my head and I can't see it at all or I have to have my neck in a very flexed position, which quickly becomes very challenging.' **Some surgical equipment (including rongeurs) can be very heavy and hard to use for smaller hands**, says Ms Lao. 'My hands are sore and can cramp afterwards as I'm having to exert so much force on them.' She **points out that equipment can vary between trusts, with some pieces of equipment a little smaller and lighter, making a big difference to the surgeon's comfort when using them**.

Another variable is the **openness of consultants to finding a height for tables and equipment that works for them and their trainees**. Ms Lao says: 'The majority of my senior colleagues are understanding but one consultant, who was much taller than me, **wouldn't allow me to use a step** so I couldn't really be a help to him as I couldn't see anything.'

Ms Lao hopes that as the profession diversifies, there will be greater understanding and a move towards a broader range of equipment sizes. She also thinks that new technology will help future surgeons. One example is the **use of neuronavigation: fewer x-rays are needed during surgery and so the very heavy (and for Ms Lao, often oversized) lead gowns are not required as frequently**.

Phil Brown, the director for regulatory and compliance at the Association of British HealthTech Industries, says that **new regulations that came into force in May 2021 put more responsibility on manufacturers to get feedback on new pieces of kit**, meaning that they should be more proactive in seeking information from surgeons. In addition, he **encourages surgeons to get in touch directly with surgical instrument manufacturers**

with their feedback. Mr Brown says: ‘As part of its post-market compliance, a manufacturer should be going to speak to people who are getting aches and pains because the equipment is too heavy. But if they don’t hear anything, they will assume there is no problem.’
This is **not purely a matter of sex**, however. One very tall surgeon commented that he also had difficulty with equipment due to his height. Another issue that affects everyone **can be the awkward positioning of screens**. Bradley Russell, a surgical care practitioner (SCP) in urology at the Royal Marsden NHS Foundation Trust, is the member of the team who is patient-side during long robotic surgery lists. He says: ‘SCPs need to make sure that the screen is in the right place for them. **Often, the monitor showing what is going on inside the patient is in an awkward position, such as behind you, so you spend the whole time twisting to look back over your shoulder**. It needs to be placed so you can look over the patient at it.’ Mr Russell is very experienced, and feels confident to move screens and table heights to the best position. ‘Someone newer to the role or team may feel less able to do that,’ he says.
Furthermore, **many may not have received the appropriate training**. A study of 53 trainees in Northern Ireland highlighting that only eight trainees (15%) were aware of the ideal operating surface height and six (11%) knew the ideal monitor position while eleven (20%) and seven (13%) knew the correct angles for grasping and suturing tissue respectively. Ms Bowbrick feels that her height (at 6 foot) did not help her neck and back when she was training if she was working for someone shorter.
Being a surgeon also involves relatively constant moving and handling. ‘Patients are getting older and heavier, and this has an impact. In clinics, I spend a lot of time bending down as my patients aren’t able to get on the bed. We need to protect ourselves as we want to spend a long time operating.’ **When working with more junior colleagues, Ms Bowbrick stresses the importance of them protecting their bodies from the strains of the job**. ‘I am **clear with my trainees that we have to operate at the right height, and for them to get a step if necessary**. Once you have a problem with your back, it’s often very difficult to get it sorted.’

Deep Dive: What are the big issues presented?

There is quite a bit presented in this particular article / case study, so let me summarise the main issues at hand.
The big issues faced would be:

- Surgeons are unable to function at the best or in the most optimal / efficient condition given a variety of reasons such as equipment not fitting them
- As a result of equipment not necessarily fitting them, surgeons are having to sacrifice some part of their physical health to operate in such conditions, sometimes even putting their lives at risk
- The working conditions are improving but perhaps not enough and not in time, but there are steps being taken to try and resolve these issues faced
- The common worries are expressed from women, who face under-representation when working or that equipment are still being manufactured from the perception that most surgeons are males
- This issue can be somewhat rectified by education of the younger generations and encouraging more active improvement and understanding from everyone

The Breakdown: Issues presented

> “Surgeons are unable to function at the best or in the most optimal / efficient condition given a variety of reasons such as equipment not fitting them”

While one might wonder why this is such an issue, it actually plays quite a fundamental role with the big issue faced by the NHS currently. One would be aware that the NHS is now

experiencing a major backlog in GP surgeries where UK citizens have to wait months to see a GP and undergo their surgeries. If the surgery is not of critical importance, they may wait up to a year to even undergo the surgery such as hip replacements etc.
If you stop and think about it, this could be a reason why. Because surgeons are unable to function at their best or in their most optimal condition, they frequently need to take breaks and relax so that they can function at their best. Surgeons are unable to operate especially for important cases unless they are super focused, and with these breaks in between, eventually they add up and cause a backlog of surgeries.

> "As a result of equipment not necessarily fitting them, surgeons are having to sacrifice some part of their physical health to operate in such conditions, sometimes even putting their lives at risk"

As mentioned in the article above, surgeons suffer from a myriad of conditions, most commonly back and neck pain either from having to stand in a particular position for hours or constantly move around to be able to operate on the patient. Over a long period of time, the pain adds up and can lead to physical conditions which affect surgeons in the long run.
In times such as COVID, with loose-fitting PPE, it would cause surgeons to have to either keep changing PPE to treat patients (which takes up loads of resources and time which can put patient safety at risk) or sucking it up and just using the PPE to treat patients. Doctors essentially sacrifice and put themselves in danger of being infected just so they can treat the patients and put the patients above themselves. Nobody should have to sacrifice their own lives to treat others around them and doctors were essentially forced to do so because they do not have the necessary support.

> "The working conditions are improving but perhaps not enough and not in time, but there are steps being taken to try and resolve these issues faced"

Here would be a good point to mention that while steps are being taken to try and improve or help those who are currently in the field, it will take time and they may not even be enough to help those who really need it. As such, more will need to be done, preferably in the short term to make up for these shortcomings and there is a need to make sure that whatever is done is adequate.
It would be good to bring up in general interview answers that sometimes solutions need to be both long and short-term, that in order to fully address the problem at hand, you need to make sure you deal with both the issue at hand and the possible issues you may face.

> "The common worries are expressed from women, who face under-representation when working or that equipment are still being manufactured from the perception that most surgeons are males"

For this particular point, you can see from the article as well that the issues faced have come from a long history of under-representation of women and that it is due time we move and progress as a society and of course, have increased integration and support for women. Remember that privilege is often invisible, and that it is on you as a person to constantly work to recognize that and try to improve as a person.
The point can be raised that it would be a waste of resources perhaps if equipment are specialized for women and could be potentially very confusing and divisive as women are seemingly given "special support". However, you should then explore that it would be very unfair to make women suffer through their profession just because we cannot spare resources. We would then need to come to a compromise of sorts, so that all parties are given the necessary treatment to ensure fairness. Good to bring in consequentialism (do the ends justify the means) and utilitarianism (overall benefit) for this question. See Section "Medical Ethics Concepts" for more.

> "This issue can be somewhat rectified by education of the younger generations and encouraging more active improvement and understanding from everyone"

It is important to know that not all solutions need resources to be fixed, and in this case it would be education. Education would be resolution at the root causes, fixing the problem at the roots and hoping that eventually over time, society would improve and step forward as an entire society. Education to this extent goes two ways.

The first would be through the manufacturer's perspective. By teaching new and budding manufacturers of this issue currently faced and encouraging them to be more supportive and understanding, in the future more manufacturers could be motivated to make such machinery to support those in need. It also breaks the stigma and old ways of thinking, encouraging them to think critically and creatively.
The second would be through the medical personnel's perspective. By encouraging new students to be more proactive in looking out for others around them, it breaks the social stigma and encourages those in the workforce to become more accepting and tolerant. It also demonstrates that it is okay to ask for help and that it is okay to make accommodations to those who need it, that disabilities or disadvantages do not make you any less of a person or human.

The Lesson: How to use in Interviews

So having read through all of this, you might be wondering how this is relevant to interviews since it seems quite abstract. I agree and it is true LOL but it is still applicable for interviews and I will try to break it down in this quick section.
So you most likely can use this as a flex knowledge (basically when I use the term "flex" I mean it more in the adaptable sense) so it can be used for various types of questions. It can be used as a conversation starter or if you would choose to use it as examples and stuff, it is also alright as well.
Some possible questions I can think of right now:

- What are some medical articles or journals that you have read recently?
- What are some reasons you think could be behind why the NHS is having such long wait times currently?
- Tell me about an article that resonated with you
- Do you think the problems that the NHS have can be solved? Why or why not?
- Anything related to Hot Topics lol

Essentially, use it as and when you think it is applicable and do not be afraid to explore the more serious sides of the conversation if necessary.

Case Study 2: Returning to Surgical Training from Parental Leave

Link to original article: https://publishing.rcseng.ac.uk/doi/epdf/10.1308/bull.2022.104.issue-8
In work conducted as recently as the 1990s, the social and cultural stereotype of a surgeon was characterised as follows: 'The "iron surgeon" [...] declares war on softness, sloth, and error. His feelings, if he has any, are private; his inner life, if he has time for one, is unengaged by his work.' **This kind of cultural stereotype has sustained perceptions into more recent times of surgical training as gruelling and requiring much self-sacrifice**. Fortunately, **these stereotypes of who surgeons are (and what training to be one entails) are being challenged**, for example by the 'I look like a surgeon' media campaign. Although the proportion of female consultant surgeons is lower than in other medical specialties at 13.2%, the number of female surgical trainees has increased to 33%. If attrition can be avoided and these trainees can be supported to reach consultancy, the surgical community can aim to redress the current sex divide. **Increasingly, male and female trainees are having breaks from their training, for research, for parental leave and now, because of shielding during the COVID-19 pandemic**. The General Medical Council 2018 training report stated that a third of trainee doctors had taken a break from training during the preceding five years. Another survey conducted by the Academy of Medical Royal Colleges of trainees who had been out of training for parental leave showed that only 3.5% of the 1,225 respondents did not have any concerns about returning to training.

The high profile case of Dr Bawa-Garba, who was sentenced in 2015 for manslaughter after a patient died on her first shift after returning from parental leave, has drawn attention to the issue of returning to clinical practice. Supporting returning trainees was included in the Advisory, Conciliation and Arbitration Service negotiations of the 2016 junior doctors' contract, and funding has been allocated to initiatives that 'remove as far as possible the disadvantage of those who take time out [of training]'.
Subsequently, **there have been advances in generic support for returning trainees: Health Education England has developed the SuppoRTT (Supported Return to Training) initiative, offering support for trainees to develop individualised packages with their supervisors, with suggestions such as enhanced supervision, mentorship and refresher courses as part of the package**. However, there has been very little research into the specific needs of returning surgical trainees despite the fact that being in a craft specialty, trainees may be more at risk of skills fading.
In a review of skills fade in 2014, the General Medical Council stated that there was very limited evidence from the medical field but that research in the wider arena indicates that time out of training would affect skills retention, with a steep decline of skills after six months. Although the Royal College of Anaesthetists has developed the GASagain (Giving Anaesthesia Safely Again) course for returners, no such course exists at present for surgical trainees.This study used purposive (ie non-probability) sampling of surgical trainees from a deanery that does not currently have a programme for supporting trainees who had returned to training from parental leave within the past five years. This time period was chosen to reduce recall bias. **Our study focused on trainees returning from parental leave as it was thought that they may have increased needs compared with those returning from a period of research (and who may therefore maintain some clinical practice during their break)**.
Seven surgical trainees who had returned to surgical training after a period of parental leave were interviewed. All were women.Overall, the seven trainees had ten experiences of returning to clinical training after parental leave (1–2 per participant). The duration of parental leave varied from 6 to 13 months. Trainees described returning to training at almost every level (ST3, ST4, ST5 and ST7). Trainees described five experiences of returning to the same training placement and five of returning to training at a new placement.
Prior to returning to training, the majority of trainees felt some degree of anxiety about returning to clinical practice and the immediate response of trainees to the overarching question of what returning to training was like was broadly negative.More than one described the sense of the unknown, worrying that they may not cope physically and that they may not remember how to operate**.Low confidence affected all trainees**.
A trainee who described herself as very confident and very secure prior to parental leave said that she then **became very insecure** after this 'heightened period of time mentally, emotionally and hormones-wise'.Trainees' responses varied over whether they felt more anxious about returning after parental leave at an earlier or later stage in their training.
Some said that leaving early in their training made them more anxious as they were only just getting momentum going on the learning curve and on their return, they felt like they had to learn everything from the beginning. On the other hand, senior trainees pointed out that they were expected to perform more complex procedures on their return and do more independent operating, which they felt was daunting.
There were **more examples of senior trainees finding it more difficult to ask for help**, both because of their **own inner drive to get back to their previous capabilities and 'prove themselves'**, and because they **perceived that their trainers thought that they would be performing at the same level straightaway and had an attitude that they could 'just get on with it'**.
This **led to trainees feeling worried that they could be pushed into situations that were potentially unsafe**.'I tried to come across quite excited [about returning] and reassure them that I'll be good. I think like most surgeons, we try and hide any insecurities.' (Trainee 1)' I was so determined not to make a fuss because I so desperately wanted to be normal and to be a professional.' (Trainee 2) **Many trainees mentioned trainers that lacked insight into**

the challenges of returning to training. They explained that **some trainers did not understand that the trainee might lack confidence** or (in cases where the trainee was returning to a new training placement) that **trainers might not even know that the trainee was returning from a period away from training**.
Trainees' confidence was affected by these perceptions of the attitudes of their peers or seniors.There were also **practical challenges to returning after parental leave**. One trainee requested in advance that she was not assigned any on-call duties for the first few weeks but all the other trainees **were scheduled to do on-call shifts, often at night, within days or weeks of their return**. **Two negotiated to swap out of these shifts, with reported difficulty. No trainees were contacted by occupational health staff on their return to training despite some trainees having significant pregnancy and birth related health problems**.
Two trainees said that **it became too difficult to continue breastfeeding and working so they curtailed breastfeeding earlier than planned**. Most trainees found that **physical exhaustion affected their training on their return**. They reported lower concentration levels when operating and physical fatigue from being on their feet for many hours at a time.'You look back and think: how did I do it? How did my children survive? How did my patients survive?' (Trainee 2)
Some trainees said that **aspects of returning to training managed by administrative or human resources staff became the most difficult of all the challenges they faced on their return**. **Many had pay issues**, which caused unnecessary stress at an already stressful time.'You know, nothing is smooth sailing, coming back from maternity leave to work.' (Trainee 3)
None of the trainees, either returning to the same or a different unit, had any kind of formal induction. **'It was almost like nobody really expected me and nobody cared whether or not I turned up.'** (Trainee 2) Operative skills trainees were particularly anxious about retention of operative skills during parental leave, and **some had found that they felt unfamiliar and hesitant with their operative skills initially on their return**.
They **highlighted endoscopic and laparoscopic skills as more difficult skills to recover than open surgery**. Trainees also reported variation according to where they had been on the learning curve for each procedure.'I initially felt deskilled. Some of it was in my head and some of it was confidence, and I just needed that nurturing.' (Trainee 4)'The operating was what worried me and I knew it would probably be like riding a bike but that doesn't take that anxiety away.' (Trainee 2)
However, **they all linked this to lack of confidence, and all reported that their skills subsequently returned quickly, within a matter of weeks**. This **was the case regardless of how long the trainee had been away from training**.'I was actually really pleasantly surprised that that wasn't an issue at all and I think that was probably the thing I was most anxious about.' (Trainee 2) **Trainees returning after a second period of parental leave were generally less anxious as they knew that they could still operate after a period away and that it would not take them long to get back up to speed**.
None of the trainees in this study were given any encouragement regarding benefits that their leave may have on their skills or training, either before they went on parental leave or on returning to training. Nevertheless, all but one trainee could easily identify positive aspects of their period of parental leave in terms of their surgical training and practice.'Oh, definitely, definitely a lot of transferable skills!' (Trainee 4)
A few mentioned increased abilities to multitask and use time efficiently at work, and in trying to study too. Many trainees **thought that they were more patient on their return to training and had improved people management skills**.'It teaches you to be so much more economical with your time.' (Trainee 5) Others **recognised significant changes to their persona on returning that had positive effects on their interactions with patients and patients' families as well as their more junior trainees. Their increased patience and empathy helped them become better trainers.**
Two reported that they were better, happier people and surgeons because of their parental leave.'I definitely changed – no doubt about it. My colleagues will tell you that. I think it's

probably improved my relationships with others... with juniors especially.' (Trainee 6)
Trainees' experiences of being a patient taught them what it is like to be on the receiving end of care. Some were able to identify changes to their surgical practice because of the experience they and their families had of being patients.'You can put yourself in that position from that family perspective much more than I could before.' (Trainee 3)
A couple of trainees **thought that being away from training helped them get a more balanced view of life and training**. One commented that she finally had time to reflect on her clinical practice and training, which she had never had time for since starting work as a trainee. Some trainees said that although they had anxieties about returning, they also felt refreshed after this 'break', and most felt excited to come back to training and operating with a rejuvenated enthusiasm for their surgical training, and an eagerness to return to their careers.
'I'd recommend a career break to anyone!' (Trainee 1)' It makes you realise you enjoy what you're doing, that there's a reason you do this job.' (Trainee 5) **The practical and logistical challenges these trainees described facing on their return to training, such as lack of inductions, raise issues with the administrative process not functioning to the standards set by the General Medical Council for medical training**. These challenges will add to the anxiety faced by returning trainees and need to be addressed by individual hospitals.**The other challenges encountered by trainees can all be linked to anxiety and low levels of confidence**.
This is in keeping with findings from Health Education England. **Confidence has been described as one of the most important traits to encourage in the training surgeon**. In their qualitative analysis of surgical performance in critical situations, Wiggins-Dohlvik et al submitted that 'if you are not confident, it is surprising how frequently you are unsuccessful'.Trainees in our study recognised that their skills were not necessarily as rusty as they worried they were and that their main impediment was actually confidence in these skills. Those returning from a second period of leave were able to allay their anxieties somewhat as they had already experienced the return of their surgical skills being 'like riding a bike'.
This indicates that if trainees facing their first return to training could hear about the experiences of trainees who have already trodden that path, their anxieties could be partially relieved.The fact that this cohort of trainees did find that their surgical skills returned quickly is contrary to the wider (non-surgical) literature on skills fade. This literature would suggest that there is a steep decline in skill after six months out of practice but with variation depending on how proficient the trainee was prior to the break. In our study, **trainees did report varying hesitancy and unfamiliarity depending on where they were on the learning curve for different procedures but they also reported that their skills returned within weeks for all procedures**.
Evidence from other fields (military, industry and police) indicates that aptitude and motivation influence skills retention. Surgical trainees have been selected into training based on aptitude. These trainees were all very motivated towards surgical training in general and to their return to it from parental leave, which could have influenced their proficiency.
Consequently, the main focus for supporting surgical trainees back into training should be on restoring confidence. The results from this study **should be used to reassure trainees that the aspect about which they are likely to be most anxious (i.e. return of surgical skills) is likely to be far less of a problem than they might anticipate**.
Hearing stories from trainees who have previously returned to training, in the form of a mentorship programme, may be beneficial. Such a programme could also be used to **help guide trainees through the administrative process of returning to training and give trainees more confidence in requesting greater support on their return** (such as relief from immediate on-call duties). A couple of trainees thought that being away from training helped them get a more balanced view of life and training
Trainers and trainees should be made more aware of the benefits of a break from training on their surgical skills and subsequent training. Only one other study in the

literature mentioned that the paediatric trainees who were surveyed believed that their experiences of parenthood would make them more sympathetic and understanding, and that missing their training had renewed their motivation to train.
The trainees in our study were all very enthusiastic about returning to training, despite their anxieties, and brought back with them many enhanced skills. They felt they had better time management skills when coping with all their training requirements (e.g. balancing clinical work with studying and academic work). In addition, they believed that their communication skills had improved, allowing them to relate to patients and their families better. Some also felt that they were automatically better trainers, with more patience and empathy.
Indeed, **results suggest that these high achieving trainees can return with little disruption to their capabilities, and in fact with wider skills and increased enthusiasm for their training. This message should be disseminated widely to surgical trainees as well as medical students and junior doctors considering a career in surgery, who according to historical and often anecdotal evidence might mistakenly think that balancing surgical training and family life is not possible**.

STARR TECHNIQUE

An often-used technique used would be the STARR Technique. We will break down the approach below.
Situation - what its about, the background
Task - aim, what you're trying to achieve
Action - what you did to achieve your task
Result - what was the end result, what did your action lead to
Reflect - what you did well, what skills you demonstrated, what you've learnt and what you could do better
Generally, the more important sections would be Action, Result and Reflect. In most cases, the examiner is not very interested in the situation / task faced, but would much rather hear what you took away and what you did to overcome the task at hand. It is advised to spend the most time on ARR compared to S&T.
Some mistakes to avoid would include:

- Getting lost in the details of the story. As mentioned, the focal point is the ARR, and you may only have up to 5 mins to answer the question. The worst case would be that one spends too much time on the S&T compared to ARR
- Using theatrical language. You may be telling a story, but it does not mean you are performing a speech for the marker. Focus on getting your points across in an easy-to-understand fashion, and as clearly and concise as possible. The examiner should not get lost in the details, but remain focused on what you did and what you learnt
- Using derogatory language towards others. You should not be putting other people down (despite you feeling that their actions are as such) but instead explain their actions in a respectful manner
- Being too technical. Again, the story may have a lot of details, but it does not mean that every detail is necessary to focus on. Pick out the crucial details, focus on relevance without sacrificing continuity

Some tips as well:

- Relate to Medicine. Even if it is a personal experience, it will do wonders to show that you can draw the link to medicine, as that is what you are aiming to do. It shows that you are able to think critically if needed, which is always a good trait to have. However, not every question needs to be related to medicine so do exercise some caution in regards to that
- Personal experience. Focus on what you have done, what you learnt and what you took away from the entire situation. This is not a chance to regurgitate a standardised answer, it is more of a chance to let you stand out against other applicants

- Do not make things up. It is easy for interviewers to spot misleading or falsified information and even if you get away with it, if there is a follow-up question, it could lead to gaping holes in your answer, worse still if you give contradictory answers

SPIES Technique

It is potentially confusing to use this technique since it sounds and seems pretty similar to SPIKES, but this technique is mainly used during scenario questions where you need to tackle SJT types of questions such as reporting superiors for inappropriate behavior.
Seek more information - Take action to find out more, do not just assume anything that what you see is what you understand
Peers, public and patient safety - Who is at risk? What kind of danger is being posed to them and how do you react?
Initiative - Check for details, if there is anything you can do, how long has this been going on for, any resulting previous medical errors
Escalation - Escalation (local escalation, nurses, escalation to educational supervisor, registrar, clinical supervisor, BMA, or to GMC (depending on severity)) – BE SPECIFIC ABOUT WHEN YOU'LL REPORT, WHO WILL YOU REPORT TO, AND EXPLAIN WHY (e.g. report to consultant quickly, so that patients are not at risk)
Support - What can you do to help that individual or those who are at risk?
Interviewers are looking for good ethics, subtlety - sensitivity of dealing with matters, how you portray yourself, relationships within teams and with patients when reporting doctors for certain actions. While it may be confusing as to how to use this technique, note that it is more of a guideline and in such scenarios, make sure you go with the flow and make it sound natural.
Mistakes to avoid:

- Jumping straight to action without establishing facts. While you may be quite inclined to make a decision quickly because "patient safety is at risk", remember that what you see is not always true since it is not the full picture. Just because it seems like alcohol **DOES NOT MEAN** it is actually alcohol. Focus on the facts first to guide your decision making
- Acting based on assumptions. Let's use the example where you have seen a doctor take a swig of what seems to be alcohol, and that after a while he has slurred speech and cannot seem to make simple decisions. Should you step in and intervene? Most definitely. However, the reason why you act **MUST BE CLEAR** to the examiner. You should be acting on the premise that he seems unfit for work and that he is exhibiting certain signs but not acting because he drank alcohol (You have not established whether it is or is not alcohol yet)
- Inappropriate or disproportionate action / response. Witnessing and reporting the inappropriate behavior is correct, however your action / response should also be proportionate to the behavior. Just because you saw a JD shout at a nurse, does not mean you go straight to the BMA or GMC. You should instead report the JD to a consultant or anyone that is above the JD in terms of seniority and authority.

This technique can and should be used interchangeably with other techniques, remember that it is a framework and **NOT** a guaranteed or be-all-end-all approach to every question.

Hierarchy of Doctors and Progression in the NHS

Foundation years
First, you will spend two years as a foundation year doctor - initially an F1, then an F2 doctor. At this point, you are a fully qualified doctor in clinical training. As an F1 doctor, your registration with the General Medical Council is provisional but will be confirmed upon successful completion of the year.

F1 and F2 doctors rotate between specialties and departments every 4 months, so may end up travelling a lot around the region in which they are working. This is a great opportunity to experience not only a variety of healthcare settings but also places to live and lifestyles.
At the end of F2, you will receive a Foundation Achievement of Competence Document (FACD) which signifies that you are ready to begin the next stage of your career.

Junior Middle Grade

At this point, doctors will generally know roughly in which area they would like to specialise. You will have a few options:

- Core GP Training: This three-year program fully qualifies you as a General Practitioner upon completion.
- Core Medical Training: This two-year program gives you a general overview of medical specialities.
- Core Surgical Training: This two-year program gives you a general overview of surgical specialities.
- Applying to a run-through program: These programs require you to apply only once, rather than twice, before you become a consultant. Core medical & surgical training programs, once completed, will require you to apply to higher speciality training. Specialities with run-through training include paediatrics, neurosurgery, cardiothoracic surgery, and more.

Examples of training pathways: (Mainly the one I am interested in following)

- Paediatrics (2 Foundation Years, Application Form + Interview, 8 years run-through programme)
- Cardiology (2 Foundation Years, First application + Interview, 2 Core Medical Training Years, Second application + interview, 5 years of Specialist Training)

Senior Middle Grade

Senior Middle-Grade doctors work for 4-6 years towards a full qualification in their chosen speciality. After this, they receive a Certificate of Completion of Training (CCT) and gain entry into either the GMC Specialist Register or GP Register.

Consultant or GP

These doctors are fully qualified, have completed their training, and are free to work independently. This is the highest achievable rank of doctor in the UK.

SAS doctors

SAS doctors are speciality and speciality grade doctors with at least four years of postgraduate training. Instead of becoming a consultant or GP, they may choose to be an SAS doctor for numerous reasons - the ability to live in one geographical location rather than rotating, freedom from the requirements of a formal training program, and more regular hours.

How much do doctors earn in the UK?

A doctor's starting salary in the UK is £29000.
Many people considering a career in medicine wonder how much UK doctors make. The rates vary significantly depending on speciality, experience, and job title.
Below, salaries are outlined for various positions. Please note that these are for standard 40-hour weeks. Additional hours, on-call time and weekend work will all result in extra pay so almost all doctors actually make more money than is outlined below. Therefore, at any level of doctor e.g. a junior doctor's salary can be highly varied.
Generally, doctors who have more experience will be paid at the upper end of given ranges. Additionally, many doctors take on work in the private sector which can be significantly more lucrative.

- F1 doctor salary (UK doctor starting salary): £29,384
- F2 doctor salary: £34,012
- Specialist training doctor salary: £40,257-58,398
- Specialty doctors salary: £50,373-78,759

- Specialist grade doctors salary: £80,693-91,584
- Consultants salary: £84,559-114,003

The NHS receives funding from the treasury of the government. In 2021, spending on the Department of Health and Social Care (England) was approximately £190bn with over £130bn of this going towards the NHS. Some of this money is then spent on national projects such as rare cancer treatments, however, most are passed onto Clinical Commissioning Groups (CCGs).
These receive funding based on factors such as population, average age, and deprivation. They assess the needs of their population to allocate resources to services such as hospitals and GP practices. CCGs are known as commissioners of healthcare, along with non-NHS local authorities. They work together as Sustainability and Transformation Partnerships (STPs) and have authority over Integrated Care Partnerships (ICPs).
ICPs consist of NHS trusts providing acute, community and mental health care alongside other providers of NHS-funded care such as GPs, the voluntary sector, social enterprises and even the private sector.

Patient Confidentiality

It is important for us to understand the importance and scale our profession entails, and more importantly the **IMMENSE** amount of trust given to us by the patients. The patients come to us in a vulnerable state, where they are seeking our help and giving us intimate details of their personal details and as a **CARE-CENTERED** profession, it is important for us to respect them by keeping things confidential. In this segment we will break down the important things that one should know regarding patient confidentiality.

Patient Confidentiality

From Google, patient confidentiality refers to a set of rules that limits access to information discussed between a person and their healthcare practitioners. With only a few exceptions, anything you discuss with your doctor must, by law, be kept private between the two of you and the organisation they work for
As mentioned, a doctor should preserve absolute secrecy on all he knows about his patient because of the confidence entrusted in him. And the aforementioned information can **ONLY** be disclosed with the patient's knowledge and consent.
It is only natural to wonder then, under what other circumstances can confidentiality be reasonably breached? We have seen in movies, shows and sometimes the news that patients' information is passed on to the relevant authorities. However, wouldn't that contradict the literal definition of patient confidentiality? We will explain this in the next section.

Breach Of Confidentiality

As previously mentioned, there are certain situations where the breach of confidentiality overrides the need to respect patient confidentiality. We will detail it as such:

- Required by law eg. notifiable infections (TB, enterovirus 71)
- Under court order
- Justified in public interest to protect third party
    - Patient is a substantial danger to others – e.g serious crime or patient revealed to you an intention of bombing
- Emergency: overall benefit to patient who is unconscious or if the patient is suicidal; need for relevant authorities to step in.

However, even when there is a breach of confidentiality,only the necessary information is disclosed and care must be taken to check that access can be granted to these individuals

before disclosure. It should be anonymised as much as possible without compromising on other factors.
When transferring patient information or other confidential information by email, services or methods that meet NHS Encryption standards must be used.

It is not permitted to include confidential or sensitive information in the body of an email. When emailing to addresses other than the secure domains or even the secure domains described above the information must be sent as an encrypted attachment with a strong password communicated through a different channel or agreed in advance.

Sending information via email to patients is permissible, provided the risks of using unencrypted email have been explained to them, they have given their consent, or the information is not person-identifiable or confidential information.

Gilick Compentence

The Gilick Competence, in summary, is to see if children under 16 have the capacity to consent to their own treatment. While often confused with Fraser Guidelines, they are different things and should be treated as such.
Gillick competence is used to assess a child's capability to make and understand their decisions in a wider context. Fraser guidelines are applied specifically to advice and treatment that focuses on a young person's sexual health and contraception.
The children have to be intelligent, competent and mature to be deemed competent. This is usually determined by a healthcare professional, and it should be noted that there are not set questions that are asked, but instead be flexible and follow the guidelines as mentioned below.
The questions/guidelines to follow or consider are as followed:

- Age and maturity
- Mental capacity
- Do they understand the treatment well enough, such as effects, short and long-term impacts and/or implications?
- Do they acknowledge the risks of treatment?
- Is the child aware of other potential treatments, if any?
- Does the child possess the ability to explain the rationale behind their decision making?

A child's understanding of different treatments can vary, and capacity can fluctuate. This means decisions must be handled on a case by case basis, each time requiring assessment of Gillick competence.

Fraser Guidelines

The Fraser Guidelines, in summary, is for children under 16 to get contraception and sexual health advice without a parental/legal guardian **(DON'T GET MIXED UP WITH GILLICK COMPETENCE)**
There are 5 main points for consideration:

- Is the child mature and intelligent enough to understand the treatment
- Likelihood of undergoing sexual intercourse with or without contraception
- Is it in their best interest?
- Is it impossible to persuade the child to tell their parents?
- Mental and physical health → will it suffer without treatment?

GMC Ethical Guidance (0-18 Years Sexual Activity)

Refer to this website if you want to read through the whole document. (https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/0-18-years/sexual-activity)
I will be mainly summarising some points that I feel are really important.
An assessment of best interests will include what is clinically indicated in a particular case. You should also consider:

1. the views of the child or young person, so far as they can express them, including any previously expressed preferences
2. the views of parents
3. the views of others close to the child or young person
4. the cultural, religious or other beliefs and values of the child or parents4
5. the views of other healthcare professionals involved in providing care to the child or young person, and of any other professionals who have an interest in their welfare
6. which choice, if there is more than one, will least restrict the child or young person's future options.

This list is not exhaustive. The weight you attach to each point will depend on the circumstances, and you should consider any other relevant information. You should not make unjustified assumptions about a child or young person's best interests based on irrelevant or discriminatory factors, such as their behaviour, appearance or disability.
Effective communication between doctors and children and young people is essential to the provision of good care. You should find out what children, young people and their parents want and need to know, what issues are important to them, and what opinions or fears they have about their health or treatment. In particular you should:

1. **involve children and young people** in discussions about their care
2. be honest and open with them and their parents, while respecting confidentiality
3. listen to and respect their views about their health, and respond to their concerns and preferences
4. explain things using language or other forms of communication they can understand
5. consider how you and they use non-verbal communication, and the surroundings in which you meet them
6. give them opportunities to ask questions, and answer these honestly and to the best of your ability
7. do all you can to make open and truthful discussion possible, taking into account that this can be helped or hindered by the involvement of parents or other people
8. give them the same time and respect that you would give to adult patients.

You should make it clear that you are available to see children and young people on their own if that is what they want. You should avoid giving the impression (whether directly, through reception staff or in any other way) that they cannot access services without a parent. You should think carefully about the effect the presence of a chaperone can have. Their presence can deter young people from being frank and from asking for help.
You should take children and young people's views seriously and not dismiss or appear to dismiss their concerns or contributions. Disabled children and young people can feel particularly disadvantaged in this respect.
Children and young people usually want or need to know about their illnesses and what is likely to happen to them in the future. You should provide information that is easy to understand and appropriate to their age and maturity about:

1. their conditions
2. the purpose of investigations and treatments you propose and what that involves, including pain, anaesthetics and stays in hospital

3. the chances of success and the risks of different treatment options, including not having treatment
4. who will be mainly responsible for and involved in their care
5. their right to change their minds or to ask for a second opinion.

You **should not overburden children and young people or their parents,** but give them information at an appropriate time and pace, and check their understanding of key points. You should talk directly and listen to children and young people who are able to take part in discussions about their care. Young people who are able to understand what is being said and who can speak for themselves resent being spoken about when they are present. But younger children might not be able to understand what their illness or proposed treatment is likely to involve, even when explained in straightforward terms.

You should only keep the type of information described from children or young people if:

1. it would cause them serious harm (and not just upset them or make them more likely to want to refuse treatment)
2. they ask you to, because they would prefer someone else to make decisions for them.

You **have the same duty of confidentiality to children and young people** as you have to adults. But parents often want and need information about their children's care so that they can make decisions or provide care and support. Children and young people are usually happy for information to be shared with their parents. This sharing of information is often in the best interests of children and young people, particularly if their health would benefit from special care or ongoing treatment, such as a special diet or regular medication. **Parents are usually the best judges of their children's best interests and should make important decisions up until children are able to make their own decisions.** You should share relevant information with parents in accordance with the law and the guidance in paragraphs 27, 28 and 42 to 55.

You must decide whether a young person is able to understand the nature, purpose and possible consequences of investigations or treatments you propose, as well as the consequences of not having treatment. Only if they are able to understand, retain, use and weigh this information, and communicate their decision to others can they consent to that investigation or treatment. That means you **must make sure that all relevant information has been provided and thoroughly discussed before deciding whether or not a child or young person has the capacity to consent.**

The capacity to consent depends more on young people's ability to understand and weigh up options than on age. When assessing a young person's capacity to consent, you should bear in mind that:

1. at 16 a young person can be presumed to have the capacity to consent (see paragraphs 30 to 33)
2. a young person under 16 may have the capacity to consent, depending on their maturity and ability to understand what is involved.8

It is important that you **assess maturity and understanding on an individual basis and with regard to the complexity and importance of the decision to be made**. You should remember that a young person who has the capacity to consent to straightforward, relatively risk-free treatment may not necessarily have the capacity to consent to complex treatment involving high risks or serious consequences. The capacity to consent can also be affected by their physical and emotional development and by changes in their health and treatment.

The legal framework for the treatment of 16 and 17-year-olds who lack the capacity to consent differs across the UK:

1. In England, Wales and Northern Ireland, parents can consent to investigations and treatment that are in the young person's best interests
2. In England and Wales, treatment can also be provided in the young person's best interests without parental consent, although the views of parents may be important in assessing the young person's best interests.
3. In Northern Ireland, treatment can be provided in the young person's best interests if a parent cannot be contacted, although you should seek legal

advice about applying for court approval for significant (other than emergency) interventions
4. In Scotland, 16 and 17-year-olds who do not have the capacity to consent are treated as adults who lack capacity and treatment may be given to safeguard or promote their health

Respect for young people's views is important in making decisions about their care. If they refuse treatment, particularly treatment that could save their life or prevent serious deterioration in their health, this presents a challenge that you need to consider carefully.

Parents cannot override the competent consent of a young person to treatment that you consider is in their best interests. But you can rely on parental consent when a child lacks the capacity to consent. In Scotland parents cannot authorise treatment a competent young person has refused. In England, Wales and Northern Ireland, the law on parents overriding young people's competent refusal is complex. You should seek legal advice if you think treatment is in the best interests of a competent young person who refuses.

You must carefully weigh up the harm to the rights of children and young people by overriding their refusal against the benefits of treatment, so that decisions can be taken in their best interests. In these circumstances, you should consider involving other members of the multidisciplinary team, an independent advocate, or a named or designated doctor for child protection. Legal advice may be helpful in deciding whether you should apply to the court to resolve disputes about best interests that cannot be resolved informally.

You should also consider involving these same colleagues before seeking legal advice if parents refuse treatment that is clearly in the best interests of a child or young person who lacks capacity, or if both a young person with capacity and their parents refuse such treatment. For further guidance on these issues see GMC guidance on decision making and consent and treatment and care towards the end of life.

To assess their best interests you should consider the religious and cultural beliefs and values of the child or young person and their parents as well as any social, psychological and emotional benefits. This may be relevant in circumcision of male children for religious or cultural reasons, or surgical correction of physical characteristics that do not endanger the child's life or health.

Sharing information without consent

If a child or young person does not agree to disclosure there are still circumstances in which you should disclose information:

1. when there is an overriding public interest in the disclosure
2. when you judge that the disclosure is in the best interests of a child or young person who does not have the maturity or understanding to make a decision about disclosure
3. when disclosure is required by law.

Public interest

You can disclose, without consent, information that identifies the child or young person, in the public interest. A disclosure is in the public interest if the benefits which are likely to arise from the release of information outweigh both the child or young person's interest in keeping the information confidential and society's interest in maintaining trust between doctors and patients. You must make this judgement case by case, by weighing up the various interests involved.

When considering whether disclosure would be justified you should:

1. tell the child or young person what you propose to disclose and why, unless that would undermine the purpose or place the child or young person at increased risk of harm
2. ask for consent to the disclosure, if you judge the young person to be competent to make the decision, unless it is not practical or appropriate to do so. For example it would be inappropriate to ask for consent if you have already decided that a disclosure is likely to be justified in the public interest.

If a child or young person refuses consent, or if it is not practical or appropriate to ask for consent, you should consider the benefits and possible harms that may arise from disclosure. You should consider any views given by the child or young person on why you should not disclose the information. But you should disclose information if this is necessary to protect the child or young person, or someone else, from risk of death or serious harm. Such cases may arise, for example, if:

1. a child or young person is at risk of neglect or sexual, physical or emotional abuse (see paragraphs 56 to 63)
2. the information would help in the prevention, detection or prosecution of serious crime, usually crime against the person
3. a child or young person is involved in behaviour that might put them or others at risk of serious harm, such as serious addiction, self-harm or joy-riding.

If you judge that disclosure is justified, you should disclose the information promptly to an appropriate person or authority and record your discussions and reasons. If you judge that disclosure is not justified, you should record your reasons for not disclosing.

Disclosures when a child lacks the capacity to consent

Children will usually be accompanied by parents or other adults involved in their care, and you can usually tell if a child agrees to information being shared by their behaviour. Occasionally, children who lack the capacity to consent will share information with you on the understanding that their parents are not informed. You should usually try to persuade the child to involve a parent in such circumstances. **If they refuse and you consider it is necessary in the child's best interests for the information to be shared (for example, to enable a parent to make an important decision, or to provide proper care for the child), you can disclose information to parents or appropriate authorities**. You should record your discussions and reasons for sharing the information.

You should let parents access their child's medical records if the child or young person consents, or lacks capacity, and it does not go against the child's best interests. If the records contain information given by the child or young person in confidence you should not normally disclose the information without their consent.

Divorce or separation does not affect parental responsibility and you should allow both parents reasonable access to their children's health records.

You **should usually share information about sexual activity involving children under 13, who are considered in law to be unable to consent.** You should discuss a decision not to disclose with a named or designated doctor for child protection and record your decision and the reasons for it.

You should usually share information about abusive or seriously harmful sexual activity involving any child or young person, including that which involves:

1. a young person too immature to understand or consent
2. big differences in age, maturity or power between sexual partners
3. a young person's sexual partner having a position of trust
4. force or the threat of force, emotional or psychological pressure, bribery or payment, either to engage in sexual activity or to keep it secret
5. drugs or alcohol used to influence a young person to engage in sexual activity when they otherwise would not
6. a person known to the police or child protection agencies as having had abusive relationships with children or young people.

You can provide contraceptive, abortion and STI advice and treatment, without parental knowledge or consent, to young people under 16 provided that:

1. they understand all aspects of the advice and its implications
2. you cannot persuade the young person to tell their parents or to allow you to tell them
3. in relation to contraception and STIs, the young person is very likely to have sex with or without such treatment
4. their physical or mental health is likely to suffer unless they receive such advice or treatment, and

5. it is in the best interests of the young person to receive the advice and treatment without parental knowledge or consent.

You should keep consultations confidential even if you decide not to provide advice or treatment (for example, if your patient does not understand your advice or the implications of treatment), other than in the exceptional circumstances outlined

If carrying out a particular procedure or giving advice about it conflicts with your religious or moral beliefs, and this conflict might affect the treatment or advice you provide, you **must explain this to the patient and tell them they have the right to see another doctor. You should make sure that information about alternative services is readily available to all patients**. Children and young people in particular may have difficulty in making alternative arrangements themselves, so you **must make sure that arrangements are made for another suitably qualified colleague to take over your role as quickly as possible**.

Process to Determine based on Age

Under 13

There isn't a lower limit for either Gillick competence or Fraser guidelines to be applicable. Most children under the age of 13 have parent involvement when consent to treatment is concerned as it is not appropriate or safe.

When it comes to contraception and sexual health, any information about sexual activity would be acted on regardless of whether the child is competent or not – because a child under 13 is not legally able to consent to sexual activity.

Under 16

If someone under 16 discloses information that raises concerns about their safety, the following needs to be considered:

- If they are Gillick competent and disclosure is thought to be essential to protect them from danger, the healthcare professional should escalate concerns through safeguarding measures
- If they aren't Gillick competent, the healthcare professional is obliged to escalate concerns through safeguarding measures
- If it is both cases, the young person must be informed – unless doing would cause significant risk to their safety

If escalated, the police or local authority could be asked to decide whether it is in the best interest to inform parents of the concerns raised. Of course, sometimes there are cases where it is not in the best interest of the young person.

Between 16 and 17

Legally, those aged 16 to 17 have the capacity to consent to medical treatment. However, unlike adults, refusal of treatment can be overridden by either a court or someone who possesses parental responsibility. This exists because of the duty to act in a young person's best interest, which involves situations where their refusal leads to death or irreversible damage, either mentally or physically.

Confidentiality is important for both → CANNOT TELL ANYONE WITHOUT CONSENT

CAMP TECHNIQUE

Similar to STARR, CAMP technique is also a useful method to answer certain interview questions, especially those that are linked towards medical settings / situations. This would be especially useful for questions that test your understanding of the roles of healthcare individuals, the considerations and roles of the doctors. The technique is broken down as such.

Clinical - Patient care, clinical duties, paperwork

Academic - Teaching and research

Managerial - Managing others, running and developing services

Personal - Doctors try to have their own personal life as well. Consider family, friends, significant others. Personal attributes, hobbies.

In contrast to the STARR technique, no section is more important to the other generally. It depends highly on the phrasing of the question given and the “given” factors named by the question. In doing so, this technique tries to engage and answer all aspects of the question as much as possible.
Some tips would include:

- Highlight all sections if possible, but aim to go in-depth for at least 2 sections. This shows the examiner that you would be able to consider a wide range of possibilities, while still developing your answer enough to show your ability to pick details to expand further upon
- Argue both the pros and the cons to each section. For example, “Academic” refers to teaching and research, and since teaching and research can lead to further developments in our medical technology + help the future generation become better doctors, equipping them with the relevant skills and expertise. However it can lead to increased burden on doctors who already have a lot on their plate, and some may not treat it seriously. Research also requires a lot of materials / resources which can be difficult when such resources are scarce
- Consider the impact on individuals and who is involved in what kind of situation. For example “Managerial”, the individuals involved would be the nurses, other doctors, other kind of healthcare professionals such as therapists, physios etc

Some mistakes to avoid:

- Focusing all your time on one segment. Not only does that quickly limit the scope of your answer, if you run out of things to say, it will negatively impact you as you are unable to expand your answer, and you may not be able to develop your answer as much as you would like
- Taking too long to decide on which segment to begin. Often this can be due to uncertainty / stress or panic, but remember: Giving a poor answer is not as bad as not giving an answer at all. Again, all sections differ in terms of importance and depends HIGHLY on the question, hence just picking one to go off on will be best

Ultimately, this technique is not a guaranteed way to answer interview questions, and similar to STARR technique, frequent practice and revision to the technique will go a long way to excelling.

ICE TECHNIQUE

ICE stands for Ideas, Concerns and Expectations. This is very useful during Roleplay scenarios during MMIs when you have to interact with actors given the scenarios. Asking about a patient’s ideas, concerns and expectations allow you to gain insight into how a patient currently perceives their situation, what they are worried about and what they are expecting from the consultation.
It can sometimes be challenging to use the ICE structure in a way that sounds natural in your consultation. As a result, here are some example phrases for covering each of the three points.

Ideas

Examples of how to explore a patient’s ideas:

- “Tell me about what you think is causing the problem.”
- “Do you have any theories about what might be going on?”
- “It’s clear that you’ve given this a lot of thought and it would be helpful to hear what you think might be going on.”
- “What do you think might be happening?”

- “What’s your best guess as to what is causing this?”
- “Do you have any ideas as to what is going on at the moment?”

Concerns

Examples of how to explore a patient’s concerns:

- “What’s your biggest worry at the moment regarding what this might be?”
- “Are you worried about this being anything in particular?”
- “In your darkest moments, what do you worry about?”
- “What’s the worst thing you were thinking it might be?”
- “What’s your number one concern regarding this problem at the moment?”

Expectations

Examples of how to explore a patient’s expectations:

- “What were you hoping I’d be able to do for you today?”
- “What would ideally need to happen for you to feel today’s consultation was a success?”
- “What do you think might be the best plan of action?”
- “What were you hoping would happen today?”
- “You’ve obviously thought about this quite a bit, did you have any thoughts on the best way we could tackle the issue?”

CLINICAL COMMUNICATION

Introduction

Wash your hands and don PPE if appropriate.
Introduce yourself including your full name and role.
Check you have the correct patient and confirm they are happy to be called by their name (e.g. Joanna or Mrs Smith).
Explain the purpose of the interview (e.g. “I have been asked to speak to you about some recent investigations you have had.”).
If you are seeing the patient instead of their usual doctor – apologise for the change and explain that you are stepping in for whatever reason.
Gain consent to discuss the topic with the patient and explain that the discussion will be confidential.

Active listening

Display active listening skills throughout the consultation:

- Maintain an appropriate level of eye contact throughout.
- Open, relaxed, yet professional body language (e.g. uncrossed legs and arms, leaning slightly forward in the chair).
- Nod to acknowledge what the patient is saying where appropriate.
- Avoid interrupting the patient throughout the consultation.

Establish rapport

Try to establish a rapport with your patient:

- Ask how they are, offer them a seat and a glass of water.

- Empathise with any emotion they display/verbalise and acknowledge the difficulty/stress of situations they could be experiencing (watch them carefully).
- Listen and respond to the things the patient says

Commonly Vaccinated Diseases

Thanks to @confused umbreon's help, we have a table of those commonly vaccinated diseases. Table 1 has the general breakdown of the disease and the symptoms of some of the diseases.
The timeline of the vaccinations for these diseases is also below this table, and it is represented as Table 2. In regards to whether it is important to know for interviews and how it can be asked during interviews, to be truthful we are not sure as well. However, it is good to know some of these diseases as possible content to use during interview answers, and would serve you well in demonstrating your understanding of the profession.

Table 1

Name of Disease	General Breakdown	Symptoms
Diphtheria	Diphtheria is a serious infection caused by strains of bacteria called Corynebacterium diphtheriae that make toxins. It can lead to difficulty breathing, heart rhythm problems, and even death.	
Hib (Haemophilus influenzae type b)	Haemophilus influenzae type b (Hib) is a bacterial infection that can cause a number of serious illnesses, particularly in young children. Can lead to meningitis, sepsis, pneumonia etc.	
Polio	A disease caused by the poliovirus. The virus can infect the spinal cord and cause permanent paralysis or even death.	
Tetanus	An infection caused by a bacterium called Clostridium tetani. Spores of tetanus bacteria are everywhere in the environment, including soil, dust, and manure. The spores develop into	

	bacteria when they enter the body. Unlike other vaccine-preventable diseases, tetanus is not spread from person to person.	
Whooping cough	Also called pertussis, is a highly contagious bacterial infection of the lungs and airways. It causes repeated coughing bouts that can last for two to three months or more, and can make babies and young children in particular very ill.	
Meningococcal group B	Infection leads to meningitis and sepsis. This can lead to severe brain damage, amputation and death.	
Rotavirus	Highly infectious stomach bug that affects babies and young children and cause diarrhoea and vomiting (also dehydration)	
Measles	Very contagious respiratory infection (used to be common in children) . Causes total-body skin rash and flu-like symptoms.	
Mumps	Very contagious viral infection (used to be common in children). Leads to painful swellings in the side of the face and under the ears.	
Rubella	Causes spotty rash.	
Shingles	Infection that causes a painful rash.	

Human Papillomavirus (STI)	Leads to cervical cancer.	
Hepatitis B (an STI)	Liver infection that is spread through blood, semen and vaginal fluids.	

Table 2

Babies under 1	Ages 1-15	Adults	For people at risk
6 in 1 vaccine (8,12,16 weeks old so 3 doses) Diphtheria Hepatitis B Hib Polio Tetanus Whooping cough	Hib/Men C	PPV (pneumococcal vaccine) Pneumonia vaccine. Caused Streptococcus pneumoniae and can lead to pneumonia, blood poisoning, meningitis.	BCG (TB) Vaccine
Pneumococcal vaccine (virus that can lead to pneumonia, blood poisoning, meningitis)	MMR Vaccine (measles, mumps and rubella)	Flu vaccine	Hepatitis B vaccine
MenB (meningococcal group B) vaccine to prevent meningitis and sepsis which can lead to brain damage	Children's flu vaccine	Shingles vaccine	Chickenpox vaccine
Rotavirus vaccine	4-1 preschool booster (for diphtheria, tetanus, whooping cough, polio)		
	HPV Vaccine		
	3 in 1 teenage booster (tetanus, diphtheria and polio)		
	MenACWY vaccine (protects against meningitis). Fresher students going to uni should make sure they have this.		

HOT TOPICS

As per any interview, especially medical school interviews, it is **CRUCIAL** to be well-informed of issues currently faced by the NHS and the relevant steps taken to face them. In this segment, we will list and try to break down as many topics as feasibly possible, while also leaving the relevant links if you would like to read further in-depth. Being aware of the stances taken by the NHS will also help shape your understanding of the profession, and demonstrate your readiness / preparation for this interview, showing that you deserve the spot in the medical school.

Vaccinations and the NHS

What is a vaccination? Well it is simply giving small amounts of a weakened or dead form of a pathogen.
When a vaccine is given, the immune system will recognize the antigens on the pathogens, and will fight them. This triggers a range of responses, such as the production of antibodies (active immunity). However, in new vaccines, the blueprint is there for the body to make the antigens, itself. This immune response means that if a person is exposed to the same pathogen again, the body will recognise the antigens and fight the infection before symptoms occur (passive immunity).
You may then be wondering why are vaccinations used? Well there are 2 reasons.

1. Herd Immunity. If you have been keeping up with recent developments such as the COVID-19 Vaccine, if there are enough people vaccinated and are given immunity to such diseases, those who cannot be vaccinated are then kept safe.

(**ADDITIONAL NOTE:** Some individuals cannot be vaccinated due to the risks they face. For example the elderly may have immunocompromised systems, and the toll the disease they face in terms of impact will be significant, potentially risking death. For the young such as babies, they cannot be vaccinated as their immune system is not strong enough to fight off even a weakened or dead form of a pathogen.)

2. Mass Protection. Similar to herd immunity, when the masses are protected, less people fall sick, hence putting a lower strain on healthcare resources such as hospital beds, healthcare professionals.

(**ADDITIONAL NOTE:** To best demonstrate the significant strain on healthcare resources due to diseases such as COVID-19, look no further than India during the second wave of COVID-19 infections. The link will be affixed below, but there was a significant shortage of oxygen canisters and hospital beds, leading to high numbers of death and even higher infection numbers.)
https://www.straitstimes.com/asia/south-asia/shortage-of-hospital-beds-and-oxygen-as-india-battles-second-wave

3. A way to return to norms as soon as possible. No economy in this globalised world is able to survive for long without the economy being open to trade, and the vaccinations grant protection and a ticket for the economy to slowly return to normal as soon as possible. Look no further than the reopening of borders for countries such as Singapore, Korea, USA and even the UK.

The NHS offers a schedule of free vaccines in the UK. The majority of the vaccines on the routine schedule are the 13 childhood vaccines.
Here's what you should know about vaccinations:

- Uptake of all 13 vaccines fell between 2018 and 2019.
- Some conditions (e.g. mumps and rubella) require children to be given multiple vaccine doses over time.

- Vaccines are also offered in schools. The HPV vaccine is offered to 12 and 13-year-olds to protect against some cancers that are commonly caused by high-risk types of HPV, such as cervical cancer.
- Most vaccines provide long-term immunity. However, the flu vaccine only provides immunity for a short amount of time as the virus mutates each year. This means the strains in last year's vaccines may not circulate in next year's vaccines.
- Those 65 and older can receive flu vaccines on the NHS, whilst primary school children can receive the vaccine in the form of a nasal spray.

(**NOTE:** Useful statistics that can be used to supplement the challenges mentioned below)
With that, let us explore the challenges faced regarding Vaccinations.

Anti-Vaccination Groups

Anti-vaccination groups claim that vaccines are unnatural and toxic, with an emphasis on the alleged risks of vaccines.
Anti-vaccination social media pages have had an increase of 7.7 million followers from the UK and US during the COVID-19 pandemic. An investigation revealed that hundreds of NHS staff were members of an anti-vaxxer Facebook group that compared the COVID-19 vaccination to poison and are opposed to wearing masks.
It's become such a big issue that Labour proposed a new law to tackle the spread of fake anti-vaccination news during the pandemic.
Why is this such a big issue? Let us delve into some of the impacts.

1. Anti-vaccination groups are often large in numbers, and are often aggressive or overly outspoken about their beliefs. They take to platforms such as Facebook, Instagram to spread their beliefs, linking group chat messages to their family and friends. Not only does this spread the wrong message about the science behind vaccinations, it can cause more people to lose faith in the vaccine and choose not to take it, weakening the herd immunity goal and communal protection in the short-long term.
2. Additionally, anti-vaxxers tend to spread misleading information on the vaccines and alternative methods to deal with the diseases faced. One such prevalent example would be in the US, where ex-president Trump told the masses that injection of bleach could help with the dealing of the COVID-19 disease as an alternative to the vaccines. While thankfully there were no heavy casualties, such misleading information could be seriously damaging to the population if not prevented, and could lead to even more issues for the healthcare profession who have their hands full from COVID-19.
3. In the extremely long term, if the anti-vaxxers were able to spread their message, this could cause future generations to no longer want to take future vaccines or forget the importance of such vaccines. This would leave us vulnerable to new diseases that can impact us in the very long run, and could pose a significant threat.

Wakefield and the MMR Scandal

In 1998, a controversial paper linking the MMR vaccine to autism was published in the Lancet, authored by Andrew Wakefield and 12 others. The paper proposed a new syndrome called autistic enterocolitis that raised the possible link between a novel bowel disease, autism and the MMR vaccine.
The paper got widespread publicity despite the fact that the sample size was small, it couldn't be replicated and the design was uncontrolled. It later emerged that the team behind the paper had engaged in ethical misconduct.
What was the impact of this paper?

- The claims have been proven to be false, but the drop in the MMR vaccine uptake has continued.
- Childhood vaccinations began to fall in 1998, coinciding with the publication of Wakefield's paper. They continued to fall until 2003/4, reaching a low of 79.9%.

(**NOTE:** Not sure how relevant this is to the argument, can be a supplement topic)

Why are Vaccination Numbers falling slowly but gradually?

There are a few reasons but we will highlight 2.

1. The rise of fake news / misleading information presented in the media. With more people influenced by the fake news regarding vaccines and the media not always presenting the "most accurate" news, this causes faith to be lost in the vaccine and its uses.
2. Timing and availability of the vaccines. Vaccines take time to develop, and since vaccines are not a 100% guarantee of not catching the disease (i.e COVID-19 vaccines), people either can't or do not take the vaccines for reasons already mentioned. Hence this would cause vaccine numbers to fall.

How does the NHS plan to tackle this problem?

The NHS Long Term Plan includes various measures that will be used to increase the uptake of both MMR doses. This includes improving local coordination and support to improve immunisation conversation in low uptake areas. They're also adding an MMR check for children aged 10 and 11 with GPs, and trying to 'catch up' young adults who missed the MMR vaccinations as children.

Potential Interview Questions

Questions like these tend to be rooted in medical ethics (see Section "The Four Pillars of Medical Ethics"), hence it will be good to read up on that and also stay up-to-date to the goings of the NHS as to be relevant in the answers.
Some questions can include:

- Should vaccinations be mandatory for all?
- How would you combat vaccine hesitancy
- How would you convince a vulnerable patient to get vaccinated ?
- Discuss the pros and cons of vaccinations, and the potential implications on the world if vaccinations are not taken.
- Should the NHS be doing more to counter anti-vaxxers? If so, what steps should be taken?
- Potential roleplay: Explaining the vaccine and counteracting questions posed by the actor

Euthanasia and Assisted Dying

Euthanasia, sometimes known as 'mercy killing', refers to ending a patient's life who is suffering from an incurable and/or painful disease, or who is in an irreversible coma.
Two types of euthanasia you need to know about include:

- Active euthanasia: when the acting person deliberately intervenes to end someone's life. For example – a Doctor who injects a patient with terminal cancer an overdose of muscle relaxants to end their life would be considered to have carried out euthanasia.

- Passive euthanasia: where a person causes death by withholding or withdrawing treatment that is necessary to maintain life. For example – withholding antibiotics from someone who has bacterial pneumonia.

We can also categorise euthanasia as:

- Voluntary euthanasia: where euthanasia is carried out at the request of the person who dies.
- Involuntary euthanasia: when the patient who dies wants to live but is killed anyway (normally called manslaughter or murder).

You also need to understand two more terms: assisted suicide and assisted dying.

- Assisted suicide: the only difference between this and euthanasia is the person who actually performs the final act. In assisted suicide, the physician intentionally gives the patients the means to take the lethal medication themselves. For active euthanasia, the physician is the one who commits the act that directly causes death i.e. by injecting lethal drugs.
- Assisted dying: This is a sub-term of assisted suicide but is only used in the context of when a patient who is already dying, i.e. terminally ill, asks for help to die. Assisted dying is not usually used in the context of bringing about the deaths of patients who are not already dying (for example, paralysed patients or those who have found out that they have developed a condition in the future i.e. Huntington's Disease).

Euthanasia in the UK

Both euthanasia and assisted suicide are illegal in the UK, with euthanasia punishable by life imprisonment, and assisted suicide illegal under the 1961 Suicide Act and punishable by up to 14 years in prison.

It's important to understand the difference between passive euthanasia and withdrawing treatment in a person's best interests. Passive euthanasia is illegal in the UK.

However, the NHS states that withdrawing life-sustaining care when in a patient's best interests can form part of good palliative care (and should not be confused with 'passive euthanasia').

In situations where doctors need to withdraw treatment from an individual where the said action of withdrawal can lead to the death of the patient, **unless there has been an ADRT issued / LPA appointed, the decision to withdraw treatment rests entirely with the doctors**. **The relatives or NOK do not have the right to make these decisions**, although it is best practice for the doctor to consult them over treatment decisions.

Timeline of Euthanasia discussions / challenges:

- **2015**. A bill was brought forward that aimed to let terminally ill patients in the last six months of their lives be prescribed medication to administer themselves, that would end their lives. Their mental health would have had to be verified by two Doctors, one of which is independent. The House of Commons rejected the bill by 330 to 118.
- **2018**. The UK Supreme Court ruled that legal permission is no longer needed to withdraw treatment from patients in a permanent vegetative state. The British Medical Association (BMA) and Royal College of Physicians (RCP) subsequently published guidance for healthcare professionals on when they are allowed to withdraw care.
- **May 2019**. Paul Lamb, who lives with chronic pain following a car crash, renewed a bid for the right to die after losing a Supreme Court case in 2014. Since this time, three other bills were introduced to Parliament with the hope of legalising assisted suicide. All three failed and, importantly, were regarding patients with terminal illness expected to die within six months. Mr Lamb's

case, however, is different in that he is not terminally ill and could live for many years.

- **September 2019**. 80-year-old Mavis Eccleston was cleared of murder and manslaughter after getting her husband the prescription medication he needed to overdose. Mr Eccleston was a cancer patient, and his wife Mavis was respecting his wishes, according to daughter Joy. Not wanting to live without her husband, Mavis also took an overdose and recovered in hospital after being found unconscious.
- **November 2019**. 49-year-old Paul Newby lost his High Court case that was challenging assisted dying. Mr Newby proposed that Judges should thoroughly examine a large amount of evidence before deciding if assisted dying is incompatible with his human rights.
- **August 2020**. Relatives of people who have previously brought legal cases for assisted dying have come together to make a joint inquiry into the current law. The new MP chairing the all-party parliamentary group on assisted dying says that there is increasing support in parliament for a 'tight' change in the law, to give terminally ill people more choice over how and when their lives end.
- **September 2021**. Members of the British Medical Association (BMA) voted to adopt a neutral stance on assisted dying, with 49% in favour, 48% opposed and 3% abstaining. Before this, the BMA had opposed assisting dying, so the new stance could potentially pave the way towards a future change in the law.

The Legal Position (UK)

In the UK, both euthanasia and assisted suicide are illegal. Relatives or carers who support such acts, even if indirectly, are routinely taken to court and often convicted of manslaughter and occasionally murder.
Even travel arrangements on behalf of a sick relative can be considered for prosecution. There are some clinics in Switzerland who offer such services and just providing the arrangements to travel there can prosecute you. While conflicting, the main argument is that just by booking such arrangements, it is effectively assisting suicide which is illegal.
HOWEVER, in real life / practice, investigations rarely lead to a conviction, especially if it is proven that the patient travelled there of their own free will and the relatives did not play an active role in supporting such arrangements.

Arguments FOR & AGAINST Euthanasia

Just like any situation there is always a pros & cons situation that should be heavily weighed and considered. This is a morally complex and extremely difficult scenario, and equal weight should be given before a decision is made. In this table, we break down the pros & cons of the situation.

Pros	Cons
No matter how excellent our palliative care services may be, there will always be some patients for whom their illness causes intolerable suffering. To help those patients end their lives would be the compassionate thing to do to end their suffering.	Many argue that the legislation would "turn Doctors into executioners". This is at odds with the principle of non-maleficence which means do no harm. However, this principle could also be used to argue for the other side – that Doctors are causing more harm by prolonging suffering.

The current law, as it stands, means that patients who want to end their lives have to travel abroad to end their life. In 2018, 43 people from the UK died at Dignitas and Life Circle (two facilities in Switzerland). It's not how they would have chosen to die if the law allowed – usually at home surrounded by loved ones.	Many are concerned that if the law on assisted dying is changed now, this paves the way for the law to change to apply to more people. For example, Belgium now has a law that legalises euthanasia for children.
Autonomy is one of the four pillars of medical ethics. This means allowing patients to decide for themselves when to end their lives at a point where medical treatment is no longer able to prolong life and is not providing adequate symptom control.	Another concern is that the legislation could be used to justify assisted dying in vulnerable groups, such as those with disabilities and mental illnesses. The legislation sends out a message that, where a life falls short of certain conditions, it is not worth preserving.
Evidence shows that the public increasingly supports assisted dying. Governments ought to represent the wishes of their people in a democracy. In March 2019, the Royal College of Physicians has now adopted a neutral stance on the topic of assisted dying. This was following a poll of around 7,000 of its members.	The legislation debated does not deal with the issue of those with terminal illnesses who are unable to take their own lives. It would not help those with illnesses such as locked-in syndrome or motor neurone disease.
In our liberal society, we allow people to make their own decisions about their health and lifestyles, as long as they do not harm other people. Choosing to end your life would not cause direct harm to others. It is, therefore, your right to do as you wish – you are the best judge of what's best for you.	As a direct counterpoint to the point on the left, harm in the physical sense may not be done but emotional damage can be, and usually have extremely long periods of time where the individual is affected. Hence, it would technically still be considered harm, just not in the physical sense that is implied.
A change in the law would also provide comfort to the dying from knowing that the option is there, even if they choose not to take it.	Although autonomy is a pillar of medical ethics, patients still do not have a right to demand treatment and Doctors can refuse treatments they believe not to be in the patient's best interests. The drugs prescribed to end life could be seen as a 'treatment' like any other.
When assisted dying is illegal, there will be people who end their lives alone, who may not be able to carry out the ending of their life properly, leading to increased suffering. Legalising assisted dying will prevent these horrible deaths, similar to how legalising abortion prevented the deaths from botched backstreet abortions (despite many people still objecting to abortion on moral or religious grounds).	Although public support for assisted dying is growing, governments are generally in a better position than individuals to understand and foresee the effects of individual actions or a change in the law on society.

The mores of society are constantly changing, and this legislation would reflect changing attitudes. There are no moral absolutes anymore. Even the prohibition on killing has exceptions, for example during war it is permissible to kill. Anyone who objects to assisted dying need not ask for help to die themselves – however, it cannot be used to justify removing the chance to help those who do not share those beliefs.	The legislation also assumes that Doctors are at all times benevolent. If the patient asks for help to die and helping the patient would be the easier route for the Doctor, theoretically, this could lead to an increase in deaths that otherwise would not have occurred. These decisions are irreversible.
Some Doctors argue that the legislation would provide a clearer legal framework for end of life care. There is a concern that current decisions about end-of-life care can hinge on the doctrine of double effect, whereby it is legal to give a patient treatment that may shorten their life if the doctor's main goal is to relieve their pain.	Another significant concern is that vulnerable people may feel pressure to spare their carers the burden of looking after them or, worse, might be bullied into choosing death. There could never be sufficient safeguards to ensure that a patient is not being softly pressurised – either by their own families or by societal expectations.
There is a similar law in the U.S state of Oregon called the 'Death with Dignity' Act. The Oregon Hospice Association was initially opposed to the legislation. However, it withdrew its opposition after eight years conceding that there was "no evidence that assisted dying has undermined Oregon's end of life care or harmed the interests of vulnerable people". The numbers of people dying there have not increased – lending weight to the argument that the legislation wouldn't bring about the deaths of more people, it would lead to more people having a good death.	It could be argued that the potential negative consequences of this legislation – the premature ending of lives – outweigh the small number of people this would benefit.

Potential Interview Questions

Similarly to Vaccinations, this is a difficult topic to tackle, but given the sensitive nature of this question, it could be even more complex to argue a stance on this. However, just like most interview questions, you are judged on your ability to present a coherent, unbiased and balanced argument whenever possible. Hence, it is advised to avoid taking a stand if possible, and instead provide a neutral approach.
This topic also heavily involves the Ethical Pillar of "Autonomy" and hence reading up on that segment would be helpful to develop further understanding regarding this topic. (See segment "The Four Pillars of Medical Ethics")
Some interview questions include:

- Does euthanasia have a place in today's Medicine?
- What are the implications of euthanasia on the individuals involved in the care for the patient and the patient themself?
- What are your views on the current stance of euthanasia?
- Do you agree with "said impact of Euthanasia"? Why or why not?
- Potential Roleplay scenario: Comforting a patient's family after euthanasia / the decision for euthanasia (aka breaking bad news to them)

Artificial Intelligence (AI) in Medicine

Artificial Intelligence (AI) is “the ability of a computer or other machine to perform actions thought to require intelligence.”
AI is therefore an umbrella term for a computer being able to make decisions. The way in which ‘it’ does this, how it gathers data, interprets and produces an output, is brought about in different ways.
Many systems we use today use technology supported by AI infrastructures, which often go unnoticed.

Current uses of AI in Medicine

AI is already in the midst of testing, if not already implemented in certain aspects of our healthcare system, both in the UK and in the world. While there are quite numerous uses, we will break down a few important uses.

Medical Diagnosis

AI systems are being designed to accurately diagnose disease from medical imaging scans and microscope slides.
Examples:

- Cancers and other diseases can be detected at earlier stages, offering better long-term outcomes.
- AI is also being used to assist in screening processes. This includes IVF, to determine how likely a fertilised embryo is to result in a successful pregnancy.

In Radiotherapy

Radiotherapy normally uses generic dose prescriptions that don’t consider the characteristics of individual tumours. However, an AI framework has been developed to use a patient’s CT scans and electronic health records to create a specific individualised dose.

For Virtual Nursing

Virtual nurses are robots designed to monitor health.
Examples:

- Wearable devices, offering advice and guidance to patients in their own homes, as well as reminding people to take their medications on time.
- There is a wearable device, called Current, which measures a patient’s pulse, temperature, respiration and oxygen saturation, giving doctors regular updates on their patient’s health, and can be used both in hospitals and at home.
- Researchers have also developed a way of incorporating AI into smartwatches to detect hypertrophic cardiomyopathy, which is often not picked up.

Virtual nursing could be implemented in line with the NHS 111 service, however, it’s worth considering the general public opinion on talking to a robot – would the benefits of having no waiting time sway people’s view? We will further discuss this below.

Robotic Surgery

Robots have been developed, which are able to carry out routine operations. Recent research has shown that these surgeries can have up to a five-fold reduction in surgical

complications. This, partnered with the decrease in staff required and time saved, could be a promising investment for the future.
Example:

- Many NHS hospitals now use robotic technology to help with certain operations, including knee and hip replacements and prostate cancer surgery.

Rf Information Services

The Department of Health announced a partnership between the NHS and Amazon's Alexa, so that Alexa now automatically searches NHS websites when asked medical questions. By integrating the NHS website content directly into Alexa's core knowledge base, it is able to reach a far wider user base as users do not need to enable this skill in advance.
The government is hoping this will reduce demand on Doctors and will benefit elderly people, blind people and people that cannot easily search for health advice on the internet. Some people are concerned about how any confidential data relating to patient queries will be stored but Amazon has confirmed all data will be kept confidential and encrypted.

Goals for AI Usage

Earlier Diagnosis

A great deal of diagnosis is about recognising patterns. For example, radiologists will look at x-ray images to spot potential disease. However, if we spot subtle patterns earlier, perhaps the disease could be diagnosed at an earlier stage.
This is where AI comes in – computers can be programmed to read data. Using algorithms, very subtle changes can be detected, either as the precursor of a disease or before it has propagated.

Data Collection

Currently, the NHS is still very reliant on paper files and most of its IT systems are not based on open standards; limiting the exchange of data and information across the NHS.
If the NHS wants to use accurate AI algorithms there needs to be an improvement in how data is collected and stored and in the quality of the data, as these algorithms are reliant on the data they are fed.

World Leader

The government aims to make the NHS a world-leader in healthcare innovation and recognises the importance of AI. Whilst there are significant costs of developing these systems, there are often projected savings in the long run. When we consider the current state of the NHS and the problems it faces, it seems that AI systems have come at the perfect time.

Pros and Cons of AI in Medicine

Let us break down the pros and cons for AI usage in Medicine. While not exhaustive by any extent, it provides a decent breakdown of the reasons stated and allows us to form a better argument **FOR** or **AGAINST** the use of AI.

Pros	Cons

AI could support the delivery of the NHS's Five-Year Forward View, by making the transition more smooth and reducing any potential disruptions.	AI could make things more complicated given the skills and training required to handle and/or operate such complex machinery or infrastructure.
AI could help address the health and wellbeing gap by predicting which individuals or groups of individuals are at risk of illness and allow the NHS to target treatment more effectively towards them via the means of early intervention.	AI prediction may not always be accurate and if falsely predicted, could lead to inefficient delegation of resources and deprive resources that should be delegated to more pressing concerns.
AI can reduce work inefficiency by boosting work productivity and allow for information to be transmitted and shared on a wider scale, across hospitals to the shared NHS system if created.	By having a shared NHS system potentially, it could put the entire country at risk if server attacks occur, severely compromising the data of the citizens since everyone's data is kept there. (**NOTE:** See Singapore's Singhealth incident where data of individuals such as the Prime Minister was taken as well. https://graphics.straitstimes.com/STI/STIMEDIA/Interactives/2018/07/sg-cyber-breach/index.html)
AI lowers the chances of human error such as shaky hands, miscalculations	AI can do so but only with regular maintenance and repair, and if there are insufficient resources, it may not be able to perform at the best of its abilities.

and allows for precise and steady action to be undertaken for the patients.	
AI also provides us the ability to reduce the demand for manpower as professionals are able to access the relevant information faster, and can take over certain actions for us, letting doctors focus on the more important aspects such as seeing patients.	While it could reduce the manpower in our healthcare industry, it could drive up demand for manpower in others and cause us to be increasingly reliant on such industries. If an issue occurs, it could take a long time before it is resolved since we will not be skilled enough to resolve it.
AI is also able to provide real-time updates and information readily for those who need it, reducing the potential cases that are faced by doctors through machine learning.	AI of such nature requires extensive time to be implemented and machine learning could be misleading at times since the AI could draw different conclusions.
AI would also potentially be more meticulous and pick up anything we might have overlooked due to reasons.	If the AI is not developed accurately, it could still miss out on data that we would have missed as well.

AI would be beneficial for us to examine very large data sets and draw conclusions which could serve as foundations for future improvements to be made.	AI may seem infallible but if the code is poorly written, there could be issues when computing such data. Some data may also be way too big to be computed.
AI can save costs in the long run, through reduced need for manual manpower to carry out menial tasks such as filing of paperwork.	AI would be extremely costly in the short run to implement, and could take a lot of money as well to develop and maintain.

Similar to many topics here, we still need more time to consolidate the pros and cons to this argument, and realistically there may not be a perfect answer to this topic. Again, a balanced argument weighing both sides would help significantly during the interview, so remain calm and stay neutral, giving equal weight to both sides of the argument.

HIV and PrEP

PrEP (pre-exposure prophylaxis) is a drug taken by HIV-negative people before sexual contact, usually with an HIV-positive person.
PrEP is not needed if an HIV-negative person has sexual contact with an HIV-positive partner, providing they are taking HIV medication and have an undetectable viral load. If viral load is undetectable, HIV cannot be transmitted.

- 'Pre' – means taken before the 'exposure', which is HIV in this case.
- 'Prophylaxis' – something that is done to help prevent a disease, which in this case is taking a tablet.

PrEP tablets contain tenofovir and emtricitabine which are medications commonly used to treat HIV. HIV can be transmitted through sexual, as well as bloodborne contact.

How Is PrEP taken?

PrEP can be taken in two ways:

- Regularly: one tablet per day.
- On-demand or 'event-based dosing': two tablets are taken 2 to 24 hours before sex, followed by one tablet 24 hours after sex and another tablet 48 hours after sex.

How Effective Is PrEP?

When taken correctly and daily, PrEP is more than 99% effective at stopping HIV infection. This reduces to 96% for those who take four tablets a week, and 76% for those who take two tablets a week.
Criteria vary between countries, but generally, PrEP should be taken by an HIV-negative person who has an HIV-positive partner with a detectable viral load and sex without a condom is anticipated.

Is PrEP Widely Available?

Sexual health clinics in Scotland and Wales provide anyone at risk of HIV with free PrEP.
In England, PrEP was initially made available to 10,000 people as part of the two-year IMPACT trial. This trial ended in July 2020, and the drug was officially rolled out to England later that year.
There is also currently a PrEP trial in Northern Ireland.

Advantages VS Disadvantages of PrEP

Pros	Cons
PrEP is effective at helping HIV-negative people to maintain their HIV-negative status, especially those who have an HIV-positive partner or have multiple partners whose HIV status is unknown.	PrEP can have serious side effects on kidney function and bone health, making it unsuitable for some people who have existing bone or kidney conditions.
PrEP has no side effects for the vast majority of people.	Regular testing is required for those on PrEP (HIV status and kidney function tests).
PrEP is freely available in Scotland and Wales, and England followed suit in late 2020.	Real-world adherence is not perfect, therefore in reality, PrEP will not be as effective as the theoretical numbers at protecting against HIV infection.
PrEP allows people to have sex without using condoms without the risk of getting infected with HIV when one person is HIV-positive.	There are concerns that PrEP may deprive HIV-positive people of the drugs that they need due to competition for the drugs which are also treatments for HIV-positive people.
	PrEP may lead to a greater rate of other sexually transmitted infections (STIs) due to misconceptions that it protects against STIs as well as HIV.
	PrEP may promote drug-resistant HIV if people take PrEP without knowing they are HIV-positive or become HIV-positive when they are on a break from taking PrEP.

Potential Interview Questions

It is quite important to stay up to date regarding this issue as an aspiring medic, as sexual health and ways to remain protected are still fairly limited. It is relevant within the UK and has relevance towards HIV-positive partners.
Some questions could be:

- Is PrEP the best way to tackle the spread of HIV?
- Should PrEP be readily available for free? Would charging a small price be more beneficial towards society?
- What improvements would you make towards the campaign for increased awareness regarding sexual health? Should PrEP be more readily distributed?

Brexit and the NHS

By now, everyone should know that Brexit has occurred due to no deal being presented, and while it may have lasting implications on the economy, society and much more, we will be taking this time to focus on the implications it has on the NHS.
A good Read-Me to the impacts on the NHS by Brexit summed up by the BMA:
https://www.bma.org.uk/what-we-do/working-with-europe/brexit/bma-and-brexit
A little background, the UK officially left the EU on 31st Jan 2020, and finished the transition period by 31st Dec 2020.
Now let us explore the potential impacts of Brexit on the NHS.

Extra £350m for the NHS

If there is one move on the Leave campaign's side that could be said to have swayed the public's opinion, it was the incorrect claim that leaving the EU would free up £350m per week to be spent on the NHS. The cross-party campaign couldn't dictate how any funds were to be spent, nor had they quoted an accurate figure.
In 2018, the government promised a £20 billion increase to the NHS budget per year for the next five years, starting in 2019/20. They said it would be partly paid for through the 'Brexit dividend' but there is no guaranteed extra money from leaving the EU, as it is expected that costs associated with leaving will outweigh those that are being saved.
Health experts have said this money will 'help stem further decline in the health service, but it's simply not enough to address the fundamental challenges facing the NHS, or fund essential improvements to services that are flagging.'
The implication of this is yet to fully unfold, but what has transpired is that the money promised was incorrect and would not be allocated to the NHS as such. The 20 billion would not be enough to address the issues as mentioned, hence the services offered by the NHS may decline in quality after all.

Staffing Crisis

Figures from the Nursing and Midwifery Council (NMC) show almost 5,000 nurses and midwives from EU countries have left the NHS from 2017 – 2019, with many identifying Brexit as the reason. However, there has been an increase in the number of nurses and midwives coming from countries outside of the EU to work in the UK.
In 2017, it was recorded that NHS England faced a shortage of over 40,000 nurses, putting a large strain on the existing workforce. The number of European workers in the NHS is expected to fall further due to the following:

- harsher immigration laws will be implemented
- the value of sterling and UK salaries will decrease

- the recent ‘seven-day NHS’ initiative deters EU staff from signing up for longer hours

In October 2021, it was reported that up to one in five nursing vacancies on some wards remain unfilled. The staffing crisis has been made worse by a drop in recruits from Europe, including Spain and Italy. Furthermore, the number of nurses from the European Economic Area joining the Nursing and Midwifery Council register has fallen more than 90%.
“There just aren’t enough staff to deliver the care that is needed, and we now have a nursing workforce crisis”, said Patricia Marquis, England director for the Royal College of Nursing (RCN). “We should never have gotten into a position where we were so dependent on international nurses. We are on a knife-edge.”
However, applications to study nursing and midwifery were up 21% this year, the Department of Health and Social Care explained. The government has pledged to add 50,000 nurses to the NHS workforce before the end of parliament.
Potential implications can include that with a shortage of staff present, this would lead to even greater disbalance in the work-life ethic of healthcare professionals as more have to cover the gaping holes in manpower, leading to longer shifts and more working days. This could lead to even greater dissatisfaction and strikes (which has already happened and will be covered in the section “Junior Doctor / Nurses Strikes”), causing the whole system to be thrown into chaos. This could also severely limit the ability for the NHS to care effectively for its patients, and if there were to be any more outbreaks of diseases, it could have disastrous consequences.

Stockpiling of Medication

In anticipation of Brexit negotiation deals, the UK built a stockpile of drugs and medical supplies – but these were used up during the coronavirus pandemic. Members of the pharmaceutical industry warned that rebuilding stockpiles could become an issue during the post-transition period, when we saw border disruptions and delays.
In September 2021 the issue of importing medicines after Brexit was still an issue. The Guardian reported that pharmacists had raised concerns about supply issues due to driver shortages, with deliveries to pharmacies being reduced.

Scientific Research Complications

With Brexit occurring, it is harder to secure funding for research projects.
The president of the Royal Society had previously voiced concern that a bad or no-deal Brexit will ‘stop valuable research in its tracks’. One of the reasons for this was that many international scientists may choose to not work in the UK as the visa costs would make it a more expensive place to work than other leading scientific nations.
As negotiations are finalised, the president of the Royal Society stated that it is imperative “the focus must now be on ensuring a fair and effective means to deliver appropriate association to EU science funding programmes, such as Horizon Europe, outlined in the agreement. Any delay in delivering such an association will damage UK science and, in the event of any delay, the Government must take quick action to protect and stabilise the world class asset that is our science base.”
Furthermore, Brexit may deter some UK researchers from joining international projects. The loss of mobility will increase the time and financial cost of moving workers to the EU, and many fear that UK-based scientists will no longer have a significant hand in larger, EU-wide projects such as the regulation of new drugs.
As a member of Euratom, the UK currently has access to a secure and consistent supply of radioisotopes, which are vital in medicine for diagnosis, clinical pathology and treatment. The UK’s decision to leave the EU will risk the UK’s ability to secure timely access to these radioisotopes, as well as funding for nuclear research. It is vital that the UK continues to work with Euratom to maintain the benefits of collaboration in these areas

In short, new drugs may take a longer time to be regulated, affecting new advancements for UK Medicine and also that research into issues such as cancer would be more limited in the long run as there is insufficient funding to carry out such research.
In a potential interview, the interviewers most likely will not expect you to have an in-depth understanding of the complications nor will they ask you to detail out every possible impact on the NHS. However, understanding some of the predicted implications on the NHS would give your answer much depth and support.

Abortion & Recent Changes to the Law

An abortion is defined as the medical process of ending a human pregnancy so it doesn't culminate in the birth of a baby. A pregnancy can be terminated by taking medications or having a surgical procedure.
Under the 1967 Abortion Act, abortion is legal in England, Wales and Scotland up to 24 weeks of the pregnancy in most cases. An abortion may only legally be carried out if two Doctors agree that continuation of the woman's pregnancy will negatively impact her physical or mental health, or that of her existing children.
An abortion is legal after 24 weeks if the woman's life is at risk due to the pregnancy, the child will be born with a severe disability or there is a risk of grave physical and mental injury to the woman – although this is generally safer if carried out earlier in the pregnancy.

Methods of Abortion

There are two methods for an abortion to take place legally.

Surgical Abortion

Surgical abortion involves an operation to remove the pregnancy from the womb. In cases up to 14 weeks of pregnancy, vacuum or suction aspiration can be used. In cases after 14 weeks, dilatation and evacuation can be used. Find out more about these methods on the NHS website.

Medical Abortion

If women choose to end their pregnancy within 10-weeks of gestation and have a medical abortion, they have to take two pills 24 to 48 hours apart.
The first pill is mifepristone, which works to inhibit progesterone (the hormone that maintains pregnancy) and must be taken at a clinic. The second pill is misoprostol, which induces contractions in the womb to pass the pregnancy and can now be taken at home or at a clinic.

Medical Abortions at Home

In August 2018 the government announced that women in England would be allowed to take the second early abortion pill at home. This came into effect on 27th December 2018 and has brought England in line with Scotland and Wales.
Women are still able to choose to take the second pill in the clinic if they want, but this change prevents the risk of women miscarrying on their journey home, which was previously quite a common, painful and traumatic experience.
Legalising use of the second pill, misoprostol, at home has been well received by gynaecologists, with the president of the Royal College of Obstetricians and Gynaecologists (RCOG) describing this as a compassionate measure which symbolises "a major step forward for women's healthcare", as it prevents the distress and embarrassment of pain and bleeding during their journey home from taking their second pill.

However, the Society for the Protection of Unborn Children believes this move "further trivialises abortion", as it pushes women to experience the emotional and physical trauma of a miscarriage without actual medical supervision, which may compromise women's wellbeing. Right To Life has also expressed their concern about the ability to adequately monitor who takes the pills and whether they are taken free from force or coercion.
In March 2020, The UK's Department of Health and Social care confirmed that it would allow women in England to temporarily manage medical abortions at home in light of the lockdown imposed due to the COVID-19 pandemic. Under the new policy, women in England were able to take both medications necessary for medical abortion at home during the first 10 weeks of pregnancy following a telephone or electronic medical consultation rather than having to take the first dose at a health facility.
This interesting development does raise a few issues, such as whether a telephone or electronic consultation is considered enough care for the patient as it lacks the "personal" or "human" feel that revolves around our profession. Another consideration would be is there enough being done for the consultation as a telephone consultation would mean that the doctors are unable to diagnose as accurately or look after the patient enough, and via the electronic consultation would the doctor be able to determine accurately how the patient is doing?

The Legal Debate

There is significant legal debate surrounding abortion, which centres around the date at which point abortion is allowed.
This debate centres around beliefs about when the foetus becomes a living organism, and thus when abortion becomes murder. Some people believe that abortion at any point in the pregnancy is murder. At the other end of the spectrum, others argue that abortion is acceptable at any point during the pregnancy as, until the child is born, they do not consider it to be alive.

Northern Ireland and Abortion Rights

Until October 2019, abortion was illegal in Northern Ireland and tantamount to murder unless the woman's life was at risk or if continuing with the pregnancy would cause serious physical or mental health effects to the woman.Rape, incest and fatal foetal abnormalities were not grounds for legal abortion in Northern Ireland.
In 2017, the UK government allowed Northern Irish women to access NHS-funded abortions in Great Britain, when previously women had to pay for the procedure themselves.
In May 2018, the Republic of Ireland voted overwhelmingly to overturn their abortion ban in an abortion referendum. The Northern Ireland Human Rights Commission brought an appeal to the Supreme Court in early 2018 over the legality of the abortion law in Northern Ireland, but it was rejected.
In May 2018, Northern Ireland voted in a referendum to make abortion legal with 66.4% of voters voting to amend the constitution so that abortion could be legalised. In October 2019, abortion was decriminalised and became lawful in Northern Ireland.
The new framework for lawful abortion services – The Abortion Regulations 2020 – came into effect on 31 March 2020. Under the new regulations, termination of pregnancy will be allowed:

- unconditionally prior to 12 weeks
- up to 24 weeks when continuing the pregnancy would risk mental or physical injury to the woman or girl that is greater than the risk of terminating the pregnancy
- after 24 weeks when there is substantial impairment to the foetus, including when death is likely before, during or shortly after birth.

Termination must only be carried out by registered medical professionals, however, those using abortion pills purchased online will not be prosecuted and health professionals are no longer under any duty to report their patients' use of abortion pills.

Ethics: Pro-life or Pro-choice?

There are a range of reasons as to why pro-life or pro-choice. We have placed it in a table for easier comparison.

Pro-life (Oppose Abortion)	Pro-choice (Support Abortion)
Human life begins at the point of conception. Therefore, abortion is tantamount to murder as it is the destruction of a human life.	Almost all abortions are carried out in the first three months of the pregnancy, at which time the foetus cannot exist independently outside of the mother's womb. Therefore it cannot be regarded as a living organism, and thus abortion is, arguably, not murder.
Instead of carrying out an abortion and taking an innocent human life, when born, the child can be adopted if the parents are not able to cope with looking after the child.	Fertilised eggs which are used for in vitro fertilisation (IVF) are often thrown away or destroyed if not implanted and some would argue that these fertilised eggs are human lives but destroying them is not considered as murder.
Some woman may be pregnant as a result of rape or incest. The unborn child is innocent and should not be punished for this crime through an abortion.	In the case of rape or incest, forcing a woman to keep the child is likely to be more psychologically damaging to her than having an abortion.
An abortion often leads to a great deal of psychological distress and stress for the woman.	Keeping abortion legal will prevent deaths and complications from unsafe backstreet abortions that are carried out in secrecy
All children have great potential and a woman could possibly decide to abort a fetus that may have been extremely important to society or to the world.	An abortion may be necessary to save the woman's life in certain cases and thus this option should be taken where necessary, rather than risking the mother's life.

Ultimately, when it comes down to it, abortion is definitely a highly sensitive topic and there are many medical ethics involved. Just like many of the hot topics, a neutral and balanced stance is recommended and it would show the maturity in thinking and understanding of the dilemmas still faced by even the most experienced healthcare professionals.

Potential Interview Questions

As mentioned, given that there are many medical ethics involved in this topic, such as autonomy, beneficence and non-maleficence, it will likely come out as an interview topic. Remember that you should not take a strong be-all-end-all stance on this question, but again show understanding of the topic.
Some potential interview questions could be:

- What are your opinions on abortion in today's medicine? Does it still have a place today?
- What are the implications of abortion on the mother, and any other individuals involved in the situation?

- Do you think all doctors should support abortion due to “autonomy” or all doctors should not support abortion in line with “non-maleficence”? (Unlikely to be asked, but good food for thought!)
- Do you agree with abortion?
- Why is it so important to be empathetic towards patients considering abortion?
- What impact does abortion have on the 4 pillars of Medical Ethics?

Junior Doctor Contract

The Junior Doctor Contract is the contract of employment for all NHS Junior Doctors, outlining pay scales and other details. The government tried to update the contract for 2016, with changes including:

- Overhauling the system of pay and hours for Junior Doctors
- Protecting Junior Doctors from any unfair consequences that could come from whistleblowing
- Designating a member of staff for each hospital to ensure that Junior Doctors are working rotas that are manageable and safe for patients

In January 2020, the BMA accepted the amended JD contract and more can be read below. (Link: you can read more about this on the BMA website.)

Proposed Pay Changes

It increased basic salary but drastically reduced the supplements for on-call shifts outside of sociable hours – effectively meaning they were being paid less.
Across the new proposed changes, the BMA has collated the updates from the old contract and contrasted against the new one.
(**LINK:** https://www.bma.org.uk/media/2000/bma-junior-doctor-contract-comparison-jan2020.pdf)

Junior Doctor Strike (more info will come hopefully)

There is a ballot for a JD strike on early 2023… so this is just a summary on what you NEED to know about it

Strike action

12th January 2016 – first general strike across the NHS, first such industrial action in 40 years. Emergency care was still provided
10th February 2016 – 2nd strike or routine care, but continue to provide emergency care
26th April 2016 – first strike where junior doctors withdrew both routine and emergency cover
It is important to note that there was no significant effect on the number of recorded deaths during the strike periods. However, nearly 300,000 outpatient appointments were cancelled.

Agreed new contract deal for Junior Doctors in England – 2019 Improvements:

1. £10 million investment in rest areas – BMA fatigue and facilities charter inspires investment in English hospitals
2. Pledge to improve record-sharing – NHS commits to end the administrative burden for juniors starting new rotations
3. Enhanced shared parental leave

4. Whistleblowing protection – new legally binding protections secured for junior doctors raising concerns at work
5. Supporting LTFT locum work – confirmation that LTFT trainees would face no regulatory barriers to pursuing locum work.

