# The Medical Interview Guide you wish you had seen first…

## What will you get out of this guide?

Too many people are confused by medical interviews. This guide will make it as straightforward as possible. It covers the 90+% of stats, context and techniques that you need for Medical School Interviews. If you follow this guide to its majority we promise you that you will be ahead of 90%+ of candidates. Make sure to really understand the concepts though not just rote learn them as this will put you the best way forward. For the personal qualities aspect, we've tried to give as much information as possible about how to link your answers together but ultimately it will be up to you if you want to get the most out of it and will require some thought on your own part to come up with really good answers but this guide is the perfect starting point. Go through each section one by one and I want you to think - how could I use my own personal experience in this context - THAT is the secret that people don't tell you. How to put YOURSELF in the answer in the smoothest way possible, while understanding all of the other things that you need to know in the process. Hopefully you find this guide useful and you feel like there is someone in your corner backing you in this journey. I know it's hard, but hopefully we've made it just that much easier. This guide is packed full of knowledge that you need and if it doesn't get you over the line I will personally send you a bitcoin (for legal purposes I am joking on this one)

Love,
Ammar and Aftab (Affy) | Co-Founders BaqsonMed

What this guide will do:

✅Teach you almost EVERYTHING of the 4 sections that you need to know at a level that is high yield
✅Show you real life examples of how to structure your answers
✅Let you understand what is special about the different parts of the NHS and being a doctor to a level that is so good that the examiners will give you an offer on the spot (hopefully…)

What this guide won't do:

❌ Write your answers for you
❌ Guarantee an offer just by reading it - YOU NEED TO PRACTICE
❌ Correct how you speak, your posture or any soft skills that you need to improve - AGAIN YOU NEED TO PRACTICE AND GET SOMEONE TO LOOK AT YOU!

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Co-Founders - Ammar Soni and Aftab Baquer

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# How I recommend you use this guide:

1. Read this guide from Top to Bottom - Doing deeper research with ChatGPT or YT videos to understand more about the process - recommend for Role-Plays especially.
2. Practice from Day 1 - You will be terrible. We know. The Interview is more about how you speak compared to WHAT you actually speak. You don't need to actually know too much for the Interview. Of course there are some pre-requisities like 4 pillars of medical ethics etc but apart from that we really, really believe that the candidates that have a really good fluent conversation with the examiner that feels as **REAL** as possible is what will make the difference at the end of the day. PRACTICE. Practice. **PrAcTiCe**.
3. Re-visit the guide for any topics you are really struggling on
4. Book a Mock MMI and Interview training if you STILL feel like you need some extra refining from an expert (BaqsonMed tutors obviously…). I fully recommend the Mock MMI above all because that will give you real pressure that you won't have seen before and the feedback you will get will be literal gold.
5. Get. That. Offer!

# What do we offer?

- Before we start the guide, we wanted to mention that we are a tuition company and have helped 100s of students with their Medical and Dental School Journeys.
- Now whether or not you decide to do something with us this guide will remain invaluable to you.
- If you want to make sure that:
    A. You learn from students who have got top offers at universities like Oxford, Cambridge, UCL, KCL etc or have 3 or 4 Medical/Dental school offers - learning EXACTLY what they did well and more importantly the mistakes that they had made along the journey - so you can avoid them and learn way faster
    B. You perfect the way that you answer questions and speak with confidence and clarity - whether you're super nervous on the day or not!

→ Then have a look at our website and if you're interested make sure to sign up.
We are student-led, student built and student focused, no large company behind us.
Just medical and dental students bringing the best to the next generation of applicants.

We also offer our FULL Interview package - with a full money back guarantee that you'll get at least one offer. Very few available → If this seems like something you'd be interested in, reach out ASAP.


Co-Founders - Ammar Soni and Aftab Baquer

Apart from paid stuff there's so much **FREE** stuff on our website → Join all the groupchats now at https://baqsonmed.com/

****We post free interview breakdowns, MMI scenarios, and study tips on TikTok and Instagram:*
*https://www.tiktok.com/@baqsonmed*
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# Basic Interview Techniques

## How to Structure Answers

A strong answer has a clear beginning, middle and end. Structure shows the interviewer you are actually a normal person with real experiences but someone who has reflected and prepared and not just someone who came just for the crack.

Use this for most questions:

1. **State the issue/Key point of argument/Maybe part of your opinion???**
2. **Why it matters**
3. **Give a real example**
4. **Your reflection and next steps**

For ethical questions, use the **Four Principles. Mention this every time even if you cannot think of anything -** :

- **Autonomy** (patient choice)
- **Beneficence** (do good)
  **Non-maleficence** (do no harm)
- **Justice** (fairness)

**Do:**

- Keep sentences short
- Make your point fast
- Link back to the patient or NHS

**Don't:**

- Ramble
- Throw random facts without a point
- Finish without a conclusion

## How to Use the News in Your Answers

News shows you care about medicine today, not in a fantasy future and you are up to date. The best candidates I saw knew at least 5-10 stats and quotes that they could use at a moment's notice. You'll find some in the later chapters and I'd recommend you join our **Whatsapp Groupchat** (follow the link to BaqsonMed.com) which has daily news articles summarised and tips to help you use those specific articles in your answers.

