# PLAB 2 sample stations with answers

23 original PLAB 2 practice scenarios, each with the task, what a strong answer does and a model answer. They are free to read and to download.

Every scenario is original, with invented patients. It is not from any exam, and it is not official material. Check clinical details against current national guidance.

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# Drowsy and sweaty man with type 1 diabetes on a surgical ward

Acute management · 8 minutes

**The task**

You are the foundation doctor on a surgical ward. It is 13:40. Mr Tobias Wren, aged 34, has type 1 diabetes and is recovering after treatment for a leg infection. A nurse says he has become drowsy and sweaty since returning from the X-ray department. Assess him, start immediate treatment, find out why this has happened and decide what to do next. The nurse is with you and will carry out your requests. The examiner will not take part in the conversation.

**What a strong answer does**

- **Safety:** Uses an ABCDE approach and checks a capillary glucose straight away, recognising possible hypoglycaemia in a drowsy patient on insulin.
- Checks whether he can swallow safely and is cooperative, and chooses the treatment route accordingly.
- **Safety:** Because he is conscious and can swallow, gives 15 to 20 g of quick-acting carbohydrate by mouth for a glucose below 4.0 mmol/L (for example 150 to 200 mL of pure fruit juice or 4 to 5 glucose tablets).
- States what would be done if he could not swallow or became unconscious: call 2222, IV glucose (for example 10% glucose 150 to 200 mL over 15 minutes) or glucagon 1 mg IM if there is no IV access.
- **Safety:** Rechecks the capillary glucose after 10 to 15 minutes and repeats oral treatment if it is still below 4.0 mmol/L (up to three cycles, then IV glucose).
- Once glucose is above 4.0 mmol/L, gives a longer-acting carbohydrate such as a sandwich or toast, and arranges a proper meal.

- Identifies the likely cause: mealtime insulin given with no meal after the X-ray trip, and checks ketones and the leg infection for other causes.
- Does not stop his basal insulin; reviews the insulin plan and informs the diabetes team and the nurse in charge, so mealtime doses are timed with food.
- Monitors afterwards with regular glucose checks and clear safety-netting for further low readings.
- Introduces self and confirms identity, explains in plain words, reassures and addresses his concerns about living alone and driving without false promises.
- Documents the readings, treatment and times, and completes an incident report if appropriate.

**Model answer**

I introduce myself to Mr Wren, confirm his name and date of birth and ask the nurse to stay with us. He is sweaty, shaky and confused but talking, so I check an ABCDE set of observations and a capillary glucose together. The glucose is 2.3 mmol/L, which is hypoglycaemia. His airway is clear, breathing 16, saturation 98 per cent on air, pulse 104 and blood pressure 132/78. He is newly confused with his eyes open, GCS 14. Because he can swallow, I ask the nurse to give about 150 to 200 mL of pure fruit juice or 4 to 5 glucose tablets, around 15 to 20 grams of fast-acting carbohydrate. I tell her that if he cannot swallow or loses consciousness I will call 2222 and give 10% glucose 150 to 200 mL IV over 15 minutes, or glucagon 1 mg IM if there is no cannula. I recheck the glucose after ten to fifteen minutes. It has risen to 3.6, still below 4.0, so I repeat the treatment. After the second recheck it is 5.4, and I ask for a slower-release carbohydrate like toast and a proper meal. I ask why this happened. He had his mealtime insulin at about midday but missed lunch after the X-ray trip. I check capillary ketones, which are low at 0.3 mmol/L, and look at his leg, which is improving. I tell the nurse not to stop his long-acting insulin, to give mealtime insulin only when food has arrived, and I contact the diabetes inpatient team. I ask for hourly glucose checks for a few hours with a call to me below 4.0. I explain to Mr Wren in plain words what happened, reassure him, answer his worry about driving honestly, and document the readings, treatment and times.

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# Memory clinic results with a worried daughter

Breaking bad news · 8 minutes

**The task**

You are a doctor in a memory clinic. Mr Bhupinder Sohal, aged 78, was referred by his GP after two years of worsening forgetfulness. Cognitive testing, blood tests and a brain scan are complete and together support Alzheimer's disease. He has come with his daughter, Navdeep. Before the appointment she asked that he is not told the word 'dementia'. Share the diagnosis and respond to both of them. The examiner will not take part in the conversation.

### What a strong answer does

- Introduces self, confirms the patient's identity and checks who is present and whether he is happy for his daughter to stay.
- Addresses the patient directly, finds out what he understands and how much he wants to know before sharing news.
- **Safety:** Acknowledges the daughter's request with respect but does not agree to hide the diagnosis from Mr Sohal, who has capacity and wants to know; explains he has the right to his results.
- Gives a clear warning, then states the diagnosis in plain words without euphemism: Alzheimer's disease, a type of dementia.
- Pauses, acknowledges emotion, and responds with empathy and silence.
- Explains honestly that it is progressive and cannot be cured, but that treatment and support can help, and that it varies between people.
- Discusses support and next steps: memory service follow-up, nurse specialist, medicines that may help symptoms, Alzheimer's Society and carer support.
- Raises safety and legal planning: he must tell the DVLA and should not drive until it is assessed, home safety such as the gas, a lasting power of attorney while he can still make one, and his wishes for the future.
- Offers support for the daughter, including a carer's assessment and where to find help.
- Checks understanding, invites questions, offers written information and arranges follow-up.

### Model answer

I introduce myself, confirm Mr Sohal's name and date of birth, and check that he is happy for his daughter to stay. Before sharing the result I ask Mr Sohal what he has noticed and how much he wants to know. He tells me he wants the full truth. I then acknowledge Navdeep's request, explaining kindly that her father has the right to know and has asked to be told, and I invite her concerns; her mother's experience explains her protectiveness. I give a warning shot and then say clearly: the tests and scan show Alzheimer's disease, which is a form of dementia. I stop and allow silence, and respond to his sadness and relief. I explain in plain words that this is a progressive condition that cannot be cured, that people are affected differently and

that there is treatment and support. I avoid prognosis figures but answer honestly when he asks about the future. I explain next steps: continued follow-up in the memory service, a named nurse, medicines that can help symptoms for some people, and the Alzheimer's Society. I discuss safety, including his legal duty to tell the DVLA about his diagnosis and my advice not to drive until that is assessed, given that he recently got lost, medicines support, and gas safety. I raise lasting power of attorney and ask about his wishes for the future. I offer Navdeep a carer's assessment and support for herself. I check understanding, give written information that he can share with his son, arrange follow-up with his daughter present and document the consultation.

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# Emergency contraception after a split condom

Counselling & explanation · 8 minutes

### The task

You are a GP. Ms Samira Latif, aged 24, has come to an urgent appointment because a condom split during sex with her new partner. She is alone. Take a focused history, explain the options for emergency contraception and agree a plan. The examiner will not take part in the conversation.

### What a strong answer does

- Introduces self, confirms identity, creates a non-judgemental atmosphere and assures confidentiality.
- Establishes timing of unprotected intercourse, cycle day and any other unprotected sex since last period.
- Asks about current contraception, medical history, medicines including enzyme inducers, breastfeeding and pregnancy risk, and weight or BMI.
- Offers a pregnancy test if indicated, and assesses STI risk.
- Explains that the copper intrauterine device is the most effective emergency contraception and can be fitted within 5 days of unprotected sex.
- **Safety:** Explains oral options with correct time limits: ulipristal acetate 30 mg up to 120 hours, or levonorgestrel up to 72 hours (3 mg rather than 1.5 mg as she weighs over 70 kg); recommends ulipristal because she is close to ovulation.
- Explains side effects and practicalities: vomiting within three hours, next period timing, no effect of oral EC as ongoing contraception, delay starting hormonal contraception for five days after ulipristal, and pregnancy test 3 weeks later.

- Arranges a same-day copper IUD fitting through sexual health if she chooses it, gives oral emergency contraception today in case fitting is delayed, and plans ongoing contraception and STI screening.
- Explores her concerns about the coil and confidentiality, supports informed choice and respects her decision.
- Checks understanding, provides written information and safety-nets for lower abdominal pain or late period.