The Facts

- Doctors were promised a 2% pay rise per year from 2019-2023
- However with inflation over the years, the 2% increase is simply not enough for JDs, infact, inflation has caused it to become a 30% pay cut despite the 2% increase
- This has caused junior doctors to feel undervalued and increased burnout within JDs
- The government has also repeatedly ignored the cries for pay restoration
- Junior doctors were also omitted from the 4.5% pay uplift due to the 2% annual rise
- 83% of JDs said the 2% increase is unacceptable and 72% said that they will take industrial action if needed
- JDs have protested on July 25th 2022 in London about their concerns and how they are ready to take action if they keep on being ignored and undervalued.

Potential interview questions:

- Is it ethical to go on strike?
- What can you tell me about the reasons for the current junior doctor strike?
- What are the impacts of JDs or healthcare professionals going on strike on the population?
- Could you explain your views on JDs striking and what the NHS should consider in response to this issue?

Sources:
https://www.bma.org.uk/bma-media-centre/junior-doctors-to-ballot-in-early-january-for-industrial-action
https://www.bmj.com/content/378/bmj.o1891

Wellbeing of NHS healthcare workers

1 in 4 adults and 1 in 10 children experience a mental health illness in any year. The rate of suicide is rising, particularly in young men with men being three times more likely to take their own life. Mental health services are struggling due to understaffing, lack of funding and resources.
To tackle the mental health crisis the government pledged £1.25 billion for a new national mental health programme before 2020/21. The Chancellor also highlighted an additional investment of £250 million in new crisis services including 24/7 support via NHS 111 and more mental health specialist ambulances. There were also aims to prioritise services for children and young people such as mental health support teams based in schools and specialist crisis teams for young people.
This is an important issue as within any field in medicine you will deal with patients that have mental health issues so you need to be well-educated to be able to identify these patients and the services you can direct them to. You could potentially be asked how you would tackle the current mental health crisis, try to mention increasing investment and staff numbers as well as educating doctors and nurses in all specialties.

The Facts:

- Increased dropout rates for nurses and midwives (27000 dropped out last year), with the main reason being poor mental health from job pressure and culture
- Moreover, a survey conducted by Nuffield trust has shown increased stress levels, lower enthusiasm rates and more people thinking of dropping out compared to previous years
-

https://www.nuffieldtrust.org.uk/news-item/fronting-up-to-the-problems-what-can-be-done-to-improve-the-wellbeing-of-nhs-staff
https://www.theguardian.com/society/2022/may/18/numbers-of-nurses-and-midwives-leaving-nhs-highest-for-four-years

Potential Interview questions:

- What do you think are the problems in the NHS?
- How would you cope with the stress of working as a doctor?
- What do you think will be the biggest challenge for you when you become a doctor?

Public Health

In developed countries such as the United Kingdom, most deaths are now caused by non-communicable diseases such as ischaemic heart disease. In particular, cardiovascular diseases cause more than a quarter of all deaths in the UK.
There's growing evidence that lifestyle choices such as smoking, alcohol and obesity increase the risk of acquiring these types of diseases. Increasingly, more money is being spent on the treatment of obesity and diabetes, with around two-thirds of adults and 1 in 5 children leaving primary school living with obesity.
Successive governments have pursued health policies with an aim of curbing these costs, with the former Secretary of State for Health, Jeremy Hunt, stating that obesity and diabetes are top priorities. Through the introduction of the sugar tax in 2018 and the drive to educate children on the dangers of binge drinking, the government is seeking to change people's behaviours and reduce the consumption of unhealthy products.
Whether a government implements a certain health policy depends on the benefits gained by preventing ill-health or deaths, against the human cost of infringing on personal freedoms. As of May 2018, the Scottish Government established a Minimum Unit Price (MUP) of 50p per unit of alcohol, and Wales introduced a similar MUP in March 2020. Research shows that these policies have reduced consumption in the heaviest drinking households, so there are calls for England to follow suit although the government has no current plans to do so.
A report published in 2021 named the UK government's failure to do more to stop Covid spreading early in the pandemic (including decisions on lockdowns and social distancing) as one of the worst ever public health failures
Now what are some public health measures that have been undertaken by the government? Let us take a look.

Sugar Tax

The sugar tax is one of the most high-profile recent public health solutions. Here's what you need to know about the UK Soft Drinks Industry Levy:

- It was introduced in April 2018
- Drinks with over 8g of sugar per 100ml have to pay a tax of 24p per litre

- Drinks with 5 to 8g of sugar per 100ml have to pay 18p per litre
- The government said the income generated from the sugar tax would be invested in school sports and breakfast clubs – but that's not actually the case because the money hasn't been ring fenced
- It's forecasted to raise £1.37bn over four years from 2020-24

Has it worked?

The sugar tax does seem to have been successful in raising awareness of the health impacts of excess sugar intake. Manufacturers have started adapting and reformulating carbonated drinks, and most soft drinks now fall below the sugar tax threshold.
Between 2016, when the sugar tax plans were announced, and 2018, when the tax came into effect, over 50% of manufacturers reduced the sugar content of their drinks – the equivalent of 45 million kg of sugar every year.
A study of UK households showed that in the year after the sugar tax was introduced, purchasing of soft drinks remained the same, but the amount of sugar in those drinks fell by around 10%.
However, as mentioned, the income generated has not been reinvested into other measures to improve and combat the obesity issue as mentioned, and the number of soft drinks purchased are still at the same level, hence showing minimal improvements to the social issue on hand. It should be mentioned that the impacts need to be observed in the coming years since education and awareness will take time to influence consumers' behavior.

Spotlight on Childhood Obesity!

A quick detour from the solutions to highlight the issue that the next few methods target and plan to resolve.
Data from the National Child Measurement Programme estimated in 2018/19 that 22.6% of children aged 4 to 5 in England were overweight (an increase of 0.2% from the previous year). This rises to a third of 10 to 11-year olds (consistent with the previous year's data). Improvements to home entertainment, combined with increased junk food consumption, are some of the primary factors.
The NHS is extremely concerned by childhood obesity, because of the concern that this is likely to cause major healthcare problems in the future. Key concerns include:

- Obese children are more likely to become obese adults
- They have an increased risk of developing type 2 diabetes – a condition that 745 children and young people under 25 were treated for in England and Wales in 2017/18.
- The number of children with diabetes has increased by 47% in the last five years.

Local Council Trials

In 2017, the government published a plan for action on childhood obesity to try and significantly reduce it over the next ten years. As part of this plan, in June 2019, it was announced that five local councils will be given £100,000 a year over a three-year period to help test and redefine ideas for addressing childhood obesity and health inequalities.
The councils being trialled are Bradford, Blackburn with Darwen, Nottinghamshire, Lewisham and Birmingham. They will all try new programmes that may help shape future national policies. For example, Bradford will partner with local mosques to help South Asian children (who are at an increased risk of obesity) by giving them places and fun ways to exercise. Blackburn and Darwen will work with local restaurants to improve menus and include healthier options.

More Exercise Opportunities

In July 2019, the government announced plans to ensure children have more opportunities to do 60 minutes of sport and physical activity every day, under the School Sport and Activity Action Plan. The Department of Education has committed £2.5m in 2019/20 for more training for PE teachers and to enable schools to open their facilities during holidays and at weekends. Also, Sport England will give £2m to create 400 new after-school clubs in disadvantaged areas to encourage children to get active.

Fat Tax

There's been discussion around a fat tax – but this is much more controversial than the sugar tax because of its connotations of punishment, judgement and blame.
The pros and cons will be broken down in the table below.

Pros	Cons
Obesity costs the government more than any other lifestyle factor	Many people are obese because of medical or mental health issues. For example, people experiencing depression have a 58% increased risk of becoming obese. Hormonal issues and some medication can also contribute to obesity The most disadvantaged people face the greatest obstacles to overcoming obesity, and inequalities in the numbers of people living with obesity have widened
It leads to health problems such as diabetes, heart disease and cancer, and is entirely preventable	Price manipulation is seen as a form of control. Not only does it drive people to a certain decision, but it implies that people are not responsible for their actions
The money spent on these avoidable conditions could be better spent elsewhere	Denying autonomy may be a step backwards for a developed society such as the UK
There is evidence to suggest that taxing vices such as fat reduces consumption and encourages people to choose healthier foods; the argument was successful for the sugar tax, and many feel that the same is true in this instance	It's likely to affect those on a low income the most – but the least affluent socio-economic groups in the UK have a higher rate of obesity It's hard to eat healthy when you're stressed
It is debated that if the obese individuals can eat so much to maintain their weight, surely the tax on them would generate income that would be useful for the government.	Many people would argue that the cost of implementing the tax could be better spent improving treatments that don't infringe on society's freedoms.

(IMPORTANT NOTE: A good point to explore in your explanation or reasoning as well would be that technically obesity, while a self-inflicted disease, falls in the same category as smoking, which is also self-inflicted. As such, should smokers also not be offered treatment since they **CONSCIOUSLY** choose to smoke? From there you can further elaborate that the line becomes more and more blurry, and it is harder to distinguish where the line for treatment should be drawn.

For example, should alcoholics also be refused treatment since they **CONSCIOUSLY** drink a substance that has scientifically proven impacts on liver and causes liver failures? What about drivers? Since they **DELIBERATELY** choose to drive, and place themselves at risk to car accidents, should they also be refused treatment?

In conclusion, you can say that there will be no end and cause even more issues for consideration as resources will need to be spent to draw lines to distinguish the new rules again. As such, it is unfair to single out "Obesity" and ignore all the other issues that also have prevalence in our society.)

Spotlight on COVID-19 & Obesity!

The government announced a Better Health campaign to help people lose weight after it was discovered that nearly 8% of critically ill patients with COVID-19 on intensive care units were morbidly obese. That's compared to 2.9% of the population that is morbidly obese.
The measures in the new obesity strategy include:

- Banning unhealthy food advertisements (classed as foods high in fat, sugar or salt) on television and online before 9pm, with consideration to extend the online ban to apply at all times.
- Ending 'buy one, get one free' promotions and other promotions of foods high in fat and sugar.
- There will also be a ban on these items being placed in prominent locations in stores. Shops will be encouraged to promote healthier choices and offer more discounts on foods like fruit and vegetables.
- Calorie labelling will be required by law for large restaurants, cafes and takeaways with more than 250 employees to enable people to make healthier and more informed choices as part of a balanced diet.
- A consultation to determine whether the provision of calorie labelling on alcohol should go ahead will be launched. It has been estimated that around 3.4 million adults consume an additional days' worth of calories each week from alcohol and it is hoped that alcohol labelling could lead to a reduction in consumption.
- Weight management services from the NHS will be expanded so that more people can get the support they need to lose weight. This step will include more apps and online tools for people with obesity-related conditions, and accelerating the NHS Diabetes Prevention Programme. GPs will be encouraged to prescribe exercise and more social activities to help keep people fit.
- A consultation to gather views and evidence on the current 'traffic light' labelling system for front-of-pack nutritional labelling will be launched to learn more about how it is used and to compare it to international examples.

Potential Interview Questions

As obesity is still a prevalent topic today, and given how the global pandemic is still ongoing, it could be asked as an interview topic.
Some interview questions include:

- Have you heard of any public health campaigns recently? What are your views and opinions on them?
- Do you think the NHS should fund treatment for obesity? Why or why not?
- What are the potential consequences of the sugar tax and how will it address the obesity crisis faced?
- Is there enough being done to tackle obesity by the NHS?

- Should the NHS or the government tackle the root causes of lifestyle diseases?

BAME and the NHS

BAME refers to Black, Asian and Minority Ethnic. In this section, we will divide BAME into 2 segments, the BAME staff as well as the BAME patients.

BAME Staff

Some of the inequalities faced by BAME staff includes:

- Unequal representation amongst board members. 19.7% of the NHS workforce is made up of BAME groups, but just 8.4% of board members are from a BAME background.
- Recruitment problems. Lack of diverse representation at a senior level produces barriers for BAME staff, particularly during the recruitment process. White applicants are 1.46 times likelier to be appointed from shortlisting as opposed to BAME applicants.
- Less likely to be supported. BAME staff are 1.22 likelier than their white colleagues to enter a formal disciplinary process. The GMC's Fair to Refer report found Doctors from diverse groups did not always receive effective, timely or honest feedback due to difficult conversations being avoided where the manager is from a different ethnic group to the Doctor. There is also a culture of blame amongst some organisations, which creates additional risk for Doctors who are seen as 'outsiders'.
- Likelier discrimination. 15% of BAME staff reported experiences of discrimination from 2019 to 2020, compared to 6.6% of white staff.

BAME Patients

BAME patients also face inequality when they seek to use NHS services. Some of these issues include:

- Death during childbirth. Black women are five times likelier than white women to die in childbirth whilst women of mixed ethnicity are three times likelier to die and Asian women are two times more likely.
- Detrimental health outcomes. The Marmot Report states that detrimental health outcomes associated with some ethnic groups are associated with their socio-economic, and sometimes economic, status.

BAME & COVID-19

The impact of COVID-19 has been disproportionately felt by the BAME community. Some of the key issues include:

- Disproportionate mortality and morbidity. In the first month of the pandemic, 95% of NHS Doctors who died of COVID-19 were from BAME backgrounds. The disproportionate death rate in BAME staff is only partially explained by health conditions, age and socio-demographic factors.
- Staff were scared to raise COVID-19 concerns. BAME staff are more likely to report experiences of discrimination, which may translate to these staff being less likely to speak out about their concerns or request. Formal disciplinary processes are more common amongst BAME groups in comparison to their white counterparts, which could be a reason for a fear of raising COVID-19 related concerns or asking for safer alternatives.

- In areas with more BAME residents, the vaccination uptake is lower than average. This is due to the low confidence and trust in the vaccine and healthcare organisations and sociodemographic factors at play. Language barriers can be an issue too.

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/952716/s0979-factors-influencing-vaccine-uptake-minority-ethnic-groups.pdf

NHS Response to BAME

- The NHS People Plan has action points to increase BAME representation across the workforce, including at senior – this will make the NHS more reflective of the patient population it serves. Structural racism and unconscious biases still need to be addressed in order for equality to be truly achieved.
- The NHS is striving to engage further with staff and staff networks so that BAME staff can be heard and share their lived experience, offer action points they feel need to be taken and what support should be offered nationally. Steps towards establishing a stronger network have been introduced in the form of webinars, the first of which was attended by more than 240 heads of BAME staff networks.

NHS England and NHS Improvement are working to address BAME inequalities that COVID-19 has highlighted. Some of the measures include:

- On 30 April 2020, NHS Employers published guidance for NHS organisations to take appropriate measures to mitigate the risk of COVID-19, including taking ethnicity and age into account alongside other factors.
- NHS Employers published guidance for NHS organisations to ensure appropriate measures are taken to mitigate the risk of COVID-19, which includes taking ethnicity into account. The assessment should consider whether adjustments to work should be made or whether redeployment is more appropriate.
- A bespoke health and wellbeing offer, which includes rehabilitation and recovering, for BAME colleagues is being created in addition to various existing resources.
- Over £4M has been provided by UK Research and Innovation and the National Institute for Health Research to fund six new research projects that will investigate the links between COVID-19 and ethnicity.

Potential Interview Questions

While BAME may not come up as a topic itself, given the potential sensitive topic, it is always good to keep in mind BAME patients or staff when answering more generic questions to show your understanding and awareness of the inequalities faced by others.
Some questions where BAME could come into play could be:

- What would you do if a patient at a care home you are volunteering at was verbally abused by a Nurse and often not given dinner?
- What are the challenges you expect to face as a Doctor?
- What do you think makes a good Doctor?
- What are the differences in paternalistic versus patient-centred Medicine?
- Should Doctors and Nurses be allowed to refuse to work to protect themselves against COVID-19?

Accident & Emergency (A&E)

There are three main types of A&E departments in England:

- Type 1 departments are what most people may think of as an A&E service: major emergency consultant-led departments providing a 24-hour service. These departments account for most attendances (63% in 2018/19).
- Type 2 departments are dedicated for specific specialities (e.g. treating only eye conditions or dental issues)
- Type 3 departments treat minor injuries and illnesses and include walk-in centres or minor injury units.

The most prominent measure of A&E performance in England is the four-hour standard. The four-hour standard is that at least 95% of patients attending A&E should be admitted, transferred or discharged within four hours.

Most A&E departments across England and Wales have struggled to achieve the four-hour standard, as the NHS has experienced a sustained period of financial austerity and staffing pressures.

The NHS has not met the four-hour standard at a national level in any year since 2013/14, and the standard has been missed in every month since July 2015 as of August 2020.

Why are patients waiting longer?

There are a few key reasons why A&E patients are waiting longer:

- Rising A&E attendances. Before the coronavirus pandemic, an increasing number of people were attending A&E. On average, in 2018-19, 67,991 people attended A&E each day in England; this is a 17% increase on the 2010-11 numbers. Get key A&E patient statistics.
- Fewer hospital beds. 'Exit block' occurs when there is a delay in admitting patients to the ward from A&E due to a lack of beds. The problem of exit blocking leads to delays in diagnosis and treatment, which can in turn cause harm to patients. See the latest analysis on hospital bed numbers.
- Age of patients. An ageing population is likely to also contribute to increased pressure on A&E, as three-quarters of 75-year olds have more than one long term condition, increasing to 82% of 85-year olds. Read the latest annual report from the NHS that breaks down A&E attendance.
- Unnecessary A&E attendances. Another issue is that many people may attend A&E unnecessarily because they don't know where to go for treatment, or can't get an appointment with their GP. "Some estimates suggest that between 1.5 and 3 million people who come to A&E each year could have their needs addressed in other parts of the urgent care system" (source).
- Delayed discharges. Sometimes it can be difficult to discharge patients from hospital as they may need additional home support or wait for a nursing home placement. A patient who no longer has a medical condition requiring hospital treatment but who cannot be discharged from hospital is described as a delayed discharge or "bed blocking", which in turn may cause a backlog to A&E due to bed shortages. This is a particular concern with the COVID-19 pandemic.
- Staffing shortages. Staffing issues in A&E departments often lead to an increased workload for the remaining workers, a greater number of sick days and loss of workers due to transfers or resignations. The burnout rate gets progressively worse for the longest-serving staff, and the cycle can drag down the efficiency of whole departments. Coronavirus has made this issue even more acute.

Is the 4-hour target still relevant?

Although the four-hour target is an incredibly useful barometer for the overall performance of the NHS and social care system, it's important not to place too much emphasis on it as it does not provide a full picture of how A&Es are performing. For example, two departments could see the same proportion of patients within four hours with very different average waiting times. Moreover, the safety and quality of care, in addition to patient experience, are just as important as how quickly care is provided.
Currently, other measures are also used alongside the four-hour target to gauge the quality of service provided in A&E, such as:

- The number of re-attendances within seven days of their first attendance
- The waiting time to see a clinician
- The Care Quality Commission (CQC) rating of core hospital services
- Patient satisfaction surveys, such as the 2018 national survey of patients who have used urgent and emergency care

In 2018, NHS England began to review the four-hour A&E standard and whether they should be updated. The review was published in March 2019, suggesting the current four-hour A&E target should be replaced with several new measures instead. 14 hospital trusts were selected to pilot a new way of measuring performance. The recommendations were due to be published spring 2020, but this has been delayed because of the pandemic.
In 2019, former Health Secretary Matt Hancock suggested the four-hour target could be scrapped, but this was fiercely opposed by Doctors.
(**IMPORTANT NOTE:** If you are wondering why doctors oppose the scrapping of the 4 hour target, they fear the days of long hours before patients are treated will return, and would have a huge impact on patient safety and care, and compromises on patient safety.)

Steps Taken to resolve the crisis

Although expensive and time-consuming, one proposed solution to the A&E crisis is to assemble GPs, A&E staff, urgent care teams and pharmacists to create new emergency and urgent care hubs. This could reduce the burden on patients to refer themselves to the most appropriate source of care. These hubs would serve much larger catchment areas, and could draw staff away from more rural surgeries which are often most used by the elderly, vulnerable and less mobile.
In February 2017, it was announced that Peterborough and Cambridgeshire CCG were to run a pilot of Local Urgent Care Services (LUCS) hubs at three hospitals. The aim was to improve access to urgent care by providing a "one-stop service" for patients suffering from minor injuries and illnesses, and to treat a broader range of patients locally. Nearly 13,500 people used the service in the first year, helping to reduce pressure on the local A&E departments. However, setting up such hubs can prove to be difficult because of obstacles such as staffing.
Investing as much money as possible in primary care – such as local GP surgeries and community pharmacies – would also ensure that more patients are treated at a grassroots level and reduce their need to go to A&E.

Potential Interview Questions

Some possible interview questions include:

- Why do you think A&E waiting times have increased?
- Can you think of any strategies for reducing the strain on A&E departments?
- What are the implications of setting targets for waiting times?
- Should Doctors and Nurses be allowed to refuse to work in A&E to protect themselves against COVID-19?
- Is the 4-hour target for A&E still relevant today? If so, how so?

Medicinal Cannabis

From November 2018 specialist Doctors in England, Wales and Scotland can prescribe cannabis-derived medicine in exceptional circumstances. It was the first change to the law on medicinal cannabis, which had been in place since 1971.
Certain cannabis-derived products have been reclassified as Schedule Two. This means they have a potential medical use and can now be legally prescribed in cases of children with rare, severe epilepsy, adults with vomiting/nausea from chemotherapy and adults with muscle stiffness caused by MS – if other treatments have failed.
As medicinal cannabis can only be prescribed by specialist physicians and cannot be imported until a prescription is written, very few patients have actually been prescribed it since the change in regulations.
There were 2 main cases that led to the development and change in Medicinal Cannabis law and we will discuss them below.

Patient 1: Billy Caldwell

Medicinal cannabis hit the headlines back in 2018 when a child suffering from autism and severe epilepsy had his medication confiscated at Heathrow airport. The coverage of this case caused a public outcry and started a campaign to change the law.
Billy Caldwell had previously been treated for his seizures by a specialist in Chicago, and his antiepileptic medication intake was reduced from six medications to one. The treatment was very successful and saw the remission of his seizures for eight years.
In 2016 the seizures returned, becoming more frequent and severe.
TIMELINE!

1. In 2017 Billy was prescribed cannabis oil by his GP. This was the first prescription of cannabis oil in the UK – but the GP received a letter from the Home Office saying he must not renew the prescription or would face serious consequences. That's because the oil contains low amounts of THC, which is illegal in the UK.
2. His mother travelled to Toronto to pick up medicinal cannabis and this was confiscated.
3. Billy wasn't weaned off the medication, and he suffered seizures. He was admitted to hospital, where Doctors struggled to keep the seizures under control.
4. There was a huge public outcry and, due to mounting pressure, the Home Office decided that Billy would be allowed the cannabis oil as a special measure.
5. A hospital trust was given a special licence to administer doses to Billy, which meant a daily four-hour round-trip for the family. His mother described it as being under hospital arrest.
6. Billy was later getting a prescription from a private paediatric neurologist in London, but this meant flying to England every few weeks to collect more oil.
7. In 2019, Billy was ultimately awarded a lifelong medicinal cannabis prescription on the NHS, in a decision that could pave the way for more patients to receive the treatment in the future.

Patient 2: Alfie Dingley

Another high profile case about medicinal cannabis was that of Alfie Dingley. His condition improved when he was prescribed cannabis in Amsterdam, and it was predicted his seizures would fall from 3,000 a year to just 20 on this medication. His family eventually moved there because they couldn't get the medication in the UK.

His mother became the first person to be granted a special licence to import medicinal cannabis back to the UK. Alfie has since become tolerant to his medication and needs a new strain – but his mother said it would take months to get access to this.

Potential Interview Questions

You may not be directly asked about medicinal cannabis, but you can show your knowledge by referencing this when you answer some broader questions on medication or ethics. Some questions could be:

- If a medication is suggested as a possible treatment but there is a very limited evidence base to support the use of it, should we try these treatments or not?
- Why is it important for medical professionals to be empathetic with their patients?

Organ Donation

Organ donation is the act of giving an organ to someone who is in need of a transplant. People can donate certain organs while they are alive, such as a kidney, but most organ donations come from people who have died.

Challenges faced for Organ Donation

The demand for organs is significantly larger than the supply, which means there is a waiting list for organ transplants. There are currently around 7,000 people on the UK Transplant Waiting List. In 2020/21, over 470 patients died before they could receive a transplant.
Only a small proportion of deaths (e.g. death from stroke or brain injury) allow for organ donation, because many types of death (e.g. circulatory death in which the organs are starved of blood) do not leave viable organs for use. With improved road safety and vehicle manufacturing, fewer deaths are resulting from brain death nowadays, meaning there is a growing shortage of organs for donation. Demand also exceeds supply because matches need to be as close as possible to ensure a successful transplant.
An additional challenge is that the BAME community typically experiences longer waiting times for organ transplant, because there is a lack of suitable organs from BAME donors. In 2020, when approached about organ donation in hospital, 39.5% of BAME families agreed to support donation going ahead, compared to 69% of white families. Many of the BAME families had not discussed organ donation with their relatives and/or had concerns about whether organ donation aligned with their religious beliefs.
There are two systems explored for organ donation, which are further explored below.

Opt-In System

With an opt-in system, doctors can only use a person's organs after death if that person signed up to an organ donation register during their life.
One of the biggest problems with an opt-in system is that many potential donors either don't register or are unaware that they have the option to register. When England had an opt-in system (pre-2020), research showed that 80% of people supported organ donation in principle but only 38% had opted in, so the support didn't translate into a high number of potential donors.
Those in favour of an opt-in system argue that this type of consent (informed consent) is the most valid and ethical, because people have explicitly agreed to donating their organs and nothing is being assumed.

Opt-Out System

With an opt-out system, if a person has not registered a decision to either become an organ donor (opted in) or not become an organ donor (opted out), they are considered to have no objection to being an organ donor after death. This is known as deemed/presumed consent. In recent years, an opt-out system has been adopted by England, Wales and Scotland. The aim is to increase the number of people on the NHS Organ Donor Register, because it is expected that only people with strong views against organ donation will opt out. There are hopes that the opt-out system will lead to more lives being saved every year.
Those who oppose an opt-out system argue that deemed/presumed consent is less valid, because people could be unaware that they are automatically signed up to donate their organs.

UK Organ Donation

In December 2015, Wales became the first UK nation to move to a soft opt-out system of consent for organ donation. The system is 'soft' because the families of potential donors have the right to a final say.
Figures from NHS Blood and Transplant show that Wales now has the highest consent rate of all UK nations – currently at 77% compared to 58% in 2015, when the new system was launched.
In spring 2020, England also adopted a soft opt-out system, in which people over the age of 18 are automatically added to the Organ Donor Register and must actively withdraw if they want to opt out of it. Families are still consulted before any organ donation goes ahead.
In spring 2021, Scotland also introduced a similar opt-out system. Northern Ireland currently has an opt-in system, but steps have been made towards changing to an opt-out system.

Opt-In VS Opt-Out (Data and Reasons)

Looking at data from the UK, Wales has been leading the way with its organ donation consent rate compared to other UK nations since it adopted a soft opt-out system in 2015. However, it can be argued that there isn't conclusive evidence, on a global scale, that an opt-out system is ultimately more effective than an opt-in system. Although many European countries are covered by a body called Eurotransplant, there is significant variance in organ donation across different countries. Spain, which has a soft opt-out system, has the world's highest organ donation rate, whereas other opt-out countries such as Luxembourg and Bulgaria have very low rates.
Hard opt-out systems around the world have seen increases of 25% in the donor rate, but it can cause controversy that this type of system disregards the opinions of surviving family members. Alternatively, Israel has an opt-in system which gives priority to patients on the donor register if they ever require a transplant themselves, providing an incentive to opt in.
Some argue that increasing the number of organ donors has less to do with the type of system adopted and more to do with how the system is managed. The recently introduced opt-out system in England, Wales and Scotland will need to be supported by ongoing communication with the public to raise awareness. Investment in education and training will also be required to ensure success.
Let us consider some of the reasons in the table below.

Opt-In	Opt-Out
This type of consent (informed consent) is the most valid and ethical, because people have explicitly agreed to donating their organs and nothing is being assumed.	Opt-out policies bridge the gap between intent and action, meaning that setting up a default like this will capture those

	individuals who aren't moved to register, but would like to become organ donors
Opt-out revolves around deemed/presumed consent is less valid, because people could be unaware that they are automatically signed up to donate their organs.	The potential signaling effect, in other words, the idea that an opt-out approach would normalize organ donation, which alone would be beneficial.
Research has suggested that opt-in systems have a higher rate of kidney donations from living donors	Family permission is nonetheless sought and/or family objection prevents the donation from proceeding.
it is effective, possibly facilitating one of the highest donation and transplant rates in the world.	It questions the validity of consent though - for consent to be valid, it needs to be voluntary & informed but opt-out is neither of them most of the time...

Potential Interview Questions

Example questions could include:

- Why is there a shortage of organs for donation?
- What is consent, and how does it relate to the issue of organ donation?
- How does the UK currently handle organ donation?
- Why did England/Scotland/Wales recently change from an opt-in system to an opt-out system?
- Organ donations are limited. How do you think we should decide who is eligible to receive an organ?
- Who should be prioritized for organ donation? And how do we decide the criteria to consider for such a situation?

Health Tourism

Health tourism refers to non-UK residents travelling to the UK with the specific intention of using NHS services.
It is estimated that the government spends between £100 and £300 million per year on 'deliberate' health tourism. When the cost of treating non-UK residents who didn't come to the UK specifically to seek treatment (such as holidaymakers and temporary workers) is added, the total spend amounts to around £1.8 billion.
There is a great deal of misunderstanding around health tourism, and the topic often ignites a wider debate about immigration. As the debate gained momentum in the time surrounding Brexit, the government reacted by amending health tourism legislation.

Changes to Legislation

In April 2015, the government introduced new regulations requiring non-EEA nationals without personal health insurance to pay 150% of the NHS national tariff for any treatment they receive. A&E and emergency services remain free to all patients.
As of 2017, foreign patients can be refused non-emergency operations unless they pay for the treatment upfront. In July 2019, the Department of Health reported that these charges had raised a total of £1.3 billion since their introduction.

Opposition to the changes

The British Medical Association (BMA) has heavily criticised the 'pay upfront' rule, likening doctors who must charge foreign nationals at their workplace to border guards. At the BMA's annual conference in 2019, delegates voted overwhelmingly in favour of scrapping the rule, so the BMA will lobby the Department of Health to overhaul it.
Deliberate health tourism only accounts for around 0.3% of NHS spending, so there is an argument that government and media focus on health tourism is disproportionate to the impact it actually has, and does not help with the public perception of migrants in the UK. People who are determined enough to travel to the UK in order to seek treatment they cannot afford or access at home are more likely to be acting out of need than greed.
It can also be argued that charging for NHS services could actually increase health tourism in the long term among people who can afford it. Potential buyers may feel reassured that what they are purchasing is legitimate and that the process they are buying into is legal, which could lead to an influx of health tourists looking for cheaper healthcare than what is available in their domestic, privatised systems.
In one case since the new 'pay upfront' system was introduced, a couple whose baby died following an emergency Caesarean in the UK were not given the body to take with them, because they couldn't present a valid EHIC (European Health Insurance Card) so were required to pay £10,000 medical fees which they couldn't afford. In addition to the BMA calling for the system to be abandoned completely, the Royal Colleges of Physicians, Paediatrics and Child Health, Obstetricians and Gynaecologists, and the Faculty of Public Health have written to ministers urging them to suspend the system. The Royal College of Midwives has also expressed that maternity care should be exempt from charges.

Potential Interview Questions

You could bring up health tourism as a topic if you're asked depth of interest questions such as 'What recent changes to healthcare have you read about?'.
Other related questions could be:

- Do you agree that foreign patients in the UK should have to pay for non-emergency treatment upfront?
- Imagine you are a Medical Student on a hospital ward placement. How would you explain to a foreign patient that they need to pay for their non-emergency treatment upfront?
- What are the possible impacts of health tourism?
- Would health tourism have any negative impacts on the healthcare system? Why or why not?
- How would you allocate resources for health tourism to flourish without compromising on the quality of national healthcare?

Ageing Population

There are currently 3.2 million people over the age of 80 living in the UK, and this number is expected to reach nearly 8 million by 2050. By this point, 25% of the population will be over 65.

Although a longer life expectancy is a positive effect of good healthcare (and is therefore a trend commonly seen in more economically developed countries), an ageing population also increases the burden on healthcare systems.

The Impact of the Ageing Population

As more people reach their eighties, the NHS must treat an increasing number of chronic conditions associated with ageing, such as heart disease, Type 2 diabetes, arthritis and Alzheimer's.
Many elderly people also have complex social needs and require additional support with daily activities. As of 2021, one in six people over the age of 80 have dementia, and 70% of people in care homes suffer from dementia or severe memory problems. The cost of support with daily activities, such as washing, dressing and cooking, can be high and often needs to be partly funded by the patient. People with dementia typically spend £100,000 on their own care.
Cuts in social care spending have led to an increase in A&E admissions among people aged 65 and over, placing increased demand on already under pressure services. Inadequate social care can leave elderly people vulnerable to infections, falls and dehydration, which would otherwise be avoidable. If an elderly person is admitted to A&E after a fall, it can sometimes take days or weeks for them to be discharged, which is described as "bed blocking".
Certain areas of the UK are affected more than others, because older people are more likely to live in rural areas or by the coast, whereas younger people are more likely to live in cities.

Healthy Life Expectancy

Average life expectancy in the UK is currently at 79.9 years for men and 83.6 years for women. However, healthy life expectancy (HLE) is only 63.1 for men and 63.6 for women. HLE is an estimate of the number of years a person will have 'very good' or 'good' health. Therefore, people are living longer, but the period of their life spent with a major health concern is increasing.
The government has an ambition to increase people's HLE by five years by 2035. To achieve this, there needs to be increased public health education and support around alcohol and smoking, better nutrition, and improved physical health and fitness. This would reduce the risk factors that contribute to conditions such as heart disease and dementia. There also needs to be improved support for people living with disabilities and long-term conditions.

Potential Interview Questions

Some questions include:

- What is your understanding of an ageing population and what issues does this trend bring with it?
- What chronic conditions are you aware of and what can be done to prevent the prevalence of these in the UK?
- What do you know about the term "bed blocking"?
- Is an ageing population the biggest issue to be faced by the NHS in the foreseeable future?
- What are some strategies that can be undertaken to address the ageing population issue?
- Do you think funding should be set aside specifically to address the ageing population? Why or why not?

Charlie Gard and Alfie Evans Cases

Case 1: Charlie Gard

Born on the 4th of August 2016, Charlie Gard appeared to be a healthy child. After a month, his parents noticed Charlie was unable to support himself or lift his head, which is something other infants his age are able to do. The weeks that followed saw Charlie unable to gain weight despite a regular feeding programme, and he was transferred to Great Ormond Street Hospital.
Charlie was later diagnosed with infantile-onset encephalomyopathic mitochondrial DNA depletion syndrome (MDDS), caused by a mutation in the RRM2B gene. Charlie's case was one of just 16 known cases of RRM2B-related MDDS.
He inherited this disease because both his parents were carriers of the recessive gene.
Charlie's brain, heart, liver, kidneys and his ability to breathe were severely affected. He also had congenital deafness and epilepsy.
Charlie suffered from severe progressive muscle weakness, which meant that he couldn't move his arms or legs or breathe unaided. He couldn't open his eyes, which weren't developing properly. It was impossible to tell if he was in pain and whether he was awake or asleep.

Potential Treatment: Nucleoside Bypass Therapy

A High Court ruling recommended that Charlie's life support be stopped.
After the ruling, neurologist Dr Hirano offered to continue treatment in the US. Dr Hirano claimed there was a 10% chance that treatment could improve the baby's condition – despite never meeting Charlie in-person.
Experts at Great Ormond Street Hospital feared the treatment wouldn't help and would prolong his suffering.
What was the treatment?

- It's called nucleoside bypass therapy. This explains more about the treatment.
- It was untested on humans or animals with RRM2B-related MDDS – but it has been shown to have some positive effects on test subjects with other mitochondrial conditions.
- It had been used in 18 cases already – but Charlie's condition was far more advanced.
- All the other cases involved people who suffered from a mutation in the TK2 gene, not the RRM2B gene, which is a different form of mitochondrial DNA depletion.
- The patient must ingest compounds needed to develop new DNA strands which their body could not otherwise produce.
- There was no evidence to suggest that the treatment would be able to cross the blood-brain barrier and resolve Charlie's brain damage.

The Legal Battle To Continue Treatment

Charlie's parents accepted Dr Hirano's offer of experimental treatment and raised the £1.3M travel and treatment costs through crowd-funding campaigns. They believed, as did their supporters, that it was their parental right and responsibility to give their child any and all life-saving treatment they could.
They made an appeal to stop his life support being switched off, so they could take Charlie to the US. It was denied when it was taken to the Supreme Court and at the European Court of Human Rights, their appeals were further denied.

It was concluded that Charlie was probably "being exposed to continued pain, suffering and distress" and that undergoing experimental treatment with "no prospects of success… would offer no benefit".
He died on the 28th July 2017, aged 11 months old, after his life support was removed.

Case 2: Alfie Evans

Alfie Evans suffered from a degenerative neurological condition. He was admitted to hospital in December 2016 after suffering seizures and remained a patient.
His parents wanted to fly Alfie to Rome for further treatment, which the Alder Hey Children's Hospital described the decision as "futile, unkind and inhumane."
At 23 months old, the courts ruled for his life support to be removed.
Read all about this case on the BBC.

The Cases' Impact on NHS and Laws

You should understand the impact of these two cases on the NHS and law in the UK.
It's estimated that there are 49,000 children and teens in the UK suffering from potentially life-limiting diseases. This number is only expected to rise as new medical advancement means sick babies are able to live for longer.

Key things to know:

- The Royal College of Paediatrics and Child Health (RCPCH) believe that such cases are "traumatic and distressing", and this could lead to difficulties in recruitment and retention of vital NHS staff.
- Conflicts between Doctors and parents are challenging. Read the RCPCH's guidance on how to handle this.
- Charlie Gard's parents are advocating for a change in the law in order to prevent other parents from going through a similar court case. They want judges to ask whether the parents' choice of treatment would cause significant harm and if not, they should be allowed to test their options.
- The change would allow independent medical mediators to get involved in any disagreements as early as possible, which aligns with new advice from RCPCH.

The Ethical Dilemmas

There are three key reasons why life-sustaining treatment is withheld or withdrawn:

Autonomy: A competent patient refuses it.

In Charlie's case, his parents acted on his behalf due to his age and mental state.

Distributive justice: expected benefit is insufficient to justify public resources being used

The National Institute for Health and Care Excellence (NICE) recommends treatment at £30,000 or less per Quality-Adjusted Life Year (QALY).
Nucleoside bypass therapy was fairly inexpensive, but the cost of ongoing intensive care was estimated at £150,000. Furthermore, Dr Hirano's best possible outcome was 10%, giving Charlie a shortened lifespan with a severe disability.
This is how you breakdown the sums for Charlie's case:

- The quality of Charlie's potential adulthood life was estimated at 0.3 of a possible 1.0, due to the severity of his disabilities
- When you multiply that over 50 years, you get 15 Quality Adjusted Life Years (QALYs)
- The likelihood of the treatment working, however, was estimated at only 10%, reducing the QALYs to 1.5
- At a cost of £150,000, the cost per QALY for Charlie's treatment was £100,000 – over three times the advisory limit

However, the money was raised privately, so the funds were illegible for redistribution. The legitimacy of the distributive justice argument is uncertain.

Treatment is not actually the best thing for the patient

This is why the parents' appeals were rejected. The High Court concluded that the success was too low to justify the trauma Charlie would experience. The success of the procedure also wouldn't have meant a sufficient quality of life.
This was a controversial decision and Dr Hirano argued that a slight chance was better than none.
One of the responses to the decision was that treatment should be given in order to have better insight and improve the chances of successful treatment for the next MDDS patients. As the court rules only in the interest of the child in question, this is unlikely to influence a judge's decision.

Potential Interview Questions

Understanding the key issues of the Charlie Gard and Alfie Evans cases gives you two really strong examples to use when answering ethics questions during your interview. While it is quite unlikely that you will be asked directly about these cases, it serves as possible examples and talking points for other questions where you can develop your answer to ground it further in reality, lending credibility to your answer.
Some example questions you could be asked include:

- What are the challenges you expect to face as a Doctor?
- Imagine that existing medications have been suggested as a possible new way to treat a different disease. If there is a very limited evidence base to support the use of these medications in this way, should we try these treatments or not?
- Why is it important to maintain the dignity of a patient?

Antibiotic Resistance

Antibiotics are essential for treating bacterial infections. However, due to random mutations in their DNA, bacteria can develop resistance to antibiotics, reducing their effectiveness. The survival of bacteria in a patient's body allows the resistant genes to be passed to the next generation, leading to a rapidly reproducing colony and infection.
According to a recent government-backed report, annual deaths due to multiple drug resistance could reach 10 million by 2050 if the inappropriate use of antibiotics continues.
Drug resistance has become so widespread it is now often customary for Doctors to prescribe multiple antibiotics to combat a single infection.
The number of drug-resistance bloodstream infections increased by 35% from 2013 to 2017.

What Is Causing Antibiotic Resistance?

Several cases of resistance to colistin, the antibiotic of last resort, have recently emerged across the world. Some of the key reasons why antibiotic resistance is increasing include:

- Antibiotics are often prescribed in hospitals in developed countries
- Livestock is dosed with antibiotics – so eating meat and dairy products contributes to multiple drug resistance

Perhaps the biggest contributing factor is that GPs feel the pressure to prescribe – and patients expect to walk away with antibiotics. This is an extensive issue:

- Recent research from Public Health England revealed at least 20% of all antibiotic prescriptions by GPs in the UK are likely to be inappropriate
- The pressure to convince patients that they have gained something from their appointments has, according to King's College London, caused a cycle wherein the GPs who prescribe fewer antibiotics have the fewest satisfied patients
- 48% of GPs in the UK have prescribed antibiotics to remedy coughs and bronchitis – but antibiotics have no effect on the common cold and prescribing them only contributes further to antimicrobial resistance

There's also a lack of education around antibiotics, causing issues such as:

- Over 40% of patients believe antibiotics will help with viruses
- Even when antibiotics are correctly prescribed, patients often fail to follow their course of treatment.

The regimen for antibiotic therapy can last days, weeks or even months, and patients frequently miss doses or even stop them entirely once they begin to feel an improvement. The most resistant bacteria survive, persist and multiply, and alternative antibiotics must be prescribed all over again.

Solutions For Antibiotic Resistance

There are a few key solutions that you need to know about:

- GPs have been encouraged to prescribe more sparingly
- New guidance for medical professionals on prescribing antibiotics appropriately
- A push to reduce infections that are contracted from surgery
- Farmers are restricted in which antibiotics can be given to livestock
- Clinical Commissioning Groups have reduced the number of antibiotic prescriptions and the use of broad-spectrum antibiotics
- Public Health England has continued to push the education of infection-preventing public hygiene, such as handwashing

There are some targets the government has set on this topic:

- A 15% reduction in antibiotic use in humans by 2024
- A 25% drop in the use of antibiotics in animals from the 2016 levels by 2020, with this objective to be refreshed in 2021

This is all detailed in a five-year plan and 20-year vision – read it here

A Push For New Drugs

Another solution comes in the form of incentivising pharmaceutical companies to research and develop drugs that can save lives by paying them based on how valuable the drugs are – instead of how many are sold. NICE and NHS England are going to trial this new subscription payment model.

Two drugs that have proven to be both safe and effective will be selected to undergo health technology assessment (HTA) by NICE throughout 2021, and this will be used to decide the level of the subscription payment.

Teixobactin

One of these, teixobactin, was discovered and found to be effective against common bacterial infections. This new drug was isolated by using an electronic chip to grow antibiotic-producing microbes in soil. However, it is still years away from being tested on humans and may not even work against bacterial infections in humans.

New Therapies

Combination therapy may work to help fight antibiotic-resistant bacteria by using two or more drugs together to increase the effectiveness of both drugs against bacteria that are resistant to normal antibiotics. Drugs working together in this way may even be effective against colistin-resistant bacteria.
The most controversial solution fielded so far is phage therapy. This process involves killing bacteria with a virus that lives inside bacterial cells but is so far unused in the West. Successful studies have been conducted in Russia, Georgia and Poland, but the risk of ingesting viruses has hindered the popularity of the method.

A Boost To Research

Furthermore, the Department of Health and Social Care has committed £32m for research centres to help improve prescribing and identify patterns of resistance. For example, University College London (UCL) and University College London Hospitals (UCLH) are going to try using artificial intelligence to help tackle antibiotic resistance. They hope this will enable earlier diagnosis and treatment with the appropriate antibiotic and dose. Also, they aim to be able to identify more quickly cases where patients don't have resistant infections to ensure that unnecessary treatment is not given.

Positive Signs of Improvement

In England, the total consumption of antibiotics in primary and secondary care declined by 9% from 2014 to 2018.

Potential Resistance Questions

You might be asked questions about prescribing antibiotics in your interview – or you may be able to weave this topic into an answer about something broader, in order to show your knowledge. For example, the topic could come up in questions like:

- Why is antibiotic resistance such a huge problem in the UK/World?
- What are the current major issues regarding antibiotic resistance?
- Tell me about future treatments for antibiotic resistance and why they may be effective?

Case Study: UK & Strep A strain

Parents in the United Kingdom are scrambling to find medicines for their sick children amid a surge in bacterial infections and a shortage of antibiotics.
In the past few weeks, pharmacies in many cities in the UK have turned away customers looking for amoxicillin and penicillin – both common antibiotics.
The shortage has emerged at a time when the UK health authorities have recorded 16 deaths of children under the age of 15 since September due to an invasive strain of strep A infection.

Strep (streptococcal) A is usually a mild bacterial infection which makes thousands of people sick every year. Generally, it is associated with strep throat (tonsillitis) and scarlet fever. But at times, it develops into deadly Group A Strep (iGAS) if the microbes enter the bloodstream. At this time of the year, it is making children sick earlier than the usual onset of the infections in the winter season.
While authorities are still investigating the reasons, experts say that it could be linked to the Covid-related lockdowns.
During the pandemic restrictions, kids didn't have a lot of interaction with each other and some of them are just getting exposed to infections against which they haven't developed strong immunity.
The contagious disease can easily spread by close contact, sneezing or coughing in close proximity, making authorities particularly concerned about the schools where pupils have been diagnosed.
Besides the shortage, pharmacies complain they are taking a financial hit as they sell antibiotics at a discount but the National Health Services (NHS), the UK state-run health provider, is reimbursing a fraction of the drug's price.
Retailers say wrong messaging by the authorities after publicly announcing that there's no shortage of penicillin and amoxicillin has fanned tensions in the country. Desperate customers lock horns with chemists--even resort to violence-- seeking access to these medicines.
David Webb, the chief pharmaceutical officer at NHS, said last week that there was no shortage of the drugs at the national level.
Some antibiotics "may be in limited supply at certain wholesalers and pharmacies" due to a surge in demand, he said.
Prices for capsules and oral mixtures of penicillin and amoxicillin have more than doubled from $4 to $5 to $12 to $18, according to The Times.
A generic drug, amoxicillin (sold as Augmentin in many countries) should have been easily available. Instead, its shortage and high prices have brought big pharma companies under the spotlight.
In recent months, the shortage of antibiotics, including amoxicillin, has been reported in the US, France, Belgium and Italy.
For years, health experts have pointed out that big pharmaceutical companies are not investing in developing a new generation of antibiotics.
Amoxicillin has been around for more than 45 years. Since patents no longer protect the drug, big companies see no incentive to shoring up their production.
Complex pharmaceutical supply chains spread across different parts of the world, where chemical ingredients come from one country and packaging is done elsewhere, have added to the health crisis in the UK.
Most of the world's Active Pharmaceutical Ingredients (API), the chemical compounds in medicines, come from China and India. China has imposed strict Covid-related lockdowns.

Medical Licensing Assessment (MLA)

As part of your degree, all UK Medicine graduates, as well as international applicants, will have to sit a new exam called the Medical Licensing Assessment. This replaces the final medical exams.
The Medical Licensing Assessment (MLA) test will have two parts: an applied knowledge test that will be computer-based, and a clinical and professional skills assessment.
The aim of the MLA is to provide a standardised means of assessing all UK doctors, which in turn will help ensure patient safety. It will also incorporate and replace the PSA.
The MLA was originally proposed for medical students graduating in the academic year 2023-24. However, as a result of the COVID-19 pandemic, there is now a revised timeframe – UK medical students graduating in the academic year 2024-25 will need to pass the MLA before joining the medical register.

It's Pass/Fail

The Medical Licensing Assessment is a pass/fail assessment. It's not designed to rank Medicine graduates and scores won't be used in the Foundation Training selection process.

When Does It Come Into Effect?

The Medical Licensing Assessment will affect anyone graduating in the year 2024-25 onwards. This means that you'll have to pass the Medical Licensing Assessment in order to join the medical register.

How Is This Different?

With the current system, Medical graduates sit their final written and clinical exams at their Medical School and if they pass, they can apply for provisional registration on the GMC Medical Register. This then allows them to apply for Foundation Training.

Does This Impact Foundation Training Selection?

Changes to the Medical Licensing Assessment don't have any impact on Foundation Training selection. It's simply a pass/fail test, and selection for Foundation Training remains the same.

Foundation Training Applications

When you apply for Foundation Training, you are assessed on your Education Performance Measure and your Situational Judgement Test. You can score up to 50 points on each. Find out more about EPM and SJT.
You also need to have passed the Prescribing Safety Assessment by the completion of your FY1 induction programme.

Revalidation

Every five years, licensed Doctors must demonstrate that they are up to date with medical procedures and fit to practice; this is known as 'revalidation' and ensures that the doctor can continue to hold their license to practice. They need to use supporting information to demonstrate that they are continuing to meet the principles and values set out in Good Medical Practice.
Good Medical Practice by the General Medical Council (GMC) is the core ethical guidance for Doctors. It sets out the principles and professional values on which good practice is founded.
All NHS staff, including doctors, are expected to have annual appraisals as part of their revalidation. Each doctor needs to maintain a portfolio of supporting information which demonstrates that they are continuing to meet the attributes set out in the framework. The main purpose of revalidation for doctors is to check that their practices, skills and behaviour are in line with the GMC's standards, as well as to reflect on their performance, using this to improve their skills or develop their practice.
Revalidation originated from the Harold Shipman affair (where he essentially killed over hundreds of patients over multiple years through the prescriptions of drugs into his patients, mainly elderly individuals).

How does Revalidation Work?

The process is as follows:

- Licensed doctors are linked to a Responsible Officer (COMPULSORY)
- Licensed doctors need to maintain a portfolio (more on this later) of supporting information drawn from their practice, that shows how they align with GMP Framework for appraisal and revalidation
- Licensed doctors are expected to participate in a process of annual appraisal based on portfolio
- The Responsible Officer (RO) makes a recommendation to the GMC regarding fitness to practice every 5 years. It is based on the outcome of the annual appraisals + feedback from the clinical governance system the doctor works in
- The GMC then makes the decision based on the RO's recommendation

What does the portfolio consist of?

It needs to contain 4 major aspects:

- General information: Personal details, scope of work, record of annual appraisals, personal development plans and review statement(?) on probity and health
- Continuous Professional Development Record: Record of courses and conferences attended, journals read etc
- Review of own practice: Quality improvement activities such as clinical audits, review of clinical outcomes or case reviews, description of significant / major events
- Feedback on own practice: Colleague and patient feedback, review of complaints and compliments

Pros and Cons of Revalidation

There are some pros and cons to explore especially for revalidation.

Pros	Cons
Formalises practices that may have been done on an ad hoc basis (probably no longer exists because revalidation started back in 2012) Ensures compliance with basic requirements, provides focus to the appraisal process Ensures doctors are kept to a certain standard and ensure that the quality of care is well-maintained	Will not stop a potential Shipman incident again Senior clinicians may see it as a way to fulfil their management responsibilities and may consequently not ensure proper management of other individuals Runs the risk of identifying underperformance too late Process may require information that certain trusts do not hold such as individual results for surgeons etc Potential drain on resources as more people need to be brought in consistently to meet the increasing number of doctors. If there is not enough people to support the revalidation process such as ROs, it could place a huge strain on current individuals working

Potential Interview Questions

You may get asked about your understanding of how you become a Doctor, and mentioning the MLA is a good way to show that you're familiar with the recent update to licensing. Some example questions include:

- Talk me through what happens and the career path once you graduate
- Do you know what happens once you finish Medical School?
- Medical school lasts five to six years. What will you do after this?

The 5 New Medical Schools

The NHS has a shortage of doctors in many different specialities – especially psychiatry, general practice, emergency medicine and paediatrics. To tackle this problem, the GMC announced in 2016 that it was going to open new Medical Schools, with an aim to boost the number of doctors and reduce the reliance on international graduates.

The Plan

From 2018, the government pledged to create 1,500 additional Medical School places – a 25% increase. This meant that in 2020, there were around 7,500 places available, compared to 6,000 previously.
Some of this was driven by an expansion of existing Medical Schools, such as in the Universities of Hull, York and Exeter. Five new Medical Schools were also opened, taking on around 400 students each year between them.
In 2021, there were 9,000 Medical School places available altogether, because the government adjusted the cap on numbers. A combination of grade inflation and a record number of applicants resulted in an unexpectedly high number of students qualifying for their place.

Where Are The New Medical Schools?

The new Medical Schools are located in Sunderland, Chelmsford, Canterbury, Lincoln and Lancashire. Research shows that doctors tend to stay and work in the area where they trained, so the new Medical Schools are in regions where trusts struggle to recruit.

- University of Sunderland – 102 places in 2021/22
- Anglia Ruskin University – 112 places in 2021/22
- Kent and Medway Medical School – 100 places in 2021/22
- University of Lincoln – 83 places in 2021/22
- Edge Hill University – 39 places in 2021/22

The GMC has tight protocols when considering applications to create new Medical Schools, and universities must tender bids to apply to provide medical training.

Why Are There New Medical Schools?

The new Medical Schools will encourage doctors to train and then work in areas which have particular medical staff shortages and difficult-to-fill vacancies. It is hoped that the UK will ultimately have enough medical graduates to support the NHS in a sustainable manner and to strengthen the workforce. This will help to address current staffing challenges, as well as the growing issue of an ageing population.
Professor Wendy Reid, Director of Education and Quality and Medical Director of Health Education England, said: "The 25 per cent increase in places shows there is a real commitment to a sustainable future home-grown medical workforce, making us self-sufficient

in the supply of doctors for years to come, giving more young people from diverse backgrounds the chance to become a doctor."
However, the BMA has pointed out that it will be several years before the benefits of the new Medical Schools will be felt in the NHS workforce.
Professor Helen Stokes-Lampard, Chair of the Royal College of GPs, said: "In welcoming the long-term benefits that these schools will inevitably bring for general practice and the wider NHS, we must not forget the short term pressures. It takes at least 10 years to train to be a fully qualified GP from entering medical school, but we need thousands more GPs now. We must work together, pulling out all the stops, to recruit more people to general practice, to make it easier for people to return to the profession after a career break or period working abroad, and to retain the experienced, skilled workforce we already have."

The Impact

With more places available, more people who have the potential to become doctors will have the opportunity to do so. However, getting into medical school will still be challenging.
There was a record number of Med School applicants for 2021 entry, which was a 21% increase from the previous year. We have also seen an increase in people sitting the UCATfor 2022 entry, with a 9% increase from the previous year.
It is not yet known if the cap on Medical School places will still be lifted for 2022 entry. This means that getting into Medicine is more competitive than ever.

Potential Interview Questions

While it is quite unlikely that you will be grilled extensively on what schools have recently opened and the number of spaces that have opened up, it is more likely that you will be tested on the **WHY** and the plan behind opening more medical schools. The potential impacts could also be discussed and you may be asked to explore the potential future of the NHS with these new schools being opened.
Some potential questions can include:

- How do you see the future of the NHS changing with the new opening of the 5 medical schools?
- How would the new opening of medical schools benefit the NHS?
- Do you think that the new opening of medical schools would actually lead to filled-up vacancies for specialities such as Emergency Medicine and even GPs?
- Apart from the opening of new medical schools, what are some methods to fill up the workforce vacuum currently present in the NHS?

Shropshire Maternity Scandal

In November 2019, a report from an interim inquiry into failings at the Royal Shrewsbury and Princess Royal Hospital in Telford was leaked to the press.
The inquiry was investigating the deaths and injuries of babies at the two hospitals dating from 1979 to present, with the majority of cases having occurred since the year 2000.
Midwife Donna Ockendon led the review, with more than 1,800 cases examined after families were invited to contact the inquiry. The review was expanded from an initial 23 families, and the Royal Shrewsbury and Princess Telford Hospitals were placed into special measures.

Key Case: Stanton-Davies Family

The Shropshire Maternity Scandal came to light with the Stanton-Davies family's fight to ensure that lessons were learnt after their baby daughter's death in 2009.
The pregnancy was meant to be flagged as high-risk and the mother, Rhiannon, should have never been on the unit in the first place. Compounding this, midwives failed to monitor their daughter Kate's condition.
The family first secured an inquest into Kate's death, and once this had been ruled avoidable, they challenged the NHS on how they investigated it. The resulting review found systemic failings of the former head of midwifery and midwives who altered notes retrospectively.
The Stanton-Davies family then worked with a second family and wrote to the Health Secretary at the time, Jeremy Hunt, who ordered an independent investigation.

Findings Of The Report

The scandal has been described as the biggest maternity scandal in the history of the NHS, with clinical malpractice continuing unchecked for over 40 years according to the leaked internal report.
An interim report examining 250 cases found that at least 42 babies and three mothers may have died avoidably. It also found that more than 50 newborns may have sustained avoidable brain damage.
The review examined over 1,800 cases. Not all cases involved death or serious harm, but many involved significant errors.
The report revealed that concerns over injuries to babies were highlighted in 2017 to regulators. The findings of this review by Donna Ockendon were published in December 2020.

Malpractice Noted

Repeated clinical errors were inadequately followed up, which meant important lessons were not learnt.
Bereaved families weren't treated with kindness or respect, with instances of staff referring to babies as 'it' and one baby's body left to decompose for weeks after a post-mortem.

The Report's Impact

The Trust was ordered to repay £1 million that was given by NHS Resolution for good maternity care. Two months after the payment in September 2018, maternity services were rated inadequate by the Care Quality Commission (CQC) and were placed in special measures.
Weekly status reports were required from the hospital bosses due to the concerns.
In June 2020, West Mercia Police began a criminal investigation into the deaths of babies at Shrewsbury and Telford Trust, to see whether there was evidence to support a criminal case against either the Trust or individuals involved. The case is ongoing.
In August 2020 it emerged that new areas of concern had been identified at the Royal Shrewsbury and Telford's Princess Royal Hospitals. The CQC Chief Inspector of Hospitals, Ted Baker, has said that failing leadership is perpetuating poor care. The trust was rated inadequate on every measure.

Potential Interview Questions

Understanding the details of the Shropshire Maternity Scandal and how they can be used when answering ethics questions during your interview is vital. Some example questions you could be asked include:

- How do cases such as the Shropshire Maternity Scandal impact doctor-patient trust?
- Do doctors have any moral duties? What can happen if they don't?
- Should the workings / data of the healthcare system be publicly published to prevent cases such as the Shropshire Maternity Scandal from happening again?

The Francis Reports

Robert Francis QC is a Barrister specialising in medical law, including clinical negligence claims. With this expertise, he led a public inquiry into poor care at Mid Staffordshire NHS Foundation Trust between 2005 and 2009.
The investigation looked into why organisations responsible for regulating and managing the trust did not spot problems before they were brought to light by the campaign group 'Cure the NHS'.

Healthcare Commission Report

The Healthcare Commission report exposed appalling treatment and high mortality rates at the hospital and concluded that an estimated 400 to 1,200 people could have died unnecessarily there between 2005 and 2008.
Recurring problems emerged, such as:

- Call bells going unanswered
- Patients left lying in their own urine or excrement
- Food and drink left out of reach of patients
- Patient falls being concealed from relatives
- Too few consultants and nurses
- Poor communication between staff and relatives of the patients

What Did The Francis Reports Find?

The First Francis Report

The first Francis report, published in 2010, cited "historic understaffing" of nurses as one of a number of reasons for poor care. Wards were re-organised without necessary risk assessments leading to patient care being compromised.
The ratio of registered nurses to healthcare assistants dropped as low as 40:60 in some areas. Francis specifically criticised the trust for being obsessed with obtaining foundation trust status and meeting targets rather than patient care. At the heart of what happened at Mid Staffordshire Foundation Trust was poor nursing care.

The Second Francis Report

The second Francis report, published in 2013, looked at how the set-up of the entire health and social care system in England can help or hinder nurses and other staff to deliver good care. It also focused on the culture of the NHS and its impact on the ability of staff to raise concerns.

What Recommendations Were Made?

The report made over 200 recommendations, including:

- Staffing levels and skill mix
- Protection of whistleblowers
- Eradication of the blame culture and bullying
- Training and regulation of healthcare assistants
- Recruitment, training and standards of registered nurses.

Response To The Report

- GMC. The GMC responded to their progress following these recommendations in October 2013 – this included an insight into education, safety in the practice environment and information sharing.
- Government. At the end of 2013, the government also responded to the recommendations of the report. It included actions for improving patient care: increasing openness and changes to regulation in hospitals.
- NICE. NICE was also asked by the Department of Health and NHS England to create guidelines on staffing capacity to ensure safety in the NHS.

Potential Interview Questions

Thoroughly understanding the key issues of the Francis Reports enables you to have a prime example to refer to when answering ethics questions and teamwork questions during your interview. Some example questions you could be asked include:

- Why is teamwork so important in healthcare? Can you give an example of where a lack of teamwork has caused problems?
- Why do you know about the Francis Reports and what impact did it have on UK healthcare?

Case of Bawa-Garba

On the 18th of January 2011, six-year-old Jack Adcock had been feeling unwell – he was having difficulty in breathing, vomiting and diarrhoea. Jack had Down's Syndrome, a known heart condition and required long-term medication. He was admitted to the Children's Assessment Unit (CAU) at Leicester Royal Infirmary following his GP's referral.
Jack's condition deteriorated that day and unfortunately, he passed away.
He was seen and assessed by junior Doctor Hadiza Bawa-Garba, a paediatric registrar in year six of her speciality training (ST6). Generally, being an ST6 junior Doctor means they were one or two years from sitting their final examinations to reach the level of a consultant. Dr Bawa-Garba was taken to High Court and on 4th November 2015 was found guilty of manslaughter on the grounds of gross negligence.

Timeline Of Events

To thoroughly understand the Bawa-Garba case, it's helpful to be aware of the mistakes Dr Bawa-Garba was ruled guilty of by the Court.
These are:

- When Jack was admitted, Dr Bawa-Garba ordered a chest x-ray that showed an infection. The x-ray results were available from 12:30, but didn't get seen until 3pm. Dr Bawa-Garba then prescribed antibiotics, which were administered at 4pm. It's important to understand that prescribing antibiotics earlier could potentially have led to a different outcome, but the ward was

understaffed and Dr Bawa-Garba was extremely busy. Furthermore, she had not been made aware that the x-ray was available at 12:30.

- A blood test revealed high levels of C-Reactive Protein (CRP), which occurs due to infection and inflammation. This was reported over five hours late, due to failings in the hospital computer system.
- When Jack was assessed by Dr Bawa-Garba she stopped the medication for his heart condition. However, she did not document this in his notes, and subsequently, this medication was administered to Jack at 7pm by his mother. Jack's mother was unaware that he was not to be following his usual course of treatment for his heart condition.
- Jack suffered a cardiac arrest at 8pm. Dr Bawa-Garba was one of the Doctors who attended the call and arrived when resuscitation was already taking place. Dr Bawa-Garba mistook Jack for another patient, whose notes were marked as DNAR (do not attempt resuscitation), and therefore Dr Bawa-Garba called off resuscitation. Resuscitation was re-continued shortly after the mistake was identified. Jack died at 9:20pm.

Failings Within The Hospital System

It should be noted that prior to the 18th of February, Dr Bawa-Garba had an exemplary record. She had also just come back from maternity leave. Whilst mistakes were made by Dr Bawa-Garba, there were also issues within the hospital's system which contributed to the negligence in care provided. Notably, these are:

- Dr Bawa-Garba was carrying out the work of two Doctors and the hospital was extremely understaffed.
- Senior consultants were not on-site and therefore Dr Bawa-Garba had no one to report to. There were not enough senior nurses on the ward, either.
- The failings of the hospital computer system prolonged blood testing results. There was also no system in place to notify Dr Bawa-Garba that the x-ray was ready for analysis.
- Nurses did not notify Dr Bawa-Garba that Jack was deteriorating.
- The administration of medication for Jack's heart condition was not carried out by Dr Bawa-Garba.

These are important factors to consider whilst weighing up whether Dr Bawa-Garba should take sole accountability for the case. Arguably, whilst mistakes were made on her part, if the hospital had been staffed correctly as well as the right administrative and technical systems in place, the situation could've been prevented.

The Legal Battle

After the sentencing in November 2014, Dr Bawa-Garba appealed her sentence. The following occurred:

- **December 2016**. The appeal was denied by the Court of Appeal. Several Doctors were outraged by this decision and felt the court had not taken into consideration the working conditions in the NHS and lack of support for junior Doctors.
- **12-month suspension**. This Court ruling resulted in Dr Bawa-Garba being suspended from 12 months from the GMC medical register. The GMC applied to have her permanently struck off the medical register. However, the Medical Practitioners Tribunal Services (MPTS) refused this application, stating "erasure would be disproportionate".
- **January 2018**. The GMC controversially appealed against the MPTS decision in the High Court. The appeal was successful and resulted in Dr Bawa-Garba

being struck off the GMC medical register, preventing her from working as a Doctor.

- **Crowdfunding**. Following public outrage from junior and senior Doctors, a crowdfunding page secured funds for Dr Bawa-Garba to continue her fight.
- **March 2018**. Dr Bawa-Garba was granted leave to challenge the erasure from the medical register in the Court of Appeal. She won her appeal and the original 12-month suspension was reinstated.
- **November 2018**. The Doctor's Association UK (DAUK) launched the Learn Not Blame campaign, in an attempt to create a better culture that promotes learning from adverse events and focuses on fairness and openness of both patients and NHS healthcare professionals.
- **April 2019**. The MPTS deemed her to be a low risk to patients, and Dr Bawa-Garba was cleared to begin practising again. The two year practice period began in July 2019.
- **February 2020**. Due to lack of patient contact since 2015, Dr Bawa-Garba has returned to work with a lower grade than previously employed at and must work with close supervision and several imposed conditions.
- **July 2021**. The Medical Practitioners Tribunal Service ruled that Dr Bawa-Garba is now fit to practise without restrictions.

Potential Interview Questions

Understanding the key issues of the Bawa-Garba will provide you with a very important example to refer back to when answering ethics questions and Junior Doctor questions during your interview. Some example questions you could be asked include:

- What are some issues within the NHS that currently impact Doctor-patient relationships?
- Why is an interesting medical article you've read recently? What did you learn from it?
- Do you know about the Bawa-Garba case? Share your views regarding the situation.
- What are some important factors to consider during the Bawa-Garba case? Who is at the biggest fault in this case?

Private Healthcare and its Costs

The Facts

Sixteen million people struggled to access NHS care during the pandemic, and the knock-on effects are far from over, as waiting lists for scheduled treatments continue to stress the system.
More than one in 10 of those awaiting NHS care during the Covid crisis turned to private treatment instead.
In fact, since the 1970s, the UK has seen the fastest rise in people paying for private healthcare of all the G7 countries, according to the annual State of Health and Care report for 2022 from think tank the IPPR (Institute for Public Policy Research).
This figure should ring alarm bells for the government, as it shows people are not currently receiving the treatment they deserve or expect from the NHS, the authors said.
People should get treatment within 18 weeks of being referred by their GP, as stated in the NHS constitution, yet currently waiting lists stand at more than 6 million, with some patients waiting a year or more for care.
This is leaving many with the unwelcome decision of delaying much-needed treatment or paying for private healthcare.

However, many people are excluded from private treatment altogether because they can't afford it – a problem only worsened by the current cost of living crisis.
For the report, 3,466 adults were asked about the NHS, 17 percent of whom said they would choose private treatment if the alternative was a waiting list of 18 weeks or longer, from referral to treatment starting, on the NHS.
A further 59 per cent said they couldn't afford to go private, while 10 per cent rejected private healthcare on principle.
The authors of the report say that the pressure on our healthcare system is undermining the foundations and the spirit of the NHS, and that it risks an unequal, two-tier system emerging, where "a mediocre standard is available for everyone, but the best is only available to those who can and are willing to pay".

The Issues Faced

The decision to choose private healthcare will depend on many factors. The kind of treatment needed, the current delays in NHS care, the costs involved, and the patient's own feelings towards private care.
Within the scope of private treatment, there are also lots of options to choose from. It doesn't cover everything, though; emergency treatment, for example, is still mostly carried out by the NHS.
Costs vary depending on the treatment and where you are having it done. As an example, a full knee replacement costs on average £11,814, a hysterectomy is £6,545, cataract surgery will set you back £2,417, and an MRI scan costs around £395, according to figures from Private Healthcare UK.
You can pay for one-off healthcare, such as an operation, upfront. If you have the money to do this, it's usually best to pay from your income or savings.
To cover the costs if you don't have enough in savings, you could also take out a loan, although if choosing this route you will need to factor in interest payments.
Some treatments can also be paid for with a credit card. Again, however, there are interest payments to consider. If you're unable to meet the repayment costs of any kind of credit, it could damage your credit score and you could be penalised with extra fees.
Private medical insurance can cover the cost of some operations and treatment. There are lots of companies to choose from, and with most you'll choose the level of cover you want and then pay a monthly premium.
The amount you pay will be based on the cover included, alongside factors such as your health and lifestyle. The average price is around £1,500 a year or £125 a month, according to Unbiased.

Actions of Private Healthcare

Nina Brown, health propositions lead at Aviva UK Health, said insurers had seen a rise in sales of private health cover from individuals and businesses in the past year.
As one of the leading health insurers in the UK, it has many options for those thinking about private health insurance.
With one of its comprehensive packages, "cover is provided for acute conditions, cancer diagnosis, treatment and aftercare, outpatient cover including diagnostic tests, [and] specialist consultations and treatments, including for acute mental health conditions", she said.
For an extra cost, dental, optical, physiotherapy or osteopathy can be added, and to keep costs down, customers can reduce the level of cover or increase their excess, which is payable when they make a claim.
Yet, like most private healthcare policies, Aviva won't cover chronic conditions – including long Covid, anything pre-existing, or pregnancy and childbirth.

When you use a health insurance policy, you usually won't have to pay up front, and costs are recovered from your insurer.
However, some won't pay the full amount – just a percentage – and you will need to pay the rest yourself. There will also be an annual limit on the amount of money available.
It's worth checking with your employer before taking out any kind of insurance, as this is often included in company benefits packages.

The Implications

As covered, with extremely long wait times for the NHS, people are forced to turn towards private healthcare. But yet, private healthcare is extremely expensive in its own right and many individuals are unable to afford it, having to either wait on essential treatment or find a way to pay for it which could cause them to further go into debt given the high interest rates if they need to borrow to finance their treatments.
The risk of an uneven healthcare system is also high as mentioned above ("the pressure on our healthcare system is undermining the foundations and the spirit of the NHS, and that it risks an unequal, two-tier system emerging, where "a mediocre standard is available for everyone, but the best is only available to those who can and are willing to pay".) This undermines the effectiveness and the trust in the NHS, which is a big issue where the entire NHS could be affected.
The private healthcare industry is indeed profiting off from this, however this does not even support everyone who needs the essential healthcare. So in the instance of someone who needs life-saving treatment in terms of chronic conditions, you may not even be able to undertake private healthcare insurance to cover your costs, which deprives people of the essential treatment they need.

Potential Interview Questions

Understanding the key issues of private healthcare will provide you with a very important example to refer back to when answering ethics questions and Junior Doctor questions during your interview. Some example questions you could be asked include:

- What are your views regarding private healthcare?
- Would private healthcare affect the way the NHS functions in the long-run?
- Can private healthcare and the NHS function together in the long-run?

Audits (The Why and the How)

Audits are a systematic examination of current practice to see how it performs against the set standards, either the individual or institution or both. It is a method for reflecting, reviewing and improving practice. A fundamental part of the duties of doctors and ensures all are compliant with the guidelines and practice standards.

The How

It is mainly referred to as the "audit cycle" since it is mainly a loop. It goes something like this:

1. Choose a topic
2. Define a standard you would like to achieve
3. Collect relevant data
4. Compare results of analysis against standard
5. Identify changes that need to be made in order to reach said standard
6. Implement the changes and give time for the changes to be fully operation (aka let the changes take effect)

7. Re-audit the loop several months later to measure the impact of changes

Why are audits important?

There are a few reasons but the main ones would be:

- It identifies weaknesses in your practice to improve on and increases the quality of service that is provided
- It identifies inefficiencies and can lead to a better use of resources
- It is used to provide information about quality of care to outside agencies
- Audits provide opportunities for training and education

Pros and Cons

Pros	Cons
It identifies weaknesses in your practice to improve on and increases the quality of service that is provided It identifies inefficiencies and can lead to a better use of resources It is used to provide information about quality of care to outside agencies Audits provide opportunities for training and education	It can potentially take up a lot of time and resources to think of and implement a decent standard of strategies to actually lead to tangible improvements Doctors may not take it very seriously especially if they do not agree with the intentions of audits which in turn would lead to minimal improvements If an issue needs to be solved immediately, the impacts of audits can only be felt in the long run and not immediately

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List Of Buzzwords

Buzzword	Meaning + How to use it + Example
MDT	MDT refers to a multidisciplinary team, where healthcare professionals from any discipline come together for the patient's care such as anaesthesiologists, nurses, physios. **EXAMPLE:** If asked what is the role of the doctor, you can mention that within a MDT, the doctor can take on many roles, such as a leader, providing the focal point for coordination of care.
Creative Outlet	Creative outlets can show your personal life, highlighting the work-life balance that doctors and medical students should be able to maintain. **EXAMPLE:** If asked how would you balance your studies and personal life, you can mention that I have a creative outlet through my hobbies such as Photography, where I destress and take time for myself outside of studying.
Patient-centered care	Patient-centered care refers to the patient and their well-being at the core of any interactions. As we know, the patient is the "leader" in their care, as they are the ones

	that know best about how they are feeling, and can communicate this most effectively to the team. **EXAMPLE:** When asked what kind of care should be given to patients, you can mention that the goal is always to deliver patient-centered care, that the patient's needs should always be strived to be achieved whenever feasible.
Mental & Physical Wellbeing	Mental wellbeing refers to the emotional & psychological state of the patient. Physical wellbeing refers to the visible state of the patient. **EXAMPLE:** When diagnosing a treatment for consultations in a role-play scenario, it is important to consider both their mental & physical wellbeing, and not downplay any aspect of their wellbeing as both are equally important.
Autonomy	Refer to the section "The Four Pillars of Medical Ethics" for more detailed explanations and examples. **NOTE:** Not all questions will test you on ethics, and certainly not all questions need you to touch on all aspects of the medical ethics. Selectively pick and answer the question, elaborating further on the ethics selected.
Beneficence	
Justice	
Non-maleficence	
Hippocratic Oath	Hippocratic Oath refers to the oath made by Hippocrates, and while no longer as relevant in this day and age, some aspects have been adopted for use by the GMC and are relevant for the NHS. The crux and most important thing to note is "First, to do no harm" **EXAMPLE:** If asked how relevant the Hippocratic Oath is in today's Medicine, it would be first good to define the Oath and its parameters, before breaking down the benefits of the Oath and where it falls short. There is an interview question of such in the R/UCAT discord.
Communication	Not only is this one important attribute for a doctor, it is probably the most important skill in this profession as it requires us to communicate with not only patients, but the rest of the team as well and the patient's relatives if needed. **EXAMPLE:** If you are asked, what qualities make up a good doctor, you can start off with communication and explain further how the entire profession revolves around this attribute.
Shared Decision Making	Shared Decision Making (SDM) mainly comes into play when there are multiple healthcare professionals involved in decisions for the patients, and it can even extend to the patient, the family and any other relevant care authorities. **EXAMPLE:** When someone is making a decision for a DNR (Do Not Resuscitate) for whatever reason, the SDM can include the healthcare professionals such as doctors,

	nurses, the family of the patient and the relevant authorities such as a lawyer or court-appointed deputy.
Problem Solving	Problem Solving is highly relevant in the healthcare profession as almost every patient requires a solution to be solved via a diagnosis. We must often think outside of the box to think of possible solutions to offer to the patient. **EXAMPLE:** When a patient comes for a diagnosis / solution for their illness, we will ask the patient questions to slowly deduce the problem that they are facing, like jigsaw puzzles, before finally coming to a solution.
Resilience	Resilience is a key aspect of the lifestyle doctors face, given that we will be faced with many struggles such as a poor work-life balance, immense pressure or stress, or uncertain work settings due to changes such as global illnesses such as Covid. **EXAMPLE:** Medical school will be a challenge, from the first year you will be faced with the immense challenge of studying so much content regarding the human body, hence resilience is crucial to be able to stay strong throughout medical school.
Taking Initiative	Taking initiative is also important not just in medical school interviews, but also very important in medical school and the future work as a doctor. One should take initiative to clarify any doubts regarding the content studied, and actively look to garner work experience in preparation to becoming a doctor when we graduate. **EXAMPLE:** During the medical school interviews, if you are given a question in a PBL scenario together with other interviewees, taking the initiative to start the conversation and help the team progress would be very important and puts a good impression on you.
According to GMC guidelines	This is self-explanatory as a future professional, it is important to abide by the GMC guidelines. By saying this phrase, it allows the interviewer to understand that you have done your relevant research into the work that you will be doing in the future, and also shows the maturity and understanding of the profession. **EXAMPLE:** If asked a question regarding a medical ethic such as autonomy, it would be good to first define what the medical ethic is and also highlight the approach via the GMC guidelines to show your thought process and understanding of the strict rules and regulations faced by doctors.
Patient safety / care	Patient safety and care is the number one priority in any given situation. Since we are a “service-centered” profession, and we have the ability to “save lives”, we must prioritize their care as per the Hippocratic Oath.

	EXAMPLE: If given a question where you need to triage / prioritize certain tasks, you should always keep in mind or prioritize patient safety / care so picking the option that puts patients less at risk would be the most appropriate option.

General Breakdown of Interview Types

There are two types of interviews, being panel (traditional) interviews and MMI interviews. The main difference is that MMIs require you to work your way around a series of stations, where you'll face a different question or task with a different examiner at each station – whereas traditional interviews involve one panel asking you questions over a longer period of time. At the end, there are some interview tips as well.
Let us break down the interview types:

Panel / Traditional

- You could be interviewed by a GP or Nurse, a Lecturer or Admissions Tutor, a Junior Doctor or existing Medical Student – or someone else altogether.
- Traditional interviews are question-focused, rather than task-based. Instead of having to role-play a scenario or communication task, you'll be asked a number of questions that you need to answer.
- The interview may feel more like a conversation between you and who you're being interviewed by, rather than a series of back-to-back questions. Plus, you'll have longer to think about and elaborate on your answers than you would have in an MMI. These are strengths of the traditional medical interview format.
- It can last anywhere from 20-40 minutes, and the questions are not released before time, nor are you allowed to discuss after the session.
- Also remember you will not get a break between questions for a panel interview, so it can get intense!

Tips for Panel / Traditional!

- Make sure you're familiar with your Personal Statement. Be prepared to answer questions about anything you mention in it, especially voluntary work or work experience placement.
- Do your research. Know what the Medical School is looking for in its applicants and what they want you to show in the interview. You can find this on their website or by reading the specific school interview segment.
- Understand the course. Research their teaching methods and be ready to discuss why you wanted to apply to the course, or why you would suit this style of course.
- Breathe when you need → answering a lot of questions without a 1-2 minute break can be tiring

MMI Interviews

- MMIs are broken down into 'stations' – or mini-interviews – that usually last 10 minutes or less. Before each one, you'll be presented with a scenario and given a bit of time to prepare an answer. You'll either be asked a question by an interviewer or have to engage in a role-play scenario with an actor whilst an interviewer watches.
- MMI Interviews will take about 2 hours, no more than 10 mins per station, and most universities have at most 10 stations.

- It can include stations such as role-playing, professional judgement, prioritisation, giving instructions, calculation, data interpretation and PBL.

Tips for MMI Interviews!

- Be confident! Calm and collected will impress the examiner from the get go, both traits that are necessary in this profession
- Ask if you need clarification, rather than trying to answer a question you haven't fully understood.
- Listen carefully to the question. Your interviewer will often provide cues or prompts designed to direct you and give you key bits of information.
- Be sensitive and compassionate. MMIs are designed to test your communication skills.
- Don't second-guess the answer. There are often no right answers – it's your explanation that they're interested in.
- Don't be tempted to prepare answers in advance. It's much better to carefully think through the question or scenario you're presented with.

How should I prepare for MMI Interviews?

- Use your work experience. Lean on this and use specific examples when giving a response.
- Know what it takes to be a good doctor. Make a list of qualities and practice demonstrating them in your responses.
- Practice giving eight-minute presentations in response to common MMI interview questions. This will help with time management on the day.
- Make sure you understand key ethical concepts relating to medicine, like the four pillars and patient confidentiality.
- Keep up to date with medical news, and check out our Hot Topics section. Questions may be inspired by stories or debates in the media.

MMI Role Play Questions

The first tip for tackling your MMI role play station is to read the scenario in detail. Think about your role in the scenario.
If you identify the context of the role play station early on, you can tailor your responses accordingly and you will perform much better.
The MMI role play station tests your ability to communicate more so than the other stations, so you need to demonstrate that you're a good communicator. You should:

- maintain good eye contact with the actor
- make sure you're actively listening, and nod your head occasionally to demonstrate this
- don't go overboard with your hand gestures
- speak slowly and clearly, and allow the actor as much time as possible to speak so they can tell you their story
- briefly repeat some of the things that have been said by the actor at an appropriate interval, to show you have taken in the information they've given
- don't interrupt or talk over the actor
- change the tone of your voice when appropriate, adapting to the context. For example, if you're speaking to a young patient, you'll want to use different vocabulary

The most common MMI role play station involves breaking bad news because interviewers want to see that you can show empathy.
These tips will help you show empathy during your role play station:

- the best way to break bad news is to give a brief reintroduction or catch up depending on the scenario
- give the actor a 'warning shot' before delivering the bad news. For example, say clearly 'I'm afraid I have bad news which I have to share with you…' or

'I'm in the difficult position of having to tell you…'. This will soften the news for the recipient.
- deliver the bad news and, most importantly, pause straight after giving it
- give them space to react to the news. The actor may begin to cry or become angry and visibly upset. Your next response will depend on theirs, so make sure you're really engaged with the conversation.

For example, if you have an MMI role play scenario where you must tell a neighbour that you broke their favourite ornament, then apologise first. You should explain that you know how much it meant to them and that you are willing to compensate them. Ask if there is anything you can do to help.
Empathy is all about putting yourself in the other person's shoes and you can do this by using phrases like, 'I know this must be really difficult for you'. If the actor begins to cry, you could offer them pretend tissues or a pretend glass of water if available.
There are two possible scenarios which are the most commonly tested: Breaking bad news and dealing with angry patients / relatives.

(SPIKES) Breaking Bad News

Structuring the consultation

SPIKES is an effective way to structure your breaking bad news consultation.

Setting

It's important to break bad news in an appropriate setting:

- The discussion should occur in a comfortable, quiet and private room. Although this is not always possible, make sure you have at least some privacy and that the patient and family have somewhere to sit. Bad news should never be broken standing in a corridor!
- Make sure to have some tissues available.
- Ensure both you and the patient/relative are sitting down.
- Arrange the chairs if necessary (e.g. at approximately 45-degree angles to each other), avoiding physical barriers between you and the patient (e.g. a desk).
- Ensure you have uninterrupted time during the meeting (turn off beepers and phones).

Other people who may be helpful to have in the room when breaking bad news:

- Other healthcare workers can provide support in breaking the diagnosis, for example, a nurse specialist.
- Ask the patient if they want anyone to be with them: "Would you prefer to have a family member or friend here?". Likewise, if there is someone else already in the room, check to see if your patient would prefer to be told alone.

Perception

Begin by discussing the sequence of events leading up to this point (e.g. scans, biopsies, etc) and assess the patient's current emotional state.
Ask about any symptoms the patient may have been experiencing up to this point. Here you could agree with the patient and say something like: "Yes, the reason we wanted to do the tests were so we could find out why you have been experiencing the symptoms you just described to me. Were you aware of what sort of things the investigations might show?"
Establish what the patient already knows or is expecting, the patient may or may not have been made aware of the possible diagnoses. If they don't know of the possible diagnoses, you could say something like: "Symptoms like the ones you've been describing can

sometimes be as a result of an infection, but sometimes they can be as a result of more serious underlying conditions". This can also act as a warning shot.

Invitation

Check if the patient wants to receive their results today – in an OSCE setting the answer will always be yes, however, on the wards, be aware that some patients may recognise the news may not be what they hoped for and may want to put it off until family are present: "I have the result here today, would you like me to explain it to you now?".

Knowledge

Ensure you deliver the information in sizable chunks, and regularly check the patient's understanding.
Use a warning shot to indicate that you have unfortunate news: "As you know we took a biopsy/did a scan, and unfortunately the results were not as we hoped".
Allow a large pause if necessary, so the patient can digest what you have told them.
Then provide the diagnosis using simple language: "I'm sorry to tell you this, but the results from the investigations show you have cancer".
Use the correct language. Cancer is cancer, death is death. There must be no ambiguity about what the results show. Avoid using euphemisms or medical jargon.
Deliver information in chunks, pausing between each piece of information. After giving the diagnosis, it's wise to wait for the patient to re-initiate the conversation.
Example of using pauses
"I'm afraid it's not the news we were hoping for Mrs Brown."
PAUSE
"Unfortunately, the lump is due to a more serious underlying cause."
PAUSE
"I'm so sorry to tell you, but you have breast cancer."
PAUSE until the patient speaks, or seems ready to talk again.
Make sure your tone is respectful, at a slow pace and clear.
It is very natural for the patient to have an emotional reaction at this stage. They may go quiet, ask questions in disbelief, deny that this is happening, start crying, or become hysterical or angry. These are all normal reactions to hearing bad news and each person will respond in their own way.
Give the patient TIME to have their emotional reaction. People often find it very uncomfortable watching patients like this but it is important to give the patient space to react.
Questions in disbelief such as "This can't be happening, can it?" or "But how am I supposed to deal with this?" are often asked at this stage. Make a judgement about whether you need to answer the questions directly, saying something like "I'm so sorry I had to break this news to you today" might be all you need to say at this point.
If they are making eye contact with you and asking questions like "So what will happen next?" then it is probable that they are ready to receive answers to their questions.

Emotions and empathy

Recognise and respond to emotions with acceptance, empathy and concern. Acknowledge and reflect their emotions and body language.
Do not lie when the patient asks questions about prognosis – it is not kind to give false hope. If you do not know information, tell them that, and suggest that you can refer their case to a specialist or that more information is needed.
"I'm so sorry, but at this stage, I don't have enough information to answer that. Hopefully in the next few weeks once we've completed other tests I can be clearer. Sorry, I can appreciate that it's frustrating to be left with unanswered questions'.'

Some useful phrases may include:

- “I can see this is a huge shock for you”
- “I can see that this is not the news that you expected, I’m so sorry”

Think about how a patient might feel when giving them any new information about their condition, and how it may impact their lives.

Strategy and summary

Make a plan together to meet the patient again and inform them of what the next steps are.
Reassure the patient that they are going to be referred to the appropriate team of specialists (if appropriate) or inform them of the follow-up arrangements.
Try not to rush the patient to make decisions about their treatment (if possible), it is respectful and considerate to let them process what has been told to them.
Check the patient’s understanding of the bad news you have delivered.
Summarise: respectfully and gently repeat any important points – patients who are shocked or upset will not take in much information.
Ensure to answer any questions or concerns that can be addressed at this stage (and listen out for any implicit ones).
Offer ongoing assistance to the patient should they think of any further questions – this may involve giving them details of a clinical nurse specialist.
Offer assistance to tell others (e.g. other family members) the bad news.
Highlight where the patient can go to gather more information or gather any support (support groups, websites).
Offer written materials if relevant and available.
If appropriate, consider asking about religious preferences, and whether the patient would like the Chaplain.

Dealing with Angry Patients / Relatives

Learning how to deal with angry patients and/or relatives is a valuable skill we can develop to support us in clinical practice. Given the nature of the healthcare environment, you will almost definitely encounter these situations in placements or when you start work. It is also a common station in OSCEs.
In this guide, we will talk through some strategies you can use to assist in these interactions, hopefully resulting in a more positive outcome for both you and the patient or relative.
Examples of reasons why patients/relatives become angry:

- They have been left to wait a long time before being seen in clinic or A&E
- An error has been made by the medical/surgical team
- There has been a delay in diagnosis or treatment
- They have just received bad news
- The patient/relative expectations are not being met

These issues can be exacerbated by drug or alcohol use, underlying mental health problems, a history of anger management issues and or violence/aggression.

Recognise that the patient is angry

It is very important that we first identify that the person we are talking to is angry.
The skill of identifying emotions is very useful when communicating with patients and relatives. Once the emotion is identified we can then start to respond accordingly with empathy, reassurance or an apology, depending on what the patient is feeling and what events have occurred.
People will vary on how they behave when they are angry. Sometimes it is very obvious. The patient may even state that they are angry.
You might note the following behaviours when a patient is angry:

- Loud speech or shouting
- Swearing/verbal abuse
- Oversensitivity to what is being said
- Aggressive posturing, not wanting to sit down
- Walking/threatening to walk away
- Pacing up and down
- A rise in the pitch of voice
- Shaking/fist-clenching
- Change in eye contact (e.g. suddenly looking down)
- Frowning

Other patients may display anger subtly (e.g. quiet and seething), however, you may still notice a sudden change in their demeanour, or how they are communicating with you. They may go quiet or start to give one-word answers. It can be useful to notice the subtle signs that patients are angry so we can address the emotion before it escalates.

Adjusting your style of communication when a patient is angry

Once we recognise our patient is angry, we can adjust our style of communication to try and defuse their anger or at least prevent them from becoming angrier.

Voice

Adjust the tone, speed and volume of your voice:

- Try to keep a calm tone and remain composed (this can be difficult when you are being shouted at)
- Speak slowly and clearly
- Do not raise the volume of your voice if the patient is shouting

Body language

Adopt a professional yet relaxed posture:

- An example, if seated, might be uncrossing your arms and legs with both feet on the floor.
- Sitting back in the chair can help slightly (though taking care not to appear like you don't care) to avoid appearing confrontational.

Acknowledge the patient's anger

At this stage, pointing out to the patient that they appear upset/angry can be helpful:

- An example might be: 'You're looking very upset by all of this'
- Sometimes hearing this back can enable the patient or relative to recognise their emotion and start to process it.

The patient might respond in two ways:

- They may correct you: 'No, I'm actually just frustrated' (you can then adapt to deal with the other emotion).
- They may agree 'absolutely' or 'of course I am!' (you have then confirmed the emotion).

Try to understand why they are angry

Often there are other emotions behind the anger for example frustration, or more commonly fear.

Ask open questions to identify the focus of why they are angry:

- 'Tell me more?'
- 'Why are you feeling this way?'
- 'Is there anything else that happened that is making you angry?'

Listen to the explanation as to why they are angry:

- Demonstrate active listening skills such as eye contact, nodding, verbal responses (e.g. 'mmm').
- Allow the patient to vent at you completely if needed – they may need to get some things off their chest. Give them plenty of space to speak.

- Avoid interrupting the patient * (see the note on interruption below).

Respond to the anger

Once you have gathered information about the patient's anger, and you feel they have said what they needed to say, start to respond to their anger and the situation they have described alongside answering any questions they may have.

Empathy

At this stage, it can be useful to demonstrate empathy towards the patient. Essentially this is the acknowledgement and appreciation of someone else's emotions.
Empathic phrases you could use are:

- 'Given everything you've told me, it's understandable you feel that way'
- 'It sounds like you have a lot going on at the moment, and it's natural that you're feeling angry'

When you demonstrate empathy, it can help make patients feel cared about and listened to. This helps build a rapport between you and the patient – potentially diffusing their anger and creating a safe environment for patients/relatives to talk openly.