Keep it simple:

- **What happened**
- **Why it matters**
- **Impact on patient / NHS**
- **What you learned**

**Do:**

- Quote **one** stat at least
- Relate it to the role of a doctor
- Show you understand both sides of an issue

**Don't:**

- Sound political or preachy
- Rely on news to carry a weak answer → If the answer isn't well structured no crazy stats can help you out.

Example:

During my work experience, I encountered a patient whose anxiety led to her having chest pain and arm discomfort, meaning she came in to seek reassurance from her GP. This experience deeply resonated with me, as I witnessed firsthand how mental health disorders can present with physical symptoms and really made me understand what holistic medicine is actually about. Observing the GP navigate this case with empathy and a genuine desire to help the patient, reinforced my understanding that effective patient care need more than just a simple diagnosis; it requires addressing underlying psychological concerns with the same level of care and treating the patient holistically .This issue is not just a one off experience, as according to the World Health Organization, more than 280 million people globally suffer from depression, highlighting the vast scale of mental health challenges globally. This experience has strengthened my commitment to developing a patient-centered approach, ensuring that I recognize and validate the complex ways in which mental health conditions affect individuals via …..

# How to Break Bad News (SPIKES)

Break bad news like a future doctor who has compassion and a plan (even though it might feel like it)

Btw if you go into the room you need to assume the role play starts straight away, don't wait for the examiner to say we are now starting the role play because it probably won't happen

No1 Rule → If the patient is speaking **LET THEM SPEAK**. You want to let them speak for as **LONG** as possible. That reduces the chance of you sitting there like a chump saying 'ummmmmm'. If you say 2 words and just nod and **ACTIVELY LISTEN** to the patient you have done your job.

Here's how to show you are actively listening

1. When the patient says something, later signpost to it and say 'You mentioned X, how do you feel about that?"
2. Nod your head and throw in some mhms.
3. Mention that "I'm so sorry to hear that" when appropriate for any bad thing
4. Show appropriate motions on your face → If they are shouting at you just keep a straight face and take it.

Now this is what you need to know about how to actually break the bad news

**SPIKES:**

- **S**etting: Privacy. Sit down.

  → Think is this set in the GP practice, because you don't want to break bad news in the open, not only because of confidentiality but also because you wouldn't tell upsetting news in front of everyone would you? In this case ask them at the start that:

  "I need to share some news with you, would you like to go to a more private space?"

  This could also go for non-medical stuff like losing someone's dog etc.

- **P**erception: Check what they already know.

  Ask them what do you know about "XYZ"

- **I**nvitation: Ask if they want the details.
  “I’m sorry to tell you but there is something bad/ some bad news. Would you want me to share it with you at this moment?”
- **K**nowledge: Deliver information slowly, avoid jargon (fancy words)

  “I’m sorry to say but XYZ is there/ XYZ happened”

  THEN PAUSE. Let them take in the feelings and give a reaction. Wait for 10 seconds. The pause isn’t awkward → You need to let them have this to process the emotion. If you don't then you’re butting in way too quick.

- **E**mpathy: Acknowledge feelings.

  “I understand that this must be difficult for you to hear, but this is how we can work together to overcome this”

  → Together is an important word as it highlights patients centred care to the examiner. The patient and doctor have a partnership relationship and work **TOGETHER** to solve problems

- **S**trategy: Next steps but mention that you are together

  → Explained above

**Do:**

- Pause after giving the news
- Say “I’m here to support you”
- Let silence do some work

**Don’t:**

- Dump information like a robot
- Say “I know how you feel” → you don't
- Rush the emotional reaction

# How to Enter the Room

First impressions are judged instantly and will add to your presence and score even if people don't say so (read this if you don't believe me). Do this right and the rest becomes easier.

Checklist ✅:.

- Smile as you walk in!
- Think “I’m confident” before entering the station - cringe but self talk will help you especially if you’re nervous

- Eye contact with the **patient** only (if in a role play) → Make sure you keep eye contact with the examiner throughout and not have your eyes wandering about.

- Introduce yourself properly:
  “Hello, lovely to meet you, my name is [Name]. → The examiner will probably start straight away.
- Sit when invited, sit upright back straight with hands on your knees. DO NOT CROSS your arms (even though it feels safer), it makes you seem less confident and more anxious (you don't want to show that to the examiner even though you probably are)
- A nice thing to do is lean slightly back before speaking and sit towards the edge of your seat. Then as you start speaking lean forward a bit more → Very captivating and makes you seem in control of the conversation (which is what we want)

**Do:**

- Take a breath before speaking
- Shake hands only if offered

**Don’t:**

- Appear nervous before saying a word
- Walk in staring at the floor

# How to Reflect

- **Need to look back on what you have done with a 1-2 sentence summary of the action** e.g. In 6th form I was a hockey goalkeeper and I once had a really bad game where I let in 7 goals.
- **Then I need to talk about how you felt/what emotions were there** e.g. I was really upset and frustrated at myself as this was not the standard I hold myself to and I realised that there were silly mistakes that were made. I also realised I had let my teammates down
- **Then say what happened when you took a moment, looked back and the mistake you made** e.g. I sat down with my coach and took some time to look back over the game footage and see what I had done wrong. This made me realise that I had been leaning back on my starting position instead of forward, which lead to us formulating a plan to try and overcome this by doing repeated shot exercises focusing on regaining my starting position
- **Finally talk about what you did to improve/ensure that it didn't happen next time - essentially what was the lesson you learned and how to improve from this** e.g. I then learned how to continue leaning forward by adjusting my technique and this ensured that I wasn't leaning back and letting more goals in than I should've been.