**Model answer**

I introduce myself, confirm Ms Latif's identity, reassure her about confidentiality and respond without judgement. I ask when the condom split: Saturday night, about 40 hours ago. Her cycle is regular at 28 days and her last period began 12 days ago, so she is close to ovulation. There was one earlier episode of unprotected sex, four days after her period began. She uses no other contraception. She takes no medicines or herbal remedies, is not breastfeeding and has no medical conditions. Her BMI is about 31. I ask about the new partner and STI risk, and her concerns about the coil and about her family finding out. I examine the findings: a negative urine pregnancy test, BMI 30.9 kg/m2 and normal blood pressure. I explain the options clearly. The copper intrauterine device is the most effective method and can be fitted within five days of unprotected sex, and it continues as long-term contraception. Ulipristal acetate 30 mg can be taken up to 120 hours after sex and, because she is just before ovulation, is preferred to levonorgestrel, which is licensed for 72 hours and would need a 3 mg dose at her weight. I explain that tablets may be less effective with her weight, which strengthens the case for the coil. If she chooses the coil, I refer her for same-day fitting and give ulipristal now in case fitting is delayed. I explain side effects, repeating the dose if she vomits within three hours, delaying starting hormonal contraception for five days, using condoms until her next period, and taking a pregnancy test three weeks later or if the period is late. I offer STI screening and plan ongoing contraception, answer her worries, respect her choice, give written information and safety-net advice for severe lower abdominal pain, and document.

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# Explaining a new diabetes medicine in writing

Drug information · 8 minutes

**The task**

You are the foundation doctor in a GP surgery. Mr Yusuf Al-Rashid, aged 52, was told yesterday that he has type 2 diabetes and a prescription for metformin was issued. He has sent the surgery an online message with questions. His message, blood results and prescription are in the patient folder. Write a reply to him in plain English that explains what the medicine is for, how to take it, the common and serious side effects, what to avoid and when to seek help. The examiner will not take part.

### What a strong answer does

- Explains what metformin is for in plain English: it lowers blood glucose in type 2 diabetes and is part of a plan that includes diet and activity.
- Gives clear instructions for use: one modified-release tablet with the evening meal, swallowed whole, and not changing the dose without advice.
- Describes common side effects (nausea, loose stools, abdominal discomfort, metallic taste) and what helps, including taking it with food and that they usually settle.
- Addresses the friend's story about kidney damage honestly: metformin does not harm healthy kidneys but kidney function is checked and the drug stopped if it falls.
- **Safety:** Mentions the rare serious risk of lactic acidosis and gives specific warning symptoms.
- **Safety:** Gives sick-day advice: pause metformin during vomiting, diarrhoea or dehydration and restart once eating and drinking normally for 24 to 48 hours.
- Advises about alcohol, contrast scans and operations, and telling clinicians he takes metformin.
- Gives clear safety-netting with 999 and NHS 111 and arranges follow-up with blood tests and review.
- Uses plain, kind language free of jargon, invites questions and respects his concerns.

### Model answer

I would write in plain English, begin by thanking Mr Al-Rashid for his message and acknowledge that starting a new medicine and hearing a friend's story is worrying. I explain that metformin is the usual first medicine for type 2 diabetes. It helps the body use its own insulin better and reduces the sugar made by the liver, and it works best alongside healthy eating and regular activity. By itself it does not usually cause low blood sugar. I tell him to take one modified-release tablet once a day with the evening meal and to swallow it whole, and that the dose is reviewed and increased slowly. For side effects I describe the common ones: feeling sick, loose stools, tummy discomfort and a metallic taste. They are most common at the start and usually settle in one to two weeks; taking it with food helps, and he should not stop without speaking to us. I explain that metformin does not damage healthy kidneys, which is why we check kidney function before starting and at least yearly,

and that long-term use can lower vitamin B12. I mention the rare serious risk of lactic acidosis and its warning signs: fast deep breathing, severe muscle pain, drowsiness or confusion, with a call to 999. I give sick-day advice: if he is vomiting, has severe diarrhoea or cannot drink, he should pause metformin and contact the surgery or NHS 111, and restart when he is well. I advise keeping alcohol low and telling clinicians he takes it before a scan with contrast or an operation. I arrange a review in a few weeks, blood tests and an HbA1c at three months, and invite him to reply or phone with any more questions.

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# Vomiting blood and declining a transfusion

Ethics, consent & capacity · 8 minutes

### The task

You are a doctor in the emergency department. Mr Emmanuel Agyeman, aged 52, vomited a large amount of blood at home this morning. Endoscopy is arranged for later today. His blood tests show his haemoglobin is low. The team proposes a blood transfusion. He has said he will not accept it. He is alert and has no relatives with him. Discuss the options with him and decide how to proceed. The examiner will not take part in the conversation.

### What a strong answer does

- Introduces self, checks identity and builds rapport, speaking with respect for his beliefs and without judgement.
- Assesses the clinical situation quickly: bleeding history, haemodynamic state, haemoglobin and need for urgent senior help and endoscopy.
- Explores which treatments he accepts and refuses, including components, fractions, cell salvage and clotting products, rather than assuming.
- **Safety:** Explains the risks of refusing blood honestly, including that he could die, and benefits and alternatives.
- Assesses capacity: understanding, retaining, weighing up and communicating, in line with the Mental Capacity Act 2005, and presumes capacity.
- Checks for coercion and that the decision is voluntary, asking about family or elders in the room.
- Asks about a written advance decision, checks it is valid for refusing life-sustaining treatment (in writing, signed, witnessed, and stating it applies even if his life is at risk), explains it would apply if he lost capacity, and documents it.

- **Safety:** Respects the capacitous refusal, does not give blood against his wishes, and plans the best non-blood management: stopping diclofenac, urgent endoscopy, intravenous iron and senior, haematology and critical care input.
- Involves the right people: senior doctor, hospital liaison committee if he wishes, and keeps his wife informed only with his consent.
- Documents the discussion clearly, reviews capacity if his condition changes, and checks his understanding and any further questions.

**Model answer**

I introduce myself, confirm Mr Agyeman's name and date of birth and show respect for his faith. I quickly assess his condition: he has had a haematemesis and melaena, he takes diclofenac, his pulse is 108 beats a minute, his blood pressure is 112 over 68 and his haemoglobin is 78 g/L. I arrange urgent senior review and endoscopy. I explore which treatments he accepts. He refuses whole blood, red cells, white cells, platelets and plasma, and I ask separately about fractions, clotting medicines, iron, fluids and cell salvage. I explain honestly the risks of refusing blood: if the bleeding continues he could die. I assess capacity under the Mental Capacity Act 2005 by presuming capacity and testing his ability to understand, retain, weigh and communicate; he does so clearly. I check he is not under pressure from family or elders. He has a signed card in his wallet. I look at the document with him and establish that it is signed, witnessed and states that it applies even if his life is at risk. I explain that while he has capacity his own decision now is what counts, and that the advance decision would guide us if he later lost capacity, for example under sedation. A capacitous adult may refuse treatment even if that may lead to death. I respect his decision, and I do not give blood against his wishes. I plan the best management without blood: stop diclofenac, give intravenous fluids, consider intravenous iron after senior and haematology advice, proceed to early endoscopy, and consider a critical care review. I do not give tranexamic acid, because it is not recommended for upper gastrointestinal bleeding. I ask whether he wants the hospital liaison committee involved and whether his wife should be called. I document the discussion, his capacity and the document, and I review his wishes if his condition or capacity changes.

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# Chest tightness that comes and goes

History taking · 8 minutes

### The task

You are a doctor in a GP surgery. Mr Gareth Williams, aged 58, has booked a same-day appointment because of chest pain. He is alone. Take a focused history. Then explain to him what you think is happening and what needs to be done next, answering his questions, and tell him what to do if things change. There is no need to examine him. The examiner will not take part in the conversation.

### What a strong answer does

- Introduces self, confirms identity and starts with an open question about the chest discomfort before using focused questions.
- Characterises the pain: site, spread to arm or jaw, quality, severity, duration, and what brings it on and relieves it.
- Establishes the pattern of progression from effort-related to rest pain, and the timing of the most recent episode.
- Asks about associated symptoms such as breathlessness, sweating, nausea, palpitations and collapse, and screens for features pointing away from a cardiac cause such as pleuritic or positional pain.
- Takes cardiovascular risk factors and family history: smoking, cholesterol, blood pressure, diabetes, premature heart disease.
- Checks medicines, allergies and relevant past history such as indigestion, ulcers and bleeding problems.
- Explores his ideas, concerns and expectations, and acknowledges his fear and his worry about work.
- **Safety:** Recognises suspected acute coronary syndrome from a worsening pattern with rest pain in the last 12 hours and says clearly that he needs emergency hospital assessment today.
- **Safety:** Arranges safe transport: calls 999, tells him not to drive or take the bus, and stays with him until the crew arrives.
- Explains in plain language what will happen, such as ECG and blood tests for heart damage, without stating a certain diagnosis, and answers his questions honestly.
- Gives safety-netting while waiting: rest, say at once if pain returns, worsens or he feels faint or very breathless, and checks understanding.
- Obtains consent to contact his wife, gives a short SBAR handover to the ambulance crew and documents.
- Offers a single 300 mg loading dose of aspirin as soon as possible after checking for allergy, and tells the ambulance crew it has been given.