Apologise if an error has occurred

If the patient is legitimately angry as a result of a medical error– apologise.
A phrase like the following could be used: 'I'm so sorry this mistake has occurred and caused you/your relative harm',
Acknowledge the seriousness of the mistake made and legitimize the patients' anger.
In the scenario of a serious medical error, it is often useful to explain to the patient or relative that when medical errors do unfortunately occur they are taken very seriously and reports are filed to ensure things like this do not happen again.
If you or the medical team is not at fault, however, be careful about how you apologise. Do not enable the patient to blame when you have not done anything wrong. You should still apologise that the unfortunate event has occurred e.g. 'Im sorry that you are feeling so angry about what has happened', whilst being careful not to assume responsibility if you or the healthcare team
were not at fault. This may affect the patients' expectations in the future.

Thank the patient

Sometimes it can be appropriate to thank the patient (e.g. 'Thank you for sharing how you feel with me, it's important I understand how you feel so we can work together to help you').

Encourage questions/solutions

You might like to ask the patient or relative if there is anything you can do for them. This shows again that you care enough about the situation that you wish to help rectify it (e.g. 'What can I do to help you?').
Sometimes when people are angry they have difficulty thinking of solutions and therefore they may welcome your attempt at suggesting one.

Closing the interview

Conclude the consultation by thanking the patient/relative for their time.

Suggesting a plan going forward can help make sure a patient/relative does not feel abandoned soon after being very angry. Formulating some action points going forward also helps to acknowledge the patient's anger.
Some examples might include:

- Organising a meeting with the clinical nurse specialist if the patient is dealing with a difficult diagnosis.
- Advise that you are going to pass on the information to a senior if an error has occurred.
- Organize a follow-up meeting with the patient or relative if they wish to discuss the situation further, and suggest they perhaps note down any questions they think of so you can be sure to address their concerns.

Things to avoid when speaking to angry patients

Suggesting a quick fix

Often patients want/need to explore the emotion they are feeling rather than finding a quick solution. Obviously, this will depend on the scenario but think carefully before coming up with a rapid solution that may not even serve you well.

Getting angry yourself

Try to be mindful and aware of how the interaction with the patient is making you feel. You, in turn, might feel angered by how the patient is speaking/the things they are saying. Try to keep control of your emotions and remain professional. You may feel entitled to being angry but demonstrating this to an already angry patient is likely to upset them even more. Perhaps talking to a colleague about the situation afterwards would be more helpful, should you feel the need to do so.

Being defensive

Becoming defensive might feel like the natural thing to do, particularly if you are feeling like someone is being angry at you for no legitimate reason. Try to avoid the temptation of responding defensively as it can escalate the patient's anger.

POSSIBLE SCENARIOS

The patient/relative is angry and does not want to sit down

If initially, despite offering the patient a seat while you are both standing the patient refuses to sit down – it is important that you do not fixate on the fact they need to sit down. It might be that they are full of anger or another intense emotion and thus feel more comfortable standing up. If you repeatedly ask them to sit down in quick succession they may feel more irritated by this.
Sitting down from standing while the patient or relative is standing up, however, can feel awkward, and perhaps even threatening if they are particularly angry or aggressive.
If they are not seeming like they are going to sit down anytime soon, sometimes remaining standing and talking to the patient at this same level can be helpful. So long as you are not aggressive in your posture, this is ok. As you communicate with the patient further they may start to relax – you can then offer the patient a seat slightly further into the consultation.
If you are both seated to start and the patient then becomes angry and stands up, sometimes it is appropriate to remain seated in this situation, so as to not appear confrontational.

If you feel threatened by an angry patient or relative

Some patients or relatives can become very aggressive when they are angry. They may have issues controlling their emotions and behaviours.
Occasionally when communicating with patients we may feel there is a possible threat of violence. If this is the case you should remove yourself from the situation and prioritise your own safety. Positioning yourself between the door and the patient can be helpful in this sort of scenario (making sure you're not blocking the exit for the patient).

Avoid any sort of physical confrontation with the patient/relative. If you can see the conversation escalating, or witness the patient or relative become angrier or start to lose control, act before it's too late. Make an excuse and leave if you have to.

Your colleague is to blame

You may encounter a situation where your colleague(s) have made an error and the patient/relative wishes to blame them. They may even start to speak about them badly in front of you.

In this situation, try not to get too defensive about your colleague. The patient may be legitimately angry. Use neutral phrases so as not to share your personal opinion about your colleague's performance. Try not to encourage the patient to be abusive.

Phrases such as 'I'm so sorry this happened' may be useful in these scenarios.

Ideally, the colleague who made the mistake should be apologizing to the patient directly, so any anger or questions can be dealt with in a conversation directly between the two of them.

The patient/relative is still very angry despite your best efforts

Sometimes despite our best efforts and excellent communication skills, patients may remain very angry. It may even be unreasonable to expect to diffuse someone's anger in one conversation, depending on the situation. Anger and other intense emotions take time to dissipate.

The patient/relative wishes to file a complaint

First, explore why the patient or relative wishes to file a complaint. This can be helpful as the issue can perhaps be dealt with on the spot. However sometimes regardless of the conversations, patients and/or relatives may wish (and are entitled to), file a complaint.

It is your duty to ensure that any patient or relative that wishes to file a complaint is given the information to do so (e.g. providing them with the contact details for the Patient Advice and Liaison Service (PALS)).

You are allowing the patient/relative to 'vent' and they are making themselves angrier (interruption can be helpful)

Sometimes we can see the patient is winding themselves up as they are venting at you – becoming angrier and angrier, with their emotions spiralling out of control. If this is the case, a gentle interruption can be helpful. Ensure the interruption includes an apology and/or empathy. You might use a phrase like 'I'm so sorry to interrupt you – I can see that this has made you very upset. I'm so sorry this has happened. Is there anything I can do to help?'.

Professional Judgement Questions

The professional judgement MMI station is often a role play scenario, when you're asked to act out a scenario with a colleague or patient. It's designed to assess your ability to make professional judgements in pressured situations, your communication skills, empathy and ability to judge patient safety. Essentially, it is an SJT station that is acted out.

If your professional judgement station involves role play, make sure you spend some time making conversation at the start. Doing this will demonstrate your ability to judge a potentially volatile situation and put others at ease. This scenario is all about communication skills and building trust while making professional decisions – and you can show this skill by making sure they're comfortable.

Being sensitive is one of the most important aspects of professional judgement. Many scenarios may involve taking a colleague to one side and asking them about sensitive topics, so it's important to demonstrate empathy.

If the station is a role play, the person acting as your colleague may become defensive, embarrassed or upset, and you'll need to make sure you show sensitivity. Remember to ask them how they're feeling and if you can help. Make sure your tone is understanding and kind, rather than accusatory. This will show your examiners you're able to handle difficult and emotive situations sensitively and sympathetically.

When presented with a professional judgement scenario, make sure you prioritise patient safety. Remember that, despite your relationship to your colleague in the scenario, patient

safety is crucial so you'll need to show that you understand this. It's important to prioritise patient safety above all else.

Prioritization Questions

A prioritisation station is when you're asked to prioritise a number of things with a specific scenario in mind.
This type of station is designed to test your ability to cope well under pressure in timed conditions, as well as your rational thinking.
The prioritisation station is really a test of your ability to think rationally under pressure – so take a moment to calm yourself and consider each object or individual given.
Ground your selections in rational thinking and make sure you consider carefully so you can explain your reasoning to your interviewer.
The best thing to do in these situations is to communicate your thought process aloud to show that you can think clearly in these circumstances.
All stations during your MMI will be timed, but this one may feel particularly pressured. However, it's important not to panic.
Don't feel so overwhelmed by the time frame that you rush straight into selecting objects or individuals immediately without considering why. Taking a few moments to calm yourself at the beginning of the station will make your decisions much better.
Additional input from @paria:
Prioritize what will **KILL THE PATIENT FIRST** and address that **FIRST.**
Use NEWS scoring and current clinical trends to support your answer (more on that in a bit), remember that they want **SAFE AND RELIABLE** people to count on.
Remember to weigh scenarios in terms of importance, such as A>B>C>D>E
Suggested opening:
I would prioritize the patients based on clinical urgency. I acknowledge that they are all unwell and need help, and would first look for colleagues to help. In the event there is not…..
I will assess this patient based on NEWS scoring, and then this patient because of……
I will page / bleep my colleagues regarding patients…., kindly ask for another set of observations, location and request that they meet me at the patient's bedside whilst I am walking towards the ward. I would then perform an A-E assessment, before explaining what A-E is & what you will do….
This is the table for NEWS Scoring:

This is how A-E assessment works:

Giving Instructions Questions

The MMI station will ask you to do something like explain how to tie shoelaces without using your hands or give directions using a map.
One of the best tips for the giving instructions station is to break the task down into smaller steps to complete the task – and try to verbalise a clear, logical thought process.
Some tips include separating each instruction according to each step and the use of clear transitions, such as 'next' and 'then', to make your instructions clear to your interviewer and help you to focus on each step.
Most of these stations will focus on your ability to explain actions and processes, so it's important to be as specific as possible with your word choice.
With these stations, the trick is to begin by stating what the goal of the task is ('our goal is to tie these shoelaces and I'm going to give you instructions') and then check that the actor or interviewer is ready.
The person following your instructions may deliberately misinterpret what you say to test your ability to re-word your instructions. For example, they may try to tie the wrong shoelace

or put a red block in the wrong place. In these situations, it's best to use specific, instructive words.
The key here is to be ready to re-word what you say to suit the actor's behaviour. They may be continually getting it wrong to test your patience, so do not flare up.
As well as testing your communication skills, don't forget that giving instructions stations are also testing your resilience, patience and ability to stay calm and persevere under pressure. It will be quite frustrating if, as mentioned above, the actor continually misinterprets your instructions – but remember to stay calm!
The interviewers are assessing your approach to the task, not the outcome of the task, so don't worry if you don't manage to guide the actor successfully. As long as you have attempted to instruct them to the best of your ability, stayed calm and reworded your instructions where appropriate, you'll be marked well.

Calculation and Data Interpretation Questions

A data and calculation MMI station will involve you taking some key data and being able to make calculations or analyse and interpret the information. You'll usually get between five and seven minutes to complete this mathematical station.
At some Medical Schools, you won't be given a calculator during this station, so a good way to prepare for these is to practice your mental maths beforehand.
You may be given a sheet of paper for your calculations, so practice working out basic sums by hand and completing practice questions, like the ones above.
Be mindful of the units in drug calculations, and practice your conversions between metrics – for example, converting from micrograms to grams and between decimals and percentages. It may be a good idea to memorise some of these basic conversions to assist you.
At a station on Data Interpretation, you may be given data to discuss – this could be on anything from study findings on blood glucose to heart monitors. This doesn't involve calculation but assesses your ability to analyse data.
These stations draw on basic Biology and Maths knowledge – for example, with the second question above, this would require maths knowledge of graphs/gradients, and also biological knowledge of antibiotics and how they work – topics you will already have an understanding of through GCSE or A-Level.
Your interviewers won't expect you to notice everything about a chart or graph, but they want to see that you can use this data to spot trends and draw some conclusions.
With these stations, the key is to vocalise your ideas and don't be afraid to state the obvious. Spend some time establishing what the graph is showing. What does the x or y-axis show? What are the variables? Is there a sudden rise or decline and what does that suggest? Remember to vocalise these things aloud, using the numbers from the graph. Then remember to focus on what the interviewer has asked you – for example, with the insulin graph, look for the specific patient and describe any trends you see in their insulin levels.
Another way to prepare for this kind of question is to keep on top of the content covered in A-Level Biology. Take a look at some of the graphs from past AS papers and the kinds of questions that were asked to familiarise yourself with interpreting graphs.
Two key terms that often appear in these papers are 'describe' and 'explain' – you could take a similar approach to the MMI data analysis. What do you see, and what does that signify?
These questions may draw on basic Biology knowledge you will have covered at school – for example, insulin levels or antibiotics – so these past papers will also be useful to get used to these kinds of graphs as well as refreshing your knowledge.

PBL Stations

A PBL station is when you experience a mini problem-based learning lesson alongside a group of other interviewees.

A rough overview of how you work through PBL sessions would be as follows:

- Read through the scenario carefully and clarify any terms you're unsure of.
- Talk through the issues raised in the scenario as a group.
- Turn these issues into learning objectives that you could research.

Obviously, at an interview, you won't have to go away and do the research, but you should treat it as if you would research the issues raised. This will help you engage with it fully.
Although it's important that you have your voice heard, don't speak over other people in your group during PBL sessions – that's not demonstrating good teamwork or listening skills! Listen to what other people have to say and respond accordingly. It'll help you gain a better understanding of the problem and is key to any teamwork-based exercise.
Everything you need to form your learning objectives is in the scenario. Don't go off course trying to think of complicated or abstract learning objectives. Think about what's in the scenario and why it is there. This is where the learning objectives come from.
Clearly, if a disease or treatment is mentioned in the scenario, you're going to need to look into it, but also consider the basic science. For example, if someone has broken their leg, don't just think about how to fix it but also the basic anatomy of the leg.
If you know something about the topics covered in the scenario, don't be afraid to share it. This will help people think more about the problem and show the observers that you have read a bit around the subject of medicine.
This is the role of the chair in a normal PBL situation but you may not have one at interview. By encouraging everyone to take part, this will show you understand that PBL is a team sport and you're interested in what everyone has to say.

General Interview Tips

1. Use Other Peoples' Praise
You need to showcase your qualities but don't want to sound arrogant. In practice, this can be tricky. For example, you might get asked what your best trait is. You can answer this question but avoid sounding arrogant by citing what others have said about you in your Medicine interview.
2. Read the GMC's Ethical Guidance
You only have up to four interviews to demonstrate your suitability for medicine. We urge all aspiring medics to read the General Medical Council's Ethical guidance for Doctors document.
At the end of reading it, you'll have a clear understanding of the role of a Doctor and can start speaking a little more like one in your Medicine interview.
Key buzzwords like this will help you stand out, as long as you can back them up. Acknowledging the growing importance of a doctor's roles as a teacher would also demonstrate insight.
3. Be aware of Body Language
Usually, you'd be advised to make eye contact and introduce yourself once you've entered a room – and to shake hands if the set-up allows it.
This isn't possible with COVID. Instead, make sure you maintain eye contact by looking directly into the camera. If you're facing a panel, always include all the assessors in your answer delivery.
Some tips for your body language:

- Don't be too fidgety, but equally don't sit completely still
- Try to stay natural
- Film yourself practicing, so you can see how you come across. You'll quickly notice your little quirks!
- Don't be afraid to smile

Specific School Interview Qns & Breakdown

In this segment we will break down specific interview questions by the schools that you can scroll through the sidebar and select the school respectively. How this is different from the Practice Questions is that these questions were collated from websites, and I will try my best to provide good answers + points to explore for our responses. The practice questions will be from ISC Medical Book mainly and We are Medics Interview Guide, and are more generic-based, so the questions asked may be the surprise type of questions where it is not so medical related.

I will also try to provide a breakdown of the school's medical curriculum, the city in general etc and also anything else I feel will be useful to help out with the answers as much as possible.

University of Sheffield

It has been recently confirmed that for this admissions cycle (for 2023 entry), that Sheffield will be holding interviews online, and the format of interviews will be carried out in a MMI format. (See Section "General Breakdown of Interview Types"). Before going too deep into their interview questions and how to answer them, let us look into their medical school curriculum, the attractions of the school and city, and other useful information.

Medical School Curriculum

Sheffield focuses on a patient-centered approach, and they believe that all teaching and learning should be based from the perspective of the patient. You will learn through clinical teaching on wards in hospitals, clinics (both in general practice and in hospitals), lectures, seminars, tutorials, small group work, dissection and personal development supported by experienced teachers and personal academic tutors. Sheffield carries out **full-body dissections**.
From the website, they seem to be focused on an Integrated approach, with heavy emphasis on patients and interaction with them.
Their course aims are: (**GOOD TO REMEMBER**)

- to equip students with the essential personal and professional skills required throughout the rest of their course and in their future careers
- to integrate the basic and clinical sciences throughout the course
- to cultivate in students an attitude of curiosity and a desire for intellectual exploration and critical evaluation

Some skills / understandings that the curriculum aims to address / incorporate in their medical students:

- Communication and interpersonal relationships
- Patients' perceptions
- Biology of disease
- Epidemiology and Public Health
- Evidence-based medicine

They have a breakdown of their 4 phases throughout the 5 years.

Phase 1 (Introductory Clinical Competency)

There are a lot of things / factors that they aim to address in Phase 1, but I will highlight some segments for those who are keen, such as MPEs (Multi Professional Experiences - 2 week teaching block aimed to impart clinical skills) and the Early Years General Practice Placement (10 half-days through year 1, which begins as early as week 2 of the first term), and lastly the Community Attachment Scheme.

Why are these so unique / you identify with them? Well MPEs give you an in-depth insight into the daily workings of the doctors / healthcare staff where work experience may not have been able to do so, additionally it also allows you to learn some clinical skills for practice / understanding which would be very useful for clinicals in the later years. The Early Years GP Placements will also allow you to have a good understanding of the profession and the more detailed workings.
In regards to the CAS (Community Attachment Scheme), you would be able to see the impact the profession has on the community, reminding us of the importance on the "patient-centered approach" and how important it is that we are able to relate to the struggles / issues faced by the community so we can figure out ways to help them (i.e accessibility issues, insufficient dedicated healthcare services etc)

Phase 2 (Basic Clinical Competencies)

A few factors worth mentioning here would be the 6-week research project undertaken at the start of the term, the split of Phase 2 into 2a and 2b, as well as a 12 week longitudinal integrated clinical placement (LICP1) in one of the hospitals in or around Sheffield.
The 6-week research project is important as while doctors are involved in the caring of patients (like how we normally see them), research still plays a large role in this profession, helping the creation of new advancements in healthcare technology, and improvements to the field will go a long way to improving the healthcare system. Getting the chance to be attached to researchers will also be helpful, as you literally get to learn from the best.
The splitting of Phase 2 into 2a and 2b allows for a clear transition in the curriculum, and what is expected from you / what you can expect to learn. 2a allows you to continue working on the theory of becoming a doctor, the essential content needed. 2b allows you to spend more time in the field, as if we are junior doctors, spending time at OPD clinics, ORs and wards. This will focus more on the practical side, the skills and the interactions needed to build clinical experiences.
LICP1 is designed to provide you with the opportunity to develop the skills that are fundamental to clinical practice (history and physical examination. You will be encouraged to use the information that you have already gained to formulate diagnoses. You will become part of the clinical team and will attend and participate in many of the everyday activities of the team, such as ward rounds, surgical operation, pathology meetings, and outpatient clinics. Why this is so unique is because it allows you to feel "involved", compared to other settings where you may be more of a shadowee and learn less as you do not get to do it hands on.

Phase 3 (Extended Clinical Competencies)

Phase 3 lasts just under two years and is clinically based. It is a period of study and clinical experience taking students into both primary and secondary care of the patient with an emphasis on 'hands-on' medicine.
The primary care element involves community placements centred on General Practice. Some things worth highlighting are that for secondary care, you are able to do more specialised placements through certain sub-specialities such as OBGYN, Mental Health, Women's Health.Students rotate in small groups through these disciplines and receive various forms of backup including small group work, seminars, tutorials and lectures.
The emphasis is on **evidence-based learning** and you are encouraged to learn by investigation and teamwork. The speciality teaching includes projects and team presentations. You also have an opportunity to study areas of particular interest to you in the Student Selected Components elements of the course.
Essentially, Phase 3 is more towards individual learnings and looking into what interests / does not interest you.

Phase 4 (Final Preparation for Clinical Practice)

The final year of the course will provide you with the opportunity to prepare for clinical practice after graduation. The year begins with a series of lectures that will allow you to consolidate and further develop your knowledge over a wide area of clinical medicine
.
You will then undertake the two longitudinal integrated placements (LICP2 and LICP3) which will be in a different hospital and clinical area from LICP1. The structure of LICP2 will be similar to LICP1 (attached to a clinical team, defined role and responsibilities, additional experiences in other departments and regular classes) but will reflect your increased experience and competence. After the Christmas break, you will continue to develop your competence in LICP3 in another hospital and clinical area.
The differences in LICP1 and LICP2 / LCIP3 are that you may now be able to take on more responsibilities given your increased amounts of training, essentially trying to emulate FY1 settings when you graduate and start your foundation programmes.
Most graduates continue their medical training in postgraduate foundation programmes. The student assistantship will provide you with six weeks of experience in the post you will take up in August (this can only be guaranteed for students who will be staying in the local area).

Attractions of School / City

- A top 100 university (QS World University Rankings 2023)
- Research Excellence Framework 2021 (92 per cent of our research is rated in the highest two categories)
- No 1 Students' Union in the UK (Whatuni Student Choice Awards 2017-2022)
- 92% overall satisfaction (National Student Survey 2019)
- University of Sheffield is within the top 100 in the world for clinical and health subjects (Times Higher Education (THE) World Subject Rankings 2021)

Apart from the accreditations attained by the university, Sheffield boasts a range of sights, attractions, and benefits within the city, from the arts, outdoors, nightlife, shopping to the food and drinks available.
I will focus on a few aspects of Sheffield specifically, regarding the city it is based in, before looking at the university.

An affordable city
Sheffield is the most affordable student city in the UK according to The Royal Bank of Scotland’s Student Living Index 2021

A student city
Cheap bus fares, student festivals, incredible food at discount prices - Sheffield is a city built for students

A creative city
Sheffield is known for its music, art and digital scenes, and has one of the largest regional theatre complexes outside London

A green city
60 percent of the city is green space: over two million trees, 250 gardens, parks and woodland areas and a third of the city lies within the borders of the Peak District national park

A diverse city
With 7,000 international students from 150 countries, and welcoming communities from all over the world
Moving onto the Medical School, some aspects are listed below.

Sheffield’s research contributions
From collaborating with Malta’s Ministry of Education, Sport, Research and Innovation via the signing of a collaborative partnership to facilitate knowledge exchange, to contributing

towards the research in fighting against COVID-19 and the recent publication of the paper revolving around “proteins that help sperms fuse to eggs + improving the fertilization treatments” where the professors from Sheffield contributed towards, Sheffield is a great place to join if interest in research is high.

Sheffield’s Healthcare Gateway

The Sheffield Healthcare Gateway provides a key point of access for businesses to our healthcare facilities, expertise and ideas.

Our broad expertise makes us an ideal partner and over the past few years we have collaborated with over 2,000 organisations keen to harness our expertise, technology and insight. These have ranged from some of the world’s largest corporations to smaller regional companies. We are happy to support you whatever your needs

There are two broad ways of partnering and collaborating with the university:

- Contracted work, where we carry out a service on your behalf
- Working together on collaborative projects.

This allows us (as potential students who may want to go into the field of research) to possibly work together with such organisations and work towards making breakthroughs for the improvement and advancement of the science / healthcare industries.

Sheffield MedSoc

Here is the link to Sheffield’s Medical Society: https://www.medsoc.net/

The Medical Society is the largest society within Sheffield Student’s Union with 1,300+ members. The society organises socials – events such as the Medic’s Annual Ball and the infamous fancy dress Pub crawl, runs Medic’s Family scheme to help first years settle in, gives students help selecting electives, runs a series of guest lectures and provides academic and welfare support at all levels of the medical course. Our main aim is to look after the well-being of medical students at Sheffield Medical School.

Sheffield Widening Access to Medical School (SWAMS)

Sheffield Widening Access to Medical School (SWAMS), are a group of medical students who are passionate about challenging misconceptions, raising aspirations and promoting medical school and medicine as a career option to those who may not have considered it. SWAMS focus on providing free resources and support to students across South Yorkshire, but particularly in low areas of participation in higher education and medicine. These students might not benefit from the support and guidance available to many others and SWAMS exist to help remove barriers in applying to medical school.

Additional Talking Points:

Geography: Sheffield is the 4th biggest city in England and is found in north-central England. It is a city in South Yorkshire. Sheffield is a green city – lots of parks, gardens, and trees! Sheffield is also very hilly. Living in the city, you will get used to walking up hills. The city is next to the Peak District National Park – a third of the city lies within the Peak District National Park. This attracts lots of tourism. It is the only UK city with a National Park within its boundary. I personally would link this to my love of hiking, as that is a genuine passion of mine.

Demographics: Racial composition fairly typical of the UK = 84% White, 2.4% mixed race, 8% Asian, 3.6% Black… These numbers are not important. The largest age group is ages 20 – 24 years old (9%) due to the large student population. Talk about how these appeal to you. The city’s students mainly come from = University of Sheffield, Sheffield Hallam University.

History:Historically, Sheffield was a heavily industrial city. Innovations around steel manufacturing helped Sheffield grow as an industrial town. More recently, Sheffield city is rapidly changing and undergoing projects to regenerate some of the more run-down parts of the city.

Retail: Sheffield is a major retail centre (IF you are going to talk about this, please do your research). Meadowhall shopping centre, located to the north of Sheffield close to the boundary with Rotherham and next to the M1 motorway, is a major regional shopping destination.
Sport: Big on football! Sheffield United (The Blades) and Sheffield Wednesday (the Owls). Sheffield was the site of the deadliest sports venue disaster in the United Kingdom, the Hillsborough disaster in 1989, when 96 Liverpool supporters were killed in a stampede and crush during an FA Cup semi-final at the venue.
Transport: Sheffield railway station is nice and well connected (from personal experience!). Very easy to get to Manchester, Leeds, London, Nottingham, Derby etc. Sheffield has a decent tram network = you can get to Meadowhall. As expected in any major UK city, it has good road/bus links. This is important to help you get around as a medical student.
MedSoc: Largest and most active medical society in the country. Perhaps mention a particular interest in one of the MedSoc's sub-societies (Men's Football Team, Teddy Bear Hospital etc)
Hospitals

- Sheffield Teaching Hospitals NHS Foundation Trust. Split into two campuses.
- West Campus = Royal Hallamshire Hospital, the Jessop Wing (maternity wing), Weston Park Hospital, Weston Park Hospital (specialist cancer treatment) and Charles Clifford Dental Hospital.
- The Northern General Hospital is the second 'campus' and is a large facility in the northern suburbs of Sheffield, containing the city's A&E department. The medical school has a large new clinical skill centre here.
- Sheffield Children's NHS Foundation Trust provides healthcare for children within the city of Sheffield, South Yorkshire, and the UK. Very well known – take about a third of their patients from outside of Sheffield.

How is it carried out?

The Medical School uses Multiple Mini-Interviews (MMIs), which will be held between December 2022 and January 2023.
The MMIs comprise a series of eight sections. In the event that you are invited to attend an interview we will send you the questions with your invitation. The questioning in these sections is typically based on the following areas:

- communication skills
- depth and breadth of interests (achievements in specific fields)
- evidence of commitment for caring
- knowledge of and interest in study in Sheffield
- medical work experience/Extended Project Qualification
- motivation for medicine + understanding the nature of medicine
- information processing, skills values and attitudes, outside interests

Each section in the interview is scored as follows:

Interview Scores	Description
5	Excellent
4	Good
3	Satisfactory
2	Borderline
1	Unsatisfactory

In addition to the eight sections in the interview, applicants' scores in the UCAT Situational Judgement Test (SJT) will be considered as a ninth virtual station. The UCAT SJT will contribute to the interview score as follows:

Interview Score	SJT Quartile	Description
5	1st	Excellent
4	2nd	Good
3	3rd	Satisfactory
2	4th	Borderline
1	Not applicable	Not applicable

Interviewed candidates can therefore attain a total score of 10-45/45. This score is used to rank applicants when deciding which applicants will receive an offer. Successful applicants are expected to perform satisfactorily or better at every section of the interview. When ranking applicants we look first at those applicants whose performance was satisfactory or better at every section.

Interviewers are drawn from medical educationalists, medically qualified senior members of staff, biomedical scientists, senior hospital doctors, general practitioners, junior hospital doctors, senior nurses, senior pharmacists, medical students, patients (who are members of our Patients as Educators programme) and lay people. Interviewers will not have read your Personal Statement, but some of the questions asked commonly relate to the sorts of things people typically write about in their UCAS Personal Statement. You are encouraged to prepare by reading the NHS Constitution, the General Medical Council's publication 'Good Medical Practice', and by keeping up to date with recent medical breakthroughs, topical controversies, ethical issues and NHS politics.

Past Years Interview Questions

DISCLAIMER: All interview questions here are from previously released years, and are sourced from websites that have released them. We do not **CONDONE** the sharing of interview questions (especially during the cycle itself) and do not **SUPPORT** any NDA violations in view of academic integrity. All of the following interview questions are released only after the test cycle, and any form of trying to cheat (asking those who have sat their interviews for the questions for example) **WILL NOT BE TOLERATED.**
Some of the interview questions asked from previous years are listed below, together with a suggested response / talking points.

Interview Questions	Suggested Responses / Talking Points
If you are successful in your application, you may be spending	I personally feel it would be great to first establish that while the phrasing of the question suggests that the city and university of Sheffield are distinct and do not overlap with one another, it

5 years living and studying in Sheffield. What can you tell me about the City of Sheffield and the University of Sheffield? What do you know about the Sheffield MBChB curriculum?	should be noted that as mentioned on the university's website, UoS (University of Sheffield) is a big part of the city, and that the city is considered a "university town". Having done some prior research into this, I would first like to highlight that Sheffield is an illustrious city with so many different things to do, be it shopping, good food, leisure activities. It is also an affordable city for students, being voted the most affordable city in the UK, and boasts of being a safe, diverse and vibrant city where there are individuals from all over the world. It is also a green city, 60 percent of the city is green space: over two million trees, 250 gardens, parks and woodland areas and a third of the city lies within the borders of the Peak District national park. The University itself is a leader in research, with many of the professors being involved in research teams on national as well as international scale. I recently read that there were a few professors involved in research for human fertilization, where "protein could help the sperm fuse with the eggs more readily" , and could have significant improvements for fertilization treatments. The University also boasts of the Sheffield Healthcare Gateway, where they collaborate with many companies in varying fields to further the research in the respective industries. The University also has been voted number 1 in student satisfaction, with the Student's Union being number 1 from 2017-2022. In regards to the MBChB curriculum, I understand that the curriculum is split into 4 phases. However, I am especially interested in the first two phases. For Phase 1, we are given the opportunity to be involved in placements from the second week during the 1st term, such as the CAS as well as the GP placements during our early years. This gives us the chance to interact with patients from the get go, building the foundation for good clinical skills to be used in the coming years. For Phase 2, it is split into 2a and 2b. I was interested to know about 2b that we would get the chance to embark on LICP1 where we get to spend approximately 12 weeks being a part of the team, and getting to learn first-hand the profession and the skills needed to excel in the field. While there are LICP2 and LICP3 in the coming years as well, this early introduction would give us a much needed deep dive into what to really expect to be able to become good doctors.
Tell me about a patient that you saw during your work experience or volunteering who inspired you to find out more about what was wrong with them. What did you find out? Where did you find the information?	Since this is more of a personal question and everyone has different experiences / takeaways, I will mainly explain the process to answering this question, aka breaking down the question, structure to be used etc. STARR is a good technique to use. (Check segment "STARR Technique"). A quick breakdown again is that the S stands for Situation, T for Task, A for Action, and the 2 Rs are for Reflect and Result. Focus more on the reflection, as that is the primary aim of the question, since the actual experience itself would be roughly the same for most and even if you did have a distinctly different experience, it makes little to no difference. 1) Link experience to why you want to study medicine.

	2) Link the experience to what it has taught you about medicine/being a doctor. 3) Link experience into why the skills you have demonstrated will make you a good doctor.
What can you tell me about the General Medical Council's code of conduct for doctors?	The following response is not mine, I took it from the website since I have not read up on these domains / code of conduct. If I have time I will return to write an example answer. The link to the response is https://www.mastermedprep.com/post/university-of-sheffield-medicine-interview-questions-explained-2022-full-guide#:~:text=1)%20Link%20experience%20to%20why,make%20you%20a%20good%20doctor
I'd like to play a round of "20 Questions" to identify an object, creature, event or place that I have in mind. To determine the answer, you must ask me a series of questions. I will answer only YES or NO to your questions. You may ask up to 20 questions. All questions must be answerable by YES or NO. You are being scored on the logical approach to your questioning, and not on whether you identify the correct answer. It is expected that this section will last no more than 4 minutes – you will be penalised for long pauses.	This is an abstract question and there is no way to tackle these types of questions in a way that you will definitely get the answer. However, the examiner is more interested in **HOW** and **WHY** you get to that conclusion, so stay calm and try your best to narrow down the possibilities. However, a few tips would be to try and quantify whatever the object may be, is it an object or is it a class of things, and also to figure out if it is alive or dead.
Studying medicine can be intense, so maintaining a work-life balance is important. How do you relax and unwind?	Again this is a personal question, everyone should think of their own responses and I will only break down the structure to approach this question. Generally, the structure would be something like this: Introduction Hobby/Passion 1 Hobby/Passion 2 Conclusion Naming more than 1 passion or hobby is good as it shows you have multiple ways of unwinding and if you are able to

	differentiate why these two hobbies help you unwind in different ways it will be even better to support your answer. Avoid the trap of listing / superficial answers by only grazing the surface of the answer and not explaining / diving deeper into the **WHY**. Remember the explanation is more important than the examples here!
The use of social media websites such as Facebook is now widespread amongst the public, students and healthcare professionals. Is it appropriate for medical students and doctors to use such websites?	I feel it is first important for us to understand the meaning of the word “appropriate”. In my view, the word suggests that the question is asking is it suitable / proper for medical students and doctors to use such websites. Just like any situation, there are pros and cons which I will address in my answer below. Let me talk about the pros first. With the increased widespread use of social media by such professionals or students, it allows the healthcare profession to have a bigger say and be heard more regarding certain issues. It provides us with the platform to amplify our voices for change or improvements, and it also serves as a way to get important messages across for the benefit of society. One such example that comes to mind would be the platform Twitter where healthcare professionals are able to disseminate important information regarding COVID-19 when it first exploded across the world, allowing the professionals to explain to the masses about the virus, how to avoid it and what to do if you are infected. This alone has kept many lives safe, and even prevented unnecessary loss of lives. Moreover, it allows us to be heard when change is necessary, such as the nurse strikes not too long ago. The use of social media allowed the nurses to explain the clear issues faced by the healthcare system and the strain imposed as a result, and explain why they are campaigning for a strike (to earn enough wages to be able to be sufficient + to encourage better government intervention to make the workload lighter for them). However, with any benefits, there will be drawbacks. One such drawback that comes to mind is that especially medical students, who are considered to be in their “prime” enjoying social events, may post stories on Instagram or tweet certain thoughts, pictures that can cause the trust in the profession to be eroded. This not only severely affects the trust in the profession in the long run, it also impacts the professional setting where healthcare professionals have to interact. Additionally, confidentiality breaches can occur if such individuals are not careful, and this severely cripples the patient-doctor confidentiality aspect in this profession, and can cause discourse and mistrust. Having stated the benefits and drawbacks, ultimately I feel that such individuals should still be allowed to use such websites and that it is indeed appropriate. In line with the ethical pillar of “Autonomy”, just like any patient who has the right to make their own decisions within capacity, healthcare professionals and students are still human, we have a basic right to be able to do what we want, and as long as measures are actively taken to minimize the potential drawbacks and abide by the code of conduct established by the GMC, I feel that it would be considered appropriate.

Tell me about a time when you have made a positive impact on someone else's life.	Since this is more of a personal question and everyone has different experiences / takeaways, I will mainly explain the process to answering this question, aka breaking down the question, structure to be used etc. STARR is a good technique to use. (Check segment "STARR Technique"). A quick breakdown again is that the S stands for Situation, T for Task, A for Action, and the 2 Rs are for Reflect and Result. Focus more on the reflection, as that is the primary aim of the question, since the actual experience itself would be roughly the same for most and even if you did have a distinctly different experience, it makes little to no difference. 1) Link experience to why you want to study medicine. 2) Link the experience to what it has taught you about medicine/being a doctor. 3) Link experience into why the skills you have demonstrated will make you a good doctor.
Medical schools around the world receive far more applications than there are places. This means that many excellent applicants will receive no offers. If this happens to you, what will you do?	I feel that first I would feel disappointed and sad that I did not get into the course, however I would understand that competition is definitely tough and since Medicine is a life-long career, one year out of the grand scheme of things is not that significant. I would take some time to accept and deal with the emotions and then seek to move on from it. What I would do afterwards would be to reach out to the Medical school to receive feedback / improvements on my application, and ask how I could have improved my chances of a spot in Leicester. It is important to take the time to improve myself during the period of time (about a year) so as to grant myself the best chance of attaining an offer next year. Additionally, what I would also do is take the time to travel to new locations and pick up some new skills such as new languages. I truly believe that Medicine is a universal language, that everyone will need the help of healthcare professionals at some point in their life. As such, by picking up new languages, it would allow me to build new communication skills and be able to converse with patients in the event I do become a doctor after my gap year. I would get to see new environments and ways of life that I may not have been exposed to before, and by doing so, I can also better relate to different individuals from varying backgrounds. In preparation I would also aim to take up a more extensive work experience in hospitals or care-related settings to build up my understanding of the profession and learn what it will really be like if I am able to enter the profession. I would also like to carry out more charity work or communal events to reach out to the people I may be taking care of in the future, so as to further my understanding even more and allow me to become the best version of myself. In conclusion, there are a lot of things to be done in the time given, but by focusing on improving myself, I would be in a better position to reapply for the next cycle.

Do you think that non-emergency services should be provided 7 days a week in the NHS?	I feel it is really important for us to understand what “non-emergency services” entails and what kind of patients they look after. For non-emergency services, it could include GP consultations for non life-threatening conditions such as the common flu, or cough, and can extend to consultations such as fertility treatments. Regarding the patients, they are in little to no danger of losing their lives and the consultations / operations that they may need to undertake. Moving on, I think it is important to break down the pros and cons of the provision of such services everyday. The cons would be quite apparent, such as the increased cost in terms of wages to be paid to the healthcare staff in the NHS and the electricity / water bills to be paid by keeping clinics and hospitals open for longer periods of time. Additionally, it is important to understand that there would be an increased demand for healthcare staff, which could lead to more stress and more mistakes if the healthcare staff are tired, affecting patient safety and the delivery of “patient-first” care. However, there are some pros to be discussed as well. This would enable patients to have 24/7 access to healthcare in any situation, which could cause the NHS to become a leader in the world’s healthcare. There is also a likelihood that wages would be increased in light of the increased workload presented, and some doctors may be incentivised to work more to attain higher pay. In conclusion, the pros and cons definitely need to be given serious consideration for a decision of this scale. However, in my opinion, the cons are much more significant given the current events of “JDs balloting to go on strike” and the previous events of “nurses striking” , that by carrying out such a decision, it could lead to an even greater amount of healthcare professionals being unhappy and leaving the profession in the worst scenario, which would severely impact the NHS.
Why is consent important in healthcare?	Consent refers to the written or the verbal agreement from the patient to the healthcare professionals for the diagnosis / operation / action to be undertaken and carried out. For this question, I will refer to healthcare in the setting of hospitals and clinics primarily. One reason why consent is important in healthcare is that there are operations or actions that are invasive for someone’s privacy or may be considered intimate. One such example that comes to mind would be surgery where operations can be undertaken on pretty much any body part. Usually the patient is given scrubs to wear but there are the occasional operations where they are unable to or have to expose a part of themselves for the operation. For instance during a Modified Radical Mastectomy (MRM), a part of the woman’s breast is cut off and to some it may be considered too intimate or personal. As such, consent is crucial because it involves such a personal aspect of the patient and only if the patient has given consent can the action be undertaken. Another reason would be that some actions have a risk to them, and that by undertaking those actions, it could affect them post-action in a significant way. One example would be a treatment

	such as radiotherapy. While it could in theory kill the cancer cells faced by the patient, there could be severe side effects such as headaches, hair loss, sleeping issues, memory and speech impediments which severely impacts the QALY (quality adjusted life year) or QOL afterwards. In light of such risks, consent is hence important to demonstrate to the healthcare professionals that the patient is **AWARE & ACCEPTS** the risks and potential complications that undertaking the suggested action could lead to. This is in line with the ethical pillar of “Non-maleficence” as the healthcare professionals do not wish to do any harm to the patients, and with consent explicitly given, the staff at hand would not be doing any harm to the patient. In conclusion, in such a profession where we are given access to the most intimate and personal details of someone, their life and when they are at their most vulnerable, consent is a form of respect to the patient and hence it is very important in this healthcare setting.
How do you cope in a new environment?	A new environment can have a few meanings but the most common would be a change in the physical surroundings where for instance, you travel to another country and relocate there, or move to a different part of the country / city / town with different and sometimes foreign settings. However, it is also possible for an environment to remain largely similar in terms of physical attributes but be different in terms of the social setting where for instance you move to a different town in the same country, but now you need to make new friends and settle into the new environment. As such I would be suggesting two different ways that I would cope One way I would cope with the shifting into a new / foreign physical environment would be to watch and learn from the locals themselves. There is a saying “Do as the Romans do”, where you learn from the locals who know the ropes really well. For example, if we are aiming to learn what is the most efficient way to travel, we can observe how the locals get to work everyday and see what they take to work (be it buses, trains, trams, bicycles or cars). It can even extend to food options where if we want to explore the best food places in town, we eat where the locals would eat since they have been there longer than we have. In no time, I will be able to get a rough understanding of what the new environment is like and it will go a long way in helping me cope. Another way would be to actively take steps to meet new people and extend any form of friendships to as many individuals as possible. In a social setting, the more people you know, the higher the likelihood that you would be able to meet people that you click with and be able to rely on. It can range from university friends, workmates or even starting off as simple as neighbours. By establishing as many friendships as possible from the get go, it helps to reduce the social pressures and anxiety of not knowing what to do in those situations, and it also helps make settling in less lonely. This in turn helps me cope with the social aspect of a new environment.

	Ultimately, everyone has different methods to coping in a new environment such as comfort food or objects, but I feel as long as both aspects of the new setting are addressed, I would be able to cope without much difficulty.
Why is treating a patient with respect and dignity important?	A patient at the core is just a human being who comes to healthcare professionals with a problem or an issue to be fixed, and they often come in a state where they are vulnerable or weak, and are seeking support from us. With this understanding, we can establish why it is so important to be respectful to patients. One reason is that patients are still humans, and they have a right to be treated with respect and dignity. Just because they are sick / need our help does not make them any less human and as such, just like anyone, we should give them respect and dignity that they deserve to be given. Additionally, it is a form of mutual respect to the patient specifically. The patient respects us, the healthcare professionals, that we have the ability and capability to heal them and support them in what they need. Likewise, as a profession that involves interaction and is heavily rooted in professionalism, it is only natural for us to return the respect to them. Additional talking points contributed from @jesus: • they need to be able to trust doctor for open communication • informed consent is an ideal that only makes sense if we believe an individual patient has dignity • understanding others dignity and giving them respect is an extension of empathy for others, maintaining this respect and empathy is an important part of staying connected with the patient's human needs, fears and concerns • medical care is shifting away from the paternalistic notion of "doctor is always right, follow along and shut up", and giving the patient dignity and respect is an extension of the more holistic approach to medicine that is occuring in our medical system • often going through their last or most traumatic moments of their lives, and so it is important of doctors to maintain their dignity for their own psychological well-being, giving some semblance of control and humanity when confronted with uncontrollable experiences As contributed from @lovebear: • patients give so much information to us, we need to respect that & ensure we are doing the best for them :) • Upholding GMC good medical practice (domain 4) As contributed from @drea: • increased patient trust and relationship, improving treatment outcomes

	• One of the NHS value → important to uphold to ensure we make a positive impact on patient's lives • Good reputation as a profession ?
At this station you will meet a patient with a long-term illness. You are asked to engage them in conversation and find out about the nature of their illness, how it is managed, what effect it has on their daily life and how they think it is likely to affect their life in the future. You are NOT expected to play the role of a medical student, doctor or other healthcare professional – you should be yourself! The patient will be scoring you on your ability to interact with them.	In this case, there is no suggested answer but instead some points to consider when asking questions. -Consider the fact that you currently know nothing about the nature of their illness, so approach the patient with a sense of empathy, respect and stay professional. -When asking how it is managed on a day-to-day basis, consider the simple things in life such as going to work, eating food, leisure activities, does it affect family in any way? Are there medications / restrictions / considerations that are important? Are they a **MUST** or a **CONSIDERATION**? -Daily life: Do not take the simple things for granted, getting in and out of bed for example, looking for transport options, finding food, reaching for things (high or low), impacts on their family / spouse / children -How it is likely to affect their life: Focus on comparing and contrasting the current lifestyle and the future lifestyle. Approach with sensitivity and know when to back off to prevent pushing the boundaries too far.
Do you think it might ever be appropriate to breach a patient's confidentiality? Can you give any examples?	It is **NOT** appropriate **UNLESS** these 3 situations are involved: • It is required by the law to report any infectious diseases • If the patient will be in immediate danger • If there is a threat to public safety (like a bomb in your body, or if the patient wants to conduct acts of terrorism) Generally speaking patient confidentiality is the number one priority and unless there are complications that can endanger the public, it will not be compromised upon. A thought process is that "Is there immediate or potential danger to others around the patient, does the need to protect society exceed the need to maintain confidentiality"
How would you advise a doctor who is wondering whether to accept one of their patients as a friend on a social media website such as Facebook? Why?	No. But on a serious note, patient-doctor relationships or friendships should not be a thing to maintain professionalism. I would advise the doctor to remember the GMC standards that all doctors aspire to achieve and that the doctor should let the patient know in a **POLITE BUT FIRM** manner that it is unprofessional to be friends on social media websites such as Facebook. We can remain on friendly terms but nothing more than just being friendly.

Should medical students and doctors always declare their profession/professional status when interacting with others on a social media website? Why?	I feel it is important for us to understand the “Why” of this question first. One potential reason why it is seen that medical students and doctors should always declare their status could be that it keeps people accountable and this could help maintain the professional image of the healthcare profession, as such improving the trust in the doctors and nurses. Another take could be that it allows what is said to be taken more seriously and with more weight, allowing us to spread any message that we may want to bring across with much more ease. However, I feel that they do not always have to do so as it is their choice. People outside of this field often have the impression that healthcare professionals transcend basic human limits, that we are occasionally seen as “special” or “inhuman”. However, medical students and doctors are still human, we make mistakes and we certainly are not perfect. As such, we are able to choose if we want to disclose the information or not, and many would not want to do so, and to force them to do so would be certainly quite unfair, and it does not reflect well on “Autonomy”. In conclusion, my opinion or take on this matter is that doctors and medical students certainly do not always have to disclose such information, but only do so if they feel comfortable or if it is really necessary.
While working at your Saturday job in a shop you find that one of your colleagues has arrived at work smelling of alcohol. They appear to be intoxicated, and you know that they drove to work. What actions would you take?	This question is not set in the healthcare scenario but a similar scenario can be given just replacing the word “shop” with in a hospital. So do remember that not all questions must be medical school related / healthcare related, and answer them accordingly. First of all, it is important to understand that they **APPEAR** to be intoxicated, and that does not mean they actually are. The worst thing that you can do is to assume or jump to conclusions without taking steps to clarify first. You also should not scold them or shout at them as it is more respectful to talk to them in a calm manner. You should approach this issue at hand with a tact manner, polite and respectful and being friendly. You can first ask how they are doing before approaching this manner, and phrasing it less explicitly such as “Have you been partying last night / recently?” Next, ease them into the topic and ask them in a non-confrontational manner if they had been drinking. You would want your tone to be friendly and seem like you are just checking up on them. From there you will be faced with two scenarios. Scenario 1: They actually were not drinking and may just have that smell for some other reasons such as cologne. As such, you can politely inform them that it smells of alcohol and suggest they find a change of clothes / take a shower to try and get rid of the smell. Scenario 2: They were drinking. In this case, you should politely inform them that they should not have drunk and drove their car to work in close succession, and explain kindly the possible dangers they pose to themselves and others. You can then get them a glass of water, sit them down to get some rest, and politely inform them that you will be calling a cab to send them home to sober up. If they are concerned about their car, you can

	suggest lending the keys to you and you will drive their car home for them after work. After all of this has occurred, when they are more sober and awake, you can once again remind them to remain safe and avoid doing such things again, making sure they **UNDERSTAND** the dangers so that they are educated about such issues and they will not repeat it again.
Based on your work or voluntary experiences, what do you think are the challenges of delivering quality care to patients? How do you think demonstrating respect and dignity impacts on patients?	Everyone's work experience and volunteering will be different so I will skip that part of the question. Demonstrating respect and dignity does have some impacts which I will break down in my answer below. One impact would be that it validates the patient and makes them feel heard / understood. Most patients come to us seeking help and support, looking to us to cure or resolve their issues that they face. By giving them the due respect, it makes them feel as if they are a part of their team and have a say over how they are treated, providing them the autonomy that they would like to keep. This is especially prevalent in some cases where they would like to be able to choose how they are treated, such as during end of life care. By doing the bare basics, it helps the patients feel assured and involved. Another reason would be that it has an impact on their recovery process, often being beneficial. When treated as such, they are more at ease, feeling less stressed with the fact that they have professionals looking after them. This has a psychological influence on them, and can induce a possibly faster recovery. Lastly, demonstrating respect and dignity would leave a professional impact on the patient, and would leave the patient impressed and have a deeper respect for the profession. In line with the domains of the GMC practice, it shows the high standards that us professionals strive to achieve in our everyday duties, and upon the patient witnessing such behaviour, they would definitely have a rooted respect for how we conduct ourselves, maintaining trust in the profession. In conclusion, demonstrating dignity and respect to patients are the bare essentials for any healthcare profession in our duty to deliver "patient-centered" care, and can have significant impacts as I had mentioned in my answer.
Medical students are selected from the best and the brightest students around the world. How will you cope with moving from an environment where you were one of the best students to one where everyone has a similar level of ability?	Look at it as an opportunity to learn from others → cope by being optimistic But also be excited and be humble as possible Recognize your shortcomings and that you will have to work as hard as everyone, but also bring in the fact that being in a similar level of ability is not necessarily a bad thing **DON'T** be cocky pls it's a red flag thanks **DON'T** shut yourself out!

As a doctor you will have to break bad news and deal with things when they go wrong. How do you think you will cope with this emotionally? https://youtu.be/BF3mdTqhoR8 - Grey's episode on Meredith's take on breaking bad news (this is irrelevant to the question but some nice info!) Remember Dr. Jing Mai On National Physician Suicide Awareness Day | by Jonas Attilus, MD MPH | Sep, 2022 | Medium A lot of good points raised, do read up on it.	Important to put a strong face and provide support for the patient etc But also if you cannot handle it mentally and emotionally, its okay to take a small break and release your emotions <3 your sadness or whatever emotion is valid! **It's important to acknowledge that we are not robots, but humans with feelings.** Talk about some stress relief methods Talking to a friend **VS** patient confidentiality (Prata's note: You most definitely can talk to your friends, spouse, family about issues or events that happen at work, but you should remember to remove any identifiable information about the patient when doing so. I will give an example below.) **EXAMPLE**: You are a surgeon and had lost a patient in the OT. You tried everything you could but are wracked with guilt because you still feel there are more options to be done. You had broken the bad news to the family in the best possible way (sensitively), but they lash out at you and blame you for it, before walking away. In this case, you should definitely talk to someone about it, because harboring such emotions is not a good thing and again, we are still human. When talking about it, you should not mention any patient details or any details that could lead to the patient (such as time and date of operation, the kind of operation) but keep it generic, at the very most mentioning that you lost a patient on the operating table. Look into wellbeing services provided in hospitals. Mental health is currently a big issue in the NHS and UK in general, and there are increasing amounts of support offered. Do take advantage of them and find an outlet for release, as keeping things pent up is never a good thing

University of Leicester

It has been recently confirmed that for this admissions cycle (for 2023 entry), that Leicester will be holding interviews online, and the format of interviews will be carried out in a MMI format. (See Section "General Breakdown of Interview Types"). Before going too deep into their interview questions and how to answer them, let us look into their medical school curriculum, the attractions of the school and city, and other useful information.
You will be assessed based on:

- Motivation to study medicine and genuine interest in the medical profession
- Insight into your own strengths and weaknesses
- Ability to reflect on your own work
- Personal organisation
- Academic ability
- Problem solving
- Ability to deal with uncertainty
- Ability to manage risk and deal effectively with problems
- Ability to take responsibility for your own actions
- Conscientiousness
- Insight into your own health
- Communication skills, including reading, writing, listening and speaking
- Teamwork abilities
- Ability to treat people with compassion, respect and dignity

- Resilience and the ability to deal with difficult situations
- Empathy and the ability to care for others
- Honesty
- Emotional intelligence
- Ethical judgement

Medical School Curriculum

The curriculum is patient-centered, where they run an integrated curriculum. Teaching and learning is based around patients and their needs. It is not a problem-based learning course, but rather a patient-focused curriculum which is delivered through a mixture of lectures, small group work and clinical teaching.
Your experience will be hands-on - you will work with real patients from the beginning. It's all designed to be clinically relevant - enabling you to acquire the medical knowledge, along with the professional competencies, that are essential to practise medicine effectively. **In your first year, you gain the Health Care Certificate and hospital ward experience that allows you to work as a Healthcare Assistant.** Simultaneously, through our Phase 1 Compassionate, Holistic, Diagnostic Detective course you start to develop consultation and examinations skills with actors and patients in our medical school and hospitals, preparing you for Phase 2 (years 3-5) where you will be based full-time in hospital, general practice and community placements.
Our world-class facilities provide a state-of-the art learning environment and allow you to experience what other medical students don't. For example, **we are one of the few courses to offer full-body human dissection.**
You will also have the chance to develop your clinical procedures in our state-of-the-art Clinical Skills Unit. During the clinical phase of the course, we offer a wide range of hospital and community placements in the region, including Leicester's big city hospitals, and district centres across the Midlands, Lincolnshire and Northamptonshire. This means you gain valuable experience in a diverse range of environments.
If you're interested in medical research and/or enhancing your career prospects, you can take an intercalated degree by undertaking full-time research with experts at Leicester or elsewhere.
Towards the end of the course, there are additional opportunities to take an elective placement in a location of your choice - it could be anywhere in the world.
Our curriculum, along with the opportunities and support we provide, mean Leicester medical students graduate ready for successful careers. **Over a five-year period, (2014-2019) Leicester Medical School graduates have ranked in the top 3 for their medical career progression. In addition, data from the General Medical Council (GMC) shows that our graduates rank in the top 10 in the UK for 'preparedness for practice'.**
(Things highlighted in yellow and bolded are potential talking points / attractions of the Medical school)
Leicester's curriculum is broken down into 2 phases, Phase 1 (Years 1 and 2) and Phase 2 (Years 3-5), and will be broken down below.

Phase 1 (Years 1-2)

You will take a series of integrated, interdisciplinary modules related to human structure and function in health and disease. You will also undertake community attachments to illustrate the social and psychological context of medicine. Theoretical study of social and behavioural science supplements this learning in the community.
Course aims for the end of Phase 1 includes: (**GOOD TO KNOW**)

- Be able to communicate with patients and examine them clinically
- Have a good understanding of the structure and function of the human body and how this relates to health and illness

- Appreciate the psychological and social context of health and illness

Phase 2 (Years 3-5)

We believe that the best way to learn medicine is to work with practising doctors. You will spend virtually all of your time in Phase 2 working full-time in clinical environments. Working with medical staff in hospitals and the community is the best way to apply your knowledge, gain experience and learn more. In each placement you will be part of a team caring for patients – the range of patients and illnesses you see will reflect the demands on doctors, preparing you for the working environment after you qualify. We have placements in various hospitals in the city, county and region, as well as community attachments. This means you will experience a diverse range of environments, colleagues and patients.
In year 3 you will have longer apprentice style placements in medicine, surgery and general practice, learning from experts in hospital or GP practices. Year 4 focuses on specialty blocks such as Obstetrics and Gynaecology, Child Health, Cancer Care and Psychiatry. In year 5 you will have time for extended foundation assistantships designed to fully prepare you for work as a foundation doctor. Learning in each placement will include structured activities, procedural training, and simulation experience. Your learning will be guided by workbooks and led by experienced clinical teachers.

The Leicester Medical School Approach

The course is patient-focused and integrated so that all learning takes place in a clinical context. In Phase 1 there is a balanced mixture of lectures, clinical teaching and group work. Group work is supported by experienced academic teachers and clinically qualified staff - you work to solve problems related to clinical cases.
In Phase 2 you will be working with doctors in hospitals and the community in a variety of clinical placements. For each placement you will be given clear outcomes defining what you should be able to do by graduation. Structured activities guide you through. Medicine requires a commitment to lifelong learning. Throughout the course you should be prepared to reflect on your skills and organise your own self-directed study.

Clinical Exposure from Day 1

You will have the opportunity to go on clinical placements from the very beginning of your Medicine degree. **We offer all 1st year students the chance to train and qualify as Health Care Assistants (HCAs)**. This gives you a taste of a clinical/hospital environment from the start of the course. The experiences you gain from working/training as a HCA can be used to support your learning as you move through Phase 1, as well as providing you with the required training to gain employment as a HCA within the NHS.

Technology Focused Training

All our video tutorials, lectures and group work material is provided in an electronic format. You can use your iPad in lectures and group work, to write notes and enhance your learning. **Alongside this, we use the latest technology-enhanced learning approaches, including 3d printing and 3d reconstructions.** When you move into Phase 2, you can take your iPad with you into the clinical setting, all your resources and learning materials will be at your fingertips.

Clinician Guided Group Work

In Phase 1, approximately 50% of your learning will be in guided group work sessions. You will have the opportunity to work with a small group of students to apply your knowledge to clinical scenarios. **All the group work sessions are guided by Clinical Teaching Fellows (CTFs). The CTFs are all qualified doctors, who have been working in the NHS for at least 2 years. They are able to share their clinical knowledge and experience as they guide you through the clinical scenarios.**

Empathy-focused Curriculum

Our students will be the first in the UK to be taught a ground-breaking empathy-focused curriculum, with the purpose of educating doctors who will be able to, and appreciate, seeing the situation from their patients' perspectives. Training in empathy has been shown to improve patient outcomes while making doctors more resilient. Our aim is to provide the NHS with the most empathic, compassionate and resilient junior doctors possible who are ready to meet the challenges of complex healthcare systems.

Attractions of School / City

In this segment we will first break down what does the Medical School offer that could be of particular interest / a possible talking point, before diving into the city that the University is based in.

The Medical School

- Our integrated course offers the best of both worlds. Learn through a mix of traditional lectures, small group work and clinical skills training. Our course is truly patient-focussed and hands-on, so you'll meet real patients from Year 1.
- We have outstanding facilities, including a large dissecting room where you will learn anatomy through **full body dissection** on cadavers. Perfect your clinical skills in our state-of-the-art Clinical Skills Unit.
- The University of Leicester is ranked 2nd in the UK for its world leading research in clinical Medicine (2021 Research Excellent Framework - REF) . We are also ranked in the top 20 in the world (and the top 5 in the UK) for clinical medicine, according to the 2022 Shanghai Academic Ranking of World Universities.
- Learn from leading clinicians at the front line of their speciality. Our many partnerships in the region offer a wide range of clinical placements in hospitals or in the community. You'll experience working in a diverse range of healthcare environments - from big city hospitals to smaller, district centres - preparing you fully for life as a Foundation Doctor.

Apart from the option of doing intercalated degrees, you can also choose to do a medical elective, where you study healthcare in a completely new environment. You are able to travel externally to other countries to carry out the elective.

Activities and Outreach

Leicester Medical School has a long history of commitment to a range of outreach programmes that you can get involved in.

- The University-led MedReach programme offers opportunities to engage with local school pupils from backgrounds underrepresented in medical schools to encourage a more diverse medical profession.
- Independent student groups such as Junior Emergency Medicine (JEM), Sexpression, Nutritank, Teddy Bear's Hospital and Medsin bring key healthcare issues to groups in Leicester and Leicestershire.
- We have a very close relationship with local homeless charities through our Project Light Initiative. It is a collaboration with Med and Law schools (where Med schools aim to provide services such as donation drives, health promotion and fundraising, and Law schools aim to provide legal services for them)

LUSUMA – Student society

It is important to have a good social life and a balanced lifestyle. LUSUMA (Leicester University Students' Union Medical Association) is run by students and organises a huge variety of social events, sports clubs, academic and medical interest groups, as well as providing support and resources for all medical students at Leicester.

The City

There are many things to be done, from the city and surrounding area, since Leicester is considered to be a university town.

Food Options

Enjoy a range of global street food options in our Food Court or make the most of your study break in the David Wilson Library Cafe.

Just a short walk from campus is the vibrant and friendly neighbourhood of Clarendon Park. Many students choose to make Clarendon Park home in their second and third years and it's easy to see why with the wonderful selection of independent shops, cafes, bars and restaurants along Queens Road. Don't miss happy hour cocktails at Bar Dos Hermanos, the finest homemade cakes and pastries from The Tiny Bakery and freshly baked Pasteis de Nata at Port and Nata.

Between campus and The Village you'll find the charming area of Stoneygate. Along the main Stoneygate shopping streets of Allandale Road and Francis Street you can explore micropubs, delis, gift shops and more. Don't miss The Real Ale Classroom, which is a must visit for craft beer and gin drinkers, and The Coffee Obsessive who pride themselves on sourcing the best small batch roasted coffee from across the world. You can also stop off at The Allandale for their daily bottomless happy hour.

Entertainment Options

Surrounding the city, the county of Leicestershire has some beautiful spaces to explore. Visit Bradgate Park, (a new event called Winter Fayre 2022, first time since 2016) an 850 acre deer park steeped in history and recently voted in the UK's top 10 most picturesque walking spots. Or enjoy a day out by the water at Foxton Locks, watching the canal boats pass through the longest and steepest staircase of locks in the country. Closer to the city, don't miss a day out at the National Space Centre. Discover your inner astronaut at the out of this world experience uncovering space history and research.

Explore Leicester by bike with the city's e-bike sharing scheme. The largest of its kind in the UK, there are 500 bikes available across 50 city-wide stations, including here on campus. Offering a quick, easy and healthy way to move around the city, it's a great low cost option to suit a student budget. With pay as you go, monthly or annual plans available you can select whichever best suits your needs and budget.

There is also the Leicester Tigers (Rugby), Leicester Riders (Basketball) and Leicester City Football Club where you can get discounts to watch games.

There is also a weekly run (Parkrun) where you can run or walk or jog the 5km, meeting new people and also there is a post-run coffee session on campus.

Past Years Interview Questions

DISCLAIMER: All interview questions here are from previously released years, and are sourced from websites that have released them. We do not **CONDONE** the sharing of interview questions (especially during the cycle itself) and do not **SUPPORT** any NDA violations in view of academic integrity. All of the following interview questions are released only after the test cycle, and any form of trying to cheat (asking those who have sat their interviews for the questions for example) **WILL NOT BE TOLERATED.**
Some of the interview questions asked from previous years are listed below, together with a suggested response / talking points. Since they are more MMI focused, and I could not find any previous releases of last year's questions, I have collated from websites / whichever question appears the most often.

Interview Questions	Suggested Responses / Talking Points
What role does politics play in the NHS?	Politics is a universal topic, like it or not, the implications of it influences the everyday life of everybody who is under the government. Politics is also quite controversial, a topic that divides individuals. However, one cannot deny that it has both good and bad impacts on systems such as the NHS, which I will break down in my answer below. One role that politics play is that it influences how the healthcare system functions. One popular example of politics in the UK would definitely be Brexit. Since the scope of Brexit is so immense, I will mainly focus my answer on two aspects. One implication is that with Brexit, more nurses and healthcare staff ended up leaving the NHS and returning home, leading to a shortage of healthcare workers in the NHS, driving up demand and forcing the remaining workers to cover by working longer hours, handling an increased amount of patients. This was definitely divisive and had implications on how the system operates after Brexit. @lovebear suggested Privatisation! **To be honest, I have no idea how to tackle this too, if anyone does please help :P**
What happens once you've graduated?	
What practicals have you done in chem this year?	Since everyone has different practicals depending on the syllabus you took (A-Levels, IB, or other qualifications), I will not focus on the examples or the answer, but I will just explain the structure. The focus is not the examples, more of what you took away from it, what are some of the

	interesting things you liked about the practicals (aka the science of it) and your reflection. The question is looking to see your passion regarding the sciences, what are things you want to do in the future (i.e research). Use STARR technique to help you develop your answer.
How will the med course differ from the A level course?	Since I took A levels, I will answer this question. But for those who took different courses, just tweak your answer accordingly! Having taken my A levels, I can say that I have a rough understanding of the potential differences between the courses. Not having studied in the Medicine course, this is purely from what I understand after talking to current students, reading up on the course description and from what I was shared. One big change would be that what we learn will be more prevalent and will be easier to observe in real life. One thing that was shared with me by a senior was that “In med school, you learn about the anatomy of the body, and you can start identifying body parts eventually, while in comparison to A level, it is more theoretical based with some application sprinkled in.” This advice was also confirmed by my brother who is a med student, that what he is studying is much easier to visualize and see in real life. While theory is definitely taught in medical school, most schools push us to enter the field as soon as we can (via placements) so we can understand what we are learning during our lectures. Another big change would be the scale of knowledge we are presented with. We always have this mentality that whatever we are facing is the hardest thing in our lives, but once we are past it and look back, we realize it is so much easier than we thought. Similarly, A level merely serves as a foundation for uni studies, imparting the base content + drilling study skills in preparation for university. However, when we start medical school, most students feel drowned by all the content knowledge we must understand, such as anatomy (a huge aspect by itself), genetics and even medical ethics and law. It would most certainly be more in comparison to my A levels in terms of content to be learnt.

	Lastly, a significant difference would be how much more hands on the course will be. A levels revolved around textbooks, notes and examinations, and while the med course will also have those, we will be also doing clinicals, placements that move further away from the textbooks and are more hands-on in terms of practical skills and actually doing what we learn in our textbooks. It is hard to visualize in our heads how the physics of an aeroplane works without being able to witness it ourselves, but in Medicine, with time we will be able to visually recognize the bones in the human body for instance. In conclusion, they are two very different courses with different aims and focuses, but these are the immediate and most significant changes in my opinion.
What areas should research be concentrated on in the future?	Research is important in every sense that it propels advancements and improves our QOL, but of course with limited resources, we are forced to prioritize areas to focus on. Admittedly, all areas are equally important in their own right, however in my answer, I will pick 3 areas, and will explore the reasoning behind them. The first area would be regarding how to address the waste pollution being generated on a global scale. It is frightening just to know how much physical waste is being produced, without even counting for other forms of pollution. For instance, the amount of waste produced being thrown into landfills leads to extensive land pollution, and scientists have already projected that it will eventually cause the Earth to become inhabitable. As such, the reason why I picked this was to address the ever-pressing issue that threatens our survival on this Earth, and also due to its global implications if left unaddressed. It is important to protect our home environment so as to ensure we still have a place to inhabit for future generations. The second area would be regarding how to synthetically produce the basic necessities on a large scale, while keeping costs minimal. It is common knowledge by now that with our natural resources being depleted at an alarming rate, we may eventually run out of the bare necessities to survive, which is food,water and air. Even with all the advancements we have now, if

	we are unable to have these 3 natural resources readily at hand, we could potentially be wiped extinct and our survival will be endangered. By addressing the critical necessities from the get-go, it allows us to then refocus our energy towards other issues that may need attention, knowing that we are safe. Lastly, I would like to focus our research towards synthetic organs that can be used for organ donation, that can replace damaged organs whenever necessary. In the NHS, there is an organ donation issue where the demand still exceeds the supply present, and this causes many desperately in need to go begging, affecting their lives and even leading to suffering or death in the worst case. This is also a global issue, and with further research into this matter, if successful, it could lead to extension of life for those who are affected and would definitely spare individuals of the suffering or poor QOL. While it is important to acknowledge that by doing so, we could lead to overpopulation, the second point which I raised could help with this implication. Ultimately, there are many areas of research that need our focus and attention. However, I selected these areas to address the bare essentials, to protect our home environment, as well as to address a growing global issue.
What major health issues are around at the moment?	Again, there are so many issues (Check Segment “Hot Topics”). Focus for this question would be “**MAJOR HEALTH ISSUES**”, so things like JD striking, while still a big issue, is not a **HEALTH** issue. Do take note of the parameters set by the question, read “Hot Topics” on how to answer this question since everyone will have different opinions on what they want to address.
What is the best and worst thing about Leicester Medical School?	Just like any school, there are bound to be pros and cons regarding the curriculum or the environment. Having done my research regarding this matter, I will highlight the two things that I feel are the most important. The best thing about Leicester Medical School in my opinion is the offer in our First Year to train and become Health Care Assistants (HCA). This is, from my understanding, unique to Leicester and not many, if at all, schools offer this option. Why

	do I feel this is the best thing? Well, firstly it allows me to have the option of working as a HCA during my studies, not only as a way to earn some income to spend, but also a way to spend my time building work experience and fully immersing myself in the future work I will be doing. Admittedly, HCAs will do less work compared to FYs or JDs, but it still serves as a springboard for me to learn more and witness upclose and even learn a few things practically from the professionals. As an international student, I was unable to do work experience in the UK and am unfamiliar with the environment, both professional and social, and would view this as an immensely important way to become more familiar with the settings. The worst thing in my view would be the Technology Focused Training. Please do not misunderstand it as I do not see technology as important. Technology is crucial in our field and is used prevalently in certain specialities where they are able to do things we otherwise are unable to. However, I personally feel that hands-on training is much more beneficial compared to technology-based. An example I bring up is that we will be using 3D constructions to learn, however personally getting to touch and practice will be much better for us in the long run as we will not forget the feeling of what it is like to do certain actions. A cadaver is definitely different from a plastic model, and that is fundamentally what I am trying to express in my answer. The healthcare industry is moving towards technology-focused settings and while it is beneficial in its own right, I still believe that hands-on learning should be the primary goal compared to relying on technology. Ultimately the worst thing is highly dependent on the individual, what I feel may be different from other students. As such, these are just the most important things I felt like highlighting in my answer.
Why Leicester?	My Why Leicester will revolve around 3 points that I feel the most attracted to and break down as detailed as feasibly possible. The first reason why Leicester for me is the curriculum. Two specific things drew my attention regarding this, one being the opportunity to train / work as a HCA in my first year and the full-body dissection offered

	with the use of cadavers. In regards to the HCA training, I believe it is specially unique to Leicester and this serves as an opportunity to fully immerse myself into the working world and profession. As an international applicant, it would be my first foray into the world of the NHS and I am keen to witness and experience first-hand how distinctly different it is in comparison to my home country, and if the future permits, where I will be working. As for the full-body dissection, I understand that Leicester is one of the few schools that use cadavers for teaching, and this was what drew my attention as it would be the best way to learn about the human body, and is much more realistic in comparison to the 3D models offered by other schools. The varied yet detailed curriculum by Leicester is one of my reasons to Why Leicester. The second reason would be the city and the clubs and societies. I am an avid dancer, photographer and content creator, and when looking through the clubs & societies in Leicester, it had a club or society present for all of my interests. I have to admit that some schools that I was looking at did not offer as much variety as Leicester did, and as a prospective student who would be spending the next 5 or more years in Leicester, the clubs are a huge draw and really made Leicester stand out as a possible second home. As for the city, it is a university city and from what I have read, there are a great variety of things to do in all aspects, and what really caught my eye was the event Parkrun hosted every week, that offers a great socialising event and allows me to meet and make more friends. Ultimately, medical school is more than just hitting the books, and with such a huge range of activities present, it would make me feel at home and hence is my second reason. Lastly, my Why Leicester has also contributed to the outreach programmes such as Teddy Bear Hospital and JEM (Junior Emergency Medicine) presented to the medical students. I am a firm believer that to make a real influence, you have to start from the community. By educating or supporting individuals from a young age, we have a role to play in shaping the future generations and that is when we really make a distinct influence. By joining these

	programmes if I am offered a spot, I would be able to help push out programmes or initiatives that really help the community in Leicester and Leicestershire. While it is a small aspect of the school, it aligns with my personal belief of helping others such as the less fortunate genuinely with no motives, and hence is a big draw for me. In conclusion, everyone has different reasons for their Why Leicester, but this is my 3 reasons which I feel most connected with.
Explain without gesture or mime, how to click your fingers?	Everyone is going to have different ways of approaching this matter so I will just write the general tips: • Be as specific as possible, do not assume anything as what you feel is common sense may not be the case for the actor (for instance) • **ALWAYS** check if they are following, ask it in a polite and respectful manner • Remain calm and stay patient, do not speak condescendingly or in an aggressive tone • Remember the rules set out in the question (no gesturing or miming) • Think of it in an age-appropriate manner whenever possible
Which of the following NHS values listed means the most to you? Give an example of where you have shown this value (Respect and dignity, improving lives, everyone counts etc.)	This is more of a personal question but do take note of the given factors to the question: • **MEANS THE MOST** so perhaps focusing on just one value • **GIVE AN EXAMPLE** means the actual example does not matter a lot, but it should tie in with the value that you want to talk about • **SHOWN THIS VALUE** means you must have demonstrated it in some form, most frequently in a physical form but can also mean emotional form / non-physical form
GP consultation: commentating on audio clip, what the GP could've done	For this type of question, **MAKE USE OF YOUR PREP TIME** and think critically and outside of the box if needed.

better (3 things), what the GP did well/not well etc	What you feel, even if you think it is minor, is still worth pointing out. Pay close attention to tone, body language, facial expressions, non-verbal cues, anything that is implied or could be implied. Take note of the parameters as well, you need 3 things for what the GP could have done better, so keep within the limit.
Roleplay station: The scenario was an upset woman in the benefits office, you just have to go down the cue and make sure you follow them & are empathetic etc.	Roleplay questions in general are easier to just do because you just need to follow your instincts, while keeping in mind the scenario that is given to you. Read Segment “MMI Role Play Questions” for more tips and how to address them.
Personal Qualities Station (so historically this would've been the poster): 3min talk presentation about yourself, they give info about this in your interview invitation email.	This is also unique to each individual so we will not dive too deeply into this question. Just follow what the email says, keep practicing your presentation and be aware of the time limit given to you (3mins). Ask friends or family to review them for you.
The ethics question was "Should it be mandatory for healthcare workers to get the covid vaccine?" Context: govt was mandating it (but then u-turned)	In this situation, I feel it is important for us to consider a neutral or balanced stance for this question. I will try to consider both sides to this question and offer my views on this matter. A possible reason why it was suggested to be mandatory for healthcare workers to get the vaccine was that they are the ones in the frontlines, fighting against the virus itself. A vaccine, which is an injection of either alive or dead cells from the virus for the body to build up antibodies against the virus, would be very beneficial as if the body is able to produce natural antibodies against it, the symptoms experienced may be minimal if not at all. This not only protects the healthcare workers, but also is a good first step towards achieving herd immunity, the desired goal of the vaccine rollout. Another possible reason would be that it gives a good impression to the public, that healthcare workers are taking the vaccines, reassuring them that the vaccine is safe and in turn could encourage higher vaccination rates which would also go a long way in helping to build herd immunity. On the flip side, some reasons why it should not be mandated is that it goes against some individual’s religious / personal beliefs, and to force them just because of their profession

	would go against their autonomy as a human. Healthcare workers are, at their core, human and have a right to choose whether they want to take the vaccine or not. The mandate of the vaccine infringes upon their rights, and is unacceptable regardless of profession. Furthermore a possible reason would be that vaccines still can cause serious side effects such as high fever, infections and in certain cases deaths. While rare, it is certainly not ruled out as there are reported cases of individuals dying from taking vaccinations. As such, to force vaccinations onto healthcare workers is essentially a way of taking a gamble for the individual whether they get serious side effects or not, and the workers do not even get a say. In conclusion, I feel that while there were good intentions behind the mandate for vaccines, it is being done in the wrong manner and as such, I disagree that it should be mandatory for healthcare workers to take the vaccine, and instead be given an option on whether they want to or not.
NHS Values station: Give an example of when you have to go against one of the NHS values	Common one is patient interest first -> you willl have to go against it when they demand a treatment that's not on the NHS Again a personal question, you can pick and choose which value you want to address, remember the example is important but the reflecting and explanation are more important!
Professionalism station: I was shown a text- something about a medical student missing a mandatory attendance event due to them partying the day before and I was asked what to do	Angles to explore when giving an answer: • Think of good medical practice, the code of conduct and the fact that medical students are being a doctor in training • What kind of role are you undertaking? A friend, a lecturer, a dean, a doctor in the hospital? The role will definitely influence how you tackle the situation • While the “What to Do” is explicitly signposted, you should also explore the

	WHY it was done and also **HOW** you can prevent such occurrences from happening again • Is this a confirmed event? A text can be fabricated, important to check with the student and other sources to be sure and prevent false accusations • Remember anything you suggest must be **FEASIBLE & PRACTICAL** • Be aware of the situation and note if there are any unusual or unexpected things such as the text not seeming real
Why professionalism is important EVEN as a medical student.	First off, I feel it is important to define what professionalism is in the healthcare setting: Professionalism essentially refers to the way we conduct ourselves competently and skillfully in front of patients and other individuals that we may work with. One reason why it is important even as a medical student would be that we are doctors in training, and eventually we will become doctors ourselves. While it could be argued that we as students still have a long way to go before we become professionals, the public still interact with us in settings such as hospitals. As such, the perception they have of us could be tainted if we were unprofessional and this impression could be carried on further in terms of interaction with other doctors. As such, maintaining professionalism is crucial so as to protect public trust in our profession, and to prevent poor public perception from interfering with our duties.
Personal "fit": We've got so many students applying, why should we choose you?	Again, everyone has different answers for this question so I will break down the approaches mainly: • Talk about the course, the curriculum and how well you

	fit it, play to your strengths as much as possible • Be unique, talk about your biggest selling points and what you have (that you might have done it frequently / versatile in) that not many individuals have • Talk about what you can bring to the school in terms of benefits, for example research, win competitions for them, bring attention to their name etc • Talk about the school (apart from just medical school), what are things you really believe in and how Leicester / whatever school can help you get there and achieve those beliefs

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University of Bristol

Interviews will take place from December 2022 to February 2023.
This year's interviews will be hosted remotely via the Zoom platform. The formal interview will last approximately 30 minutes in a structured interview format, with four assessors in total. Each assessor will assess your response separately; these independent scores will form an average for each question, which will produce your final interview score.
As a medical student, you will attend teaching sessions on professionalism and will be sign-posted to appropriate guidance. In preparation for your interview, we would like you to read very carefully Achieving Good Medical Practice: guidance for medical students published by the General Medical Council.
This guidance reflects our important values as a medical school. It will give you a better understanding of what you commit to in becoming a medical student and help answer some of the questions and scenarios posed in the interview.
From what I understand, you are allowed to make written notes to assist you in the answering of questions **BUT ONLY IN THE INTERVIEW ITSELF**.
Before going too deep into their interview questions and how to answer them, let us look into their medical school curriculum, the attractions of the school and city, and other useful information.

The Medical School Curriculum

Generally speaking, Bristol Medical School uses a CBL approach that is very apparent in Years 1 and 2, where you learn the bulk of the theory. In Year 1, you will be learning through System Cases of cardiovascular, respiratory etc. (Not much more information regarding what System Cases is unfortunately). In Year 2, we learn primarily via CBL cases such as Joint Pain, Headaches, Collapses etc, all while undertaking Student Choice Projects as well as Effective Consulting Clerkship.
Specifically the programme will develop the student in the domains of Doctor as Scholar and Scientist, Practitioner and Professional as set out in the GMC standards, Outcomes for

Graduates. Additionally we will **develop students as Citizens and Agents of Change**. Students will learn in a research-rich environment and will be encouraged to develop their scientific curiosity through self-directed learning. The **importance of the population perspective and of preventative healthcare** will be emphasised throughout the curriculum.
Bristol students get to study in **VESALIUS CLINICAL TRAINING CENTRE** which provides full support for surgical anatomy training, education and research.
Bristol graduates will possess all the core competences, knowledge and practical skills to enable them to enter the workplace as safe, effective and compassionate practitioners. Through recognition and fostering of their individual talents, they will contribute to the wealth and diversity of the medical workforce. Learning opportunities will foster students' abilities to be adaptable, resilient and able to deal with uncertainty.
On this course you will learn about the art, science and craft of medicine through:

- early clinical exposure in hospital, community and primary care settings;
- a blend of lectures, case-based learning and practical work;
- state-of-the-art anatomy facilities including **cadaveric prosections**;
- integration of basic science and clinical learning throughout the course;
- inter-professional working on placement with allied health professional students;
- broad experience in a variety of clinical academies;
- a substantial student choice programme to explore personal interests in more detail, experience potential career options, and gain the opportunity for involvement in audits and research;
- an exciting opportunity to study abroad as part of your final year elective;
- a final year that is constructed explicitly to prepare you for your first job as a foundation doctor.

There is usually one inter-professional event a year where you will attend a day with a group like nurses or pharmacists. In second year for example you spend the day talking about the roles, doing mock scenarios where you prescribe a drug, the pharmacist checks it, notices any issues etc and just to introduce you to the multidisciplinary environment.
You do not attend classes with other degree programmes.
As for cadaver stuff, all our specimens are prosected so they've already been dissected by professionals and the specimens are just laid out on tables with demonstrators with you. They go through each station with you, so usually diagnosis, pathology, physiology, radiographs etc with your group.
They are all cadaveric specimens, and you can pick up/touch/manipulate etc as you'd expect, we just have no 'live' dissection unless you intercalate.

Course structure

First year

This year will help you to explore health and wellbeing through case-based learning, to provide a foundation for your knowledge and skills, alongside clinical placements in primary and secondary care.

Second year

In this year you will explore disease processes and construct a list of differential diagnoses for common symptoms through **case-based learning, alongside clinical placements in primary and secondary care.**

Third year

You will work in primary and secondary care settings in our clinical academies, where you will meet patients presenting for scheduled (elective) and unscheduled (emergency) care and learn about how common conditions are managed in the NHS.
Intercalation
Between years three and four, there is an opportunity to spend an additional year studying for an intercalated degree in a medical science or humanities subject.

Fourth year

You will learn about the care of patients across the life course, from birth to old age in primary, community and secondary care in our clinical academies in preparation for your final knowledge-based and clinical examinations.

Fifth year

Following your elective study, you will prepare for your Foundation programme posts by working within clinical teams in the clinical academies, experiencing teamwork and decision-making in primary, community and secondary care clinical practice. You will be supported to deal with the uncertainties inherent in the practice of medicine to equip you to provide safe and effective care in all clinical settings.

Attractions of School / City

Again this segment is broken down into the school and city. We will focus on the Medical School first before looking at the city of Bristol.

Bristol Medical School

Bristol university is extremely aware of the socio-political situations at any point in time. It educates not only in science, but also incorporates relevant health issues into the course. For example, '**3D days' focus on diversity and disability, where students are educated about race, disability, sexuality and gender disparities. Along with this, there is clinical contact from the first month in 1st year, where students begin to join in consultations at GPs, get to know patient's stories, and go on home visits**. This allows students to gain confidence, and develop their communication skills.
The MedSoc at Bristol uni is absolutely fantastic. There are MedSoc formals 2-3 times a year, where everyone gets dressed up, eats good food, and socialises between years. This is a brilliant way to get to know one's peers in a relaxed, non-academic environment. The MedSoc also **has a vast number of sub-societies**, such as Plastic Surgery soc, Homeless and Inclusion Health Society, and so much more. It also has a wide variety of roles, ensuring everyone feels looked after, included and comfortable.
In Year 1:
All students will have experience of the healthcare environment through training and practice as a healthcare assistant.
Case-based learning, supported by lectures, practical sessions and workshops in the biomedical sciences will be used to learn about how the body systems work in health using an integrated approach incorporating biomedical and clinical science.
Patient contact will take place through community visits, including GP practices.
All students will be taught basic life support and first aid skills by senior students.
Students will complete their first Choice project.
In Year 2:

Concepts of disease are introduced by building on the systems-oriented cases in year 1 to a symptom-based approach to consider disease processes and differential diagnosis. This will be complemented by **live-streaming and recordings of post mortem examinations**.
Students will be introduced to the basic principles of pharmacology and clinical therapeutics.
Community visits will involve meeting patients with chronic disorders, such as dementia, kidney failure and cancer, to find out what it's like to live with these conditions.
Intermediate clinical reasoning will begin to introduce to students how to receive a history from a patient and perform a physical and mental state examination leading to the formulation of a list of differential diagnoses for common symptoms.
Students will continue to develop their Choice portfolio through project work.
In Year 3:
All students will learn about basic research methods and will **complete a research/audit/quality improvement project** as part of their Choice portfolio

In Year 4:
Primary care and community attachments will take place at least one day per week throughout the year to give students experience of undifferentiated presentations and dealing with uncertainty.
Case based learning will continue to ensure all core topics are covered including Biomedical Science and Helical Themes.
In Year 5:
Year 5 will start with an **elective period of study** as part of our student choice portfolio.
The remainder of the year will be spent in longitudinal clinical clerkships in Acute and Critical Care, Ward-Based Care, and Primary and Community Care. During these, the student will act as a member of the healthcare team and will expect to embed into practice the clinical skills that they have learned throughout the course.
Students will complete their clinical skills log and their portfolio of reflective practice.
Students will complete a patient safety and quality improvement project during their clinical clerkship.

INSIGHT INTO BRISTOL MEDICINE

Thanks to the sharing of one of the members of the discord @paul who has graciously provided us with information regarding what Bristol Medicine is like on a day-to-day, as well as providing us some answers into what to expect if one makes it into Bristol Medicine.
Below is a timetable for a typical Year 1/2 Medical Student:

All our teaching is organised in two week blocks, either a system (first year) or a symptom (second year). You will have a CBL "set" in that block, 5 hours across three sessions but also 10-12 lectures.

You can also have labs such as anatomy, primary or secondary case sessions, and some helical theme / cross-disciplinary session.
This continues for all of year 1 + 2 except the first ten weeks of year 1 which is called 'foundations of medicine', a 10-week whistle-stop tour of medicine to get everyone up to the same level. Years 3-5 are 100% clinical, but central teaching sessions still occur once a week, and are held online. Despite being more clinically inclined, CBL is still done a ton in Years 3-5, even more than the first 2 years.

The medical school academies are in Bristol, Taunton, Gloucester, Swindon, Bath, Weston and Yeovil primarily. However, in Years 3-5, CBL sessions are very short, 3-4 hours max a day a week.

All year 1 students have to do three 12-hour HCA shifts in first year as a mandatory component. This doesn't *allow* you to work as a HCA, but you can very easily join the hospital bank as a medical student so that's easy enough to do. As a medical student you do the basic HCA training more or less, you just have to spend a few days in a classroom to 'finish up', but you should be able to join local trust banks.
Student Choice Project is years 1-3, in year 1 you pick from a list of about 8 topics and you have to write an essay/make a leaflet about it. In year 2 you pick from a list of about 300 projects and you get three weeks to do it, finishing up with writing a middle-sized essay + making a poster which you present at a conference. In year 3 you pick from a smaller list, you write a mid-sized essay about it and you get about six weeks to do it, then you present at a conference. You get to explore really cool things such as scuba diving medicine or wilderness medicine.
In regards to the elective in Year 5, you are able to apply for financial assistance and guidance, where the school aims to provide support for you to choose wherever you intend to go. However, it also depends on what you are able to afford.

ECC (Effective Consulting Clerkship) is a three-week block where you are hospital based at one of the academies and you have to **clerk patients (take their history) and present them to doctors**, plus you learn all the normal exams (neuro, abdo, resp, cardio).
On top of that, you do clinical CBL and teaching, can do some clinical skills if you want (taking bloods, dressing wounds, injections, go to the operating theatre, etc) and basically just experience the clinical environment for the first time as a medical student seeing patients.
Some **good things** directly from @Paul:
In my opinion, Bristol has the best medical school curriculum in the country because we focus so much on the art of medicine, consulting skills and ability to work with and communicate with our patients. It's no use knowing all the nitty gritty pathophysiology if you can't manage a patient crying in front of you.
We don't do as much nitty gritty basic sciences, but that is good because we focus more on the more important stuff like above + the clinical relevance of the sciences we do learn, and 90% of the extra stuff is useless past second year anyway. Also we care less about the portfolio, you aren't doing endless QIs/audits/exams/papers/etc. You do one written exam at the end of each year (and an OSCE too in years 3/4) plus one essay a year from student choice, no extra portfolio shit to distract you.
As for clinical placements, you see your first patients in the second week of year 1 in GP placements. In year 1 you do half a day in GP or academy every month, plus skills practice with actors (consulting) once a month for half a day.
In year 2 you start with a 3-week hospital placement where you consult with patients, can try venepuncture, go into surgery, revise all the basic examinations, etc. Then you do half a day in GP or secondary care every fortnight along with actor sessions as in year 1.
Then in year 3/4/5, you are 100% clinically based except 1-2 weeks each year of central lectures, you never come into uni.
Some **drawbacks** mentioned directly by @Paul:
Quite poor admin that varies over years, not the fault of the staff though, they are just understaffed. Some things don't make much sense, like the fact I had my first ever OSCE last week halfway through my medical training to the day haha, it should be sooner.
Expensive to live here and the uni can be a bit inflexible with placements sometimes and what is expected of you.

Bristol, The City

There are a range of topics you can talk about in regards to the city:

- Independent spirit

Bristol is proud to be an independent city. Bristol has a strong tradition of activism, with citizens who are engaged, expressive and ever-ready to get involved. When we **became the first city outside London to choose a directly-elected Mayor**, people seized the opportunity for a new approach to politics.
Get a taste of this independent spirit through locally sourced food and drink, soak up the culture and revel in Bristol's offbeat and alternative character. The Bristol Pound encourages local spending and supports independent business.
A playful, playable city, there's so much to see and do. Practice parkour at the UKCF academy, have a game of ping-pong at tables across the city, or be amazed by a high-flying circus act.
Hot air balloons are one of Bristol's most iconic symbols and every year over 150 take to the skies in the Bristol International Balloon Fiesta. Why not take a trip? Or better yet, join the BUHABS society and learn to fly in our University balloon.
Bristol is the kind of place where you can shut off a main street to install a public water slide, watch a magic show while you eat dinner, and go to year-round festivals that celebrate everything from street art to sea shanties.

- Culture

Bristol offers something for everyone, whether you're into music or museums. If you enjoy film and independent cinema, you're spoilt for choice. Try Cube, Watershed, or the newly reopened Everyman theatre. Film clubs abound, from Bristol Bad Film Club to the Sunset Cinema, and if you want to see something seriously retro, visit 20th Century Flicks and pick up some videos.
Laugh out loud at the Bristol Improv Theatre, or visit the oldest continuously running theatre in the UK, Bristol Old Vic. For other great shows, don't miss Bristol Hippodrome, or plays at the Wardrobe Theatre and Tobacco Factory.
Bristol is the birthplace of Arcadia, famous for their shows fusing sculpture, engineering, lighting, circus and robotics.
We The Curious mixes fun with learning, and you can **wonder at the night sky in the UK's first 3D planetarium**. Learn about the city at the M Shed museum and explore the animal kingdom at Bristol Zoo Gardens and the Bristol Aquarium.
Listen to live jazz at The Old Duke, dance to folk and rock at the Canteen, or see something classical at Bristol Beacon. You can keep the records spinning at one of many vinyl shops, from Rise in Clifton to Wanted Records in St Nicholas Market and Idle Hands in Stokes Croft.
Keep your balance at a roller disco at the Trinity Centre, a converted church, or rave on a boat at Thekla. Other eclectic nightlife is on offer at venues across the city, from the compact Cosies in St Pauls to the larger clubs Motion and Lakota.

- Location

Perfectly placed, Bristol is a gateway to the South West. Take a hike in the Mendip Hills, taste cider in an apple orchard, and discover Glastonbury, home to one of the largest music festivals in the world.
South of the city, Somerset plays host to a wide range of attractions, including Cheddar Gorge, Chew Valley, the Wookey Hole caves and the medieval city of Wells. The Mendip Hills are a recognised Area of Outstanding Natural Beauty. To the north-east, the Cotswolds offer breathtaking rural landscapes, and nearby towns like Gloucester and Cheltenham are well worth a visit.
The Forest of Dean is on your doorstep; chase adventure through the tree-tops at Go Ape and admire nature at its finest in one of England's ancient forests. Hike through waterfalls in the Brecon Beacons, and stay overnight to take advantage of the national park's status as an International Dark Sky Reserve.
It's an e**asy trip to see the seaside and discover local beaches** at Weston-super-Mare, Brean Down and Sand Bay. Play in the arcades and enjoy fish and chips, and ice-cream cones, or find a wilder coastal spot and relax in peace. Don't forget the suncream.
Bristol itself is **one of the warmest and sunniest cities in the UK**, and while the hills may be tough to climb, they do make for incredible views.