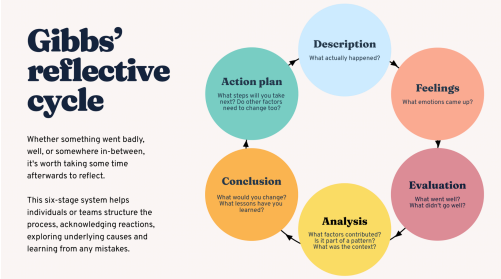
THIS IS LITERALLY IT DONT LET ANYONE ELSE CONFUSE YOU!!!

→ In a nutshell it's about looking back over what's happened , why it happened and what you could learn from it to try and make sure it doesn't happen again. That's it.

This is the key framework that worked for us and our students and what will probably work for you too!

The definition of something/describing what it is → What you learned from an event (reflection pattern we saw before) → How this links to medicine/Another shorter WEX reflection

This is a good reflection cycle to look at too:



# What is Med School looking for in your reflection?

Can you be succinct? They don't need Doctors who explain every little detail in notes/handovers. Need to be able to distill main points in the most effective and efficient manner
Have you shown across ALL stations:

Leadership
Teamwork
Communication skills
Organization skills
Dealing with problems?
Resilience + Perseverance.
Understanding what the profession involves.
How do you learn?
How to deal with ethical scenarios.
Empathy!
Time management,
How to deal with stress.

**Overall you need to come across as confident but remain HUMBLE!**

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# How to Approach the Role Play

Remember:
The task is to **help the person** → And the ultimate task (REMEMBER THIS: is that you need to find the underlying cause behind everything → WHY did this event happen?)

The best example I can think of is the drunk consultant role play → What is the underlying reason as to why the consultant is drunk? Is it stress, addiction, accidental etc. That's why the first port of call should be "why" and making sure patient safety isn't compromised before giving the consultant a punishment.

Steps:

- Introduce yourself

- Ask open questions at the start → Means questions that don't have a yes/no answer like “How does that make you feel”  or “Why do you think that might have happened?”
- Listen. Don’t fill every silence - same as before. Them talking is pure gold and let the role player talk as MUCH as possible.
- Show empathy and understanding - basic stuff
- Help them navigate through their problem and then look at what else needs doing.

Key survival rules:

- Patient safety first
- Maintain confidentiality
- Know when to get help

**Do:**

- Pick up emotional cues - explore them further. “You seem a bit upset by that - is it ok to ask why?”
- Validate feelings - “It’s totally ok to feel like that”

**Don’t:**

- Give medical advice you aren’t trained for → You aren’t even a medical student
- Argue or judge

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## How to Do Pros/Cons Questions

They are testing your ability to balance and reason. Keep it structured.

Formula:

- **Pros**
  List 2-3 strong reasons

- **Cons**
  List 2-3 real concerns

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- **Conclusion**
  Pick a side and justify it

Example topics:

- Assisted dying
- Physician associates
- Mandatory vaccination
- Private healthcare expansion

**Do:**

- Think about patient, staff, NHS, society
- Prioritise which point matters most

**Don't:**

- Sit on the fence
- Dump too many weak points

## How to Present Yourself

Look like someone patients trust → Don't come in a tech fleece please.

Basics:

- Neutral colours - Black, Blue, Grey
- Smart but simple - School Uniform works best
- Hair tidy
- No gum
- Minimal jewellery
- Keep posture strong which chest out and back straight

# How to Actually Speak Properly

Speak so people can understand you. That's it.

Rules:

- Medium pace → You will feel like speaking REALLY fast because of the adrenaline and nerves but don't. If you do find yourself speaking faster, consciously slow yourself down by tapping your finger on your leg. Think to yourself - "I need to slow down"

- Medium volume → Make sure they can hear you, but you're not shouting or being too quiet (main problem). If the patient is mentioned to be deaf in the brief before the station, ask if they can hear you clearly.

- End every answer with a point - "and that is why I think that…"

Break up your speech with breaths. Thinking is allowed and actually encouraged because it makes you seem even smarter than you already are.

**Do:**

- Speak like you already belong there
- Use the patient's words when summarising

**Don't:**

- Monologue like you're reading Wikipedia
- Overcomplicate your vocabulary to seem smart

## ⟶ If you ever get stuck in what to respond to a question this is your First Aid Life Savers:

- Bring a water bottle to sip on and drink if you are ever stuck so you don't look like you are freaking out (although I know I was on the inside!)