### Model answer

I give the examiner my name and GMC number, then introduce myself, confirm his name and date of birth, and ask him to tell me about the chest tightness in his own words. I characterise it: central heavy tightness spreading to the left arm and jaw, with sweating and nausea. I establish the pattern: three weeks of effort-related symptoms that have become easier to provoke, and a twenty-minute episode at rest this morning. That worsening pattern matters most. I check for features against a cardiac cause, such as pleuritic or positional pain and indigestion, and I ask about breathlessness, palpitations and collapse. I take risk factors: heavy smoking, untreated high cholesterol, and his father's heart attack at 54. I check medicines and allergies, including to aspirin. I explore his ideas and concerns and hear that he fears a heart problem and losing work. I measure pulse, blood pressure, oxygen saturation and an ECG if available, which shows ST depression. I summarise and explain that the pattern suggests his heart arteries may be narrowing and that pain within the past twelve hours with an abnormal ECG needs emergency assessment now, rather than a routine appointment. I tell him I am calling 999 for an ambulance, that he must not travel alone or drive, and that I will stay until the crew arrive. As he is not allergic, I offer 300 mg of aspirin to chew now and record it for the crew, and I would give glyceryl trinitrate if the pain returns. I explain the likely tests, including ECG and blood tests, without promising a diagnosis, and I address his worries about work. With his consent I phone his wife, give an SBAR handover to the crew, safety-net for returning pain, faintness or breathlessness, check his understanding, and document.

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# Mental state examination in a GP surgery

Mental health · 8 minutes

### The task

You are a doctor in a GP surgery. Miss Imogen Hartley, aged 34, a primary school teaching assistant, has come because her sister was worried about her. She is alone. Carry out a mental state examination by talking with her and observing her. You may ask the examiner for any observation you would make by looking. Then summarise your findings to the examiner and say what you think the immediate management should be. The examiner will not take part in the conversation with the patient.

### What a strong answer does

- Introduces self, checks identity and sets a calm, unhurried tone with open questions about how she is.
- Observes and describes appearance and behaviour, speech and psychomotor activity in structured terms.
- Explores mood in her own words and affect, and screens for low energy, sleep, appetite and concentration changes.
- **Safety:** Asks directly and sensitively about thoughts of ending her life, plans, intent and access to means.
- Asks about perceptual disturbance and delusional ideas, and explores thought content including guilt and hopelessness.
- Assesses cognition with orientation, attention and recall, and comments on insight and judgement.
- Asks about alcohol, drugs, past history and protective factors such as her sister.
- Gives a clear structured summary to the examiner: a depressive episode of more severe type with suicidal thoughts but no plan or intent, no psychosis, and states their view of her current risk.
- **Safety:** Agrees a safe plan with her: review within days, same-day advice or urgent referral from the mental health crisis team, therapy and medicine discussed, sister involved with consent, and crisis contacts, and does not dismiss her or leave her at risk.
- Responds with empathy, acknowledges her feelings without false reassurance and checks her understanding.

**Model answer**

I introduce myself, confirm Miss Hartley's name and date of birth and ask how she has been in an open way. While she speaks I note her appearance and behaviour, speech and psychomotor activity, and I ask the examiner to describe what I see. I explore her mood and affect, then biological features such as early waking, weight loss, low energy and poor concentration. I ask directly about thoughts of not wanting to be alive, whether she has made plans, what she has at home, and I ask about alcohol and drugs, past episodes and protective factors. I ask about hallucinations and unusual beliefs and explore the content of her thoughts, including guilt and hopelessness. I test orientation, attention with serial sevens and recall, and consider insight and judgement. I then present to the examiner in a structured way: a woman with a two month depressive illness, low mood, early waking, weight loss, guilt and hopelessness, suicidal thoughts with a passing idea of overdose but no plan or intent, no psychotic features, intact cognition and reasonable insight. This is a more severe depression. Her risk is raised and could change. She does not appear to need hospital now, because she has no plan, has a

supportive sister and is willing to engage, but I will speak to the mental health crisis team today. I agree a plan with her: review again within a few days, urgent mental health referral, an offer of talking therapy with discussion of an antidepressant, involving her sister with her consent, reducing alcohol, keeping medicines out of easy reach, and a written safety plan. I give crisis contacts, including 999, NHS 111 and the Samaritans, and tell her to seek help urgently if her thoughts worsen. I check she understands and document the assessment.

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# Cardiovascular examination in a breathless man

Examination · 8 minutes

### The task

You are a doctor in a medical outpatient clinic. Mr Alan Fraser, aged 66, has had breathlessness on exertion and two near-faints on climbing stairs. He is sitting on the couch. Perform a cardiovascular examination. Say aloud what you are doing at each step. The examiner will report the findings when you say what you are doing, so describe each step as you go. At the end, summarise your findings and say what you think is going on and what you would do next.

### What a strong answer does

- Washes hands, introduces self, confirms identity, explains the examination, obtains consent, positions and exposes the patient appropriately and checks for pain.
- Inspects generally from the end of the bed: breathlessness, colour, scars, and signs of cardiac disease.
- Examines the hands and peripheral stigmata: clubbing and splinter haemorrhages.
- Assesses the radial pulse for rate and rhythm, and measures blood pressure, recognising a narrow pulse pressure.
- **Safety:** Palpates the carotid pulse on one side at a time to assess character and volume. Pressing both carotids together is the safety failure.
- Assesses the jugular venous pressure correctly with the patient positioned at 45 degrees.
- Inspects and palpates the praecordium: scars, apex beat position and character, heaves and thrills.
- Auscultates all four valve areas, listens over the carotids and with the patient leaning forward in held expiration, and times the murmur with the pulse.
- Completes the examination: sacral and ankle oedema, lung bases, peripheral pulses, and suggests relevant tests such as ECG and echocardiogram.

- **Safety:** Presents findings accurately, gives the impression of aortic stenosis with exertional symptoms, and arranges an echocardiogram and urgent cardiology review. Reassuring him or treating this as routine is unsafe.
- Explains the findings and the plan to the patient in plain language, addresses his concerns and offers safety-netting for chest pain or collapse.

### Model answer

I give the examiner my name and GMC number, then wash my hands, introduce myself, confirm Mr Fraser's name and date of birth, explain that I would like to examine his heart and chest, and obtain his consent. I ask him to undress to the waist, position him at 45 degrees, offer a chaperone and check he has no pain. From the end of the bed I look for breathlessness, cyanosis, pallor and scars. I examine his hands for clubbing and splinter haemorrhages and take the radial pulse, which is regular. I measure the blood pressure and note a narrow pulse pressure. I assess the carotid pulse, palpating one side at a time, which is slow-rising and low in volume. I assess the jugular venous pressure and inspect the eyes and face. I inspect the chest, palpate the apex beat, which is heaving, and check for heaves and thrills. I auscultate all four areas, listening at the carotids and with him leaning forward in held expiration, and I hear a soft second sound and an ejection systolic murmur radiating to the carotids. I check the lung bases, the sacrum and ankles for oedema, and the peripheral pulses. I thank him, wash my hands and present my findings: a slow-rising pulse, narrow pulse pressure and an ejection systolic murmur that suggest aortic stenosis, with exertional symptoms and near-syncope. I explain this to him in plain language, say I would arrange an ECG, an urgent echocardiogram and cardiology review, and advise him to avoid heavy exertion and to call 999 for chest pain or collapse.

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# Reviewing an older patient's drug chart on admission

Prescription review · 8 minutes

### The task

You are the foundation doctor on an acute medical ward. Mrs Edna Pyke, aged 82, was admitted last night after a fall and a urinary tract infection. The drug chart written in the emergency department is in the patient folder, with her allergy status, weight and blood results. Review the chart, identify the prescribing safety

problems, and write what you would change, who you would inform and what you would document. The examiner will not take part.

### What a strong answer does

- **Safety:** Checks the allergy status first and identifies co-amoxiclav as a penicillin in a patient with documented anaphylaxis, and acts at once.
- **Safety:** Recognises that ramipril and spironolactone should be withheld with potassium 5.9 mmol/L and acute kidney injury.
- Identifies that ibuprofen should be stopped in this patient with kidney injury on an ACE inhibitor and diuretic, and with apixaban.
- Withholds metformin because of acute kidney injury and an eGFR below 30 mL/min/1.73 m2.
- Recognises apixaban for atrial fibrillation needs the lower 2.5 mg twice daily dose, showing the criteria (any two of: age 80 or over, weight 60 kg or less, creatinine 133 micromol/L or more).
- **Safety:** Identifies duplicated paracetamol from co-codamol plus paracetamol, with a total daily dose above the maximum, and proposes a safe single regimen.
- Uses a systematic review of every line, considering indication, dose, route, interactions and renal function.
- Plans monitoring: repeat blood tests, an ECG and potassium management, with sensible restart criteria.
- Escalates appropriately: informs the nurse, pharmacist and senior doctor, and reports the allergy error through the incident system.
- Documents changes clearly and tells the patient honestly about the error, following the duty of candour.