- Sustainability

Bristol was the **first British city to be named European Green Capital**. Bristol impressed with its commitment to clean transport and energy, and its role as a low-carbon hub of industry. The city influenced international policy at the UN climate change summit in Paris in 2015, sharing best practice and presenting ambitious sustainable action.
Ecotricity, a green energy group based in nearby Stroud, has recently set up a team in Bristol with plans to open a tech hub. Whilst Bristol Energy reaches over 100,00 customers, helping to tackle the effects of social inequality and fuel poverty.
There are many charities and opportunities for you to get involved and make a difference. Bristol is a place where people care - where you can do your bit to protect our environment by learning more about sustainability, joining a campaign, or making small changes to your lifestyle.
Bristol was the **UK's first cycling city, birthplace of the National Cycle Network and home to Sustrans, the UK's sustainable transport charity**. Hire a bike and explore the many routes around the city.
Pet the animals at one of the city's farms, or visit the vibrant CREATE centre and its purpose-built Ecohome to explore environmental issues and get practical ideas for greener living.
If you're visiting the Avon Gorge, lookout for rare fauna and flora in a designated Site of Special Scientific Interest. The bones of Thecodontosaurus, also known as the Bristol Dinosaur, were discovered here in 1834.

- Festivals and events,

From Big Green Week to the Festival of Nature and the annual Walking Festival, celebrate the city's commitment to sustainability. Bristol's events and festivals are **WORLD FAMOUS** such as the Bristol Balloon Festival.

- Creative industries

Bristol's modern economy is built on the creative media, technology, electronics and aerospace industries. Bristol's modern economy is built on creative media, technology, electronics and aerospace engineering industries. From Airbus to Bristol VR Lab, from the BBC to the science and tech hub FutureSpace, we've got high ambitions and the drive to deliver.
We have **England's strongest digital media supply chain outside London**, and Bristol is a buzzing incubator for start-ups and new enterprises. Named best business incubator in the world by UBI Global, Bristol's SETsquared has helped over 2,500 UK start-ups.
Enterprise and collaboration are central to Bristol's success with ventures such as the Engine Shed providing space for entrepreneurs, businesses, academics and students to interact. Check out the digital partnership Connecting Bristol, and imagine a new kind of smart city through Bristol Is Open.
Bristol is the birthplace of Wallace and Gromit, with Aardman Studios reaching an international audience through stop-motion animation, apps and games.
It's a city where creative technologies playfully rethink public space, winning a number of Playable City awards led by Watershed's Pervasive Media Studio. From lampposts that text you back to sensor-triggered projected animals, this meeting of art and technology is representative of the city.

- Friendly faces

Laid-back, welcoming and kind: your typical Bristolian. We've won a host of accolades in national surveys, including **most liveable and kindest city**.
With over 1,500 voluntary and social economy organisations, there are hundreds of opportunities to get involved. Break bread and share culture with the 91Ways project, which celebrates the 91 different languages spoken across the city.
Or brush up on your Bristolian - the strong accent is another thing that make's Bristol special. So take a moment to thank your bus driver, with a cheery 'cheers drive!'.
Our people are proud of their local heritage and with good reason. Look behind the street names and discover community history through the Know Your Bristol project, which digitally documents stories and voices absent from official records.

Bristol is a City of Sanctuary, part of a national network to welcome sanctuary seekers and celebrate their contribution to society. Local groups, including businesses, community organisations and individuals, work together to support a range of initiatives from a transport fund to a scholarship scheme.

- Walkability

All the buzz of a major city without the expanse, Bristol is truly walkable. Everything you could need is within reach - in fact you'll be spoilt for choice when it comes to activities, sights, food and drink. The abundance of street art and beautiful buildings is another reason to take a walk: you never know what you might discover.
Take in Bristol's rich architectural heritage with the Walled City Walk, and discover hidden spaces on foot. Stroll along Corn Street, part of the old city that was the medieval heart of Bristol. There are plenty of walks to choose from, and we even have our own walking festival.
Take advantage of Bristol's numerous walkable green spaces, from Clifton Downs to Ashton Court. Or you can visit the Architecture Centre in the heart of the city to learn more about good design in the built environment.
A joint project with Sustrans, Nike and Active Living Research named Bristol as one of the nine most active cities in the world, alongside New York City, Adelaide and Copenhagen. Pedestrian areas are commonplace, and new initiatives and investment continue to make this a wonderful city to wander.

- A thriving art scene

Be inspired at the numerous artist studios and spaces across the city. **Awarded UNESCO City of Film status**, Bristol offers cultural cinema, pop-up screenings and festivals for film fans. Film-makers will find popular locations, skilled crew and world-class education.
Visit Spike Island, a gallery in an old tea warehouse, or see local emerging talent in Hangfire Bristol or Soma. Take advantage of a variety of workshops and unlock your creative potential.
Hamilton House hosts a wide range of artists, and runs events spanning physical therapy, music, and capoeira, while the Folk House teaches everything from stained glass to wood carving as well as hosting regular exhibitions.
For jewellery and crafts, check out the Christmas Steps Arts Quarter, and pick up something beautiful. Enjoy events, talks and contemporary art at the spectacular Royal West of England Academy in Clifton, the **UK's only regional Royal Academy of Art**.
By the waterside, Arnolfini gallery showcases contemporary art across dance, performance, music, and visual arts, while Bristol Museum & Art Gallery has a wide range of collections in the centre of the city.
Of course you simply have to wander around to discover the city's most famous artist. Banksy's original artworks can be seen all over Bristol, and you can take a walking tour to guide you.
Stokes Croft and Southville are both great places to enjoy urban art,but you can find hidden gems in every corner of the city. Discover up-and-coming artists at Upfest, Europe's largest street art and graffiti festival. And if you want to make your mark, why not try a graffiti workshop?

- An abundance of nature

A buzzing city which is also calm, restorative and full of green spaces. Discover 4,500 species of plants at the Botanic Garden, or enjoy a living history of the city's trade and maritime past at the Floating Ballast Seed Garden.
Nearby nature reserves like Chew Valley offer the opportunity for hiking, spotting wildlife, and fishing. For something more central, there's Brandon Hill, the oldest park in Bristol and a tranquil oasis just minutes from the bustling Park Street. In summertime, residents line the banks of the River Avon, relaxing in the sunshine by the harbourside.
Take a dip at Clifton Lido, or, for the more adventurous, try wild swimming at Claverton Weir in neighbouring Bath. For further fun: take a boat to Beese's Tea Gardens, travel along the river in style with Bristol Ferries, or try your hand at paddle boarding at the harbourside. After

being on the water, relax and unwind in one of Bristol's numerous floating bars and restaurants.
Enter the Giant's Cave if you dare, and enjoy the folklore and mystery of Clifton Observatory, as well as the views. Spot red deer at the beautiful Ashton Court, or learn to rock climb in the Avon Gorge. Nearby Leigh Woods has excellent walking and biking trails, and Clifton Downs is a huge area of protected parkland stretching north of the city.

- Heritage

A starting place for early voyages of exploration to the New World. **Bristol once was known as "Bristgow".** A starting place for early voyages of exploration to the New World, Bristol has always had strong links with the ocean. As a vibrant port city, Bristol's trade and industry in tobacco, glass and chocolate boomed and merchants prospered.
The city's role as a key port also led to its brutal and shameful part in the Atlantic slave trade. See these important stories at the Bristol People gallery at the M Shed.
Bristol was renowned for ship building with the finest materials and skilled techniques, leading to the phrase 'shipshape and Bristol fashion'. Visit the SS Great Britain, a former passenger steamship combining size, power and technology that changed the way that ships were built forever.
These ships weren't alone on the waves. **Discover the infamous pirate Captain Blackbeard's hideaway cave under St Mary Redcliffe Church, and his original birthplace and childhood home on the harbourside**.
Hear history come to life through sea shanties, or discover letters, diaries, photos and film spanning 800 years at the Bristol Record Office. Marvel at the Clifton Suspension Bridge - since 1864 this feat of engineering has been a testament to Isambard Kingdom Brunel's amazing designs.
Take a tour of the neo-Gothic Wills Memorial Building, and climb the tower for sensational views across the city. Or visit any of the 100 Grade I listed buildings in Bristol, including Bristol Cathedral and Blaise Castle.

Bristol-specific Interview Tips

Bristol emphasises that medicine is an art as well as a science.
To demonstrate that you share this mantra, include both biomedical and psychosocial perspectives when answering questions about work experience, and when given scenarios to think through.

Bristol medical school has a huge focus on welfare.
So think about the importance of the mental wellbeing of medical students and doctors. Explore how you might manage your own mental health and stress at medical school and as a doctor, as well as the effect of poor mental health on you, your peers and your future patients.
Medicine is very much an art and a science
An interest in both are required if you want to go to Bristol medical school. Ensure you have other interests outside of medicine that you can explore at interview and that you have experience working with people in various settings like a job or volunteering.
Bristol tend to use picture scenarios in their interviews
Understanding what kind of attributes make up an effective team, not just in healthcare is really important! Really focus on how you might come across, think about your facial expressions and therefore how friendly you might seem. They want to see students who speak calmly, confidently and clearly. Most interviewers are lovely, so try and form a discussion with them rather than just answering the questions. Develop your responses whilst keeping relevant.

Past Years Interview Questions

DISCLAIMER: All interview questions here are from previously released years, and are sourced from websites that have released them. We do not **CONDONE** the sharing of interview questions (especially during the cycle itself) and do not **SUPPORT** any NDA violations in view of academic integrity. All of the following interview questions are released only after the test cycle, and any form of trying to cheat (asking those who have sat their interviews for the questions for example) **WILL NOT BE TOLERATED.**
Some of the interview questions asked from previous years are listed below, together with a suggested response / talking points. Since they do not specify the form of interviews, and I could not find any previous releases of last year's questions, I have collated from websites / whichever question appears the most often.

Interview Questions	Suggested Responses / Talking Points
Tell me about a time you failed. What is resilience? How have you shown this quality?	This is a personal question, so only suggested approaches + talking points for this answer: • Define what resilience is. According to Google, it is the capacity to recover quickly from difficulties; toughness. Try to define it outright in the first introduction to the answer • The question is looking for the **HOW**, so it actually matters what steps you took + the rationale behind why you took them • Try to have a logical flow when detailing your actions (make it sequential, first you did this, then this, then after you did this, this happened….)

	• In regards to the “How have you shown it”, try to get other people involved in it. Remember “Show Not Tell” so to demonstrate resilience you can say, “My friends shared after that….” or “My team leader explained that through this action…..”
What does integrity mean? How do you ensure a sense of trust?	Again another personal question. Suggested approaches: • Define integrity again. From Google, integrity refers to the quality of being honest and having strong moral principles; moral uprightness. • Give examples (past occurrences especially) to demonstrate **WHAT IT MEANS TO YOU**, or **WHAT IT MEANS TO THE PEOPLE AROUND YOU** • Remember that integrity is a hard trait to explain and with the use of examples will help go a long way with

	breaking down the concept In regards to the second question: ● Trust is one of the most difficult traits to build and inculcate, so it is very important to know that **ENSURING TRUST** is not always possible ● Pursue healthy and open communication , it is crucial for trust ● Think about what makes you trust someone, what things you consider and then explain your thought process behind picking these factors ● Throw in real life examples as well to help ground your argument, such as what steps have you taken to try and “ensure” some trust as well
Give me a situation where you have used teamwork? What makes you a good team member?	The situation for the use of teamwork again is highly personal, but do pick examples that highlight teamwork explicitly so that the examiner does not need to think so hard to try and understand how teamwork is used. Talking points for what makes you a good team member:

	• Objective-oriented / people oriented • Flexible / adaptable • Strong interpersonal communication • Responsive • Respectful of opinions • Essentially any attribute you can think of
Why is teamwork important?	Teamwork at the core is working with different individuals to achieve either the same or potentially different goals. Let us break down some reasons as to why it is so important and critical for teamwork to be used at times. One reason why it is important is that it helps break down complex events into manageable duties. One such example would be if I was given the task of organising Freshers Week for the university. As I have done similar events before, I am comfortable with the planning as well as execution of such tasks. However, I understand that practically speaking it would be impossible to plan such an event on my own. As such, teamwork is so crucial here as it allows for the event to be carried out without placing extraordinarily strain on a few individuals. This in turn leads to better performance as a whole by the team, ensuring that the event is carried out without a hitch. Another reason is that it can lead to increased efficiency and patient safety. While this is more towards the healthcare context, teamwork

	in a clinical context is extremely important. One example that comes to mind would be during my work experience, I had the opportunity to shadow a surgeon and was given the chance to witness multiple opportunities. During a routine surgery where there was a hernia mesh repair operation, the nurses and surgeons were working together as a team where everyone was doing their respective duties. As a result, the teamwork displayed allowed the professionals to be efficient, carrying out the operation smoothly and quickly, while also preventing the occurrence of any mistakes that could compromise patient safety. The last reason would be that it enables personal growth. One thing that teamwork brings out in individuals is a sense of safety, where individuals feel more protected as they are a part of a group where their mistakes could be defended without serious implications. An example of this would be when I was doing project work with my classmates for my A Levels. As a part of a team, I felt safe in knowing that I could think outside of the box, trying out new ideas creatively and that I had a safety net present with my teammates who could help me out whenever I needed their support. As a result, it allowed me to experience growth as an individual as I learnt to explore alternatives and think outside of the box, and it allowed me to learn to rely on my teammates as well, which was personal growth for me from someone who always

	used to rely only on myself when it came to important tasks.
What are the challenges of teamwork?	Teamwork, while with its benefits, still has some of its challenges or disadvantages. The debate regarding whether teamwork is a good or bad thing is still ongoing today, but I will be focusing more on the challenges faced. One challenge is that it can lead to hesitation and minimal action due to potential infighting or extensive discussion to the point of inaction. In a team, there are bound to be opinions that differ, and have views that are potentially clashing against one another on how something should be done or carried out. It is of course reasonable to then assume that if members of the team are unable to work out a compromise or give in to one another, it would lead to hesitation and infighting between members when trying to decide the next course of action, causing nothing to get done. Additionally, even if the team does not experience disagreements, if the team consists of many individuals, the discussion and exploration of ideas could take a very long time, leading to inaction as a decision could not be reached. Another challenge would be that it can bring up personal issues within team members. In a team, there is bound to be a time where members have to work closely with one another, leading to conflict with one another if members are not professional enough to set aside their differences. For instance, the planning of a

	school event could be derailed if members in the team have personal beef (issues) with each other, such as disliking the person for individual reasons. This in turns jeopardizes the entire project at hand, and definitely affects how the team will move forward in regards to the communication and teamwork present. At worst, there would be withholding of information from one another, or even purposefully misleading to blame one another, which places the success of the operation in jeopardy. Lastly, another challenge of teamwork would be that it could lead to interior competition. As with any individual, there is a chance that multiple team members have strong personalities that aim to be the best, and if so they are unable to place the needs of the team before themselves. This could lead to them attempting to constantly one-up one another, even at the sake of sacrificing the team or the intended objective. At times it can even lead to the creation of a toxic environment, where team members are unable to operate optimally, again placing the success of the project at risk. In conclusion, there are multiple challenges to be listed, but I feel that these are the most important to highlight.
Where would you signpost a patient to if they were struggling with their mental health? Helpful Websites I found! https://stayingsafe.net/ https://www.mind.org.uk/information-support/guides-to-support-and-services/crisis-services/planning-for-a-crisis/	I personally think it is first to understand the state of the patient and to what extent they are struggling with their mental health. To immediately signpost a patient to services without understanding them

https://www.nhs.uk/mental-health/feelings-symptoms-behaviours/behaviours/help-for-suicidal-thoughts/	would be disproportionate in terms of responses, since where I would suggest depends on the severity of the issue at hand. If a patient were to come in, suggesting that they are feeling that they are possibly stressed / anxious / depressed, I would first encourage them to seek out individuals that they trust and can talk to in order for them to relieve the emotions that they are feeling. It is a little too early to determine whether intervention is necessary at this point, and as such I would include a phone number to a psychologist where they can turn to if the situation does not improve. There is no need to suggest a psychiatrist at this stage as medication may be too extreme. If a patient comes in and suggests that they are depressed / anxious / stressed and upon further diagnosis, I find that it is in line with the common symptoms shown with mental health issues, I would suggest a psychologist and psychiatrist to them, and recommending that they seek further treatment regarding such issues including medication as it may be able to significantly help them. Both professionals are able to work hand in hand to diagnose and prescribe any medication if needed to help the patient. If a patient comes in and informs me that they are considering potentially life-threatening actions such as suicide / self-harming / overdosing on medication, I would immediately signpost them to a psychologist and psychiatrist if they do not have

	one currently, and immediately recommend they approach suicide prevention hotlines such as SOS Silence of Suicide, Samaritans or Papyrus for someone to turn to for the immediate future. If they are uncomfortable with speaking, I would also recommend a textline Shout Crisis Text Line where they can provide assistance. I would also attempt to create a safety plan or even a Joint Crisis Plan (JCP) which could include: • signs that you might be experiencing a crisis • what support you might be offered in a crisis • practical help you might need if you go into hospital, such as childcare arrangements • who you would want to be contacted. In conclusion, where I signpost them depends greatly on the individual circumstances faced by the patient, and that I should take proportionate measures in response to the task on hand.
Should doctors be healthy?	Let us first explore the definition of healthy in this case. I imagine that the word suggests that doctors are indicative of, conducive to, or promoting good health, where they are not diseased or ill and are in good condition (physical, emotional or otherwise). A reason why people may expect doctors to be healthy is that these professionals

	should be practicing what they preach to the rest of society, and if they do not do so, it would be quite ironic, rendering their words a hollow echo. With how doctors promote a healthy lifestyle to avoid experiencing illnesses such as diabetes and obesity, it is ironic that doctors do not follow what they preach, pursuing lifestyle options that they themselves promote. This renders the message that is being promoted to be hollow, as even the professionals do not follow it, which in turn affects the trust placed in the profession. As such some people would expect doctors to be healthy, setting an example to those around them and leading by said example. However, a reason why doctors do not necessarily need to be healthy is quite the simple one, and that is they have a choice in how they want to live their lifestyle. At the end of the day, a doctor is still human, and can have autonomy in their choices, making their own decisions as and when they deem fit. As a professional, it is likely that they are aware of the issues that they may face and have already accepted the potential risks and are okay with them. Just because they are a professional in this field, does not mean that they should be deprived of autonomous choices or be made to follow what is expected of them blindly. Ultimately, I feel that doctors should not be forced to be healthy, but instead be given the option on whether they want to be or not. While it would be good if they could be healthy as to set an

	example for the public, at the end of the day doctors should still be allowed to make their own decisions.
Why should patients trust you?	Again, this is more personal so I will focus more on the talking points: ● Talk about why trust is so important for us to be able to function (if there is withholding of information, we cannot diagnose or treat them correctly), and if we diagnose wrongly can lead to terrible scenarios (such as worsening of symptoms or even death in terrible scenarios) ● Talk about how much they put in our hands to manage such as their personal details, their vulnerabilities etc
As a doctor you will have to break bad news and deal with things when they go wrong. How do you think you will cope with this emotionally?	Personal Question! So here are suggested approaches: ● Read up on what services are present, what kind of approaches can you consider (explicitly asking for help, more subtle ways of asking?)

	• Think about how you have dealt with things before, when you had to survive stressful situations etc • No method is wrong, there is no right or wrong when dealing with such emotions • Recognize the **WHY** it is so important to talk about these emotions / let them out, and elaborate upon them • The question may have focused on the **HOW**, but they are also interested in the **WHY** • Recognize also and explicitly mention that all emotions are valid! • You can also mention you have different ways of coping with different situations, raise examples of things you did when you had to break bad news to a friend / teammates or when things go wrong (during an event etc)
Organ donation in the UK is currently via an opt-in system, whereby by default option is no donation.	Opt-in scheme refers to the signing of forms or the agreement by the patient for

Discuss opt-in schemes, and other methods to increase donations of organs in the UK.	donation of their organs. Opt-in schemes is a method used previously by the NHS and it has its benefits and disadvantages. Opt-in schemes do increase organ donation as it has a higher rate of kidney donations from living donors. Patients feel that they have more autonomy, and hence choose to donate organs. However, due to poor public education and awareness, opt-in schemes tend to have lower donations of organs. Other methods include: ● Opt-out method (For England, Wales, Scotland - but opt-in for Northern Ireland until Spring 2023) ● Increased public education / incentives to donate
What is an opt-in and opt-out scheme? What are the pros and cons of an opt-out scheme?	Read Segment (Organ Donation -> Opt-In VS Opt-out (Data and Reasons)
You are prime minister for the next 3 minutes. Outline what you would do to change the NHS. Name one specific area you would like to invest a greater proportion of the budget in.	Personal question again. Focus on the talking points: ● Pick one Hot Topic from the extensive list in this document ● Think of **WHY** the specific area, **HOW** will the budget be used, **WHO** does it impact and **WHEN** will the impacts / benefits be felt ● Remember that there must be

	justification as to why that area deserves a greater proportion of the budget • Should also mention that all areas deserve funding, but bcas of the greatest impact / most beneficial impact, this area is picked • Remember Prime Minister also has its limitations, can only do so much
Why Bristol?	Read Segment “University of Bristol” to answer this question
What can you bring to our medical school, and what can you improve?	This is a personal question, suggested approaches could be: • Think of personal qualities and whether it is unique and new, bringing it to the med school. After that, think of how these qualities can improve the settings / scenarios in the medical school • Remember your answer has to have some sort of **BENEFIT** to the school • Be sequential and break

	down your answer logically so as to signpost to your examiner that you can think clearly and follow structure
How does Bristol compare to your other choices?	Personal question given that everyone has different schools. Suggested approaches: ● Be calm and collected when discussing the different schools, try not to lean too hard towards one school, including Bristol ● Break down the university, the curriculum, the city life, the student union etc ● Talk about your passions and non-academics related stuff, remember that medical school is more than just studying! ● Look at research, work opportunities etc, what makes each school unique (such as dissection) ● In 5 mins, it is almost impossible to discuss 4 schools in length, focus on 1-2 schools

	to compare with Bristol ● Focus on the selling points mentioned in the school website if you are uncertain, but also talk more about what research you did into the schools ● Can mention that you also talked to prospective students to learn more, highlights the initiative taken to learn more about the school ● Remember everyone will have the same points, but how you elaborate and explain how Bristol **FITS YOU** and also how Bristol **brings out the best** in ways that other schools can't.
What do you know about the learning methods at Bristol Medical School?	Do read the segment "University of Bristol -> The Medical School Curriculum" on how to answer these types of questions
What are important qualities of a doctor? Please discuss these.	Talking points: ● Any positive attribute works here as an example, but the elaboration on **WHY** it is **IMPORTANT** is the more

	crucial part here • Use STARR technique here, and really focus on Reflection when explaining. • Relate it to past experiences if possible, such as how you witnessed doctors demonstrating / exhibiting it on work experience • Remember that listing out qualities is not the aim here, the goal is to list out at most 3 crucial qualities, and focus on expanding and elaborating the concept • You can use the PEEL format (Point, Example, Elaboration and Link) to structure your answers as well
What do you know about the NHS values and can you name any?	Read segment “Values of the NHS” on the examples of the values, as well as how to develop answers.
What is more important as a doctor? Being intelligent or having empathy? Read more about empathy: (https://theconversation.com/understanding-others-feelings-what-is-empathy-and-why-do-we-need-it-68494)	It should be first recognized that both attributes are highly important in this field, where they both serve different but equally crucial aspects of the profession, where being intelligent would help with the

	understanding, processing and memory of the content we have to understand for this profession such as in Medical school, while having empathy would work well during our clinical years / when we become professionals such as FYs or JDs. I will break down each aspect, comparing the pros before making a decision at the end. Being intelligent, as mentioned, would help with the memorization or academic aspects of the profession. It is known that medical school, especially in the first year, would have a significant amount of content to memorize and process, and having some intelligence would go a long way in helping to understand the large amounts of content. Additionally, being intelligent would also help in regards to research, where you could perhaps ideate different approaches or work with academics to pursue different research methods to help make scientific breakthroughs. In the form of interpersonal intelligence, it could also make the job of talking to patients simpler and would allow for stronger doctor-patient relationships, which makes the process more manageable. However, being empathetic would also make the communication with patients simpler as one would be able to place themselves in the patient's shoes, and try to feel how the patient does, working out possible solutions from the patient's ideas, concerns and expectations. Empathy would also serve a huge role in relieving the pain experienced by the patients,

	as you demonstrate the emotional intelligence to listen in and offer moral support towards them who are sometimes just in need of someone to listen to them. Empathy also helps in the regulation of emotions, where for surgeons it is crucial to regulate their emotions in high stress scenarios. Empathy also serves as an initial step for the profession, where trust is built upon the very foundation of doctors being empathetic towards those in need. Without empathy, doctors would seem really aloof, and would hurt the trust placed in us. Having listed and compared the two, in my opinion empathy is more important. It is the core of our profession, where we have to treat patients by understanding how they feel, and empathy is a very important aspect that allows us to be able to carry out our jobs effectively. While intelligence has its benefits, I believe that empathy goes a long way in the profession and without it, it would fundamentally change the profession and how it functions. Although as mentioned, both are equally important and in an ideal scenario, both would be necessary and needed in a doctor.
What is the difference between empathy and sympathy? Read more about empathy: (https://theconversation.com/understanding-others-feelings-what-is-empathy-and-why-do-we-need-it-68494) Read more about the differences between the two: (https://www.psychmc.com/articles/empathy-vs-sympathy)	According to Google, Empathy is the ability to understand and share the feelings of another, while sympathy refers to feelings of pity and sorrow for someone else's misfortune, and understanding of people. According to Google, the difference between the two is that the difference between

	empathy and sympathy is found in how we relate to the other person. Empathy is shown in how much compassion and understanding we can give to another. Sympathy is more of a feeling of pity for another. Empathy is our ability to understand how someone feels while sympathy is our relief in not having the same problems. When we relate with empathy, we give the other person space to own their emotions and feelings. We reflect on what they are feeling and provide a safe space for all emotions, even negative ones. When we relate with sympathy, we move into problem-solving mode. We have ideas and judgments about how the person feels and what they should do. This not only minimizes the person's problems, but it ignores their feelings. Sympathy comes from our ego. It is what we know we should do, and often, it is telling others what to do or feel as well. Empathy comes from the heart. It is feeling another's pain and sharing a human experience. Everyone wants to be accepted and understood, and empathy fosters those feelings in the person sharing and the person listening. Another main difference between empathy and sympathy is that empathy is an appropriate emotion at any time. Showing empathy will bring you closer to others no matter what the circumstances. Where sympathy is only exhibited during tough times, being empathetic is an attitude we can adopt at any time.

Why did you do work experience?	There are a few reasons why I carry out work experience, ranging from getting to know more about the profession to expanding my interest in the field, which I will break down in my answer below. As mentioned, one reason would be to get to know more regarding the profession. As a student coming fresh from studying for my examinations, I would not have had the chance to develop my understanding about the workings of the profession, and would have little to no understanding of what the profession entails. For example, we all would have a rough understanding that a doctor would be seeing patients, diagnosing medication if necessary or prescribing certain procedures if need be. However, we would not be aware of the amount of paperwork present to be done, as well as the extensive handing over to the next shift, including ward rounds to check up on their patients. Through work experience, it allows us to view the realities of the profession, and develop a much more realistic view of the whole profession. Another reason would be expanding my interest in the field of Medicine. For many applicants, many would have started off watching TV shows or movies, where doctors were doing incredible life-saving operations or engaging in extremely high-pressure scenarios between life and death. Many would then assume that Medicine would be as such, mainly high-stakes and adrenaline filled operations. However, Medicine has such a wide

	scale of specialities and to name a few, would be OBGYN, Internal Medicine, Family Medicine, Orthopedics, Neurology, Radiology etc. By doing work experience, it allows me to view up close and personal the scope and varied fields that Medicine has to offer, and allow me to expand upon my interest in Medicine, to have a rough idea of what I would perhaps like to explore in the future. Lastly, another reason why I do work experience is to learn from the immense experience accumulated by these healthcare professionals. Depending on the work experience that one gets to undertake, you will either be shadowing a GP, a nurse, a Surgeon or perhaps a certain speciality. Usually between cases or patients, or while following the doctors / healthcare professionals around, I get the opportunity to communicate and interact with them, where I would then take the time to ask more personal questions about how their work is and how it is like being in such a position. Many times, I am able to take away huge lessons from such interactions, where they impart knowledge ranging from life lessons to certain anecdotes on how their duties are like. This not only serves as valuable learning experiences for someone who is just starting out in life, it also allows me to have a much more intimate and personal understanding of the profession, away from what is usually seen by patients or even other healthcare workers. This all comes together for me in helping me

	grow and develop into the best version of myself. In conclusion, this is why I do work experience. While there are many other reasons to explore, I feel these are the most important ones that I felt like highlighting.
What did you do and learn in your work experience? Tell me as much as possible from your placements with a GP, a consultant, a surgeon, a nurse or another healthcare professional. You can talk about one or multiple.	Talking points: ● Any work experience works here as an example, but the elaboration on **WHY** is the more crucial part here ● Use STARR technique here, and really focus on Reflection when explaining. ● Relate it to past experiences if possible, such as how you witnessed doctors demonstrating / exhibiting it on work experience ● Remember that listing out qualities is not the aim here, the goal is to list out at most 3 crucial experiences / events, and focus on expanding and elaborating the experience ● You can use the PEEL format (Point, Example,

	Elaboration and Link) to structure your answers as well
A homeless man comes in with injuries and several needle marks. You found out he is only 16 years old and may have been suffering from neglect. How would you approach this situation? Assume you are a first year medical student on placement.	Talking Points: ● Remember that you are a first year medical student, so you are limited in terms of what you are able to do ● Approach the homeless man with respect and dignity, just like any patient that comes to you for help. Being homeless does not matter in how you should treat someone (i.e social environment, their status) ● Note that it seems that he is “possibly suffering from neglect”, does not mean he is actually suffering from neglect. Try not to make assumptions and explain that you will make attempts to talk to verify your views ● First of all, injuries should come first depending on the extent of injuries faced. If it is very big

	in terms of injuries (such as open wound bleeding excessively, huge scale infections etc), focus on those first ● Needle marks is a sign of drug use, however again it does not mean he actually used it. It could be some other reasons, but you should ask discreetly to verify if he uses drugs or is using some form of substances via injections ● Ask him how his situation is in a non-confrontational way to try and understand his situation, and if he needs help, do encourage him to speak to services. ● You can ask senior management on how to deal with such situations, and if offering services / hotlines for him to reach out for help
Here are two images of the lungs. Please take notes on them. What do you notice is different?	For this type of tasks / stations, aim to talk about the obvious things first, before

	trying to infer possible reasons to why it occurred. Talking points: ● The lung on the left is pinkish, shiny and it is visibly consistent in terms of colours, as compared to the right lung that is less consistently pink with black spots and white sections, it is almost spottish with white and black spots more prevalent than the pink colors ● The blood vessels do seem to remain consistent in both lungs where despite the changes in colors, they are still as numerous in both lungs ● The white spots are also more extensive in terms of scale, where the white spots are bigger compared to the black spots which seem more concentrated. ● The bottom of the lungs is more black while the white spots are more towards the top and the middle of the lungs

	• A possible reason as to why they are different from one another would be due to possible actions such as smoking by damaging your airways and the small air sacs (alveoli) found in your lungs. If you want to know more about how smoking affects the lungs: https://share.upmc.com/2016/04/how-smoking-affects-lungs/
Mental health roleplay A patient is currently having a low mood/anxiety. Talk to the patient to figure out why, how you can help the patient and help them calm down.	Talking points: • Remember to comfort the patient first, focus on **LISTENING** and **ASKING** questions to help you further understand the situation at hand • Use the ICE approach (Ideas, Concerns and Expectations) • Remember also that the patient might not always need a solution or need you to fix them, sometimes they might just want a listening ear or some basic advice. Listen to the prompts given

	and respond accordingly ● Figure out what is affecting them, and **SUGGEST** solutions to help them. Forcing solutions or making them irrelevant in the discussion of how to solve their issues faced is **NOT APPROPRIATE** ● If it is something physical causing them worry, remove them from the situation or remove the thing that is affecting them ● Don't be afraid to ask for help from your seniors (such as consultants). Sometimes the situation is out of hand and it is too difficult for you to deal with by yourself, so asking for help will maintain patient safety and of course their best interests at heart ● Be respectful and let them lead the conversation! Try not to pressurize

	them into speaking about things, by letting them dictate the conversation it goes a long way in helping them feel less anxious • Suggest to them breathing exercises and ask them if physical contact is okay, so for example you could hold their hands and help them regulate their breathing
Managing an emergency in A & E Multiple casualties just appeared in the A&E. Who do you prioritize and why? List them in a clear and easy way to follow. Read more regarding triage: https://hsl.lib.unc.edu/wp-content/uploads/2018/09/ETATModule_1_Lecture.Triage.pdf	Talking points: • Use the ABCD approach (ABCD – airways, breathing, circulation, danger.) • AVPU is also a really good approach (Alert, Verbal, Pain and Unconscious) so focus on those in pain and unconscious first • Make sure you use a logical approach. • Like the question method, make sure it is clear and easy to follow, so signposting is the most important way

	and truthfully the easiest way to deal with it. (Firstly, I would prioritize __ because….. Next I would focus on ___ because …….Lastly I would deal with ____ because of …..) ● Focus on those who are unconscious first as if they are able to speak / conscious, they at least can be vocal and we know that they are alive ● Note and delegate work if necessary, remember it might not be just you in the A & E and other people can help you if needed ● Stop any bleeding if necessary and while working quickly is important, try to still deliver the best quality of care whenever possible
If you could choose to allocate an additional £20 million to either of the following areas of healthcare, which one would you choose and why? Cancer research, mental health, Covid-19 research, palliative care, prolonging life research	Talking points: ● Try not to jump straight into giving a stand right away, because it might make your argument

feel biased and unbalanced. You still **NEED** to take a stand but not take one too early
- Will be breaking down each point, try to balance out your argument for each point by listing out the pros and cons for each areas of healthcare, and also who it will benefit

Cancer Research:

Pros	Cons
Prevents more loss of life as cancer will now be curable	Only helps a specific group of people since not everyone has / will experience cancer
It helps with funding more research, in turn potentially leading to more breakthroughs in other areas	20 million may not lead to any substantial improvements / exploration of new ideas

Mental Health:

Pros	Cons
It is becoming even more prevalent and important in	20 million could also lead to more issues within this, as it then

today's society, and will be very beneficial to having more treatment methods	becomes a question of how should the money be allocated, to illnesses such as anxiety / depression etc.
Could help reduce the stigma surrounding this topic and normalize this	Mental health is a complex topic that treatments may not actually improve or help those affected

COVID-19 research:

Pros	Cons
Would help prevent more loss of lives, and if a treatment can be found, would cause the pandemic to be over / make things more manageable	COVID-19 is a relatively recent event, and it pales in comparison to some of the other issues that are faced in terms of duration (like mental health or cancer)
It can also allow for the world to return back to normal, returning normalcy for the whole world	There has already been a lot of delegation / allocation of resources towards COVID-19, 20 million would not lead to

	much changes possibly
It can protect the more vulnerable (i.e children and elderly) more extensively while also maintaining protection for the rest of the world	-

Palliative Care:

Pros	Cons
Improves quality of life for those suffering from the disease, eases their suffering and aligns with the NHS values	Not all are affected by such diseases, and may not be affected by it, hence it only benefits certain individuals
Allows for more professionals to help those affected, hence there can be more trained people to help those if needed, reducing pressure on the current staff	20 million could lead to little to no improvements for those affected since the amount is split among so many people

Extension of life research:

Pros	Cons

	<table><tr><td>Leads to more time for the general population and can live for longer + experience more fulfilling lives</td><td>Puts a bigger strain on resources and causes a bigger ageing population</td></tr></table> Remember to take a stand at the **END** of your entire answer so as to answer the question.
Prioritisation How would you manage several patients at once?	Talking points: ● Use triaging if necessary ● Delegate work to those around you, such as nurses to help you manage the patients ● Focus on any life-threatening issues first, prioritize saving lives ● Talk about your reasoning on choosing these patients, **WHY** in this order, break down as concisely as possible ● Since the question's command word is **HOW**, remember detailing your actions clearly and how it is practical to do so ● Try not to mention biases such as (She is a woman, I should treat her first) as it shows really

	poor judgement • Be practical in your answer, saying things like juggling three patients as once is not practical and not possible as well • Show empathy and respect to those affected, it is likely that they are going to be frantic / panicked etc, so do not dismiss their concerns
What will be the long-term consequences of the Covid-19 pandemic on the NHS?	The COVID-19 pandemic is still ongoing currently but there are already consequences and impacts that are shaping the NHS and how it functions in the long-term, and I will break down the implications in my answer. One long-term consequence would be it would fundamentally change how the NHS deals with potential infectious diseases, It is no surprise that the whole world was caught off guard by the disease known as COVID-19 and the NHS was also heavily affected by it, not having enough beds, healthcare workers going above and beyond having to work excessively to attempt to stall the spread of the disease, high amounts of deaths. The NHS at that time also did not have a plan on how to react and respond to the spread of the disease, leading to high infection numbers. Over time, the NHS managed to respond by formulating plans to deal with the disease, and

	definitely it is not a reach to assume that the NHS would be also formulating potential plans to deal with future diseases in the future, where they learn from their diseases. Another consequence would be that the NHS would also be seeking to increase the number of healthcare staff. As mentioned in the previous points, healthcare workers were stretched beyond their limits and this caused many healthcare workers to struggle mentally, physically as they were forced to work longer hours. As a result, many healthcare workers resigned in protest, leading to a vacuum in the amount of workers left in the force. As such the NHS would be willing to increase the number of staff to be able to deal with future outbreaks or any crises. (https://www.theguardian.com/society/2022/feb/26/stressed-nhs-staff-quit-at-record-rate-of-400-a-week-fuelling-fears-over-care-quality) Lastly, a consequence would be stocking up on the essentials such as hospital beds or oxygen canisters. While this may seem as a reactionary response and perhaps even an oversight / over-allocation of resources, it is not too far to assume that the NHS will allocate more resources and stockpile them in future emergencies. Again as mentioned, the NHS was in huge shortage of essential equipment when COVID-19 hit, and perhaps in the long term, the NHS would look to stock up in preparation to avoid being caught out again in the future. In conclusion, these are some of the consequences long-term on the NHS. While there

	may be more, these are the most important ones.
How has Brexit impacted the NHS? Read more below: (https://www.bma.org.uk/what-we-do/working-with-europe/brexit/bma-and-brexit)	Brexit has caused quite some implications on the NHS, and some of these are short-term and long-term impacts. Looking at the impacts, there are a few worth mentioning. One impact would be that it resulted in the loss of foreign healthcare workers, leading to a hole in the healthcare workforce. Brexit as a whole made it harder for healthcare workers, especially those foreign, to move back and forth between their home countries and the UK. As such, less foreign workers would be less willing to move to the NHS to work, as such this causes less staff to be present in the NHS to work, hence it will potentially cause the current workers to be forced to work longer hours, causing higher amounts of stress and dissatisfaction which could also lead to even more resignations. Another impact is that it affects the ability of the NHS to procure radioactive isotopes for diagnosis, treatments and clinical pathology. As a member of Euratom, the UK currently has access to a secure and consistent supply of radioisotopes, which are vital in medicine for diagnosis, clinical pathology and treatment. The UK's decision to leave the EU will risk the UK's ability to secure timely access to these radioisotopes, as well as funding for nuclear research. It is vital that the UK continues to work with Euratom to maintain the benefits of collaboration in these areas.

	Lastly, another consequence would be the impact on employment rights. The UK's membership of the EU has had a significant impact on the development of employment rights for doctors. Legislation such as the European Working Time Directive, the right to equal pay between men and women, and other EU laws around equality have strengthened safety and equality provisions for doctors in the UK. This improves patient care, as well as working towards creating a better work environment, which is more likely to retain doctors – the effect of which is incredibly important given the current pressures on the NHS. Once the UK has left the EU, Parliament will decide which areas of EU-derived legislation, including legislation on employment rights, should remain, undergo amendments, or be repealed. The BMA is aware of the potential risks to doctors if such legislation is repealed and opposes Brexit for a number of reasons, including the threat posed to the NHS workforce by allowing important employment protections to be repealed. In conclusion, the impacts range from affecting the healthcare professionals working for the NHS and even the rest of society, and have long-lasting impacts for the foreseeable future.
Follow-up: How could foreign healthcare workers be attracted to work in the NHS?	In any job setting, there are ways to attract more workers via the use of prospective benefits or job security. Foreign healthcare workers to

	work in the NHS are no different, and the provision of some of these points could help attract the workers to work in the NHS. The first point would be to provide prospective benefits that are more targeted towards foreign workers. To understand this, it is important to note that foreign workers come from other countries to make a living, sometimes being able to adapt easily while other times having more difficulty in adapting due to potential language barriers, differences in lifestyle or even moving to the country in the first place. As such, if the NHS can provide benefits such as easy movement between countries for foreign healthcare workers, language lessons / buddy systems for new members or a general introduction to the city / town environment they will be living in, it could go a long way in making the foreign workers feel more at home and be more comfortable in the new settings. The second point would be to provide some level of job security for these workers. I understand that it could be relatively unfair towards the rest of the workers if some groups are given priority / treated differently, however we should also understand that these workers are quite literally leaving their homes, uprooting themselves from the comfortable environments they are used to and putting themselves in a new and uncertain environment where it literally makes or breaks their ability to stay on in the country. It is quite unfortunate for the workers to be dismissed or fired if they were

	to come to the NHS to work, and as a consequence waste a huge part of their savings to do so. I would like to mention that foreign workers should not be given unfair / excessive protection / priority over home workers, but instead just be given some form of understanding / cover so as to make them feel more safe in an uncertain setting. Lastly, a point should be to develop policies / structures that protect these foreign workers. It is not a reach to assume that most foreign workers that come to the country would not be of the same ethnicity as the majority of the population such as the BAME workers, who are more susceptible to facing discrimination or other issues. As such, it is more likely that they will be harassed or treated differently, and hence by providing policies that protect these healthcare workers, such as anti-discrimination policies, these would help the workers feel more protected and that they can explore options if they ever feel threatened or need support. Ultimately, any person would prefer to feel that they have a strong backing by the organization and through the creation of such policies, they would be more inclined to come to the NHS to work. In conclusion, these are some ways to encourage more workers to come to the NHS. There are other possible methods, but by exploring these options that aim to cover the essentials for most workers, it would be able to encourage the bulk of the workers to come and work in the NHS.

How do you see the future of the NHS?	Since everyone has different opinions on how to tackle such questions, and since it is also pretty objective, where everyone has different opinions, I will just provide the talking points: ● Since the question mentions "future", your answer should be looking at the long-term of the NHS, but do remember also that the short-term should also be addressed, but to what extent will then depend on you ● Be feasible, keep into account current events such as "privatization", "junior doctors / nurses striking" and "COVID-19" ● You don't have to always be positive about the future, showing a bit of realistic expectations such as "the NHS may struggle with…." will help demonstrate maturity and understanding of how the real world works ● Give 2-3 opinions on how you see it and try to

	support it with examples • Don't be afraid to admit that you are uncertain of what can happen in the future (because things can always change dramatically), just try to structure a clear and easy to understand answer • Remember that your answers do not **NEED** to be in a chronological order, but it is recommended to be because it allows for the examiner to follow along much easier
One liver transplant has been made available and there are two suitable patients who require the transplant. Patient A has…….and Patient B has……Which of these two patients would you allocate an organ to and why? Additional Reading: https://www.nhsbt.nhs.uk/organ-transplantation/heart/receiving-a-heart/how-does-the-offering-system-work/	Talking points: • Address that personal opinions / biases should not be incorporated into your decision making and that you will make **ALL DECISIONS** in the best interests of the patient (always patient centered) • Objectively view the situation and place emotions aside (such as

	this patient was rude to me etc) ● First you should clarify if there is any other potential factors that could help differentiate between the two patients such as ADRTs (Check segment “Extension of Autonomy” for more details) ● You should also mention that this is not a lone decision that is made entirely by you, involve the relevant healthcare team to help you make a decision Patients are prioritised for a donated heart based on: ● Urgency status (Super-Urgent, Urgent or Routine) ● Their blood group ● The weight and height of the donor compared to the recipient ● The presence of antibodies in the recipient blood that may react to the donor heart ● The geography: some priority is given to minimising the distance

	between donor and recipient as a longer travel time can have an adverse effect on heart function • How long patients have waited for heart is taken into account, once the above factors have been considered In conclusion, these are the factors for consideration. While not exhaustive, it serves as a relatively comprehensible approach on deciding who gets the organ transplant.
Can you think of any strategies to improve A&E departments?	A & E departments are often full or are faced with a large influx of patients of all natures, and it is an issue faced by the NHS for a while now. I believe that to adequately address the issues faced, we should target the root causes to see an adequate address of the problems faced. One strategy would be to encourage more healthcare staff such as doctors to pursue emergency medicine as to adequately increase the number of professionals to deal with the patients. While it should be noted that such a speciality or setting is not for everyone, if more people are able to be encouraged to join such departments via monetary compensations / non-material benefits, this would increase the supply of staff present, and could lead to an improved staff:patient ratio, hence allowing for more

	patients to be attended to and improve the number of crowds in A & E departments. Another strategy would be to push for nationwide education regarding A & E and when you should head to the A & E for help. I believe that most individuals are somewhat aware of when to do so, but there is a small minority that do not, and when they all flood A & E departments, it leads to the overcrowding that we are too familiar with. I recognize that there are occasions when people feel a certain sensation, panic and then proceed to head to the A & E in fear of what can occur. However, such situations are not the bulk of why A & E departments are flooded, but are in fact those who experience a small inconvenience (small cuts, coughs, hiccups etc), and want to receive immediate treatment instead of waiting for a GP. As such, with proper education on when to head to the A & E could lead to a long-term improvement in the numbers at A & E departments. Lastly, a strategy would be to delegate more locum GPs in such departments, or a reallocation of manpower during busy periods. According to research done, the busiest times are often Friday - Monday, and as such to deal with the increased influx of patients present at A & E. Alternatively, hospitals can restructure and reallocate the number of staff to work on the busier days, while encouraging them to take off days during the less hectic days. While this should be done in moderation to ensure that there are still sufficient

	professionals everyday, through such tactics, it would serve as a temporary way to address the overcrowding of A & E departments until another more effective / long-lasting decision can be used. In conclusion, these are some possible approaches to consider when addressing the A & E issues faced. As with all problems, every possible factor should be considered and explored before making a decision.
Do you think doctors should be involved in rationing patient care?	
What medical advances have you come across recently? Tell me about an article that you have read recently	This is more personal, so please do your relevant research into this :)
	This is more personal, so please do your relevant research into this :)
What changes do you envisage in the NHS in the coming years?	Similar to the question “How do you see the future of the NHS above”, just tweak your answers a little. Talking points: ● Since the question is asking about “changes”, your answer should be contrasting now and the future, to clearly signpost the changes ● Coming years is a bit vague in terms of timeline, so it could range anywhere from 5 to maybe 20 years down the line. It would be good for you to highlight

	the time duration you are focusing on in your answer • Remember that things can change drastically so anything you feel that could happen is technically feasible, try not to rule out any points you want to address just because it seems “unlikely” • Structure answers in a clear and easy to follow manner, try not to jump points and make the examiner confused • PEEL structure is recommended for this answer (Point, Example, Elaboration and Link)
What could be done to improve healthcare delivery?	Healthcare delivery refers to the services offered by healthcare professionals to the general public. In this question, I will focus mainly on the NHS and its delivery in hospitals and GP clinics. One way to improve the delivery would be to attempt to extensively publicise the waiting times / queues at hospitals or clinics, as to provide enough information for those who are thinking of visiting. It is a common sight to see long queues or

	extensive lists of appointments as the public is unaware of how many individuals are also waiting to seek healthcare. By trying to push out more information to the public, it allows for more of the public to be informed and make more detailed decisions on whether they would want to seek healthcare at that current time. This would also help prevent public dissatisfaction as they would be aware of the wait required, and if they choose to join the queues, would mean they accept the wait necessary. Another way would be to improve / create a feedback channel for the public to provide constructive criticism on how they would like the system to improve, and act upon it accordingly. As an international student, I am unaware of the exact specifics which the system operates upon, but I have heard of the British public airing their grievances on platforms such as Twitter. Not only does this create potentially misleading information for those who do not know the specifics, it does not provide enough information for the system to actually work and improve upon itself, leading to a continual loop / cycle where there are no improvements made. As such, with the presence of such a channel, it allows for the necessary individuals to take the needed action to improve upon the shortcomings of the system, leading to improved healthcare delivery. Lastly, one way is to encourage the training of more healthcare workers such as doctors and nurses. As the simple law of supply and

	demand teaches us, if there is an increased demand for something, increasing the supply would help to address that demand. While it should be noted that caution should be taken to prevent an excess of workers, increasing the number of staff present would help to reduce the workload for current staff, making it more manageable and preventing the taxation of the healthcare staff. In doing so, this allows for increased retention of the workforce (given that many workers resigned due to unfair / challenging work hours, that they were pushed beyond their limits), and would lead to better patient-centered healthcare delivery, improving upon the current state. In conclusion, these are some ways to be considered for improvements. While they have their cons just like any method, I believe the pros outweigh the cons in this situation.
You are a junior doctor in charge of looking after an elderly lady. She is showing signs of confusion and is refusing a life-saving operation. How would you proceed?	This question is testing the concept of autonomy. Do read up on the segment “The Four Pillars of Medical Ethics - Autonomy” and the extension of the ethical pillar as well. Talking points: ● Recognize that the operation at hand is a **LIFE-SAVING OPERATION** a nd that you need to act quickly ● Attempt to look for any ADRTs that have been signed prior (ADRTs are Advanced Decisions to

	Refuse Treatments) and contact any LPAs or anyone that has been determined to make decisions on her behalf if she has any • Determine if the patient has capacity while ADRTs are being checked upon, since she is showing signs of confusion, it can be determined that she **POSSIBLY** does not have capacity to determine the best course of action in her interests • When a decision about life-sustaining treatment is needed and the person has neither an ADRT nor an LPA, it must be made by the clinical team on the person's behalf, based on his or her best interests. Where a person has nobody to represent them or no one who it is appropriate to consult, an IMCA must be instructed.

	• If all else fails, in terms of contacting LPAs or determining capacity, as a JD in charge of the healthcare team, you will make the decision on behalf of the lady, and since you abide by the “Non-maleficence” and “Beneficence” ethical pillars, the life-saving operation would most likely to be undertaken to save the elderly lady’s life. • Don’t be afraid to admit that this is a complex issue and if you have the time to, contacting consultants for advice or the Court of Protection for advice regarding such issues.
Four people are awaiting a liver transplant, however only one liver is currently available. How would you decide who to allocate the liver to?	Similar question to the one above. Talking points would be the same. Patients are prioritised for a donated heart based on: • Urgency status (Super-Urgent, Urgent or Routine) • Their blood group

	• The weight and height of the donor compared to the recipient • The presence of antibodies in the recipient blood that may react to the donor heart • The geography: some priority is given to minimising the distance between donor and recipient as a longer travel time can have an adverse effect on heart function • How long patients have waited for heart is taken into account, once the above factors have been considered In conclusion, these are the factors for consideration. While not exhaustive, it serves as a relatively comprehensible approach on deciding who gets the organ transplant.
Examine these two pictures. One shows a gardener, and the other shows a surgeon. Compare their roles.	Talking points: • The word “compare” is used, so you should be making clear distinctions in your answers when you are comparing the two

	• Talk about the physical attributes that you can obviously notice, the emotional aspects (such as what do they go through in certain scenarios, if they would feel certain emotions in some settings), the job scope and skills necessary • Anything goes, be creative and not be afraid to explore your views on the matter • Avoid biased answers such as “Surgeons are more important than gardeners” or “Surgeons have it harder than gardeners”, while there are room for exploration of such views, it gives off a very definitive approach to the question and it makes you sound haughty and dismissive • Give equal respect to both professions, that they serve different purposes but

	still contribute to society in some way, shape or form. • The question mentions “roles” and if you want to, you can also mention their responsibilities, who do they report to and who is involved in their day-to-day etc • The 5W1H is a good approach for this question
Examine these two pictures. One shows two pilots holding a checklist, and the other shows surgeons in an operating theatre. Compare their roles.	Similar approach and question to the one above. Just note that there are actions that they are taking, so you should explicitly mention their actions as well.
Medical procedure vs cookery. What can you tell me about the similarities and differences between these two tasks - cooking a meal as a chef compared to a surgical medical procedure?	It is a more personal question as well so I will just list out the similarities and differences in the answer. Similarities: • They are both physical activities and are carried out in a certain setting (cooking is usually in a kitchen, procedure is in a surgery theatre), however if the situation demands it, they can also be done in outside settings (such as cooking in an outdoor

	setting, operating at the roadside etc) ● They are usually done to achieve a certain purpose (cooking is to produce food for consumption mainly, procedure is done to fix, remove or add something) ● It requires the use of external equipment such as tools (surgery needs surgical tools, cooking needs pots and pans) ● The equipment should be sterile and clean to prevent contamination and/or infections ● The tools are often specialized for a certain action (whisk is used to whisk things, a retractor is used to retract and maintain a FOV) ● In certain circumstances, the tools can be used to carry out certain actions that they are not specialized to do (knife can be used to mash things, a

	scalpel can be used to hold something in place with the flat side of the blade) Differences: ● The amount of training required for the profession is completely different (chefs can take years to train as well, but definitely less than some specialities such as neurosurgery) ● The number of such professionals also differ (chefs are everywhere, surgeons are less than chefs and are only found in healthcare related settings) ● Work-life balance is vastly different (where surgeons have longer schedules than chefs, and sometimes do not get breaks between shifts) ● Scope of duties are distinctly different (surgeons may need to do paperwork, ward rounds after operations, consultations -

	compared to chefs who need to cook, source for ingredients, clean their utensils, potentially run the business) ● The amount of regard given to each profession is also different / admired for different reasons (chefs are admired based on culinary skill, ability to produce good food under certain time restrictions - surgeons are admired based on their operating skills, able to treat certain issues to help save people's lives) ● Location they work in have different environments (surgeons can be under extreme pressure to save someone's life, chefs rarely if ever are in such settings) ● The amount of people they work with is also different (operating teams can range from 2-10 people,

	chefs can command up to 50 individuals in certain environments) Listing out such reasons still need some elaboration afterwards, so make sure to justify why you see it this way (link to work experiences or what you have noticed on a day to day basis) + try not to jump back and forth between similarities and differences, focus on one segment first, before focusing on the other factor.
You are at the site of a car crash, as a medical student who would you help first: the pregnant unconscious woman; the elderly man with bleeding from his abdomen; the lost toddler who is screaming for his father; or the young woman who is crying out in pain	I would first take into account all possible factors: ● Am I the lone individual able to help? Is there anyone around that can help? If so, would they be willing to help escort others to safety / call emergency services? ● Is there any immediate danger? Am I at risk by helping them / putting myself at risk? ● How far apart are everyone from one another? Can I feasibly help everyone in a certain time limit? Or can I only help certain people? After all factors have been considered, I will approach this with the AVPU approach in mind. AVPU stands for Awake, Verbal, Pain and

	Unconscious. You should be focusing on the Pain and Unconscious individuals as they are more important / have potentially bigger issues to deal with. **MUST RECOGNIZE** that you are **ONLY A MEDICAL STUDENT**, you are really limited in what you can do for them, and you are **NOT COMPLETELY TRAINED**. As such you should probably be focused on getting the relevant authorities alerted + removing those individuals from the car crash whenever possible. Doing first aid (especially if untrained) is a **NO GO**, because you can cause the situation to get worse. Stop any bleeding if there is by just compressing the wound. So the order I will approach in, from first to last: ● Pregnant unconscious woman ● Elderly man with bleeding ● Young woman in pain ● Toddler screaming for his father Pregnant unconscious woman: ● She is unconscious and for all we know, she could have stopped breathing (and without oxygen, it can lead to extensive brain damage and even death). ● Additionally, she is pregnant and essentially

	she is a host for the fetus in her body, if she dies the fetus would also be unable to sustain and could lead to fetal death as well, losing 2 lives in the process ● While she may not have any visible bleeding, she could be experiencing internal bleeding as well, and you will not be able to immediately tell Elderly man with bleeding: ● Bleeding if not stopped can be excessive in nature, and can cause them to fall unconscious in a short amount of time if not addressed ● Being elderly also makes his mobility potentially worse, he might find it harder to evacuate himself afterwards Young woman in pain: ● Could be experiencing internal bleeding, but at least she is being vocal about it and I know that she

	is able to voice out any potential danger ● Being in pain is also important but bleeding poses a bigger danger to dying than the pain ● Being young can also possibly suggest that she is able to move slightly easier compared to the elderly man, so if any immediate threat is posed to her, she might be able to move away in time Toddler screaming for his father: ● While a toddler is less able to move away from immediate danger compared to the rest of the adults, he is at least alert / verbal about his situation which demonstrates that he is not unconscious or in pain ● While a toddler is also much younger compared to the adults, and we should theoretically care for the young as adults can

	handle themselves, the other individuals in this situation require more help compared to the toddler hence would be last on the priority list • Additional point is that if you help to stabilise the other individuals such as the young woman, you could then get her to help you with the toddler to care for the toddler or call emergency services if you haven't already done so • Moving him/her away from the danger first is also not necessarily a good thing as you will not be able to supervise the toddler while you are helping the rest, and the toddler could affect you helping the rest of the people that need it
You are a medical student and have been asked to talk to a patient about their alcohol dependence.	Talking points: • ICE Approach is recommended here (Ideas, Concerns and Expectations)

	• Proactively listen to the prompts given by the actor / talking points that they want you to address + note how they want the conversation to be steered • Take a few pauses here and there to reassure the patient that you are listening actively, and also check if the actor is doing okay (if they need any pauses to gather themselves) Try not to push the actor too far into uncomfortable settings • Alcohol dependence has its causes and these causes are tough to talk about, actively trying to talk with respect and empathy helps a lot with the approach of such topics • Be patient if the actor needs time to talk about certain factors • If things get too complicated, out of your scope (since you are only a medical

	student), refer the patient to your superiors (such as consultants or supervisors) or relevant services ● Take notes if you need to of the issues they are facing and suggest (**NOT FORCE**) them to the patient if they want to take up on these suggestions
What steps have you taken to assess if a career in medicine is something for you?	Talking points: ● Work experience. Talk about your experience, using the STARR technique or PEEL structure. Focus on reflecting and elaborating the changes you experienced, any misconceptions that you clear up, and any advice you are aware of ● Medical readings or any experiences such as Open Days at universities. Remember that Medicine is more than just a job, it is a lifelong career + you still have to get through

	medical school. Medical school is a big part of medicine and by talking to students, you get to know more about medicine as well ● How you exposed yourself to the profession through reading of autobiographies by doctors etc. Reading about past experiences goes a long way in helping you understand the profession ● Watching documentaries / videos / listen to experiences General tips: ● As long as you've demonstrated you didn't just go like "aha now let's apply to medicine bc I have good grades & I have no clue what I'm doing" then you would be fine. More importantly it would be to connect how your experiences led you into medicine. It's not as much how much/what you did than how

	you reflect & communicate it in your answer! ~Love bear • Focus on reflecting and demonstrating changes in mentality! Show your growth and progress as a person and the understanding in the profession • Understand that the example / work experience is not the point of this question, reflecting and explaining what you learnt is the most important thing!

Additional Bristol Interview Preparation

Since my interviews are coming up, these are some last minute questions I feel are relevant to Bristol and am using them in my preparation!
From their website, "As a medical student, you will attend teaching sessions on **professionalism** and will be sign-posted to appropriate guidance. In preparation for your interview, we would like you to read very carefully Achieving Good Medical Practice: guidance for medical students published by the General Medical Council.
This guidance reflects **our important values as a medical school**. It will give you a better understanding of what you commit to in becoming a medical student and help answer some of the questions and scenarios posed in the interview."
I believe it is really important to know these inside and out:

- GMP
- NHS Values
- Attributes mentioned by the school
- Specific factors I highlighted in Bristol's section

University of Dundee

Interviews this year will be in person and involve staff and students from our School of Medicine. Overseas students will be given the option of a remote interview in case travel restrictions prevent them from attending in person.

We hold our interviews between December and January. It is wise not to plan holidays over this period so that you don't miss out on an interview date.
After the interview, some early decisions will be communicated but most applicants will be notified after all interviews have been completed.
Final decisions will be made by the UCAS decision date. This decision will be communicated via UCAS and will be emailed to both your personal and @dundee.ac.uk email accounts.

Interview format

Face-to-face interviews will involve moving from one station to another and meeting a different interviewer at each station. Remote interviews will take the form of **a panel interview**, with the same panel interviewing for all stations.
In both formats, you will discuss five scenarios during your interview. It will be 5 stations with 6 minutes each.
There will be a short break in between each scenario where you will have time to read the briefing material for the next station before answering the questions.
Even though the scenarios are often framed in a clinical or medical context, no prior medical knowledge is required to address them. We want to find out about your ability to think critically and flexibly, "on your feet" as it were.
We are looking to assess your communication skills, your ability to work in a team, and your personal values. These are all hugely important in shaping the kind of doctor you will be and we place a lot of weight on them.
We seek caring and hardworking individuals. We will also be interested in your work experience, but we recognise that your ability to gain this may have been affected by the pandemic.

Medical School Readings for Dundee

https://www.dundee.ac.uk/medicine/stories?f%5B0%5D=story_date%3A2022
IMPORTANT NOTE!
Dundee is a diverse region situated in Scotland, with a number of local factors and diseases that is different from the rest of the UK. Ensure that you research both communicable and non-communicable diseases in the area. How might this impact healthcare provision in the area? Make sure you know about the Scottish NHS. Although not stated explicitly on their website, questions revolving around NHS Scotland may pop up in your Dundee medicine interview. Make sure you understand how it differs from NHS England and the NHS overall, what it means that the NHS is devolved, as well as the pros and cons of the devolved system.

List of Recent Dundee Medicine Interview topics

Theme	Dundee Example Questions
Academic Skills	Knowledge of reliability measures in research Knowledge of hypothesis' and carrying out scientific research Factors that impact clinical research
Work Experience	General work experience questions Questions based on personal statement Transferable skills as noted in personal statement

Communication & Role-Play	Communicating with those with learning difficulties Managing conflict Prioritization
Motivation for Medicine	Motivation to pursue a career in Medicine Realities and challenges of a career in modern Medicine
GP-Patient Interaction Station	Summarise video Assess interactions

Medical School Curriculum

Throughout your studies, you will mainly be based at Ninewells Hospital, Dundee, but there are other opportunities for placements in hospitals and general practice in other areas of Scotland.
With around 160 students in each academic year, the size and structure of our medical school helps you get to know your peers and the academics and clinicians teaching you. You'll **feel part of our community** from the start - especially as you'll be interacting with real patients from early in the course.
The curriculum starts with a foundation block which explores the fundamental science that underpins the field of medicine – this will help you start to think like a doctor and begin clinical problem-solving.
Our **spiral curriculum** helps you build on knowledge in relevant areas year-on-year – you won't be expected to learn everything in one block and then remember it forever. We'll revisit topics to help your knowledge become second nature.
For the first three years, you'll learn about body systems, examining normal and abnormal functions before exploring clinical cases. You'll also learn **anatomy by dissection**. We use **Thiel-embalmed cadavers which retain life-like tissue quality**. This experience is as close to examining the anatomy of a living person as possible, and will give you an experience and understanding that no other medical school in the UK can offer.
After the first three years you'll have the option to intercalate and gain a BMSc in a range of subjects, but whether you decide to do this or not, in Levels 4 and 5, you move into clinical training. This is a series of placements that will give you a well-rounded experience in a number of clinical areas, and enable you to put your training into practice at the point of care for real patients in real healthcare settings.

Levels 1-3

Principles/Foundation block

Level 1 will start with an introductory block where you'll cover the scientific principles that underpin the function of the human body.
You'll learn the basic principles of the normal structure and function of body systems, and be introduced to broad categories of disease (for example, infection and cancer).

Systems-based teaching

You'll then move on to **systems-based teaching**, which looks at the body's organ systems. Weeks within these blocks are themed according to the specific but common things patients may present with.

Classroom-based teaching is complemented by the development of your vocational skills through clinical skills practice, and hands-on experience on wards and in general practice. This is something you'll gain from the start of Level 1.
In Dundee we use a spiral curriculum. This essentially means that from day one, we lay the building blocks needed for all aspects of a medical career and keep revisiting and adding to these as you progress through the course.

Clinical skills

Throughout your studies you'll build on your clinical skills in our **Clinical Skills Centre** (CSC) – a purpose built simulation-based education facility that is made up of fully-equipped replica wards. This means that by the time you graduate, you'll be able to complete important tasks, like taking a case history or a blood sample with confidence, accuracy, and efficiency.
Within the CSC, procedure rooms are used to deliver training on a variety of areas of medical practice. These range from **simple, but important, skills** such as appropriate hand hygiene to more complicated skills and procedures used in medical specialties such as ophthalmology.
This includes infection control, assessing and documenting vital signs, communicating with patients and other healthcare professionals.
The Centre also has a **multipurpose simulation suite which allows you to participate in simulated exercises**, including dealing with trauma victims, cardiac arrest scenarios, and managing a deteriorating patient. We use a mix of mannequins, actors, and real patients throughout our simulation training.

Student selected components (SSCs)

You'll take at least one SSC during each year of your studies.
SSCs are **self-directed opportunities** for you to undertake relevant work experience, and are designed to give you the opportunity to **explore areas of interest in more depth, and build your wider skillset**. Examples of recent SSCs include

- in-depth study of clinical specialities (pathology, microbiology, biochemistry...)
- creating learning aids including podcasts, wikis, and apps
- arts-based modules covering medicine in literature or the history of medicine

Levels 4-5

Clinical teaching

Levels 4-5, focuses on developing your practical skills in preparation for your role as a junior doctor.
You'll start with a **transition block that will help you learn how to get the most out of your ward-based learning**. Throughout these years, you'll rotate around a variety of hospitals and primary care centres in a series of clinical attachments where you'll explore a wide range of clinical problems, looking at the patient as a whole rather than focusing on specific disease entities. This strategy will ensure patients' concerns and problems are central to your practice.

Clinical attachments

There are a variety of clinical attachments throughout Levels 4 and 5. These cover:

- medicine - general medicine and medical specialities (neurology, oncology, and infectious diseases)

- surgery - general surgery and surgical specialities (ENT, ophthalmology, and urology)
- integrated specialities - old-age medicine, dermatology, orthopaedics, rheumatology, emergency medicine, and anaesthetics
- obstetrics, gynaecology, and child health
- general practice and psychiatry

Electives

During Level 5, you will have the opportunity to undertake an **eight-week elective, which can be overseas** - this is a period of clinical practice that you'll organise and will allow you to focus on your own objectives.

Preparing for practice

During Level 5, you'll complete a series of placements to prepare you for practice as a foundation doctor. These will take the format of Student Selected Components and Pre-registration (Foundation) Apprenticeship blocks. Our apprenticeship model allows our graduates to be fully prepared for work after graduation.

Attractions of School / City

Dundee, The City

A safe city
Dundee is also one of the safest cities in the UK, ranked 2nd safest city in Scotland the Complete University Guide 2022.
An international community
Like the University, Dundee is international and multicultural. It is home to residents from many countries and ethnic groups. Within easy reach of the campus, you will find specialist food shops such as Chinese, Indian, Polish and Russian supermarkets, as well as halal butchers. The major UK supermarkets also stock a wide range of international food.
There are places of worship for many faiths, including Islam, Sikhism, Hinduism, Judaism, plus many Christian denominations.
Local schools are well equipped to support children for whom English is a second language.
Location
Dundee is at the heart of Scotland’s road and rail network and puts spectacular scenery, skiing, championship golf, mountain climbing, and sailing within easy reach.

The major cities of Edinburgh and Glasgow are a short trip away. Scotland’s four main international airports all operate both national airlines such as British Airways, and low cost airlines. This makes it easy to get to all the major centres of the UK and Europe.
Attractions listed by students:
Dundee Contemporary Arts. This wee gallery on Perth Road has frequent new exhibitions (often free!) along with workshops and a cinema! It’s a funky and welcoming venue with plenty to offer whether you want to go on your own or with others. They also often do discounted film screenings for those living in Dundee Halls, which is always handy to know.
Mary Ann Lane and other street art hubs. Mary Ann Ln is an open wall just after the Seagate bus station where anyone is free to go and create art. Even if you’re not an arty-type yourself, a walk down there is mesmerising and you can often find other artists at work. Other street art can be found dotted around Dundee but there is a nice collection on the wall behind Seabraes near the railway tracks.
The V&A. A classic to anyone visiting Dundee, but its always pleasant to head out onto the balcony or have a wander round.

The Riverfront. Whenever I need to clear my head, I go for a walk along here. Just after the Tay Road Bridge there is a small platform which is very peaceful to go up and look over the river.
Slessor Gardens. When the sun is shining in 'Sundee' this is a wonderful place to relax.
Blend Café. This café really encapsulates the community spirit of Dundee. They host many events like yoga mornings, open mics, poetry readings, art exhibitions and so much more! Check out their insta for more info!
Olympia. A swimming pool just after the Wellgate Centre with 4 slides, diving boards, a wave pool and a lazy river! So much fun for those who like physical activity!
Escape Rooms Dundee. This place was honestly so much fun – I'd never been to an escape room before but I will definitely be going back here to try another of their 4 rooms.
The Law. A beautiful place to go, especially around sunset, even if the walk is a killer!
Avertical Centre. This is a climbing centre just beside the hub. You won't be able to use the high walls if you don't know someone who is an instructor, however, the bouldering walls are free to use for everyone and it is honestly a fantastic afternoon that will leave you aching!
Broughty Ferry Beach. For only a £6 train ride, this makes a lovely day out for you and your friends.
City Quay. There's a lot happening around the quay: lots of restaurants and coffee shops; the Frigate Unicorn; and during summer, Foxlake aquapark opens up! Foxlake was possibly the highlight of my activities I did in Dundee last year, so grab some friends and head on down this summer!
St Andrews. Technically not a place in Dundee, I know. But hop on one of the 99 buses and take the half an hour ride across the Tay to St Andrews to visit the beach, ruins and, of course, grab a world-famous ice cream from Janetta's.
Charity Shops. Dundee's charity shopping scene is one of the best I've seen. In the city centre alone there are a plethora of shops, and with so many students in Dundee, it's so easy to find something to suit you for a fraction of the price you'd normally pay! (Also, it's brilliant for saving the planet and combatting fast fashion).
Gate Church Clothes Swap. Once a month, this church puts on a clothes swap once a month where you can find some gems for completely free! This helps save some pennies for some poor students.
The Braes. 25p Wings every Wednesday, 25p pancakes every Thursday. Need I say more?
Botanical Gardens. Free entry for Dundee Uni students – just remember your student card.
Top of the Tower cafe. This cafe has one of the best views of Dundee and it is right on campus! Lectures are held in the tower building, so if you find yourself there, be sure to head up for a coffee or snack. Plus, their hot drinks are half price before 10am, so its a cheap way to get that caffeine in before lectures!
Create Station in the Library. If you've not seen this advertised all over the library then where have you been? But I can't recommend checking it out enough. There's Lego, badge makers, an embroidery machine and so much more! It's great for a quick study break after those long hours in the library.
DUSA (Dundee University Student's Association). We make it our duty to know what our students want and need from us, and seek to exceed their expectations. We do this by providing bespoke products and services, excellent recreational facilities and employment opportunities, which produce lasting memories of a first class student experience. Societies include MedAID (student-run charity and society that collects unused, out-of-date equipment from local hospitals around Dundee), Sunday Football League and many more.

The Medical School

New Refurbishment

The medical school has recently undergone a complete refurbishment, with two new lecture theatres opened in the last four years. The medical school facilities include a hospital campus library, two lecture theatres, multiple teaching rooms, a student shop and cafe. Also,

you have all the facilities of the hospital itself to use! Plus, you will also have full access to the actually university campus facilities

Medblogs

Dundee uses an excellent online platform, which again has been newly updated, to store all lectures once taught, provide formative assessment and all material required for each respective system block. This is a brilliant resource that you can use to refer back at exam time, or even in later years!

Opportunities

The medical school has a number of programs which allow students to explore research, health care improvement and medical education which are often accompanied by scholarships. This is absolutely brilliant as it allows students to gain publications and attend conferences.

DUMS (Dundee University Medical Society)

The website to it is: https://www.dundeeuniversitymedicalsociety.co.uk/societies

Dundee University Surgical Society (DUSS) - Dundee University Surgical Society (DUSS) is one of the largest and longest running societies present within Dundee medical school. As your undergraduate teaching in Dundee consist of limited surgical content, joining DUSS could provide you with learning opportunities that not only complement teaching at medical school, but also experiences that you would otherwise never get.

Membership will allow you to attend a whole series of our events free of charge or at discounted prices. These include suturing workshops, case-based teaching, career talks and practical surgical workshops. If you have the slightest inclination to surgery as a career choice, or simply want to bolster your repertoire of skills such as suturing or other procedural skills, DUSS is the society for you!

Dundee University Widening Access to Medical School Society (DWAMSS) - The Dundee Widening Access to Medical School Society (DWAMSS) was founded by students in 2018 to support WA here in Dundee, and across Scotland. Our aim: to support primary and secondary school pupils raise their aspirations, to voice that they can achieve, and that we are here to aid them. We have designed workshops and talks to be run in classes, assemblies and career events, in addition to building a relationship with our local schools. Our workshops comprise hands-on experiences with medical equipment in medical scenarios, ensuring all material relates back to their biology, chemistry and physics classes. DWAMSS events are run by our bank of volunteer medical students, all of whom are given training on our workshops, coaching on how to work with secondary school pupils and ultimately experiences to learn vital teaching skills they can use all through medical school.

Teddy Bear Hospital - We are a fun and free student-led society that runs events to teach (the cutest) primary school children all about their own health and what happens in hospital. Anyone who enjoys working with children is welcome to join!

We run our hour-long sessions most Wednesday afternoons (1330-1430) in the medical school at Ninewells, with some in the evening for Rainbows or Beavers groups in the Dundee area. The kids and their teddies will rotate through 6 stations (led by you!) where they will learn about a range of healthcare related topics in a fun and friendly way. Our big aim is to help reduce the anxiety that many young children have about visiting the doctors. We give you all the information you need the week before, provide you with the props and will be there to coordinate these sessions so that you and the children will have the best time! It's also a great opportunity for you to practice your comms skills and you will receive a portfolio certificate for volunteering.

Thiel Cadavers in Dissection: Dundee uses cadavers that have been embalmed using the Thiel method which preserves maximum authenticity of the tissues in terms of structure, color etc. This makes for richer and more accurate anatomical learning.

Spiral systems-based curriculum: Dundee has a strong focus on revisiting key concepts to ensure thorough understanding and active learning. This is a particularly strong point to mention if applicants can tie it back to their individual learning needs and styles.

State-of-the-art Clinical Skills Centre (CSC): Dundee boasts a purpose built simulation facility to expose students to real-life ward, consultation and emergency scenarios. This breeds confidence and again, is particularly useful to mention in the context of individual learning needs.

Medic Insight

Medic Insight Dundee is a student-led society at the University of Dundee that provides school pupils from Tayside, Perth & Kinross, Angus and Fife with an insight into a career in medicine and other healthcare specialties.

We liaise with clinicians within NHS Tayside to organise a range of experiences for our pupils.

Read more: https://www.facebook.com/MedicInsightDundee

We bring together a unique blend of cellular medicine, clinical insight, data science and whole pathway innovation to create the perfect platform to research, innovate and test solutions designed to improve the lives of our global citizens.

Our clinical researchers are data-focused, and they understand the importance and value of routinely collected healthcare data and the power it has to change the way we diagnose and treat patients across a range of debilitating conditions such as cancer, diabetes and cardiovascular disease.

It is this collaborative ecosystem across our research disciplines – as well as our special relationship with NHS Tayside – that attracts stakeholders to work with us, and has enabled us to deliver both commercial and clinical impact year on year.

Data-driven healthcare

We are focused on data-driven solutions for advancing the detection of disease and designing stratified treatment solutions that improve patient outcomes. Dundee and NHS Tayside have invested significantly in the development of the Health Informatics Centre, now housing over 50 data scientists working with complex healthcare data, across imaging, prescribing and biometric data.

The SHARE programme, a national database of biometric data was created in Dundee and combines routinely-collected healthcare data with consented blood samples from around 300,000 patients across Scotland. This genomic resource, linked to comprehensive and highly detailed longitudinal electronic medical records, generates new and pivotal insight into the pathogenesis of diseases and new drug targets.

Our data capabilities and secure infrastructure combined with clinical excellence attracts both global industry and smaller innovative enterprises to partner with us across a range of research themes including biomarker discovery and AI advancements in healthcare.

Healthcare by design

We offer our partners a thriving innovation landscape where designers, creative thinkers, engineers, clinicians, and business minds work together to develop the next generation of medical technologies.

Our clinical expertise in minimally invasive surgery and image-guided therapy provides industry direct access to expert knowledge to help advise, build, and test products within the patient pathway to demonstrate real benefit to the provider.

There has been significant growth in our collaborative medical device activity with industry over the last three years. This set to grow dramatically following the announcement of a £25m investment from the Scottish Government to grow the Tayside Biomedical Cluster with a focus on stimulating innovation and enterprise in the region.

Modelling disease

Our disease modelling research is led by our fundamental researchers in partnership with our clinical leads. Projects span the interface between biochemistry and whole-body physiology, providing a perfect platform to develop novel ways to fight disease with real clinical benefit. From modelling tumour progression using complex mathematics to monitoring the effect of medicines on disease, Dundee has become a major centre for translational medicine.
Our research is focused on the most challenging of chronic diseases that have significant impact on both our health and economy. This includes diabetes, heart disease and cancer, and spans multiple branches of medicine from pharmacology to epidemiology.
Our expertise leads into the design and management of both randomised controlled clinical trials and large multi-centre studies.
The Tayside Medical Science Centre (TASC) is one of Europe's leading drug trial sites, offering its many industry partners a trusted, high quality, and innovative clinical research environment that offers end-to-end support across the trial lifecycle. In the last five years alone, TASC has taken part in over 170 commercial research studies that generated £7million further investment into the research infrastructure at Dundee. Industry partners come to Tayside for reliable patient recruitment times, world-leading clinical expertise and over a decade of experience in delivering best-in-class research.

Research

We aim to act locally and have an impact globally by improving health through teaching and research.
The School of Medicine is based on the University of Dundee's Ninewells campus, co-located with Ninewells hospital (one of the largest teaching hospitals in the UK).
We are: **1st in the UK for Medicine and Medical Technology (2021 Complete University guide)**; most influential scientific research institution world-wide in pharmaceuticals (Clarivate Analytics 2006-2016) and 5th in the world for field-weighted citations (2019 CWTS Leiden Rankings). **Our researchers have featured in the Reuters/Clarivate Highly Cited Researchers List and was rated 1st in the UK for Impact in REF 2014**.
Translational research and teaching in the School of Medicine focuses on the application of discovery, knowledge transfer, research and innovation, improving our understanding and treatment of disease and the maintenance of health. Our shared vision is to develop a vibrant community where the interconnected activities of research and teaching are uniformly respected, discussed and valued, and where we train the next generation of clinical and non-clinical academics. We will promote interdisciplinary activity, encouraging cross-division and cross-school collaboration, and work in partnership with the NHS, our local and the global community.

Research divisions

Research within the School of Medicine is organised into five Divisions:

- Cellular Medicine
- Systems Medicine
- Molecular and Clinical Medicine
- Population Health and Genomics
- Imaging Science and Technology

Research is **organised thematically** across divisions and schools in order to enhance interdisciplinary partnerships and is strongly informed by our close working relationship with NHS Tayside through Tayside Medical Science Centre (TASC) which supports researchers in the delivery and governance of high quality clinical research and provides patients with access to innovative treatments, interventions and medicines.

The Centre for Medical Education carries out world-class research into faculty development; technology enhanced learning; Social, Health and Wellbeing and Research and Evaluation Methods.

Research themes

The principal research themes of the School of Medicine are:

- Precision Medicine
- Health and Bioinformatics
- Translational Neuroscience
- Cancer
- Infection and Antimicrobial Resistance
- Cellular stress and metabolism
- Medical Education

Research Impacts

Our discoveries have led to new ways of diagnosing and treating major diseases such as cancer, liver failure and cardiovascular disease and we continue to be in the forefront of drug safety research and the clinical management of respiratory disease and chronic pain.

Intelligent Liver Function Testing (iLFT)

iLFT provides highly cost-effective automated pathways for the investigation of abnormal liver function tests, improving quality of care and saving lives by earlier diagnosis and treatment of liver disease. Implementation of iLFT as standard NHS care has contributed to the effective elimination of hepatitis C in Tayside. iLFT is being rolled out in other regions across the UK.

The impact of sodium containing effervescent, soluble and dispersible drugs on cardiovascular events

Long-term consumption of sodium-containing effervescent, soluble and dispersible medications causes significant increases in cardiovascular events and hypertension in vulnerable patients. Our research has resulted in changes in labelling legislation that has reduced the prescribing of potentially harmful high sodium medications.

Use of population-based health informatics research to improve care for patients with cardiovascular metabolic diseases

The availability of population-based electronic health records creates affordable and efficient research opportunities benefitting from large sample size and generalisable patient populations. Our research has shown how this approach with enhanced linkage to vital records can support regulatory decision-making and guideline development, thus widening treatment options to improve health outcomes.

Faecal haemoglobin estimation in colorectal cancer screening and the triage of symptomatic populations

The impact of this research has been to introduce and modify the UK's national bowel cancer screening programmes that prevent approximately 2000 deaths from the disease each year and are now leading to a reduction in disease incidence. In addition, using the same technology in symptomatic patients is leading to a more targeted approach to investigation.

Opioid prescribing in Scotland: stemming the epidemic

Our research has identified rising rates of opioid prescribing and related harms in Scotland and informed national guidance for clinical management of pain. These rates have been falling steadily following publication of this guidance.

Management of bronchiectasis

Our research has transformed the global management of the lung disease bronchiectasis. Dundee has established a European Bronchiectasis Registry which has enrolled more than 20,000 patients with this previously neglected disease. Data from this project have

underpinned changes in diagnosis, severity assessment, treatment and the development of international clinical guidelines.

Past Years Interview Questions

DISCLAIMER: All interview questions here are from previously released years, and are sourced from websites that have released them. We do not **CONDONE** the sharing of interview questions (especially during the cycle itself) and do not **SUPPORT** any NDA violations in view of academic integrity. All of the following interview questions are speculated, and any form of trying to cheat (asking those who have sat their interviews for the questions for example) **WILL NOT BE TOLERATED.**
Some of the interview questions asked from previous years are listed below, together with a suggested response / talking points.
It seems like from what I have been reading, Dundee does test on your personal statement during interviews, so it will be good to know your PS in and out, as well as be ready to defend it whenever necessary.

Interview Questions	Suggested Responses / Talking Points
What is the system in place for organ donation in Scotland?	
Why is confidentiality important?	It is important to understand what confidentiality means and the context it is applied in. Confidentiality refers to a set of rules that limits access to information discussed between a person and their healthcare practitioners. With only a few exceptions, anything you discuss with your doctor must, by law, be kept private between the two of you and the organisation they work for. And it is important to know that information usually can only be disclosed with the patient's consent. A reason why confidentiality is so important is because without it, it would affect the entire basis of the profession and the doctor-patient relationship would be heavily affected as a result. Let us take a moment to think about how the doctor treats the patient. It is usually through the asking and answering of the questions, where the patient divulges the details for the doctors to diagnose. Now imagine that without confidentiality, patients may not feel comfortable expressing such opinions since it is not guaranteed that doctors will protect their information, as such may leave out certain details that are critical for doctors to make the necessary deductions. At best, it is a minor inconvenience and at worst, it heavily jeopardizes patient safety, which goes against the intentions of the NHS. As such, confidentiality matters so much in our

	profession especially, as without it, it could upturn our entire profession. Another reason would be that without confidentiality, it will severely hurt the trust in the profession and could really affect public perception, which has implications on its own. If doctors cannot be trusted to protect the most intimate details of their patients, the general public would view the profession with disdain and could think of doctors as unprofessional. This view could cause them to actively choose not to seek out healthcare when they need it, or not listen to the advice given out by the industry. This could be especially dangerous in global pandemics such as COVID-19 where the impacts could be disastrous if the public did not listen to the benefits of taking a vaccine. It would have ran rampant and could have caused even more deaths, which would have been disastrous as a whole. In conclusion, confidentiality is the foundation that the whole profession is built upon and without it, it would jeopardize how the profession functions. As such, it is really important to maintain confidentiality as much as feasibly possible.
A fellow medical student has been involved in a drunken altercation overnight and he turns up to a lecture hungover the next day. Decide the best course of action. Assume the position of the medical student's friend for this question.	I would first approach my friend in a casual manner and talk to him generally first, asking some questions to catch up on how he is doing first. I would also note that because he turns up "looking" hungover, does not necessarily mean that he is hungover, and that there are a multitude of reasons that could have caused him to look like such. However, I would take steps to probe a little further to confirm if he was indeed drinking the night before by asking, "So what did you do last night?" This gives him the chance to share openly with me the truth and does not place any pressure on him. While he is sharing his story, I would also look for any physical signs such as bad breath, slurred speech, increased fatigue. While not a dead giveaway, it is a good way for visual confirmation as to what I was suspecting. After confirming that he is indeed hungover, what I would do is to check the current schedule for the day, and if he has any mandatory lectures to attend. If he does not, I would advise him to head home to rest up

	and would escort him home if possible for his safety. I usually would not advise or condone skipping academic lessons, but in his current state, not only would he not learn anything useful, he runs the risk of being disruptive to the session, causing a bad impression for fellow medical students if he were to sleep in class. As his friend, I would take the necessary notes and provide them to him to catch up when he is more sober. After he is fully rested, I would respectfully and firmly remind him of what is expected from us medical students and the behavior that we should be exemplifying, and that he should have known better than to get involved in a drunken altercation the night before when he had lessons the next day. I would also remind him that any altercations could affect him in his studies especially if the issue was escalated, and he should be more responsible for himself, and to his fellow medical students as well.
Instruct a child on how to build a lego model	Talking points: ● You need to speak in an age-appropriate manner since it is facing a child ● Be patient and slowly explain your points, note that you might need to repeat your points again if they misunderstand or do not hear you ● Use simple language, and use colours ● Check with the child first if they recognize colours because it will make your instructions easier to understand ● Ask the child to sort all the legos into colours before beginning ● Ask if they have an instruction manual to follow ● Remember some of the basic configurations such as 4x2, 3,2 or 4x1 so it is easier for you to pick the lego pieces for them to use
Name 3 Reasons why you picked Dundee	I picked Dundee for a few reasons which I would break down in my answer below,

	which consists of academic and non-academic reasons. The first reason would be the curriculum offered, in particular the state-of-the-art Clinical Skills Center and the opportunity to use Thiel-embalmed cadavers while learning anatomy. As far as I am aware, Dundee is one of, if not the only medical school that offers Thiel-embalmed cadavers that retain life-like tissue quality which would allow me to obtain the most realistic opportunity to examine the anatomy of a person in medical school. This would contribute greatly towards my learning as I would quite literally be given the chance to experience the anatomy with my own hands. Furthermore, with the CSC which allows medical students to practice simulated scenarios with realistic replications of wards, it would allow me to boost my confidence in my clinical abilities and best prepare for realistic scenarios in my future career as a JD. This would also align with my personal learning style of consistent practice to hone my clinical skills to be as fully prepared as I would like to be. The second reason would be the Dundee University Medical Society (DUMS) and the range of sub-societies offered. One particular sub-society that really caught my attention would be DWAMSS, known as Dundee University Widening Access to Medical School Society. Why this is so special to me is because of how much I relate to the experience, as I did not really have the best resources to support me during my medical school applications, and had to really put in a lot of effort to obtain the necessary support, and I would like to help all future aspiring medics to fulfill their dreams just like how I intend to fulfill mine. I plan to contribute to the society if given the chance and would actively seek out ways to support the community within Dundee. Lastly, the third reason would be the city of Dundee itself. Labelled as one of the safest cities in the UK, ranked 2nd safest city in Scotland the Complete University Guide 2022, Being an avid photographer myself, I have done some research into the city and realised that it has a lot to offer in terms of picturesque settings for photos such as Broughty Ferry Beach and City Quay. This would really be an ideal setting for me

	to pursue the course for the next 5 years or possibly continue working there after graduation as Dundee is a safe environment with a lot of heritage and culture surrounding it, allowing me to have the most unique experience living in the UK. In conclusion, these are my 3 reasons as to Why Dundee, where I hope to pursue my dream of becoming a doctor in a safe and vibrant city.
What do you know about the Dundee Medicine course? How is it taught?	I have done my relevant research into the curriculum offered at Dundee Medical School and there are a few things I would like to highlight. The first thing I would like to mention would be the spiral curriculum offered, where content previously taught is revised in the later years of the course to help us refresh what we learn in the earlier years. Why this is so special is because given the amount of knowledge we are expected to learn, it is especially important for us to constantly revise what we have covered to help build familiarity with the content and prevent us from forgetting the important knowledge accumulated. This would particularly benefit me as it falls in line with my work ethic of frequent revision and my personal study habit of studying consistently throughout to avoid last minute cramming. With this spiral curriculum it really allows me to develop a strong understanding of the content and serve as a firm foundation for my medical studies. The second thing would be that we learn anatomy by dissection with the help of Thiel-embalmed cadavers which retain the feel of lifelike tissue quality. This would allow us to best simulate the experience of a human being and allow us to practice with the closest feeling to what we would be experiencing in our future career. Furthermore, I believe Dundee Medical School is one of the few schools, if not the only school, that offers such an experience which I personally feel is invaluable and definitely something which will support me during my studies. Being a person that values hands-on learning compared to trying to visualize it in my head, it will definitely suit me when I am trying to visualize the content taught to me in a real-life setting.

	Lastly, the course also offers access to state-of-the-art facilities such as the Clinical Skills Center (known as the CSC). I also understand that as we would be honing our practical skills in this center, we would be running realistic simulations of the wards via simulated exercises, including dealing with trauma victims, cardiac arrest scenarios, and managing a deteriorating patient. We use a mix of mannequins, actors, and real patients throughout our simulation training. I feel this is especially useful to me as it would allow me to feel more confident and prepared when I head for my future placements in later years and even when I graduate to become a FY1. Through frequent exposure to realistic scenarios, it would also allow me to fully understand the scale and realities of the profession, which would serve as valuable learning experiences throughout my time as a medical student and eventually as a professional. In conclusion, these are just some of the main highlights of the course, which really resonate with me and my personal way of learning, which would allow me to become the best possible version of myself.
How will you contribute to Dundee medical school?	I would first like to consider this question in a few approaches where I would elaborate on how I would contribute in the academic, non-academic and even communal way. In regards to the academic contribution, one way I really feel like I would be able to contribute would be through the form of research, which the school places high emphasis on. For instance, the disease modelling research is led by the fundamental researchers, where research is focused on the most challenging of chronic diseases that have significant impact on both our health and economy. This includes diabetes, heart disease and cancer. As someone who has always been interested in the functions of the heart, I would like to further my interest through contributions to the research currently done at the university. While I may not have the complete understanding of how exactly I would contribute for research given my limited exposure to such projects, I would be more than keen to take on the opportunity when it is offered.

	As for the non-academic contributions, I felt I could contribute towards the Dundee University Medical Society (DUMS) in my spare time. A few things that caught my eye would be the Teddy Bear Hospital as well as the Dundee University Widening Access To Medical School Society (DWAMSS). I personally am a believer that everyone, regardless of their economical status, should be allowed to pursue their dreams and be given the necessary support to do so. DWAMSS allows me to do so via the provision of support via academic resources to those who need them and allow them to build up the necessary experiences which would contribute to their admissions when the time comes. As for the Teddy Bear Hospital, I personally align with their aim of reducing anxiety for these children when approaching medical professionals as I once was terrified of doing so, and I would love to contribute by conducting some sessions myself for these children. Lastly, I feel that I could contribute towards the community of Dundee by the provision of my business that I had recently started. As one of my passions is photography, I have started a business that is aimed towards affordable photo-shoots towards the university students and the rest of the community. This started because before I bought my own camera, I could not afford photography services given my tiny budget when I just wanted to head out for some shoots with my friends. As such, I feel that I can provide this service towards those in the community who need it (for instance coverage of an event, or if they were performing and needed performance pictures). I aim to keep prices affordable especially to those who are in university, and while I have yet to work out the exact price, I am excited to be able to provide this experience to those who need it. In conclusion, these are the main points I wanted to highlight for my contributions. While there are possibly more ways to contribute, I felt these would best describe the impact I can bring if I am given a place in the course.
What are the negatives of a career in medicine?	Because I feel like this question has a lot of factors to consider, I decided to do a talking points approach over a suggested answer.