- Say “can I have 10 seconds to think about that” → Makes you seem a lot more sophisticated.
- Say “Please could you repeat the question for me?” → Buys back extra second s
- Say “That's a really interesting question, but what I actually think about that, is that…” → 10 seconds of waffle to think of a point

# Roleplay Cheatsheets

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## 1. Drunk Consultant

Common scenario - mainly about you are a medical student and the drunk consultant walks in. He has a patient in minutes, what would you do? It is either a roleplay or it is just an answer - either way it’s the same kind of answer. Main point is that you are not trying to catch the consultant out, rather trying to work with them to see what the underlying problem is

**Framework**

1. **Ask the consultant how they are doing - maybe they might break down and tell the truth?**
2. If they don't say anything, mention that you can smell alcohol somewhere and ask the consultant if they have any idea how it could’ve got there → I know it sounds silly but you can’t just jump straight in - there is still the respect hierarchy of you as a medical student and them as a consultant.
3. If they say no - which they probably will - reply with "I'm concerned that perhaps you may have been drinking and I’m worried about the patient’s safety as well as your own - could we have a discussion with the ward manager, as I’ve already mentioned my concerns with them?” → Involve a much more senior authority to make sure that you have ‘backup’, as you are a medical student so you can’t tell the consultant directly what to do really.
4. Remain calm throughout, let them be angry and remain calm. You win the station this way.
5. You can keep prompting the consultant as to why they might have been drinking in a manner that suggests that you want to really know the reason

why they are drinking and mention that there are lots of support available for stress in the NHS as well as for the consultants mental wellbeing → you could quote a stat here if it is a verbal answer to a role play saying about how stressed consultants are?

6. If they want to carry on seeing patients, then say you will immediately inform the ward manager and appropriate action will be taken → don't say anything explicit , as again, you are in no position to say what will or will not happen next.

**Underlying cause:** The consultant might be struggling (burnout, marital stress, depression). Show compassion while prioritising safety.

**Model answer:**
"I'd remain respectful but clear: patient safety comes first. I'd raise my concerns, suggest they step away, and escalate to a senior manager if needed. I'd also reflect that the consultant may be under personal stress, so they might need support rather than judgement."

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## 2. Talking to a Patient Who's Just Received Bad News (But You're Not Delivering It)

**Framework: EEE (Empathy – Explore – Encourage)**

1. **Empathy:** Acknowledge feelings — *"I'm sorry you've had some difficult news."*
2. **Explore:** Ask open questions — *"How are you coping with what you've just been told?"*
3. **Encourage:** Support — *"You don't have to go through this alone; there are people who can help."*

**Underlying cause:** They may not be upset only about the illness, but about **practical worries** (family, work, finances).

**Model answer:**
"**I'd listen more than I speak,** acknowledging their emotions and asking gentle open questions. If appropriate, I'd signpost to support. I'd avoid false reassurance, but make sure they feel heard and not alone."

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## 3. Friend Has Exam Papers (Academic Dishonesty)

**Framework: AIC (Acknowledge – Integrity – Consequences)**

1. First just say it is wrong and suggest that they give it back
2. Again, try and find the reason behind the exam papers being taken by your friend - are they struggling with something in life, is the work too hard for them - offer to tutor them and help them with their studies.
3. No matter what, tell your friend that they need to be reported as it's not about blaming them but rather if loads of students have the paper, then people will be passing without correct medical knowledge - potentially putting many patients' lives at stake.
4. Say that you are there to support them but ultimately have a duty to your future patients to make the teachers aware of this, not to punish your friend, but to find out how they can help students more and make sure something like this doesn't happen in the future.

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## 4. Friend Asks You to "Sign Them In" (Attendance Dishonesty)

**Framework: CARE**

1. **C – Clarify:** Ask why they want you to sign them in - are they struggling mentally etc
2. **A – Address:** Explain it's dishonest and could get you both in trouble - breaking GMC rules
3. **R – Redirect:** Suggest alternatives — *"If you're struggling, talk to the tutor."*
4. **E – Escalate:** If persistent, refuse and escalate appropriately - head of year, tutor etc.

**Underlying cause:** They might be struggling with **mental health, family issues, or motivation**. Show empathy, but keep professional boundaries.

**Model answer:**
"I'd ask why they wanted me to sign them in. If it's because they're struggling, I'd encourage them to speak to staff. But I'd refuse to falsify records because it's dishonest and risks both of us. Supporting them in the right way is better than covering up."




# MEDICINE HOT TOPICS + NEWS

# COVID-19 — Interview Notes

## Why it matters

COVID-19 changed healthcare permanently after 2022. Many challenges we see now — waiting lists, staff burnout, pressure on services — come from decisions made during the pandemic - some were good. Some were BAD. Very Bad indeed.

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## Key Facts

- **Waiting lists in England**: Around **7.39 million people** were waiting for planned hospital treatment as of June 2025[1]. This is due to a variety of issues that we will go through underneath. Think about that magnitude - approximately 10% of the population!

- **Doctors moving abroad**: In the last year, nearly a third of doctors considered leaving the UK (from a group surveyed) and relocating elsewhere in the world[2]. This is counting people moving to Canada, Australia, US and the Middle East which seem to be the top choices for Doctors. This highlights staff burnout due to the waiting list (see the link there) and retention challenges as a result of erosion of pay - especially for junior doctors (more on that later) - and a feeling like doctors are working out of excessive charity compared to actually being compensated fairly for their work. The main reason behind this is that they have a 40 work week contract - however many junior doctors go past this due to shortages and admin burdens while regularly not being compensated fairly for this as well.
- **Doctors are burning out** - You can see the toll on the doctors through the junior doctor strikes. It's on the news and this has stemmed from COVID but also from poor NHS management. In the last year, 20,286 secondary care doctors left NHS organisations

[1] https://www.england.nhs.uk/2025/06/nhs-waiting-list-hits-two-year-low-as-staff-work-to-turn-the-tide/
[2] https://www.bma.org.uk/news-and-opinion/a-third-of-doctors-consider-leaving-uk

[3]

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## Why this happened

- Elective procedures and routine care were cancelled during lockdowns, building a backlog which we now see today
- Billions were spent on emergency responses (PPE, Test & Trace, Nightingale hospitals) — later criticised as poor value for money. £1.4 billion wasted on PPE and were not used and were eventually destroyed[4]. £13.5 billion on Test and Trace - parliament has literally said that billions were lost unnecessarily
- Staff faced fatigue and low morale, with many considering leaving the NHS or moving abroad - as mentioned previously.