### Model answer

I begin with the allergy status because it is the quickest route to serious harm. Mrs Pyke has a documented penicillin anaphylaxis that was not transcribed onto the chart, and she has been prescribed co-amoxiclav. I would stop it immediately, check the administration record to see whether a dose has been given, correct the allergy box and choose an alternative from the local antimicrobial guideline with urine culture results, avoiding nitrofurantoin at this eGFR and trimethoprim with her high potassium. Next I review the blood results: creatinine 156 micromol/L against a baseline of 80, eGFR 26 and potassium 5.9 mmol/L. This is an acute kidney injury with hyperkalaemia. Ramipril and spironolactone both raise potassium and impair renal function, so I withhold them. Ibuprofen should be stopped because it harms the kidneys, especially alongside an ACE inhibitor and a diuretic, and increases bleeding risk with apixaban. Metformin is withheld because of the risk of lactic acidosis when the eGFR is below 30. Apixaban 5 mg twice daily is too high: she

is 82, weighs 54 kg and her creatinine is above 133 micromol/L, so for her atrial fibrillation she meets all three reduction criteria (two are enough) and needs 2.5 mg twice daily; I also review her bleeding risk after the fall. Finally, co-codamol 30/500 two tablets four times daily already provides 4 g of paracetamol per day; adding paracetamol 1 g four times daily would give up to 8 g, so I stop one product and keep a safe paracetamol dose for her weight. I arrange repeat urea and electrolytes and an ECG, tell the nurse to hold doses, speak to the pharmacist and my senior, complete an incident report, document each change and explain the error openly to Mrs Pyke.

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# Teaching a student to measure blood pressure

Teaching · 8 minutes

### The task

You are a foundation doctor in an outpatient clinic. Priscilla Okwu, a third-year medical student, has been asked to measure Mr Gordon Fenwick's blood pressure and has never done it before. Mr Fenwick has agreed to help. Teach her how to measure blood pressure correctly, as you would with a student, speaking aloud to her and to Mr Fenwick. Include preparation, technique, recording and what to do with the result. The examiner will not take part in the conversation.

### What a strong answer does

- Prepares the patient: introduces, explains, confirms identity and consent, and asks about recent caffeine, smoking, exercise and the need for the toilet, noting that coffee in the last 30 minutes can raise the reading.
- **Safety:** Ensures the patient rests for about five minutes seated with back supported, feet flat, legs uncrossed and the arm supported at heart level, without talking.
- **Safety:** Teaches choosing the right cuff size by measuring the arm and using a large cuff for a 36 cm arm.
- Teaches correct cuff placement on a bare arm, with the bladder centred over the brachial artery and the lower edge 2 to 3 cm above the elbow crease.
- Teaches the procedure: feel the pulse for rate and rhythm, inflate until the pulse disappears, add 20 to 30 mmHg, deflate slowly at about 2 mmHg per second and record systolic at the first sound and diastolic at its disappearance.
- Measures both arms at first assessment and uses the arm with the higher reading afterwards, noting a difference of more than 15 mmHg.

- Teaches recording to the nearest 2 mmHg, noting arm, position and cuff size, and repeating the measurement if it is 140/90 mmHg or above.
- Explains what to do with the result: confirm raised readings with ambulatory or home blood pressure monitoring, and measure standing blood pressure if indicated.
- Uses a teaching method that checks understanding, gives feedback and invites the student to try.
- Includes the patient respectfully, explains the result in plain words and addresses his concerns.

**Model answer**

I introduce myself, ask Mr Fenwick whether he is happy for Priscilla to measure his blood pressure, and confirm his name and date of birth. I ask Priscilla what she already knows, then explain that the technique matters because small errors change management. I ask Mr Fenwick about recent exercise and caffeine; he has hurried in and had a coffee, and needs the toilet, so I let him go first and arrange for him to rest. I tell Priscilla that recent coffee and hurrying can push the reading up, so we note it and would recheck at another visit if the result is raised. He sits for five minutes with his back supported, feet flat on the floor, legs uncrossed and his bare arm resting on the table at heart level. We do not talk during this time. I show Priscilla how to choose the cuff: we measure his mid-upper arm, which is 36 cm, so a large adult cuff is needed. I demonstrate a small cuff gives a falsely high reading. She places the cuff on the bare arm with the bladder over the brachial artery and the lower edge 2 to 3 cm above the elbow crease. She feels the pulse to check it is regular, inflates until it disappears, goes about 20 to 30 mmHg higher, then deflates slowly at about 2 mmHg per second, noting the first sound as systolic and its disappearance as diastolic. The reading is 146/92 mmHg on the right arm and 144/90 on the left; at the first assessment we check both arms and note a difference of more than 15 mmHg would need follow-up. I teach her to record the value to the nearest 2 mmHg with arm, position and cuff size, and to repeat when the first reading is 140/90 or above. I explain that raised clinic readings are confirmed with ambulatory or home monitoring, and that standing pressure is checked in people with dizziness. I ask her to explain the steps back, let her try under supervision and give feedback, then tell Mr Fenwick his result in plain words.

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# Telephone follow-up after discharge with a chest infection

Telephone consultation · 8 minutes

### The task

You are a doctor in the GP practice. You are making a planned telephone call to Mrs Olwen Davies, aged 71, three days after she was discharged from hospital following treatment for a chest infection. She lives alone. She was sent home on a five-day course of antibiotics. Find out how she is, decide what is safe, and agree a plan. The examiner will not take part in the conversation.

### What a strong answer does

- Introduces self, confirms identity with two identifiers and checks it is safe and private to talk.
- Asks structured questions about breathlessness, fever, cough, chest pain, eating and drinking and confusion.
- **Safety:** Assesses how she is speaking on the phone and recognises that breathlessness at rest and speaking in short phrases are red flags.
- Asks about the antibiotic, allergies, other medicines and her support at home.
- **Safety:** Recognises that she is worsening on treatment, with possible sepsis or pneumonia, and that she needs urgent assessment today rather than home advice.
- **Safety:** Arranges safe transport by calling 999 for an ambulance, not by waiting for her daughter or advising her to travel alone.
- Gives a plan for staying safe until the ambulance arrives: stay seated, unlock the door, keep the phone nearby and take her medicines list.
- Offers to contact her daughter and gives a concise handover to the ambulance service with SBAR if needed.
- Responds kindly to her fear and reluctance, explains the reason clearly and checks she agrees.
- Documents the call, the findings, the decision and the time.

### Model answer

I introduce myself to Mrs Davies and confirm her full name and date of birth. I check that she is able to talk and then ask open questions about how she has been since discharge. I listen carefully to how she speaks: she pauses for breath between phrases. She tells me her breathlessness is worse than when she left hospital and she is now breathless sitting still, with a sharp right-sided pain on breathing in, ongoing green sputum, a hot and shivery night, poor intake and some muddle this morning with a near fall. She is on day three of amoxicillin and has no allergies. She lives alone, does not drive and her daughter is working. I recognise that she is getting worse on antibiotics, with possible sepsis or a complicated pneumonia, and that breathlessness at rest and new confusion are red flags that cannot be managed safely by a telephone call. I explain this clearly and kindly and tell her that she needs urgent assessment in hospital today. Because she lives alone, is breathless at

rest and should not travel alone, I arrange an emergency ambulance by calling 999. I stay on the line until it is arranged, and I give a clear handover of her symptoms, her recent admission, medicines and living situation. I tell Mrs Davies what to do until the ambulance arrives: sit upright, unlock the front door, keep the phone nearby and gather her medicines. With her permission I contact her daughter, Carys. I answer her fear of returning to hospital with honesty and reassurance, check she agrees with the plan and document the call, my findings, the decision and the times.

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# Sudden chest pain and breathlessness in a young man

Acute management · 8 minutes

### The task

You are the foundation doctor in the emergency department. Mr Elliot Svensson, aged 20, has walked in with sudden chest pain and breathlessness that began two hours ago. A nurse has taken his observations. Assess him, decide what immediate treatment he needs and telephone the on-call respiratory registrar to hand over and agree the next step. A chest X-ray is available once you request it. The nurse is with you and will carry out your requests. The examiner will not take part in the conversation.