	Talking points: • Earning a decent amount less than other professions, may affect ability to sustain yourself / lead a comfortable lifestyle when compared to others • Poor work-life balance depending on the speciality you choose, may not have enough time for those you love • Public Perception, public can feel that you are not as important compared to other fields, may affect ability to attain higher pay (i.e Doctor Strikes) • High stress and pressure depending on the speciality selected, or environment you end up working in (understaffing for example) • Long training times, can cause high amounts of loan debt to pay for medical school • Encroachment / chance of being made redundant with advancements in technology and healthcare, some jobs can be automated eventually • Constant need to upskill and study for the rest of your life, can be time consuming and take a lot of money as well • High competition for jobs • Insufficient public support for proper working hours, pay etc (see Doctor Strikes)
You are an FY2 Junior Doctor on a medical ward and you are required to leave the hospital in 30 minutes to collect your unwell child from school. Outline the order in which you would complete the following five tasks: • You have agreed to meet your registrar to discuss changes to the medical rota • A ward nurse calls you regarding a 57-year-old gentleman who is	Before I answer this question, I would like to preface by stating that doctors are still human, and should have a proper work-life balance just like everyone else, and while our work is important in the sense that we take care of people's well-being, we should also take care of our own well-being. In the order that I would do first to last: • The gentleman complaining of chest pain • The bleep from the pharmacist regarding the medication error

complaining of left-sided chest pain. ● The pharmacist has bleeped you regarding a possible medication error that you had signed for. ● A family member has requested to speak to you to discuss the progress of their relative ● Your phone alarm rings with a reminder to purchase flowers for your wife, as it is your wedding anniversary.	● Family member regarding the progress of the relative ● Medical registrar for changes to the rota ● Purchasing of flowers Why I would focus on the gentleman first is because patient safety should always come first and in this case, left-sided chest pain could indicate something to do with the heart for instance, and that is an essential part of the circulatory system. If left untreated, it could possibly transpire into something potentially life-threatening, and place the safety of the patient at direct risk. Next, I would address the possible medication error. While it could just be the pharmacist double checking, it is also possible that I made a mistake and it could definitely affect patient safety depending on the scenario. By addressing it, it would allow for the pharmacist to get on with their work and also resolve any worries I have regarding the patient and the safety of them. Moving on, I would address the concerns of the patient's family member. I am approaching this with the assumption that the patient has given me permission to update the family member (to protect confidentiality), I would then aim to address any of their concerns. Why I felt this is important is because the family member could experience increased stress and worry if their concerns were left unaddressed, and possibly could make assumptions about the relevant details, which could only worsen things. As such, resolving their concerns would be an important thing to consider when prioritizing the tasks. Next, I would meet up with the registrar for rota changes. Why I would do so is because i had already agreed to meet them, and it would be very rude for me to just cancel or not show up to the appointment. Why it is second last on the list is because it does not have an immediate implication on patient safety and the registrar being a fellow healthcare professional, would understand the need to prioritize patient safety first, which is why I had to meet them after all the patient concerns were addressed. Lastly, I would deal with the flower issue last. Now I recognize that I had previously mentioned that doctors should maintain a

	work-life balance, however I am unable to take any viable action to address the flowers when I am still within the hospital and would only be able to do so once I have left the hospital. This is with the assumption that I have to physically buy the flowers myself, and since I have to leave the hospital anyway to pick up my child, I can stop halfway to buy the flowers for my wife. If not, I could always order them for pickup / delivery when I am on the way to pick up my kids. In conclusion this would be the order I approach the tasks given to me. Patient safety is a big consideration when I am deciding the order of the tasks, and the importance of each is also important.
You are asked to give a patient 10 g of the drug WondaDrug. This comes as a 5% solution in bags containing 1 L. What volume of the 1 L bag do you need to give?	The approach is to consider what is the total volume first. It is 1L, which is 1000 ml. Next, the drug comes as a 5% solution, there are 5g in 100ml. So you will take 5 times 2 to get 10g which is what is needed, in 200ml. Answer is 200ml.
How might healthcare in Scotland be different to that in England?	
How do you deal with overpopulation?	Overpopulation loosely refers to having too many people for the amount of resources available such as land. In this question, I will assume that it is the UK that is experiencing overpopulation, and I have the authority or power to implement the methods I wish to do so. One way I would do so is to invest into land reclamation projects. Land reclamation is essentially the pouring of sand and other materials into the sea with foundations in place to expand the current land already existing in the country. This would be able to create artificial land where more buildings can be created to house the excess individuals to relieve the overpopulation stress on the UK. This has already been done by countries such as Singapore, and has been successful in relieving the pressure on overpopulation to a certain successful extent. With the creation of more land to house more people, this would allow us to tackle the overpopulation issue at hand. Another way I would do so is to encourage the building of high rise buildings such as

	condominiums over houses such as terrace housing. High rise buildings essentially go upwards and allow us to house more individuals in the same amount of space as terrace houses for instance. While I recognize that it may require more resources to build up such buildings, in the long run it would allow us to resolve the issue faced at hand which is overpopulation. However, these methods merely target the consequences of overpopulation and not the root causes. Hence, the next method I would like to suggest would be to have better education regarding family planning and sex education. There is a possibility that the overpopulation was caused by poor family planning or a lack of sex education, and by attempting to improve the education surrounding these topics, it would be able to tackle the root causes mentioned, curbing the issue at the base. While it probably will take a while for the effect of the method to be felt, it hopefully would be able to provide a bigger impact on the overpopulation issue. In conclusion, these are some of the possible methods to tackle this issue, and while they have their pros and cons, they would hopefully be able to improve on the overpopulation issue more significantly.
What are the main challenges that face the NHS?	Of course, the NHS is facing numerous challenges today. Three of the biggest include: • Ageing population: Key demographic shifts are causing problems for the NHS. Not only is the population growing, but it is also aging. No longer is a 50-year-old diagnosed with a single condition that ails them until they pass away 20 years later. Now, people are living into their 80s, 90s and 100s, accumulating numerous medical conditions and requiring a complex network of medications. These all interact with each other to make individual patient cases not only more complex but also less confined to a single speciality. Therefore, the importance of teamwork

	between specialities becomes far more important as each patient demands more time, resources and energy from physicians. • Privatisation: The NHS's key goal is to provide high-quality care that is free at the point of use. Privatisation of various components threatens this, as the possibility of a US-style insurance-based system looms large. Key things to consider here are wealthy lobbyists for privatisation of parts of the NHS, and deals that the government may make with the US government as part of trade negotiations to give large pharmaceutical companies more power in the UK. • Understaffing: Understaffing is both a contributing factor to the problem of the ageing population and an issue in its own right. Many healthcare workers move to countries with better working conditions such as Australia, and Brexit has significantly decreased the number of international workers coming to the UK to contribute to the NHS. This stretches resources thinner and makes it more difficult to give patients the care that they deserve.
How does NHS Scotland differ from NHS England?	
How does the healthcare system differ here compared to other areas in the UK?	
You were playing football in the back garden when you accidentally kicked the ball over the fence into the neighbour's garden. You hear a smash and, upon going to look, find that you have destroyed a garden gnome which you know holds particular sentimental value to them. Go	So this is essentially a breaking bad news question, just framed in a different context. You should take a look at what SPIKES stands for if you have forgotten (see segment MMI Roleplay Questions for more in depth explanation) **Setting:** I would first approach my neighbour when they are at home and are

next door and break the news. Begin the scenario by knocking on their door.	not busy, knocking on the door and politely asking them if they have any time to speak to me. I would also ask them if they would be able to take a seat before I break the news to them. **Perception:** I would first begin by saying that I am here to share something to them and disclose some news to them. I would also confirm that they are okay before I begin. **Invitation:** I would ask them if it is okay for me to disclose some bad news, and if it is not, I can let them know at a future time. **Knowledge:** I would first begin by disclosing the setting and situation, that I had been playing football in the back garden and had kicked it over the fence by accident. I would then take a quick break before continuing with just the facts. What I would say: I had kicked the ball over and accidentally hit your garden gnome with the football. **PAUSE** I am sorry but I had destroyed the gnome with the football **PAUSE** and wait for them to speak or be ready to speak **Empathy and emotions:** I would express how sorry I was for the accident and acknowledge that no amount of “sorry”can reverse the damage done in both the material and non-material sense. I would also expressly mention how much I regret my actions knowing that it meant a lot to them. **Strategy and Summary:** I would also express that I would be willing to make up for my actions in whatever way possible, and for them to let me know when they are ready if they need me to make up for it in a certain way. I would also give them the necessary space to be sad over the incident, promising them to be more careful in the future and will actively take precautions to prevent similar incidents such as playing out in the front instead.
What are the largest challenges GPs face in their work? How do these challenges differ from the hurdles faced by hospital doctors?	I can think of some challenges faced by GPs since the environment they work in is vastly different to hospitals. One challenge they face could be increased possibility of burn out. While doctors in hospitals work about the same hours as GPs depending on their schedule on the

	day, hospital doctors may not constantly see patients one after another, and may have small breaks in between when they move between wards or sections of the hospital. However, GPs have to see patients one after another throughout since their workplace is static on a day to day basis. Additionally hospital doctors have other doctors to help evenout the workload in general, while GPs usually have to treat each patient individually. The constant patient interaction can become exhausting after a while and as a result, cause increased burn out compared to hospital doctors. Another challenge they could face is a stagnated work environment that can cause fatigue or loss of interest in the profession. It is undeniable that hospitals are generally more dynamic than GPs since there is a larger healthcare workforce there and a higher chance of interaction as compared to GP clinics where there could be about 2-3 staff present. This as a result could cause GPs to feel that their work is monotonous and stagnated in the sense that there is minimal changes on a day to day basis and as a result, they could feel fatigued and bored of their work since they see the same people on a daily basis. In regards to how the challenges differ, it could be different in the sense that GPs face challenges that are more individual-focused, as compared to hospital doctors that face wider scale issues. Hospital doctors of course have to follow hospital policies and can feel suffocated by how things are run / executed daily, while GPs have more control in regards to how they would like to manage the clinic's day-to-day operations.
Why do you want to be a doctor rather than a nurse?	
Has anyone ever tried to dissuade you from applying for medicine? What convinced you to do otherwise?	There have been a lot of people in my life that have attempted to change my mind regarding my career choice, including people that I look up to and respect. One such instance that comes to mind would be a close family friend who is working as an ENT consultant, where during a gathering, he approached me to have a conversation of what I would like to do after graduating with my A level qualifications.

	I still remember his face when I mentioned that I wanted to pursue medicine. With a big frown, he tried to share that it would be a long arduous journey, with few material returns and could potentially be a lifelong commitment. He proceeded to elaborate on how his family life was affected (not having enough time for the kids, poor sleep schedule), and tried to convince me to consider another field that could earn a lot more than Medicine, but yet have a better work-life balance than Medicine. I remember feeling a little affected by his words, that if it came from someone that is currently in the profession, means that it really must be true. Furthermore as I looked up to him as a role model, I could feel myself feeling uncertain. This uncertainty remained with me, fading in and out until I started on my work experience. While it is hard to single out the exact turning point, one instance that comes to mind was when I saw how the doctors had this ability to make things right for many that came to see them, to relieve them of their worries and serve as a beacon of hope for those who needed them. The humanity demonstrated by these professionals, coupled with their academic and interpersonal skills showed me that even with all the possible drawbacks, the feeling when the patient shows gratitude to you for helping them would outweigh any of the negative implications of the profession. Having done my work experience, I could feel that this was a profession that resonated with me significantly and was a “calling” of sorts, and that I was willing to commit myself to this lifelong career.
What was the most important thing you learned about being a doctor through your work experience?	During my work experience, I actually learnt a lot of valuable lessons and grew as an individual throughout, and while it is hard to exactly single out one lesson, I feel this is probably the one lesson that I would take with me throughout my future career and possibly life. I remember following the doctor into one of the wards during my work experience, when she was doing some ward rounds to check up on the patient. She asked me if I was comfortable with the possibility of facing someone that was on their deathbed and while I was a little taken aback, I agreed that I was. Following her to the bedside, I was a

	little taken aback to see so many machines hooked up to the elderly woman, who was curled up into a ball. Initially I felt it was probably because it was cold, but noticing the blazing hot sun ruled out that possibility. The doctor then shared with me that this elderly woman was suffering from Stage 4 cancer, and that her children had abandoned her after her diagnosis. She also informed me that while she was pretty much nearing the end since the doctors were unable to do much given her old age, she still experiences some level of pain which explains her position. At first I thought that she was only here to do a quick checkup on the condition of the patient, but that view changed when I saw her pull up two chairs for us to sit. We then spent the next 45mins next to her, listening to whatever she had to say and interjecting only occasionally to speak. It was at that point did I realise how important it was for a doctor to listen and be there for those who need it in those moments of weakness , and just how much a little humanity could go a long way to heal those in need. The doctor frankly did not have to sit there to spend time with the patient, but she chose to spend a little bit of her life with that patient, to make the patient feel less lonely in the closing moments of her life. As such, the lesson I took away was that while academia makes up a huge part of the profession, at the center of it is our humanity. With it, it drives every interaction we take and is what makes the “healing” so impactful for those who come to us for help.
You are a 3rd-year medical student. Together with a group of your classmates you've been working on a presentation on the impact of different calcium sources on hip fractures in older adults. As you prepare the setup you realise you forgot to save your part of the presentation. How would you approach your group’s leader to discuss the issue with them?	I would first take into account the situation before deciding how to approach the issue with my leader. Is the presentation due immediately? Or is it in a few days? Is there enough time to pull together an answer or is there none at all? The situation would affect how I approach this matter and the suggested solutions to the issue. However, regardless of the situation, I would still approach my leader and first inform him of what has occurred. Transparency is important in any situation so that an informed decision can be made by the leader. After explaining what has occurred, I would also apologize to the leader for my mistakes, accepting full blame for what has

	happened and suggest possible methods to resolve the matter on hand. For example, if the presentation is in a few days, I would suggest that I get back to work and recreate the slides for the presentation since I already know what I wrote on those slides and it would not take as long to recreate them. If the presentation is soon and there is not a lot of time to recreate the slides by myself, I would ask if my teammates could chip in to help me and I would also explore the possibility of recovering the slides I created. I would also try to make it up to them by covering a bigger portion of the presentation or buying them a small gift as a thank you afterwards. In conclusion, I would be transparent and also apologetic for the panic I caused to my team, and depending on the situation, would suggest appropriate solutions to resolve the matter on hand.
How would you approach a friend who is feeling very low, because they didn't get to medical school?	I would first slowly approach them so as to not surprise them and give them enough time to be aware that I am approaching them. Next I would sit down next to them if they are okay with that, and just sit in silence with them until they are ready to speak. I feel this approach is good as sometimes people do not want to hear words of comfort, and may instead just want to have someone to be there for them during this difficult time. On the flip side, there are people who need to hear constant words of reassurance and cannot stand silence during such times as they tend to overthink. When my friend is comfortable speaking, I would then ask, "Are you looking for comfort or solutions?" This method is suggested as it places the power back in their court, and they feel heard and respected that they are given a choice in this matter, which is especially important since they may feel that they have no control over their current situation. If they answered that they prefer comfort, I would first provide some words of comfort and then proceed with the conversation based on their replies. I would also acknowledge that these words can sound hollow but I really mean well with my intentions. I also would not bring up my personal situation unless explicitly asked, so

	as to keep the focus on them. Sometimes the comfort comes from just being there, so reacting accordingly to their prompts helps to validate them and make them feel better. If they chose solutions, I would then help them explore their options. I would ask them if they are still keen on Medicine, and if so, would help them out in terms of how to best prepare themselves for future applications such as boosting their work experience or working on areas they fell short such as interviews. This again helps them to feel more in control of their situation as they are able to take actual steps towards improving their circumstances, and could help them feel better. At the end, I would leave them with a firm sign of support such as “I am here if you need me” so that they know they are not alone in this journey. I also give them the choice of whether they want my help so as to not impose upon them.
Have you read any medical articles of interest recently?	Talking points: ● Structure your answer in easy to follow paragraphs so something like “One article is …..” and the next paragraph could be “The second reading is …..” Avoid listing too many articles ● Focus on reflecting upon your articles and what you learnt from them, use the suggested reflection methods ● It would be good to talk about articles that the university puts out, such as what research the university has done as it shows you have done your relevant digging into the university and also it saves you a bit of time in the sense that you don't need to go and dig for articles

General Practice Questions + Model Responses

Practice Questions	Thought processes / Quick breakdown of answers	Example answer

Should the NHS treat patients with self-inflicted diseases?	• Substance abuse → maybe provide therapy after transplants.. ??? • NHS should kinda still treat everyone…. • Consider both POVS before jumping into conclusion → patient and NHS • Everyone has different definitions of self inflicted diseases • Cause of substance abuse…? • Treatment of substance abuse might remove responsibility of the patient	I feel it is important for us to understand what kind of diseases would fall within the self-inflicted diseases category, and some instances that come to mind would be obesity, smoking, or diabetes. Let us explore why or why not the NHS should treat patients with such diseases. One reason why the NHS should still treat patients with self-inflicted diseases is because that is a part of the NHS values that everyone counts. Even in the situation where it is possibly self-inflicted, every patient in need of help should still be given the necessary treatment whenever possible. Additionally, the line in which self-inflicted diseases would be increasingly blurred as it is difficult to define what is considered self-inflicted. Let's say that obesity is self-inflicted since we consciously choose to consume food that makes us obese, would that same logic apply to smoking and diabetes as well? If the NHS chooses to stop funding treatments, there will be inefficient allocation of resources to draw lines on what is considered self-inflicted as time is wasted to debate and decide. As such, to conserve resources, it will be best for the NHS to continue to treat these patients. On the flip side, one reason why treatment should no longer be funded is because the patients are literally "self-inflicting" these illnesses upon themselves and they should be the ones taking responsibility by paying for whatever treatments they need since they caused it themselves. It would be unfair for the NHS to allocate these resources for them when it could be used in other situations for the betterment of society. Another reason why would be that treatment would relieve responsibility from the patient, where they could feel that they always have someone to treat them if things go back, and hence would be less inclined to quit their habits / actions that lead to the infliction of the diseases. Ultimately, I feel that the NHS should still continue with the treatment of self-inflicted diseases since it is the goal of the NHS to provide treatments for those in need and it is one of the NHS values

		as well to leave no one behind and care for anyone that needs it.
Why not nursing or any other healthcare profession? Good links to check out: Why be just a nurse? Why not a doctor? : nursing (reddit.com) Difference between nursing and medicine : nursing (reddit.com)	• Equally as important as doctors, recognise their impact and how much they contribute • You should start first by stating indeed "Why not these other professions" , go into the similarities and elaborate on them before speaking about the differences • The approach here is to show you recognize why these other professions matter and why you respect them, and then elaborate on the differences and what specifically about a doctor that makes you want to become one • Strongly recommend reading the ISC Medical Book	Indeed, why not nursing or other healthcare professions? I definitely understand where you are coming from especially since nurses and other professions are also patient-centered, with a focus on service and caring for others. For nurses, I definitely understand and appreciate their importance to the MDT that we function in, serving as a "backbone" of sorts so that we as doctors can carry out our duties in the best possible way. However, there are some small differences that I feel push me more towards medicine compared to these other professions. The first one would be that Medicine allows me to have knowledge and experience beyond the clinical speciality. For instance nurse specialists have clinical expertise in that speciality only and may struggle to think of other treatment options when faced with patients with multiple conditions as they are not 100% certain on all the factors to consider. On the other hand, as a doctor, having undergone more general training, I would be more aware of the factors to consider and may be able to best provide a solution to the issue faced. A second difference that I personally agree with is that nursing from my understanding, is highly reactionary based, while Medicine is more comprehensive, involving both reactionary and preventive intervention. While I fully understand that nurses are involved in research projects and activities, in a typical hospital setting, nurses tend to react to patients' needs such as responding to the needs of the patients or supporting the doctors' actions on a day-to-day basis (and based on my WEX). However, doctors not only do what the nurses do, but they also carry out preventive actions such as encouraging a healthy lifestyle or making recommendations to patients to prevent worsening of their conditions. Personally, I align with this view that to heal others, we must both prevent and also treat

	because their elaboration is so much better than what I can possibly break down in this answer (it is pinned in the #interview channel for the r/UCAT discord) • Demonstrate your understanding and motivations for a doctor and recognition of other professionals, especially how they complement one another • Never ever criticise other professionals since you may need to work with them or some of them might even be your interviewers	conditions that patients have, which is why I feel more suited towards Medicine. [Third possible answer: ?] In conclusion, nursing and Medicine go hand in hand, complementing each other. With an analogy I have, doctors are the brain, considering multiple factors to make an informed decision, and nurses help to execute said decision. Without one another, patients are not treated properly. As such, with my beliefs I would align more towards medicine than nursing or other professions.
A 14 year old requires birth control pills and asks you to not tell her parents, what would you do?	• Can consider Fraser Guidelines • Understand why she wants it • If she could demonstrate they could	I feel that this question is a really complex question that needs to be approached carefully as there are many guidelines to consider such as the Fraser Guidelines and Gillick Competence. Gillick Competence is used in medical law to decide whether a child (a person under 16 years of age) is able to consent to their own medical treatment, without the need for parental permission or

	understand it or they are mature enough to handle it • Use Gillick Competence	knowledge. Fraser Guidelines is similar to Gillick Competence but the slight difference is that it is more towards advice and treatment towards contraception or sexual health. How I would approach this is using the ICE approach, and explore her ideas, concerns and expectations. For example I would explore her ideas and ask her first, “It is clear that you have an intention behind this question from me, can I explore your ideas behind why you feel it is important for me to provide you these birth control pills?” I would also approach this question in a sensitive way and ask her in a firm but respectful manner to demonstrate that I am not dismissing her views on this matter. Next, I would like to explore some of her concerns. I would ask her in a sensitive manner to determine her understanding of this situation and the possible complications that could occur. I would ask her, “What is your number one concern right now regarding this matter?” And upon further understanding, I would like to ask her, “What do you understand about the impacts of this medication? What are your intentions by taking this birth control pill?” Afterwards, I would explore her expectations with questions such as “What were you hoping that I could do for you today?” and “You have obviously given this a lot of thought, and as such this is a matter that I will explore with a lot of consideration”. This allows for her to be heard and understood, which allows her to feel comfortable in this situation, which could allow her to share more details for me to better understand her circumstances. Upon exploration of all the aforementioned, this would allow me to have as much of a complete overview as possible to make the necessary decisions. There are 5 main points for consideration: • Is the child mature and intelligent enough to understand the treatment

		• Likelihood of undergoing sexual intercourse with or without contraception • Is it in their best interest? • Is it impossible to persuade the child to tell their parents? • Mental and physical health → will it suffer without treatment? There isn't a lower limit for either Gillick competence or Fraser guidelines to be applicable. Most children under the age of 13 have parent involvement when consent to treatment is concerned as it is not appropriate or safe. When it comes to contraception and sexual health, any information about sexual activity would be acted on regardless of whether the child is competent or not – because a child under 13 is not legally able to consent to sexual activity. If someone under 16 discloses information that raises concerns about their safety, the following needs to be considered: • If they are Gillick competent and disclosure is thought to be essential to protect them from danger, the healthcare professional should escalate concerns through safeguarding measures • If they aren't Gillick competent, the healthcare professional is obliged to escalate concerns through safeguarding measures • If it is both cases, the young person must be informed – unless doing would cause significant risk to their safety If escalated, the police or local authority could be asked to decide whether it is in the best interest to inform parents of the concerns raised. Of course, sometimes there are cases where it is not in the best interest of the young person.
Why do you want to do medicine?	• This is a personal	It is too personal of a question to provide a model answer, but do feel free to read

	question so any reason is valid EXCEPT red flag reasons eg money or family pressure
	• Past present Future structure
	  • Past →what inspired your interest in medicine?
	  • Present → any work you've done to further affirm your passion?
	  • Future → anything you look forward to?
	• You can also approach this question using the CAMP method as
		the model answer in the ISC Medical Book if needed.

	you can address each aspect to why you would want to do medicine	
Explain why Junior Doctors may be experiencing stress during their work	• This question would be good to approach via the use of the CAMP method since Junior Doctors are essentially consultants just on a smaller scale, and do more extensive duties. • It will be good to also define what stress is and how stress can be manifested in terms of physical, emotional aspects, because it allows you to then explain the impacts it can have on the JDs • The focus of the question was "Explain" so do remember to structure your answers in a	I feel it is important for us to first define what kind of stress we are talking about in this question. It could be stress due to several factors caused by physical or emotional aspects. One reason why Junior Doctors could be experiencing stress could be due to the Clinical environment that they are in. Essentially, Junior Doctors are doctors on their way to become consultants and may need to take on a longer list of duties and responsibilities such as caring for more patients, doing more ward rounds, working longer and more exhaustive shifts. As such, these physical factors could lead to increased fatigue over time where they are pushed to their limits at times, and this in turn causes them to feel the burn of working and as such causes them to feel stressed as they have so many things to consider and take care of at a time. Additionally another reason why JDs may experience stress could be due to their Academic duties. JDs may occasionally be tasked with the responsibility of having to take care of medical students or be tasked to give lessons in the form of lectures to large groups of medical students. As a result they need to produce the academic content by creating the necessary slides or producing cases to impart the needed knowledge to the medical students. With all this, coupled with their already long list of tasks to handle, it could lead to them feeling panicked and stressed out that they may not be able to juggle all of their work effectively. Lastly, a reason why JDs would be stressed could be due to their Managerial duties. Admittedly, JDs are not always going to be the head of the team given that there are consultants around, but there are occasional times when the consultants are not around and JDs

	chronological order. • You can also refer to the Personal aspect of JDs, but I did not highlight it in my answer as I feel that it can be different for every individual but do feel free to talk about it.	would be leading the healthcare team, especially during settings where there is a shortage of healthcare professionals around. As such, JDs need to take into account the managerial duties of the ward such as accounting for the nurses and staff, organising work hours for the rest of the team. With all these things to take note, it is undoubtedly stressful for JDs as they may not possess the necessary skills or experience to handle such tasks, causing them to become stressed as a result. In conclusion, these are some of the possible reasons as to why JDs would be stressed. While there are more reasons such as personal circumstances that can lead to stress, I felt these reasons were the most universal experienced by most if not all JDs.
Discuss the many different types of stress encountered, for example working unsocial hours, dealing with psychologically and mentally challenging situations, balancing a career with your personal life, studying for postgraduate exams, and having a fear of making a mistake. Demonstrate how you've arrived at your examples. Was this first-hand through work experience or talking to Junior Doctors? Or was it through additional reading, watching documentaries etc.?	• The command word to this question is "Discuss", so similarly to the command word "Compare", you should try your best to consider both sides of the question as much as possible. In this case, you would want to consider both types of stress, the good and the bad types of stress. • There were a lot of factors named, such as unsocial	Different factors can lead to different forms of stress and at times, it may even overlap as they could cause different forms of stress. As mentioned previously, working unsocial hours can lead to emotional stress as you may not have as much of an opportunity to hang out with your friends, family or SO since your work hours are vastly different from the conventional ones that they work. I have seen some of my family friends who are doctors having to leave for consultations or operations during dinner hours or in the middle of the night. While it is understandable that it is a sacrifice that you make for this profession, over time it takes a toll emotionally as a lack of connection and interaction affects us who are fundamentally social creatures. Dealing with mentally and psychological challenging situations can also lead to emotional stress, but can occasionally cause chronic stress or even physical stress. After prolonged exposure to such situations over time, it can cause chronic stress where you continually experience such stress over long periods of time. Additionally there would be times where it has a certain impact physically on the individual. It is common to hear that individuals who are stressed experienced physical symptoms such as increased

	hours, situations, exams, career + personal life, so you should not address all the factors that are named in the question. Aim to cover as many types of stress as possible while still referencing the given factors • The second part of the question is “Demonstrate” so you should have a very clear chronological order in terms of timeline to show your thought process when approaching the question. • The question also gives you a few factors to consider but it is not necessarily important to address all since the question is probably going to be	heart rates, shaky hands, blurred vision. This as a result heightens the emotional stress experienced as well given that you would be more panicked and worried about your inability to function as normal, causing you to be more worried and stressed as a result. How I came to this conclusion would be through many avenues such as work experience, talking to JDs and additional readings. However, I felt that work experience and talking to JDs allowed me to have a deeper understanding of the stress faced given that I was able to ask follow up questions and learn about specific circumstances that they may have experienced.

	quite long and you might not have enough time to answer. (Assuming you have about 10 mins to answer, the first part may take about 5-6mins depending on your answer)	
Talk about how you've seen or read about Doctors dealing with these stressful work situations, such as creating job lists, delegating tasks to different team members and asking for help when they recognise a problem out of their expertise	• So this question in particular offers you a choice in how you have "read" or "seen", so it is up to you regarding how you want to approach this. • In regards to it being "seen", work experience will probably work best for this question. Additionally, the STARR method or the CARL method. There are many approaches including the 5Rs, so find what you	This is a little too personal to talk about, at least in terms of the work situations that we will pick as such I felt that it would be better if I did not give a model answer here. Using the given approach would be best (and also I would like to encourage you to give this a try yourself since it is quite common)

	resonate best with. • You can mention that you picked up some relevant skills or ways to deal with the stressful situations from watching the doctors, so it shows that you actually learnt something from the professionals • In regards to “read”, it would be good for you to know the medical readings thoroughly so that if any backup question were to follow, you would be best able to defend what you have read	
Have you always wanted to be a doctor or is this something you have decided in recent years?	• There is no right or wrong answer here, but do understand that whichever option you pick, you should be giving a well structured	I feel that it is first important for me to identify that the time when I decided that I would want to become a doctor could be different for everyone and what really matters is that I had made my decision and took the relevant steps to make sure of it. With that being said, from as far back as I could remember, I had always been interested in the profession. I remember that I was interested in how cool the doctors looked with their white coats and fancy instruments. As I grew older, I

	answer so as to show your thought process behind that answer • You can also pick both as you could actually have had a rough idea when you were young but once you did your recent work shadowings, you knew straight away / had a better understanding • A good way to discuss this question is to use the STARR method to approach this question • Remember that it is more important to reflect and focus more on the process which you understood why you wanted to be a doctor • You can also mention that the time does not quite matter, aka whether you decided	became more fascinated with their seemingly “inhuman ability” to diagnose and treat people to heal them, and that they were able to do it so flawlessly and without effort. This fascination stuck with me all the way till after my A levels where I started to take the interest seriously. After my A levels, I undertook up multiple job shadowings and got to witness the profession in multiple settings such as Clinical and Academic settings. Witnessing the way the doctors consulted the patients, approaching them with a mix of professionalism and respect showed me that this was a profession that I resonated with and that I could feel a “calling” that this was for me. This was further developed during my attachment in the Surgery department where I got to witness a field that has heavy hands-on implications and highlighted my interest taking a direct approach to caring for my patients. Additionally, witnessing the doctors giving lectures to medical students allowed me to pursue a possibility of being a mentor to future generations, and it aligned perfectly with my vision of playing a role in shaping the future generations. In conclusion, the interest has always been there since I was young, but over time and through recent undertakings such as my work experience, it allowed me to really make an informed decision of my Why Medicine.

	it early or just recently.	
How do you think Junior Doctors cope with stress in the workplace?	• Similar to previous questions, it is good to define what stress is and how it manifests in physical or emotional forms, it is also a good way to help develop your answer as it gives you examples • It will be good to give examples of what JDs do in the workplace and how it can lead to stress (such as ward rounds -> stress because a lot of patients to look after etc) • Good to recognize that everyone has different ways of coping with stress, so the ways you are suggesting are non-exhaustive and there will be more	I feel that there are many ways to deal with stress in general, and having done my work experience, I got the chance to witness up close how JDs destress from the worries of the workplace. One way they do so is to head out together as a group after work to get some dinner or some drinks to unwind. In a hospital setting, after a long day of work such as extensive ward rounds, or multiple operations, they like to separate themselves as much from the setting as they possibly can, and do activities that are further from their line of work to fully disconnect. While I am not advertising alcohol as a good coping mechanism, some of the JDs that I have spoken to use it as a way to numb the emotions they feel after work such as fatigue. In doing so, it allows them to fully relax after their duties and forget about the stresses that they may have that day. Another way they do so would also be to head for a night out with friends / head home to unwind with their family. Some of the JDs I have the chance to interact with find solace with interacting with individuals outside of their profession as they do not feel the pressure to communicate in the lingo that they have already spent the entire day speaking. Furthermore, they find it comforting that at the end of the day, they experience a clear break from their duties This allows them to cope with the stress given that they experience a distinct change in environment and allows them to let go of their worries and fully unwind from their tasks to handle. A way that I have also known some JDs to do is to create a safe space without any work related stuff for them to return to after work. This applies more towards the Academic duties given that bringing clinical work home is not recommended, and how they do so is to remove any lecture materials or any devices that could remind them of work from this safe space, so that they have a “shielded environment” from their responsibilities

	options possible • Draw from work experience to say what you learnt from the professionals themselves (so as to ground yourself and the answer) and show that you actually observed something from it • Good to note also that stress in the workplace can come from Clinical, Academic or Managerial situations, so as to have an answer that covers all possible factors	and allow them to get well rested in preparation for the next day. In conclusion, there are probably more ways to deal with the stresses faced by JDs, but having talked to many JDs during my hospital work experiences, these were the most common methods used.
Which area of medicine would you like to go into?	• This question is a bit of a trap in the sense that you should not be specifically highlighting a specific field (Ecolier has mentioned this to us before that	Thank you for your question, but before I answer this question, I would like to preface this that I have not managed to shadow all the possible specialities in the field of Medicine given the large scope of specialities present, and even if I had done so, i would not be able to get the best understanding needed to make an informed decision. With that being said, having done my work experiences, I have some understanding of the type of speciality I would like to pursue and what I would like to be able to do in my future chosen path. One thing that I have understood from the

	we should **NOT** specifically mention a field), but instead take a more general approach • Instead of naming a field, you should acknowledge that you do not have a good understanding of the specialities yet since you did not get to shadow all of them • Instead what you can talk about would be your interests, and what you would want to do in your future speciality (such as you are looking to do a more hands-on speciality, or you are looking for a speciality that is more patient-interaction heavy etc) • You should also bring up the fact that in Medical school, in Year 2-5	get-go was that I would like to pursue an area that is more hands-on and involves physical action more predominantly as compared to one that has less hands-on actions. I acknowledge that all specialities involve some level of hands-on action but I would prefer a speciality that involves the use of tools. I would also prefer a speciality that intellectually and physically challenges me. As an individual that aspires to put in my best in everything that I do, I am always looking to step up and out of my comfort zone as and when possible so as to be the best possible version of myself. Hence, this would be why I would like to pursue a dynamic and tough specialty, to push myself constantly and contribute back to society as much as feasibly possible. In conclusion, while I may not have the best idea of which area of Medicine I would like to pursue as of now, I hope that when I do get to enter Medical school, during Years 2-5 depending on the school I attend, I will have an idea of where I want to dedicate myself to. All areas of medicine are equally important in their own right, contributing to the betterment of society and with medical school, it would give me the necessary experience to make a decision then.

	onwards you will get the chance to do placements in hospitals so you will really be able to get the exposure to understand more about each area of medicine, so you will be able to best give an answer then (play a little humour into this, so you break the tension a little)	
Can you/how would you maintain a doctor-patient relationship?	• It is good to first define that a relationship can be many types, such as romantic, platonic or professional • Should first identify that a professional doctor-patient relationship is important because it is the basis for any interaction in a clinical setting especially, since you need the patient to	A doctor-patient relationship can come in many forms such as a professional relationship, a romantic one or even a platonic relationship. It is important to define and separate them from one another as to make the best and most informed decision on what actions to undertake if a relationship were to be maintained. In the event of a professional relationship, it is very important to maintain such a relationship as it is the basis of any interaction in a clinical setting especially. Without this relationship, the patient may not trust us enough to share all relevant details for us to make informed decisions for their holistic care, which puts patient safety at risk and consequently could even hurt the trust in the profession. As such I would actively attempt to maintain such a relationship by staying respectful, committed and professional to the patient, while aiming to exemplify the 4 GMC domains & NHS values as much as possible. In regards to platonic relationships, it is inadvisable to maintain one as the situation where the doctor and patient

	trust you enough to share details so that you can diagnose them properly • Without a professional doctor-patient relationship, it will be difficult to do our respective duties as a doctor • A platonic relationship would not be advisable as the formation of the relationship, especially in such a sensitive setting is not the most appropriate. Yes, it is possible for the doctor and patient to be friendly, courteous towards each other, but it should not develop any further than that • A romantic relationship would be even more inadvisable given that it is a particularly	meet is not the most appropriate. While doctors need to stay friendly and communicate with patients on a comfortable scale, courtesy and professionalism should not be mistaken as an invitation to form platonic friendships. This could cause implications in regards to decision making in the future and jeopardizes the doctor-patient relationship professionally. As mentioned, a romantic relationship is even more inadvisable as it strictly goes against professional boundaries. The GMC Domain 4: Maintaining trust mentions that doctors should not be pursuing improper emotional or sexual relationships, and I believe romantic relationships fall into this scope as well. To form and maintain such a relationship is quite unprofessional and goes against the nature of our profession at the very least, but at worst it could severely jeopardize the trust in the profession and skew the decision making necessary in certain occasions. In conclusion, a professional doctor-patient relationship can be and should be maintained as much as feasibly possible, but anything beyond a professional connection would be inadvisable.

	vulnerable setting and it goes against professional boundaries to pursue anything more than just a professional relationship • Should also mention GMC Domain 4: Maintaining trust, that doctors should not be pursuing improper emotional or sexual relationships with patients and this extends to platonic relationships.	
What qualities should a good doctor have? Which of the ones that you have listed do you feel you have? How do you know you have these qualities?	• Should first identify what a “good doctor” entails and what makes a doctor “good”. Can a doctor be “bad”? • A “good” doctor could be someone that exemplifies the GMC 4 domains very well, and abides by the 4 pillars of medical ethics	This question is difficult to answer without making it personal so I probably will not be answering this question unfortunately. But do ping @Prata on the discord if you need any help when answering it.

	whenever possible. ● Avoid listing qualities, naming 2-3 and developing a proper reasoning behind why you mentioned them will be much better for your interview answer. ● In regards to the 2nd question, it is okay to say that you have all of them but you must be able to back them up with relevant examples ● It would be good to mention that you have all of them, but occasionally falter because we are still human by nature and can make mistakes ● For the third question, remember to “Show Not Tell”. Avoid saying things like “I know because I did this….” or “I know I have them	

	because I exhibit them….". Instead you should be approaching this question along the lines of "My friends mentioned that I show these attributes by doing…." or "Through these events which I worked with my fellow members, I was told that…."	
What's the best book you have ever read?	• The question is not asking you about the book specifically, the interviewer wants to know **WHY & HOW** it is the best book, so the example is not as relevant in this scenario • They want to know what you have learnt, what your reflection is and how it has helped you learn and grown from it as a result	While this is a personal question, I wanted to highlight how to approach this question with a simple book that is more conventional and not so medical related. **Facts:** One book that really has stuck with me was a book by J.K Rowling, and was a part one of the most famous series in the world. This book in particular is Harry Potter, the Deathly Hallows. It was a book detailing the final journey of the protagonist, Harry Potter and his journey to defeat the ultimate evil, Voldermort, to prevent the Wizarding World from falling into disorder and disarray. Why this book in particular was the best to me was because of how it imparted very important lessons to me which I still hold dearly to my heart today and how it shaped me from my childhood to today. **Feelings:** I still remember reading this book and feeling a little disturbed by the darker approach of the book, where the protagonist and his team were fighting each other and hurling abuse at each other at times. During these tough times, the characters in the story managed to reconcile by communicating about their struggles to each other. This allowed me to understand from a young age that while people can fall out due to

	• The 4 F's of Active Reflecting is a good approach for this question, so is the Gibb's Reflective Cycle • Focus on pulling out examples that occurred in the book, to use for reflection, and do try your best whenever possible to link it back to medicine and why you would want to do medicine • In the model answer, I will just pick a Harry Potter book (lol) to show you what I mean in terms of the example not mattering so much, but you can still spin it to be related to medicine	disagreements, clear communication and effective discussion of each other's ideas, concerns and expectations helps to resolve the misunderstandings faced. Additionally, the plot twist of one of the characters being good the entire time despite being so unlikeable throughout the series was a big learning point for me. It really allowed me to understand that everyone has two different sides to them, and that what is taken at face value is not necessarily true, that people behave a certain way at times to play a role. **Findings:** I feel that while there were many more examples that I could raise to elaborate how much this book meant to be, the one thing that stood out to me most was the characterization of those involved in this story. Everyone was well-developed with their respective character arcs and had their strengths and weaknesses. This is also mirrored in real life as everyone has their life story, how they came to be who they are, and this as such shows us that they are indeed human and are just trying to be the best versions of themselves, just like I am. As such, I should respect everyone that I meet and always be kind to them, even when they may not do the same to me. **Future:** Ever since I read that book, I have always been consciously trying to work on clear and effective communication with everyone I meet or have to work with, as I believe it is the first step to maintain a friendship with each other or to get to know one another. I believe this would be especially important if I were to become a doctor, as I would need to work with numerous healthcare professionals in my duty to care for my patients. Furthermore, I have also been trying my best to be understanding towards anyone I meet, and attempt to be respectful towards everyone as everyone is different, having gone through distinct life experiences to become who they are today. This would be distinctly important in my journey to become a doctor, especially since every patient would have a different experience behind how they came to be, and it is my responsibility to be respectful and help them as and when possible.

		In conclusion, Harry Potter: The Deathly Hallows is the best book I have ever read, not only because it was the beloved conclusion to one of my favorite book series, but because it has also taught me many lessons that have shaped my growth and personality as I grew up.
If I gave you a thousand pounds and you had to spend it on YOURSELF in the next hour what would you buy?	• This question is more personal and definitely an abstract question in some sense so try not to be completely taken aback and just approach the question as best as you can • Take note of the factors that will limit your argument such as a thousand pounds (whatever you buy must fit within that range), on yourself (so no charity work, no feeding the needy etc. Its impacts have to be on you) and in the next hour (you have a time limit to buy certain things)	Again this is a more personal question so it is entirely up to you how you want to answer it. However, there are some things you can consider: • IPad / Tablet: It serves as a learning device for you to use for lectures. It is also more portable as compared to a computer / laptop which can be brought for clinical rounds or to view anything academic related on the go • Anything related to your passions / hobbies / interests: Allows you to pursue it on a more serious scale and it also enables you to possibly even turn it professional to earn some side hustle money • Subscriptions to certain websites such as Lecturio etc: Allows you to stay on track of your medical school work, and helps with revisions if needed

	• The question mentions “buy” so whatever it is, it needs to be a tangible object with a monetary cost (so answers like happiness is probably not correct) • While this is not entirely Medicine related, it is important to note that you can still sprinkle in bits to relate it to Medicine such as how it will be used / beneficial in your Medicine journey	
What have you read/seen in the news lately which is outside of the UK/Europe, and has nothing to do with medicine?	• Note the factors given to you such as news lately (so it must be relevant enough to be reported in the news), outside of the UK / Europe (the context given must be anywhere outside the world) and nothing to	Again this is a more personal question so it is entirely up to you how you want to answer it. However, there are some news you can consider: • Russia’s invasion of Ukraine and the ensuing political war + heightened tensions regarding the matter • Radical Protests such as Just Stop Oil which vandalized a Van Gogh painting in the Vatican to drive across a message to reduce oil usage and for the UK to reverse the support for new oil and gas fields • Egypt’s COP27 Summit

	do with medicine (pretty self-explanatory) ● This question is testing your wider reading, how well informed you are of what else is ongoing in the world apart from just medicine, and looking to see if you have other related hobbies / interests apart from medicine or academia ● Pretty much anything works to be honest, so literally anything you have read can be mentioned ● Try not to fall into the issue of listing so naming 2-3 relevant news issues will be pretty good already ● Use the PEEL approach to this question to help you structure your answers in a	● Biden's Student Loan Forgiveness ● Trump's ongoing subpoena and Jan 6 implications

	clear and logical manner	
Have you had an experience which made you want to research more about medicine?	• Note the factors regarding this question such as an experience (so it should be a singular event that occurred) and research more about medicine (so basically you had to dig more into it, so to know more you had to find out through means such as Googling or talking to professionals about this) • This is a more personal question so approach it with the STARR method, CARL or the 4 F's method. It helps to develop your answer in the most comprehensive way possible	Again this is too personal of a question so do attempt it on your own, but ping @Prata if you need any help with the answering of this question.
What would you change about your work experience…if	• The 5R Framework is a good	

you had the chance to repeat it?	way to explore this question, and the Integrated Reflective Cycle as well is a good way to structure your answer. The STARR approach is also a really good option if you are not comfortable with other methods. • Try to focus on 2-3 aspects of your work experience at most, and avoid listing. Remember that the example is not the most important thing in this question, nor is the work experience. The most important thing is to reflect and focus more on changing and how you would improve upon the previous experience	
What experience has your previous employment given	• Everyone has different work	

you that will be useful in a medical career?	experiences as well so it will be difficult to address this in general, but do try to focus on one event that are going to benefit you • Focus on 1-2 things at most and avoid listing if possible, the term “experience” suggests one singular event • Good to define what a medical career is as well, so are you considering this question in the context of a consultant, a Junior Doctor, a specialist? • The STARR method is also recommend ed for this approach, a good way to develop a comprehens ive answer • Remember what are the important things about a medical career, such as communicati	

	on and see how your previous employment links to that	
Can you tell me about the importance of IT to healthcare?	• Identify how IT is used in healthcare, such as in OT the use of machinery for certain operations or in certain specialities like Radiography , how prevalent the use is and how important it is • Can IT also be considered for normal paperwork, such as filing of patient notes? How important would that be, where proper computer systems can be used? What are some of its benefits? • So far we have mainly considered healthcare in the sense of doctors or nurses, but the healthcare profession is	IT is now becoming increasingly prevalent in today's healthcare with the introduction of machinery that does specialized functions that we otherwise would be incapable of doing ourselves. In my answer, I would say my definition of "important" refers to impactful and needed in a certain way. One reason why IT is so important to healthcare is because without it, we would lack the ability to observe certain things and as a result, be unable to undertake accurate treatments for the patients. One such example would be X-Ray machines which essentially use X-rays to take pictures of certain body parts and allow the doctors to get a clearer view of the issue at hand. This is especially useful when what the doctors are looking for is not visible to the naked eye such as damage to internal organs. While it is a possible argument to say that the doctors could use their hands to feel for the injury, it is honestly impractical to do so. With such IT, it makes the decision-making a much smoother process and allows appropriate actions to be carried out. Another reason would be that IT allows for the progression and advancements of medical treatments. With IT involving the use of supercomputers able to run large-scale simulations and trials, it allows the researchers in the healthcare industry to tweak and adjust their suggested treatments to make it safer and more successful in targeting treatment for diseases. Without IT, we would be unable to formulate essential treatments for the diseases we face and the suggested treatments would not be 100% safe given the lack of prior trials. Lastly, IT is also important in improving the efficiency of the healthcare workforce. While it is easy to overlook smartphones, laptops and pagers compared to fancy research technology, without such smartphones and means of contact,

	much bigger than that. So what are some possible aspects of IT that can be used for other healthcare related industries? • Good to also explain what you define as “important” since everyone has different definitions on what important can mean	patient care would take a significant hit in productivity as healthcare professionals are unaware of what requires their attention at certain times or information that is transmitted via verbal communication could take a while to reach the right individual. Without IT, the workforce would be a slow but possibly functioning system, which could have implications on the perception of the healthcare system and even patient safety (where doctors are not bleeped in time to intervene for high-risk patients). In conclusion, these are some reasons why IT is so important especially in the healthcare setting.
How do you feel about working on human / animal tissue?	• Those who have done Biology may have an advantage here since you guys would have done some form of dissection before, so try and recall what it feels like • Since the question is asking about the “feel”, you can approach it in the sense of either the physical feeling or the emotional feelings you have from	I think it would be good for me to contrast between the two types of tissues and perhaps the physical characteristics before I explain how I feel regarding the matter. While it is hard for me to exactly picture human tissue such as cadavers, I would like it to be similar to the human skin, just more loose. As for animal tissue, it depends entirely on the sample obtained, and it would be hard for me to generalize an answer for this. In regards to how I feel about working on such tissues, I personally think that it is a necessary action to do so, perhaps even a “necessary evil” of sorts. Why I say so is because I feel it is a little cruel to take tissue that once belonged to living creatures or even human beings to experiment on. However, without such tissues to be used for actions such as experiments, it would be difficult for advancements to be made as we would lack a testing subject to check against in terms of determining the effectiveness. As such, I would feel honoured to be given the chance to work on such tissues and of course give the appropriate

	working on the tissues mentioned • Human tissue would probably be hard (in the sense you probably would not have had the chance to dissect a human yet), but you can relate it to your own skin since it is also human tissue in a sense • You can bring in scientific knowledge if you have any, but remember this question is not aiming for you to flex only your academic knowledge, it also wants you to be aware of your own feelings (aka they are looking for a personal touch) • You can also compare between the two tissues and explain anything that you feel is relevant	respect to the action that I am undertaking.

	enough for you to bring into the answer	
Can you tell me about the history of medicine?	• I genuinely doubt this would be tested but in the event it is, it will be good for you to come prepared and do a little bit of prior reading just so you have something to discuss • Remember the important milestones regarding Medicine, perhaps how it came about, the progression of it, what we learnt over the years, basically the evolution of Medicine • Present it in a chronological order so it is easy to follow and understand • The ISC Medical Book has an entire segment dedicated to the history of Medicine, so if you	As much as I wanted to give this a shot, I have yet to read up as much on this issue, so do check the ISC Medical Book for more talking points and how you should approach the question. It is linked in the #interview channel on the discord.

	need any talking points, you can check there • You should definitely mention the Hippocratic Oath, because while not entirely followed today, it is the foundation for most if not all medical institutions even till today	
If you dug up a skeleton in your garden, how would you say what gender it was? Link to point 5: What Happens to Our Teeth When We Die? - Daniel G. Kline DDS - Chandler Dentist (klinedentistry.com) Link to point 6: https://www.bing.com/search?q=how+to+identify+gender+of+a+skeleton&cvid=5e41a1b200c9492584a27b51428bd5b8&aqs=edge..69i57.9245j0j1&pglt=43&FORM=ANNTA1&PC=ASTS	• Can include a little joke that digging up a skeleton should probably lead to a police call because it is out of your capacity to deal with • Mention Carbon-Dating, one of the most utilised methods to date the time when the skeleton would have existed • Should also draw attention to the fact that it is a skeleton, so	I would like to think that if I ever dug up a skeleton in my garden, it would probably be best to alert the relevant authorities such as the police to avoid getting into trouble :) But moving on, I feel that there are a few ways to do so, and the most important step to take first is to try and identify the time period the skeleton existed in. This would give us some important information which could help us when determining the gender. The method of carbon-dating, where a sample is taken to the laboratories to be tested. I assume that the skeleton would be considered to only have bones left, which would make immediate viewing difficult since most identifiable parts would be long gone/ One method I would do so is to alert relevant authorities such as museums as they may have relevant tools and professionals who can help to identify the gender of the skeleton. While not all museums have labs around, most if not all are in contact with some professionals who may be able to lend their services in determining the gender. Another method I would consider is the use of dental records. Since dental records have been kept for quite a long

	any defining features (such as certain body parts) would probably no longer exist • Involve relevant authorities such as museums to help you out since you may not have the relevant tools to identify the gender • Teeth / Dental records are a good way to check if the skeleton lived in recent times because teeth take a very long time to decay and break down (Don't ask me how I know, I just do LOL) From there, you can probably identify the gender if it is recorded • You should also mention that the length of certain body parts can help play a role in identification such as men	time, and teeth take a long time to decay, with the help of authorities, they could contrast and compare the structure of teeth in the skeleton to past records which would then allow us to identify the person and hence the gender of the skeleton. Lastly, I would also explore the idea that bone strength could help us identify the gender. I had once read that in the past, males had stronger and denser bones as compared to females given that males usually had to do extensive work such as physical labour, and genetic evolution granted males with stronger bones to help us in our duties. While it would certainly be hard to compare bone strength with a lack of a secondary skeleton, I could suggest it to the professionals as a way of identifying the gender given that I do not have the lab equipment to do so myself. In conclusion, by myself it would be impossible to identify the gender of the skeleton dug up. However, with the support of professionals, it would be much easier to do so.

	having stronger bones genetically	
Being a doctor requires teamwork, who are the people that doctors have to work with on a daily basis?	• Note that doctors can be working in clinics as GPs or in hospitals, and also if you do a certain speciality such as Surgery, you will definitely be working with specialized individuals • You should also note that doctors do not just work with healthcare staff alone, but they also work with administrative staff such as receptionists and even patients • In this answer, you should also try and give a brief description of how they work together and what the intentions of them working together are (aka what are their end goals)	I feel that it is first important to set the situation clearly as doctors can be working in either hospitals or clinics, which could have distinctively different individuals such as in a hospital, a doctor could be working with specialists more often than a doctor in a clinic. However, I will try to explore all possible options in my answer below. One group of people that doctors work with daily is the patients. While it may seem a little confusing since patients come to the doctors for treatment and not necessarily work, but patients and doctors need to communicate and work together to achieve the end goal of treating the patient. Patients need to communicate effectively with the doctors, and the doctors would need to listen closely and provide the right treatments, which is teamwork to achieve a common goal as mentioned. While certainly not an immediate group of people that comes to mind, it is certainly important. Another group would be the healthcare staff. I refer to the nurses, specialists or any other healthcare staff whose specific role contributes towards the care of patients. Nurses are of course important people that doctors work with often, especially in wards since they help us to take care of the patients' needs when the doctors are unable to do so. They are also the first point of contact whenever something goes wrong as they would page or bleep us for our help. In regards to specialists, it differs for everyone but an example would be a surgeon working together with anaesthesiologists during operations for the care of the patient. Lastly, a group that deserves some recognition would be the administrative or other staff not directly involved in the care of the patients. I would like to highlight the receptionists who support the doctors in the organisation of patients on a day-to-day basis and effectively take off some of the workload for doctors. Additionally, the cleaning staff help the doctors and

	• I think it is good to mention the cleaning staff as well since they keep the relevant environments clean for you to work in and technically you do work with them! • Avoid listing too many without explaining, focus on the people you work most with and highlight / mention the honourable people you work with (aka honourable mentions)	healthcare staff keep the wards and clinical environments sterile, which allows us to maintain cleanliness and hygiene in our work environment. They are individuals that work together with us but yet receive little attention compared to the rest of the healthcare team In conclusion, these are some of the individuals doctors work with, all serving a specific role and contributing in a way or form.
If you were in charge of controlling MRSA in the NHS, what policies would you implement & what changes would you make? **Methicillin-resistant Staphylococcus aureus** (MRSA) is a cause of staph infection that is difficult to treat because of resistance to some antibiotics. Staph infections—including those caused by MRSA—can spread in hospitals, other healthcare facilities, and in the community	• I think it is good to first recognize how MRSA infects others and the current issues surrounding MRSA (such as the aforementioned resistance to antibiotics) and approach the question from there • Frankly I did not know this was a	[redacted]

where you live, work, and go to school.	thing also, so it would be good to read up on this and see if it is still relevant enough • Infection spreads can be controlled through hygiene such as frequent hand washing (similar to COVID-19 hygiene measures) but since it is a different form of infection, different methods should be taken to deal with this issue	[redacted]
Should failing doctors be re-educated or thrown off the register?	• It is quite a strong / harsh statement to say that doctors should be thrown off the register, so do take note of the stronger language used.and adjust your answer accordingly • Also note that “failing doctors” is quite vague,	I feel that we should first understand what “failing doctors” means exactly as it seems relatively vague. I assume it is referring to FY1s who are unable to clear full GMC registration. Let us explore both options before making a decision. Personally, I feel that to be “thrown off the register” is a relatively harsh decision to be made and may be quite disproportionate for the issue at hand. Just because some doctors are unable to pass a certain test or exam once does not mean they deserve to be entirely struck off. Additionally this has certain implications such as placing extreme pressure in an already stressful scenario, where all the years of studying could be rendered useless. This could deter future students from entering the profession, severely reducing the future workforce. While this measure could be a strong

	so it would be good to define what it means (such as doctors who fail the UKMLA?) • Re-education is good but note that it also has its flaws (re-education takes time and resources, and can the system support that?) • For this question, you should not take a stance so early in your answer, but instead argue the pros and cons for both suggestions, before taking a stance in your conclusion (will show the structure in the model answer) • It is also a good point to bring up the fact that doctors can be “failing” for many reasons where re-education or	message to take the profession seriously and improve the quality of doctors trained, it is still quite disproportionate in terms of scale. In terms of re-education, it is certainly a good method to consider as it is a decently-scaled measure towards the issue at hand. Through re-education, it also allows the failing doctors to be given another chance to make things right and show their potential (or correct anything that they may have messed up). It is also important to consider the drawbacks of such a method. Some issues I can think of would be that re-education takes extensive time to take effect and resources, and could the UK system support failing doctors sufficiently for them to be able to do things right. In conclusion, failing doctors should be re-educated over being thrown off the register. Re-education, while with the drawbacks mentioned, is still a proportionate response to the issue at hand and most importantly, gives the chance for failing doctors to prove themselves after making mistakes.

	kicking off the register does not resolve the issues faced by them. They can be struggling with personal issues such as family or work-life balance, which subsequentl y influences how they perform in their jobs	
What is evidence based medicine?	• According to BMJ, Evidence based medicine refers to the application of the best available research to clinical care, which requires the integration of evidence with clinical expertise and patient values. By best available research, we mean clinically relevant (i.e. patient oriented) research that: • Illuminates the accuracy and precision of	Check out the BMJ Best Practice website for a more detailed breakdown. What is EBM? | BMJ Best Practice Additional reading material: What is evidence-based medicine? - InformedHealth.org - NCBI Bookshelf (nih.gov)

	diagnostic tests, • Highlights the importance of prognostic markers, • Establishes the efficacy and safety of therapeutic, rehabilitative, or preventive healthcare strategies, or • Seeks to understand the patient experience. • The question is testing your knowledge of this type of medicine, so a simple PEEL structure would do for this question. Bring in any relevant examples if necessary.	
Do you think doctors practice defensive medicine? Link to read more: Defensive medicine - Wikipedia	• Important to know what defensive medicine is first before answering this question. Remember to always define terms before answering the question	Defensive medicine, also called defensive medical decision making, refers to the practice of recommending a diagnostic test or medical treatment that is not necessarily the best option for the patient, but mainly serves to protect the physician against the patient as potential plaintiff. Defensive medicine is a reaction to the rising costs of malpractice insurance premiums and patients' biases on suing for missed or delayed diagnosis or treatment but not for being overdiagnosed.

	(never assume anything!) • According to Google, Defensive medicine, also called defensive medical decision making, refers to the practice of recommending a diagnostic test or medical treatment that is not necessarily the best option for the patient, but mainly serves to protect the physician against the patient as potential plaintiff. Defensive medicine is a reaction to the rising costs of malpractice insurance premiums and patients' biases on suing for missed or delayed diagnosis or treatment but not for being overdiagnosed. • Use relevant work experience	I would like to also preface this answer with the fact that while I had done my relevant work experience, it is difficult for me to ascertain if doctors actually do so and I can only determine it based on what I have seen. In my opinion, in this day and age, it is understandable that doctors are more aware of the potential issues they could face from malpractice, and as such would take certain actions to protect themselves as they may not necessarily be protected from the hospitals or clinics. There have been many cases in the news where doctors were sued by patients when things did not go their way, and as such it makes sense for doctors to take active steps to prevent lawsuits. One instance that comes to mind would be during my work experience when I got the chance to witness an interaction between doctors regarding a patient. It was regarding a case where a patient was suffering from a possible kidney stone issue. While the doctor mentioned that she was quite certain that the patient was not suffering from kidney stones, during the conversation with the other doctor, it was mentioned that the test should still be undertaken either way just to be sure in the event that it actually was a kidney stone case. At that time, I did not quite understand why they felt the need to order such tests when they already had a relatively good idea of what was the problem, but looking back now I do understand why. In conclusion, yes I do believe that doctors do practice defensive medicine nowadays but it is mainly to protect themselves from the possibility of potential lawsuits.

	to support whether you think they do or do not practice defensive medicine • Should also express the point that it is hard for you to determine if doctors do practice such medicine because you only do work experience and may not have the necessary knowledge to deduce whether doctors actually do so • This question is **NOT** asking you to state the **PROS AND CONS** of defensive medicine, they just want to hear your stand on this matter. So please take a neutral stand all the way until your conclusion.	
Do you read any newspapers/medical journals?	• They give you the choice to pick between	I have unfortunately not read many medical journals but have been keeping up with the news, especially the global issues faced and reported in the newspapers. I read up using platforms

Can you tell us about a story you've read recently?	newspapers and medical journals, and it is important not to be pressured into picking medical journals just because it is “medicine related”. You will be **EXPECTED** to defend whichever you pick, so picking whichever you are more comfortable with is more important • If you choose medical journals, make sure you are confident with answering about the content you brought up, so you should have a proper understanding of what you are actually reading • The second part of the question asks about a story being read “recently”, so a relatively	such as BBC, Apple News and many more. One particular story that I have read recently was the unfortunate passing of Dr Jing Mai from suicide. For context, she was a resident doctor in the US and was struggling from depression, anxiety and had difficulty sleeping. She chose to end her life recently after a long struggle with her responsibilities and constant feeling of inadequacy. This led to a ripple throughout the US Healthcare industry and the trending of the hashtag #ForJing in response to her passing in hopes of improving the health (mental and physical) for current doctors and medical students in the US. Why this article or story has particularly stuck with me is because it seems to be a universal issue across healthcare professions, especially doctors and medical students where we are constantly pushed to our limits, with much less support and resources to help maintain our well-being. Additionally, as seen during COVID-19, we are only appreciated when it is necessary and even when seeking remuneration or support in terms of a pay rise to deal with rising inflation, we are constantly denied such options. It pains me to know that we are overlooked and mistreated just when we are trying our best to do our duties for those who need them. I sincerely do hope that it will lead to actual change within the profession and community with the passing of Dr Jing Mai, and that she becomes the catalyst for change in as many countries as feasibly possible by highlighting the issues plaguing the system currently. In conclusion, this would just be one of the stories I read in newspapers and I picked this specifically as I genuinely felt impacted after reading up more about it.

	recent story (within the year at very most will be recommend ed) should be picked, not something published like 5-10 years ago • Try not to namedrop a nything if possible just in case you make a mistake (such as talking about the exact name of the newspaper), in the event they do factcheck and realise it is not there + you invented a story. It would look quite bad on you if you do so • The point of this question is to test your wider reading and knowledge of things around you, not the **EXAMPLE**. So there is no need to worry about getting a specific example or your example not	

	being as “competitive ” as other candidates	
What do you think the NHS will be like in the future?	• Good to tackle this question in the long-term approach that I once mentioned in the UCAT discord. Break down the “future” into segments such as “1-Year, 5-Years, 10-Years” for three easy and simple points • Present your answer in a chronological order so it is easier to follow so tackle the 1-Year first, then 5-Year and eventually 10-Year plan • Be creative since the question does not give you much to work with, so think of creative but still feasible things that the NHS will possibly have in the future	I feel it is good for me to approach this question with an approach that breaks down the future into 1-Year, 5-Years and 10 Years from now. It would allow me to cover as wide of a scope as possible when answering this question. 1 Year from now, I think the NHS would still be grappling with the long waiting times for GPs and the impact of COVID-19 on the NHS workforce, but would be more in control of the situation. I bring this up given the current long queues for GP appointments in the NHS, with a rising demand due to an ageing population and slashed funding for the profession. While I do not expect the issue to be fixed in the immediate future, I think that the Royal College of GPs would be able to communicate this need to the government, and talks would be undertaken to resolve the issue faced currently. Additionally, given that COVID-19 is still a global issue, with no cure in sight for the foreseeable future, I think that the NHS would still be struggling to deal with the cases presented, albeit more experienced with relevant resources to tackle the number of infections. 5-Years from now, I think the NHS would have been able to control the impact of COVID-19 and the long waiting times for GPs, but instead would be facing potential issues such as a rapidly ageing population. Due to advancements in healthcare and technology, it has led to extended life for many, with the average age ballooning towards 80 years and above. This in turn would lead to more resources being dedicated towards funding of homes and facilities to take care of the elderly in the UK, which could place a strain on the NHS as more healthcare workers would need to take on a heavier workload and care for more patients such as GPs, who are generally the first line of contact for such patients. 10-Years from now, I would think that the NHS would be more developed and

	• It would be good to also note the current changes or issues facing the NHS and using that as a springboard to answer the questions, so for example if the NHS is currently struggling with GP appointment waiting times, perhaps in a year it could be still a problem but of a smaller scale, but in 5 or 10 years it would have been resolved for whatever reason • It is okay to be pessimistic or optimistic for the future of the NHS, but make sure you backup your points with relevant examples to ground your views in reality	would have incorporated the use of technology more heavily. Ranging from a nationwide system to increased integration of AI such as Robotic Surgery, this would enable the NHS to become a world leader in terms of the standard of healthcare provided. Why I feel this particular way is because while the NHS has failed to once incorporate such a system, they would be able to learn from their mistakes and improve upon them in the future, and follow in line with the rest of the world. Additionally, current medical students who are trained in the use of such technology would have graduated by then, and would be comfortable in the use of such tech, leading to the increased integration of such resources. In conclusion, while I hold both optimistic and pessimistic views for the future of the NHS, I truly believe that the NHS would be in good hands provided proper management and adequate funding.
The law states “that an organ that has	• The question is	Personally, I feel that for this law to have been instated, there must have been a

been removed from someone's body then it belonged to the government” Give your opinion on this. How would you feel about using it for research?	asking for your opinion so there is not necessarily a good or wrong stance to take for this question ● Think about the why for this question. Why did the government make such a law saying this? Was there previously a dispute over this matter? What are their intentions with this law? Is there a need for such a law to exist? ● The next part of the question is focusing on the research element. How are organs used during research? What role do they play? Can you think of any real life scenarios where body parts are used etc? ● The question is asking for feelings, so	previous dispute perhaps regarding such organ donation, where donors thought they could choose who to donate to instead of the government doing so. With that said, I personally feel that it is the right approach to do so. As organ donation is done via mutual agreement (where the donor consented to the donation and the government approved for it to be donated to those in need), it would not be wrong to place it in the hands of the government and particularly the NHS to utilise the organ in the best possible way. I am aware of certain cases where the donors in particular refused to donate to certain individuals based on their race or other factors, as such by giving the authority to the government, it would prevent such disputes from breaking out. Additionally, by placing it in the government’s possession, it allows the government to protect the donated organ with the relevant resources to prevent theft or misuse of such valuable resources. Regarding how I feel towards using them for research, personally I would feel a sense of honor and gratitude. As such resources are so valuable that not many would be able to get their hands to experiment with, they would need to be treated with care and dignity as to respect those who have donated them. I would also personally feel a sense of fascination as I am able to physically interact with the organs which is definitely an experience that few get the chance to do so in their life.

	do mention a specific feeling or feelings that you have towards it. After doing so, justify why you feel this way and also what made you feel this specific feeling? • Can you picture yourself using organs for research in medical school? Why or why not? Justify all these in your answer	
What is your opinion on euthanasia? Should it be legalised in the United Kingdom?	• Define what Euthanasia is. There is a definition in the docs for this and it would be good for you to define before continuing with your answer • Question is asking for your opinion and there is no right or wrong, just how you defend and present your point to the examiner. Focus on developing a	Euthanasia, sometimes known as 'mercy killing', refers to ending a patient's life who is suffering from an incurable and/or painful disease, or who is in an irreversible coma. I will discuss the pros and cons of euthanasia, as well as whether it should be legalised before I take my final stance on this matter. In regards to why euthanasia should be legalized and the pros of it, one factor that immediately comes to mind is that it is able to relieve the pain of those who are suffering from terribly inflicted diseases and are in extreme suffering. In the Hippocratic Oath, medical professionals swore to "first do no harm" and without the provision of euthanasia, it would be in a way "doing harm" to the patient as they are still suffering, going against the Beneficience and Non-maleficence Ethical Pillars. Additionally, legalizing euthanasia would also prevent more suffering for those who choose to end their lives alone, where things may not go in the way they expect it to. This would allow a safe and legal option for

	strong and structured answer over the worry of picking the “right” side • The question mentions legalised so has euthanasia not been legalised? If so, why not? What are the pros and cons of euthanasia? Are there any relevant points to mention such as real-life examples of euthanasia? • Question also specifies UK so your answer’s scope should be limited to the UK and not deviate from the region specified	those who choose to do so, and grant them their autonomy and dignity that every individual deserves. As for the flip side, one argument would be that if euthanasia is legalized, whoever that carries out the action of “mercy killing” can be considered as a murderer, even though it is legalized by law. It can also have long-lasting impacts on doctors who carry out such actions (mentally and possibly physically). Additionally, euthanasia sends the message that life is not worth preserving when certain conditions are met, which could lead to people choosing such an option either by their own choice (to spare others of the pain) or pressurized by those around them (who may not wish to care for terminally ill individuals). In conclusion, my stance on this matter is that euthanasia is a sensitive topic with numerous implications, and that any decision to legalise it would need to be carefully weighed and debated before being carried out. As a potential medical student, I appreciate both sides of the matter and am personally unable to take a stand on the matter as I do not know enough about this to make an informed decision.
How can medical students learn to be better communicators?	• This question suggests that medical students may currently be good communicators, but how to make them become even better?	I would first like to preface my answer that while medical students are seen as the “cream of the crop”, everyone has room for improvement and that nobody is perfect. This principle applies to everyone, including medical students. As such, one method I feel would be useful to help said medical students is to create awareness through courses (delivered by lecturers or peers). I have heard many opinions from friends who know medical students, and one common view I hear is that medical students are “arrogant” and think they are the best at

	Remember that you should not jump to say that medical students are incredible communicators because everyone has room to improve • Similarly, the question is not saying that medical students are **BAD** communicators, so please do not focus on arguing that they are good communicators • Since the command word is "How", your focus on this question should be presenting 3 logical and structured ways for students to become better communicators, not reasons to become better communicators • Think about when medical students need to communicat	all times. Having pondered and discussed this with some medical students, the issue is more that such students simply aren't aware that they come off in such a manner. As such, through events or courses to raise awareness, it would allow students to become more self-conscious and be willing to learn how to become better communicators by becoming more humble. Another method I would recommend would be frequent practice with individuals from varied backgrounds, the more diverse the better. Medical students are occasionally in their own bubble, conversing with only medical students and healthcare related individuals / patients. They are not exposed to communicating with others outside of their own environment and as such could struggle in communicating with students from other courses or the general public in general. By encouraging medical students to engage more actively with others through activities such as community attachments, this would help provide frequent practice and in turn allow better communication skills to be honed by these students. In conclusion, by tackling the root cause and encouraging frequent practice, it would lead to a more refined honing of the communication skills necessary for medical students to become better communicators.

	e and to whom they are communicating with. This serves as a driving point for you to think of solutions, essentially giving you the context needed to formulate solutions • Think widely of people they communicate with (patients, healthcare staff, friends, family, lecturers etc) and see if you can lump some of them into a group so you can answer them evenly	
Take us through today's journey from your home to the interview.	• A little unconventional question designed to throw you off but it is a good way to show your creative thinking • Think about the big aspects but try not to dive too deep into the details (i.e I don't	[redacted]

	need to know how much every ticket costs) • Think about the special things that you saw on the way, especially if you travelled across the country to come to the interview • The journey can be not physical also, it could be an emotional journey that you took such as the emotions you experienced from the start of the day until you just entered the interview session • Remember to stop every now and then to ask the interviewer if they are still following because it might be a little confusing for them to follow directions, especially those that are listed extensively	[redacted]

How will your extracurriculars help you become a better doctor?	• First, define what your extracurriculars are. What did you do? When and how did you do them? What about these extracurriculars? • Remember to reflect deeply as well regarding what you learnt and what you experienced, and also note what traits or experiences would a good doctor possess • The question is also posed in a sense that these experiences from your extracurriculars somehow make you a “better” doctor, so how so? Break it down clearly and in an easy way to understand • The question is posed with the command word being	I was in a Dance society during my A levels and participated in numerous leadership boards before my A levels. These experiences have allowed me to grow overall as a person in many ways, which I will break down in my answer below. During my time in the Dance society, I was the vice-chairperson and was exposed to numerous scenarios such as the national competition for Performing Arts. This experience allowed me to develop my leadership skills in directing a team towards a common goal, which would be really important in the healthcare scenario as a doctor as the doctor has to lead the healthcare team in the care of patients. Additionally, my time in Dance instilled in me a strong sense of discipline and commitment to the cause, where I put in hours of training everyday in preparation for the success of the event or performance. This would be particularly impactful as a doctor as it is the discipline to constantly place patients first in everything that we do and be committed towards patient-centered care in our daily interactions. Moving on, my time in leadership boards taught me the importance of respect and how it is earned, not given. This is particularly important as a doctor as it would guide my actions as a professional to always strive to provide the best care possible and work for the respect of patients, instead of assuming that it is a given. Furthermore, it provided me with many soft skills such as interpersonal communication where I had to communicate with many varied individuals, which would mirror how doctors interact with patients from diverse backgrounds and would be especially important in the healthcare profession. In conclusion, these skills are the foundation for a doctor’s duties and with my skills being refined and enhanced from frequent practice and exposure, it would allow me to become more proficient and confident in my duties to become a better doctor.

	“How”, so your answer should be structured in a easy to understand manner	
What motivates you in medicine? Tell us about a situation where you showed empathy. (I am not answering this question here, as I have done it above)	• The question is asking for your motivation, so break it down in a clear manner since motivations are not always the easiest to comprehend. • This is essentially your Why Medicine, so think deeply for this question and do not be afraid to take some time to really think before you answer this question. • The second part of the question is asking you about empathy and how you demonstrated it, so the STARR method is a very good way to break down the situation and	My motivation in medicine is probably similar to many aspiring candidates who are applying for medical school, and given how motivations are generally quite complex, I will attempt to break this down as best as I can. My first interest in Medicine was when I was exposed to the profession through frequent interactions with my family GP. Since I was young, I was told by my parents that I was not the healthiest baby, suffering from bronchitis and anemia inherited from my mother as a newborn. This in turn led to numerous visits to the GP and hence allowed me to be exposed to how the doctor conducted himself and the way he seemed to be able to “cure” any issue he faced. I still remember to this day his kind demeanor and patient communication (often breaking down the scary terms into things that I could understand and comprehend). This in particular sparked an interest in me regarding the profession and served as my role model for any interaction even till today. As I grew older, I developed an interest in the difficulty and intricacy of the profession. As someone who appreciates proving myself when dealing with difficult and complex situations, it is no surprise that I migrated towards the profession in particular. Especially during my work experience, I witnessed up close the amount of knowledge and dedication these professionals commit themselves to, which is a lifelong learning process with the constant need to upskill themselves. This served as an inspiration as it aligns with my personal work ethic to constantly push myself to higher limits and never to settle for less when I am able to do more. Lastly, having talked to current medical students and doctors, I also fell in love with the idea of becoming educators and

	what you learnt from it • While the question is not asking you to talk about what you learnt, you should still mention your reflections and how it has helped you grow and develop as a person and how this falls in line with your motivation to do medicine	guiding the future generations. As someone who took numerous leadership positions over the years, the interactions and experiences of guiding the younger generation to their goals and dreams have been some of the best experiences I had the privilege to experience. In this profession, the chance to become CTFs (Certified Teaching Fellows) or lecturers to guide the younger generations was a major draw for me, and the chance to play a role in developing the future leaders was a major inspiration for me when deciding upon this profession. In conclusion, these reasons serve as my motivation for Medicine and while there are many more reasons that seem generic, they all accumulate to form the passion and motivation I have for this career option.
Burnout rates are one of the highest in medicine among all professions. How will you manage the stress, pressures and emotional toll that you'll likely experience as a doctor?	• The question phrases it in the sense that stress, pressures and emotional toll are all different aspects, but is it necessarily different? Stress is a form of pressure and the emotional toll is definitely pressure in a sense • If you have different ways to deal with stress and/or pressure, just pick one or two to	I think it is important to break down each factor before addressing a possible solution to manage them. Stress as a doctor could relate to the juggling of clinical, academic and managerial duties, or the decision-making necessary. Personally I feel this would be addressed with proper time-management and proper planning to deal with the tasks on hand. By having perhaps a planner for everyday duties, including writing down appointments, it helps to relieve the stress of maintaining and keeping track of everything, allowing you to maintain a sense of control in an already hectic environment. By feeling a sense of security and avoiding possible surprises, it would go a long way in addressing the responsibilities and subsequent stress. While I acknowledge it is not always possible to keep on top of responsibilities or things could always overrun, it is still helpful if you could address most of the stress experienced. Regarding pressure, I feel it is related to the pressure of always maintaining a professional image or being "all benevolent". One way to deal with this is to know when to ask for professional help. While it may seem highly stigmatized to ask for help in a profession

	develop your answer with • It is also very important to define what the stress and pressures are in the profession, as well as what causes the emotional toll for a doctor. It will be good to keep things generic first such as focusing on GPs before diving into specialities • It is also good to note why is there such a high burnout rate in the profession so how do your methods specifically deal with the causes • The question also mentions "likely experience" so you can bring up the fact as well that you might not face all the aforementio ned issues, but your	of helping others, it is important to note that we are still human by nature and knowing when to ask for help is a strength, not a weakness. This would allow us to deal with the pressures of such an environment and release some of the pent-up energy or emotions experienced as a doctor in the healthcare scenario. Lastly, the emotional toll could be the possible burnout experienced by professionals or the weight of the wrong decision made in certain healthcare settings, where it could be life or death depending on the actual setting. As such, one method I would deal with this is to approach professional help or take a break when matters get too serious. How this differs from asking help would be that I am seeking out professional support instead of my friends and family as they may not be as qualified to help manage such emotions. By talking through such experiences and obtaining support from the NHS services, it allows me to detach myself and give myself a break from all the worries plaguing me. In conclusion, while burnout is definitely a big issue in this profession, I believe with these methods, I would be able to regulate and deal with the issue when I face them.

	methods can still resolve them	
How will you contribute to X University?	• It is good to know that your contributions can be in almost any category and can possibly be valid. Examples could include academic contributions, social contributions, non-academic contributions, contributions towards the overall school or city etc • Academic contributions: What kind of contributions could it be? Research is probably the most common one, but could there be more etc? • Social contributions: Think about this in the sense of the medical school community (not the	I feel that contributions can occur in many ways such as academic, non-academic and even social contributions which I will attempt to break down in my answer below. In terms of academic contributions to the university, I aim to participate in research opportunities as much as I feasibly am able to. I acknowledge that I may not necessarily know as much regarding research projects as other candidates as I did not quite have the opportunity to do so during my A levels apart from my Project Work (essentially UK EPQ). Additionally, I was not that interested in the traditional options offered then, and focused on honing the skills such as attention to detail and task management which I hope to be able to utilize more during my research projects in the university. In regards to non-academic contributions, I hope to join (insert club name / society) and contribute to the efforts to win national competitions / championships as I have been doing this since young and feel that I can bring this expertise to the table to improve the team currently. Additionally I would like to partake in outreach programmes hosted by the school to reach out to support students in their application to medical school / the community / homeless charities etc. As if I get into medical school, it would be an achievement of a dream of mine and I would like to personally support others into achieving their dreams just like how I attained mine. Having come from an environment similar to those who need help, I personally relate to the struggles faced and would love to do anything possible to aid others overcome their situation. Lastly, I would like to pursue one of my hobbies more in-depth in Medical School, which is photography. How this would be useful to the university would be that I would be willing to help work on publicity / coverage of events through pictures and

	entire school community first). Focus on the medical school community, how can you make this community better? How can you improve this community and make the medical school better overall? • Non-academic contributions: This is also a good thing to talk about, and usually most will jump straight to clubs and societies. Focus on that! How can you contribute? Win championships? Improving the reputation of the society in the city/town or even on a national level? • Contributions towards overall school and city / town: This would be more	work with others in the promotion of the university. As someone that runs a YouTube channel, I have some understanding of business / marketing which I think is useful to the university in particular where the university would like to be seen in the best possible light. Admittedly I am unsure of the specifics but I still feel that I could contribute this to the university if I were to get in. In conclusion, these would be some of my contributions to the university, which I feel would have a tangible impact on the community and university as a whole.

	towards your own personal businesses or hobbies. What can you do? Can you provide a service / an experience that others are unable to do so? Think more creatively about this, and do not be afraid to take your ideas and develop them to be interesting selling points about yourself.	
What has been the most challenging thing about doing your EPQ / A Levels and how have you overcome it?	• Most challenging in what sense? Academically? Psychologically? Emotionally? It would be good to mention that what is challenging to people is **DIFFERENT** for everyone, but **YOU** found this the most challenging • Whichever you pick, remember that the	Personally, my A levels were a difficult time in my life as I was struggling with a lot of responsibilities, emotional troubles and external pressure. While definitely difficult to specify one thing, I could view this as my biggest challenge given the impact it had on me as a person. The most challenging thing during my A levels was dealing with my expectations and how I saw myself. As someone that was never exactly gifted at academics, I always had to work harder than the others around me to keep up with academic content and knowledge. Additionally, having undertaken leadership positions (as the vice-chairman of the Dance Society) I was under heavy scrutiny from everyone around me to be the best leader, infallible in any aspect and always doing the right thing. Coupled with the pressures my teachers placed on me to become a role model, I struggled to stand under the weight of the expectations and constantly felt dread, anxiety over what others viewed of me.

	example is not the main focus, the more important thing is the experience and what you learnt (Use the STARR technique) • The next part of the question is also asking about the **HOW**, so it is good to detail your answer in a clear and easy way to follow • Try to focus on one example instead of listing examples because that would just lead to underdeveloped answers	Additionally, my parents and I were going through a difficult period, and it only added on to the list of issues I faced. As a result, I felt the devastating pressure of being seen as a failure and it severely crippled my confidence and self-belief. I truthfully did not know who I was, and having the mentality of always needing to live up to the image others wanted of me, I could not bring myself to look at myself at all and constantly struggled with depressive episodes. While it may seem a little cliche, after one particular breakdown nearing my A levels, I felt an overwhelming desire to break free of all these expectations placed on me, and to simply just be happy. I started cutting loose the expectations others had on me, and focused on realistic but personal goals for myself such as maintaining a pass grade for my results, and simply being more forgiving to myself when I made mistakes. The process has not been an easy one by any means, but I have been on the road to recovery and am feeling better by the day. By placing myself first, I allowed myself to learn that by being in optimal condition, only then will I be able to help others. The saying goes that "You can fill other people's cups only when you are filled" and I truthfully stand by that ever since my A levels. As such, it is the most challenging thing I overcame given the extent of change I experienced as a whole.
Have you witnessed any examples of inappropriate behaviour during your work experience?	• The question mentions "any examples" so it is okay to mention multiple but then again, do try and keep it within 2-3 examples so that you have the ability to develop all	Personally, during my few months of work experience, any instances have been few and far between but there are two examples that come to mind. I would also clarify that "inappropriate" in this sense would be considered as against the code of conduct from doctors or unprofessionalism in general. One example that I have witnessed would be the way doctors and nurses carried themselves in front of patients during my surgery rotations. While this could be different due to work experience carried out in different countries, one thing I feel that it is standardized would be that ORs are meant to be sterile and clean, and that professionals should stay

	the points that you raise • It is also mentioned that “witnessed” so you should have seen it with your own eyes, so basically not hearsay. • The question also mentions “inappropriate behaviour” so it is inappropriate in what sense? Define what the appropriate behaviour is first, before saying what inappropriate behaviour you witnessed • You should also note that what you deem as “inappropriate” may not actually be inappropriate, so how do you deem it as inappropriate? What guidelines did you follow? Or perhaps was it clinic or	professional when the patient is in the room, regardless of being awake or not. However, throughout my attachment, I consistently noticed that the healthcare staff would use their cellphones in the OR, sometimes even during the operation itself. Additionally, they would be talking about other matters such as ordering lunch during the operation where the patient can hear them, which can leave the impression that it is quite unprofessional. Personally, while I believe that the environment can be casual / comfortable to avoid unnecessary stress, a certain level of respect for the room and occasion would go a long way. What is routine for these professionals may not be the case for these patients, and we should treat every patient with a certain level of respect. Another example that comes to mind would be a case when we had multiple surgeons in the room to deal with a particularly complex case. Due to the intricacy of the case, I was not given much explanation and was only allowed to observe the operation from outside of the OR. Given that most of the operation was carried out in silence, it was particularly shocking to me when I heard an exclamation of the doctor at one of the nurses, ordering her to get out of the OR. While the patient was under anesthesia, it was quite unprofessional to scream at a fellow staff even with the stress and pressure faced. I had heard that some of the nurses have experienced such treatment on a regular basis, and either way it is still unprofessional to do such a thing. Additionally the surgeon did not apologize for his actions afterwards, which shows a lack of respect and regret for what he had done. All professionals deserve to be given respect and a safe environment to work in. In conclusion, while few and between in terms of instances, I did witness some of these experiences and took away some valuable lessons as well, learning points to support me if I were to become a medical professional.

	hospital policy etc?	
What's the single most important lesson you took away from your work experience?	• Good to note that work experience actually allowed you to take away many lessons and that it is hard to actually to pinpoint one • Most important in what sense? Important in the sense that it was so unique that you might not be able to learn it as well? Or important in the sense that it helped greatly improve your understanding of the profession? Or is it so important that it lead to huge personal growth etc • It is also important to highlight why it is so special to you and why you felt the need to highlight it • STARR is really	[redacted]

	important and also using a reflective method (such as the 4 F's) is also a good way to help you reflect	[redacted]
What steps have you taken to find out if medicine is the right path for you? Why would you make a good doctor?	• First part of the question is asking you about the steps you take. So you should break down the steps. Was it physical steps in the sense of like work experience? Or was it physical in the sense that you took up relevant medical readings or went to open days etc? • I think it would also be a good thing to mention that you took emotional steps as well since it is a difficult choice to make so what kind of emotional preparation did you take for this role?	I took both physical and emotional steps to determine whether Medicine is the right path for me. Given that Medicine is such a complex profession, it is difficult to ascertain if it is the right path at such an age where exposure to the field is limited, and I came to the conclusion with the amount of exposure I had. The physical steps I took would probably be the same as any candidate, where I read up medical articles / biographies of doctors to learn more about their profession and lifestyle, coupled with work experience and participated in an open day where I got to listen in to a medical lecture carried out by the school to get a taste of the profession. I also spoke with current professionals (doctors and nurses) to learn more about their duties and what they learnt from doing this particular career choice. The emotional steps would be less quantitative where I reflected upon these physical actions and asked myself if I would be okay with pursuing such a career option, and that I may not earn as much as other possible jobs. I also took the time to really think about what I wanted to do in life and the main goal I would like to achieve from my profession, before coming to a decision. In regards to why I would make a good doctor, I personally feel that I would as I currently possess the basic skills essential for the profession and that through medical school I would be able to refine these skills and hone them to the best possible level for execution purposes. While other candidates may also possess such skills, I believe that my skills are more refined than theirs as I have had frequent exposure to diverse environments to practice them. While

	• You should also mention that it is difficult to ascertain that it is the “right” path, since it is such a big career choice to make, that even professionals now may not necessarily know if it was the right path • Second part of the question is asking why you would make a good doctor. It is very important to define what a “good doctor” is first • Everyone’s definition of a good doctor is different, so focus on explaining your answer clearly over trying to get the “correct” traits • Explain your characteristics clearly, focus on your special traits (which still align with medicine!)	difficult to determine exactly what skills a “good” doctor possesses, interpersonal communication in a clear and concise manner as well as empathy + selflessness are skills that are fundamental which I believe I have and have been refining them throughout my years. Additionally, I have been described to be selfless and adaptable to any situation faced, traits which may not be applicable to everyone, that I would always be willing to put other people’s best interests first whenever feasible and would be able to react and respond in a dynamic workforce such as Medicine. In conclusion, while it is difficult to ascertain immediately whether I will be a good doctor, I feel that my belief and maturity would serve me well throughout my journey if I were to become a healthcare professional.

	and make sure that you really show that you are unique (compared to the other candidates)	
A 14-year old boy is rushed into A&E after a car crash. The patient is unconscious and has sustained huge blood loss as a result of the accident. Together with your team, you decide the boy requires an urgent blood transfusion. As you are about to take the boy into the OR, his parents arrive and forbid you to carry on with the blood transfusion on religious grounds. How would you proceed, and what factors should you consider?	• Very common ethical question, it is recommend ed for you to familiarize yourself with the answering of such questions • First, the 4 pillars of Medical Ethics will play a **HUGE ROLE** in your answer so you must familiarize yourself with these ethical pillars • You should also know that the factors you are mentioning it should be relevant to the situation • Take note of the situation given (that the boy had already suffered huge blood loss - so if you do not	In this scenario, given that the patient is unconscious, Gillick Competence may not necessarily be applicable as the patient lacks capacity to determine the best course of action for himself and that the responsibility for what happens next would fall to either the parents or the healthcare team. One factor I would definitely consider would be the ethical pillar of Autonomy, where all patients have the right to consent to certain treatment options and can also deny it if necessary. However, since the patient is unable to verbalize his opinions regarding such matters, the responsibility would then fall onto the healthcare team, possibly the doctor who would be in charge of the team. Now it may be a little confusing as to why the parents are not given the authority to make the decision, but based on the BMA toolkit for determining best interests, the next of kin are not granted the power to make decisions just because of their relationship with the patient. In such a scenario of life and death, the clinician with the highest authority would be granted the power to make the decision. Another factor I would also consider would be the ethical pillars of Beneficence and Non-maleficence. Given that the 14 year old boy has suffered huge blood loss and is in immediate danger of losing his life, it would go against these pillars to decide against providing blood transfusion as it would be harming the patient and would not be doing good to the patient in particular. In order to save his life, action has to be taken which would fall in line with the ethical pillars. Lastly, I would also consider the opinions shared by the healthcare team and the parents. The parents have a right to

	take action he would die) + (unconscious - cannot give consent to the decision, basically he lacks capacity, how does that affect your approach? A & E - It is a high pressure scenario to be in, will it affect your decision making?) • You should also take note of the Gillick Competence, while probably not going to be a big point, it is also a way to flex your knowledge and understanding • Religious grounds VS saving the patient's life? Which is more important? How do you act in the patient's best interests?	express themselves and their opinions, and it should be undertaken into consideration for decision-making. According to the BMA Toolkit previously mentioned, the healthcare team should also be consulted as any individual involved in the care of the patient should be consulted before a decision is made. In conclusion, what I would do is to express the immediate danger posed to the parents and be fully transparent about the potential death to be faced by the patient, providing them full disclosure to make an informed decision. If the parents still decide on not granting permission for a transfusion, I would then consult the healthcare team and with the assumption that I am the most senior authority, I would authorize the blood transfusion as I am keeping the patient's best interests at heart and protecting the safety of the patient.
Imagine you are on a raft and swimming	• Remember the scenario	In such a scenario, I feel it is best to prioritize safety and the three basic

towards a deserted island. Luckily you have a backpack with a few necessary items for survival. Suddenly your raft starts to sink. You need to get rid of five out of the ten items listed below. Which one's would you choose and why? Items: Box of matches, Water repellent jacket, Hammock, Sunscreen, Box of sardines, Mirror, Cell phone, Encyclopedia, Flip flops, Knife	given to you, that you are swimming towards a deserted island (so you may not have the 3 basic necessities for survival) • Think of the items and their uses, so what can each item contribute towards your answer • The items themselves don't matter as much but what is more important is your why behind picking each item • Structure your answer in a clear and logical manner so it is easy for the examiner to follow • Develop your answer for each item as evenly as you can since you have to mention 5 items you are getting rid of and why • Note the question is asking you	necessities for survival (which is air, water and food). Based on survival guides, the most important resource apart from food would be water as humans can survive weeks without food (assuming a healthy human being). As such, the 5 things I would get rid of would be the cellphone, sunscreen, flip flops, sardines and encyclopedia. I will break down my reasoning for my choices. Cellphone: Given that it is a deserted island, there would probably be no cell coverage, rendering the one use of it irrelevant. Additionally, since I am swimming to shore, it has a high chance of getting wet and would destroy the phone anyway which makes the entire phone a brick with no use. Sunscreen: While it is tempting to have protection against the sun, which would allow you to be more active during certain hours of the day, the other items have much more use and would be more essential for your survival. Additionally, it also allows you to also get rest during the particularly hot hours in the day, which maintains your water levels by avoiding sweat. Flip Flops: I was considering keeping the flip flops initially as it would allow a small form of protection against potential injuries such as sharp objects in the floor, it seems to only have one use and the plastic / material that the flip flops are made of do not particularly support me in any other way for my survival. Sardines: While it is an odd choice, as sardines are a form of food for sustenance, as mentioned it is not the biggest priority at the moment and that the other items have much more use for the long term as compared to sardines Encyclopedia: While possibly a great source for fire, given that it can be lighted immediately to keep you warm, there would be other drywood around that could also serve as a fire source on the island. Additionally, if it got wet on the swim to the island, it would be rendered useless as the pages would be too wet to be lit to make a fire. In conclusion, I threw out these items after considering the usefulness of such items in the short and long term. In an

	to “GET RID” of 5 items, not asking you what 5 you will keep, so your answer should be focusing on why these 5 items should be removed (do not get confused!) • There is no right or wrong answer so just think of items you would personally choose to remove and explain accordingly	ideal scenario, I would have carried all of them but I prioritize the bare essentials when making such a decision.
What are the largest challenges doctors face nowadays?	• The question is asking “largest challenges” so they should be significant in some way or form • The question also dictates “nowadays” so it should be recent and not too outdated • Reading up on the NHS Hot Topics would definitely give you some talking points for this question	Given the ever-evolving nature of the profession and workforce, doctors face many challenges of varied natures nowadays, but the challenges that pose a biggest threat would be the danger of inflation, being made redundant and the potential dwindling of the workforce. The first challenge that comes to mind would be the rising inflation and the insufficient pay for healthcare professionals. I am sure we are aware of the strikes carried out by healthcare professionals such as the recent JDs strikes and the nurses striking not too long ago, where the healthcare professionals essentially were struggling to keep up with the rising prices due to inflation and their wages not being adjusted accordingly. Why this is such a big challenge for doctors would be that they would be unable to pay for their bare essentials or support their families, leading them to possibly taking on more shifts just to survive, which would inherently impact the quality of care delivered and eventually patient safety.

	so do read up • The question also mentions “challenges” so your answer should touch on at least 2 challenges faced • Think critically, is it monetary? Work-life balance challenges? Public challenges? Be willing to think outside the normal standard answers such as COVID-19	The second challenge would be the threat of being made redundant by AI and relevant healthcare technology. With AI and the increasing use of technology in fields such as Surgery or Radiography, it is without a doubt that the increased use of technology has made certain actions / jobs easier to manage. As such, with increased integration, it raises the question of whether such technology could overtake professions such as nurses where AI could end up doing the duties executed by the current professionals. While healthcare professionals do take on upskilling lessons to stay relevant, if the advancements in technology exceed the rate of upskilling, doctors could eventually be threatened being made redundant which is definitely an impactful challenge of considerable scale. Lastly, the challenge that could have the biggest impact would be longer, more strenuous hours caused by the dwindling workforce. COVID-19 has really shown just how heavily taxed the workforce is, with exceedingly significant amounts of work to be done in terms of managing patients. Doctors were working longer hours with little to no time for personal rest, demonstrating the poor work-life balance. Coupled with Brexit, this caused many healthcare professionals to resign and leave the workforce, which leaves a vacuum in the workforce where medical schools may struggle to fill. This in turn would lead to increased demand for healthcare professionals to step up and take more shifts to cover the amount of work present, which possibly could lead to resentment and eventual collapse of the system. In conclusion, while the future is uncertain, based on current trends and occurrences, these would be some of the biggest challenges faced by doctors.
What are the advantages and disadvantages of being a GP and the first point of contact for a patient?	• This question is asking you for your understanding of being a GP and it	GPs in the NHS are generally the first point of contact for a patient, where they refer patients on to specialists if necessary depending on the case of the patient. An advantage of this that I foresee would be that GPs would feel like they have

	wants you to discuss the pros and cons • For both advantages and disadvantages, place yourself in the shoes of a GP which could help make things easier when formulating talking points • Think about the roles and responsibilities of being the first point of contact. How does that differ from other specialities that do not need to be the first point of contact? • Understanding of how the NHS functions would be an excellent way to approach this question, so reading up on this would go a long way	genuinely made a difference in the patients' lives as they would have played a key role in impacting how the patient undergoes the relevant help and support. Compared to other specialities where you may not see patients on a regular basis, GPs would feel that they made more of an impact, perhaps causing higher job satisfaction and overall improved mental well-being. Additionally, being a GP has a lower chance of experiencing extremely high pressure scenarios as compared to specialities that involve themselves in life or death scenarios such as A&E. They would feel less high pressure, high stakes and could overall feel happier in the duties and responsibilities they have, potentially having a better work-life balance. However the most likely disadvantage would be increased risk of burnout. As GPs see more patients on a regular basis, it could cause monotony in the job and perhaps on busier days, they could have little to no time for themselves, leading to higher risk of burnout. Additionally, they may face higher workload as compared to those in the hospitals. This is because in a hospital, chances are that you would have more doctors around to balance out the workload present, but in a clinic setting, it would be likely only 1-2 GPs around. As such, they would have to handle more responsibilities as compared to other professionals, which could affect their work-life balance in a negative way. In conclusion, there are advantages and disadvantages to every profession, and to a GP it is no different.
What are the long-term consequences of Covid-19 on the NHS and its patients?	• What is long-term? I suggest using the	It would be good to look at the consequences in the long-run in terms of yearly blocks, such as 1,5 and eventually

	same approach of breaking down your answer into 1-Year, 5-Years and 10-Years • Consequences usually imply negative impacts, but can it be positive? Can you think of anything positive? • The question mentions the NHS and the patients, so in each paragraph you answer, you should also mention both of these groups and the impacts it has on them • COVID-19 is explicitly mentioned in this question so you should raise up relevant examples (especially in the UK since NHS is mentioned)	10 years, to provide a comprehensive understanding. One year from now, I feel that the NHS would still be grappling with the impact of COVID-19, albeit having a better understanding of how to control the spread and infected patients. The NHS would also be able to better delegate resources to manage and care for those infected. Given that COVID-19 has shifted from a pandemic to endemic, it may not be likely to have a cure in the immediate year to come, but the experience would definitely contribute towards better quality care for the patients. 5 years from now, I feel that the NHS would be able to deal with COVID-19, either with a cure or herd immunity, but could be still struggling with the management of patients given the workforce vacuum caused by healthcare professionals striking or leaving. As we are aware, there have been articles published of healthcare professionals striking or leaving the workforce due to issues such as Brexit or unfair working conditions. This will cause a gap in the workforce as the training of healthcare workers would take at least 5 years in the case of doctors, and that the workforce issue cannot be immediately dealt with just by bringing in foreign labor. As such, patients may struggle with achieving enough / sufficient healthcare, as healthcare professionals struggle to take up the workload left behind. 10 years from now, I feel that COVID-19 would be a thing of the past and the workforce issue would be better managed, while not completely resolved. Most healthcare students in training would have graduated and assuming the majority enter the NHS, it would definitely plug up the gaps in the system to some degree. Regarding COVID-19, even if a cure is not produced, herd immunity / mass vaccinations would have reduced the threat to the same scale as the common flu. Enough experience over the years would also help with the management of such issues.