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## Why it matters for interviews

- Shows awareness of **real, current NHS pressures.** It is probably the biggest medical disaster in the last decade - unless you lived under a rock.
- Really nice way to flow topics together and really see what the cause and real life effect of previous events is. If you connect stats to it as well it allows the examiner to really see the specific effects that you are trying to point out making it so much easier for them to give you the marks.

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[3] https://www.bma.org.uk/advice-and-support/nhs-delivery-and-workforce/workforce/medical-staffing-in-the-nhs

[4] https://www.bbc.co.uk/news/articles/cll476qzm85o

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## How to link in interviews

- **To inequalities**: The backlog disproportionately affects patients who cannot pay privately or travel easily → Another link to the North/South divide → Avg spending per person →
- London (South): £3,946 per person
- North West: £3,489 per person
- North East: £3,455 per person[5]

- **To workforce issues**: Staff burnout and pay disputes push doctors abroad → More waiting times and lower levels of patient care → More pressure faced on doctors who stay → Have worse work-life balance → They leave and cycle continues.

- **To technology & AI**: COVID sped up digital adoption like tele-medicine via online consultations for GP's → Reduced GP time for consultations → Can potentially be less burnt out in the future. Surge in registrations as well for the NHS app → Digitilised economy and allows quicker patient record retrieval and more reliable than paper records as can be accessed from anywhere - safety concerns however for data protection. AI wise → A large database was made containing over 40,000 chest scans (CTs, MRIs, X-rays). Lead to AI tools development for diagnosing COVID-19. These AI tools helped speed up diagnosis, enabled early treatment, and identified which patients would need intensive care. One of the FIRST USES OF AI IN THE NHS.

  Important to mention think about the -ves of AI

→ Safety - more people could 'Hack' and access data if correct security protocols are not taken

→ AI is trained on a data set. If the data set is skewed by having way more of one race than another, this could lead to more people of a certain race being misdiagnosed. This similar thing happened with police tracking data with people of African descent being more likely to be categorised as criminals (when they were not) because the training data was skewed and it was also trained on free Internet data → Racism then creeped into the AI algorithm.

→ Who takes responsibility if the AI makes a mistake. The coder? The doctor? The company?

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5 https://www.bma.org.uk/advice-and-support/nhs-delivery-and-workforce/funding/health-funding-data-analysis

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### Reflection link to your experience

- If you witnessed postponed treatments, virtual GP consultations, or patient anxiety during volunteering or work experience, link it to lessons about communication, adaptability, and compassion.

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# Obesity & Lifestyle Diseases

## Why it matters

Obesity is one of the biggest pressures on the NHS, driving diabetes, heart disease, cancer, and mental health issues. Interviewers often test awareness of both prevention and treatment approaches - by this I mean you should know at least 2 or 3 specific examples for how the NHS is trying to overcome this (more on that later). The best way to come up with these types of answers is to really think as an examiner what question would I ask if someone answered me this question with the answer that I have given. You can use ChatGPT for this as well and we will link a prompt at the end as well.

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## Key Facts

- Around **26% of adults in England are obese**, and a further **38% are overweight** (NHS Digital, 2024).
- The NHS spends an estimated **£12 billion each year** on obesity-related ill health (NESTA, 2025)[6]. To put into perspective that is about 7% of the total budget (£202 billion)

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## Why this happened

- Lifestyle factors: Poor diet → Cost of living crisis right now meaning that people will not be able to spend as much money on food due to pressures like rent etc. Reduced physical activity via social budget cuts in schools, social deprivation → again could quote the North South divide mentioned earlier.
- COVID worsened weight gain due to lockdown inactivity → Self-explanatory really
- Gaps in public health funding and reliance on BMI as a flawed measure → Net public spending is now decreased by a real term value of 13% - due to problems like COVID damaging the economy (people have less jobs, less imports into the country etc) and the rise of inflation - **If you don't understand inflation** watch this video

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6 https://www.nesta.org.uk/report/the-economic-and-productivity-costs-of-obesity-and-overweight-in-the-uk/

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here. This is important to understand later when we are talking about Junior Doctor strikes

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## Why it matters for interviews

- Shows you can discuss **what some of the key problems facing the NHS are and that you are up to date with what is troubling the patients most.** A nice way to seem really smart is to lead to conversation with this structure: Obesity prevalent because of Social inequality, COVID, lack of education and sports in schools → CHildren grow up and keep same habits → Rise of diseases like Diabetes, High BP (Formal name is hypertension), cancers → More pressure on the NHS → More spending → Less for prevention in schools → Cycle continues. This is why this is such an important topic and needs to be addressed way quicker.

- Lets you show **balance** between prevention (sugar ta) vs treatment (new drugs like Ozempic, bariatric surgery ).
  Bariatric surgery is basically where you cut some of the stomach to make it smaller → Eat less food and lose weight.