### What a strong answer does

- Introduces self, confirms identity and starts a rapid ABCDE assessment with observations and a focused history of onset, pain and breathlessness.
- **Safety:** Recognises a possible pneumothorax and checks for tension features: tracheal position, blood pressure, pulse, JVP and breath sounds.
- Examines the chest and reports correct findings: reduced expansion, hyperresonance and absent breath sounds on the right.
- Requests an erect chest X-ray and interprets it as a large right primary pneumothorax with no tension.
- Uses oxygen sensibly: not needed for hypoxaemia with a saturation of 96 % on air (target 94 to 98 % if given), and prescribes analgesia.
- Because he is symptomatic with no high-risk features, recommends intervention in line with BTS 2023 (needle aspiration, or an ambulatory device where available), discusses the options with him, and plans a chest drain if aspiration fails.

- **Safety:** States the action if he deteriorates (tension pneumothorax): immediate decompression, call 2222 and senior help.
- Gives a structured SBAR to the respiratory registrar with size, stability, observations and the plan requested.
- Advises no flying until an X-ray shows full re-expansion and he is cleared, no diving for life unless he has definitive surgery, stopping smoking and vaping, and follow-up in the chest clinic.
- Explains clearly and kindly, checks understanding and answers his worries, with consent for the procedure.

**Model answer**

I introduce myself to Mr Svensson, confirm his name and date of birth and begin an ABCDE assessment while the nurse attaches monitoring. He is a tall, thin young man with sudden right-sided pleuritic pain and breathlessness at rest, a vaper with an uncle who had a collapsed lung. His pulse is 106, blood pressure 124/76, respiratory rate 22, saturation 96 per cent on air. I look for signs of tension: the trachea is central, the JVP is not raised and he is not shocked. The right side is hyperresonant with absent breath sounds in the upper and mid zones. I request an erect chest X-ray, which shows a large right pneumothorax with more than 2 cm of air at the hilum and no mediastinal shift. His saturation is above 94 per cent so he needs no oxygen, but I ask for simple analgesia. Because he is symptomatic and has no high-risk features, I recommend needle aspiration with local anaesthetic, with a small-bore chest drain if that fails. I tell the nurse that if he becomes shocked or the trachea shifts I will decompress at once and call 2222. I telephone Dr Tiller using SBAR: the situation is a large right primary pneumothorax; the background is a 20-year-old, stable, vaping, with no trauma; my assessment is a symptomatic primary pneumothorax needing intervention; I ask for her advice and to review him. I repeat her plan. I explain to Mr Svensson what has happened, obtain his consent, advise no flying until an X-ray shows full re-expansion and he is cleared, no diving unless he later has definitive surgery, stopping vaping and smoking, and chest clinic follow-up, and document the findings and plan.

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# A son arrives on the ward at dawn

Breaking bad news · 8 minutes

**The task**

You are a medical doctor on an acute medical ward. Mrs Phyllis Blackwood, aged 86, was admitted three days ago with pneumonia and frailty. Her condition worsened overnight. The ward rang her son at about four o'clock, when she became worse. She died forty minutes ago, comfortable, with a nurse at her bedside. A decision not to attempt resuscitation was agreed with her on admission. Her son, Ewart, has just arrived and has been shown to the relatives' room. Tell him and respond to his concerns. The examiner will not take part in the conversation.

### What a strong answer does

- Introduces self, confirms who he is and his relationship, and checks he is sitting down in a private room.
- Finds out what he already knows and gives a clear warning shot before the news.
- **Safety:** States clearly and kindly that his mother has died, using the word died or dead rather than euphemisms.
- Allows silence and responds to his emotions, including guilt and anger, with empathy and without defensiveness.
- Gives honest information about her final hours: she deteriorated from the pneumonia, was comfortable and had a nurse with her.
- Explains the resuscitation decision accurately, confirming it was agreed with her and that she was treated according to her wishes.
- Answers questions about timing honestly, acknowledging he was called and offering to explain the timeline without blaming anyone.
- Offers to let him see her and sit with her, with a nurse available, and asks about religious or cultural wishes.
- Explains practical next steps: the medical certificate, the medical examiner's review (their office may phone him), registering the death, belongings and the bereavement office.
- Offers support for him and family, checks he is safe to get home or has someone with him, and invites further questions.

### Model answer

I introduce myself in the relatives' room and invite Mr Blackwood to sit. I confirm who he is and ask what he has been told. I give a warning that I have sad news and say clearly that his mother died about forty minutes ago, using the word died and no euphemism. I pause and give him time. He is angry that he arrived too late and guilty; I acknowledge his feelings, avoid defensiveness and do not make excuses. When he asks, I explain honestly that her pneumonia worsened during the night, that she was comfortable and that a nurse was with her. I confirm that, as agreed with her on admission, no attempt at resuscitation was made and that it would not

have helped. I acknowledge that we rang him when she deteriorated and that I am sorry he could not be there. I offer to explain more or to review the timeline later. I ask whether he would like to see his mother and sit with her, and I offer a nurse or chaplain and ask about his wishes. I explain the next steps in plain words: I will complete the medical certificate after the medical examiner has reviewed the death, the bereavement office will explain how to register the death and collect her belongings and he can ring the ward at any time. I ask whether someone can be with him and whether he is safe to drive home, and I invite his remaining questions. I thank him, document the conversation and ensure the team knows.

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# Irregular pulse found at the pharmacy

Counselling & explanation · 8 minutes

### The task

You are a GP. Mr Gethin Lloyd-Parry, aged 67, has come for the result of tests after a pharmacist found an irregular pulse. His ECG shows atrial fibrillation. His blood tests, including kidney function, blood count and thyroid function, are normal. He has high blood pressure. He is alone. Explain the diagnosis, discuss the risk of stroke and the options to reduce it, and agree a plan. The examiner will not take part in the conversation.

### What a strong answer does

- Introduces self, confirms identity and asks what he already knows and what worries him.
- Takes a focused history of symptoms, past history and bleeding risk, including alcohol and over-the-counter painkillers such as ibuprofen.
- Asks for pulse, blood pressure, ECG and blood results, and works out the stroke risk score (CHA2DS2-VASc) and the bleeding risk score (ORBIT) from them.
- Explains atrial fibrillation in plain language: an irregular heart rhythm that can let clots form and cause a stroke, but is common and treatable.
- Recommends anticoagulation as the way to reduce stroke risk, explaining the benefit against the bleeding risk in clear terms.
- **Safety:** Explains that aspirin is not advised to prevent stroke in atrial fibrillation and that a modern tablet is usually chosen rather than warfarin.
- Addresses modifiable bleeding risks: stop regular ibuprofen, cut alcohol, treat blood pressure, and suggests alternatives for knee pain.

- Uses shared decision-making: acknowledges the neighbour's experience, checks understanding and respects his choice.
- Covers practical points: take it regularly, what to do if a dose is missed, tell dentists and pharmacists, and when to seek urgent help for bleeding or stroke symptoms.
- Arranges follow-up and rate or rhythm review, blood pressure control, written information and a chance for questions.

**Model answer**

I introduce myself, confirm Mr Lloyd-Parry's name and date of birth, and ask what the pharmacist said and what worries him. He fears a stroke like his father's and a bleed like his neighbour's. I ask about palpitations, breathlessness, chest pain and faints, then past history, bleeding risk, falls, alcohol and medicines. I find he has high blood pressure, takes ibuprofen most weeks and drinks about ten pints a week. I review the pulse, blood pressure, ECG and blood tests, and I calculate a CHA2DS2-VASc score of 2 from age and hypertension, and an ORBIT bleeding score of 0, which is low. I explain in plain words that atrial fibrillation is an irregular rhythm that can let clots form and cause stroke. I explain that anticoagulation is the best way to reduce that risk, and that aspirin does not protect adequately and still carries bleeding risk. I say that a direct-acting anticoagulant would usually be offered in preference to warfarin and does not need routine INR checks. I acknowledge his neighbour's experience and discuss benefit and bleeding risk honestly. I ask him to stop regular ibuprofen and suggest paracetamol, advise cutting alcohol, and say we will keep his blood pressure well controlled. I explain practical points: take it every day, what to do if he misses a dose, tell his dentist and pharmacist, and carry an alert card. I safety-net: seek urgent help for bleeding that will not stop, black stools, a head injury, or stroke symptoms, calling 999. I check his understanding and agreement, give written information and arrange a review, and I document the discussion.

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# A lorry driver asking for a fitness letter

Ethics, consent & capacity · 8 minutes

**The task**

You are a GP. Mr Michael Tolliver, aged 46, had a witnessed collapse with shaking at home ten days ago. The hospital discharged him and a neurology appointment is pending. His discharge letter says he should not drive. Today he tells the

receptionist he wants a work letter saying he can return to driving his heavy goods vehicle. He is alone. Discuss the situation. The examiner will not take part in the conversation.