		In conclusion, this is how I view the future of the NHS and the possible consequences on the NHS and patients.
How would your friends describe you?	• It is common to panic and worry over the attributes to choose for this question, but the examiners are more interested in the reasoning behind it and how you substantiate your answers • The question mentions describing, so the process should be detailed. PEEL approach is recommend ed, with emphasis towards the Example and Elaboration • Pick one example that supports your point (aka it should be relevant to what you are talking about) • While the term "friends" is	Two attributes commonly attributed to me would be resourceful and persistent. I will attempt to break it down as concisely as possible in my answer. As mentioned, one attribute commonly mentioned would be that I am resourceful, able to make the most of what is given to me and even make something from nothing. During my A levels, my friends observed that I would study and exhaust all possible materials given to us students (either in lecture slides, tutorials, practice papers), all while approaching friends from other schools to request for their materials to cross reference with what I was learning. While I was not consciously aware of it, my friends later informed me that I had done every single exam paper from every school before my A levels, as shown from the pile of papers in the corner of my room. This showed in my A level results where I ranked top 3% in the entire national population and my ability to take the best out of anything I am given, and make the most out of it as much as possible, where in medical school if I am accepted, I could do the same and bring out the best in everything I do, everyone that I meet. A second attribute would be that I am persistent, determined to reach the end goal regardless of what it takes for me to reach it. While I was aware that generally I can come off as someone determined, that I would be willing to do whatever it took for me to achieve my end goal, I was not aware of just how intense it could come off to others. During the training for national competitions in my Dance society, I would be training every opportunity I could from rehearsing the steps in my room to waiting for classes to begin or even during weekends where I would head to public spaces to practice for it. In my friends' words, "Once I set my mind to a goal, nothing in the world will stop me from getting to that goal". While others may be deterred from the time and hard work needed to get to the end goal, I

	used, it does not really mean it must be friends. You can link it to perhaps family or people you have shadowed if your friends really did not say much (so no need to panic if you are not able to think of any)	view it as nothing more than the process, which this tenacity could serve me well during difficult times in medical school if I were to make it. [Additional Point: One other attribute would be that I thrive under pressure and high-stakes scenarios. As someone who has always felt inclined to take up leadership positions / voted into such positions, I am frequently exposed to tasks that are challenging or to care for those under me. All these scenarios place a constant pressure on me to live up to certain expectations and perform to a certain standard. While others may buckle under such scenarios by feeling overwhelmed, I instead thrive and perform above and beyond expectations. The best example I have would be during my A levels, I was vice-chairman of the Dance society and also involved in school-wide projects such as running Fresher's Camp and Orientation. Not only did I perform excellently at my A levels, I had led my Dance society to 2 national distinctions and successfully executed those other events as well. This would serve as a testament to how I could function in medical school, if I do make it.]
What are the 3 most important qualities for a doctor?	• How do you determine what is most important? Mention that most important defers in many, if not all situations and people (so this would be highly situational) • Recognize also that what is most "important" in one situation may not be the most	In my answer, I define the term "most important" to refer to what qualities have made the most impact on those around them. The first quality I would mention is empathy. Empathy refers to the understanding of others emotions, while you may not necessarily share it. Why this is so important would be because as a doctor, you most likely would not be suffering from the same illnesses as the patients who are consulting you, however you will need to be understanding towards them and work with them towards a solution. Without empathy, this would lead to a cold-hearted individual and perhaps cause a gap between the doctor and the patient from a lack of trust, which severely undermines the relationship and hence action undertaken. The second quality would be compassion. This quality particularly stood out to me when I witnessed a

	important in the next. ● Set the context and scene clearly for the examiners to know why **YOU** think this is so important ● Think of the roles and responsibilities of a doctor, and how these qualities complement / improve / support the execution of such responsibilities ● Draw examples from your past work experience, what have you seen IRL and how it was implemented to ensure a successful action / outcome ● Keep it to 3 since the quantity is specified, so no more or no less should be mentioned	doctor sit down with an elderly woman who was struggling with the physical pain from her symptoms for over 1 hour during her own break to listen and try to relieve the elderly's pain. The doctor simply did not have to do so, but felt that it was more important to listen and provide support when no one else would. Why this is so important for doctors is because without compassion and the desire to help others through their pain, the profession simply cannot function as doctors would not seek to help others when they are suffering. Lastly, the third quality would be communication. In a field that is so important, there is a lot of medical jargon expressed during discussions or diagnosis. However, to the common individual, they may not necessarily understand what it means, and could be confused. As such, communication is so important as without it, patients would not be understanding of what they are facing and could severely hinder the acceptance of treatment or communication of their issues. Having witnessed multiple consultations throughout my work experience, one thing in common was the doctor's willingness to simplify things or to use the "common slang" to express certain things to patients. Without this quality, it would be impossible for anything to get done as the lack of understanding is huge. In conclusion, while these qualities may differ compared to other candidates, it is important to recognize that different qualities become most important in different scenarios and that it is best to have picked 3 general attributes to cater to as many scenarios as feasible.
Empathy vs sympathy - what's the difference, which one is more important in medicine and how	If you are like me and am not quite sure of the difference, do read up on it (it is quite unique and different depending on the	Empathy refers to the understanding of certain emotions, while you may not necessarily feel the same or share the common feelings. Sympathy refers to the sharing of common emotions, that you

can they be cultivated among medical students?	context it is used in). It should not be used interchangeably if anyone is curious. ● Empathy: You have empathy for a person when you can imagine how they might feel based on what you know about that person, despite not having those feelings explicitly communicated. Ultimately, you are understanding. ● Sympathy: the act of having common feelings, the act or capacity of entering into or sharing the feelings or interests of another. Essentially, you are sharing. ● The question has a clear structure of what is to be answered: The difference, which is more important, and **HOW** they	feel the same as whoever is involved. The difference would be that sympathy means both share the same emotions, but empathy does not necessarily mean so. As to what is more important in medicine, it would be highly dependent on the scenario and the context given. While empathy should be a given for most if not all doctors, sympathy will also come in useful in certain scenarios. For instance if the doctor has lost a loved one before, when consoling relatives, it is easier to express and share the same emotions. However, empathy is more utilized in the everyday duties of a doctor, where you might need to empathise with the patient and their context when devising a plan for their treatment since you might not have experienced the same thing as them. As such, it would be difficult to give a general answer that encompasses all. One way to cultivate empathy for medical students would be to provide them frequent exposure to patients / individuals from diverse backgrounds. While some may argue that empathy is an emotion, I view it as a skill where you get better at understanding and expressing empathy with more practice. By allowing medical students to communicate with individuals from various backgrounds, empathy would become more natural and used by medical students as they understand how these patients are impacted. Regarding the cultivation of sympathy, it is difficult to do so especially if the students do not undergo a similar experience. As such, one way would be to encourage students to read up more about how it feels like to be in such scenarios, and to digest the emotions felt, in hopes that they would be able to share such emotions in the future.

	can be cultivated **AMONG MEDICAL STUDENTS**. Make sure to address all 3 points • Can one emotion be more important than the other? Which is more important is **HIGHLY** dependent on the situation and the task in Medicine in particular, so you should mention it is not possible to always say which is more important? • You should aim to provide two scenarios (one for each factor) where it is more important than the other, to provide a balanced argument • In regards to the last part, the **HOW** should be addressed clearly and directly, detailing a	

	few solutions / methods (ideally 2-3) and keeping it relevant to medical students • Anything proposed should be feasible and practical (nothing too extreme)	
What do you like doing in your spare time?	• This question is more of a personal question, and you do not need to link it back to medicine (it is quite awkward to do so as well) • Keep the points to about 2-3 at most, focus on developing them and highlighting unique things about yourself (demonstrate the importance of work-life balance in your answer!) • The focus of the question is not to give extremely quirky answers or make	Personally I am an avid photographer and someone that likes to dance. Photography has always been a draw for me, as I love the idea of capturing a moment in time that we may never get to experience again, especially since time passes without stopping. It is even more impactful for me as I personally enjoy seeing the excitement and joy others have when I take a nice picture of them, to keep or post on their social media platforms. Additionally, photography to me is an art, where it can serve as good or bad memories, and definitely provides many lessons depending on the occasion taken. As the old saying goes, “A picture is worth a thousand words”, it really encapsulates the setting, context and moment and records it for the future. Dance on the other hand is my way of expressing myself. Since I am not the best at vocalizing my emotions in the form of singing, I prefer to express it through dance. Not only is it a way of exercising, it is also a way for me to unwind and take a break from the hectic nature of studying for my academics. Additionally, I dance to train my self-discipline and to remind myself that excellence can only be achieved through hard work and persistence. Just like any skill or profession, to be good at it requires the effort and the determination to stay consistent throughout, which dance is able to provide for me. It maintains the work-life balance which is so important in the career I wish to

	yourself seem so special with special hobbies, but it is more of an icebreaker to get to you know more as a candidate and build any follow-up questions if there are • Keep things simple, but show your passion about your hobbies / what you enjoy doing	pursue so as to be able to provide the best quality of care possible.
What's the one thing you are most proud of?	• Whatever it is, make sure that you justify why you are so proud of it (perhaps it's the journey that you took to get there, or the achievement itself etc) • Focus on just one aspect by the way, since the question's requirements is "one thing" • STARR approach is recommended for this, or PEEL is	I have had quite a few big achievements in my life, accomplishments that required a lot of commitment and established the amount of effort it took to attain it. However, the biggest achievement that I am most proud of was how I developed and matured as a person throughout my A levels. When I first started my A levels, I was someone who was so focused on being happy for others, and that I should always fit in with others. I could not accept that other people did not like me and always put others before me. It has always been ingrained in me from young to place others before myself, that the happiness of others is fundamentally more important than my own. I seeked my own happiness and satisfaction from others around me, and that at the end of the day, if others were happy, I would be too. However, throughout my A level journey, I learnt through many painful lessons and experiences that at the end of the day, I am only left with me, that only I will be here at the end of the day when others have left me behind. This in particular served as a stepping stone towards my journey of learning to put myself first. It

	also a viable option.	has not been easy, with my parents chiding me everytime I choose to place my own mental and physical well-being in front of others. However, my one big takeaway was that “You can only fill other people’s glasses when you have filled your own” and as someone who enjoys helping others, it has really given me a much needed perspective of loving myself. Why I am so proud of this is because it has not been easy to overcome the conditioning since young and that it is heavily stigmatised in society, being seen as lazy or selfish when you put yourself first. It has served as a brand new perspective on life for me and will influence the rest of my life.
What makes for good communication skills in medicine?	• What exactly are good communication skills? Communication with who? In what context? It will be good to break down these factors before answering • In Medicine gives you the context necessary, now it is important to consider whose perspective are you considering from? A doctor? A nurse? • PEEL structure is recommended and focusing on	Personally, the field of medicine is so diverse with so many possible scenarios that to narrow down exact traits that make for good communication skills will be quite difficult. As such, I will try to encompass as wide of a scope as possible in my answer by focusing on patients and healthcare professionals. One factor I feel makes for good communication would be empathy. Empathy essentially refers to understanding the emotions and views of the patient despite not sharing the same feelings or opinions as the patient. This is so important during interpersonal communication with patients as most of the time, doctors would not have experienced the exact illness or the impacts it has like the patients do, and that without empathy, doctors are unable to relate and form a doctor-patient relationship. This in turns causes the extent of patient care offered to be lower and affects patient outcomes. Only if doctors are able to empathise with patients can they then understand what it feels like to be in their shoes and work towards a common goal with the communication skills. Without empathy, communication skills would be rendered hollow and essentially just “words”. Another factor I feel strongly about would be respect. This is quite important when communicating with other professionals within a multidisciplinary team, where

	2-3 skills will be enough to make sure you have a developed answer • It is also good to remember certain skills can be subjective or dependent on the situation, so perhaps clarifying the context before picking the skills will go a long way for this answer	there are professionals working closely with one another. If such professionals do not respect one another, it causes the team work ethic to be heavily impacted as these professionals cannot work with one another, which heavily places the success of patient care at risk. Respect, especially mutual respect is so important in a professional setting where both sides respect the effort and time gone into working towards the career they are undertaking. Without respect, any communication would come off as shallow and even confrontational in some situations which heavily jeopardizes the care of the patient. In conclusion, empathy and respect makes for good communication skills as they serve as the foundation for communication with any individual and without it, communication would be heavily impacted.
What's your definition of a good teacher?	• This is more personal since they are asking for your **DEFINITION**, so make sure that whatever your answer is, it is clear and transparent so the examiner can follow easily • Teacher in what setting? Is it as a doctor in a clinical, academic, managerial setting? Or would it be in a setting that is not	A good teacher is a role model, someone I respect deeply given that they are of great character and display certain traits that I personally believe a lot in. Having met some good teachers throughout my years, I have observed two specific traits which I will breakdown in my answer. Firstly, my definition of a good teacher would be someone that recognizes when to adapt and adjust their teaching methods to bring out the best in someone. Personally, the best example of this would be my math tutor when I was doing my GCSEs. I was personally slower than the rest of my classmates to grasp the concepts taught in class, but my strength was that once I fully understood it, I was able to apply it and solve almost any question. My math tutor back then had recognized this, and adjusted his teaching style specifically just for me, encouraging me to come and do more questions with his supervision so that he could guide me to understanding the concepts faster. He took time off his own personal breaks to support me in my learning because he knew that it would lead to a great impact on me. As

	healthcare related? • Use PEEL structure for this question and work on the explanation mainly, using relevant examples to support your stand • I would advise two specific traits in the definition to be mentioned, and essentially use 2 PEELs to elaborate on your points	someone who has met many teachers throughout my education, a teacher that knows when to react accordingly and appropriately to the needs of their students demonstrate the calibre of a good teacher, Secondly, my definition of a good teacher would also be a teacher that recognizes when they are wrong and is willing to learn from their students. It is easy to fall into the trap of pride and be upstuck about yourself as the “professional”, looking down on the students just because they are just “students”. My Geography teacher during my GCSE years embodied my definition of a good teacher to a tee, where he would be open in admitting that he did not have the answers to all my questions and that he would get back to me when he did. If he made a mistake, he would genuinely apologize and admit his mistakes without making excuses. Additionally, he admitted that he learnt a lot from my class and I, being impressed by our eagerness to learn and put in hard work and effort. This not only showed me that even professionals can make mistakes, but also the fact that admitting mistakes is a strength instead of a weakness. No one is perfect, and by admitting humility and respect for others, it demonstrates great character and hence is a part of my definition of a good teacher. In conclusion, a great teacher has many important traits, but these two specific definitions form the core of my understanding of a good teacher and have impacted my growth as an individual.
What is the hardest thing you have ever had to do?	• Whatever it is, make sure that you justify why it is the hardest thing you had to do (perhaps it's the journey that you took to get there, or the	The hardest thing I have ever done in my life was walking away from a friend when I should not have. I unfortunately lost this friend to suicide not too long after I chose to walk away. The context of what happened was that I have been friends with him for a good 2 years, where during the course of 2 years, he started to develop depression, anxiety and eventually suicide ideation and attempts. While I was not aware of the full context of what happened, I only found out that he was struggling with

	action itself etc) • Focus on just one aspect by the way, since the question's requirements is "hardest thing" • STARR approach is recommended for this, or PEEL is also a viable option. • You should have done a physical action or taken some sort of action since the command word is "to do"	family, academic, financial and social issues throughout the 2 years and that he never once confided in anyone. When I found out about this, I tried everything in my power to help him, but realized that I was not healing him or helping him, but merely slowing his descent into taking his own life. Additionally, it was draining me, and causing me to develop some of the issues that he was experiencing himself, which I am still struggling to heal from to this day. As such, I eventually made the difficult decision to let go and move on, where he then passed on not too long after. Why this was so difficult for me was because of my nature, being someone that refused to give up, and always seeing the best of people even when I should not. I always believed he would make it out better, and that I could heal him. It was also very difficult to accept that after all I have done, I could not save him. It crushed me entirely to know that I was going to lose a friend, and also that I "failed" as an individual. Till today, I still bear the guilt that I could have saved him, just maybe if I had held on a little more. It was incredibly challenging to place myself first over others, and that affects me till today where it shaped me as a person and how I approach such issues in the future.
What is your biggest failure?	• This is a personal question, focus on the emotions and feelings you experience, how it has influenced and shaped you as an individual • Nothing too much to write for this, I recommend the STARR approach and focusing	Similar answer to question above.

	more on your result and reflection • Remember to define why it was your biggest failure, perhaps the emotional toll it took on you or perhaps it was because of a certain impact / consequence afterwards	
Have you ever been away from your family & what was hard about it? How did you cope with staying away from family?	• Again, a more personal question so your answer would be unique to yourself • While it may be tempting to invent an event that needed you to stay away from family, it will cause your answer to be more shallow as you have not genuinely experienced it and as such may not be able to express the emotions properly • Be truthful if you have or have not,	I actually have been staying away from my family for the good half of 7 years and have been staying independently for 6 years. I am no stranger to the difficulty of living alone and would consider myself a veteran by now. Truthfully there were 2 very difficult things about staying away from family. The first thing would be the slow but perpetual drift from family, losing the sense of family slowly but surely bit by bit. While I recognize that family relationships are now maintained with more ease thanks to the Internet and such applications, it cannot be denied that you would experience vastly different things compared to your family. For instance, when I was studying in Singapore alone, my day-to-day life honestly had little to no involvement with my family as I had my own things to handle, so did my parents. It was very difficult to digest the fact that family just slowly did not quite feel like family, and had evolved into more of close relationships. The second thing would be the feeling of loneliness, especially if there were certain events going on at home. I still remember when my parents celebrated my grandmother's birthday, and I was overseas in Singapore for my education. Looking through the pictures posted, I just felt a sense of loneliness hit me, as if I was just

	and the examiner will guide you accordingly if you have not been away from home, by adjusting the question for you • Think about the possible emotions and reasons why it will be difficult, perhaps a foreign environment, a lack of support etc • Regarding how to cope, listing 2-3 will be enough and try to cover as wide of a range as possible (such as obtaining physical or emotional support etc) • Good to recognize why family is so important and has so much impact on our well-being	an outsider watching in on others and their happy events. It was particularly hard for me as I valued my family a lot even though I may not always express it, and to feel so separated from it all hurt me a lot emotionally. Regarding how I coped with staying away, one thing I did was to be more open about what I was feeling and that help will come to those who ask. I remember crying it out once with my parents on the phone about everything I had kept pent up, and afterwards the amount of emotional support that came helped me get over the loneliness and pain I was suffering. By asking for help from my parents, it made the reconnection easier and that it was a reminder that family was just a call away, regardless of distance. The second thing I did was to learn and thrive in my own environment, developing my own “second family”. As much as phone calls or video calls are able to do, they cannot substitute the physical support as they are miles away. As such, by making my own second family around, it allowed me to seek the necessary physical support as and when required, which went a long way in helping me cope whenever I needed someone there physically to lean on.
How do you think you will cope with the course?	• Be truthful, no one will be 100% able to cope with the scale of medical school and	Having not yet been in the course, it is quite difficult to just imagine the scale of content and responsibilities I would experience in the course, but if I had to take a guess, I would think I would do alright with the course. I may not excel or thrive immediately, but with time, I would

	responsibilities • Believe in yourself as well, while important not to come off as bragging / arrogant, but you made it to interviews which mean you have a certain calibre / standard already • Think of the academic and non-academic aspects! Medical school is not just about studying, it involves university life as well • Highlight work-life balance and how important it is to be able to juggle responsibilities (do you have anything that allows you to be able to juggle all the responsibilities?) • Think of good time management / attributes that will help you in	be close to being the best possible version of myself. Why I bring this up is because medical school is tough, a big jump in terms of content and applications compared to my A levels. Given that I am on my gap year as well, my studying skills may be a little rusty which could cause the content to feel overwhelming at the start. But similarly to jumpstarting a car, it will take a little push but I am confident in my ability to get right back into gear for studying. With my initiative and desire to make the most of my situation, I would have already started a little before medical school by reaching out to my brother to learn more about how I should start on the right foot for the medicine course. Moving on, I personally think I would fit in perfectly in the university and the course. As someone personable and enthusiastic, I am able to bring a certain extroverted energy that is infectious to my fellow medical students and encourage interaction with one another. Additionally as someone resourceful, I would explore every possible outlet to reach out to form connections and seek help whenever necessary, which would make the transition easier as I moved through the course. Lastly, as someone resilient and persistent, I would be able to tackle any issue thrown at me with time and achieve my goals regardless of the amount of work needed for it. As my friends have always told me, I am someone that once I have set my mind to it, no barriers can feasibly hold me back from achieving it, and that I just need time to get there. This would be particularly useful during the course as I would be thrown into unfamiliar and challenging scenarios, but with time I would be able to deal with them and become the best I could possibly be.

	coping with the course	
What makes you a good leader?	• Important to first recognize what is a leader, what attributes make up a leader • Remember to also highlight a "good" leader is different in various scenarios, set the scene and the context as to why it will be considered good • The question is asking about "You" in particular, and you should be highlighting 2-3 aspects about yourself in particular • Use PEEL structure to supplement your answers and provide an organized tactical approach to your answer • Remember the roles and responsibilities that a leader has,	Personally, a good leader to me is difficult to define as there are many possible scenarios and situations where a "good" leader may not be as effective. However, I can generalise a few attributes that are consistent throughout capable leaders. The first thing that makes me a good leader would be my resilience. As a team leader, it is fundamental that the leader is able to withstand any challenges faced and guide the team through tough times. My resilience in any scenario given to me would allow me to stay firm and focused on the end goal, to be able to push on and guide my team towards the objective. Similar to how I led my dance society towards 2 distinctions in a national competition during the peak of COVID-19, I will draw on my resilience to navigate uncertain terrain towards the end goal, slowly but surely. The second thing would be my humility. A good leader is someone that recognizes that they are just a team member with more responsibilities and is not better than anyone in the team. Personally, I always carry the belief that I am not the best, that I always have room to improve and learn from others. As such, I would not be ashamed to ask my team members for help, feedback or support when I need it. By recognizing that the team is more important than the individual, I personally feel that it makes me a good leader as I would make my members feel valued and supported throughout the process. Lastly, I would like to mention my adaptability. A good leader would be able to adjust to any situation, any developments and always bring out the best in the team. This parallels my Project Work during my A levels, where I adjusted the work delegation to play to everyone's strengths and allow us to achieve the highest grade possible. By being flexible and having the awareness to tweak things as and when necessary, it allows everyone to shine through and prevent any potential complications from

	and what attributes would be useful / contribute to the roles and responsibilities	arising as the team is happy and performing at the best they can be. In conclusion, these three attributes would be particularly important and make me a “good” leader as best as possible, and these traits would be particularly important during medical school and eventually as a doctor since it is universal and can be applied to any situation.
What sort of sportsmanship do you have, competitive, giving up, gracious, backing away?	• The specific sportsmanship is not really important, what is more important is how you justify your answers and how you approach the question (essentially how you structure your points) • Try and relate it back to Medicine, but implicitly relate it instead of explicitly, because you do not want to come across as robotic or too well-rehearsed (aka boring) • Draw on past experiences to supplement your answers (so any previous competition experiences if you have any, or any	I personally feel that my sportsmanship is a blend between being gracious, backing away and competitive. A certain attribute would be more dominant depending on the scenario and situation. I have always been a competitive person, where I like to challenge myself to see just how far I am able to push myself to become the best possible version of myself. This, as a consequence, spills over whenever I am competing in certain scenarios. For instance, when I was previously leading my dance society for the national championships, I constantly scheduled more practice sessions for myself as compared to my teammates, where I would spend hours in the room preparing and rehearsing the steps. I wanted to see just how good I could get and wanted to be in the best form possible when I was actually performing. While I rarely desire to compete against others, preferring to fight against myself, it occasionally does happen at times when I get too excited. However, when things are not as high-stakes or when it is more casual, I tend to have more of a gracious and backing away mentality. I recognize that there is no need to be so intense or competitive since the goal is not to win, but more to have fun. As such, I would be usually inclined just to play for enjoyment and also allow others to experience the joy and satisfaction, where I normally would be playing more of a support role as compared to an offensive role in such situations. (offensive meaning a strong desire to win). Personally, if I am playing against others who may not be as skilled as my classmates, I would occasionally lose on purpose just so that my classmates can feel the joy of winning. I feel happy knowing that they are also

	tests / examinations) • Remember that sportsmanship is not only displayed in sports, it generally is but can be displayed elsewhere as well, so do not panic if you do not have any sports experience	ecstatic to win, and to me that is sufficient. Similar to sports, medicine and the study of it would definitely involve different scenarios where certain traits would be more dominant than the rest, and that is personally alright as it is more important to be able to adapt according to the situation and context.
If you were head of health what would be your priorities & what problems might you encounter?	• Head of health is relatively broad, so it will be good to narrow down a position such as Health Secretary • Remember your scope of the job and who is impacted by your actions, as it will serve as a guiding point on how you should structure your priorities or problems • The question has 2 serious / complex questions (regarding priorities	Since the Head of Health is a little vague, I will assume the position of Health Secretary and would be in charge of the NHS and overall healthcare of those in the UK. One priority I would definitely make would be to address the issue of healthcare workers striking and provide them with appropriate support such as sufficient remuneration to deal with the inflation experienced. I am sure we are aware of the recent strikes organised by healthcare professionals such as nurses and doctors, who are campaigning for fair wages and relevant support to deal with the crunch experienced in A & E wards or GP clinics for instance. Why I would make this a priority would be because it could potentially stop healthcare professionals from striking and help to prevent the situation from getting worse. Additionally these healthcare workers are the frontlines who support the system and without them, the system would completely collapse, and they are still human, without proper support they would not be able to do their jobs. However, an issue I foresee would be that there would be a lack of funds to support these healthcare workers, or that the impacts of my intervention may not be in time to help the workers. As the news reports that the NHS would potentially not

	and potential problems) so structure your time evenly to address both as best as you can • I would recommend 2 points for each question so as to maintain a relatively developed answer for both questions • Think of recent NHS Hot Topics to help you with the potential problems you may face (think more than just COVID-19 since a lot of candidates will just jump straight to that)	see the billions promised after Brexit, it is potentially a problem I would encounter. Additionally, such interventions take time to be implemented and by the time the impact is felt, it could be years from now where the situation already spirals out of control. Another priority I would have is to find ways to address the current issue of long GP waiting times. It has been reported in the news recently that patients could experience up to weeks in regards to waiting for their appointments and that GPs are struggling to keep up with the long queues. Why this in particular would be a priority as thousands who need support from healthcare professionals are not receiving it and that operations that are needed are also not undertaken at the end of the day, which compromises patient safety. I would make it a priority to deal with so as to relieve the pressure on emergency services and the healthcare system, preventing A & E from being overrun. However, a complication I foresee is a lack of healthcare professionals to supplement the GPs. Even if I were to get locum doctors to support me, many would be deterred by the long waiting times and extra workload they have to handle, feeling that they do not want to take on so much work just to receive little financial return. As such, I would need to find a work around for such a complication. In conclusion, while as Health Secretary, there are a lot of issues that need to be worked around, I have chosen these for my answer as I feel they are the most pressing issue as of now given real world events.
What strategies do you use to deal with stress?	• Question is asking for specific strategies so whatever it is, it should be feasible and practical (essentially what do you do to	I mainly view stress as an indicator of how I should respond to the physical or emotional triggers I experience, and usually use some methods to deal with the stress and how it arose. One method in particular that I use is to create an environment purely just for relaxing, away from work and any responsibilities. While it may seem pretty difficult to disconnect from everything given how interconnected work is to our daily lives now, I made it my personal

	resolve the stress) • Remember to admit that everyone struggles with stress, no one is a god and is completely stress-free all the time • Keep to 2-3 strategies and use the PEEL structure to provide a well-developed answer • The question, while generic, should still be linked back to medicine and particularly medical school (so talk about how you will use it in medical school **IF** you make it)	goal to distinguish my bed as purely for relaxing purposes and all work-related issues or anything apart from unwinding is to be kept strictly away from the bed. This allows me to experience a clear transition between the environments I am in from a day-to-day perspective and that I can let go, be free when I am done with my work. This would be particularly useful in medical school for instance as once I am done studying for the day, I can hit the bed and get proper rest in preparation for the next day without having to worry about things to be done. Another method that I use would be to speak to friends who are in a similar situation to me, and to let out whatever feelings I may have pent-up. For instance, during my A levels I could feel a lot of pressure on me to perform well academically, and by talking to my friends who were also studying, it allowed a channel for me to ”vent” and release all the emotions I felt stored up within me. Knowing that my friends struggle with the same amount of responsibilities and the same concerns as me reassured me to some extent, and that help was just close by if I needed it. Realistically, this would be common in the working world where if I was a doctor, I would speak about my job stresses with trusted friends or my family to help regulate the worries that plague me during work. In conclusion, stress should be dealt with appropriately to prevent poor work-life balance and allow for sufficient rest, and these are some methods I would use to help deal with it.
What kind of achievements do you take pride in?	• The question is asking about the **KIND** of achievements, not the **ACHIEVEMENT ITSELF**. So you should be focusing on factors / categories	I personally take pride in things in quite a fair bit of things but if I had to narrow it down, it would probably be achievements that have contributed significantly to my growth / changed me as an individual and achievements that are personally difficult to attain. Achievements that have shaped me significantly especially in a good way is one that I feel a lot of pride in. It demonstrates an ability that not many individuals have, which is personal growth and it allows me to show that I have developed and matured as a

	• Why do you take pride in it? What about these kinds of achievements deserve pride and respect? You should focus on developing your answer around this aspect, and break it down as detailed as possible • While the question is not focused on the achievement itself, you should still raise relevant examples (1 should be enough) so as to provide substantial grounding of your answer • Not much else to say for this question, STARR or PEEL would both be good approaches for this question	candidate. For instance, I used to have a gaming addiction back during my GCSE years, and it took me almost 2 years to dig myself out of that hole that I was in, and I had to learn to battle my addiction to games on my own as I was living away from my parents. That is honestly one of the most difficult times of my life, and having been able to beat such an addiction where not many can say the same shows just how far I have come as an individual. It shows the effort and dedication I put in to improve myself, and personally that is something I am very proud of. Achievements that are difficult to attain are also things that I take pride in. We always look in awe at those athletes who compete and do things that we are unable to do ourselves such as winning the FIFA World Cup or climbing Everest, and personally I feel the same way. When I accomplish something that has never been done before or rarely been done in the history of the competition or event, it fills me with a huge sense of pride and makes me feel that I managed to peak in regards to the achievement. One example would be during the national competition that my Dance Society participated in, where we were aiming for distinction awards (the highest standard attainable). To come remotely close to that standard, one would need to be faultless and execute every move perfectly. Not only did I manage to lead my team to a perfect performance, we also attained 2 distinctions, which was never done before in my school's history. It was a meteoric achievement and it demonstrated the calibre and standard we held ourselves to. Achieving such awards makes me feel a sense of pride to just how much we put into getting those awards. In conclusion, these are the type of achievements I take pride in the most, and while it differs for everyone, I personally chose these as a demonstration of effort and ability.
What people have influenced you & how?	• Tempting as it may be to always think	I have met my fair share of great teachers over the years, people who have left a distinct impact and influence on me,

	of positive influences, you can also explore negative influences in your life and how you dealt with it • Naming 2-3 people would be good enough for this question, using the PEEL approach would be beneficial • Structure your answer in a manner that is easy to follow, and focus more on the elaboration • Influencing you does not necessarily need to have made a change, but if there is, good. You can also say if they taught you any lessons etc • Since the command word is "How", remember to show a logical process in how it happened	shaping me as I developed. While it is hard to narrow down specifically, 2 individuals come to mind. The first individual would be my math tutor called Mr Tan. I first met him during my GCSE years when I enrolled in his math class. Back then I recall being particularly playful, and had developed a strong distaste for studying, especially Math. There was an incident when I went to his class without doing his homework, and I still remember the amount of scolding I received and how I was thrown out of class. This came as a shock to me as I had never been kicked out of a class before and it really mellowed my boisterous attitude. Over the 4 years I knew him, he worked tirelessly to guide me with my academics and taught me a lot of valuable lessons such as I should know when and where to be more serious. I credit him for shaping my personality to this day, as without his influence I would still be the playful and unassuming kid I was back then. He serves as my role model on how a teacher should really be, fun but firm on what really matters. The second individual that comes to mind is another teacher of mine called Mr Kelvin. He was my Geography teacher for 2 years, and he demonstrated to me the power of having "hope" and trusting the process. During my GCSE years, I hated Geography and was a consistent poor student during lessons. While I did not disrupt lessons, I just didn't really care because my grades never seemed to improve. He sat me down once after class, and told me that I had to trust the process of learning and that making mistakes is how you learn and grow as a student. He said that if I place my hope in my grades becoming better, I will achieve what I want at the end of the national exams. And so over the years, he pushed me to study for the subject, always volunteering his time to support me whenever I had questions and always telling me to "trust the process" whenever I wanted to give up. At the end of it, I came out with the equivalent of A*, and finally understood what he was telling me all the years he taught me. Why I picked

		him in particular is because of him, I understood how important it was to commit to whatever I was doing, and that if I set my mind to it, it can and will happen. This just so happens to have developed into one of my greatest strengths, which is being persistent and without his influence, I would not be where I am today. In conclusion, I have picked these two individuals as they have played a huge role in shaping who I am and where I am today.
When are your strengths and weaknesses most apparent?	Since there was a similar question above on strengths and weaknesses, I decided to modify the question so I don't repeat the same thing. ● Highlight your strengths and weaknesses , do not assume the interviewers know ● Apparent suggests that it must be obvious / easy to tell so whatever you say, you should make sure that it is easy to tell when these are involved / exhibited ● PEEL structure should be okay here to be used ● Good to mention 2 for both factors since they use the plural form for both	My strengths would be being resourceful and persistent, while my weaknesses would be being stubborn and not being firm enough in certain occasions. Interestingly, my strength of being persistent fits in perfectly with the weakness of being stubborn. I have been told that while I am very determined about what I want and have a lot of self-belief that I will reach my end goals no matter how much effort it takes, it sometimes becomes an issue of stubbornness, where I could be too insistent on the way I would want something to be carried out, or that I would have tunnel vision and could sometimes miss out certain things for consideration. It would be the most apparent during sessions such as group work or projects where as a team leader, I would be able to guide my team towards whatever outcome and more often than not actually achieve the goal. However, I sometimes can get too rigid and too "objective-oriented" that I fail to consider everyone's opinions or that I get too zoned in, forgetting to note how others are feeling. Admittedly I am still working on finding the balance between these, but usually with the help of my teammates, I am able to step back when I get too stubborn. Being resourceful does somewhat align with the weakness of not being firm enough when it comes to decision-making. One example of this would be during team discussions or larger scale projects. My resourcefulness allows the team to attain the best out of whatever is given to us, and to produce the best

	strength and weakness • Structure recommended: Strength 1 Weakness 1 Strength 2 Weakness 2	results from whatever we have on hand. However, due to the abundant resources obtained, it becomes difficult for me to make decisions as I get overwhelmed with all the materials we gathered such as data, statistics, feedback and opinions. As a result, it becomes very difficult for me to make a decision and can cause me to hesitate and jump back and forth regarding certain decisions. This is very clear during big decisions that only I can make, such as the authorization of certain aspects of the project having been the team leader. I have taken the initiative however, to reach out towards old friends to get feedback on striking a balance, and to obtain just the necessary and relevant factors to make a decision, and prevent future back-and-forth decisions. In conclusion, my strengths and weaknesses are most apparent in team projects as usually those are the times when teamwork is prevalent and I am placed in a position where judgement calls are very important.
What would you like to improve about yourself & why?	• Everyone has room for improvement, try not to be arrogant and come off sounding as if you are perfect and do not need to improve • 2-3 points would be enough, and the use of PEEL is recommended • Focus on the word “improve” and explain the “why” also. You either already have this attribute (but	Everyone has room for improvement whether it be working on their strengths to become even better or to work on their weaknesses to improve upon them and make them less influential. I can think of a few things I would like to improve about myself. The first thing I would like to improve about myself would be to absorb and understand content taught to me at a faster rate, perhaps on part with the rest of my peers. I am personally not the smartest person in the room, and usually when something is first taught to me, I feel a strong sense of uncertainty and feel that I lack understanding about the topic at hand. Throughout my education, I feel that I absorb what is taught to me at a slower pace compared to my friends and at times I would need to take more time to digest and internalise what was taught. While I make up for the lack of “smarts” with hard work and consistent studying, I would like to be able to understand knowledge at a similar rate to my friends around me so I feel less behind and can help others as well if they

	it is not a very strong attribute), or do not possess it and would want to have it • Make it personal since the question is asking for "yourself" and that you should still try and relate it back to Medicine as and when possible • Think before answering this question to show some level of reflection (jumping immediately to answer can be bad especially if you pick the wrong thing to mention)	need any clarification, just like how my friends helped me. The second thing I would like to improve upon would be my time management. While it may seem a little odd to be focusing on this since I personally am a very organized and structured individual, I feel that there must be more optimal ways to allocate my time to be able to get the most done in the least amount of time. For instance, in a day, I may be able to study for 5-6 hours depending on the situation, and still have time to be able to unwind and relax. However, this causes me to not have much time to volunteer in helping others out as much as I would like, such as helping my juniors in their preparation for A levels. As such, I would like to improve my time management to be able to efficiently allocate my time to get as much done as possible, and be as impactful as feasibly possible. If I have better time management, it would allow me to better help those around me while still maintaining the quality of what I am doing on a day-to-day basis. In conclusion, I have quite a few areas I would like to improve upon, but these two are the main areas I would prefer to prioritize.
What do you think you will get out of the medical course?	• Think of tangible and perhaps more non-tangible aspects that you can obtain (Tangible means physical, non-tangible means non-physical) • You do not need to be super certain since	Personally, the medical course is 5 years and would definitely have a significant impact on me and allow me to attain great personal growth as an individual. One thing I think would allow me to get out of the course would be the medical knowledge necessary for the profession to heal patients. It would be expected that as I pass through the 5 year course, I would be equipped with the necessary knowledge for the profession and receive appropriate training for life as a FY doctor. While this sounds like the bare minimum, I felt it was important to highlight it as that is the university's aim and the intention of enrolling in such a university course.

	the questions uses the word “think”, but still try and be realistic and think creatively as well • You can say the obvious “learning how to be a doctor”(I personally would as well), but just make sure to elaborate more upon it. Link it to specific university aims or your goals / motivations if possible • Perhaps explore the non-academic goals you may have also such as having a good university life etc • Structure could be: Medical knowledge Personal skills Non-academic related stuff	Another thing I would like to mention would be well-developed interpersonal skills such as communication and empathy. As the 5 year course allows frequent exposure to the healthcare community and the patients in the city / town, it would be a platform where communication skills are developed regularly, refining them to the best of their abilities. Additionally, I would also be exposed to different healthcare settings and individuals from varied backgrounds, where I would have the chance to empathise with those I seek to serve in this profession. Hence it allows me to be able to develop and hone these skills, and to me it would be something I take away from the course. Lastly, I think one takeaway would be the experience and growth I personally attained over the years, in the form of lessons learnt. Why I felt this was something important to highlight is because I would be spending 5 years of my life in a new environment, constantly working and adapting myself to the bigger world, hence I probably would have faced new experiences or grown as an individual having gone through many challenges. This serves as a takeaway as I can draw on these experiences to guide me for the rest of my life, in a healthcare or non-healthcare setting. Memories of such experiences will stay with me long after I have graduated, and will serve as learning points. In conclusion, these are some things I would think of as takeaways from my time spent in this course.
If you got into the course what would you change about yourself?	Similar to the question about “What would you improve about yourself”, but the notable difference	If I got into the course, one thing I would really like to change about myself is the belief that I need to be good at everything I do, even for the first time. Personally, I

	is that now you have made it into the course, so whatever you change should still be relevant to the course ● Again, think before speaking so that you start of on the right foot since this type of questions are relatively tricky ● Always relate it back to how it impacts you on the course and how much it changes you ● Similar talking points to "What would you improve about yourself"	have always been a very motivated individual that always wants to excel at whatever task is at hand such that I am able to feel good about myself and support others if needed. Moving into medical school where new and abundant experiences are everywhere, it is quite likely that I will no longer be able to always be good at things, and I would really like to improve upon that mentality. While it is great to always push myself to be the best possible version, it would be more important for me to be kind with myself and develop a mentality that it would be okay even if I am not the best, but what matters more is the amount of effort put into it. A second thing I would like to change about myself would be balancing my emotional and logical approach to tasks faced. While I personally think that I am able to transition back and forth both approaches rather quickly, I sometimes catch myself leaning more towards a certain approach rather than giving a balanced view to both approaches. This would be especially important in medical school and as a professional as while logical approaches are very important, the need to incorporate emotions such as empathy into this logical approach is also really important. For instance, during breaking bad news, the doctor needs to be factual yet sensitive to how the patient handles the news. As such, I would really like to improve upon this so as to be the best possible version I can be as a medical professional eventually. In conclusion, these would be the things I would like to change about myself if I got into the medical course.
How do you handle criticism?	To be honest with this question, whatever you think immediately after being criticized is how you react to criticism. There are different types of reactions such as defensive, offensive. Do look it up and read more about it. ● If you have a mix, just say you	I personally handle criticism in a mix of ways, especially depending on the context. I primarily am accepting of criticism and seek to improve myself based on feedback, but in certain scenarios I can get defensive. I am someone that recognizes that I am still very flawed as a person and can make mistakes, and consequently have room for improvement. I actively seek out feedback from trusted friends especially when I feel that I did not handle a

	have a mix in terms of how you handle it and make sure to break it all down clearly and in an easy to understand manner • PEEL structure is recommended for this question • Draw from relevant examples in your past to support your points • Remember that everyone reacts and handles differently, that it is not necessarily bad to react defensively • Handling criticism suggests that you should raise relevant methods, so 2-3 should be enough. Avoid overlapping your methods (so basically they should handle criticism in distinct ways)	situation as best as I could, and try to take active steps to address the feedback given. As such, I usually accept criticism, and try to understand the intention behind such criticism and how I can become better as a person by asking questions to those who have provided critical feedback. I try not to be too defensive and maintain an open view on the matter at hand, to explore both sides of the issue. One example of this would be during my preparation of national competition in my Dance society, I remember my coach providing harsh but constructive feedback on how I could be performing better and while it definitely stung, I accepted the well-meaning intentions behind his words and worked to improve the standard of my performance. However, there are times when I can get defensive and deflect the criticism given to me. This occurs often when I feel that criticism is unwarranted or if it is more of a personal attack via destructive criticism rather than it being constructive. This generally occurs when someone singles me out for something I didn't do or when I have to take the fall for someone else's mistake. I have been working on this issue and have been actively reminding myself to stay open to whatever is given, and not assume that just because I am singled out means it is a personal attack. It is a long and difficult road, but I do feel I am getting better at it, especially during my gap year as I had the chance to really reflect and think. In conclusion, this would be how I react and respond to given criticism.

Is there anything in medicine you think you will have trouble with?	• The term “in medicine” is used, so you are not restricted to just medical school, you can consider working life as a Foundation Year Doctor, consultant etc • You can also consider the issues of trying to make it to the consultant role, or competing for speciality places etc • The term “trouble” also suggests difficulty, so think about what kind of difficulty could it be (physical, emotional etc) • PEEL structure will be easier to tackle this question, and 2-3 points will be sufficient • Remember to acknowledge that it is still quite far / you are not there yet so to be able to	Not having actually experienced life as a medical student or medical professional would make it rather difficult to answer this question, but I will draw from my work experience and what I understand to answer this question. One thing I definitely foresee having trouble with would be the amount of immense content we would be studying when we enter medical school. I have heard many stories from my work experience and my brother who is a 3rd year medical student, that no matter how prepared you are, you will still struggle. Being intelligent helps but when confronted with the scale of understanding required, it can stumble even the brightest students. Additionally, coming from a gap year, I personally may find it a little rusty in terms of studying content despite taking regular classes currently. As such, I can definitely foresee some difficulty regarding this matter, but I believe with active steps such as revising content before entering medical school and communicating for help when needed would help to lessen the impact it could have when I enter the course. Another thing would be possibly juggling all the responsibilities when I graduate as a FY1 or FY2. As a medical student, we would not be fully exposed to all the responsibilities of a JD until we are actually a JD and given all the clinical, possibly managerial and academic responsibilities, it can definitely be overwhelming for someone who has just started off as a brand new doctor. Additionally, you could be studying for admissions into specialities (and given the high competition currently for specialities), it could provide even more work and stress to even the most well prepared individual. As such, I foresee this being a concern as I graduate from medical school. However, I believe that drawing from past experiences such as Y4 or Y5 students would help ease the transition period and seeking support from my fellow FYs would help tackle this issue. In conclusion, life as a medical professional, especially when starting out new, can definitely serve quite a few

	say for sure is impossible, that you can only take intelligent guesses • Also consider your involvement using CAMP approach, anything in particular about CAMP that would make it difficult or cause you to have trouble? Don't be so stuck in trying to just think of it in the clinical perspective	difficulties but with time and patience, it would be able to be tackled and solved.
Which role do you usually take in a group?	• There is no right or wrong answer, just make sure to justify why and provide relevant examples to support your stance on this issue • Are there more roles rather than just team leader and team member? If so, what are their responsibilities and how does it	Personally, I have almost always taken a leadership position within the group, either as the overall leader or second in charge voted in by my groupmates. However I also take up support roles whenever necessary. Personally, I am inclined towards leadership as I feel a sense of responsibility and have a great understanding of people, which are incredibly useful skills in a group situation as it allows me to bring out the best in others and achieve whatever goal that we have set out to do. An example of this would be for the past 7 years, I have always held a leadership position, with the highest achievement being granted the position of a Senior Leader, which was essentially the top 10 student leaders in the whole school. I have undertaken the planning and execution of large scale events such as concerts, camps, open days and have experience working with groups of all sizes. As a result of my characteristics, I tend to be

	separate them apart? • Question says “usually” so if you want to explore other options, you also can but focus should be on which role you lean most heavily towards • Provide relevant examples by drawing from past group work projects or discussions to support the points raised • Good to mention that every role is important, it is just that you lean more heavily towards certain roles because of your traits or attributes that allow you to contribute more significantly in your given capacity	the figurehead of the group and serve as a focal point for the project’s success. However, whenever called upon, I also play support roles for the team. As someone who has had a lot of leadership experience, I recognize that every member is important and that a leader is just a member with a title, also that the success of the group is as strong as the weakest link. As such, I recognize that there will be times when I need to step back and support my teammates more than placing myself in a leadership position. An example that best reflects this was when I willingly gave up my election run for president of the dance society, and instead channeled my efforts into becoming a stunt coordinator. While in the end I was elected as vice-president and stunt coordinator, I was personally willing to change my goal and focus on supporting the stunts within the society rather than becoming the president itself. I understood the need for the coordinator and placed that over my own desire to become the president, hence playing a support role. In conclusion, every role is important and that at the end of the day, whichever role is picked would be more specific to our strengths. As such, I would usually play to my strengths and play a leader role, but when needed am able to adjust to become a support role.
Do you like working in a team or alone?	• Similar to the question above, there is no right or wrong stance on this, but	I personally prefer to work in a mix, where I am a part of a team while still doing my own individual roles. However, I recognize from my work experiences that doctors need to be able to work in both situations, and that for this question, I

	make sure to take a stand while still providing a balanced argument • A good way is to argue pros and cons to both sides, before concluding • Additionally, you should know doctors need to be able to work as both in a team and alone, and if you have any examples from past work experiences do pull them out to support your points • Mainly use your own past experiences so that your points are more grounded and become more personal since the question is asking about "You" • Try and stay neutral for the majority of the question, only taking a	would need to pick one side, which I will at the end of my answer. Looking at why I like working in a team first, that is because the responsibility is split among the members and it is less stressful to plan and execute any actions with the support of a team. Similar to the team in a OT, past experiences of working on school camps (the planning and execution), all team members have a role to play, and that the huge task is split into more manageable duties, making it easier for the project to be successful. Additionally, the companionship in the team would allow for team members to cover for one another when needed, providing a safety net where if help is needed, all I would need to do is ask. This is especially important in scenarios such as deadlines or responsibilities to fulfill. However, I also enjoy working by myself at times as one big draw would be the autonomy I possess in making decisions or the direction I would like to take the project in. In a large-scale project such as planning Open Days which I have done before, it is very difficult when different individuals have differing ideas on how to carry it out, and this can cause the project to stagnate or even cause disharmony within the team members. On my own, I have full control over the decisions to be made and how I would want to carry things out. Additionally, being alone helps me keep control and aware of the entire scale of my duties. In a large team where work is delegated, you would end up working on only a small part of the overall project, which diminishes the scale and importance of what you do. However, by myself, I can really appreciate the effort I put into the project and makes me feel a much higher sense of satisfaction when the project is completed at the end of the day. In conclusion, if I had to pick, I would prefer to work as a team. While I appreciate the control I have over the project when I am alone, I tend to prefer the companionship and the safety net if things go wrong.

	stand when needed	
What would you do if someone were not pulling their weight?	• Try not to jump into being on the offensive and pointing fingers. Take steps to actually determine if they are pulling their weight or not, the last thing you want is to accuse falsely • **ALWAYS** communicate clearly and transparently, so that you can solve the issue soon • Show a clear process on how you handle the matter, make sure its logical and easy to follow for the examiners • Suggest that you understand that there are reasons behind why someone may not be pulling their weight and you should try to explore those reasons	This is a very common scenario in school, and definitely in the workforce as well. I will approach this context with the assumption that I am doing a group project in medical school, such as a presentation. The first thing I would do is to assess the credibility of the source of information. If it was through word of mouth with a lack of physical evidence, I would be hesitant to confront the individual as it could be hearsay or misleading rumours. I would take any necessary steps to determine the credibility through text messages or what I personally witness for instance. Assuming that I personally witnessed such an action, I would first choose to gather physical evidence such as screenshots or pictures to support my point if the person gets defensive. Next I would privately request to speak to that individual first, assuming a non-confrontational tone and keeping it respectful and light. I would ask him tactfully if he is aware of his actions and if there is anything he would like to tell me. This puts the power back into the person's hands and grants them the chance to speak their mind without pressure. I recognize that sometimes, someone is not pulling their weight because of external circumstances, and if they share it with me, I would explore them and provide any support that is feasible to help improve their situation. I would be understanding and empathetic to their situation, and try to support them through it. However, if the person turns aggressive and starts denying his wrongdoings, I would show the evidence collected to him and ask for an explanation. If he continues to be in denial or aggressive, I would not hesitate to escalate matters to my tutors or other individuals as I have already undertaken all steps possible to support them

	before suggesting actions or ways to tackle the issue • Remember to stay neutral and not let emotions get in the way of your answering	
How do you bring the best out of people in a team situation?	• Acknowledge that people have different strengths and to bring out the best, you need to play to the strengths of them • A team situation also complicates the context a little, since it changes how you approach the situation. While you may be a little confused, if the team is big, it is possible that you cannot possibly play to everyone's strengths so you need to manually adjust, but if the team is small then it is much	I think it is important to recognize that to bring out the best in people, you need to play to their strengths which may be difficult in a team scenario since the team can be quite big which affects how you tackle such an issue. However, with that being said, it is still possible to do so, and one method in particular would be to communicate transparently with those in your team. Communication is key as it allows everyone to express their opinions, feel heard and be engaged in the team, additionally transparency helps to build a sense of trust and belief in the aims or intentions of the team. By doing so, this allows the team to build a sense of safety and trust, which then allows them to fully express themselves and commit to producing the best possible results. Having done many events during my education. I always strived to build such connections by actively engaging with those around me. Similar to how icebreakers are carried out to help form connections in new environments, building a safe and honest culture would definitely help with bringing out the best in those around you. Another method I would explore is to be flexible and adapt to the circumstances presented. In a team, things can change in the spur of the moment since the team's dynamics can change depending on the situation, and a good leader would be able to recognize that and adjust accordingly. Being flexible with the team would allow the team members to feel heard and appreciated, where they know

	easier to do so • Communicate, communicate and always communicate. Transparency is really important to the team and the intended goal, if the team aligns with the goal, they will be more motivated to work and contribute the best they can • The question asks for "How", so you should be listing perhaps 2-3 methods or listing out a clear process on how you plan to bring out the best in others	that they are being accommodated to, and hence would be more willing to contribute and give their all towards the end goal. An example of this was when I was stunt coordinator for my dance society, and since many guys were not flexible, they struggled to do those stunts. What I did was to adjust the roles of the guys, to lift the girls who could actually do the stunts and it allowed the team to still carry out the stunts, while playing to everyone's strengths.
Describe some traits you would like to have, but don't have.	• 2-3 traits would be good enough for this, personally I would go for two well-developed traits with relevant examples	I recognize that I am not a perfect individual and often envy others when they have certain traits that I do not possess. While I am satisfied with what I have, there are some traits that I would like to mention. The first trait would be healthy. Now this is perhaps a trait that is not commonly raised as most individuals are healthy or at least doing well physically. However, I have a mild condition of anemia, which is essentially low amounts of red blood cells in my body. This has in turn caused me to

	• Think of practical and useful traits that would benefit you in medical school or like your future career as a medical professional • I would also recommend that you draw on work experience or any readings that you may have done in the past, so that you can provide relevant examples to support your answer • If you are struggling for traits, think of the GMC domains or think of the values of the NHS / values that the school would like to see in a candidate • Demonstrat e that you are currently working on trying to get those traits, and while you may not have it yet, you will have it soon	struggle much more with extensive physical activity and having to breathe much more compared to my peers just to be able to maintain enough oxygen. Why I singled out this trait in particular is because I felt that if I was healthy, I could explore and do more physical activities without always having to slow down and catch up. Additionally, I personally feel that it would be beneficial in the profession and during my academic journey as I would fall sick less frequently, and be able to devote more time to studying or working consistently. While I have been taking steps such as consistent exercise to help with improving my health, personally it is a trait I would like to possess. Another trait that I would like to have would be more trusting of others. I personally have gone through quite a few hardships and have been backstabbed by some of my closest friends that I call family, and as such have “inherited” a colder and much more wary demeanour and approach to those around me. Gone are the days where I would wear my heart on my sleeve and consistently trust everyone around me without hesitation, and now I am more cautious, slowly opening up bit by bit to those I care about. At times even, I can feel myself torn between opening up and pushing those around me away, because I am scared that I would undergo hurt and pain again. This trait in particular has caused me to be even more independent, choosing to do things by myself as much as feasibly possible. I personally would like this trait as it would be very important in the medical field as I would need to trust my patients that they provide accurate information for me to diagnose them and even trust my fellow healthcare professionals to support me in my duties if I were to become one. In conclusion, I have been actively taking steps to attain those traits by working out consistently or interacting more with those around me, and I do hope that eventually I will be able to achieve them.

What is an adjective that describes you that you wish didn't?	• Focus of the question is just one adjective, so really think hard before answering • PEEL is recommend ed for this question, make sure its a well-developed structure with relevant examples • Explore why you wish that adjective did not, perhaps the ideas, expectations that come with it or even the implied tone of the adjective • Perhaps use examples of friends saying certain things that affected you and caused you to not want to be described that way • The focus is not the adjective, more focused on how you elaborate upon it and what you LEARNT / how you developed	While I have been called many different adjectives by my friends throughout the years, some even being really mean and offensive, this adjective in particular is actually a commonly described strength about me, but yet I wish it didn't. The adjective in particular is resourceful. Now that admittedly is a little confusing, isn't resourceful a positive trait, where it essentially describes someone that is able to make something out of nothing, able to explore and attain more resources for the team to achieve the intended objectives. In the academic setting, I have often been described as a wizard of sorts, always having resources to supplement my learning in the form of additional practice papers or notes. Whereas in the non-academic / social setting, I have been described as someone full of ideas and always able to make something better than it is, regardless of the situation such as a party. Why I wish it did not describe me is because of the expectations generated. While I did not notice this initially, after a while I realised that people had an expectation of me to always be able to solve anything that we faced. For example, during my A levels, in class I was always expected to be able to solve any question, or pull out lots of resources specific to people's needs such as specific topical papers. When I informed them that I did not possess such materials they were often dejected and blamed me for not possessing them, which only reinforced the pressure on me to be "resourceful". While in the social setting, I was expected to always know the best places to eat, for entertainment and even education. This only piled on pressure for me and served as a major stressing point whenever I went out with my friends, eventually leading to the formation of anxiety.

Imagine that existing medications have been suggested as a possible new way to treat a different disease. If there is a very limited evidence base to support the use of these medications in this way, should we try these treatments or not?	• This is a pros and cons question, so carefully and unbiasedly arguing both sides to provide a balanced view is the way to go for this question • 2 pros and 2 cons should be enough, but you can go more or less depending on your comfort level • Note the factors given, that it is an existing medication (could have test results or research already done for it), the very limited evidence base (limited in what sense?) • Consider multiple scenarios and the context of the question. Is it a must to use these treatments? Is it urgent enough that we need to ignore	Personally, this is a difficult question to answer as it touches borderlines on ethics and of course is a prevalent issue in today's society. I would like to examine the pros and cons of such an issue before taking my stand. The pros that I can think about would be the fact that it would allow us to treat the different disease and consequently improve upon patient safety. Assuming the different disease is life threatening, the use of such a medication could in fact help to save the patient's life and even recover from the affliction. This in turn aligns with the beneficence and non-maleficence ethical pillars, as we would be doing good in the patient's best interests by offering treatment. Additionally, there has already been some evidence to support the use of medication in such a way, and if that evidence is reliable, it becomes reliable to a certain degree that it is safe for use, which essentially is a way to treat the disease and avoid "doing harm" to the patient. However, the cons are also quite apparent in this scenario. For instance, the evidence base is very limited, where the sample size may not have been large enough or perhaps the evidence produced is not reliable due to possible conflicts of interest. By choosing to use these medications which have not been extensively tested, it could pose a threat to patient safety and possibly even cause the patient to deteriorate. This in turn would be doing harm, and go against the "Non-maleficence" ethical pillar. Additionally, there is no telling if the disease functions in the same way that we expect it to, where the previous evidence collected could have been impacted by anomalies. In conclusion, my opinion is that we should not offer such treatments until it has been proven through extensive clinical trials that the use of such medication is safe. However, in a life-saving scenario, the benefits would outweigh the cons and if the patient consents to the treatment, then it can be offered and carried out.

	potential safety issues? Can we do more research? • Do the pros outweigh the cons or vice versa? Is patient safety the most important consideration here? Or is the need to save ppl's lives more important?	
Why is antibiotic resistance such a huge problem in the UK/World?	• The context has been set as either UK or the world, but it would be good to show your understanding of the issue in particular if you can address both UK and world to demonstrate awareness • The question is asking for "Why" so aim to use 2-3 PEELs to answer the question, making sure they are developed and well supported by relevant examples	Antibiotic resistance has become a bigger issue day by day as it progresses, and I can think of some reasons why it is such a huge problem. One reason why it is such a huge problem is because it now causes diseases to become more resilient against antibiotics, which places people at risk of potentially worsening in condition if infected. With antibiotic resistance, previous medications may no longer be able to actually kill the diseases / illness which could allow it to remain for longer in our body. This in turn can cause us to become more sick and for longer durations, potentially putting our lives at risk if the disease is allowed to run unchecked in our body. Another reason would be that it would lead to more resources being needed to be diverted towards research for other methods to cure illnesses, where those resources could have been allocated elsewhere. Essentially with antibiotic resistance present, in order to deal with the diseases experienced, we would need to invest more money into research to discover alternative treatments to get around the antibiotic resistance. These resources could be monetary assistance, to physical resources such as laboratories and necessary equipment. It becomes a waste of resources as if antibiotic resistance was not a big issue,

	• If you have not read up on this issue, it would be good to do so since you cannot answer (properly) without some level of background knowledge • While I understand it may not seem as much as a "Hot Topic" per say, it is still quite a big issue that all healthcare professionals should be aware of Stop using antibiotics in healthy animals to prevent the spread of antibiotic resistance (who.int)	these resources could have been allocated to different areas or fields to further development in more crucial areas such as cancer research. In conclusion, antibiotic resistance is a huge issue in the world currently as not only does it potentially place us at a higher risk of more severe symptoms, it also drains resources that could have been utilised in a more useful manner.
What are the current major issues regarding antibiotic resistance?	• If you are looking for points, read it in the "Hot Topics" segment. It should give you a breakdown of what you need to know / a head start into how to tackle this issue • The question specifies "current" so	There are many major issues surrounding this topic, but I feel it is good for us to define what exactly "important" means since everyone has a different definition to what important entails. To me, "important" would refer to having a substantial impact on how the situation evolves and affects how we problem-solve towards a solution. One major issue I would like to highlight would be that GPs are expected to give antibiotics for just about anything, even when it is completely unnecessary. The pressure to convince patients that they have gained something from their appointments has, according to King's College London, caused a cycle wherein the GPs who prescribe fewer antibiotics have the fewest satisfied patients. This has been evidenced by 48% of GPs in

	it should at least be within the past year, and the question also uses the word “major” so you should break down how exactly is something considered major (aka what criteria do you use to determine the importance) • 2-3 PEELs should be enough, again focus on logical and structured approach with relevant examples if you have any • Good if you can explore the context of this issue with the world in mind, since it is not only just UK or Australia that is affected by antibiotic resistance	the UK have prescribed antibiotics to remedy coughs and bronchitis – but antibiotics have no effect on the common cold. Why I feel this is a particularly major issue is because prescribing them only contributes further to antimicrobial resistance, and in a way it is the cause for antibiotic resistance. It is particularly influential as GPs are the main outlet for prescriptions of antibiotics, and if they are able to restrict such prescriptions, it would allow the amount of antibiotics taken to be lower, subsequently decreasing the amount of antibiotic resistance experienced. Additionally, another issue I would like to mention would be the lack of education surrounding antibiotics and their use. Over 40% of patients believe antibiotics will help with viruses and even when antibiotics are correctly prescribed, patients often fail to follow their course of treatment.Why this is so impactful is because the regimen for antibiotic therapy can last days, weeks or even months, and patients frequently miss doses or even stop them entirely once they begin to feel an improvement. The most resistant bacteria survive, persist and multiply, and alternative antibiotics must be prescribed all over again. As such, if we are able to increase public education regarding the use of antibiotics and how to utilize them efficiently, we would be able to effectively cut demand to a proportionate level and hence less people would be taking antibiotics, lowering the resistance experienced. In conclusion, while there are many pressing issues regarding this topic, these two issues were more prevalent for me as I felt they were the root causes of the antibiotic resistance that we are currently experiencing.
Tell me about future treatments for antibiotic resistance and why they may be effective?	• The question is asking for “future treatments” which essentially	There have been quite a few treatments being tested currently and there are some that I would like to raise in my answer. One of these treatments would be teixobactin. It was discovered and found to be effective against common bacterial infections. This new drug was isolated by

		means that you will need to have been aware of any recent medical advances or breakthroughs in this field since answers such as public education is not particularly "future". • The second part of the question is also asking about the "Why" they may be effective, so it is especially important to elaborate further on the reasoning behind why you think they will be effective against the issue being raised • Additionally, good to define what "effective" means because everyone has a different definition to what exactly effective means	using an electronic chip to grow antibiotic-producing microbes in soil. However, it is still years away from being tested on humans and may not even work against bacterial infections in humans. Despite the aforementioned shortcomings of this treatment, why I think it may be effective is because it was able to be isolated and can be increased in quantity which could allow it to become stronger against bacterial infections of a higher load. This would be particularly important since in a human body, there would likely be more amounts of bacteria and by the isolation of the drug it would help manage the load of the disease. Another method would be using AI to improve prescribing and identifying patterns of resistance. The Department of Health and Social Care has committed £32m for research centres to help improve prescribing and identify patterns of resistance. For example, University College London (UCL) and University College London Hospitals (UCLH) are going to try using artificial intelligence to help tackle antibiotic resistance. They hope this will enable earlier diagnosis and treatment with the appropriate antibiotic and dose. Also, they aim to be able to identify more quickly cases where patients don't have resistant infections to ensure that unnecessary treatment is not given. Why this in particular would be so effective is because it would allow us to be able to stop excess prescribing of medication and that adequate treatment is given without making things worse. By preventing the situation from getting worse, it is effective in dealing with antibiotic resistance. In conclusion, while there may be many more solutions or treatments out there, I felt these treatments were worth highlighting as they are able to target the issue at the causes effectively and prevent the situation from becoming worse.

	• Read the segment in "Hot Topics"if you are unaware of how to answer this question and also it is good to do your own relevant research into the topic since the writing of this answer, there could have been more advancements	
How would the new opening of medical schools benefit the NHS?	• Think long term, remember that medical students need at least 3-5 years to be trained, so what are some long-term benefits? • The question is asking for benefits, so just stick to the question and think about 2-3 benefits that you want to raise up • Do medical schools just only contribute in terms of producing doctors?	A while back, there was an announcement that 5 new medical schools would be opened such as Hull York Medical schools. There are some benefits targeted from the opening of such schools which I will break down in my answer below. One obvious benefit would be that it could lead to an increase in the healthcare workforce as more doctors are trained and would join the NHS. Assuming each medical school trains up to 50 medical student (a small number just to make calculations easier), with 5 new schools, that would be another 250 trained doctors and taking away some who may not work in the NHS, at worst it would still be 200 doctors at the end of the day, which would contribute towards the gaping hole in the workforce, as more doctors enter the NHS to help work as GPs or in certain specialities that need more doctors. This benefits the NHS as the strain on the healthcare workforce will be reduced, allowing waiting times at A&Es and GPs to be reduced and more patients to be treated. Additionally, I think with more medical schools opened, it could lead to an increase in research carried out and in turn possibly lead to more healthcare

	What about research? • Could medical schools also encourage more students to apply to medical schools either UK or international students? What are the possible impacts of that • What are some issues faced by the NHS now and can opening new medical schools resolve those issues? • The question is asking for benefits, so you must show a clear "cause and effect" that originally it was like this, and then after new schools were opened, it became like this	advancements in the long-run. With medical students doing some form of research during the curriculum, while insignificant by itself, when collated it could lead to small contributions which over time can cause bigger advancements towards the healthcare field. Additionally, with more medical schools, some doctors at the end of the day could move into research fields and possibly help to contribute to advancements in certain fields, where the NHS can then incorporate and use which could lead to improved patient safety and quality of care offered. In conclusion, while medical schools could take up to 5 years to produce doctors, these would just be some of the possible contributions to the NHS.
Do you think that the new opening of medical schools would actually lead to filled-up vacancies for specialities such as	Similar to the question above, this one is asking for your opinion and whether **YOU** think it will fill up vacancies. • Again, explore both	It is certainly a difficult topic to approach since I am still a medical school applicant, and despite doing some work experience, it is difficult to really broach this topic and if such spots would be filled up at the end of the day, However, I

Emergency Medicine and even GPs?	sides of the argument and stay neutral throughout before coming to a conclusion / taking a stand • About 2-3 reasons for each side will be enough, and try to back up any points with relevant examples or observations • Do you know any stats? For example, statistically speaking most students become GPs and very few actually get specialities • Any pros and cons of such specialities that could allow the vacancies to actually be picked up? Such as emergency med being very stressful etc • Conclude with a clear statement to show your opinion. “In conclusion, I	would like to consider both sides before offering my opinion on this issue. On one hand, I do think that new medical schools could lead to filled up vacancies. Theoretically speaking, graduated medical students having gone through the 5 year course would move into the NHS, the core system of healthcare in the UK. As most medical students aspire to be a consultant or specialist in some form, eventually most speciality spots would be taken, which pushes the rest to take up specialities in EM and even GPs. Additionally, with medical schools allowing medical students to rotate through various specialities, it could spark an interest in certain fields and as a result push students towards filling up certain specialities. However, theory does not equate to practicality. While most medical students would end up working in the NHS, some international or even home students would consider moving elsewhere to work, which if significant enough, would still leave some vacancies in such specialties. Additionally, the responsibilities and scale of such specialities could be particularly taxing and have certain causes for the vacancies. As such, new medical schools may not necessarily lead to such vacancies being filled up since the root causes are not tackled. One example I witnessed during my work experience is that specialities such as Emergency Medicine is particularly taxing and exhausting due to the stress of certain cases handled, and as such drives away a lot of applicants who do not function well under such situations. As such, there are still vacancies in such specialities. In conclusion, I personally think that the opening of new schools would do little to actually fill up the workforce vacuums in certain specialties as the root causes are not targeted and solved. However, if steps were taken to help fix those issues, it could definitely fill up those spots. However, this is based on my prediction and that at the end of the day, predictions based on trends would not be an accurate representation.

	think the opening of new medical schools …..” • Can bring in personal experience / motivation as examples • Remember to mention that it is difficult to tell, since the system changes often and predicting on trends is not entirely accurate	
Apart from the opening of new medical schools, what are some methods to fill up the workforce vacuum currently present in the NHS?	• Note the factors given in the question, opening of new medical schools are already mentioned, the workforce vacuum (in what sense? Only doctors or do they include healthcare staff in general), and the term “currently present” (means that they are referring to the past 6 months to a year) • The time frame is seriously important so	The workforce vacuum currently present is a consequence of issues long unresolved and recent developments which exacerbate the situation. In order to adequately address the issue, methods would need to target both the root causes and current developments to be effective. One method that seems pretty obvious would be to increase the pay for healthcare professionals as well as provide additional resources to help achieve the demands of such staff. One instance that comes to mind would be the potential JDs striking due to pay being unable to keep up with inflation and the pressures / stresses faced by their jobs. As such a method would be simply to meet the demands of such professionals and also provide support services such as channels for healthcare staff to seek support if needed. By ensuring the needs of such professionals are met and they are kept happy, it would lead to more healthcare workers being willing to return to work and fill up the vacuum. While in theory it sounds fantastic and definitely something feasible, one concern I have would be that if it was as simple as stated, it would have been done by now. The issue is more towards the fact that money cannot be procured immediately, and the impact of such an issue can

		do not bring up examples from the past or if the issue has already been addressed • Currently the big issues are JDs balloting to strike in 2023, nurses striking, Brexit causing many healthcare professionals to leave / not wanting to join • Monetary is a good way to explore potentially helping to solve the problem, but where does that money come from? Do not just throw out random answers without any logical backing or reasoning • Think creatively and justify your views, explain out thought process CLEARLY and do not assume interviewers	possibly only be felt years down the line as policies take time to be passed. Another method could also be lowering the barriers to entry for healthcare workers to enter and work in the UK. Ever since Brexit occurred, many healthcare workers such as nurses actually left the NHS since it is more difficult to return home when working in the UK, causing the vacuum present. By removing such barriers, it could encourage healthcare workers from all over the world to come to the UK to work. However, such a method also has its drawbacks. The first issue could be that despite lower entry barriers, healthcare workers could be scared away by the deteriorating situation such as inflation and poor working hours / support. And hence choose not to come to the UK. The second issue would also be that such a policy has a lot of legal red tape around it and even if healthcare workers come, they may not fit with the standard of NHS care and as a result could even make the situation worse as more time is needed to upskill such workers to the quality of care expected. In conclusion, these are some methods that could potentially fill up the workforce vacuum. However, with anything, there are certain drawbacks and if addressed, it could definitely lead to some improvement in the workforce vacuum.

	know anything	
Should the workings / data of the healthcare system be publicly published to prevent cases such as the Shropshire Maternity Scandal from happening again?	• First things first, break down what is the Shropshire Maternity Scandal. You do not need to break it down super detailed but painting a rough picture of what it is and why it matters is the most important thing to do before actually answering • This is a pros and cons question, and your approach should be as such. Explore both sides as evenly as possible (2-3 reasons for each side would be good) and use relevant examples to back it up • Think of the implications that publishing such private data could have not just	The Shropshire Maternity Scandal was an incident where an interim report examining 250 cases found that at least 42 babies and three mothers may have died avoidably. It also found that more than 50 newborns may have sustained avoidable brain damage. Repeated clinical errors were inadequately followed up, which meant important lessons were not learnt. Bereaved families weren't treated with kindness or respect, with instances of staff referring to babies as 'it' and one baby's body left to decompose for weeks after a post-mortem. Let us explore the pros of publishing such workings and data of the healthcare system. For one, it could most definitely prevent such tragic occurrences from occurring again where data is published and makes sure that the healthcare system is kept up to professional standards as it is expected to uphold. Additionally, with such data presented, it encourages healthcare professionals to fully commit to providing the best quality of care whenever possible and drives up honesty, responsibility which most definitely could drive up the standard of the NHS in general. However, with any pros, there must be cons. The obvious one would be that with publication of such sensitive data, not only would that be a breach in patient confidentiality as information is publicly accessible to anyone, it also places patients and healthcare staff in danger. Patients could be targeted by blackmailers who may use their personal private data for nefarious purposes, while healthcare staff may be targeted by disgruntled families who deem the efforts of such staff insufficient. Similarly to the cyberattack on Singapore's healthcare system (SingHealth 2018 data leak) it is most definitely a serious threat to everyone. Additionally, another con would be that the workings and data could be manipulated and circulated publicly, causing confusion and mistrust in the profession if left unchecked. With the

	on the profession, but on the professionals and the patients themselves • You will need to take note of the word "Should", which essentially means you need to take a stand on the issue / in your answer. The answer should be quite obvious, make sure you justify your reasoning why.	prevalence of fake news currently, it is not difficult to see such workings manipulated and used to spread false lies, which would harm the profession in the long run. In conclusion, while the Shropshire Maternity Scandal was a very tragic event, publishing such data would be inadvisable since the cons outweigh the benefits significantly. There would be other possible methods to explore to prevent such tragedy from occuring again.
Why do you know about the Francis Reports and what impact did it have on UK healthcare?	• You need to know what is the Francis Reports first, break it down into a manner easy to understand for the examiner since they may not know what it is • The question is asking "Why do you know" instead of "What do you know",	The Francis Reports exposed appalling treatment and high mortality rates at the hospital and concluded that an estimated 400 to 1,200 people could have died unnecessarily there between 2005 and 2008. Recurring problems emerged, such as: • Call bells going unanswered • Patients left lying in their own urine or excrement • Food and drink left out of reach of patients • Patient falls being concealed from relatives • Too few consultants and nurses • Poor communication between staff and relatives of the patients Why I know about this matter is because of just how much of an influence this played on the evolution and progression of UK healthcare, and just how shocking

	so your answer should be more towards the Why and how you know about it, what impact did it play etc • There is also a second part to the question so explaining and delegating equal time to both parts is very important • What kind of impact is a little vague, perhaps break it down in the social context, the professional context etc • Read up on the Francis Reports if you are unsure of what it is about • UK healthcare is not just doctors, it includes other healthcare professionals as well, so try to diversify your argument or your	certain issues were so prevalent and unacceptable, that without this set of reports, it could have continued to be hidden for unknown amounts of time. The Francis Reports may seem like an issue of the past, but the lessons and subsequent actions taken after has shaped UK healthcare to this day. There are some impacts that it definitely had on UK healthcare, with one being the measures taken to protect healthcare professionals. Staffing levels and skill mix were improved and the culture that was previously toxic and hostile was actively removed through protection of whistleblowers and eradication of bullying. This was evidenced by the government taking actions to improve patient care, increasing openness and changes to regulation in hospitals at the end of 2013. Additionally, another impact would be the increased regulations and standard of training for healthcare workers. Training and regulation of healthcare assistants were improved and recruitment, training and standards of registered nurses were also increased. This was evidenced by NICE. NICE was also asked by the Department of Health and NHS England to create guidelines on staffing capacity to ensure safety in the NHS. In conclusion, the Francis Reports were a shocking exposure at that time and it has led to significant impacts in the form of improvements in the quality of care offered and protection of healthcare workers.

	explanation to widen the scope represented	
Do you know about the Bawa-Garba case? Share your views regarding the situation.	• Explain what is the Bawa-Garba case, not everyone knows about this case • Answer the question directly, "Yes I know about it….." or if you do not, "No, I do not know about it…." • While it may be tempting to say that you do even when you actually do not, **DO NOT LIE** because the whole question is based around the case and follow-up questions may be asked • Additionally, if you at any point start to feel uncertain about what is being asked / talked about, admit it that you are not very familiar and seek help since it is	Yes I am aware of the Bawa-Garba case. This case is regarding a young child called Jack. Jack's condition deteriorated that day and unfortunately, he passed away. He was seen and assessed by junior Doctor Hadiza Bawa-Garba, a paediatric registrar in year six of her speciality training (ST6). Dr Bawa-Garba was taken to High Court and on 4th November 2015 was found guilty of manslaughter on the grounds of gross negligence. To thoroughly understand the Bawa-Garba case, it's helpful to be aware of the mistakes Dr Bawa-Garba was ruled guilty of by the Court. These are: • When Jack was admitted, Dr Bawa-Garba ordered a chest x-ray that showed an infection. The x-ray results were available from 12:30, but didn't get seen until 3pm. Dr Bawa-Garba then prescribed antibiotics, which were administered at 4pm. It's important to understand that prescribing antibiotics earlier could potentially have led to a different outcome, but the ward was understaffed and Dr Bawa-Garba was extremely busy. Furthermore, she had not been made aware that the x-ray was available at 12:30. • A blood test revealed high levels of C-Reactive Protein (CRP), which occurs due to infection and inflammation. This was reported over five hours late, due to failings in the hospital computer system. • When Jack was assessed by Dr Bawa-Garba she

	impossible to know everything perfectly • Since the question is asking you to share your views, you should provide a balanced argument to both sides of the questions, saying anything you think you agree or disagree with the situation etc • Remember it is not necessary to take a stand on this issue, because the question is asking for your views on the matter at hand, not your stance • Be empathetic to those involved especially the doctor in particular since she went through a lot prior to the incident	stopped the medication for his heart condition. However, she did not document this in his notes, and subsequently, this medication was administered to Jack at 7pm by his mother. Jack's mother was unaware that he was not to be following his usual course of treatment for his heart condition. • Jack suffered a cardiac arrest at 8pm. Dr Bawa-Garba was one of the Doctors who attended the call and arrived when resuscitation was already taking place. Dr Bawa-Garba mistook Jack for another patient, whose notes were marked as DNAR (do not attempt resuscitation), and therefore Dr Bawa-Garba called off resuscitation. Resuscitation was re-continued shortly after the mistake was identified. Jack died at 9:20pm. In my view, it is a highly tragic event which was exacerbated by multiple factors, where there were multiple parties at blame here. The first that comes to mind would be Dr Bawa-Garba herself, whose negligence to a certain degree caused the death of the young child. However, there were also multiple shortcomings by the system which added onto the situation and worsened the situation at hand. It should be noted that prior to the 18th of February, Dr Bawa-Garba had an exemplary record. She had also just come back from maternity leave. Whilst mistakes were made by Dr Bawa-Garba, there were also issues within the hospital's system which contributed to the negligence in care provided. Notably, these are: • Dr Bawa-Garba was carrying out the work of two Doctors and the

		hospital was extremely understaffed. ● Senior consultants were not on-site and therefore Dr Bawa-Garba had no one to report to. There were not enough senior nurses on the ward, either. ● The failings of the hospital computer system prolonged blood testing results. There was also no system in place to notify Dr Bawa-Garba that the x-ray was ready for analysis. ● Nurses did not notify Dr Bawa-Garba that Jack was deteriorating. ● The administration of medication for Jack's heart condition was not carried out by Dr Bawa-Garba. These are important factors to consider whilst weighing up whether Dr Bawa-Garba should take sole accountability for the case. Arguably, whilst mistakes were made on her part, if the hospital had been staffed correctly as well as the right administrative and technical systems in place, the situation could've been prevented.
What are some important factors to consider during the Bawa-Garba case? Who is at the biggest fault in this case?	Similar talking points to the question above, just adding on some parts. ● The question mentions "important factors", so what makes it important? How do you define importance? Make sure that part is clear in your answer in particular ● The question is also asking for who is at	I personally feel that it would be good to define what "important" means in this context as everyone has a different understanding of what important means. In my answer, I will be referencing something as important provided it had been crucial to how the situation transpired, or perhaps influential if something was done differently. One important factor would be the system's shortcomings. As referenced in the case itself, the doctor was handling workloads worth of two consultants without any help, and healthcare staff did not alert the doctor even when Jack was deteriorating. Additionally, the system did not alert Dr Bawa-Garba of the ready test results and the medication, which affected Dr Bawa-Garba's ability to care for Jack. While it can be debated that the doctor should have taken more initiative to care for Jack, given her heavy

	the biggest fault, but can there be someone at biggest fault? How do you decide who has the biggest fault? Is it fair to pick someone? • Should also mention that everyone / no one is at fault since the issue is so complex that it is difficult to pick a side essentially but if you had to pick, you would pick because…..	workload it would have proved impossible. Why I feel that this is so important to consider is because it drastically influenced the outcome of the situation where if healthcare staff had alerted Dr Bawa-Garba of the situation, Jack could have been given proper care immediately, saving his life. Additionally, Jack could have been treated much faster if the system had actually alerted the doctor of the confirmed test results, and potentially be treated in time to prevent deterioration. However, another important factor would also be the Dr herself. The Dr had seen Jack a little over 2 hours late, and prescribed medication for Jack in the form of antibiotics. If that medication was given earlier it could have led to a potentially different outcome, which to some extent makes her guilty of gross negligence. Additionally, she did not document vital information on stopping the medication usually given to Jack in the notes, and had also mistaken Jack for another DNR patient. These events in particular were important as if they did not happen, Jack could still be very much alive today. In regards to who is the most at fault here, personally I think it is impossible to come to a definite conclusion as there were many factors to be considered and to what extent these factors were influential on the outcome is debatable. However, if I really had to pick one, I would say the system was at the biggest fault here. This is because if Dr Bawa-Garba had enough support and took on a standard workload, she could probably be not as fatigued and may not have actually committed the mistakes that she did, given her stellar record prior to the incident. While her actions were definitely at fault to some extent, I believe that the system had the biggest role to play.
What are your views regarding private healthcare?	• Question is asking for your views, so either way you should be taking a	Private healthcare, essentially refers to privatisation of healthcare, where people pay for healthcare such as operations or simple treatments / diagnoses. I can see the pros of such private healthcare as argued by some people in the UK. For instance, private healthcare

	stand or at least providing some opinions on how you feel about the matter • Approach the question rationally, break down the concept of private healthcare first, raising any relevant examples before going into your opinions • Structure wise, I would recommend: What is private healthcare / breakdown of private healthcare Pros of such healthcare Cons of such healthcare Personal views / does it work or fit in the country (which is UK for this question) • Be methodical, remember private healthcare is a HUGE topic so break it down in an easy to	enables people to pay for certain operations that they may want to undertake but are unable to because of long waiting times, or seek immediate treatment to settle any worries that they may have instead of waiting weeks to meet a GP. Additionally, given the long waiting times at A&Es and GPs currently in the UK, it serves as an alternative to healthcare where they can get treated before things get worse. Additionally, private healthcare encourages competition to some extent as companies / systems fight to provide the best quality of care at lowest prices possible to retain "customers", as learnt in Economic Theory. This could drive up the standard of care offered, as patients receive quality care. However, like a coin, there is a flip side to the benefits listed. One con would be that such healthcare is only available to those who can afford them, and as a result deprives those who actually need such treatments from them. Additionally with privatisation, queues could be made longer as people jump ahead to receive treatments since they can pay and that at the end of the day, others who really need the treatments could be forced to wait and worsen as a result. Another consideration would be that competition may not necessarily lead to improvement in services but worsen them, as companies / systems would be too focused on fighting against competitors. In conclusion, my personal view on private healthcare would be that I agree with some parts of it, but on principle, I disagree with it. I personally agree with the NHS that healthcare should be free and accessible to all, and privatisation could ruin the system entirely. However, there is no denying that such privatisation has its benefits, and that blending the two together into a two-tiered system could be the best possible way forward.

	follow manner • Personally, I do not think there is a right or wrong, interviewers are just looking for your approach and logical reasoning behind the question	
Would private healthcare affect the way the NHS functions in the long-run?	• First you got to know how the NHS functions, which is essentially free healthcare to all residents in the UK • Break down first what is private healthcare, how does it work and how can it be incorporated • Compare the two and think if they can co-exist, if they are unable to, then think more about whether they will improve or destroy each other • I would recommend exploring both	Private healthcare, essentially refers to privatisation of healthcare, where people pay for healthcare such as operations or simple treatments / diagnoses. I personally would like to explore two situations in my answer below. The first situation would be whether private healthcare would be able to coexist with the NHS. On principle it does seem contradictory as the NHS is focused on free healthcare to all but yet private healthcare charges patients for the costs of seeking and providing treatment. But yet, it seems to become increasingly prevalent as the private healthcare industry grows ever steadily. As such, in my opinion it seems that private healthcare may not be able to peacefully co-exist with the NHS in the long run, since private and public healthcare pull out healthcare workers from the same pool of workers and if one thrives, the other would struggle. That then raises the question, would the NHS and private healthcare improve or destroy one another? Looking at the BMJ reports, it was stated that such a system is a realistic prospect “only in London and southeast England, where coverage by private medical insurance is already heavily saturated”. For most people living in other parts of the UK, “the NHS is the only option for most complex types of care”. There is an undeniable benefit that with private healthcare, it takes off pressure from the NHS as there are less patients to deal with, but the cons to it

	possibilities that it can improve and can also destroy the NHS and how it functions • Use relevant examples to back up your points before explaining the possible impacts • Question also uses the term “long-run” so use the approach of breaking it down into 1-Year, 5 Years and 10-Years. Or you can just simplify it into 5 Years and 10 Years since 1 Year may have little to no impact on how the system is affected	would be that the healthcare pool of workers are shared between both industries, and if one industry has more workers, they would most likely destroy the other industry. In my opinion, I personally feel that private healthcare would most definitely impact how the NHS functions in the long run, as the NHS would need to become more competitive to fight against the private industry. Additionally, the NHS may eventually evolve to a system that mainly treats those who are unable to afford private healthcare, with the private practice becoming the more dominant healthcare provider in the long term.
Can private healthcare and the NHS function together in the long-run?	Similar to the question above, now it requires you to focus specifically on whether it can function together, essentially your scope of answers does not need to be so wide anymore. • Similar talking points to the question above	[redacted]