  Ozempic → Copies GLP-1 hormone (makes you full sooner and reduces blood sugar more via insulin) → Eat less and so lose weight. Originally made for people with Type 2 Diabetes to reduce their blood sugar.  Now there are shortages in supply because private practices are prescribing it to people who don't need it → Problem for people who do need it.

  Think of 2 Advantages and Disadvantages for the use of Ozempic to people with Type 2 Diabetes and those who are taking it for the 'aesthetic appearance'

  (Hint: Think side effects, cost to NHS and people abusing to to become too thin)

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## How to link in interviews

- **To inequalities**: "Obesity rates are higher in deprived groups, showing a link with the social inequalities of health."

- **To NHS funding**: "It costs billions — investing in prevention may save more long term" → Link this again to the NHS 10 year long plan that specifically talks about this in the phrase *"The shift from treating sickness to prevention is the ultimate prize as it*

*will enable a truly transformational approach."*

- **To ethics**: “Should the NHS fund treatment of ‘lifestyle diseases’?” → How much is it genetic and how much are the diseases due to things like personal preference? Is it discriminatory to do so? You could compare it to the fact that smokers aren’t eligible for fertility treatments because they have done stuff to their bodies by choice that has now really damaged it to the point where their fertility is affected → We need to respect a patient’s **autonomy**, as they have a right to choose what they do to their own bodies.

  **GOLDEN NUGGET**

  → Ever stuck when they ask “What is the NHS doing to tackle obesity?”

  → Talk about the Sugar tax (2018) – reduced sugary drink consumption → Stats before

  → Soups and Shakes diet

  → In 2025, about 20% of children aged 10–11 (Year 6) across the UK are estimated to be living with obesity → Needs to change

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## Reflection link to your experience

- If you’ve seen patients struggle with weight management during volunteering, talk about **empathy, non-judgement**, and the role of the MDT (e.g. dieticians, GPs, psychologists).
  → The **most important** point here is to **not** judge people about their decisions, I have only given the above points to make you think about both sides of the argument, but ultimately you need to say this if ever asked whether people should be refused treatment based on obesity: “*There are many social determinants for ill health and for obesity related diseases, that withholding care from patients like this has a larger and more profound negative impact on patients that will eventually lead to more problems such as discrimination based on weight - violating the medical ethical pillar of justice. There are also many pre-determinates of weight such as genetics that cannot be changed.*

# Mental Health

## Why it matters

Mental health is so mentioned nowadays that it, rightly so, has its own place in the NHS 10 year long plan (more on that later). It really increased in awareness especially after COVID where more people were lonelier than ever. Interviewers want you to show awareness of the scale and the need for it to be on par with physical health in terms of how important it is to know about as a health professional.

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## Key Facts

- In 2023/24, **1 in 6 adults** reported a common mental health disorder like anxiety or depression (Office for National Stats, 2024)

- Waiting times for child and adolescent mental health services (CAMHS) often exceed **12 months** in some areas (NHS England, 2024) → Mostly in the North as well (think about previous stats and now do you see how topics link together?)

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## Why this happened

- COVID isolation → Loneliness is one of the biggest risk factors for mental health disorders and this combined with the rise of social media (funny that something social is reducing our social time between each other) leads to a rise in mental health issues.
- Social media pressures are present with mainly teenagers getting affected by body-dysmorphia from highly edited pictures as well as a NEED to go to certain events and live life like they see everyone else living (I know we've all seen something like this at some point)
- Cost-of-living stress → Inflation is rising so food costs, rent etc is rising however wages are not rising at the same rate. This means there is a mismatch between the amount people are being paid and then how much they are spending. If you are worried about money → You have chronic (long lasting) stress → WAY more likely to have mental health issues which then can lead to physical health issues → Leads to mental health issues and the cycle continues.

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- Shortage of psychiatrists and community services - In 2024, 19.2% of child and adolescent consultant psychiatrist posts in England were vacant, rising to 36.8% when including temporary staff, according to the Royal College of Psychiatrists.[7]

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## Why it matters for interviews

- Shows you appreciate medicine is **holistic** — such an important term and is something that examiners will be looking at when it comes to your answers.

  → Definition: "*Looking at the patient not just for the physical aspect but also looking at it in terms of social, mental and spiritual wellbeing e.g how they are socially, mentally and spiritually"*

  → NEED TO MENTION THIS LATER WHEN TALKING ABOUT DOCTORS IN GENERAL. Mention that they are 'holistic'

- A key topic that really will influence medicine in the next few decades. We have solved a lot of the secrets about the human body but what is missing is the research on the brain → Say that mental health will be at the forefront of medicine in the next few years.
- Such a key topic that is ALWAYS mentioned in the news and mention that it is an integral part of the 10-year plan

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## How to link in interviews

- **To workforce issues**: "We need more trained staff and retention in psychiatry so we could try to incentivise more psychiatrists to be presented in part of the country with lower rates and try and give more support to psychiatrist"

- **To inequalities**: "Children in deprived areas are less likely to access timely mental health care → Mention the statistics that we gave before about the 12 month waiting times → Could mention as well that suicide is the leading cause of death in young

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[7] https://www.rcpsych.ac.uk/news-and-features/latest-news/detail/2024/11/28/children-s-mental-health-crisis-deepens--severe-shortage-of-psychiatrists-to-meet-growing-demand

males under 50 → Better staffing would alleviate this ”