### What a strong answer does

- Introduces self, confirms identity, explores the episode and sets a calm, non-confrontational tone.
- Takes a focused history of the event, triggers and past history, recognising a probable first seizure that needs specialist assessment.
- Asks directly whether he has driven since the seizure and whether the DVLA and his insurer know.
- **Safety:** Explains clearly that he must not drive any vehicle, including tomorrow's delivery, and that he has a legal duty to tell the DVLA, with stricter rules for heavy goods vehicle licences than for car licences.
- Explains the risks to him and others on the road, in plain language, without lecturing.
- **Safety:** Declines to write a letter saying he is fit to drive, explaining why.
- Encourages him to tell the DVLA himself and offers support, and says the GMC requires disclosure if he refuses and there is risk, after he has been told.
- Addresses practical and financial concerns: employer, insurance, benefits advice and alternative work, and suggests a plan with his wife.
- Arranges follow-up: urgent neurology review, tests, advice on seizure safety, and a clear safety-net about further seizures.
- Documents the discussion, including advice given, his understanding and the plan for disclosure.

### Model answer

I introduce myself, confirm Mr Tolliver's name and date of birth, and take a non-confrontational approach. I ask what happened ten days ago: a witnessed generalised seizure with a period of confusion and incontinence, his first, after poor sleep and alcohol. I ask about head injury, illness, medicines and family history. I ask directly whether he has driven since, and learn that he has driven his car and a lorry, and has not told the DVLA or his insurer. I explain that this is probably a first seizure that needs specialist assessment, and that he must not drive. I explain that he has a legal duty to inform the DVLA, and that rules for heavy goods vehicle licence holders are much stricter than for car drivers, so he may be off the road for a long time. I describe the danger to himself and others without lecturing and acknowledge the financial pressure. I decline to write a letter saying he is fit, and I explain why. I encourage him to tell the DVLA himself and offer help with the form. I explain that GMC guidance requires me to disclose to the DVLA medical adviser if he

does not, because of the risk to the public, and that I would tell him before doing so. I discuss his employer, insurance, benefits advice and alternatives such as non-driving work, and offer to involve his wife. I arrange follow-up with neurology, give seizure safety advice and tell him to call 999 for a further seizure. I document the discussion and the plan.

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# Breathlessness and cough in a long-term smoker

History taking · 8 minutes

### The task

You are a doctor in a GP surgery. Mr Rajesh Patel, aged 61, has come because he is becoming short of breath. He is alone. Take a focused history. Then explain what you think needs to happen next and why, answering his questions, and tell him what to do if things change. There is no need to examine him. The examiner will not take part in the conversation.

### What a strong answer does

- Introduces self, confirms identity and opens with an open question about the breathlessness and cough.
- Characterises the breathlessness and cough: time course, exercise tolerance, sputum, wheeze and previous diagnoses.
- Specifically asks about haemoptysis and elicits it.
- Asks about weight loss, appetite, fatigue, hoarseness, chest pain and bone pain.
- Takes a smoking history in pack-years and an occupational and exposure history including asbestos.
- Takes past history, inhaler use and family history, and asks about allergies.
- Explores his fear of cancer and his expectation of a stronger inhaler, and responds with empathy.
- **Safety:** Recognises that unexplained haemoptysis at his age, with persistent cough, weight loss and heavy smoking, needs urgent investigation for lung cancer, and does not simply prescribe a stronger inhaler.
- **Safety:** Arranges a suspected cancer pathway referral and an urgent chest X-ray, gives a clear time frame, and explains the next steps and likely further tests such as CT.
- Explains honestly that the cause is not yet known, avoids false reassurance, and offers support with smoking cessation and his family.
- Gives safety-netting: seek help urgently for heavier bleeding, severe breathlessness, chest pain, or fever, using 999 for emergencies.

- Checks understanding, agrees who to involve, and documents the plan.

**Model answer**

I give the examiner my name and GMC number, then introduce myself, confirm his name and date of birth and invite him to describe his breathlessness. I establish that it has worsened over two months, with exercise tolerance falling to a short distance, and I ask about cough, sputum and wheeze. I ask directly about coughing blood and elicit streaky haemoptysis over the last month. I ask about weight loss, which is six kilos, fatigue, hoarseness and chest pain. I take a forty-year smoking history and an occupational history including possible asbestos exposure from garage work. I check past history of suspected COPD, his inhaler use and family history. I explore his ideas, concerns and expectations and respond to his fear of cancer and his wish for a stronger inhaler. I summarise back to him. I explain that although COPD may be part of the story, coughing blood, weight loss and hoarseness in a long-term smoker over 40 need urgent investigation for lung cancer. I say that I cannot be certain what the cause is and avoid false reassurance. I explain that I will arrange an urgent chest X-ray and refer him under the suspected cancer pathway, with a CT scan and specialist review likely, and that the aim is to give him an answer within 28 days. I offer help with stopping smoking and ask who he would like to support him. I safety-net: if he coughs up more than a small amount of blood, becomes severely breathless or has chest pain, he should call 999. I check his understanding, answer his questions and document.

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# Feeling low ten weeks after having a baby

Mental health · 8 minutes

**The task**

You are a GP. Mrs Kiran Dhillon, aged 26, has come for a routine check ten weeks after the birth of her first child. At the reception desk she said she had been feeling low. Her baby is with her husband in the waiting room. Take a focused history, assess risk, and explain what you suggest. You do not need to examine her. The examiner will answer questions about screening scores. The examiner will not take part in the conversation.

**What a strong answer does**

- Introduces self, confirms identity, ensures privacy, and creates a safe, non-judgemental space for her to talk.
- Uses open then specific questions to assess mood, anhedonia, sleep, appetite, energy, concentration and onset (the depression questions).
- **Safety:** Asks directly and sensitively about intrusive thoughts of harm to the baby, and distinguishes unwanted intrusive thoughts from intent.
- **Safety:** Asks directly about suicidal thoughts, plans and protective factors, and about self-harm.
- Screens for postnatal psychosis (hallucinations, delusions, elevated or very disorganised thinking) and asks about previous mental illness and family history.
- Explores support, partner, alcohol or drug use, and bonding and feeding.
- Interprets the screening score as consistent with probable depression and explains the diagnosis, that this is common, treatable and not her fault.
- Explains that intrusive thoughts are common in depression and anxiety after birth, are not the same as wanting to harm the baby, and does not label her as a risk to the baby, while still making a safe risk assessment.
- Proposes a management plan: referral to talking therapies or the perinatal mental health team, review within a week, involve husband and health visitor with her consent, discuss medication choices compatible with breastfeeding if needed, and crisis contacts.
- Safety-nets with clear instructions: contact the GP, NHS 111, Samaritans 116 123 or 999 if she has thoughts of harming herself or the baby, or develops confusion or hallucinations.

**Model answer**

I give my name and GMC number, introduce myself, confirm Mrs Dhillon's identity and check we have privacy. I speak gently and let her know she will not be judged. I explore mood, interest, sleep, appetite, energy and concentration and learn she has been low since week five, with weight loss and numbness towards her baby. I ask about her bond with the baby and, directly and kindly, about frightening thoughts or images of harm. She describes unwanted images of dropping him which horrify her and which she avoids. I distinguish these intrusive thoughts from intent. I ask about suicidal thoughts and self-harm, plans and protective factors: she sometimes wishes she would not wake up but has no plan and would not leave her son. I screen for psychosis, previous mental illness and family history, ask about support, alcohol and drugs, and check her Edinburgh score of 17. I explain that she has postnatal depression, which is common, treatable and not her fault, and that intrusive thoughts occur in many new mothers and do not mean she will harm her baby. I am honest that my priority is keeping her and her baby safe, and that having these thoughts and asking for help does not by itself lead to a baby being removed. I plan referral to the perinatal mental health team or talking therapies, review in a

week, involvement of her husband and health visitor with her consent, and discuss medication options compatible with breastfeeding if needed. I give crisis numbers including Samaritans 116 123 and 999, and document.

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# Respiratory examination in a woman with cough and fever

Examination · 8 minutes

### The task

You are a doctor on an acute medical ward. Mrs Grace Adeyemi, aged 58, was admitted with a cough, fever and right-sided chest pain. She is sitting up on the bed. Perform a respiratory examination. Say aloud what you are doing at each step. The examiner will report the findings when you say what you are doing, so describe each step as you go. At the end, summarise your findings and say what you think is going on and what you would do next.