Where would you like to practice medicine after you qualify?	• It will be good to show maturity and understanding of the real world that you cannot predict things especially at such an age, and that you are keeping an open view on things • Not sure if this is true, but medical schools will mainly want applicants to say that they want to practice in the country they study in, in the region of the UK / Australia / etc. Would be good to mention (even if you are not sure) • In regards to after your qualification, it is quite open ended so don't be afraid to mention if you would like to practice elsewhere after you become a consultant	Personally, I think given the current world situation and the ongoing events within the countries, it is really difficult to ascertain where I would like to practice, especially since new developments can cause the infrastructure to fundamentally change in a matter of months. However with that said, I would like to practice medicine in the UK, preferably in the NHS if possible after I qualify. This is because I have always held the belief that healthcare should be free at the point of access, and that those who need it do not need to worry about exorbitant fees. Healthcare should be a fundamental right and working in the NHS would allow me to do so. Additionally, I align with the NHS values set out, such as "Commitment to quality of care" and "Everyone matters", as whatever we do should always be done to the highest possible standard, while including everyone who may want or need the help. Taking a rough look into the future, perhaps after working in the UK for most of my career, I personally would like to return back home to my home country Thailand, and perhaps settle down in a less well-to-do area, such as a rural setting. This is because having done my WEX in such environments, my heart really goes out to them and it was one of the driving decisions for me to want to pursue medicine, where I can set up my own practice to offer to these people. While I thought of carrying out care on missions (where you can volunteer to go to developing countries to support the system), I personally would like to return to my roots and would want to contribute to the environment that I grew up in. In conclusion, it is quite difficult for me to make a decision now, since eventually I may need to consider the needs of my family and children, but I have a rough idea as of now.

	etc for instance • This is kind of a motivation question in a way so it would be good for you to elaborate more in-depth rather than going for scope	
Have you overcome any biases in your life?	• Define what biases are and perhaps what kind of biases you have had previously (racial,social , etc). While I do not recommend portraying extremely sexist / racial comments or basically being very controversial , if you really want to you can. • The word “overcome” suggests that you have changed (pretty much completely) so the process is important, but your main focus should be what you learnt, how you grew as	I would like to think that I am a relatively self-aware person who actively tries to take steps to resolve any biases I may have, but there are definitely going to be some that we overlook at times. There is one particular bias which I feel fundamentally changed how I am as a person which I would like to bring up. Back when I was around 7, I was a very insensitive individual who often spoke my piece of mind without much thought, and felt that “freedom of speech” meant I could say anything I wanted. I remember having the belief that able-bodied individuals could do everything better than disabled individuals, and often went around shooting my mouth off. I remember when I had encountered a stranger in a wheelchair playing basketball, I spoke out loud that I do not want him to play since “he would not contribute to the team”. He then proceeded to laugh and challenge me to a 1 on 1, which he absolutely demolished me in. Looking back on this now, the social bias I had towards disabled people was wrong and it was very insensitive for me to say such things at all, especially around them. This is because while it may not have a “physical” impact, it could most definitely have an “emotional” one, and it in fact could be a fear of theirs which I amplified with my comments. I deeply regret having that mentality and ever since have proactively tried to educate myself and be more aware of the impact my words can have on others. I came to the understanding that everyone is equal

	a person and how you have changed • In my opinion, STARR works quite well for this question but you can use other techniques if you feel comfortable • Remember that for STARR, the most important aspects are RR and STA should only be enough for context, not too long or too short	regardless of their position in life, and that we all should be kinder and more understanding of those around us, not to be insensitive or discriminatory.
If you could watch any medical procedure being performed, what would it be and why?	• Truly a difficult question especially if you do not have a lot of knowledge about difficult procedures (since they may prompt you further) or if you do not know much about procedures in general • Try to avoid procedures like consultations or speaking to patients since those	I have done quite a bit of work experience and have actually done my shadowing in the surgery department, where I got to witness orthopedic operations, C-section, and general surgery procedures. However, there is one particular procedure that caught my attention since I was young, and that would be an organ transplant, in particular the heart. Why this is so special for me is because I have always had a fascination with the heart and how it functions. I always viewed it as the engine of our body, keeping us alive and removing it seems quite natural to assume that we would die. While we have technology that is able to mimic the operations of the heart, to keep blood pumping to the rest of the body, I think it is so intriguing for me because it seems like such a complex organ to place back into the body, and that it runs such a high risk of being rejected by the body especially if it does not fit the donor. Additionally, I have heard stories or seen videos such as dramas of transplant

	are things you would most definitely have seen in your work experience • The term procedure does not mean that it is **ONLY** surgical related (it is a common misconcepti on), it can be clinical related as well. It does not need to be specifically medicine, since medical procedure can mean research as well • The question is looking for 2 aspects, the "What" and the "Why" so your answer should just follow the prompts given (so you have a proper structure + cohesive explanations) • You can relate it to your interests but just be careful to not name or	surgeries taking a very long time to do so given the complexity of the operation. To me, I view it as a testament to the skill of the healthcare team and a medical achievement, and as such would like to witness such an operation first-hand if possible. It may be routine for certain healthcare professionals, but during my work experience I did not yet have this chance to do so, and hence would be a dream of mine of sorts. While other candidates may pick seemingly more "impressive" operations, I feel that transplant surgery, in particular the heart, would be something I would like to witness. I have tried to study a little more into this by watching videos and speaking to professionals, but given the lack of training I am still quite lost and hence would appreciate the opportunity to witness this procedure myself.

	make it sound like this speciality is all you are interested in • For the "Why", if you are unsure, just go for two points, perhaps that are more generic. Admit to the examiner or interviewer if you are unsure because waffling for this kind of question is not recommend ed	
How has the public perception of doctors changed over the last 50 years?	• For this question it would be good to avoid listing too many aspects, especially if you are not very aware of how much has changed. In my opinion I would go for two major aspects • Remember that public perception is a very vague thing. Apart from just how patients view doctors as a	I think there have been some changes in terms of how the public views doctors now compared to 50 years ago. The first thing I could think of would be that previously the public may have viewed doctors as infallible individuals who were always doing the right thing, but now the public understands that doctors are still human like the rest of us. Back when medicine was not well-understood due to a lack of education, the public viewed doctors as "gods" or "flawless" as supported by the old and outdated perception of doctors always being able to do good and be on their job all the time. However, after incidents like the Harold Shipman incident in the UK where he was convicted of murdering 100s of patients, the public has since been more aware of the truth, that doctors at the core are still human and are not what they may seem to be. The public has since adopted a more human view on doctors and are more understanding of how doctors really are. Having mentioned this, I also would like to mention that public perception has not

	profession, you can touch upon how doctors are now viewed differently as people etc • Since the term used is public perception, try not to limit your answer to one specific country (i.e UK only). You can raise examples of specific countries for instance • You should show a very obvious change (cause and effect) in your answer, to make sure the interviewer knows that the perception has evolved etc • In my view, the time aspect of 50 years is not the most important, but instead something you keep in mind in your answer. If you are not entirely aware of	been all bad, but instead it has also experienced some positive changes. 50 years ago, the professionals were viewed as cold, distant and scary to some since they appeared to be foreign. However, nowadays, doctors are viewed in a more positive manner where there is less of a distance between the public and doctors. I refer to the recent COVID-19 crisis, where the public actually applauded healthcare workers and consequently doctors for their efforts in combating the virus. In my view, if the public still felt that doctors were cold and scary, they would not have been willing to do such an action for them, which shows the progress that the perception has had in the long run. In conclusion, while it is hard to summarize all that has changed from the past 50 years, in my view public perception has changed for both the good and bad regarding doctors.

	what has happened in the past 50 years, avoid naming specifics	
“Lawyers say if you never get sued, you’re not a good doctor” - Dr Ranjana Srivastava Do you think this is true?	• Remember always do balanced views / arguments, since this is an especially divisive viewpoint, it would be good to show that you can see both sides of the argument • Define what is a “good doctor”. What do you consider to be a good doctor, what is your criteria? Make sure you explain it clearly for the examiner to know how you see it (since everyone sees it differently) • Think about why lawyers may see it this way (perhaps it could be because they lack awareness or	I think it would be good for me to first discuss what makes a “good doctor” in my view since everyone has different criteria for what makes a doctor good. In my view, a good doctor is someone who upholds professionalism and the ethical pillars as much as possible, actively aligns with the GMP 4 Domains. With that said, let me explore the possibility of the statement being true. I can see where they are coming from, with the intention meaning that if a doctor is not willing to take risks to help a patient, the doctor may not be actively trying to do good for the patient and in their best interests. This comes from the basis that doctors get sued by the patients for undertaking certain types of treatments to try everything they can to help the patients. If the doctor is not trying their best, it would be in violation of professionalism + ethical pillar of beneficence and hence by the definition I laid out previously. However, looking on the flip side, I also think that this statement may not be true. As mentioned, this statement comes from the basis that doctors do not take risks to help their patients. However, it could be a lack of understanding of the medical profession that it is not because the doctor does not want to, sometimes it could not be done by the law (regulations) or that the action may not actually be in the best interests of the patient. For instance, the undertaking of a very specific treatment that has not been trialed may actually cause a patient to suffer worse as compared to not undertaking the treatment in the first place. As such, based on my definition, the doctor is aligning with the ethical pillar of Non-maleficence and is acting in the patient’s best interests which would make them a good doctor, proving the statement wrong.

	understanding of our profession?) and explore it in your answer to show your support for the proposed view • The question asks as well if “YOU” think it is true so it is really important to provide your own personal opinion in the answer. I recommend putting it in the conclusion over in the introduction to avoid potential bias in your answer	In conclusion, in my personal view I feel that this statement is a gross simplification of the profession and is false, although the intentions may have been in the right place. Good doctors do not need to be sued to be a good doctor, and I feel that the statement is hence untrue.
Why might the practice of medicine be different in the UK and developing countries?	• Define what is the practice of medicine. Since it is so broad (could be consultations, diagnosis and prescription or surgical operations, education and awareness etc), if you define it can	I think the practice of Medicine in this question could extend from not only the consultations that occur but also perhaps the diagnosis and prescription of medication as well as surgical operations. Moving on to why it may be different, one reason I can think of is the lack of resources in the developing countries compared to the UK. Assuming the UK is considered to be a developed country, the lack of resources such as money, natural resources and manpower in developing countries could explain why it is different. Developing countries may lack the money and resources to build infrastructure such as clinics or hospitals, and may not be able to purchase medication for prescription in their

	give you a lot of talking points to mention in your answer. Remember that medicine (especially the practice) is not just consultations, there is more to it than just that • Think about the differences in the UK and developing countries, especially regarding socio-economic and environment issues. Think about access to healthcare resources, or even just resources and political will for instance • The question uses the word “Why” as the command word, so avoid listing things and focus on explanations (2 in-depth points should be	country, as such leading to a difference in practice of medicine. In developing countries, doctors may end up practicing out of their own homes using tools that are made by themselves for instance if they were to carry out operations such as surgery. Another reason would be the lack of education and possibly the cultural differences experienced in developing countries compared to the UK. Developing countries may not have access to medical schools and hence the doctors there may be trained in different ways compared to the UK, which would be similar to how cultural differences may play a part. For instance, developing countries may follow a particular way of treatment since that is how it has always been done, as such accounting for the difference in the practice of medicine. In conclusion, I feel that the lack of natural resources and possible cultural differences may be able to account for the difference in practice of medicine, since it is a relatively complex topic to break it down definitively.

	enough, and better than 3 rushed points) • Frame your answer in a way that does not mock or look down on developing countries, you should not be insensitive towards them and make it sound as if you are arrogant and hence looking down on them	
Should doctors or politicians be in charge of running the NHS?	• In my opinion, this question is a bit of a loaded question because if you are not careful it can come across as too critical or insensitive towards either side you pick, so it is best to remain neutral • I would suggest a structure along of PEEL, where you make cases for both sides why	In my view, I think it would be good first to break down the roles and responsibilities of both sides, and the possible benefits and drawbacks of running the NHS before making a decision. For doctors, I view that they are the ones who currently work in the NHS, and would be well-versed in the operations of the healthcare industry. As such, a possible argument for why they should run the NHS is that they would most likely be the most aware of the current issues facing the NHS and can best delegate resources to tackle them to improve the situation. Additionally the doctors would also be able to best decide the direction of the NHS and where it should be headed as they would likely be aware of potential health issues and take measures to deal with them before they occur such as possible re-emergence of COVID-19 or improving the tools used by surgeons to accommodate for increasing number of female surgeons. However, a possible argument against this would be that doctors may not be well-versed in the field of politics and navigating legal issues, which could cause red tape

	they should be in charge of running the NHS, before providing a conclusion • Remember to argue both sides to the question, especially here since they provide two sides who are involved in the situation • Think about how the NHS should be run (you can draw from current experience of how it is being ran) and think about the skillsets of both sides, which side is able to supplement and support how the NHS should be ran • Their roles sometimes overlaps so that should clue you in on how to actually answer this question	complications and find difficulty in implementation. As for politicians, I view that they are the opposite of doctors in the sense that they are well-versed with the legalities of the system but not as informed in the healthcare aspect. A possible argument for this would be that politicians may be able to weigh more factors apart from the healthcare benefit and navigate the legalities more efficiently, leading to faster implementation of policies. However, the counter argument would be that they may lack a full understanding and awareness of the issues faced in the NHS now and in the future, leading to slow implementation of possibly ineffective policies that may not resolve the issues that are faced. In conclusion, I feel that it would be best for both doctors and politicians to be involved in the running of the NHS, where politicians consult doctors on the best course of action to take and doctors support politicians in the implementations of the policies to ensure the maximum possible benefit is attained.
What do you think about the recent doctors' strikes, particularly when	• In this question, the question actually separates	I think it is really important to look at this from two perspectives, before and after the withdrawal of emergency care to demonstrate the shift in my opinions.

emergency care was withdrawn?	itself into two aspects, before withdrawal of emergency care and after the withdrawal. So you should structure your answer along those lines since that is how the question phrases itself • Think more than just clinical impacts, what are some social or economic implications of doctors striking? How does it affect the doctors, the healthcare teams, the public etc • Remember patient safety and how important it is, can bring in GMP 4 domains if you want to as well • Avoid leaning too heavily towards supporting or criticising the doctors striking, because	Before the withdrawal of such care, I had already felt a sense of empathy towards the doctors and the healthcare professionals as they were already placed under a lot of pressure given the recent COVID-19 pandemic and the staffing shortages brought about by Brexit. Additionally they were facing pressure on their wages due to inflation and were striving to receive enough to be able to survive. I viewed it as an important way of raising awareness about the difficulties faced in their work environment and a way to express the need for additional support from the government both long term and short term. While I originally thought it was an action that could perhaps violate patient safety, in a consequentialism perspective, where the “ends justify the means”, I thought it was a necessary action to occur. However, after the withdrawal of such care, I felt an even stronger sense of empathy towards them as it was to me a desperate last-ditch effort to receive support from the government. Reading about the long shortages and staffing crisis demonstrated to me that now doctors were not only striking to receive support for themselves, they were also striking to demonstrate just how desperate things were getting and that if there is no intervention now, the NHS would completely collapse. Initially I thought that by removing such care, the doctors would be going against the domain of Safety and Quality in the GMP, where they are disregarding patient safety. However, having read more about what is going on, I now see that it was a really desperate action to invoke change in the short-term just so that patient safety is maintained. In conclusion, I have always held an empathetic view towards this situation but after the withdrawal of emergency care, I really began to fully understand how severe the situation was getting and why such an action was necessary in order to resolve the situation.

	balanced views • Explore motivations behind the strikes, and remember why it was done. It was not a decision made overnight, it was a decision long been coming and a cry for help from the profession itself (Show empathy for why they had to strike) • Bring in relevant statistics if you actually know any (good but not necessary)	
What do you think about the ethics of private healthcare?	• 4 ethical pillars should be brought into here and if you know about the other medical ethics concepts such as utilitarianism / deontology / consequentialism, do bring them in as well	I think it would be good to consider this question from two perspectives, one being the ethical pillars of autonomy, beneficence, non-maleficence and justice, and the second being from a utilitarianism perspective. From the first perspective, in line with the Autonomy and Justice ethical pillars, I feel private healthcare abides by those pillars, where patients are allowed to choose whether they want to seek private healthcare or seek public care via the NHS. Private healthcare also operates within the guidelines imposed by the government, and is legal in its own way. While a case could be made that private healthcare is unfair because only those who can afford it are able to pay for such care, I feel that if you regard purely those

	(but do remember not to force them, make it natural) • PEEL structure for the ethical pillars + concepts should provide a decent way to explaining it • Make sure you present both the good and bad regarding each ethical pillar / concern so as to demonstrate balance • Is private healthcare inherently bad? Why or why not? Make sure to explore why • You can bring in context of how healthcare is like in the UK or Australia to help formulate your answer	that can pay, private healthcare is "fair" as all who can pay do end up receiving said treatment. As for Beneficence and Non-maleficence, while some cases have occurred in which private healthcare practitioners do harm to patients due to monetary motivations, in general, private healthcare still seeks to do good and do no harm towards patients. As for the second perspective, utilitarianism refers to fundamentally that society's welfare is maximised. From this view, private healthcare can be deemed as maximising society's welfare in the sense that they provide healthcare services that can be essential for the population, allowing patients to seek out help when needed. This could potentially be seen in the UK, where due to long waiting times and backlog of patients, private healthcare can help to relieve some of that burden and support those patients who need them, ensuring patient safety. However, an alternative view could also be that private healthcare does not fundamentally maximise society's welfare. It is understood that private healthcare is a profit-driven business, and that at the end of the day, the prices charged could be higher than the actual cost, leading to patients paying more than necessary, which causes them to lose out on potential benefit that the money can lead to, hence not maximising the welfare. In conclusion, I feel that private healthcare is considered to be a divisive topic, especially in the UK, and can be seen as either ethical or unethical depending on where you stand.
Should surgeons get to know their patients before operating on them?	• Pros and cons structure for this question is recommend ed since you	I think there are both benefits to be had and drawbacks that could affect the individuals in this case. Looking at the possible benefits, one I think is worth mentioning is that it provides the surgeons a chance to reassure the patients prior to the

	can split the question easily to show a balanced view ● Think about the benefits obtained from not only the patient, but also the doctors / surgeons. Sometimes speaking to patients can allow the doctors to double check information etc or can help make the process easier to handle depending on the extent of operation needed ● Good to bring in any relevant work experience examples if you have any, to show that you can support your points and validate them ● While benefits are quite easy to see, the drawbacks must also be mentioned. If you	operation and also to confirm any details before the operation. There will be patients who are very nervous in such situations given the unfamiliar environment, and speaking to the patients would allow them to feel assured and less panicky. The surgeons can also ensure that they are operating in the right location and there are not any details that were overlooked that could jeopardise patient safety. I remember during my WEX, all the surgeons I followed around took the time to speak to the patients prior to the operation outside the OT, at times even escorting them inside to calm their nerves. All in all, there are benefits to be obtained from both the patients and the surgeons if they were to get to know each other. However, there are also some possible drawbacks. One of it would be that it could make the situation more complicated if the operation was to go south, where personal emotions can paralyse a surgeon's decision making and in the worst case, if the patient passes away it could pose an even heavier emotional toll on the surgeon who has to deal with the emotions of losing a patient. I have read some autobiographies online where some surgeons recount losing a patient as they were distracted or paralysed by certain factors during critical moments. Another drawback could be that if all surgeons took the time to really get to know the patients, it could cause fewer operations to be done in a day which can contribute to an even bigger backlog in patients and cases to manage, such as the backlog currently faced at the NHS. In conclusion, I feel that a balance should be struck, seeking to maximise the benefits while minimising the drawbacks. Surgeons should get to know the patients but from a professional standpoint so as to prevent any complications such as emotions clouding decision-making during the operations.

	cannot think of many, 2 will be enough, just make sure to balance them evenly • Personal views are ok to bring in but not necessary • Conclude in a neutral stance	
Is there an area of medicine that you know for certain does not appeal to you, and if so why is that?	• Whatever you do, **DON'T** pick an area of medicine, it is a trap to do so. You do not want to say that you definitely do not want to do this area (even if you are 100%) sure since it is a red flag • Advice is to remain neutral, admit that you are not sure because (WEX did not cover this area, have not gone through medical school etc) but you can talk about an area you feel that you are not very sure about	I do not actually have an area of medicine in mind currently as given the limited amount of work experience I have done and the fact that I have not gone through clinical rotations as a medical student, any views I have would be quite surface level at this stage and would not be an accurate representation that I know definitively that it does not appeal to me. During my work experience, I only got the chance to rotate through GP, General Surgery, Dermatology just to name a few. However, to answer your question, I think one area I would like to know more about would be Paediatrics. I only got to experience a day in the department and while my experience there may not have been the greatest since I had to work with quite a few difficult children, I am still quite keen to learn more about it. I personally am quite good with children and while I could have worked on my communication skills during my rotations, I believe if given the chance to undertake said rotations in medical school, it would allow me to have a more accurate understanding of what the profession entails and form a more comprehensive view on the area of medicine.

	• Demonstrate enthusiasm in wanting to try and learn more about the area you are uncertain about, for example wanting to go through rotations in that area to see more about it etc • This question is not complicated, just remember to keep a level head and avoid coming across too critical or arrogant in your answer	
Why is 'bedside manner' important for doctors?	• Define what is bedside manner first, once you define it becomes easier to see why it is important, good to also describe what you consider as important • Professionalism is a must say by the way, make sure it is mentioned and you link it to how	In my understanding, bedside manner is considered to be professionalism when interacting with patients, maintaining a friendly yet professional approach when speaking to patients. An example of this could be speaking to patients during ward rounds, checking up on them and clarifying any questions they may have. One reason why I think it is important is because it would be in line with the professionalism expected of doctors as mentioned in the GMP. If doctors do not behave in a professional manner, it could cause the patient to feel a sense of disrespect and may lose faith or trust in the profession. Not only does this affect the doctor-patient relationship, it could also affect the public attitude towards the profession, making the environment for doctors to work in even more hostile than it already is.

	doctors act and then why it is so important • Think further than just how it appears to the patient. Does it have any additional benefit than just “it helps with professionalism”? • Can bring in GMC Domains too if you want and can link it to your answer without it sounding forced	Another reason why it is so important is because it helps with the recovery and healing of patients. When patients interact with doctors who have good bedside manners, they feel safe and respected, knowing that the doctors are looking out for them and their best interests. This would hence allow patients to focus fully on their recovery, and as studies have shown, the mental and emotional manner of patients do in fact play a role in their recovery. This hence boosts faith and respect for the profession and can help alleviate the hostile manner towards the profession that is currently occurring as seen by the jeers and boos faced by healthcare staff in one of the clinics in the UK. In conclusion, bedside manners play a bigger role apart from just professionalism and hence are very important to doctors to maintain and act upon..
What is the placebo effect, and should NHS doctors be allowed to use it on their patients?	• Placebo effect is something you definitely have heard about but perhaps did not know the name for, so if you need a refresher, it basically is a substance, pill, or other treatment that appears to be a medical intervention, but isn’t one. • The question is should NHS doctors be allowed, and	The placebo effect is essentially a substance, pill, or other treatment that appears to be a medical intervention, but isn’t one. It is commonly used in a way to convince the patients taking it that it has beneficial impact and can help in their recovery when it actually does not have any impact. Looking at the pros or the reasons why NHS doctors should be allowed to use it, one reason I can think of is the positive impact it has on the patients. Not only does it reassure the patient and put them at ease (although it may be false reassurance), it can even lead to them recovering from whatever they are experiencing as research has shown. Additionally, it can lead to patients having a more positive view of the situation and profession as they feel that the doctors are able to support them, which would improve and strengthen the doctor-patient relationship in the long-run. On the flip side, one reason why I do not think doctors should use it on their patients is because it is based primarily

	since the question is directing you to it, it would be best to provide two sides to the answer • Would be good to discuss the pros and cons of placebo effect, and the implications they have on not only patients but also the healthcare team, the profession etc • Pros and cons is probably the best way to tackle this question • Can link to ethical pillars as well, more importantly Beneficence and Justice + Non-maleficence	on a false promise, a false reassurance that it has a positive impact even though it does not. If patients were to find out, not only would it affect the current doctor-patient relationship, it could even harm trust in the profession in the long-run. Additionally, in line with the ethical pillars of Justice and Beneficence, it would not be right for doctors to carry out such actions even if they meant to do good. In the event a doctor chooses to provide such treatment over actual scientifically-proven medication, the patient's safety could be threatened if the situation deteriorates. In conclusion, I believe that while the placebo effect potentially has its benefits, I do not believe NHS doctors should be able to use it. It provides an alternative that has not been strictly tested and could pose potential dangers to the patient as well as the profession.
Do you think we need more nurses or doctors?	• Will be good to first define the roles and responsibilities that nurses and doctors undertake, if they are always distinctly different or if	I think it is first important to understand the roles that nurses and doctors play. Nurses are the professionals who spend the majority of the time around the patients, being much more hands-on compared to the doctors, where they act in line with the instructions given. Nurses are protocol-driven most of the time on a day-to-day basis, compared to doctors who may have more freedom in figuring out how to best treat the patients. Doctors spend a slightly less amount of time with patients, where they see many patients in

	they have any roles that overlap • Would be good to give some theoretical examples (especially if you can link it to real world examples that are currently happening) and show that nurses might be more needed here, or doctors might be more needed here • The question asks for your personal opinion so remember to include it in your answer (perhaps the conclusion will work best) • Best to remain neutral in your answer, showing that you understand both sides and perhaps it's best to have more of both • PEEL structure for	a day but experience less personal interaction with them. To decide, let us explore the current situation in the NHS. The NHS is currently experiencing a shortage of healthcare workers with a huge backlog of patients waiting to see GPs and undergo operations. As such, it may feel common sense to say that more doctors are needed, since doctors are able to prescribe medication and do clinical diagnoses compared to nurses who generally cannot prescribe and do a different form of diagnoses (nursing diagnoses). With more doctors around, it might help to manage the backlog currently experienced as more patients can be seen by the GPs, hence relieving the pressure experienced on the healthcare system. However, looking deeper into the situation, the pressure is actually caused due to a lack of manpower available to support patients who are ready to be discharged but have no place to go. In this case, nurses may actually be more beneficial to the cause compared to doctors as with more nurses around, they are able to best support the patients who are ready to be discharged through nursing diagnoses where they work together to formulate care plans for the patients to care for themselves. In doing so, not only would this possibly relieve the pressure on carers such as social health workers, it would also free up more beds where the backlog can then be subsequently cleared up. In conclusion, I think it is quite difficult to pick a side definitively that one is more needed than the other, and we should be aiming to increase the number of both nurses and doctors, while also seeking to improve the healthcare infrastructure with more healthcare workers as well.

	your answer, keep it simple to avoid overcomplication in your answer	
What do you think about the phenomenon of the 'postcode lottery', and is it fair?	• Postcode lottery is a very prevalent thing especially in the UK, so please do read up on what it is considered to be. As a quick refresher, postcode lottery roughly refers to the fact that your healthcare treatment depends largely on your location where you stay at. If you stay at a well-off place with good infrastructure, you may receive better care than compared to living in a rural area with poor infrastructure • The question is asking	The postcode lottery refers roughly to the fact that your healthcare treatment obtained depends mostly on the location where you stay at. If you are in a place with good healthcare infrastructure, you will likely be able to receive better quality of care compared to a rural location with poor facilities. Regarding my thoughts about this phenomenon, I personally feel that it came about due to the huge area that the UK occupies and that it was brought up given complexities in distributing resources. For instance, it may be really difficult to get patients to travel from somewhere like London up to Sheffield just for a treatment (which may not be able to fully help the patient as well), forcing them to travel even further out to receive the adequate amount of support. This would be especially true for the NHS as it is just not feasible to drive patients all around the country to seek support. In a way it is also caused by the fact that resources were not evenly distributed to all the cities in the UK, causing them to have differing amounts of healthcare infrastructure set up. Moving on to the fairness of such a situation, I think in my opinion it is quite unfair that the treatment available is restricted heavily on the patient's location. While some could argue that it is considered fair since "that is just how things are", I feel that it is a poor argument since there is no substantiation behind those views. In line with the ethical pillar of Justice, postcode lottery can be seen as discrimination against the general population, and would not be "just" or fair in any way. While it does not violate any specific law, it is unethical and unfair to discriminate against people just because of where they stay (since they

	whether it is “fair”, so think about it. What is considered fair? How do you quantify fairness? In what sense do you consider it to be just, equal? • Ethical pillars of Justice should be brought in here (show understanding of ethical pillars) • Can also bring in hot topics if relevant (but try not to force it)	did not choose to stay there, especially for those who are not well-to-do). In conclusion, while I have heard some views on why postcode lottery is fair from reading articles or speaking to others living in the UK, I still feel that it is unfair.
Do you have a favourite medical-themed TV series or book? What do you think about the representation of doctors in the media?	• The favorite TV series or book is the first part of the question, and while it is a good chance to show what interested you and demonstrate passion for what you read or watched, it is not the main bulk of the question • Do a quick summary, mention or highlight 1-2 points about	My favourite medical-themed series would have to be “Grey’s Anatomy”. While I did not manage to watch every season (as I felt the story kind of deviated away from the medical aspect into different genres), the seasons I watched had me fall in love with the way doctors conducted their duties, in particular exposing me to the realities of the profession. In the show two parts really stood out to me. The first was just how human the doctors felt, from struggling with self-doubt and having conflicting personal values which affected their duties such as one of the doctors being scared to lose a close patient, it demonstrated to me that doctors were at the core human and experience these emotions just like any of us. While I roughly understood the idea already that doctors were human, this show really allowed me to appreciate just how human doctors were and it gave me a more realistic understanding of how things were in the world.

	the book or series before concluding • In regards to the second part of the question, remember both sides of the argument must be argued, both the good and bad representation • The question uses the word "media" so it can include social media, not just old media like newspapers or radio, and remember to raise relevant examples • Use any real life examples if possible to show substantiation to your points, to show it is realistic to raise these points • The question is asking "What do you think" so it is really really important	The second part was just how realistic things felt as a whole. While other series seemed to make it seem like doctors had to always handle complex cases all the time, Grey's Anatomy really showed me that doctors have more on their plate than just clinical duties and that they often had family duties or personal issues to attend to. It also introduced how personal politics or hospital politics can play a part in how doctors operate, and allowed me to really appreciate the realistic nature of the profession. What I think about the representation of doctors in the media would be a good and bad thing. I think the media does a good job of representing doctors in the form of increased documentaries or commentaries being released on YouTube by companies such as BBC where they openly discuss how the profession is doing and show us accurate representations of how the profession is struggling especially with the backlog of patients currently faced in the NHS. They portray and help to overcome preconceptions that doctors are always able to cope and that the profession is 100% doing well, which I feel is really beneficial. However on the flip side, I feel sometimes doctors are portrayed in an unfair or negative manner in the media. I would refer to the current discussion ongoing about JDs striking, where the media seems to portray the strikes as "unnecessary" and "disproportionate" even though the strikes currently are very necessary and a last desperate measure to advocate for change. The media outlets make the BMA or JDs come across as self-entitled, and slam our calls for help as "disproportionate", making us seem like the enemy the public should root against. In conclusion, I feel that the representation of doctors in the media is both good and bad, in the sense that there are very accurate ones and also some that are very twisted, which is to be expected in every profession.

	that you provide your own personal insight, sprinkled in during the bulk of your answer and a strong conclusion	
Do you think that the lives and social responsibilities of a GP and a heart surgeon are very different?	• The question uses the words “lives” and “social responsibilities” distinctly, so perhaps for the lives part, you should mention family life, personal life and distinguish the social responsibilities as work-life balance or social interactions with friends or colleagues just to ensure they do not sound the same • Think of the workload and responsibilities undertaken by both professionals and try to formulate	I think just before I answer this question, it would be good to distinguish the “lives” and “social responsibilities” from one another. In my view, they actually overlap but for this answer, when I refer to lives, it would be more of personal and family life, while social responsibilities would be more towards hanging out with friends or colleagues outside of work. I can definitely see why some would think that the lives and social responsibilities are very different for both professionals. As a heart surgeon, given the complex operations undertaken such as transplants for instance, it may seem like they have less time for their family, social or personal life. Compared to a GP who seemingly works a more regular schedule with few instances of overshooting their time given their workload, it might be common sense to say that the responsibilities would be very different. However, this is quite far from the truth as just because GP sees more patients / heart surgeons spend a lot more time in OT that they will have “very different” lives and responsibilities. In fact, surgeons may actually undertake fewer cases in a day which would lead to about the same amount of time the GP takes to see the patients. In line with the European Working Time Directive, all professionals regardless of specialities should be working the same amount of hours which would then provide them with enough time to pursue their other responsibilities. In conclusion, while I can see where some people come from, it is simply not true to say that it is very different. With proper time management and

	your answer around it ● Do not be so quick to jump to conclusions that just because GP sees more patients / heart surgeon spends a lot more time in OT that they will have “very different” lives and responsibilities ● The trap here is to make you pick one, so instead you should try to express that provided good time management and organisation, they will be very similar and may only appear to be very different if either does not plan their duties accordingly ● Be respectful and tact in your answer, show an understanding and respect for both professions	organisational skills, they would be very similar instead of very different.

Should cosmetic surgery be available through the NHS, such as breast implants or nose alterations?	• For this question, pros and cons approach will be very good since it shows the balanced argument in a clear and easy-to-understand manner • I personally would want to hear some of the NHS values name dropped and brought in to the explanations as well (such as Improving Lives and Everyone Counts) • Ethical pillars can be brought in too but I feel like NHS values make your answer much stronger at least for this question • Try not to only think about it in the sense of clinical benefit or impact, look beyond that such as financial impact or	For this answer, I would like to explore the pros and cons before providing an answer. Looking at the pros, there are definitely some to be argued about. In line with the NHS values of Improving Lives and Everyone Counts, it provides the opportunity for patients who perhaps may have experienced burn marks to undergo surgery to “feel normal” again, allowing them to feel more confident and comfortable in their own skin, improving their lives. It also allows patients who need it to be included and not feel left out by the system, in line with “Everyone Counts”. It could also be a source of medical tourism as tourists from other countries travel to the UK to undergo such surgery, like how Korea’s economy has improved with cosmetic surgery present. However, there are also some cons to be mentioned. One would be that it could cause younger generations to have a skewed perception of themselves such as body imaging where they feel that they need to undergo cosmetic surgery to be “beautiful”, and even doctors may be influenced to undergo the operations themselves given their more frequent exposure to such a speciality. This could pose harmful thoughts or perceptions towards society and the mentality which would not be good in the long run. Additionally, the financial cost to offer such services in terms of equipment or training of such individuals could pose a heavy strain on NHS resources which could affect the NHS, either only having services available in certain areas or the quality of care offered not being to the best standard possible. In conclusion, I view this as a particularly complex topic where the pros and cons need to be weighed heavily before implementation. Perhaps more research can be done so that an informed decision can be made through case studies of countries who offer such services.

	societal benefit etc • Perhaps you can even explore cosmetic surgery in the sense of how it impacts future doctors and their thinking? Will it cause them to have a skewed perception etc? • Personal opinion is okay to include but not necessary	
Doctors display a higher prevalence of mental illnesses than the background rate in the general population, particularly among young members of the profession. Why do you think this might be?	• Think about CAMP. CAMP is actually a really good way to explain this since it covers all aspects, especially how JDs need to teach medical students while handling a really heavy clinical workload • As for managerial, think about how JDs have to participate in	I think the reasons why can be explored in the framework CAMP, Clinical, Academic, Managerial and Personal. This would allow us to explore as much as we can in terms of the duties and potential reasons that the young members experience. In terms of Clinical, the young members, for example Junior Doctors, actually end up taking a bigger workload in terms of clinical duties to do. They may see more patients, be more involved in operations or be in charge of more members of the team as compared to consultants who may take a more relaxed role. This as a result can cause high amounts of stress, where the JDs have to constantly work in pressuring situations in a heightened state of mind, which can lead to burn out and in some cases, anxiety or even depression. As such they are more likely to display such prevalence of illnesses. Looking at Academic, JDs end up being more involved in the academic aspects for example teaching medical students, preparing for their speciality

	many staff meetings due to their heavier workload and need to manage more responsibilities at any one time ● As for personal, you can mention the stresses of handling personal life, the fact that their peers might be living a more relaxed life with higher pay compared to them etc ● You can also mention social media and the impact it has especially on young members (given how much we actually use social media etc) ● There is not really a need to talk about both sides, because it is not really a pros and cons question ● You can also mention the current hot topics if	examinations, attending seminars or conferences more often than the senior members. This hence would cause them to handle a heavier workload and perhaps may have less time for themselves, leading to insufficient rest or recharging which can drain their mental strength, causing them to have a higher likelihood to demonstrate mental illnesses. As for Managerial and Personal, I believe that JDs may not necessarily be in charge of leading the entire MDT yet, but perhaps the stress and worry of having to work with a huge team can cause them to experience anxiety as they could potentially be afraid of messing up. Additionally, JDs may have to work longer hours as compared to their friends who may work in fields with shorter hours but higher pay, which can cause them to feel a sense of inadequacy and may end up making them feel depressed as it seems like they are giving so much more for a lower repayment. These feelings can eventually snowball and lead to the formation of mental illnesses. In conclusion I feel a variety of reasons contribute to the higher prevalence of mental diseases in the long run and hence could explain why.

	you know any and if it links, try not to force them if it does not fit	
With increasingly accurate anatomical models and computer simulations, do you think that cadavers are still necessary for medical education?	• The question is asking for your personal opinion so do remember to include your personal views. I recommend it to be at the end so it does not come across as biased in your answering • This question should be tackled in a pros and cons / for and against structure just so that it is really clear that you have balanced views • Think more than just the medical / clinical benefit, also consider the possible financial considerations or the public perception etc	I think it is really important to consider both aspects or sides to this argument, before weighing in with my personal opinion. Looking at why cadavers are still necessary for education, I think one reason I have would be that technology, despite its current advancements, is still unable to fully replicate the entire physical experience of being able to use cadavers. For instance, the smell and feeling of touch when you physically interact with body parts is still unable to be replicated with the anatomical models or simulations. In a simulation, you do not actually get to feel what it is like and even with anatomical models, the feelings can never be fully replicated (as of now). Additionally, it would be quite an expense to provide such models and simulations to all medical schools around the world, especially with the maintenance costs required, and if we are still able to have cadavers who were willingly donated for educational purposes, we should make use of such resources. On the flip side, I can understand that cadavers are difficult to obtain, especially given the low number of people who are willing to donate their bodies to science. As such, there is an increased need to integrate technology and simulations for education, and if it is able to replicate the learning experience, then cadavers should no longer be used. Additionally, if cadavers were phased out, the public may have an improved perception of the profession, since some individuals still hold the outdated view that the profession steals bodies to use for research and educational purposes. In conclusion, in my personal opinion, I feel that cadavers should still be used and are still necessary for educational purposes. This is because right now, technology has not yet reached the stage where it is fully able to match the

	• I doubt there are any hot topics relevant here (at least at the point of writing this) but if you can work it in, by all means do so • Can AI fully replicate the experience currently? Has current technology reached the point that it can replicate the physical, emotional experience fully? If no, then what should we explore in our answer?	experiences offered by cadavers and it is still rather expensive to provide such technology to all medical schools around the country. Perhaps when technology is more advanced and at a cheaper cost, it would be more practical to phase cadavers out of medical education.
Should homeopathic treatments and alternative therapies be provided by the NHS?	• First if you do not know what homeopathic treatments are, they are essentially to get health back by using the body healing powers. In the treatment process, each patient is treated as an individual. Homeopathic cures by using the minimum	I think it would be good to look at the pros and cons of providing such treatments and therapies before forming a conclusion. Looking at the positives, one reason often voiced out is that homeopathic treatments are natural, and often have few to no side effects, that it is the way we should fight off illnesses using our immune systems. I can somewhat understand the positives, as compared to treatments such as chemotherapy, which might have a lot of side effects such as hair loss, loss of appetite etc, homeopathic treatments ensure that at the very least, you do not experience negative side effects on top of the illness currently experienced. Additionally, it is also claimed that such treatment is able to resolve instances where science-based medicine is unable to do so, and through my research, I found cases far and between that do support this statement, which highlights

	amount of dose. ● A succinct way of summarising it would be to say that it is basically treatment using "natural" methods that are not extensively scientifically proven to try and heal the human body ● Again, pros and cons structure would help a lot to provide a balanced view and answer ● Think about patient safety and given how it is not science backed, how it could potentially threaten the patients if used ● But at the same time, it is good to recognize that just because it is not science-based, there have been cases where it is effective and helped patients out when science-	the potential that such therapies can have, and the benefit it could provide for patients. However, on the flip side, something worth mentioning is that it is not science-based and for the NHS to provide such treatment, it could potentially place patients' lives at risk. In line with the NHS value of "Improving Lives", if the NHS offers such treatment it might not actually do so and in fact go against the improvement of patients' lives. Additionally, if such treatment fails it could cause the trust in the profession to be lost in the long run, which would definitely affect the doctor-patient relationship in the future. In conclusion, I feel that while such treatments have potential to really help others, it should be researched into more extensively to ensure the safety and reliability of the treatments before being considered for implementation in the NHS, as to maintain trust in the profession and to ensure patient safety.

	based medicine could not • Since the question mentions the NHS, it would be really good to bring in NHS values if possible or the NHS constitution especially to show understanding and awareness of the NHS	
As of 2016, only 52% of junior doctors that finished their two years of foundation training proceeded straight into GP or specialist training programmes with NHS England. Why do you think this is?	• Think about the positive aspects while also considering the negative aspects. It is easy to say for example all the JDs leave because of the state of the NHS etc, but what if they just want to leave for some family time off / do PHDs etc? Show that it is not always bad to take time off and that proceeding straight into training is a pathway that should not be	I think there are quite a few reasons that could possibly explain why. One reason I can see is that the workload for JDs is extremely taxing and could result in burnout or mental stress for them, which in turn forces them to take time off to recover. As a JD, apart from the numerous clinical duties undertaken, JDs also need to teach medical students, participate in seminars, workshops and even participate in audits. With this extensive workload, it is understandable that they may struggle to maintain a good work-life balance and especially can cause them to experience potential mental health complications such as anxiety or depression, forcing them to take time off to recover and deal with the illnesses, and hence would lead to a lower amount of JDs continuing after FY training. Another reason I can see would be that JDs may want time off to pursue personal matters that they care dearly about. From my work experience, I heard from JDs themselves that some of them are soon starting their own families and plan on taking time off to support their family especially during the pre and post pregnancy time. Some JDs also expressed that they would like to further pursue a doctorate or academic research in certain respective fields, and given the

	considered necessary • For the negative aspects, try not to limit only to clinical factors, you can link to personal or academic aspects. Work-life balance is something to consider, so is the pay that JDs get (Link to Hot Topics if you can) • For the positive aspects, use relevant examples to back up your points such as personal examples (if you see any during your WEX etc) • Is there a possibility that the statistics may be under-reported? Talk about the scale of the NHS England and how sometimes data collected is not entirely representative, especially if	additional workload, it is not possible to do both to the best standard desired. One JD also told me that he wanted to take this time after training to travel the world before committing to specialist training since he may no longer have that liberty in the long run. As such, I feel that it is a probable reason that could explain the low number of JDs immediately pursuing specialist training after FYs. In conclusion, I feel these are some possible reasons that could explain why. I think it is also fair to assume that the numbers could actually be higher given the scale of data collection done, there might be some data that was not collected or perhaps under-reported.

	some data slips through the cracks of collection	
Why do some medical students drop out before finishing their course?	• I think for this question, it would be good to split your answer into three aspects: Personal, family / social and lastly financial because it covers quite comprehensively all possible reasons • Try to back up with personal examples or real-life examples especially since this question is rather abstract and with examples, your answers become more supported • Try to remain neutral and unbiased as much as you can, basically showing impartiality and no judgement in your	I think there are three possible aspects to explore why some medical students drop out before finishing. The first possible reason could be due to personal reasons. Some might find that they are unable to cope with the course's strict academic workload, or they may find out they were misled into thinking why they wanted to pursue medicine. For example, they may have thought that medicine would be something they fit and align with, but after studying, they realize that they are incompatible and no longer want to study in a degree they feel nothing for, hence leading to them dropping out. Given how most applicants would not have sat through medical school prior to admission, it is an understandable reason for why some drop out. The second reason could be due to family or social reasons. Some medical students fight tooth and nail to get into medical school, but their family may not support such aspirations and in turn, pressure them into leaving the course. Similarly, some medical students may see their friends who are having a much happier time studying other courses / earning much more than they possibly could, and hence would choose to quit in hopes of other aspirations. As a result of familial or social pressures, it is a possible reason as well. The third reason could be the financial aspect. It is understood that medical school is an expensive course to undertake, and even with the aid of the NHS bursary, it still poses a heavy burden on the family to support the student. When finances become tight, some students are either coerced or forced to quit the course as they can no longer finance their studies. I have heard some stories from my brother (who is also a medical student) that some of his coursemates left because of financial constraints. While it is definitely a difficult topic to broach, money is still important at

	answer because you should not be judging people for quitting medical school • Nothing much else to say for this question, it is quite freestyle in answering	the end of the day and could explain why some medical students may choose to leave in the end.
How many attempts at in-vitro-fertilisation (IVF) treatment should women receive on the NHS, and should we continue to offer it for free?	• What is IVF? Essentially it is mature eggs are collected (retrieved) from ovaries and fertilized by sperm in a lab. Then the fertilized egg (embryo) or eggs (embryos) are transferred to a uterus • The question asks for the number of attempts, in my opinion giving a number defeats the purpose of the question. Instead you should show the weighing of the pros and cons (such as financial	IVF essentially refers to the mature eggs that are collected (retrieved) from ovaries and fertilized by sperm in a lab. Then the fertilized egg (embryo) or eggs (embryos) are transferred to a uterus. Regarding the number of attempts women should receive, I personally believe this is a really complex situation and a hard, fast rule is not the right solution to this. Every woman that receives IVF is different from the next individual, and to have a determined number right from the start is counter-productive as some may achieve a higher chance of success upon multiple IVF treatments. While I most definitely understand and can relate to the heavy financial constraints faced by the NHS in provision of such treatment, to restrict the number of treatments may not be the best way to deal with this situation. In line with the NHS value of “Improving Lives”, IVF should be given as and when possible to help women achieve their dreams of being a mother. In my view, more research should be done individually before the healthcare team comes to a conclusion on the number of attempts to provide. In relation to the second part of the question, I understand why some individuals would not want treatment to be continually free. IVF treatment can be expensive and poses a significant strain on NHS resources, where the money could be reinvested elsewhere to improve services. However, on the flip side, NHS healthcare has always been free at the

	constraints especially from the NHS, the NHS values of Everyone Counts and Improving Lives) and explain that it is difficult to ascertain a number, more research etc should be done (you run the risk of not answering the question, but showing a balanced argument is more important) • Think about the offering for free aspect (because NHS healthcare is free at point of access, but at the same time, what are some of the issues that come along from such treatment provided such as financial constraints, overloading of resources etc)	point of access, and to start charging could pose potential issues for those who need this treatment. For example, while the well-to-do may have no issue paying for such treatment, those who are less well-off may experience a difficulty in affording such services and at the end of the day, potentially deprive them of such treatment which they need. In conclusion I feel that perhaps to reach a compromise, what could be done is to have the first initial few attempts provided for free (which more extensive research can help determine the best amount of tries to provide), and for those who want to continue pursuing treatment can pay for it. To help those who may be unable to afford it, a certain criteria could be discussed and the subsequent treatments are subsidised so as to make it affordable within their means.
Should previously convicted criminals be	• Explore the yes and nos	Let us explore the reasons on why they should be allowed to become doctors.

allowed to become doctors?	clearly and in a manner that is unbiased. Remember that just because they were once a criminal, does not mean they cannot reform and be better! Avoid being biased and saying that "just because they are a criminal, they will always be a criminal" • In terms of the nos, be logical in your explanation. Show that even though we give the BOD, there can be cases where this trust is abused or like they go back their old ways (Can cite Harold Shipman as an example) • You can also present the view that perhaps it can depend on the crime that was previously done, but in	The first reason I can think of would be that just because of their past, they should not be discriminated against and be given a chance to reform and do right this time. Some criminals had committed crimes because they had no choice, or perhaps they were pushed into criminal life unwillingly, and after reform in prison, may actually have changed and want to do good. To stop them from pursuing their dreams of becoming a doctor just because of their past would be quite discriminatory and unfair for them, especially if they did not have a choice. Another perspective I can think of would be that it could actually help to reduce stigma around criminals and help society progress forward. By showing that criminals who are reformed can have a second chance at life, in such a profession, it would help reduce public stigma and allow these individuals to get back to normal life (with an easier transition). However, looking on the flip side, it is quite difficult to ascertain just who has reformed and would not go back to their old ways from those who will relapse. In such a position, where they may have access to highly sensitive information, if the criminals were to relapse it could wreak havoc on the patients' lives especially if it was used for extortion purposes. This can cause patients to develop a fear of the profession and detrimentally harm the doctor-patient relationship in the long run as the profession loses the public trust. Moreover, given the public stigma around criminals, even if they were to become doctors, they may not be able to live a normal life as patients may not want to see a doctor who was previously a criminal, which could lead to the same issue of public trust being lost in the long run. Additionally as doctors, many would have access to potentially harmful medication or be involved in decision-making that could be life-altering, and in the long run In conclusion, I feel that this is a particularly complex situation that needs a lot of factors to be considered. While we should always strive to give the

	my opinion that logic has a lot of issues with it so perhaps not ideal to do so • For the yes, I think the main point of your answer should revolve around reform and why it is important to be human / give BOD or forgiveness	benefit of doubt to those who deserve a second chance, that does not mean we do it recklessly without adequate support and guidelines. The compromise here could be that while criminals can be given such an opportunity, there should be extensive regulations and screenings to reduce all possible risks.
Do you think that entrance exams like the UKCAT and BMAT ensure that the best people become doctors, and should we continue to use them?	• Note the word used is "ensure", and the word is quite strong so honestly you should know which stance you should be on already • Balanced views are really important here because if you heavily criticised entrance exams and say it is useless, you effectively are criticising yourself and the system that got you here	I think it is first important to understand what the term "best people" refer to in this instance, perhaps in my view it could mean those who are most suited for the profession and pursue Medicine as a career. Looking at possible reasons on how these entrance exams can help to filter out the individuals who may be best suited, one reason would be that such exams test for certain attributes that seem to be useful or present in all doctors. For instance, the UKCAT examination tests for VR, DM, QR, AR and SJT, which are all soft skills desired in a healthcare professional such as the ability to determine patterns or make common healthcare decisions, which helps to filter out those students who may do well in medical school and eventually as a doctor. For BMAT, it is a test of academic prowess to a certain extent, whether the student has the scientific ability to handle all three sciences which would correlate to the student's possible ability of handling the academic curriculum in medical school. Through these exams, it allows a higher probability of picking those who are most suitable for the profession. However, on the flip side, these exams are unable to fully capture the whole

	• At the same time, think back to why entrance exams like this were introduced and what were the intentions, whether they were fully achieved or not etc • The question also phrases the prompt to ask for your opinion on the future, it is really important to demonstrate progress and advancements, so maybe it may not be useful in the future etc • Or if you want to mention it could be useful in the long run, how so? What aspects of it can last in the long run and what aspects cannot? Can you modify or adjust them to become better in the long run?	picture of applicants and are based on a set criteria which is relatively inflexible. Some applicants who may be academically strong, may not possess the personal skills required to be a doctor and may possess certain traits that a doctor should not have such as arrogance or looking down on others. Additionally, with these examinations having some element of luck to it or being able to drill using third-party resources, it is not entirely representative of the applicants' ability. For instance, UCAT uses 5 different sets which are randomly assigned on the test day itself, where some applicants are given the very easy or very difficult test, causing their result to be affected, and with most students using resources such as Medify or Medentry to prepare, it can be quite unrepresentative. While interviews is an additional filter present to prevent exceptional cases from slipping all the way through, the prior filters in terms of the entrance examinations would have removed candidates who may have been a better fit. Regarding whether these examinations should be continued, I personally believe that they should as these examinations are able to provide a certain level of filter which reduces the workload medical schools need to do when selecting students. While sometimes unrepresentative, most applicants who do well in these examinations do turn out to be the best applicants in a way. However, looking into the future, these examinations should also evolve together with society as more students become smarter or more able to answer these entrance examinations. For the UKCAT and BMAT, perhaps certain sections can be maintained with other sections undergoing a revision to ensure that it keeps up with the needs of the medical profession.

	• The question mentions the “best people become doctors”, how so? In what aspect are they the best? How do you quantify or determine who is the best?	

Drug Calculation Interview Questions

To calculate the number of tablets, use the following formulas
Strength required / Stock strength = Number of tablet(s) required
Or another way this drug dosage formula can be expressed is:
What you want / What you’ve got = Number of tablet(s) required
To calculate the volume dose for liquid medicine, use this formula:
(Strength required / Stock strength) × Stock volume = Volume dose required
Or another way this liquid dose formula can be expressed is:
(What you want / What you’ve got) × What it’s in = Volume dose required
Table for conversion purposes:

Units	Equivalencies
1 microgram (mcg)	0.000001g
1 milligram (mg)	0.0001g or 1000mcg
1 gram (g)	1000mg
1 kilogram (kg)	1000g
1 kilogram (kg)	2.2 lbs
1 grain (gr)	60 or 65mg
5 grain (gr)	300 or 325mg
15 grain (gr)	1000mg or 1g
1 teaspoon (tsp)	5ml
1 tablespoon (T)	15ml
1 fluid ounce (fl oz)	30ml
1 cup (C)	240ml

1 pint (pt)	480ml
1 quart (qt)	946ml
1 pound (lb)	16 ounce
2.2 pounds (lbs)	1 kilogram

Methods for Drug Dosage Calculations

The commonly used formula for calculating drug dosages, where in:

- D = Desired dose or dose ordered by the primary care provider.
- H = dose on hand or dose on the label of bottle, vial, ampule.
- V = vehicle or the form in which the drug comes (i.e., tablet or liquid).

STANDARD FORMULA

Formula = (D times V) / H =amount to administer

EXAMPLE:

Order: Acetaminophen 500 mg
On hand: Acetaminophen 250 mg in 5 mL
Desired (D) = 500 mg
On hand (H) = 250 mg
Vehicle (V) = 5 mL
Computation:
500 TIMES 5 /250 = 10
Answer: 10 mL

Ratio and Proportion Method

Considered as the oldest method used for drug calculation problems.
For the equation, the known quantities are on the left side, while the desired dose and the unknown amount to administer are on the right side.
Where in:

- D = Desired dose or dose ordered by the primary care provider.
- H = dose on hand or dose on the label of bottle, vial, ampule.
- V = vehicle or the form in which the drug comes (i.e., tablet or liquid).
- X = amount to administer

Once the equation is set up, multiply the extremes (H and x) and the means (V and D). Then solve for x.

RATIO AND PROPORTION METHOD

H : V = D : x

EXAMPLE:

Order: Erythromycin 750 mg
On hand: Erythromycin 250 mg capsules
Desired (D) = 750 mg
On hand (H) = 250 mg
Vehicle (V) = 1 capsule
Computation:
250 (H) : 1 (V) = 750 (D) : x
Multiply the extremes and the means:
250x = 750
x=3 capsules
Answer is 3 capsules.

Fractional Equation Method

A method similar to ratio and proportion but expressed as fractions.
Where in:

- D = Desired dose or dose ordered by the primary care provider.
- H = dose on hand or dose on the label of bottle, vial, ampule.
- V = vehicle or the form in which the drug comes (i.e., tablet or liquid).

FRACTIONAL EQUATION METHOD
H / V = D / X
EXAMPLE:
Order: Digoxin 0.25 mg
On hand: Digoxin 0.125 mg tablets
Desired (D) = 0.25 mg
On hand (H) = 0.125 mg
Vehicle (V) = 1 tablets
Answer is 2 tablets.

Fluid Intake and Output Calculation

Intake and output (I&O) measurement and recording is usually done to monitor a client's fluid and electrolyte balance during a 24-hour period.
Intake and output is done for patients with increased risk for fluid and electrolyte imbalance (e.g., heart failure, kidney failure).
Unit used in measurement of I&O is milliliter (mL).
Measuring fluid intake entails recording each item of fluid consumed or administered, all of the following fluids are recorded:

- Oral fluids (e.g., water, juice, milk, soup, water taken with medication).
- Liquid foods at room temperature (e.g., ice cream, gelatin, custard).
- Tube feedings including the water used for flushes.
- Parenteral fluids
- Blood products
- IV medications
- Measurement of fluid output includes:
- Urinary output
- Vomitus
- Liquid feces
- Tube drainage
- Wound and fistula drainage

Measurement of fluid input and output are totaled at the end of the shift and documented in the patient's chart.
Determine if fluid intake and fluid output are proportional. When there is a significant discrepancy between intake and output, report to the primary care provider.

Practice Questions	Example answer
You are asked to assist the nursing staff in giving medication to a patient weighing 70kg. The recommended medication dose is 2.5mg/kg. A syringe is prepared containing 350mg in 2ml. What volume of the solution in the syringe do you need to administer?	[redacted]
You are asked to assist the nursing staff in giving medication to a patient weighing 70kg. The recommended medication dose is 2.5mg/kg. A syringe is prepared containing 350mg in 2ml. What volume of the solution in the syringe do you need to administer?	
A patient requires atenolol 75mg. The available stock is 25mg tablets. How many tablets are required?	75mg / 25mg = 3 Answer: 3 tablets are required
Mrs X is being discharged from the hospital. On her TTO, she has been prescribed ramipril 2.5mg once daily for 7 days, then 5mg once daily for 14 days till review with the	2.5mg / 2.5mg = 1 tablet 1 tablet × 7 days = 7 tablets then 5mg / 2.5mg = 2 tablets

consultant in clinic. How many tablets should the pharmacy technician dispense if the available stock is 2.5mg?	2 tablets × 14 days = 28 tablets In total: 7 tablets + 28 tablets = 35 tablets Answer: 35 tablets should be dispensed
Mr S is prescribed bumetanide oral solution 500mcg once daily. The doctor has ordered 14 days supply. The available stock is 1mg/5ml. What volume should the pharmacist dispense?	Convert bumetanide from mcg to mg so that the units of measurement are the same: 500mcg × 1000 = 0.5mg 0.5mg / 1mg × 5ml = 2.5ml 2.5ml × 14 days = 35ml Answer: 35ml should be dispensed
Mr Doe has been prescribed prednisolone 30mg for twelve days by the respiratory consultant. How many tablets will Mr Doe receive from the pharmacy if the 5mg strength is dispensed?	30mg / 5mg = 6 tablets 6 tablets × 12 days = 72 tablets Answer: 72 tablets
The urologist has prescribed nitrofurantoin 100mg once daily at night on Mrs P's drug chart. Mrs P is having trouble swallowing tablets so the ward pharmacist has stated on the drug chart to give nitrofurantoin oral suspension. What volume should the nurse administer to Mrs P if the available strength is 25mg/5ml?	100mg / 25mg x 5ml = 20ml Answer: 20ml should be administered
A patient requires itraconazole 200mg. The doctor has stated on the drug chart to give only oral suspension. The available stock on the ward is 50mg/5ml. What volume is required?	200mg / 50mg x 5ml = 20ml Answer: 20ml is required
Mrs J is being discharged from the hospital. On her TTO, she has been prescribed colecalciferol oral solution 800 units once daily. The available stock is 2000 units/ml. The pharmacist has asked the pre-registration pharmacist to also state how many mls of colecalciferol Mr X should take on the dispensing label. What is the correct dosage on the label?	800 units / 2000 units x 1ml = 0.4ml Answer: Take 800 units (0.4ml) once daily
The doctor ordered 0.45 mg Thyroxine po daily. The pharmacy sends up one tablet labeled 0.15 mg and 1 tablet labeled 0.3 mg. Is this the correct amount?	Yes, 0.15 + 0.3 = 0.45
The M.D. ordered 75 mg Demerol to be given by injection three times every day. What is the total daily amount of Demerol received?	75 times 3 = 225
The M.D. ordered 0.5 mg Robitussin cough syrup to be given every four hours po for cough as needed. The nurse has on hand 0.25 mg/5mL. How much would you give in one dose? mL or tsp	10 mL; 2 tsp;

The doctor ordered 0.05 mg of medication po daily. On hand you have 0.15 mg/mL. How much mL do you give?	0.33 mL;
The M.D. ordered: 75 mg. of medication po daily. The nurse has on hand 200 mg/mL. How much mL do you give?	0.38 mL
The doctor ordered: gr 1/4 of medication po daily. On hand you have 1/2 grain/mL. You will give mL.	0.5 mL
The M.D. ordered: 30 mEq of Potassium mixed in every bag of intravenous fluid. The dosage available is 20 mEq/2 mL. How many mL should be added to the bag of IV fluid?	3 mL
The dosage strength is 125,000 units/1.5 mL. The order is administer 175,000 units sc once daily. How many mL should be given?	2.1 mL
The doctor ordered: Lanoxin 0.125 mg to be given every day intravenously. The vial is labeled Lanoxin 0.5 mg/2 mL. How many mL should be given?	0.5 mL
The solution available is 5 mg/1.5 mL. Prepare a solution with a dosage of 8 mg. How many mL should be prepared?	2.4 mL
The doctor ordered: Myleran gr 1/6 every day po. The dosage available is gr 1/10 per tab. How many tablets should be given daily?	1.7 mL
The doctor orders 8 units of Hydrocortisone IM daily. On hand you have 40 units/mL. You will give mL.	0.2 mL
The doctor ordered: 0.05 mg of elixir q po once daily. On hand you have 0.02 mg/2 mL. You will give mL or tsp.	5 mL or 1 tsp
The doctor ordered 3.75 mg of medication po daily. On hand you have 7.5 mg/tab. You will give tab.	0.5 tab
The doctor ordered Keflex 500 mg po daily. On hand you have Keflex 0.250 g per capsule. How many capsules will you give?	2 caps
The doctor ordered Gantrisin 750 mg. PO daily. On hand you have Gantrisin 0.5 g per tab. How many tablets will you give?	1.5 tablets
The doctor ordered Valium 15 mg. On hand you have Valium 50 mg per mL. How many mL will you give?	0.3mL
The doctor ordered Demerol 35 mg IM. On hand you have Demerol 50mg per mL. How many mL will you give?	0.7mL

The doctor ordered Morphine 3 mg. On hand you have Morphine 0.002 g per mL. How many mL will you give?	1.5mL
The doctor ordered Ampicillin Liquid 250 mg PO. On hand you have Ampicillin Liquid 125 mg per 5 mL. Give mL or tsp	10mL ; 2tsp
The doctor ordered Digoxin 0.375 mg PO. On hand you have Digoxin 0.25 mg per tablet. How many tablets will you give?	1.5 tabs
The doctor ordered 20 mg of Valium. On hand you have Valium 60 mg per mL. How many mL will you give?	0.33mL
The doctor ordered Kantrex 150 mg. On hand you have Kantrex 0.5 g per 2 mL. How many mL's will you give?	0.6mL
The doctor ordered 0.125 mg Lanoxin. On hand you have 500 micrograms/2 mL. How many mL will you give?	0.5mL
The doctor ordered Ampicillin Liquid 0.3g. On hand you have Ampicillin Liquid 250 mg. per 5 mL. You will give _mL	6mL
The doctor ordered 0.00068 g of Drug A. On hand you have 0.4 mg per mL. You will give _mL.	1.7mL
The doctor ordered 0.625 mg of Drug A. On hand you have 0.3 mg per mL. You will give _mL.	2.1mL
The doctor ordered 0.22 g of Drug A. On hand you have 0.12 g per mL. You will give mL.	1.8mL
The doctor ordered 250 mg of Keflex. On hand you have Keflex 0.125 g per tab. How many tablets will you give?	2 tabs
The doctor ordered Valium 15 mg. On hand you have Valium 0.005 g per tablet. You will give how many tablets?	3 tabs
You are to give Digoxin 0.125 mg. using Digoxin labeled 0.25 mg per tablet. How many tablets will you administer?	0.5 tab
The doctor ordered Ampicillin Liquid 500 mg. On hand you have Ampicillin Liquid 250 mg. per 5 mL. How many mL will you give?	10mL
The doctor ordered 0.475 mg. of Drug A. On hand you have 0.125 mg per mL. How many mL will you give?	3.8mL
You are to administer 500 mg Tetracycline four times a day. The Tetracycline bottle is labeled 250 mg per tablet. How many tablets do you administer? In terms of one singular dose and in one entire day	2 tabs per dose and 8 tabs a day

Convert the following: (a) 0.05 g to mg (b) 0.025 Litre to mLs (c) 1575 micrograms to mg (d) 750 mg to grams	(a) 50 mg 0.05 g X 1000 = 50 mg (b) 25 mLs 0.025 L X 1000 = 25 mLs (c) 1.575 mg 1575 micrograms ÷ 1000 = 1.575 mg (d) 0.75 g 750 mg ÷ 1000 = 0.75
A patient is prescribed 0.25 mg of digoxin orally once daily. How many tablets should you give? (Stock = digoxin 250 microgram tablets)	One tablet NB The correct way of writing the dose on the drug chart is 250 micrograms
A patient is prescribed insulin 22 units subcutaneously. How many mLs should you give? (Stock = 10 mL vial of 100 units in 1 mL)	0.22 mL (22 units ÷ 100 units) X 1 mL = 0.22 mL
You draw up 10 mL of 2 % lidocaine in a syringe. How many mg of lidocaine is there in 10 mL?	200 mg 2 % = 2 g lidocaine in 100 mL Therefore 0.2 g in 10 mL 0.2 g X 1000 = 200 mg
You have a stock vial of diclofenac (75 mg in 3 mL) and need to draw up a dose of 50 mg for your patient. How many mLs should you draw up to give this dose?	2 mL (50 mg ÷ 75 mg) X 3 = 2 mL
A patient weighing 60 kg is prescribed intravenous dopamine 4 micrograms/kg/minute. Calculate the infusion rate in mLs/hour. (Stock = dopamine 200 mg in 50 mL glucose 5%)	3.6 mL/hour 60 kg X 4 micrograms= 240 micrograms/min To convert to micrograms/hour: 240 micrograms X 60 = 14 400 micrograms/hour To convert to mg/hour: 14 400 micrograms ÷ 1000 = 14.4 mg/hour To convert to mLs/hour: (14.4 mg ÷ 200 mg) X 50 mL = 3.6 mL/hour
What is the total daily dose in mg, when drug B is prescribed to an adult weighing 75 kg at a dose of 40 micrograms/kg/day in 3 divided doses? How many mg is required for a single dose in the question above?	3 mg 75 kg X 40 micrograms = 3000 micrograms which is equal to 3 mg 1 mg 3 mg per day ÷ 3 doses = 1 mg
To administer 500 micrograms of adrenaline intravenously, how many mLs should you give? (Stock = adrenaline 10 mL solution of 1 in 10 000)	5 mL 1 in 10 000 = 1 in 10 000 = 1 g in 10 000 mLs, which is the same as: 1000 mg in 10 000 mLs = 1 mg in 10 mLs Convert this to micrograms: 1 mg in 10 mLs = 1000 micrograms in 10 mLs Therefore (500 micrograms ÷ 1000 micrograms) X 10 mLs = 5 mLs
To administer 400 micrograms of folic acid syrup orally, how many mLs should you give? (Stock = folic acid 2.5 mg in 5 mLs)	0.8 mL 2.5 mg in 5 mLs = 2500 micrograms in 5 mL (400 micrograms ÷ 2500 micrograms) X 5 mL = 0.8 mL

If you want to administer 3 mg / kg of 1 % lidocaine to a 72 kg man, how many mLs should you give?	21.6 mLs 3 mg X 72 kg = 216 mg 1 % = 1 g in 100 mLs = 1000 mg in 100 mLs (216 mg ÷ 1000 mg) X 100 mLs = 21.6 mLs
To prepare 62.5 micrograms of digoxin for intravenous administration, how many mLs should you give? (Stock = digoxin 500 micrograms in 2 mL)	0.25 mL (62.5 micrograms ÷ 500 micrograms) X 2 mL = 0.25 mL
You are required to administer 150 mg hydrocortisone intravenously, how many mLs should you give? (Stock = hydrocortisone 100 mg in 2 mL)	3 mL (150 mg ÷ 100 mg) X 2 mL = 3 mL
To administer heparin 3500 units, how many mLs is required? (Stock = heparin 5000 units in 1 mL)	0.7 mL (3500 units ÷ 5000 units) X 1 mL = 0.7 mL
A child weighing 19 kg requires 400 micrograms/kg of adrenaline 1 in 1000 for nebulisation with a maximum dose of 5 mg. a) What dose should be prescribed for this child? b) How many mLs of adrenaline is required?	a) 5 mg b) 5 mL a) 400 microgram X 19 kg = 7600 micrograms which is equivalent to 7.6 mg; however maximum dose is 5 mg. b) 1 in 1000 = 1 g in 1000 mL Equivalent to 1000 mg in 1000 mL (5 mg ÷ 1000 mg) X 1000 mL = 5 mL
A patient weighing 65 kg is prescribed intravenous aminophylline 500 micrograms/kg/hour. Calculate the infusion rate in mLs/hour. (Stock = aminophylline 500 mg in 500 mL sodium chloride 0.9%)	32.5 mL / hour 500 micrograms X 65 kg = 32 500 micrograms/hour = 32.5 mg/hour (32.5 mg ÷ 500 mg) X 500 mL = 32.5 mL/hour
A patient weighing 75 kg is prescribed intravenous phenytoin 1500 mg. Over how many minutes can you give the infusion over so that the maximum rate of 50 mg/minute is achieved?	30 minutes To give 1500 mg at a maximum rate of 50 mg/minute: 1500 mg ÷ 50 mg = 30 minutes
A patient weighing 80 kg is prescribed subcutaneous tinzaparin 175 units/kg once daily. How many mLs should be administered to the patient? (Stock = tinzaparin 20 000 units in 2 mL)	1.4 mL 175 units X 80 kg = 14 000 units (14 000 units ÷ 20 000 units) X 2 mL = 1.4 mL
A patient is prescribed prednisolone 40 mg once daily in the morning for 5 days. a) How many tablets should you give the patient every morning? b) What is the total number of 5 mg tablets required to complete the course? (Stock = prednisolone 5 mg tablets)	a) 8 tablets 40 mg ÷ 5 mg = 8 b) 40 tablets 8 x 5 = 40
You are required to administer 8 mmols of magnesium sulphate intravenously. How many mLs of magnesium sulphate should you draw up for further dilution? (Stock = magnesium sulphate 5 g in 10 mLs; where 1 g = 4 mmols of magnesium)	4 mLs 1 g = 4 mmols therefore 2 g = 8 mmols (2 g ÷ 5 g) X 10 mL = 4 mLs

MMI / Scenario Practice Questions + Model Responses

Practice Questions	Thought processes / Quick breakdown of answers	Example answer
"You are the captain of a successful sporting team that has just won their finals. Everyone in the team works together really really really well. After winning your finals, the whole team goes out for celebratory drinks and at the end of the night, two people get into a car and drive home. The driver crashes the car and suffers minimal injuries, but the passenger and other teammate is severely injured. Following the incident, the team ceases to stop working together well and begins to fight over seemingly unrelated or irrelevant issues. The driver of the car is noticeably more distraught and possibly depressed. As the captain of the team, what do you do?	• Take control of the situation, what things can I solve by myself first before I have to escalate or ask for help from others? Try to resolve things on a personal level before escalating things • Remember that this is a traumatic experience for everyone, and issues can run deep for those affected, so there is a chance that the issue cannot actually be solved • Try to think objectively, what if you were in that situation? How would you want others to respond to it? That	I feel it is important for me to first take control of the situation and note everything that has happened prior to this incident. While it is quite easy to note the car crash as the leading incident, I would personally choose to dig a little deeper to see if there were any other incidents prior or after the car accident. It would grant me insight into whether there are any underlying issues that were exacerbated by the car crash, and better guide me in my actions moving forward. Next, what I would do is to speak to both individuals by themselves to learn more about what has happened and how they feel about the other individual. By doing so, it grants them a safe space to speak about their feelings and also prevents any misunderstandings or hostilities as both sides are able to speak their mind as transparently as they can. I would personally approach them to ask if I could talk to them at a suitable time in a location of their choice. After hearing both sides, I would then reflect about what was told to me, before asking for both of them to meet me for a discussion. I would be transparent in my request, informing them that I am facilitating a respectful discussion with the other party and that I will mediate the discussion as and when necessary. I would draw upon the authority as a captain and also the close friendship that I maintain with both parties to encourage both of them to come for the session, where hopefully we would be able to work something out.

	should guide you on how you should approach the situation • Explore feelings sensitively and respectfully, since some people may not want to talk about it • Does the team take priority over certain individuals? If so, how do you justify that?	I also recognize that the team could have been split due to the incident where certain team members take sides with certain individuals, and to address that, it is best to resolve the conflict between the two individuals before moving on to the team. After the conflict has been resolved, I would organize a team meeting where I would encourage both individuals to shake hands to signify that we are moving on from the incident as a team, which hopefully would lead to an improvement in circumstances.
"You are on a 4 week rural placement as part of your medical degree. You have been on placement for a week and don't know many people; the doctors in the hospital are not very friendly. Some of the nurses are but you haven't made any friends yet." How would you approach this situation?	• Recognize that it is a very high possibility of occurring since usually placements can be anywhere. So if you were in this scenario what would you do? • How would you tackle this issue? Would you just ignore everyone? Would you only talk to nurses? • Think about your own experiences where you were faced in similar	I would first take stock of the situation and what factors are in my control, and what factors are not. Why I would do this first is because in such a situation where it can be emotionally challenging, I could miss out on certain factors that could be very important in my situation. By taking control of my circumstances and noting down everything, it helps return a sense of familiarity and would help me make a more informed decision. Next, I would consider approaching some of the nurses that I am more familiar with, approaching them possibly during non-work hours such as before or after shifts. Why I feel this is particularly important is because we should remain professional when we are working, and it is easier to hold a conversation when we are off work where there are fewer work responsibilities. Additionally, it makes setting up hangouts easier as for instance, after work we would be free and perhaps grabbing lunch or dinner would be more convenient for everyone.

	situations (such as a new school). How did you respond? That should guide you on how to respond to this matter • Note that there are now professional boundaries as well, such as the hospital. So how do you differentiate professional boundaries from personal boundaries ? • Suggest 2-3 methods, that should be enough in terms of tackling the question. Make sure to justify why with relevant examples as well	After getting to know some individuals, I would slowly interact with the other co-workers I have, perhaps joining in on events or activities hosted by other groups. By saying simple greetings first, it allows familiarity to build and slowly allows me to build the basis for friendships with them. By seeing familiar faces frequently, the doctors could be more willing to open up and make friends with me. However, I would also recognize that it is impossible to win everyone over and that I can try my best but still be unable to forge connections. As such, if I fail in my interactions, I would accept it and seek to make connections elsewhere. I may also seek to forge connections apart from those in my work setting such as making friends with my neighbours or new friends through connections or events hosted. It is equally important to have friends apart from those at work as not everyone may want to hang out after work and it provides a good work-life balance.
You live in a small flat behind the hospital on your own, you have no car and your mobile phone does not work. After a week of placement you are beginning to feel that you cannot stand the place any longer. What do you do? Keep in mind that this is a very, very real situation.	• Take note of the extensive factors given to me in the question: small flat (a lack of funding perhaps?), no car	Personally, what I would do first is to take note of my situation, writing down the things I have issues with and the things that I am personally grateful for / happy to have. I realise it is easier for me to place things into perspective when I have them written out and it allows me to make an informed decision when I can see everything that I need to consider.

You may well be faced with this exact situation at the end of second year on your 4-week rural placement / external placements	(understandable if there is a lack of funds), mobile phone does not work (no money to fix it?) • I cannot stand the place any longer (in what sense?) Is it the physical conditions of the flat itself or would it be the emotional toll taken on me since I am on my own and have a lack of resources to make the journey easier • Question is asking what I would do, so I need to give solutions. But do I have enough context to make solutions? Or do I need to formulate certain assumptions? • Consider many possibilities and think	After that, I would then start to sort things out into 2 categories, 1 being factors that I can change and the other being factors that I cannot change. In doing so, it allows me to really understand what things are out of my control and that I would need to find a way to live with it, and also allows me to plan tangible actions to take to address those factors I can change. For instance, if I have a mobile phone that does not work, and if it is something I can afford to change, I would then explore alternatives to swap for such as selling my current one to subsidise the purchase of a new one. By planning out feasible actions to take, it restores a sense of control and allows me to better cope with the emotions I am experiencing. In regards to factors that I cannot change, I would explore if it is impossible to change at all, or would it be possible to change it if I had the help of others. To illustrate this point, let us say that I would like to travel but I do not possess a car. Would it be possible for me to take public transport via the Underground or buses to get around, or even ask my colleagues around me if I could borrow their car or join them if they were to travel? I personally do so because what we imagine to be impossible to solve, is actually able to be remedied if we ask others for help. If I have friends that could help me in my situation, it would resolve some of my grievances and make surviving the rest of my placement more doable. Lastly, I would find a way around those factors I cannot change. For instance, if I have to live with the small flat for the rest of my placement, I would see what can I improve about the flat itself to make it more livable, and if there is really no way out, I would just accept it and “suck it up”, taking it as a lesson learnt for the future where if

	outside of the box in terms of what I can do. State any assumptions you make • Can you ask for help? Or take certain steps to resolve the issues faced? Try to fix things by yourself before seeking help	I were to find places to stay after this placement, I would look for one that is bigger than the one I currently stay in.
Universities are commonly faced with the complicated task of balancing the educational needs of their students and the cost required to provide learning resources to a large number of individuals. As a result of this tension, there has been much debate regarding the optimal size of classes. One side argues that smaller classes provide a more educationally effective setting for students, while others argue that it makes no difference, so larger classes should be used to minimise the number of instructors required. What are your views on this matter, and if you were in charge, what would you do?	• The context has essentially been set for you, and the question clearly signposts how you should be answering this specific question. Recommended structure would be: Talk about smaller classes (pros and cons etc) Talk about bigger classes (pros and cons etc) What you would do + Conclusion • Show that you can	I feel that it is important for me to explore both sides of the argument so as to have a balanced view on the matter, which would then guide me on my decision if I were to be in charge. Exploring the smaller class sizes, one reason expressed is that it provides a more educationally effective setting. I can most definitely see where this comes from as I used to study in Singapore, and there was actually research done on the optimal number of students per class. I remember reading that with a smaller class size, teachers are able to better delegate their time to teach and give the highest quality of care. Additionally, since a teacher has administrative tasks as well on top of teaching, with fewer students, it greatly reduces the amount of work and allows teachers to have a decent work-life balance, where they can focus more on teaching the highest quality of content. However, looking at the flip side, I can also see why this conclusion was made. Smaller class sizes would depend on teachers being

	have a balanced argument and weigh things objectively instead of actually just jumping straight to answers without justifying why • Are there any real world examples that you can perhaps draw on to answer this question? What about past experiences ? • Consider as widely as possible in terms of factors so the monetary aspects, social aspects, education aspects etc. Diversify your points as much as you can • Only bring up past experiences to justify points that are stated, try not to make it sound too biased	willing to put in more effort for less students, but that does not necessarily hold true as not all teachers would be willing to do everything for the students. It really depends on the teacher specifically. As such, to conserve resources it could be better to have bigger class sizes and would still allow students to receive the education they need. If I were in charge, I would choose to go with small class sizes. Having looked at both sides of the matter, I personally prefer smaller classes as it helps to build a sense of friendship and closeness within classmates easier compared to a bigger class, and I found that teachers tend to be more willing to put in the extra work when there are fewer students. This was based on my past education experience of 14 years where I have experienced both large and small class sizes. Additionally being close to my teachers, I learnt that they would much rather prefer smaller classes so as to better understand and support students who need it.

	towards one side • You should first mention and justify what has been given to you in the question (use that as a starting point for your answers)	
You are a pizza delivery worker. The pizza shop he works for has a 30 minutes or less delivery guarantee or else the customer does not have to pay. On your most recent delivery, you spot a woman bleeding on the street. There is no one else around and the woman seems to be unable to move by herself. However, you know that if you return empty handed again, you will be fired from this job you most desperately need. What do you think you should do? Justify your solution in terms of practicality and ethical considerations.	• It is so easy to justify that you will pick the woman because "that is what healthcare professionals will do" but you forgot that you most **DESPERATELY NEED** the job (so there is a huge issue that without this delivery, you will not be able to survive financially • Think creatively and critically, try not to rule out any possible steps that you can take • Whatever you choose to do, make	I think it is important for me to first understand the situation that I am in, while I feel morally obliged to place all my focus and care on supporting the bleeding woman on the street, I would be unable to deliver the pizza and would lose my job which I need really badly. As such, I would first take into account what I have on me and what I can possibly use to tackle this situation that I face. In terms of practicality, I think what I would do is to immediately approach the woman and ask if she needs help. If so, I would take out my phone to call emergency services and stay by her side as long as feasibly possible, attempting to get the public to help the woman in the event I have to leave. I would also follow any instructions given by the emergency services as to not exacerbate the situation, while staying on the line in the event I need to relay any additional information such as having to leave. Why I feel this is the most practical approach is because it maintains a clear line for communication with help, and that I do not accidentally make things worse by doing something inappropriate. Additionally, I still respect that I have my own pressing concerns such as financial concerns and attend them so as to not affect my own situation.

	sure you justify clearly why • Consider things with different ideas in mind (such as financially, the job makes more sense but ethically the woman needs more help and it is morally right to do so) • Since the question mentions practicality and ethical considerations, make sure you mention those terms **CLEARLY AND LOUDLY** • I would recommend giving 2-3 solutions (and break them down in terms of practical and ethical considerations) so that you make sure to answer the question	In terms of ethical considerations, I think the 4 ethical pillars are still relevant here for consideration. In line with beneficence and non-maleficence, the right action to take would be to drop everything and support the woman in her recovery from that situation, as it would be doing harm to leave someone potentially in need and danger of bleeding out alone and it is doing good to seek the relevant help for her. However, in a way by dropping everything to help the woman it is doing harm to me as that could place me in a difficult financial situation, and since it was mentioned that I desperately need that job, it would not be doing good for me to jeopardize myself. While autonomy and justice are not as prevalent here, I would say it is in line with the law of Good Samaritans if I attempt to offer aid to the woman in need and that the woman has a choice to tell me whether she needs or does not need help, that she can make without any external influence.
A couple, who are good family friends of yours, come to you asking your advice as a doctor about their infant son. They are	• Communication skills should be empathy, using the	I think there are quite a few communication skills that are important here, and I will touch on two specific skills. The first skill would be empathetic

considering circumcision but are unsure about whether or not it will be beneficial, especially as they are concerned about the risks involved in this procedure. What communication skills do you think are important for this situation? How would you structure your response to the couple?	ICE approach is also feasible as well • Note what is given to you in the question. The couple are “good family friends of yours, so does that affect how you respond to the situation? Additionally they are asking about circumcision as well as the benefits and risks about it. How do you structure a response while still including the factors? • The second part of the question is asking how you would structure your response, so you need to signpost clearly what exactly you would do such as saying “I would explore their ideas….”	communication, where I communicate to the couple that while I may not fully understand their concerns, wishes or views as I do not necessarily share them, I will do everything possible to support them through their decision-making. I feel this is really important as there are times when patients expect doctors to possess the same views or assumptions that they have, and may not necessarily disclose all information to me based on the assumption that I would know. By expressing this skill clearly, it would make the discussion process much simpler and allow me to best support them in their decision making. The second skill would be transparency and easy-to-understand language, where I disclose all information possible in a clear manner to let the couple make an informed decision without any external bias from individuals such as me. Why I feel this is really important is because the questions prompts me that the couple is unaware of the benefits and especially concerned about the potential risks, as such I should be providing any information possible for them to understand without adding on to their confusion and clarifying any potential misconceptions they may possess. How I would structure my response to this couple would be to utilise the above mentioned skills and use the ICE approach, exploring their Ideas, Concerns and Expectations to help them resolve their worries. I would first ask them to establish what they are already aware of, which would then be able to guide me on what I need to elaborate to them. I then would elaborate whatever is necessary to them in an easy-to-understand manner which hopefully would then be able to guide them to an informed decision. Regardless of the decision made, I would also inform

	• The question is also asking about what communication skills are considered important so again what is considered important? How do you define importance ?	them that while we may be good friends, I personally think it would be best for them to get a second opinion from a professional apart from what I have informed them so that they can make a secondary decision without potential bias.
You are a volunteer at a homeless shelter. One day you meet a 42-year-old woman who is dying from alcohol-related liver disease. She tells you that she hasn't had a drink in days and wants to "get hammered" before she dies but cannot get the last bottle of vodka from her locker at the shelter. You know that alcohol is not permitted at the shelter. What do you do?	• Ethical pillars are very important for this scenario, in particular autonomy, non-maleficence and beneficence . It will be good to dedicate some time to explore each ethical pillar individually • You should also be considering things apart from ethical pillars, such as your role and responsibilities as a volunteer. What is within your job scope and what is beyond	I would first take into account the entire situation before making a decision, considering important factors such as my position as a volunteer (where I may not have enough authority to retrieve items from lockers for the homeless, and that I could be out of my depth in this situation to make a decision since I am only a volunteer), the woman's circumstances and wishes (that she is currently dying from alcohol-related liver diseases, and that she wishes to have a "last drink" before her passing, something like a last meal) and lastly that she currently possess a bottle of vodka in her locker at the shelter (which it is not permitted and against the rules of the shelter). I would also consider the 4 ethical pillars in this situation as it is a difficult situation to be in. In regards to Autonomy, it is the woman's right to choose to take a drink even in her circumstance and that she should be allowed to make such a decision that she has thought through and weighed prior. However, in line with Beneficence and Non-maleficence, it would make more sense for me to refuse the woman's wish as it would be actively doing harm to provide alcohol to the woman when she is

		what you can do as a volunteer? There is an important distinction here that you should know as and when to escalate matters especially if it is beyond your ability to help • Note the woman's wishes as well and weigh it accordingly with the potential harm it can do to her (which one should take precedence) • You should also be considering the fact that alcohol is not permitted at the shelter (so even it being in the locker is illegal already, how does that influence what you do) and if you give it to her, you are enabling her	already suffering. However it is also worth considering that it is quite a decision to deprive the woman's last wishes, especially since she is currently afflicted with liver disease. Lastly, I would consider the legal implications of possessing alcohol when it is clearly prohibited in the shelter, and by choosing to give it to her or keep quiet about such a situation would be breaking the law or not. What I would do is to move closer to the woman and ask her to repeat her instructions such as to clarify that I heard her correctly, and if it was the same as what I was told, I would then firmly but kindly inform her that I cannot possibly do so given the rules of the shelter (explaining the logic and rationale behind such a decision patiently) and that it is out of my scope as a volunteer to make such a decision. I would then offer to call a more senior colleague over to listen to her concerns and subtly inform her that this patient has a bottle of vodka in her locker, and that it is possible for other homeless individuals to possibly possess alcohol as well. By doing so, I would abide by the rules of the shelter and prevent future possible occurrences of alcohol being sneaked into the shelter again.

It is late afternoon and you have four patients left to see. You have promised to be home in time to attend an important family event that evening. Just before you see the remaining four patients, you receive a call informing you that one of your long-term patients is failing dramatically. The patient and her family had previously agreed to a Do-Not-Resuscitate order; however the family is now having second thoughts and wants to discuss the situation with you as soon as possible. How will you manage your time? Read up on NHS DNR guidelines here: Do not attempt cardiopulmonary resuscitation (DNACPR) decisions - NHS (www.nhs.uk)	• Note all the tasks and responsibilities you have to manage, such as the four patients left to see, the need to be home for an important family event that evening, your long-term patient failing drastically, the implications of a DNR • Can a DNR be rescinded or overturned? Under what conditions? When the DNR order was signed, did the patient have capacity? Does the patient still have capacity? • The question is asking how you would manage your time so in a way it is a prioritization and judgement station so you should explain that	Before I make any decisions, I would first take a quick step back to view the situation from an objective view first, considering the factors without emotions as to not cloud my judgement (which it could since it is a time-pressured and tense situation). I would consider just how much time I have left and what I can afford to squeeze into that time period while making it back in time for my family event. Why I establish such a duration is because while my job is important and that it matters to take care of my patients, a work-life balance is still important and this event is particularly important as established in the question. I would also consider if I have any colleagues that could take over the four patients for me while I attend to the patient who is failing drastically so as to still provide the necessary care for them and address the current development. Regarding the patient who is failing dramatically, I would first ask to check the DNR order and review when it was last signed and whether it has been updated since the previous reviews, while also checking for ADRTs (Advanced Decision to Refuse Treatments) as well as if the patient had previously appointed any LPAs prior to the incident. By checking for all possible circumstances it would then guide my decision-making where for instance if the patient has signed an ADRT together with the DNR form and has no appointed LPA, I would then meet with the family to inform them that I am unable to change or allow any revisions as the patient had already made a decision when she had capacity. In the event that there are no ADRTs or LPAs, I would then immediately seek advice from members of the MDT and the IMCA (Independent Medical Capacity Advocate), escalating if necessary

	clearly to the examiner as well on why you chose what you did and how you arrived at that conclusion • While possibly tempting to say that you are willing to forego the important family event to show dedication to the profession, work-life balance is very important too. It is a huge talking point for this question so you should mention it	to make the most informed decision for the patient. At the end of it, I would still try to wrap up my duties to make it home on time for the family event, as mentioned above to maintain a work-life balance that is really important in this profession. However, I would still attempt all my duties as a professional to the highest standard to care for the patients.
Dr Cheung recommends homeopathic medicines to his patients. There is no scientific evidence or widely accepted theory to suggest that homeopathic medicines work, and Dr Cheung doesn't believe them to. He recommends homeopathic medicine to people with mild and non-specific symptoms such as fatigue, headaches and muscle aches, because he believes that it will do no harm, but will give them reassurance. Consider the ethical problems that Dr Cheung's behavior might pose. Discuss these issues with the interviewer.	• The question specifically mentions "ethical problems" so as you would, you should mention the 4 ethical pillars and consider all 4 of them equally. They should make up the bulk of your answer	Since the question prompts me to discuss the ethical issues, I think it would be best to discuss the question in line with the 4 ethical pillars. Looking at Autonomy, I think it could pose an issue in the future, where the patients could ignore similar symptoms that they are currently having and choose to undertake the same homeopathic medicine that was previously prescribed, which could potentially jeopardize their safety as they could choose to avoid heading to the doctor for future recurrences. Additionally, they could ignore such symptoms thinking that it is in their head which could be warning signs

	• You should also be considering the scientific issues and lack of theories to suggest the use of such medicine and how it could affect patients, in particular patient safety • You should also consider his intentions behind doing so, what is he trying to gain from it or what is he intending to do from suggesting these forms of treatment (Is it justifiable?) • Additionally the question mentions that it is for mild and non-specific symptoms so what are the implications for that? How does that influence your views or opinions on this matter?	for other illnesses, affecting their safety at the end of the day. Looking at Beneficence and Non-maleficence, I can see why Dr Cheung has chosen to do so and empathise with his decision a little. In his view, since it is not actively doing harm to the patient and it is doing good in a way by helping the patient to feel comforted and prevent them from over worrying or being too distracted by such symptoms. Reassurance can be a powerful tool for healing and to Dr Cheung, it is considered to outweigh the potential negatives of doing such treatments since it is mild and not severe anyway. However, in my view I see that while the short term implications are minimal, the long-term effects could be disastrous, similar to the point I raised above during the discussion of Autonomy. It could be doing harm to the patient in the long run especially if they become too obsessed with homeopathic treatments and choose not to take any other forms of treatment. Lastly, in terms of the Justice Pillar, I feel that even though it is a relatively small transgression, it is potentially against the law especially if he is taking advantage of these patients by providing them misinformation and charging high prices for it. I personally am not too familiar with the exact UK rules surrounding this matter, but I feel that it would be unfair to charge high prices for such treatments especially if they are unproven. In conclusion, while I can see and somewhat empathise with Dr Cheung's motives behind such actions, I personally disagree and do not support such actions as they violate the 4 Ethical Pillars healthcare professionals should abide by.