- **To personal qualities**: “Listening and empathy are essential when supporting mental health patients → Show why this is important from experience - could be while tutoring a child and see that their performance increases when you really listen to them. Also could link to a care home and mention about a time when you found that listening intently to an older person - for example someone with dementia or Alzheimer's - they responded a lot better to you and showed that just the empathy itself is enough to improve patients responses

  For more on empathy this is from Dr Rangan Chaterjee’s podcast:

  Empathy plays a crucial role in patient recovery. Studies involving a large sample size have demonstrated a strong correlation between the level of empathy perceived by patients and their recovery speed. Effective communication is essential for patients to genuinely feel the empathy being expressed. For instance, in a study of patients with the common cold, those who rated their doctors 10/10 for empathy recovered 16% faster[8] than those who gave lower scores. This highlights the significant importance of demonstrating kindness in patient care.

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## Reflection link to your experience

- If you’ve volunteered in schools, care homes, or hospitals, discuss how you noticed mental health challenges and the importance of listening without judgement → Similar to what I’ve mentioned before

Thought I would mention the difference between Alzheimer's and Dementia here:

1. What is Dementia?

General term for problems with memory, thinking, and behaviour that are bad enough to affect daily life.

It’s an umbrella for many different conditions, not just one.

[8] https://pubmed.ncbi.nlm.nih.gov/21300514/

2. What is Alzheimer’s Disease?

Alzheimer’s is the most common type of dementia (about 60–70% of cases) and causes gradual memory loss, confusion, and changes in mood and behaviour.

It gets worse over time (progressive).

Basically dementia is the overall term and Alzheimer's is the specific type:

NOTE: These are not mental health conditions but they are Neurodegenerative disorders - they are to do with a physical condition however I included them as they lead to a lot of mental health disorders and are something that a lot of people would be aware of

PS: Nice research to do with treating these diseases if you are interested. Here is a summary of one:

*“One major challenge in treating Alzheimer's is that most medications struggle to reach the brain. According to research, over 98% of drug molecules cannot pass through the blood-brain barrier (BBB), which is the brain's protective shield.*

*However, scientists have developed an innovative solution. They inject tiny bubbles filled with harmless gases into the patient's bloodstream, then use low-frequency ultrasound waves targeted at the affected brain area.*

*When these bubbles reach the targeted region, they begin to expand and contract, gently pushing against the blood vessel walls. This action creates temporary openings in the blood-brain barrier, allowing medication to pass through and reach the brain tissue.*

*Recent research by Morse demonstrated impressive results: this technique reduced Alzheimer's plaques by 50% in just two months. This is significant because these plaques gradually destroy neurons and lead to memory loss if left untreated.”*

*Morse SV, Pouliopoulos AN, Chan TG, Copping MJ, Lin J, Long NJ, Choi JJ. Rapid Short-pulse Ultrasound Delivers Drugs Uniformly across the Murine Blood-Brain Barrier with Negligible Disruption. Radiology. 2019 May;291(2):459-466. doi:10.1148/radiol.2019181625. PubMed PMID: 30912718; PMCID: PMC6493324.*

Link to research

# Technology & AI in Healthcare

## Why it matters

AI is one of the fastest-growing debates in medicine and if there is any hot topic that should be mentioned it should be this one. It offers potential benefits and so much efficiencies that can be talked about, however there is a lot of ethical and practical concerns - the main one is patient safety and data protection

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## Key Facts

- AI has shown **accuracy rates up to 90% in detecting breast cancer scans**, often higher than human radiologists (Lancet, 2020) → Think about radiologists job security at this point. Or will it just become a tool that Radiologists use in the future like the calculator for mathematicians.

- NHS England is piloting **"virtual wards"** using AI and remote monitoring to reduce admissions (NHS England, 2023) [9]→ Look at waiting lists right now with the stats from before.

- CoDE-ACS tool: AI can eliminate the possibility of a heart attack with 99.6% [10] accuracy by analyzing troponin levels, compared to standard testing models → Important as nearly one third (168,534) of patients were initially misdiagnosed for heart attacks. The AI tool was tested on almost 10,000 patients across 6 countries. → this will reduce inequalities as AI addresses the problem where the same threshold is used for all patients regardless of other factors - has led to women being **50%** more likely to receive a misdiagnosis.[11] Imagine how many lives it could save

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## Why this happened

[9] https://www.england.nhs.uk/statistics/statistical-work-areas/virtual-ward/
[10] https://www.nihr.ac.uk/news/artificial-intelligence-could-speed-heart-attack-diagnosis
[11] https://www.bhf.org.uk/what-we-do/news-from-the-bhf/news-archive/2016/august/women-are-50-per-cent-more-likely-than-men-to-be-given-incorrect-diagnosis-following-a-heart-attack

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- Push to improve efficiency and reduce costs:

  → The NHS is running in a deficit of £6.6 billion (basically how much it will go over the budget this year)

  → AI allows for some jobs to be eradicated such as monotonous data entry tasks and is much more efficiency meaning Doctors and other healthcare workers spend less time on admin and more time on patient interaction

  → Means patients are seen quicker, have better satisfaction and also will have less future problems further reducing the burden on the NHS in the future

  → Saving the NHS money

- COVID sped up adoption of remote technology → Mentioned before as desperate times call for desperate measures. This is not typical of the NHS as it is usually a slow adopter of new technologies due to many problems such as red tape and a large amount of hoops that need to be jumped through to get new technology adopted in the NHS.