### What a strong answer does

- Washes hands, introduces self, confirms identity, explains the examination, obtains consent, positions and exposes the patient appropriately, and checks for pain.
- Inspects from the end of the bed and notes respiratory rate, effort, and oxygen saturation.
- Examines the hands, pulse and neck: clubbing, tar staining, flap, pulse rate, JVP, trachea and lymph nodes.
- Inspects and palpates the chest, assessing expansion and tactile or vocal resonance.
- Percusses and auscultates all zones comparing both sides, and examines the back.
- **Safety:** Recognises the abnormal observations (respiratory rate 24, oxygen saturation 91 percent on air, pulse 104, temperature 38.4), with or without calculating a NEWS2 of 7, and states that she needs oxygen, immediate senior review and prompt treatment for possible sepsis from pneumonia.
- Completes the examination: calves, sputum pot, temperature, and requests relevant tests such as chest X-ray, blood tests including urea, and cultures.
- Presents findings accurately and gives an appropriate impression: right lower lobe pneumonia, with a differential of pulmonary embolism or malignancy, and a sensible plan.
- Explains the findings and plan clearly to the patient, addresses her concerns and gives safety-netting about worsening breathlessness.

### Model answer

I give the examiner my name and GMC number, then wash my hands, introduce myself, confirm Mrs Adeyemi's name and date of birth, explain that I would like to examine her chest, obtain her consent and offer a chaperone, and ask about pain before I start. She sits at 45 degrees with her chest exposed appropriately. From the end of the bed I look at her breathing, noting a respiratory rate of 24, and I measure oxygen saturation, which is 91 percent. I check her hands for clubbing, tar staining and flap, and take the pulse. I look at the neck, check the trachea is central, assess the JVP and feel for lymph nodes. I inspect the chest, assess expansion, which is reduced on the right, and assess vocal resonance, which is increased there. I percuss and find dullness at the right lower zone, then auscultate and hear bronchial breathing with coarse crackles. I compare the two sides and examine the back, then check the legs for swelling. I recognise the abnormal observations. Her NEWS2 is 7: respiratory rate 2, oxygen saturation 3, pulse 1, temperature 1, blood pressure 0, alert 0. That is an emergency score, so I would give oxygen aiming for 94 to 98 percent, call my senior now and treat for possible sepsis from pneumonia with prompt antibiotics. I wash my hands, thank her and present my findings: fever, tachypnoea, reduced expansion, dullness and bronchial breathing at the right lower zone, suggesting right lower lobe pneumonia, with pulmonary embolism and malignancy in mind. I request a chest X-ray, blood tests including urea, cultures and sputum. I explain to her that she probably has a chest infection and will be treated with antibiotics, answer her questions, say we will look again if her symptoms do not settle, which addresses her worry about cancer, and advise her to tell staff if she becomes more breathless.

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# Writing the drug chart for pneumonia

Prescription review · 8 minutes

### The task

You are the foundation doctor on an acute medical ward. Mr Leszek Brzezinski, aged 74, has just been admitted with community-acquired pneumonia. The clerking details, observations, blood results and his current medicines are in the patient folder. Prescribe the treatment he needs on the drug chart: oxygen, an antibiotic suitable for his allergy status and severity, and any thromboprophylaxis. Record the allergy, and note your monitoring, escalation and review plan. The examiner will not take part.

### What a strong answer does

- **Safety:** Documents the allergy accurately in the allergy box with the reaction, source and signature before prescribing.
- Calculates the CURB-65 score correctly (2) and judges the severity as moderate.
- **Safety:** Prescribes oxygen with a target saturation range of 94 to 98 % and a titration method.
- **Safety:** Chooses an antibiotic appropriate to the allergy history and severity, with dose, route, frequency and duration, referring to NICE and local guidance.
- Prescribes thromboprophylaxis after a documented risk assessment and bleeding check, with correct drug, dose, route and review.
- Prescribes paracetamol safely with a maximum daily dose and indication.
- Writes a clear chart entry: legible, generic names, doses with units, dates, signature and GMC number.
- Sets monitoring and review: observations at least hourly while NEWS2 is high, repeat blood tests, microbiology samples as indicated and a 48 to 72 hour antibiotic review.
- **Safety:** Calculates NEWS2 as 7 (high clinical risk) and escalates now: urgent senior review by SBAR with critical care outreach, 2222 for acute deterioration, and asks the pharmacist to clarify the allergy.

### Model answer

I begin by clarifying and recording the allergy. Mr Brzezinski reports that penicillin caused a widespread rash as a child, with no swelling or breathing problems. I write this in the allergy box with the reaction, source and my signature before prescribing anything. I assess severity with CURB-65. Urea of 8.2 mmol/L scores one, age 74 scores one, he is not confused, the respiratory rate of 24 is below 30 and the blood pressure is normal, so the score is 2: moderate severity, appropriate for hospital treatment. His saturation is 91 per cent on air and he has no chronic lung disease, so I prescribe oxygen with a target range of 94 to 98 per cent, titrated by the nurses. For the antibiotic I follow NICE NG250 and local policy. Because of the reported penicillin reaction I choose a non-penicillin antibiotic, given now, within 4 hours of arrival: doxycycline 200 mg orally on the first day, then 100 mg once daily, for a total of five days, with a review at day three. I also prescribe paracetamol 1 g four times daily as required, with a maximum of 4 g in 24 hours. He is in bed most of the day with an acute illness, so I complete a VTE risk assessment. Platelets are normal, eGFR is 72, he has no bleeding history and takes no anticoagulant, so I prescribe enoxaparin 40 mg subcutaneously once daily and plan daily review. His NEWS2 is 7 (respiratory rate 2, saturation 3, heart rate 1, temperature 1), which is high risk, so I call the registrar now using SBAR, ask for critical care outreach review, and set observations at least hourly. I consider blood and sputum cultures, plan repeat CRP

and urea and electrolytes in 48 to 72 hours, and will call 2222 if he deteriorates acutely. I ask the pharmacist to help clarify the allergy, and sign every entry with my GMC number.

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# Teaching a junior doctor to take blood cultures

Teaching · 8 minutes

### The task

You are a doctor on a medical ward. Mr Desmond Walsh, aged 77, has a temperature of 38.9 °C and needs blood cultures before antibiotics. Dr Aroha Ngata, a foundation doctor in her first week, has never taken blood cultures and has asked you to show her. Mr Walsh is awake and has agreed to you both being at the bedside. Teach Dr Ngata how to take blood cultures safely, as you would with a junior colleague, speaking aloud to her and to Mr Walsh. You do not need to complete the procedure. The examiner will not take part in the conversation.

### What a strong answer does

- Introduces self, builds rapport with the junior, checks her experience, confidence and learning needs before starting.
- Explains why blood cultures matter and when to take them: before antibiotics in suspected sepsis, but without delaying antibiotics.
- **Safety:** Confirms the patient's identity, explains the procedure, and gets consent for both the procedure and the junior's involvement.
- Teaches preparation: equipment set up in advance, hand hygiene and an aseptic non-touch technique.
- Teaches correct skin decontamination: chlorhexidine in 70 per cent alcohol, allow to dry, and not touching the site again, and sampling from a fresh venepuncture rather than an existing cannula.
- Teaches filling the bottles correctly: disinfecting the bottle tops, the volume marked on the bottle (usually about 10 mL in adults), the order in local policy, and labelling at the bedside.
- Uses a good teaching method: demonstrates and explains, lets her try under supervision, asks questions and checks her understanding, and gives constructive feedback.
- Ensures patient comfort and dignity during teaching, asks about allergies and skin reactions, involves Mr Walsh, and attends to his worries.
- Covers what follows: prompt antibiotics, sending the bottles to the laboratory, recording the time, and what to do if the sample cannot be obtained, and encourages her to ask for help.

### Model answer

I introduce myself to Dr Ngata and ask about her experience and worries so that I can pitch my teaching correctly. She has watched one blood culture but never taken one and is anxious about contamination. I explain why blood cultures are taken: to identify the organism in suspected sepsis, before antibiotics where possible, but without delaying antibiotics. I explain the procedure to Mr Walsh, confirm his name and date of birth, ask about allergies, and obtain his consent for the procedure and for Dr Ngata to take the sample under supervision. I talk through each step as I would demonstrate it. I gather the equipment first and perform hand hygiene. I use an aseptic non-touch technique, choose a fresh vein in the left arm rather than the existing cannula, and clean the skin with chlorhexidine in 70 per cent alcohol for thirty seconds, letting it dry fully without touching it again. I disinfect the tops of the bottles, fill each to the marked volume, usually about 10 mL in adults, in the order set by local policy, and label them at the bedside. I stress that antibiotics must not be delayed and should be given straight after. I invite Dr Ngata to take the sample under my observation, then ask her to say the steps back. I give specific, kind feedback on what went well and what to improve. I attend to Mr Walsh's comfort and worries throughout, tell Dr Ngata to ask for help if she cannot get blood after two attempts, and end by asking what else she would like to practise.