Your company needs both you and a co-worker (Sara, a colleague from another branch of the company) to attend a critical business meeting in San Diego. You have just arrived to drive Sara to the airport. Sara is in the room. It isn't stated explicitly but in this station there is an actor playing Sara. Sara has developed a fear of flying as a result of the September 11 tragedy and you have to show off your communication skills.	Answered in my Leicester video on YouTube (Channel name: pratamark).	[redacted]
Recently, the Prime Minister of the UK raised the issue of deterrent fees (a small charge, say 10 pounds, which everyone who initiates a visit to a health professional would have to pay at the first contact) as a way to control health care costs. The assumption is that this will deter people from visiting their doctor for unnecessary reasons. Consider the broad implications of this policy for health and health care costs. For example, do you think the approach will save health care costs? At what expense? Discuss this issue with the interviewer.	• This actually was suggested a while back by current PM Rishi Sunak but was actually vetoed soon after, so that should guide you on how you should approach answering this question • This question is asking you about broad implications so try not to narrow your argument in terms of scope really early, focus on expanding your scope and make it wide before narrowing down	I feel that for us to have a comprehensive discussion about this matter, we should evaluate the pros and cons of such a policy, looking at the implications and potential consequences. There are some pros of such a policy that I can understand why it was suggested in the first place. Like the prompt mentions, it could deter people from visiting the doctor for unnecessary reasons as the public would not want to pay 10 pounds unnecessarily. In turn, the revenue generated across the UK could add up to a sizeable amount in the end, which could then be reinvested into the healthcare infrastructure such as increasing JD pay or support into better working conditions for healthcare professionals. Additionally, it could also control healthcare costs as the revenue generated can subsidize some of the costs faced such as maintaining the quality of care offered by the NHS. However, there are definitely some cons to this policy, and can be quite glaring in some aspects. For starters, 10 pounds may be chump change to those affluent, and hence would do little to deter them from visiting for unnecessary reasons. However, those 10 pounds could actually be significant to the less affluent, which could

	• Answer whatever the question poses to you, such as implications on health and healthcare costs, as well as addressing the other questions posed to you • This is a pros and cons type of question so try to talk about both sides equally, weigh both sides as neutrally as much as you can	take up quite a sizable portion of their income, forcing them to avoid seeing the doctor even when necessary to avoid paying the fine. This definitely jeopardizes patient safety in a way, and goes against the values of the NHS and their mission. I also would like to mention that the prompt uses the term “unnecessary reasons” but what does that mean exactly? It is quite vague and could serve as further confusion and add on to the worries of the general public. If left unchecked, it could push patients from seeking help when needed, further jeopardizing their patient safety. In regards to the potential benefit to be gained from the additional revenue, given the size of the NHS, the income generated may not even be enough to lead to any physical change, causing the “benefit” to be lost. In conclusion, I personally view that while the policy originated from an idea that had good intentions and was aimed to try and cause change for the greater good, the real-life implications of such a policy and potential shortcomings outweigh the benefits that it can bring about.
The Canadian Pediatric Association has recommended that circumcisions not be routinely performed. They base this recommendation on their determination that the benefits have not been shown to clearly outweigh the risks and costs. Doctors have no obligation to refer for, or provide, a circumcision, but many do, even when they are clearly not medically necessary. Ontario Health Insurance Plan (OHIP) no longer pays for unnecessary circumcisions. Consider the ethical problems that exist	• The question also mentions ethical problems similar to questions above, so you should consider the 4 ethical pillars clearly for this question • The question has given you quite a	With the question mentioning “ethical problems”, it would be good to tackle this question with the help of the 4 ethical pillars and keeping them in mind as we break down the scenario given. Looking at Autonomy and Justice, there is not much to consider as the prompt does not provide much context to us regarding the legal implications of such changes. However, I would like to highlight that in line with Autonomy, patients have a decision to make an informed decision on their own without any external influence. This would hold true for this case even with recommendations from the Pediatric Association, where if the patient still wants a circumcision,

in this case. Discuss these issues with the interviewer.	bit of information such as organisations not recommending it and OHIP no longer paying for **UNNECESSARY** circumcisions so make sure to take all of it into account when you are answering • Since there is a lot of things to take note in your answer, try to structure your answer to address everything in a fair and balanced manner, giving equal weight to all factors • Would be good to explore reasons behind why doctors still carry out such actions even though it is no longer required and when it is no longer necessary	they should be allowed to make such a decision. Moving on to the ethical pillars of Non-maleficence and Beneficence, it would be potentially more complicated to tackle. As mentioned by the prompt, there was a determination that the benefits have not been shown to clearly outweigh the risks and costs, which in line with the two ethical pillars, doctors should hence avoid providing or referring for a circumcision as they could be doing harm to the patient and overall not acting for the overall good of the patient if they were to carry on. However, it could also be argued that the benefits may actually outweigh the risks and costs, and by choosing to not provide for such actions, it would be doing harm to the patient as doctors are not acting for the overall good of the patient. Additionally, as mentioned, OHIP no longer pays for unnecessary circumcisions, I think a potential problem here would be that it is difficult to determine what is considered necessary or unnecessary circumcisions by doctors, especially if they have to make such a decision under timed and pressurized scenarios. As such, doctors could make a wrong decision due to human error and could potentially be violating the two ethical pillars of Non-maleficence and Beneficence in doing so.

You are a cardiologist at a local hospital, who just finished a shift and has a tight run to your daughter's high school graduation ceremony. As you headed off to the door, Mark, a patient who knew you well, saw you from the waiting room and grabbed your attention. "Doctor! I have a bad chest pain. Please stay for a bit. I'd feel much better if you were here." What would you do?	• What are some of the considerations here? Your clinical duties, your personal duties? How do you weigh and judge them and decide which one to attend first? • You should also be considering your situation first such as the amount of time you have to deal with all these tasks, how does it affect the way you handle this situation? • Remember that work-life balance is still very important so at the end of the day, do not just jump straight to saying that you will prioritise work all the time • The question's intention is to explore how exactly you approach this	I would first take into account the responsibilities that I have on hand, and the amount of time I possess, before calculating how to best address the situation in the limited time I have. I would first start by noting just how much time I have left to get to my daughter's high school ceremony (and if there is any way I could make it there in a shorter amount of time, which would free up more time to help Mark). The reason why I choose to still attend my daughter's graduation ceremony is because I am firstly no longer on shift, and I would prefer to maintain a healthy work-life balance and spend time with my family. After doing what I mentioned above, I would turn my attention to Mark and first do a quick check-up on him using my expertise as a cardiologist to see if he has any pressing issues or in any danger of worsening immediately. If he is well, I would then kindly but firmly explain my situation to him and seek his understanding about the situation, while also looking to hand him over to a senior nurse or the doctor on shift, making sure that he is in safe hands before leaving. In the event that he needs immediate intervention from me and the doctor on shift is unable to respond in time, I would first prioritize treating him, while phoning my daughter to inform her that I will be running late due to a situation that just transpired. I feel that by doing so, it shows a level of accountability towards Mark and my daughter and respect for one another that we keep each other informed of what is happening. I would then focus on treating Mark to get him to a stable condition or as soon as a fellow colleague is able to take over for me, and then quickly leaving to make up for lost time and attend the ceremony. While most definitely not ideal, to leave Mark when he is in critical

	scenario which can be quite common, and explore your ideas behind why you choose to do what you do so make sure to justify them and explain clearly why • Remember that chest pain can be quite serious, so doing some level of examination is recommended to make sure that things do not escalate beyond control • Since the question mentions the patient knows you well, how does that influence how you respond, if in any way? Additionally, is the patient leaning on you for help just because he knows you well?	condition would be directly harming patient safety and most definitely violate the ethical pillars of Non-maleficence and Beneficence, and as a professional, I would be willing to make some level of compromise to look after the patient and maintain best interests at heart.
You are a family physician. One of your patients, Mark,	• This is a very	I would first take a quick break to process the information that was

did not attend one of his classes and missed an important exam. He told you that his teacher would like a doctor's note explaining his absence from class; otherwise, he will receive zero, and all hell will break loose. He wants you to write a note for him, indicating that he was not feeling well enough to write the exam. Not able to find any physical symptoms, explain how you would deal with this. Some follow up questions: 1. What if Mark told you that he wasn't really sick, but he really really needed your note? 2. What if Mark was your son? What must you consider in this case?	realistic scenario and can happen when eventually you head out to work, so do keep it in mind what you would do if you ever face such a scenario and take some time to formulate a response before answering • Note what is being asked from you, a doctor's note. What are some of the guidelines behind the issuing of such a note and what should you be considering before deciding whether to issue or not • It is mentioned that you could not find any physical symptoms, are there emotional symptoms? Psychological symptoms?	explained to me, that Mark needs a doctor's note to explain his absence from class, and if he does not get one, he will be in big trouble. I would also consider that upon first examination I could not find any physical symptoms. What I would do after that is to do a second, possibly more thorough examination exploring his ideas, concerns and expectations about his consultation with me, actively looking out for physical, emotional and maybe even psychological symptoms. As a medical professional, it is important to cover all bases and check for symptoms that may not show up physically. If he does possess certain symptoms that align with the guidelines of issuing a doctor's note, I would prescribe one. However, if I am unable to find any symptoms for a prescription, I would firmly but kindly inform him that I was unable to find any symptoms and that I am unable to provide a doctor's note in line with the professional standards I abide by. I would explain that it is unethical for me to lie and falsely provide a note for him , and it is wrong for any doctor to do so. I would apologize that I cannot provide the note and end the consultation if he has no further questions. 1. If I was informed that by Mark, I would still not waver from my original decision, standing firm that it is unethical for me to lie on his behalf and that I cannot possibly prescribe a doctor's note on false information for him as it is very unprofessional of me to do so. While I am tempted to also press further on why he felt the need to skip the exam and come to the doctor's to ask for the note, it would be beyond my duties to do so and I would not share any of my own views on the matter, only sticking to the facts that I am aware of.

	Could you have missed something and possibly need to redo another examination? • Do you need to consider ethical pillars? Any ethics that you should be keeping in mind? • Note the follow-up questions that are asked, and make sure to give enough time to address them as well • Use PEEL structure, ICE works too but it is a very tiny aspect of the question	2. If Mark was my son, it does somewhat complicate matters as I would see him on a daily basis and if he flunks his examination, it could have a bearing on our family relationship. Additionally, the potential academic implications would also play a part as since I am his father, I want the best for his academics and by not providing him with a note, I am directly influencing his performance in school. However, I will still be firm in my decision not to provide the note, and telling him that I cannot possibly provide a note since there is potential bias. If he would like to seek a second opinion, he is more than welcome to find a different GP. What I would do after is to approach him in a more comfortable setting as a father to speak and learn more about his reasoning on why he chose to do what he did, and provide advice from a father's perspective.
A woman is at the bus stop with 2 boys and one girl, and a baby in a stroller. She looks tired and angry, the boys are running around and the baby is crying. Suddenly, she grabs one of the boys and slaps and screams at him. The other children start crying and the other boy tries to move away. What do you do? Follow up questions:	• Consider your role and the location you are in. Are you in public? Are you a bystander or do you actually know the woman?	While it may be instinctive to immediately jump at the woman and call her out publicly, confronting her about her actions to protect the children, I think that does not really benefit anyone and could actually make the situation worse as the woman can get defensive. In my opinion, what I would do instead is to keep a more watchful eye on the situation at hand, and prepare myself to step in if things escalate even further. Why I chose

If you intervene, how would you approach the woman? What are your thoughts when you see that happening? What if the woman wasn't the mother, would your view change?	• I feel like this approach to the question will really depend on how you were raised, some ppl think it's normal and some don't. Make sure it's justified and that you explain yourself clearly on why you do what you do? The "right" answer is to immediately step in but personally I disagree, so I would say focus on justifying why you would do a certain action instead of worrying if it is right or wrong • There are follow-up questions so again, make sure you have enough time for the follow-up questions as well • Physical violence should never be resorted to,	this particular action is because I grew up in a culture and environment where such actions are considered normal and while I may not necessarily agree with it, I believe that parents can discipline their child in public if they so choose to. However, in light of their safety as well, I would personally intervene if the violence escalates any further to protect them. If there is a need to intervene, I would respectfully ask the mother if everything is okay & if they need any assistance to make things better. Personally, violence to me is never the answer and while I may not intervene immediately, I would be ready to step in if things get even more physical. 1. If I need to intervene, I would ask the woman first if everything is alright and if she needs any assistance. This would allow me to approach the woman in a non-confrontational manner and give her the opportunity to first ask for help / reflect on her own actions. If she continues to abuse the children even after I had asked for help, I would step in and be more firm this time round, informing her that abuse is not acceptable and that violence is not going to make the situation better. I would ask her to stop verbally and physically abusing the children and if she still continues with her actions, I will not hesitate to call the relevant authorities. 2. Regarding my thoughts when I witness such actions, I would probably first feel a sense of anger towards the actions as I personally understand the fear and panic that these children feel, and that I am angry to see their mother do such things. I firmly believe that violence is never the answer and that matters like this can be resolved peacefully. I would also feel sad and empathetic towards the mother as while her actions are not

	and you should bring up this point in your answer as well • Avoid being super confrontational in your answer (such as saying “I will immediately challenge the woman and call her out”). There are better ways to deal with this matter than to immediately escalate matters	excusable, she must be under a lot of duress and pressure as the lone adult taking care of her children, and that her lashing out at the kids was her way of releasing the pent-up emotions within her. 3. If the woman was not the mother, my views would be slightly altered. If a total stranger started to shout and scream at others, my first reaction would be that it could be assault and that the stranger may have experienced some form of mental illness, as such my focus would be to get the children away and to safety first. I would also pay attention to my own personal safety. I understand that by saying this, it seems that I am “allowing” or discounting that mothers can hit their children or can abuse them, but it is more of the context that is presented. I stand by that violence is never the answer and no one should be enacting violence regardless of position or connections. In conclusion, my immediate response would change but my views on abuse and violence would not.
A man has been responsible for taking care of his wife who has been in a vegetative state for 6 months after a car accident. She can breathe on her own but that is the extent of her abilities. He requests that her feeding tube be removed. What should you, as her physician do? Why?	I edited the question from 6 years to 6 months because feedback from Ecolier was that it does not make sense for it to be that long. • What are the extent of your powers as a physician? Can you make the conscious decision to remove the feeding tube? Are you the sole decision-maker in this position or is there a	The first step that I would take is to acknowledge the man’s request, but also informing him that I would need to sort through legal documents to best ascertain the patient’s best interests before making a decision. I would do this first because clear and transparent communication would allow the man to feel heard and he would then be able to feel reassured that he will be taken seriously. Next, I would look through the patient’s medical notes or any legal documents that she may have signed to express her advance decisions such as ADRTs or what she would like to be done in a situation like this. I would also look into any LPAs that she may have appointed (which may or may not have been the man) to seek guidance and counsel on the next

		LPA that you should consult? • The wife has been in a vegetative state for 6 months now so does that mean that there is a guaranteed chance that the situation does not improve? If so, what would be the patient's best interests in this position? • Are there any documents previously signed by the patient to help determine the best wishes? It is stated that she can breathe on her own but that is the extent of her capacity (so does that mean there are no other ways to determine capacity or a decision from the patient?) • Remember that it is okay to escalate	steps. I would also consider trying to seek a decision from the patient (given her limited capacity). It was mentioned in the context that she can only breathe on her own, so is there a way to use this as a form of communication to determine the patient's best wishes? If there was no LPAs or advance decisions made in any documents, as per the BMA toolkit for determining best interests for a patient, the decision would then fall upon me (as the most senior physician) and I would talk to all members involved in the care of the patient to obtain their input before making any decisions. I would also speak to the man to learn more about why he chose to submit this request (perhaps it could be due to financial strain on his end, or fatigue for caring for his wife with no clear visible improvement) to determine if he really does have his wife's best interests at heart. At the end of the day, as a physician, I would note all relevant information and make a decision in the best interests of the patient. I would also like to mention that if I encounter a roadblock in the sense that my team and I are unable to come to a general consensus, I would be willing to escalate to the courts or ask for a IMDA to help make a decision in this case since it is very complex and with additional help, I can make the best possible decision.

	matters if you are not sure on what to do since this is such a complex situation • I thought about bringing about the 4 ethical pillars, but could not work it into the answer naturally so I didnt. But if you want to, go for it.	
You are working on a group project with 5 other students. One of the students doesn't show up for meetings or if they do show up – they are late and leave early. They have put no effort into the group project but show up on the day of the presentation and try to take credit for the project. What do you do in this situation?	• Ideally speaking, you should not have left things to just be as it is until the presentatio n to do something (aka you should have intervened sooner to prevent it from escalating to this point) • What is your position in the group project? Are you the leader and hence only the only decision-maker? Have you consulted with your	In such a scenario, I usually would not have left things to deteriorate to this extent, and would have sought out the student to speak to them beforehand. However, what I would mainly have done is to speak with the rest of the team members to make a general consensus on what to do about this team member, and keep a backlog of evidence as proof in case I need to present my case to the professors about their lack of contribution. Moving on, assuming that the presentation is about to occur, I would inform the rest of the team to focus on the presentation and deliver it to the best of our abilities first, and that we as a team can think about what to do after the presentation. I would ask the team member who did not contribute to come for a team meeting and present all the evidence of their lack of contribution, condemning them for trying to take credit for the project and that this matter would be escalated to the professors or lecturers for them to decide a punishment or penalty. Why I feel that this would be the best course of action is because it is important

		other team members before making a decision or are you acting all on your own? • Have you been keeping a backlog of all that has happened such as physical evidence of their lack of support for the group project? Any recordings of them leaving early even though they came late? You want to avoid a “He said, she said” situation where you have no proof of what they did • Are you just going to let them walk all over you? Or are you going to stand up against it? Why? • What are the consequences of them taking the credit for the project?	to be firm and respect the other members’ efforts into the project as it would be quite unfair to the rest if someone could just take credit without any effort. If the teammate is apologetic, I would not change the approach I mentioned, but may be a little less harsh in terms of reporting them to the professors as a sign of leniency. However, if the teammate is adamant that they have done nothing wrong and try to still force their way into taking credit, I would be less willing to be lenient and would present all evidence as it is, while rallying my team members to support this decision. While mean, I feel that it is important to send a message to this teammate that the world is not as kind to those who try to con and lie their way through it, and hopefully it can serve as a wake-up lesson to get their act together.

	Will it negatively impact you or them if you were to stop them from taking credit for the project?	
You are a second year student shadowing a doctor in the O.R. Once the patient, an obese female, has been given general anesthetic and the procedure is underway the doctors start to make comments about her weight and call her names that you find inappropriate but most of all unprofessional. Do you talk to the doctor about his comments or do you keep your comments to yourself? Why? Read up on Anesthetic Awareness: Anesthetic Awareness (aana.com)	• Note your position before making any decisions. You are **ONLY** a second year student (on placement probably to shadow the doctors). How does that affect the decision you make, and the subsequent actions you will take? Does being a second year student mean that you cannot step in at all? Or does it mean you should be reckless and report straight to the BMA without local resolution first? • The question gives that the patient	I would first acknowledge my situation and the role I play in it. As a second year medical student, it is likely that I may not be taken very seriously especially without proof of such comments given that the doctors seem to be in consensus about allowing such behavior to occur. I would then consider either asking any of the other staff such as nurses if they feel that the comments made by the doctors were inappropriate and if they would like to file a complaint together, or if it is permitted, to record an audio note of what was being said to back up my claims. While I note that any recording in such environments would be against confidentiality, it is the lesser of the two evils as by keeping these comments to myself it would be enabling these doctors to continue with their actions. After getting some evidence, I would first speak to the doctor about his actions and seek to understand why he said what he said. I acknowledge that what I find inappropriate may not be inappropriate for others, but I would establish that it was very unprofessional for the doctor to do so. I would also maintain that I am speaking up regarding the unprofessionalism demonstrated and that it is nothing personal to the doctors. If the doctor still tries to deny what he did, I would then inform him that I would need to escalate matters accordingly as the patient could have overheard their

		is an obese female, but does that matter? Are you reporting just because it is fat shaming, or are you reporting because it is inappropriate and unprofessional? • The question also says that "**YOU** find inappropriate", so keep in mind that what you think is inappropriate may not actually be inappropriate by official guidelines • The question is asking you to make a choice between the two, so pick either of them, try not to invent your own choice. Remember to justify why as well in your answer • Does the fact that the patient is	conversation (albeit very unlikely) due to Anesthetic Awareness and that could harm the image and reputation of the profession. If the doctor still refuses to admit any wrongdoing on their end, I would first choose to speak with my educational supervisor to determine the best person to approach regarding such a situation since I am only a second year student and may not be very aware of what to do. I would then approach the recommended individual such as the senior consultants or upper management and present my case. I would not jump straight to reporting to the BMA or GMC since the action would be very disproportionate to the issue caused as local resolution should always be done prior to escalation. While likely that it could cause some tension between me and the doctor, I feel that it is important to stand up for what is right and for those who may not be able to defend themselves, in the case the patient who placed their trust in us and did not deserve the slander and rude comments given to her.

	under anesthetic matter? Perhaps the doctors feel enabled and safe because the patient cannot hear? But there are cases of patients being able to hear under anesthetic so what are the possible consequences of that?	
Your friend asks you to mark them present at a compulsory tutorial, which they are not present at. They will fail the course if you don't. What do you do?	• A lot of people would tell you that being a snitch or not helping your friend makes it a bad friend, but it is more important to understand that the tutorial is compulsory for a reason and by choosing to mark them present when they are not, it not only implicates you and your friend, it could have an eventual	I think in such a setting, it is quite hard to make the “difficult” decision because you are a friend of theirs, and you would not want to sabotage your relationship with them and affect their studies. Additionally, it may seem like a trivial matter to just sign your friend as a present, as a favor or goodwill to help them out in their time of need. However, I would still choose to not mark them as present. What I would do is to first firmly and clearly state that I am unable to do so because it is against the rules and that while I really would like to help out a friend, I do not support rule-breaking and would encourage them to come for the tutorial themselves. I would also explicitly mention that I would be willing to help find alternatives if he could explain his reasoning to me as to why he is unable to come to the tutorial himself. Why I choose to do what I did is because while there is a possibility I did not get caught, there is a reason why the lecture is said to be compulsory and if my friend skips

	risk on patient safety • Note the severity of the action that if you do not mark them present, it will cause them to fail the course and that is a really big issue • The question does not give you much context on what is going on (such as is it a week from the tutorial, a day from the tutorial, hours or even minutes from the tutorial?) so it would be important to make assumption s and state them clearly for the interviewer to know your thought process • Remember that while you are helping your friend, you are putting yourself in	the tutorial, it could have long-lasting implications on his studies potentially and cause him to be affected as a student healthcare professional. Additionally, if I am caught, not only would he be in trouble, I would also be in trouble for being willing to support him in his actions and that could have an adverse impact on me as a student in the school.

	danger of being caught and/or exposed which has huge implications such as you also possibly failing the course	
A student is working in a clinic where the office double books elderly patients. The student asks their reasoning and the receptionist replies that "Those people never show up for their appointments." If you were the student, how would you deal with this situation?	I adjusted the question from "aboriginal patients" to "elderly patients" since I am applying to the UK, but the thought process should be the same, just adjust the talking points. ● While tempting to be super righteous and jump straight to "escalating matters and reporting the office", it is more important to resolve the situation that is at hand on a local manner first before escalating ● Note that you are only a student, so it should affect how you approach and deal with the manner since you do not have authority to	I would first stop and think about what was just informed to me, that the office double-books elderly patients because they never show up for their appointments, and these bookings could perhaps cost money to these elderly individuals. Having processed what I was told, I would then proceed to ask the receptionist if they could explain their approach a little more and why they choose to do so. After listening to the receptionist, I would then gather my thoughts and offer an opposing view on the topic (where if the receptionist says that with double bookings, the elderly would have twice the opportunity to seek care, I would politely counter that the double bookings could be taking away valuable spots for the general public to seek care, placing patient safety at risk). I would do so as I feel it is important to try and resolve the matter on a local scale first, seeking the understanding of the receptionist that what they are doing may not be the best. I would also raise the concern of monetary burden on the elderly if the bookings happen to cost money, and that it is unfair for them to pay for a second booking unnecessarily. If the receptionist still stands by their decision and does not seem to think that they may be in the wrong, I would then consult my educational supervisor or whoever I report to at

	"scold" them for their reasonings ● Can double booking have an advantage? If it is free, it could potentially provide two slots so the patient can still be seen (benefiting patient safety) but it can also be a tax on system resources to double book (where other patients cannot see the doctors, affecting patient safety etc). If the booking is not free, what implication does that have? ● Make sure to gather all the facts first before making a decision, which you should talk to the office members first to get a proper understanding to make	the clinic for advice on the situation, giving the facts transparently and in an unbiased manner while also sharing the views that I have and were discussed by the receptionist. I would do so as since I am only a student, I have limited authority to deal with this situation and escalation would be the more appropriate way to deal with this compared to me trying to resolve this alone.

	an informed decision	
It has been proposed that there should be a ban on lung transplants for heavy smokers or liver transplants for alcoholics. Discuss the implications of this.	I have answered this question quite a fair bit on the Discord, so I feel that I would not want to waste time to explain it here again. It is very similar to the first question in "General Practice Questions + Model Responses" so I do recommend reading my answer there :)	
You recently told a long-time patient of yours, Sheryl, that she has multiple sclerosis. After hearing that the appearance of initial symptoms takes two to five years, Sheryl says that she will not be telling her family. You are also the family's general practitioner and you know that they would want to be told. How do you deal with this conflict? Read up on multiple sclerosis: Multiple sclerosis - NHS (www.nhs.uk)	• First, determine if Sheryl has capacity to make such a decision, and whether she has enough information to make an informed decision about this. Is she rushing into this? Is she making a decision based on her emotions? • Remember that patient confidentiality should always be respected (except some circumstances which are not at play here) so if Sheryl has capacity, her decision should be respected and you should not try to influence	I would first acknowledge the request from Sheryl and determine if she possesses the capacity to make an informed decision. Why this is so important is because it could be a particularly distressing situation for her to receive the diagnosis, and may be making a decision on the fly or based on her emotions instead of rational thinking. Additionally, if Sheryl possesses capacity, then I believe it is important for me as a physician to respect her decision that at the end of the day, her decision is final and I should not be attempting to persuade her or convince her to change her decision based on external influence. With that said, assuming Sheryl has capacity, I would then provide all relevant and important information as a quick recap and advise Sheryl to give it some time before she makes her decision, but in the meantime I would not disclose anything to anyone without prior permission. This is to prevent on-the-spur decision-making and to allow Sheryl to really take some time and comprehend what exactly her decision involves. I would use the ICE method (Ideas, Concerns and Expectations) to help determine what Sheryl knows so as to provide her with the best possible care. If Sheryl at the end of the day still chooses to keep it a secret, as her GP I am bound by patient confidentiality to maintain it as a secret, and while I understand the wishes of the family, Sheryl is capable of making her own

	her to change her decision • Remember your role as a GP, that you are there to provide all relevant information for them to make an informed decision and that you should not let your views or relationships with them influence what you do in the end • Stress the importance of her safety and make sure to confirm that she understands the scale of her decision (use the ICE method) • Does the fact that you know the family of Sheryl wants to know influence how you approach the situation? If yes, how so? And if not, how so? Make	decision and I should respect it. My main concern then would be providing the best possible care to maintain her patient safety and allow her to live the best quality of life after her diagnosis.

	sure to express that clearly and for the examiner to know	
A neurosurgeon on his day off has been having a few drinks with his extended family, when his neurosurgeon colleague to help with an urgent case calls him in. The colleague tells the neurosurgeon that the person who's meant to be working with him has gone home due to the flu, and there is a patient that urgently needs to be operated on. The colleague tells the neurosurgeon that he is the best and the closest one to the hospital. The neurosurgeon hops in his car and drives off to the hospital to help. What are the issues here? Do the neurosurgeon's actions indicate that he is an alcoholic? Why do you think the neurosurgeon did what he did?	• There are 3 questions asked, so make sure to address all three questions clearly and allocate enough time to address them equally • The first question is just identification of the issues (so be sure to state them out clearly and explain why it is an issue, based on what guidelines or based on what understanding) • The second question is more towards an opinion since they are asking if the actions suggest that the neurosurgeon is an alcoholic, so you	There are quite a few issues at hand here, the first being that the neurosurgeon chose to hop into the car and drive, despite having a few drinks. While the act of drinking itself is not a crime, drink driving is against the law in most if not all countries, as there are potential implications of crashing the car and potentially putting others on the road at risk. The second issue would be that the neurosurgeon chose to help with the operation, despite being aware that he had quite a few drinks prior. This would raise a few alarms in regards to fitness to practice especially since alcohol can impair judgement and decision-making, especially important attributes in a speciality such as neurosurgery. While he probably had good intentions, it is definitely an issue as the risks of patient safety outweigh the benefits in this scenario. I personally think that it is important to define what an alcoholic is first, so that we can determine if the neurosurgeon is an alcoholic. In my understanding, an alcoholic is someone who drinks alcohol on a regular basis, in amounts that may or may not be large, but suffer from withdrawal symptoms (minor or major) when they do not drink alcohol, overall having a dependency on it. While the context given does not quite provide the glimpse necessary to determine if the doctor was an alcoholic, based on what was given to me in the prompt, the neurosurgeon was merely enjoying a drink with his family and it is not a crime to unwind during his downtime. I think the neurosurgeon did this because he saw a friend or a

		should try and explore both sides to the argument before choosing a stand (so talk about the why it may seem like he is an alcoholic, and then about why it may not seem like an alcoholic, before taking a stand if you choose to do so) • The third question is asking for your views and why you feel the neurosurgeon did what he did, so you have to include personal opinions for this part of the question • Break down the why clearly and concisely, be mindful of the time you have left (The question is not asking for solutions too, so do not waste time elaborating	colleague in need and that there was a patient in need, where if the neurosurgeon did not step in and sacrifice some of his personal time, the patient's safety would be compromised. Additionally, he has enough faith in his ability as a neurosurgeon and given his close proximity to the hospital, he felt that he would be able to best support his colleague in the duties and that he can get there in time to prevent patient safety from being compromised.

	on things that do not need your attention)	
You are driving along a highway and you see an accident happen – there are two casualties. You assess both and Casualty One is bleeding an enormous amount whilst Casualty Two is steadily bleeding, but not as much. There is no one else around you, both casualties are unconscious and are safe from potential danger. However, if Casualty Two is not treated, his prognosis will worsen and may risk death. You have 10% saving the life of Casualty one, but Casualty Two has 75% chance of being saved. You only have time to treat one, who will you choose? The family of the Casualty you did not choose comes to visit you at the hospital because you were the doctor in charge of the scene. They ask for an explanation of how the Casualty died. What do you say and how would you feel?"	I asked Ecolier and he said that this question has no right or wrong, and is more of a “Show Your Working / Reasoning” question. So focus on elaborating why and make sure it is clear and easy to understand. • Break down the scene and focus on the details. You have two patients, one has a higher probability of surviving than the other, you can only pick one. On what criteria and what basis do you select who to help? Why do you choose that Casualty instead of the other individual? • While it is quite tempting to say things such as “I would find others to help Casualty Two while I help Casualty One”, remember	I would first assess and triage the injuries as best as I can, and after careful consideration, I would focus on saving Casualty Two first before trying to help Casualty One. I would like to first address that in an ideal scenario, I would be able to save both Casualties and that the order would not matter. However, being realistic, given the chances of saving the two casualties, Casualty Two has a higher chance of being saved of 75% compared to 10%. Additionally, I feel that when it is in such a situation, my priority would be to focus on saving someone who has a higher chance of survival compared to trying to save someone with a lower chance of survival and potentially losing both casualties. In regards to the family approaching me in the hospital, I would be transparent and truthful with them, breaking down what exactly happened and the thought process I had when I was deciding who to save. I would also be honest and admit that the situation was a tense one, and that I do not know if i made the best decision in such a pressurised scenario. I would then apologize with as much empathy as I could and genuinely demonstrate my regret for not being able to save their loved one. I would probably feel a mix of guilt (where I was unable to save the loved one of the family), sadness and regret that I tried everything in my ability, yet it was not enough.

	the factors given such as having no one else around to help you, and you need to intervene now • It is important to recognize triage as the main tool for decision-making, and also to understand that at the end of the day, you would probably end up with losing someone (either of the Casualties) • For the second part of the question where the family visits, it is important to be transparent and honest, do not give misleading information (such as Casualty 1 was dead when you arrived even though Casualty 1 was alive,	

	just unconscious) • Demonstrate empathy and admit the details of the situation clearly, explaining your logical reasoning behind it • Be transparent about yourself as well, that the situation you were in was a stressful and difficult one, that you feel guilt for not being able to support both	
Due to the shortage of physicians in rural communities, it has been suggested that medical programs preferentially admit students who are willing to commit to a 2 or 3-year tenure in an under-serviced area upon graduation. Consider the broad implications of this policy for health and health care costs. Do you think the approach will be effective? At what expense?	• The question is asking about the broad implications and since it is so vague, it is really important for you to define what are these broad implications and in what context? Financial? Social? Political? • The question is asking	I personally think that this measure is merely tackling the symptoms of the issue and that it does not address the root causes of the physician shortage in rural communities, and has some implications on healthcare and the costs in general. The first implication is that while it could address the shortage for a short term, the problem could resurface again eventually and be worse than it originally was. The context given is that the students who are willing to commit to a 2-3 tenure, but it fails to provide context on whether it is legally binding, or if the students can leave after the tenure is up. As such, the professionals could end up leaving as soon as the tenure is over or even not recognize the tenure and move away, causing the issue of

		about implications on health and healthcare costs but you can explore more options, just make sure to explain the two mentioned factors • Think about the ethical implications of such a move. Would it be unfair to other applicants just because they are not as willing to commit to the tenure? • Additionally, it is important to consider if these students are just committing to the tenure because they really want to work in such settings or only to get into medical school. How do you determine their intentions? Can they	shortage of professionals to come back a few years later. This would hence be quite ineffective as the problem is only solved for a short period of time. Additionally, this could incur higher costs in the long run as more money would need to be invested to resolve this issue such as compensating doctors to move to rural areas. However, I can see the intended benefits of such a policy. By encouraging the admission of such students, the shortage of doctors could eventually be filled up once they have graduated from medical school. Additionally, with the movement of such doctors into rural regions, it would potentially lower healthcare costs as with an increased supply of healthcare professionals, those in rural areas may not need to pay as much for healthcare anymore and the government may not need to compensate doctors to move to such regions as much financially as before. In conclusion, my view on this approach is that while there were good intentions, there are too many drawbacks which limit the effectiveness of such an approach. It can be disputed that it is not fair to other medical school applicants who are not as keen to move to such rural regions, and that the benefits of such a policy only exists in the theoretical sense. As such, the government should explore other options to resolve the root issues of the shortage, such as consulting healthcare professionals on what can be improved or installing additional infrastructure to develop the rural regions.

	dishonor the agreement? Can they leave immediately after the tenure, making the problem worse? • The second part of the question is asking about your view on whether it will be effective and the costs of it. This is where you can raise up the questions posed above as talking points and explain the impacts of it • Does it fix the issue at the root cause or does it only affect it in terms of symptoms? It is important to differentiate since the effectiveness depends on it	

A pregnant, fifteen year old girl is expelled from her Catholic school. She seems to be highly in favour of abortion. What are your views on the situation? Discuss. Read up on NHS Teenage Pregnancy Support: Teenage pregnancy support - NHS (www.nhs.uk) GMC Ethical Guidance (Broken down in section "GMC Ethical Guidance") https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/0-18-years/sexual-activity	• It is a highly complicated situation since this is teen pregnancy (I checked with Ecolier and there is no minimum age that the baby must be terminated or aborted) • Under 15, if they are Gillick Competent, they can make decisions regarding this on their own without parental intervention • It is important to note the context of this as well. The girl just got expelled and had her life upturned in a matter of a few days / weeks, so perhaps her decision to abort the baby could have been made in a hurry to appease others or even influenced by others around her so	I would separate my answer into a professional view and a personal view. In a professional view, the patient has a right to make their own decision without external influence, also known as Autonomy. The patient's autonomy should be respected (provided they have capacity or are Gillick Competent) and as a professional, I should respect the decision made by the patient regardless of whether I agree with it or not. If the girl is Gillick Competent (where a series of assessments have been made to determine if she understands the full extents of her actions and the possible consequences), she then is able to go ahead with her decision of abortion. As a healthcare professional, I would do my duty of providing all relevant and appropriate information for her to make an informed decision with no bias, and respecting her final decision after consideration. Given that she was just expelled from her school, she could have been under societal pressure by those around her into this decision, and it is my duty to help her fully understand the potential implications of her choice. In my personal view, I would agree with her decision to abort the pregnancy on a few grounds. The first reason would be that at 15 years of age, she may not be ready to fully carry a healthy baby to term and deal with the implications of having to raise a baby. While there are relevant support services provided by the NHS such as Care to Learn scheme (funding for young mothers under 20 to allow mothers to carry on with their education), there are other financial costs as well as sacrifices that need to be made, which a 15 year old may not be able to meet. The second reason would be that she still has her whole life ahead of her and at 15 years old, she may not be fully

	essentially she may not be making an informed decision • The question is asking for your views, so personal opinions should be brought in to validate your argument. Good to show balanced views if you can, so try not to immediately dismiss the other side • You can briefly mention the action plan you will take to "flex" understanding of the possible steps to take (but try not to make it a big chunk of your answer since it is not the main point)	ready to deal with the side effects of pregnancy such as postpartum depression or juggling future work and maternal responsibilities as a teenager, no matter how "mature" or competent she may be as a teenager. While I feel that abortion is potentially murder (which is a complex topic by itself), it is perhaps for the best if she chooses to abort the baby.
Mrs. Jones has signed a donor card indicating that she is willing to donate her body to science without notifying her husband and son. She gets into an accident and it is determined she is brain dead. The family doctor, who is on call that	• Good to know that this is a very common situation that you could face IRL so it would be	If I was the doctor, I would first acknowledge the husband and the son, thanking them for their time and attention to the meeting and that whatever they are feeling is valid. I would highlight that the concerns they have are definitely understandable, and if they are okay with it, I would like to invite them to a more comfortable setting

afternoon, reviews the chart and determines that she would be perfect for medical students to practice the removal of organs for transplantation purposes. The doctor then talks to the family to discuss the procedure and to confirm their consent. They both oppose the procedure and refuse to allow their doctor to move forward. The doctor points out that Mrs. Jones could be helping hundreds of people by educating the medical students and that technically consent has already been provided. The husband understands how beneficial the educational experience is but is too emotional to allow them to continue. The son, a medical student, refuses because he knows the bodies are not treated with dignity. If you were the doctor, how would you proceed? Why?	good if you can recognize it that you may potentially face this in the future • Technically speaking, the consent has already been given and they do not need the support of the husband and son, but do explore why the doctor felt the need to do so and what was his intentions • The husband mentioned that he understands and is just too emotional to allow them to continue, so what should you consider as the doctor? Give some time for the husband to grieve, but there is a time limit for organ donation because the organs can fail? Note that this is a particularly	to speak with them. In such a situation, it would be important to break the news and explain it to them following the SPIKES technique. Once they are comfortable, I would express empathy for their situation and admit that while i may not share the emotions that they feel right now, I understand how difficult it must be and that I am here to support them if they need anything. Moving on, I would first address the husband as he seems to understand and accept the decision, just that he is too emotionally overwhelmed to continue. I would repeat that what his wife did was to help the future generation of healthcare professionals and that she is supporting a good cause. I would express my gratitude to him and advise him to take some time for himself to drive and come to terms with what has happened. Moving on to the son, I would be respectful and patient to the son, exploring his ideas, concerns and expectations of the procedure. I would first speak with the son about the ideas he has, perhaps any preconceived notions he has or how he feels towards bodies that are donated to science. I would listen to his point that the bodies are not treated with dignity and provide some explanation that what he sees may not be representative of what actually happens, and that while what he expresses is valid, I can assure him of the professional actions taken to treat the bodies with respect and dignity. I would also address the concerns he may have, and provide realistic information to help address them. After addressing both the husband and the son, I would once again thank them for their support and that the decision made by Mrs Jones is not in vain, and that the benefits of such a decision is greatly appreciated by the

	emotional experience and can be traumatizing so you should be empathetic to them as well • The son refuses because he knows the bodies are not treated with dignity. Is this only in his school? Do you have any statistics or evidence that could perhaps change his mind? Make sure to explore using the ICE technique to best understand what the son feels before making a decision • In a way this is breaking bad news, so some of the skills and techniques such as SPIKES should be used • The question is also asking	healthcare professional. I would also conclude with a quick summary of any important information and an action plan moving forward, what to expect and if they have to do anything for the procedure.

	for your reasoning behind your process, so you should make sure to elaborate upon your reasoning and why you feel or do what you do	
You are spending your evening as a JD in the hospital. It is late and you see a member of the staff duck into the supply closet with an empty bag and reappear in a few minutes with it appearing full. You have heard other staff members discussing that supplies are missing on a regular basis that cannot be accounted for. After observing the actions of the other staff member, what do you do?	• This is a SJT question basically LOL (so think back to the SJT options and what are the actions that you should undertake) • Remember that what you see =/= what you think it is. You may have misinterpreted what you saw and jumped to conclusions about what the staff member was actually doing (making assumptions) • It seems full but may not actually be full, so you should mention that you	I would first take a moment to consider what exactly I had just witnessed and compare it to what I have been overhearing. While it may seem on first consideration that this staff member is stealing supplies since it lines up quite perfectly with the discussions going around, it is important for us to note that it could be a possible misinterpretation of the situation and that what I saw may not be actually what I think it is. As such I should note what is going on, before taking some personal action to speak to the staff member to clarify. I would first approach the staff member in question in a friendly manner, making some small talk before asking the staff member what is in their bag in a non-confrontational manner. I would also inform them that there have been reports of supplies going missing recently and if they know anything about it or have seen anyone behave in a suspicious manner. I would first give them the opportunity to own up to their actions by encouraging them to show me what is inside their bag willingly. If they are not willing to and continue to behave in a suspicious manner, I would then politely but firmly inform them of what I saw and that I have reason to believe that they may be taking supplies. I would also state that while I am not accusing them of

	would take active steps to figure out what is going on • Avoid being confrontational as well, be calm and approach the situation professionally • You should note and keep in mind what you would do particularly if the staff member was actually stealing supplies (remember that local resolution should be done before any relevant escalation) • Also take note that you are only a JD, so your authority to some regard is there, but you are not on the same level as senior consultants for example so do keep that in mind when deciding what to do	stealing supplies, I just need to be sure and take the necessary steps to help resolve this issue that the hospital is facing. I would encourage them to be honest and own up if they were actually stealing supplies, or else I would need to escalate the matter to security and the consultants. If the staff member becomes aggressive towards me, I would firmly warn them that I would escalate things to security if they do not stop trying to threaten me. As a JD, I recognize that my authority is limited and that when things get beyond my ability to manage, I should escalate matters so as to take appropriate action.

Imagine you are the principal of a large, respected school. There has been an allegation that a humiliating film of a young disabled person has been circulating on the Internet. Two final year students are up before you to explain their actions in the creation of the video. The video appears to show a young person with intellectual impairment being verbally abused by one of the students whilst a group of senior students look on laughing. What are the issues that you, as the principal, are likely to consider both before, at and after a disciplinary hearing?	• The question is asking for issues so perhaps think of categories beforehand and think about it. Is it an ethical issue? Or is it a social issue? • The question is also asking before, at and after the disciplinary hearing so your answer should be structured in such a manner • Think about the issues apart from just the local level. While yes it was spread about on the internet and quite likely that it was seen by most of the school population, was it seen by the rest of the public? • The school is large and respected so think about the reputation of the school, how	Given the emotional, ethical and physical complexities of this issue, there are a lot of issues to be focused on which I will try to break down in my answer. Before the hearing, I would focus my attention on finding out as much as I can about this issue, the context and how the situation actually transpired. Why this issue in particular is because I strongly believe in making an informed decision, similar to how healthcare professionals communicate all relevant information to a patient, and I can only do so when I discover as much as I can about the scenario. I would also first choose to address the biggest concern which is the young disabled person, making sure that I pull out all stops to check up on them, offering all relevant help and support to them. I would speak to them and assure them that I will take those responsible and bring them to justice, and that I am here to support them given the trauma experienced. At the hearing, I would be more focused on listening to those who committed the heinous action. While what they did is inexcusable and definitely horrifying, they still deserve to be given a chance to speak and voice their views on the matter. I would keep an open mind and listen to them with reason and understanding, so as to best understand why they did what they did and to clarify or verify the claims made by them. I would also focus on the discussion of the meeting, making sure to bring up the implications it had on the young person and our school, particularly the reputation since the video was publicised on the Internet. After the hearing, I would consider the entire issue as a whole and weigh everything that has been presented evenly. I would consider all parties and think rationally about

	it is affected etc • Think about the intellectual impairment student and the possible trauma they went through. Think about how you as a principal can support them? While the aim is to focus on the act done by the senior students, you should also care for those affected	this, making sure not to let emotion cloud my decision. At the end of it, the decision would most likely be to punish the students who committed the action and find relevant support to help the affected young individual, so I would consider the possible punishments we could take and how to best teach them a lesson that bullying is not tolerated in any form.
You have been accepted into medical school and one of your early clinical placements is with a surgical team. Your supervisor, a senior surgeon, like to make jokes about the race, religion, sexual orientation, of the more junior members of the team. What, if anything, would you do in this situation?	• You may be tempted not to say anything especially since the person in question is your direct supervisor and is in charge of helping you in your attachment / clinical placements. But it is very important for you to know that keeping quiet about matters like this is enabling and	I would first consider what was said to me by the senior surgeon and weigh up everything that I know. I would take a moment to think whether what he said was actually against the code of professionalism and/or the Good Medical Practice that all doctors should exemplify. This is because what I find inappropriate may actually be considered appropriate by certain guidelines or standards, and that I should make sure that I am objective about this before making a decision. I would also take this time to speak to the more junior members to better understand how they feel and more details such as how long has this been going on for. Next, having decided that it is against the Good Medical Practice, in particular being unprofessional, I would speak to the senior surgeon first. It is very important that I clarify with the surgeon and try to resolve matters locally before escalating. I

	supporting them indirectly in their actions. You **MUST** step up and say something • Good to think about how you want to go about doing it. Do you have enough evidence or eyewitnesses? Do you understand the scale and process of carrying out such a complaint? • Remember that at the end of the day, you need evidence to be taken seriously and make sure that you carry out the escalation of matters in a respectful manner • Think about the impact of reporting such an issue and why it is so important (think about MDT and the way they work	would first ask the surgeon politely about his remarks in the room just now, and why he made them. I would explore his intentions and bring up the fact that his behavior is unprofessional and sets a bad impression for those under him. I would also highlight the impact it has on the more junior members, that it makes them uncomfortable and in such a multi-disciplinary team where everyone has to work together well, it affects the relationship within the team. I would kindly but firmly then inform him that he should probably apologize for making such statements to the more junior members, reminding him that just because he finds it acceptable does not mean that it is accepted by everyone. If he still refuses to apologize for his mistakes, or tries to turn it against me, I would then tell him firmly that I have no choice but to escalate matters to the superiors such as consultants. I would then move to ask the junior members of the team for support and to take this case to those who are able to handle the issue from here, informing them that staying silent is just going to enable the surgeon and the cycle would never end. I would also take the time to consult my educational supervisor and find out the correct procedure to take and escalate matters accordingly to be resolved.

	together, maintain good relationships etc)	
One of your old patients comes in to see you. You have received the results from his recent tests, which state that his heart is failing and he only has 6 to 12 months to live. Before you have a chance to disclose the information, your patient says that he is aware it is something serious, but he does not want to know what it is. He wants to live his life to the fullest, without any knowledge about the predicted life-span. What do you do?	• The 4 ethical pillars are HUGE here, make sure you incorporate them into your answer and work out what you should do in this situation • Remember that your duties as a clinician and what you have to do as a doctor • Can you find a compromise in this situation? Is this situation so black and white to the point that you cannot find a compromise? • The question does not say the age of the patient, so you can briefly mention things such as Gillick Competenc	I would first speak to the patient again and clarify what he said. This is important for two reasons, the first being that I am taking the time to verify his wishes and the second being that I am giving him the chance to repeat himself to prevent any confusion. Given such a complex and potentially serious situation, it is really important to make sure that everyone is on the same page and there is no confusion. I would invite him into a comfortable setting and ask if he needs anything. I would also check with him once again that he has thought through the decision and is certain that these are his wishes. After confirming his consent and that he does not want to know, I would first ask him to sign a form of sorts to reflect his decision as it is a relatively big decision and it should be documented for future purposes if needed. After he has agreed and signed the form, I would then quickly recap what his decision is, and any relevant information I can give in line with his wishes. This is because the old patient still has capacity and has made a conscious decision that he does not wish to be informed. In line with the Ethical Pillar of Autonomy, it is important that I respect his decision and support him in whatever he needs. After all is done, I would thank him for his time and exchange professional pleasantries.

	e if you want to (but not necessary) • The structure I would recommend is more using PEEL and break down the situation as detailed as you can. Try and avoid overcomplicating matters • In a way this is breaking bad news, so SPIKES would be a good method to answer this question with. You can also use ICE to explore and navigate the answering of this question	
You are obtaining consent from an old man before a major surgery, which is required to give him the best chance of survival. The old man says, "Do what you need to do Doc, I don't want to know the details, they are only going to make me worried." Do you get his signature without proper explanation of the risks/chances of complications/etc.? Or do you force this information	• The question poses two scenarios so it is very important for you to pick one scenario and choose it wisely. Important to remember to explain why as well	I personally think it would be good to explore both arguments presented and look through the possible pros and cons before making a final decision. Looking at the first argument where I obtain his signature without proper explanation, one benefit of this would be that I am respecting his wishes and in line with the Ethical Pillar of Autonomy, he is allowed to make such a decision without external bias or influence. Additionally, it would be in line with my duties as a professional where I

upon him, even though he insists on staying uninformed?"	• Note what the old man says and check with the hospital guidelines or guidelines meant to be followed for doctors. Is this situation black or white to the point that you cannot compromise ? Or can you find a compromise in this scenario? • Remember that consent is still very important, and in all cases should be written down and documente d clearly, if unable to get it written down consent should be made in the presence of multiple individuals to ensure reliability • Think about the forcing of information onto the old man and how it affects the 4 ethical	obtain his signature as evidence to be documented for future purposes. However, there are some glaring drawbacks of this. One issue would be that the patient technically is not making an informed decision since all available and necessary information is not disclosed to him to make a decision. Additionally, it could be in violation of the ethical pillar of Beneficence + Non-maleficence, as it could be potentially doing harm to the patient if I do not disclose the information to him. However, on the flip side, there are also some pros and cons to be mentioned. By forcing the information upon the patient, it would allow him to have all relevant information to make an informed decision which would be doing good for the patient as he is fully aware of what will occur. However, the biggest con would be that it would be disrespectful towards the patient as his autonomy to make a decision is disregarded and not respected. It gives off the impression that patients' views are disrespected which could have lasting implications on the profession where the doctor-patient relationship is disrespected. In conclusion, I would find a compromise between the two solutions presented, where I explain all and necessary information with his opinions and guidelines in mind so as to respect his wishes. Patient autonomy should be respected as and when possible and it is our duty in a service profession to respect and accommodate to his wishes, while carrying out our professional duties.

	pillars that all doctors should follow. Is forcing the information purely bad? Or are there possible benefits to it as well? • I would recommend breaking down both sides evenly before picking a side for two reasons. One, it allows you to show balance and demonstrate you can discuss contrasting opinions. Two, it shows that you are open to discussion and willing to consult others before making a decision	
X is dismissing a student and tells him to find another teacher, as he has not kept up to date with his work. You feel that X is being unreasonable. What would you do, as the student's friend?	• Think rationally about this situation before you actually make a decision. As a friend you might want to jump and defend	I would first speak to my friend to learn more about the context, bearing in mind that what he said is only one version of the events and it could be slightly biased or incompletely reported. It is very important to gather as much information about what has occurred from reliable sources before jumping to a decision. After learning more about what has actually occurred, I would see if I

		them but it is also important that X had their reasons for doing what they did. • Make sure to gather as much information about the situation first before making a decision. **NEVER EVER** act on incomplete information • The question is asking what you would do so your answer should be a process + explanation of why you chose to do what you did • Present your argument in a fair and balanced manner, make sure to consider both views of the students and X before you make a decision • Think a little whether you should actively	can verify any of what is said through sources such as X or the students around during such an incident. Now while it may be tempting for me to take what I know and head to speak to X since I verified what was being said and I felt it was unreasonable as well, I would instead choose not to intervene in this matter. While albeit a little confusing, after some thought this matter does not concern me, and while I should most definitely help my friend out, this matter should be settled personally between X and my friend. I could be a mediator of sorts, offering to be a bridge of communication to resolve this issue, but I should only be involved if really necessary. As such, I would speak to my friend first, stating that I will not be involving myself for reasons stated above, but am willing to try and reach out to X to ask if he would be open to discuss this situation with my friend. I would also inform my friend that he should probably be open and honest with X about why he has not kept up with work, and apologize for making a mistake to show some sincerity and effort to make up for it. I would then approach X and kindly explain the situation to him, and explain that I am acting as a messenger because my friend was afraid / unable to contact X and that he would like to make amends. While this could be seen as active intervention, this would be the only thing I would do, before letting go of this matter.

	intervene in this. Is it your issue? Or are you intervening when you should not be doing so? Remember that you should only intervene if really necessary but if you intervene, does it get worse?	
You are a member of the university disciplinary committee and have been asked to review a case of a full fee paying medical student who forged a doctor's signature to confirm he completed his attendance requirements during placement. The student is in his 4th year of 5; both his parents are educated professionals to have met with the committee to vouch for their son's otherwise exceptional standing in the community. The student argues that the doctor had been busy and that he couldn't find him to sign his attendance form. The other two members of the committee are advocating the student repeat the year and pay the full fees for the extra year's tuition. What would you do as the head committee member?	• Make sure to seek out all facts and lay it all out on the table first before making a decision; show that you actively take steps to determine what is going on instead of jumping to conclusions • Consider this accident as a whole instead of looking at it as just one incident by itself. Make sure to look at his supposed “exceptional standing” and the reasons	I would first call a meeting to validate and find out the whole context from as many involved parties as possible to establish a common timeline of events. This is because what is reported from one end could differ greatly for the other end, and that it is important to listen to all parties to make a balanced and fair decision. I would call the medical student, the doctor involved and any other individuals involved in the care of this student to listen to their stories independently and then form a timeline to validate the stories. After verification of the story, I would then call a discussion with the committee members. I would inform them what I know and listen to what they know, to ensure that we are all on the same page. I would ask them to further elaborate upon why they advocate the student repeating the year in particular, and to substantiate why this particular measure since it seems quite disproportionate. I would listen without judgement or bias, and focus more on providing logical arguments to make the best decision. After discussing with the committee members, I would then proceed to

	provided on why he forged • The meeting with parents should not really influence your decision-making, you can consider it but personally I think it is better if you do not consider it • Is there any way for you to validate the student's claims? By checking hospital records or speaking to the doctor directly • Are the proposed actions from the other two members of the committee proportionate to the issue? Is there another way to resolve this issue without taking such a harsh step? Is there a reason why specifically	call the disciplinary meeting with the student and the doctor in question. I would only allow those directly involved with the issue to attend as to prevent any external bias. I would invite both parties to share what they feel and how they view this matter to ensure fairness and that they are heard. I would then move ahead with the decision made by the committee members as a whole, as despite being the head, this matter should be tackled by the committee as a whole and not by me alone. (Add-on: If I had to make a final decision by my own judgement, and with the assumption that the doctor was indeed unable to be found by the student), I would first explain to everyone that the doctor was indeed at some fault given that he did not consider the student or make any attempt to cover for the student, despite knowing how important this is. I would then also explain that the student is at fault as he did not try to ask the doctor to sign the sheet beforehand, and did not communicate this issue to anyone else to ask for help. The student is more at fault as not only did he not ask for help before doing such an action, he was tempted to do such which could lead to worse behavior down the line if similar situations occur, just on a bigger scale. As such, the student is more guilty and would be punished accordingly.)

	they want him to do it this way? Potential ulterior motives? • Can you come to a compromise with both parties? Remember what is reported may not be the full truth. Speak to others to determine the whole story	
Vaccination has been lauded as an important public health measure but it requires at least 80% of people, ideally more than 90% of people, be vaccinated before a whole population is protected. Some groups in the UK are opposed to vaccination, often referred to as conscientious objectors. Overseas and in the UK, there have been calls to make vaccination compulsory for children in public schools. What is your opinion on this issue and what are your reasons?	• This question should be done via the structure of weighing the costs and benefits, discussing both with equal weight before coming to a conclusion • Bring up what you know about the benefits of vaccinations such as herd immunity and why it is so important (to protect others around them etc)	I feel that there are two topics to be addressed here, the overall topic of vaccinations and whether it should be made compulsory for children in public schools. Let me tackle the idea of vaccinations first. I definitely agree with some of the benefits such as potential herd immunity, where the majority of the population is vaccinated and protected against the disease, which in turn prevents the spread of the disease and protects those vulnerable. Additionally, vaccinations have been proven in some trials to lower the extent of symptoms experienced and the severity / threat much more diminished compared to those unvaccinated. This is particularly important as it lowers the threat to patient safety, which in turn relieves the stress on the healthcare industry and the staff. However, I also see the negatives of such a measure. Taking COVID-19 as an example, where the vaccine was made using MRNA technology that was developed somewhat quickly, it is easy to fear the potential implications since we do not know

		• Why is vaccination compulsory for children in **PUBLIC SCHOOLS** ? Why specifically public schools? Why especially children? What are the long-lasting implications or expectations / intended impacts of doing such vaccinations? • The question is asking for opinions (so make sure it is personal and use words / statements to show your views clearly) and reasons (so use the PEEL structure to explain clearly) • Also do consider the views of the other side (the anti-vaxxers or the term used "conscientious objectors"). Show	much about it. Additionally, I also understand there have been reported cases of patients who have received vaccinations and died from side effects. This in turn causes fear and worry in the "conscientious objectors" or known as anti-vaxxers. Moving on to the topic of compulsory vaccinations, I can also see the benefits and drawbacks of this issue. The biggest benefit would be that it vaccinates those at high-risk (as children have immune systems that are not very well-developed yet and may not be able to fight the disease off if infected). Additionally with the compulsory vaccinations, it would help contribute to the desired herd immunity as the children heading to public schools make up a considerable portion of the population, and could in turn encourage more to vaccinate themselves. However, the flip side also has some good points. One reason would be that it infringes on the autonomy of such individuals, that they are forced to vaccinate against their wishes and do not necessarily align with the ethical pillars that we should follow. Another reason would be that it could set a negative impression on the healthcare profession as it seems quite oppressive and could make the profession come off as untrustworthy if people die after receiving the vaccination. In conclusion, I feel that vaccinations are important and should be adopted to help combat the spread of the disease, but measures should be taken to improve the reliability and educate the public more about the vaccines. Regarding forced vaccinations, I believe that while there are good intentions behind it, it is quite disproportionate to the intended outcomes and that other measures should be explored.

	empathy and discuss their views in a positive and respectful manner even though you may not necessarily agree	
You are a GP. A mother brings in her child for her monthly checkup; on looking at her record she has had none of the expected vaccinations. On further probing you find out that 3 years ago her other child died 12 hours after receiving a flu injection. You firmly believe that vaccinations should be given to everyone, especially children. Do you still maintain your stance and ask her to comply with the vaccinations?	• Understand that expected vaccinations =/= mandatory vaccinations. If it is not mandated but voluntary, then she is not at fault (at least in the eyes of the law) • After probing, what you know is what she felt comfortable with sharing. You should not press any further than that. Respect her decision to share and respect why she chose what she did • Perhaps consider she had some form of trauma or	I would first thank her for sharing this particular piece of information with me. It is clearly a traumatic experience to undergo where she lost her child. I would then offer her any support such as tissue paper if she needs it, while also taking the time to look up the vaccinations in particular. The context given mentions that it is “expected”, and it is important to know that just because it is expected does not mean that it is mandatory. It would be good due diligence to check before continuing with the discussion. Regarding my action, I would respect her decision as the mother of the child and continue with the original purpose of the visit, the monthly checkup. While it can be argued that by not giving her child the vaccinations, it would go against the ethical pillars of Beneficence and Non-maleficence since it would be doing the child potential harm as they are at risk of infection and potentially death if it worsens to that point. However, in view of the ethical pillar of Autonomy, it is important to respect the decision made by the mother as the guardian/parent of their child and that she has her wishes. Additionally it would be in violation of the Ethical Pillar of Justice since it is illegal to force someone into a decision that they do not wish to partake in. As for whether I will maintain my stance, I would still maintain my

	PTSD since she lost her child (which is very traumatic for a mother) and she could understand ably have a fear of vaccination s since • Consider the 4 ethical pillars but in particular Autonomy (and how it applies to the patient) • The question also asks about your stance and if you maintain it. Consider whether your stance should change just because of a patient or case, and if you are allowed to feel or have certain views as a healthcare professional • Remember your professional duties and how you should conduct yourself as a doctor	view, but keep it separate from my professional behavior. This is to keep in line with the professionalism standards expected of us doctors, where even though we may disagree with certain decisions or viewpoints personally, as a service-centered profession, we should respect and do our best to support the patients' wishes.

You are working at a hospital as a medical student. A nurse comes up to you and exclaims, “Are you with the medical team?” She goes on to explain that a patient has been discharged from hospital with the wrong medications about 2 hours ago. What are some of the issues here? Follow up questions: What would you do, in what order? What are some possible explanations for the error? You find out the patient made an error when filling out her discharge paperwork, is she to blame for this incident?	• The word “exclaims” suggests that it is done in a very loud way, potentially dramatic. If done in a private setting it could be somewhat allowed / no major issues, but what if this was done in a public place in front of the patients etc? The word also suggests a certain connotation (positive/negative), does that affect your answer? If the nurse can be heard, it is potentially a confidentiality issue as well • How did the nurse get confused? Is it because you actually are doing placements as a Y2? Why did she approach you?	Personally, I can see some issues to be addressed here. The first issue would be the way the nurse exclaimed what she said. Exclamation can be particularly loud and given the context of the sentence, it could suggest that something has gone wrong, and the medical team is required. If done in a private place, it may not be as big of an issue, but if done in front of patients, not only does it have a chance of alarming patients, it can also lead to unease and potential trust being affected in the profession. The second issue would be the fact that the patient has been discharged from the hospital quite a while ago with the wrong medications. Not only does this mean that the patient is at the moment uncontactable physically to correct the mistakes, it could also affect her personal safety as a patient if she ingests the wrong medication. Another small issue I also notice is that this mistake was only just brought up (at least via the nurse), perhaps it suggests that the system is overloaded with patients and that there could have been more of such instances that we may not have been aware about. The potential issue would be a breach of patient confidentiality especially if the nurse can be overheard in a public setting. While no explicit details such as names were directly mentioned, the details given are still potentially traceable and hence places confidentiality at risk of being breached. **Follow-up answers:** What I would do in this situation is to first explain to the nurse my position as a Y2 medical student and that I am / am not part of the medical team. I would also politely remind the nurse of where we are, and the potential chance that we are overheard, hence placing confidentiality at risk. Afterwards, I

	• The question mentions the patient received the wrong medications **AND** got discharged afterwards, so you should most definitely mention both aspects here • Regarding what you would do, think small before going big. Address the nurse first, then escalate matters given that you are only a Y2 medical student. Local resolution first, before escalation • Regarding possible explanations, try not to jump to things such as “It was (this person’s) fault” or “It was a mistake by the system”. Show that you can admit to mistakes	would offer to help get in contact with the medical team either by approaching the doctors or nurses involved in that patient’s care. As I am only a Y2 student, I am unable to make direct decisions regarding the care of the patient and hence would escalate accordingly for help. Regarding possible explanations about the error, while it may be easy to just mention that “It was the doctor’s fault or the administrative department made a mistake”, I believe that pointing fingers like this is not helpful. For instance, there could have been a system error where the input from the doctors were not registered, causing the system to default to the common medication which was then picked up. Additionally, the patient themself could have also made a mistake as they may have accidentally grabbed the medication meant for someone else, leading to a mixup. This is not to say that it was definitely not a mistake from the healthcare team, it is more of just an exploration of the wider possibilities. In my opinion, I feel that without further information, it is unfair to put all the blame on the patient for the mistake she made. For instance, she may have miswrote certain information due to poor understanding or a lack of attention to which part of the form she was filling in. If she did not understand the information necessary to fill in, it could be argued that it would then be the healthcare staff’s fault for not explaining it to her. Additionally, some may even present the view that it is the healthcare staff’s fault for not catching the mistake prior to allowing her to be discharged. As such, I think it would be difficult to assign blame and if there is a need to do so, more should be done to research who is at fault..

	and that you take said responsibility for it • Regarding who to blame, is there really someone to blame? Or is everyone to blame? Should you even blame somebody? What if it is nobody's fault, do you still just blame them just because?	

Good Medical Practice (GMC) Domains

To make sure a doctor's practice meets the standard, the GMC has provided 4 domains.

1. Knowledge, skills, and performance
2. Safety and quality
3. Communication, partnership, and teamwork
4. Maintaining trust

Professionalism according to the GMC:

- Good doctors have the care of their patient as their first concern (see NHS patient-centered care)
- Good doctors know their competence
- Good doctors establish and maintain good relationships
- Good doctors are honest and trustworthy
- Good doctors act in partnership (in a team) with their patient
- Good doctors are familiar with good medical practice
- Good doctors (or anyone in the medical field) are prepared to explain and justify their decisions and actions

DOMAIN 1: Knowledge, Skills, and Performance

~Develop and maintain your professional performance
~Apply knowledge and experience to practice
~Record your work clearly and legibly

- Be competent in work (management, research, and teaching) + know your limit
- Keep your skills up to date + regularly take part in activities + follow the law
- Be willing to find and take part in structured support groups
- Be familiar with guidelines

- Adequately assess a patient's condition, provide the right course of action, refer patient if needed
- Make sure you have consent before going on with a procedure
- Be careful when you prescribe (know the patient and their needs/history)
- Alleviate pain and discomfort
- Consult colleagues and respect the patient's rights to seek a 2nd opinion
- Avoid medical care to yourself and your close ones
- Record your work asap and make sure it's clear and legible
- Data protection law requirements (patient confidentiality)

DOMAIN 2: Safety and quality

~Contribute to and comply with systems to protect patients
~Respond to risks to safety
~Risks posed by your health

- Regularly take part in reviews and audits for constructive feedback, and reflect.
- Review patient feedback
- Contribute to adverse event recognition (such as drugs risking patient's health and safety + suspected adverse drug reactions)
- Respond to requests from organizations monitoring public health (while respecting patient confidentiality
- Promote a space that staff can raise their concerns openly and safely in
- Take prompt action if a patient's safety, dignity, or comfort is seriously compromised (not receiving basic care, at risk because of inadequate premises and equipments, colleague being unfit to practice) and make records of steps taken
- Offer help in case of emergencies (be careful of safety and competence)
- Consider the welfare of vulnerable adults and children and young people and offer help
- If you have a serious/contagious condition that can be passed on or can affect your judgement don't work
- Be immunized against common communicable diseases (unless contraindicated)
- Be registered with a GP outside your family

DOMAIN 3: Communication, partnership, and teamwork

~Communicate effectively
~Working collaboratively with colleagues
~Teaching, training, supporting, and assessing
~Continuity and coordination of care
~Establish and maintain partnerships with patients

- Listen to patients, take account of their views, and respond honestly
- Give information to patients in a way they can understand (language and communication needs should be met)
- Be considerate to those close to the patient
- Be accessible to patients when on duty, and answer them
- Work collaboratively with colleagues and respect their skills and contributions + treat them with respect
- Be aware of how your behavior influences inside and outside of the team
- Take up any post you have formally accepted before, and work your notice period before leaving a job

- Be prepared to contribute to teaching + take a mentoring role for more junior doctors
- Make sure all staff you manage have appropriate supervision
- Be honest and objective when writing references
- Support colleagues with issues with their performance and health, but patient safety comes first
- Share relevant info before handing your patient to another colleague, and do not withhold info
- Check if another clinician has taken over your patient when your role is over
- Be polite and considerate
- Treat patients as individuals: with respect, fairly, and allowing their beliefs
- Work in partnership with patients. Share their progression, their treatment, who's responsible for them, and other info before asking for consent
- Confidentiality remains even after death
- Advise patients on their lifestyle choices and their health and well-being
- Explain to the patient if you have an objection to a procedure, and ask them to seek help from another doctor, making sure they have enough knowledge. Make sure arrangements are made before you completely let the colleague take over.

DOMAIN 4: Maintaining trust

~Show respect for patients
~Treat patients and colleagues fairly and without discrimination
~Act with honesty and integrity

- Do not use your professional position to seek improper sexual or emotional relationships with a patient or their close ones
- Do not express your personal beliefs in a way that will cause them distress
- Be open and honest when you did something wrong
- Give priority to patients based on their clinical need
- Don't deny treatment if their medical condition might put you at risk
- Do not unfairly discriminate or allow your personal views to affect things
- Consider and respond to the needs of disabled patients
- Respond promptly to complaints and apologize
- End a professional relationship with a patient after break of trust
- Make sure you have adequate insurance
- GMC number or registered name should be given when asked
- Your conduct should justify the patient's trust and the public's trust in the profession
- Maintain patient confidentiality on social media
- Make sure the info you publish is factual
- Any document and report you write and sign should be factual and no information should be left out
- Be honest in the court and trials + cooperate with official and formal inquires
- Let the GMC know if you've ever been found guilty, or criticized by an official inquiry, or are unfit to practice
- Inform all places you work asap when you have restrictions placed on your practice
- Be open about conflicts you face, and declare it formally, excluding yourself from decision making.
- Do not accept or ask for gifts from patients

Clinical records should include:

- Relevant clinical findings
- The decisions made + actions agreed + who did things

- Info given to patients
- Any drugs given or treatment or investigation
- Who and when is the record being made

References should include:

- All information relevant to the recipient's competence
- Performance
- Conduct

What to do when you did something wrong:

1. Put matters right (if possible)
2. Offer an apology
3. Explain fully and promptly what has happened and the likely short and long term effects

Definition of vulnerability according to the GMC:
Some people have illness, disabilities, frailty, or current circumstances that will make them vulnerable.
Vulnerability may be temporary or permanent
Ppl under 18.

Good Medical Practice (GMP) Interview Questions

It was highlighted to me that some schools have a really big fixation on GMP and actually ask quite a fair bit of interview questions based on it. So I thought why not create a section for GMP interview questions since I plan on studying it in greater detail anyway?
Again, these are speculated questions and if you need help, read through the GMP again to answer the questions! Since my Bristol interview needs to focus on GMP, the phrasing of questions will occasionally include Bristol, but do feel free to substitute with the relevant schools.

Practice Questions	Thought processes / Quick breakdown of answers	Example Answer
Which of the 4 domains in the GMP is the most applicable to you as a medical student, and how can Bristol help you with these domains?	• Good understanding of 4 domains is really important here and you cannot answer if you do not know about them • Keep 1-2 specific examples of each domain at the ready in the event you need them to answer • Good to first define what the 4 domains are, and what the term "most applicable" means • Note the second part of the question that says how can Bristol	I think it is really important to first understand that all 4 domains are equally important and it is really difficult to pick one specifically. Regarding the term "most applicable", in my view and understanding it would mean the most frequently practiced or utilized in my duties and responsibilities as a medical student. With that clarification, if I had to pick one, I would pick Communication, partnerships and teamwork. While this would be a little confusing as a medical student spends quite a fair amount of time studying, which would make Domain 1: Knowledge, Skills and performance more applicable, however I feel that in medical school, it is more important to

	help support you, so remember to link it • Specific examples of Bristol's course would be very useful to show research into the course	have communication skills. In medical school, not only do you need to speak with lecturers, other coursemates, the university staff, you also need to interact with patients during clinical placements or attachments, as well as members of the MDT. Without the ability to communicate clearly and concisely, it would definitely pose a huge impact on your clinical and university experience. Additionally, with communication, you can express and clarify any doubts with the lecturers or professors which would help to improve your skills and knowledge as well. I think Bristol really does support the medical students in these domains through certain aspects of the course. One such example would be the CBL course structure, where students are encouraged to actively discuss cases and deepen their learning / understanding of the knowledge being imparted, which provides an excellent opportunity to build these communication traits and skills. Additionally, Bristol also offers events that are interdisciplinary once a year, where medical students get the chance to interact with nurses or pharmacists, learning the appropriate communication skills and being able to refine them for future use when students enter the MDT.
Tell me about the GMP guidelines regarding professionalism.	• Again, important to read up on GMP guidelines regarding professionalism. Without it you cannot possibly answer this question • Have 2-3 examples	The GMP actually lays out quite an extensive set of guidelines regarding professionalism, which I will touch on a few in my answer. One aspect would be that doctors are aware, and regularly adopt the guidelines mentioned by GMP. I feel this is a particularly important aspect of the guidelines as if doctors do

	specifically mentioned in the GMP to build upon in your answer, using the PEEL structure ● This question is phrased in an open-ended way so that there is room for discussion and interaction, so do not need to be afraid that you do not cover every point ● Good to bring in relevant work experience to support the points that you raise to show understanding on how it actually applies in the real world context ● Conclude that while there are many more aspects to this, the GMP serves as a guide and aims to provide constructive support to the practice of a doctor	not follow aforementioned guidelines, it can be seen as a lack of respect for the rules and unprofessional from the perspective of the patient. Having done my work experience in Thailand where we follow a similar set of instructions according to the GMP, I have regularly seen my doctors who I shadow practice the aforementioned aspects such as knowing their competency and limits, and always prioritising patient safety in everything that they do. In my view, doctors who demonstrate an understanding and respect for rules or advisories demonstrate professionalism. Another aspect would be that doctors act in partnership with the patients as well as the MDT. Why this is seen as professionalism is because doctors show an understanding and respect for the patients who come to them, listening to their concerns without bias and doing everything possible to support the patients. This was also regularly reflected in my work experience where I got to witness doctors engaging actively with the patients during consultations, working out an action plan and discussing what is the best course of action to take to manage or address the patients' issues. In my view this represents the standards a professional should abide by and is considered as professionalism. In conclusion, the GMP touches on many other possible aspects of professionalism, and serves as a guide on how a doctor should conduct themselves and their practice.
Talk to us about one of the	● Whichever domain you feel comfortable taking	One domain I would like to touch upon would be Communication, partnerships and teamwork. This

domains in the GMP.	the question with, just do so. Remember the domain is not the focus, the bigger aspect would be how you develop your answer and present it to the examiners • Again, it is an open ended question, you will get follow-ups, so do not panic if you are not sure on entirely how to develop your answer • PEEL structure highly recommended, supported with work experience example • Can possibly explain and link to how it is applicable to you as a medical student or as a future doctor, or how it can impact those around you etc	domain is mainly focused around how a doctor should conduct themselves when interacting with those around them, and how their practice should be like. I would like to touch upon one specific aspect of this domain, where a doctor should be considerate and respectful in their interactions, always providing clear and concise delivery of information. I feel like this is something really important to mention as a medical student, we are sometimes tasked with certain duties such as taking histories or taking blood, and as a medical student it is really important to be able to deliver the message in a way that is easy for the patient to understand and provide consent. Additionally as a future doctor, when carrying out consultations with patients, it is really important that I filter out the medical jargon and explain the diagnosis or issue to the patient in terminology that they understand and can process. Regarding the doctor being respectful and considerate during interactions, it is definitely done to be in line with professionalism guidelines. If doctors do not carry themselves appropriately, it could make patient interaction difficult and affect the doctor-patient relationship ultimately, which would make things difficult especially if the public loses trust in the profession.
What are the 4 domains of the GMP and how relevant is it in today's healthcare?	• Standard is to define what GMP is, what are the 4 domains of the GMP, before diving into your answer • You should discuss all 4 domains since the	The GMP is essentially a code of conduct guiding doctors on how they should conduct themselves as well as their practice. There are 4 main domains in the GMP, namely "Knowledge, skills and performance" , "Maintaining trust" , "Safety and Quality" and lastly "Communication, partnerships and teamwork".

	question name drops “4 domains” and while you might need to sacrifice some depth, if you can do it just try to in-depth for one • The question uses the word “relevant” which suggests that there may have been changes that could invalidate the 4 domains, so your primary answer should be to explore both sides that it could have invalidated, or it did not invalidate • The use of the term “today’s healthcare” as well really means that you need to have relevant examples of certain advancements such as AI, robotics etc in your answer	With advancements in today’s healthcare, I can see why some would say that the 4 domains may not be as relevant anymore. With information stored in our hand-held devices where we can pretty much pull up medical knowledge at a click of our fingers, the domain “Knowledge, skills and performance” may no longer be as relevant given that we may not need to study as hard anymore and that we can just find all the information from PDFs of medical textbooks. Additionally, with AI being increasingly incorporated to interact with patients, some may argue that communication skills are not as important since AI could do it all for us, to clarify any of the patient’s concerns. However, I do not think it is as simple as it first appears. While yes we could most definitely pull up information by looking it up, it still takes a trained eye to know what to filter out and pay attention to, which falls in line with “Knowledge, skills and performance” where as a medical student, I would need to study the rigorous content to know what is medically proven and what is just “nonsense”. Additionally, despite AI advancements with increasingly complex algorithms, it is still not able to resolve every issue faced, and it is important as a doctor to have those communication skills to clarify and speak to the patients personally to address their concerns. Some things such as breaking bad news, also need a personal touch which AI is unable to express but as a doctor, with empathetic communication is able to do so. In conclusion, while I most definitely understand why some people have certain views that the domains may not be as

		relevant, I still feel that they are, and most definitely still applicable in today's healthcare.
Do you think it is always possible to abide by these 4 domains? Why or why not?	• The question uses the term "always possible", that itself should tell you what is the right approach to this question • Remember balance is key, make sure you provide two sides to your argument and balance them accordingly to remain neutral • In my opinion you don't need to go into all 4 but at least mention 2 domains in your main answer, but namedrop and quickie explain all 4 in your introduction • Use work experience examples! It helps to show realism that even in the real world, you cannot possibly achieve all aspects • Conclude by explaining that ideally, all 4 will always be abided by, but because of (so and so), it is not possible to	The GMP is essentially a code of conduct guiding doctors on how they should conduct themselves as well as their practice. There are 4 main domains, "Knowledge,skills and performance" , "Maintaining Trust" , "Safety and Quality" and lastly "Communication, partnerships and teamwork". Looking at the 4 domains, as a doctor we should always strive to align ourselves with these 4 domains, doing everything we can to abide by them. For example, in our day-to-day practice during a consultation, a doctor would need to ensure he is well kept-up with the medical knowledge needed to diagnose the patient, that he respects the sensitive information being shared and that patient safety is number one, and that he provides all and relevant information to the patient in a clear and concise manner so that they understand what is going on. This can extend to the range of duties a doctor undertakes in his daily duties such as teaching or research, or in his managerial duties as a member of the MDT. This was duly reflected in my WEX where all doctors kept themselves informed and up to date with their medical knowledge when they went on ward rounds or did OPD clinics. However, there are times when a doctor may not always be able to abide by these 4 domains. For instance, if a patient comes in and informs the doctor that they plan to hurt others because of their medical condition, or that they plan to harm themselves, the doctor would then need to go against maintaining

		confidentiality in the patient's best interests and break confidentiality to protect others and the patient. Additionally, for instance in a hospital ward that is very busy that I witnessed during my WEX, it is very difficult for a doctor to be able to look after everyone possible and still maintain the highest quality of care possible. These instances are just one of the many possibilities that could happen which could force doctors into not being able to fully abide by these domains. In conclusion, in an ideal scenario a doctor would be able to always abide by the 4 domains, but given the constraints faced in the real world, it is not always possible to do so.
Tell me about a time you demonstrated the domain "Knowledge, Skill and Performance".	• For these questions, you want to start off with the definition of the domain with a specific example of that domain. Afterwards use the STARR technique to tackle the question • In terms of examples you do not need WEX per say, you can use any generic example but just make sure you draw the links clearly for examiners to see • Would be good to include too what you felt you could have done better • I do not think you need to really link it too much to Medicine, do so if you can but no	This domain "Knowledge, skills and performance" is essentially describing how a doctor should keep up to date with their medical knowledge and how they apply it during their medical practice, in particular keeping up to date with the latest advancements or changes in the field of medicine, and being able to use the said information in their interactions with others. One example I have here would be that I actually did a similar thing for my medical school interviews. Having completed my UCAT examination, I had a rough feeling that I would get an interview and hence spent the past 5 months studying and preparing for an interview. I created this document of 530+ pages as a way to consolidate and study for my interviews, using it as a way to practice answering questions, and dissecting any articles or health news I felt was particularly interesting to speak of in my interviews. By doing so, I kept up

		need to force the connections especially if it is going to be awkward	to date with the latest health news such as long GP waiting times, A & E chaos so as to be able to discuss them in the event it is posed as a question.Regarding the application process, I used it as a platform to discuss with other applicants and practice speaking during interview mocks, and helping other applicants out during these mocks as well by sharing my document. In conclusion, I felt this experience was really representative of the domain as I not only put in the effort to study and prepare, but also applied them in helping others out.
Tell me about a time you demonstrated the domain “Communication, Partnerships and Teamwork”.			This domain “Communication, partnerships and teamwork” is essentially referring to how doctors should express themselves when interacting with others and highlighting the importance of maintaining good and healthy relationships with those we interact with. One experience I can think of here would be during my time as a national dancer where we trained for performances during the national Singapore Youth Festival (SYF). I was the vice-chairperson and was in-charge of helping to choreograph and clean up the performance. During this time, I was in close contact with members of the team, my teachers and the instructors, often having to attend meetings with the higher-ups before disseminating the information to my members. I learnt during this time the importance of expressing terminology in an easy-to-process manner, simplifying the complicated steps for my teammates to avoid confusion. Additionally I also learnt to stay on good terms with those I worked with, that sometimes

		letting go of small issues was for the overall benefit of the team and that the social cohesion was more important than winning a small argument. As such, I always did my best to maintain peace in the team, helping to serve as the negotiator when fights broke out or playing the role of Bad Cop when de-escalation was crucial. In conclusion, I feel this experience was quite representative of the domain, having learnt the importance of clear and concise delivery of information and maintaining good relationships.
Tell me about a time you demonstrated the domain ”Safety and quality”.		The domain “Safety and quality” essentially refers to how doctors should always strive to provide the best quality of care whenever possible and that patient safety is a non-negotiable, always a priority. One experience I had was during the planning of this leadership camp called VELOCI-T (Victoria Enhanced Leadership Outdoor Camp Instructor Training). I was in charge with my team of planning a fun yet informative camp designed to impart leadership skills and lessons to them. During this camp, we got to partake in high-elements where we climbed a 3 storey-tower with nothing but straps as a safety measure. I actively intervened by suggesting to the team that we should include multiple people in a team along with an instructor for safety instead of just letting them go one by one during this experience, so as to ensure there was a trained professional watching out for the individuals at all times. Additionally, I worked tirelessly with the team to refine the leadership handbook and activities planned to ensure that they always learnt

		something from the activities done, and that all activities were organised with the best possible materials to ensure quality. I feel this experience would be quite representative of this domain as I actively learnt to place safety first and that in everything I do should be done to the highest quality possible, a lesson that has stuck with me to this day.
Tell me about a time you demonstrated the domain “Maintaining trust”		This domain “Maintaining trust” is essentially how doctors should conduct themselves in their interactions with patients and the members of the MDT and that trust should always be first as to maintain the doctor-patient relationship. One experience I had would be my time as the vice-chairperson of the dance society. As the vice-chairperson, I was in charge of communicating with my team members, the committee members as well as the higher-ups. There was some internal speculation especially among members that the committee was too exclusive and were acting superior to the other members, hiding secrets and overall not being truthful. To counter this issue, I regularly took initiative to show raw, unedited screenshots of instructions that were passed on to us and also actively worked to include all members in meetings to discuss action plans and steps we were going to take to resolve problems. I also demonstrated respect for all individuals regardless of position, always striving to work with integrity and honesty. I learnt through this experience that trust is the basis of all relationships, and even if you already have trust, you should still actively try to reinforce that trust instead of taking it for granted.

		In conclusion, I feel this experience was particularly reflective of the domain "Maintaining trust" and is representative of always taking steps to maintain mutual respect and belief.
Which of the 4 GMC Domains are you most likely to break as a medical student or a doctor? Why?	• Very difficult question and ideally you should not be breaking one but for the sake of the question, pick one • Consider which domain very carefully and what it can imply about you (If you say Domain 1, they may counter and ask does that mean that you cannot keep up with academic curriculum etc) • Whichever domain you pick, make sure you can defend it well or engage in extensive discussion in the event of additional questions • I feel it is best to tackle this question from the perspective of a medical student, especially because you kind of have the excuse of saying "As a medical student, I may not be as proficient in doing so and so…." It can soften the blow that it has on you • Recognize that ideally you would	While certainly in an ideal scenario, I would not break any of the 4 domains and do everything I can to pick one, as compelled by the question, if I had to pick one domain, I would say that Domain 3 is the one I am most likely to do so. Regarding Domain 3: Communication, partnerships and teamwork, it essentially refers to doctors needing to maintain good working relationships with those around them and refining their communication skills to ensure clear and concise delivery of information. I think this is the one I am most likely to break because as a medical student, who is just starting out, my prior communication skills may not be as effective as I envisioned it. For instance, when I first join the MDT for clinical placements, I might not be able to communicate as effectively with the team as I might not be aware of the shorthand language used or the technicalities expressed in a day-to-day practice. Even if I drew on past experiences of speaking to individuals, I would not have had the chance to practice it in a medical context and hence could end up speaking information that may not have been clear or concise. Additionally, as a medical student, I would have few interactions to fully interact and engage with the MDT especially in my first few years, this could make it difficult to make connections or partnerships with those around me such as nurses

	not break any and always abide by them but if you had to choose or if you had no choice….. • Use WEX or personal examples (what other medical students have told you or what doctors have told you) to support your answer	or doctors. Moreover, I may only see them in a professional setting and may not fully get the chance to interact with them outside of work, which could limit the partnerships and professional relationships developed. These experiences were echoed to me by medical students I spoke to such as my brother. In conclusion, it is not ideal that I had to pick one domain to break given that I would like to abide by all 4 domains as much as possible, but if I had to pick one, it would be this.
How would a doctor demonstrate the 4 domains in their everyday practice?	• Be practical and give examples based on WEX or personal recounts if you can to show that it is feasible • Good to quickly explain all 4 domains quickly before giving examples • PEEL structure for this answer is highly recommended • The question says “everyday practice” so it should apply to all general doctors, so perhaps give an example of a GP instead of picking some specialist to speak about • Remember doctors interact with loads of other people and not just patients, such as the MDT, admin staff etc • Explain and clearly draw links between how they actually demonstrate or	The GMP has 4 main domains, “Knowledge, skills and performance”, “Safety and quality” , “Maintaining trust” and “Communication, partnerships and teamwork”. Regarding “Knowledge, skills and performance”, how a doctor demonstrates this would be during consultations where a doctor diagnoses a patient. For instance, during a GP consultation I witnessed, I saw the doctor provide all and relevant information to the patient to help them understand the issue and the course of treatment necessary, demonstrating how he has kept up to date with the knowledge needed as a doctor, hence portraying the domain accordingly. Regarding “Maintaining trust”, during my WEX, I got to witness the doctors explain their course of actions clearly to the family and the patient, demonstrating transparency and clarity in the course of operations that this was the course of action taken with no hidden actions. This allowed the patient and the family to feel reassured and had trust in the doctors that there was nothing malicious done,

	portray the 4 domains	which maintains the trust when they first interacted with the doctor. Regarding “Communication, partnerships and teamwork”, during my surgical WEX, I witnessed the interactions of the surgeons with the MDT during the operations, the way they delivered information in a clear and concise manner to one another to ensure a smooth operation. Witnessing how the doctors used professional language to discuss the course of action to take and keeping one another updated on the patient’s status at all times really allowed me to witness this domain in action. Lastly, regarding “Safety and quality”, I really got to witness how doctors always placed their patients first and always strived to provide the best quality of care. From witnessing doctors go out of their way to double check operations prior to commencement by discussing with the patient the operation area, what to expect to being willing to travel out into the city to purchase food for the patients who were craving it, it really allowed me to witness the quality and standard doctors held themselves to and how patient safety was always a priority.
Should the GMP be the only standard that doctors are held to?	• Talk about what GMP is first, what is the standard that GMP sets and if there is room for negotiation in terms of other standards to be set • GMP covers the professionalism aspects of the job, is there anything else that doctors should also follow?	The GMP refers to a code of conduct on how doctors should conduct themselves as well as their practice on a day to day basis. There are 4 main domains: “Knowledge,skills and performance” , “Maintaining trust” , “Safety and quality” and “Communication, partnerships and teamwork”. I can understand why some may feel that the GMP is sufficient to uphold doctors to. The GMP essentially serves as a professional guideline on how

	• The question is set in a way that dictates doctors only follow GMP and nothing else. What about legal standards (such as the law?) • A very unconventional question, set in a difficult scenario to really test your understanding of the GMP and adaptability	doctors should behave and is quite comprehensive as it is, ranging from personal aspects to professional aspects. Additionally, some may even argue that with the workload and pressure on doctors already, it would be quite unfair to impose more restrictions or guidelines on doctors which could cause even more suffocation for them. However, with the phrasing of this question, it seems to suggest that doctors only need to abide by the GMP and as long it is not dictated in the GMP, doctors are able to do it. As such, I personally feel that doctors should also be held to legal standards such as the common law that applies to all citizens as just because one is a doctor does not mean that they are above the law. Additionally, the GMP is mainly healthcare related and may not cover aspects outside of healthcare which could leave loopholes for those ill-intentioned to exploit. In conclusion, I feel that while the GMP is a good standard to uphold doctors to, legal standards should also be implemented as common sense would suggest since no one can be above the law just because of their profession.
With technology advancing, would any of the GMP domains become irrelevant in the future?	• The question states “with technology advancing”, which suggests that you should probably give some examples of what exactly has advanced and how does it affect each domain • The structure for this question is more towards:	The GMP has 4 main domains, “Knowledge, skills and performance” , “Maintaining trust” , “Safety and quality” and “Communication, partnerships and teamwork”. I can definitely understand why some people may think that the GMP domains may soon become irrelevant. For example, with the progression of AI, where AI is becoming increasingly capable of processing large amounts of information and giving certain instructions such as ChatGPT, it is not difficult to

	Yes, so and so domains become irrelevant because…. No, even with such advancements, it is not irrelevant because….. • Personally I think there is no need to explore every domain given constraints in time and also a lack of material to really fully break down in your answer • The question also suggests the context of the future, so you need show that your answer is based in the future (looking forward a few years etc)	imagine that AI could eventually help diagnose patients down the line, which invalidates the need for doctors to memorize large amounts of information, causing Domain 1 to become invalidated. Additionally, with robotics becoming more prevalent in aspects such as surgery, it is also not difficult to imagine that with advancements in AI as well, the robots could eventually do surgeries instead of doctors, eliminating the need for surgeons and reducing the human risk factor, causing Domain 2 to be less relevant since robots could do the operation pretty much independently. However, I feel that it is a little too optimistic to have such an understanding. While having robots carry out surgeries is theoretically possible, it eliminates the human aspect to adjust if any complications were to arise and if something does go wrong, the robots may not be able to adjust to save the patient, hence violating Domain 2. But with human surgeons, they can do so and hence would still make Domain 2 relevant in the grand scheme. Additionally, the thought of AI treating patients could make patients feel unsafe given that it is a foreign concept, hence Domain 4 may not be irrelevant as there will always be a need for human doctors to intervene in the process of treating patients. In conclusion, I feel that while I can understand why some may think the GMP domains may become irrelevant over time, it is quite unlikely to happen.