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# Telephone call about blood test results

Telephone consultation · 8 minutes

### The task

You are a GP. You are making a pre-arranged telephone call to Mr Rajinder Sandhu, aged 53, a self-employed plumber, to tell him the results of blood tests taken last week for tiredness and increased thirst. His results are in front of you. The examiner will give you any result you ask for. Speak to him as you would on the phone. The examiner will not take part in the conversation.

### What a strong answer does

- Introduces self, confirms the identity of the person on the phone using two identifiers, and asks if it is a convenient and private time to talk.
- Explains the reason for the call and checks what he already knows and expects, using a warning shot before giving results.
- Gives the result clearly in plain language: the blood sugar is in the range of diabetes, and with his symptoms this confirms type 2 diabetes.

- **Safety:** Checks symptoms and risk of an acute hyperglycaemic emergency (vomiting, abdominal pain, drowsiness) to decide whether he needs same-day assessment.
- Explores his understanding, ideas and fears, including his father's illness, and corrects misconceptions.
- Outlines a realistic management plan: dietary and activity advice, structured education, a face-to-face review within a day or two, further tests (glucose and ketones, kidney, eyes, feet, cholesterol), and a discussion of medicines, usually starting with modified-release metformin.
- **Safety:** Gives specific safety-netting: when to seek urgent help (vomiting, abdominal pain, very thirsty, drowsy, rapid breathing, confusion), and to call 111 or 999 as needed.
- Discusses practical issues: driving and work, that he should not drive while his vision is blurred, that most people with type 2 diabetes can continue to drive, and when DVLA notification would be needed.
- Checks understanding, offers written information and a follow-up appointment, and documents the call.

**Model answer**

I introduce myself, confirm Mr Sandhu's full name and date of birth, and ask if it is a convenient time and whether he is somewhere private. I explain that I am calling about his blood tests and ask what he expected. I give a warning shot and then the result clearly and in plain words. His HbA1c is 62, and a level of 48 or above is in the diabetes range. Together with his thirst, night-time urination, weight loss and a random glucose of 16.4, this confirms type 2 diabetes. I pause and acknowledge his reaction. I ask about vomiting, abdominal pain, drowsiness and rapid breathing, because I need to exclude a hyperglycaemic emergency. He has none, so same-day hospital assessment is not needed. I explore what he knows and fears, in particular his father's complications, and explain that outcomes are much better now and that type 2 diabetes is often treated with lifestyle changes and tablets. I outline the plan: a face-to-face appointment in the next day or two to recheck his glucose and ketones and to check his blood pressure, weight, feet and urine, refer him for structured education, discuss dietary change and activity, and talk through medicines, usually starting with modified-release metformin, with an SGLT-2 inhibitor if suitable. I advise on cholesterol and blood pressure risk and the retinal screening programme. I discuss driving and work: he can usually continue driving, but should not drive while his vision is blurred. I give safety-netting: if he becomes very drowsy, is sick, has abdominal pain or fast breathing he should call 999. I check his understanding, offer written information, arrange follow-up and document the call.

# Cough and wheeze in a six-year-old

Acute management · 8 minutes

### The task

You are the foundation doctor in the emergency department. Zayan, aged 6, has been brought in by his mother, Mrs Ayesha Farooqui, with a cough and wheeze that have worsened over two days. A paediatric nurse has just recorded his observations. Take a focused history from his mother, decide what the observations mean, start immediate treatment and telephone the paediatric registrar to hand over and agree the next step. The nurse is with you and will carry out your requests. The examiner will not take part in the conversation.

### What a strong answer does

- Introduces self to the mother and child, confirms identity, and quickly establishes the history, triggers and treatment already given.
- **Safety:** Interprets the observations as acute severe asthma (saturation below 92 %, respiratory rate above 30, heart rate above 125 and unable to complete sentences) and recognises the risk of deterioration.
- **Safety:** Gives oxygen to achieve a saturation of 94 to 98 %.
- **Safety:** Starts a short-acting beta-2 agonist: salbutamol 5 mg by oxygen-driven nebuliser because his saturation is below 92 % (or up to 10 puffs by spacer while oxygen is given), repeated every 20 to 30 minutes as needed, with reassessment.
- Gives a systemic corticosteroid early: oral prednisolone 30 to 40 mg for a child over 5 (2 mg/kg up to 60 mg if already on maintenance oral steroids).
- Adds nebulised ipratropium bromide 250 micrograms with the salbutamol because of the poor response, and states escalation options including IV magnesium sulfate 40 mg/kg (maximum 2 g) over 20 minutes after senior review, and intensive care help.
- Reassesses regularly and recognises life-threatening features such as a silent chest, poor effort, cyanosis or exhaustion, calling 2222.
- Gives a structured SBAR handover to the paediatric registrar with observations, treatment and response.
- Explains the diagnosis and treatment simply to the mother, reassures honestly, involves her in keeping the child calm and checks her understanding.
- Plans admission and safe discharge elements: preventer inhaler review, asthma action plan and follow-up.

### Model answer

I introduce myself to Mrs Farooqui and confirm Zayan's name and date of birth. I take a brief history: a cold then two days of worsening wheeze, ten puffs of salbutamol an hour ago with only short-lived benefit, missed preventer doses, no allergies. His observations show a respiratory rate of 38, heart rate 138 and a saturation of 90 per cent on air. He speaks in two to three words and uses accessory muscles. These findings meet the criteria for acute severe asthma in a child over five: saturation below 92 per cent, respiratory rate above 30, heart rate above 125 and inability to complete sentences. There is no silent chest or cyanosis, and he is alert. I ask the nurse for oxygen by mask to aim for 94 to 98 per cent and for salbutamol 5 mg by oxygen-driven nebuliser, repeated every 20 to 30 minutes as needed. I prescribe oral prednisolone 30 to 40 mg and ask for nebulised ipratropium 250 micrograms to be added because he has only partly responded. I reassess after fifteen minutes: his saturation is 94 per cent on oxygen but he is still wheezy. I state the warning features I am watching for: silent chest, poor effort, exhaustion, cyanosis or reduced conscious level, and that I will call 2222 if they appear. I telephone Dr Alderton with an SBAR: acute severe asthma in a six-year-old, partial response to initial treatment, and I ask him to review now and to consider IV magnesium sulfate 40 mg/kg, about 840 mg for his 21 kg. I explain to his mother what is happening, that he needs to be admitted and watched, reassure her honestly and let her stay with him. I document the observations, doses and times and plan an asthma action plan before discharge.

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# Scan results two years after bowel surgery

Breaking bad news · 8 minutes

**The task**

You are a doctor in an oncology outpatient clinic. Mrs Rukhsana Begum, aged 58, had surgery two years ago for bowel cancer. Recent scans show that it has spread to her liver and lungs. The team plans treatment to control the disease, but a cure is not possible. She has been told only that her scan 'showed some changes'. She is alone. Explain the result and respond to her concerns. The examiner will not take part in the conversation.

**What a strong answer does**

- Introduces self, confirms identity, ensures privacy and offers a support person to be present.
- Explores her understanding and how much she wants to know before sharing results.

- Gives a clear warning shot, then states plainly that the cancer has come back and spread to her liver and lungs.
- **Safety:** Is honest that the cancer cannot be cured, while explaining that treatment aims to control it, extend life and improve symptoms.
- Allows silence, acknowledges her emotions and responds with empathy.
- Answers the question about time honestly without false precision, saying it is hard to predict and may be months to years, and that the team will review how she responds.
- Explores concerns about family and wishes, acknowledging the wedding goal and what matters to her.
- Explains next steps: discussion by the cancer team, chemotherapy options, specialist nurse contact, symptom support and palliative care involvement alongside treatment.
- Offers support for her and her family, checks understanding, gives written information and arranges follow-up.

**Model answer**

I introduce myself, confirm Mrs Begum's identity and offer her husband's involvement. I ask what she understands and how much she wants to know; she wants the truth with few numbers at first. I give a warning shot and say plainly that the cancer has returned and spread to her liver and lungs. I stop and allow silence, acknowledge that she feared this, and give her time. When she asks whether it can be cured, I answer honestly that it cannot, while explaining that treatment can control the disease, extend life and ease symptoms. When she asks how long she has, I explain that I cannot be exact, that people vary widely and that it is often months to years, and that the team will learn more as treatment is given. I avoid false reassurance and avoid giving rigid numbers. I explore what matters to her, including her daughter's wedding in April, and explore her fears about pain and about her family. I explain the next steps: her case will be discussed by the cancer team, and chemotherapy options will be reviewed with her and her husband. A clinical nurse specialist will be her point of contact, and palliative care will help with symptoms alongside treatment. I offer to write things down and to book a follow-up with her husband present, check what she has understood, and ask whether she wants to ask more. I give contact numbers, ensure she has support to get home safely, and document the conversation.