  If you take anything away from this it is mainly the fact that AI fixes a lot of the inefficiencies in the NHS like the time taken from referral to actually seeing a specialist → Eventually saves the NHS money and who doesn't like saving money??

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## Why it matters for interviews

- Shows you can weigh **benefits vs risks**: efficiency, early diagnosis vs bias, safety, cost, depersonalisation.

Benefits and risk are as follows:

- Obviously the money mentioned before
- Less work for doctors admin-wise so less burn out, less leaving the NHS → More retention
- Can help spot missed diagnosis for doctors
- Can do the preliminary work for doctors → Can resolve issues quicker → Means more patients can be seen quicker → more satisfaction

Negatives:

- Companies will use NHS data to make AI models → Larry Elisson has tried this → Outside companies that are not in the UK under UK law will have data and could abuse it for monetary purposes
- AI can be racist and discriminate (as mentioned before)
- WHo is to blame if the AI is wrong
- Could AI malfunction and harm the patient, what are the safety protocols
- People could hack and steal data.
- AI hasn't been used like this before - will elderly patients trust it?

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## How to link in interviews

- **To patient care**: "AI may catch disease earlier, but human oversight is essential."
- **To inequalities**: "AI risks excluding those without digital access."
- **To ethics**: "Who is responsible if an AI makes a mistake?"

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## Reflection link to your experience

- If you've seen digital health tools (apps, remote GP), reflect on accessibility, safety-netting, and the balance between innovation and compassion → What are some things you might want to include in the NHS → Examiners love this kind of initiative

# Healthcare Inequalities

## Why it matters

Healthcare is not distributed evenly. Understanding inequalities is central to being a compassionate and fair doctor.

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## Key Facts

- **Life expectancy gap**: people in the most deprived areas of England live **7–9 years less** than those in the least deprived (Marmot Review, 2020)【9】.

- Maternal mortality for Black women in the UK is **more than twice as high** compared to White women (MBRRACE, 2025)【10】
- Plus all the stuff mentioned beforehand:
- Regional spending on healthcare:

  London (South): £3,975 per person

  North West: £3,580 per person

  North East: £3,465 per person (22/23)[12]

- AI misdiagnosis: AI addresses the problem where the same threshold is used for all patients regardless of other factors, which has led to women being 50% more likely to receive a misdiagnosis for heart attacks.
- The postcode lottery is there - basically some areas of the country get better access to NHS services than others purely based on the fact that they live in better areas. The most notorious one is fertility treatments which breaks the NHS's constitution that everyone should get the same level of treatment whether rich or poor → the richer areas get better access

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## Why this happened

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[12] https://www.bma.org.uk/advice-and-support/nhs-delivery-and-workforce/funding/health-funding-data-analysis

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- Social determinants poverty, housing, education etc → Most of Britain's spending is in London, outside London the divide is so poor that a large amount people live below the poverty line and don't get the same access that other people do to healthcare → Means a lot of people in these areas have a lot more health problems and challenges to see the doctor → Think about getting to the doctor as well, not everyone has a car and outside London the cities are not as well connected via public transport.

- Regional divide: North vs South, rural vs urban → GP Incentives to work in rural Wales

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## Why it matters for interviews

- Interviewers want to see you **care about fairness** in healthcare - this is of the utmost importance and relates to justice as one of the key pillars of medical ethics.

- Lets you discuss how the NHS tackles inequalities

  → Some key points here: Increased screening of patients at higher risks of diseases due to their ethnicity such as for Type 2 diabetes and people of Asian Descent.

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## How to link in interviews

- **To ethics**: → Justice needs to be fulfilled → Is this currently the case in the NHS?
- **To NHS funding**: “Resources should be directed to areas of greatest need → Less needs to be given to London and more needs to be spread out to areas of greater need such as the Northeast of England → Also needs to be allocated to places in a way that prioritises higher levels of efficiency

- **To your experience**: “On work experience, I saw how social background affects access” → Especially if you did WEX in a deprived area (such as the north east) → I know how big of a problem this is for the NHS → Link back to some of the stats mentioned before.

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### Reflection link to your experience

- If you've volunteered with disadvantaged groups, link it to awareness of barriers in healthcare and also the other stuff mentioned above.

# Antibiotic Resistance

## Why it matters

WHO calls it one of the biggest global health threats. Interviewers may ask about it to test basic scientific understanding and public health awareness. It is a really common topic and you may have seen it at GCSE but it is important to understand and learn about it.

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## Key Facts

- Around **700,000 people die each year globally** from resistant infections (WHO, 2019)

- Without action, deaths could rise to **10 million per year by 2050** (O'Neill Review, 2016)
- In 2023, the UK recorded 66,730 cases of serious antibiotic-resistant infections—a rise from 62,314 in 2019 and surpassing pre-pandemic levels

ANTIBIOTIC RESISTANCE SUMMARISED

- There will be some bacteria in a certain place
- There is variation in all species like humans etc so obviously there will be in bacteria as well → We are all shapes and sizes as we have different genes. So do bacteria.
- Now some bacteria are 'resistant' to antibiotics. This means they are not killed by the antibiotics either due to shape, size, having a different enzyme etc.
- Now if you basically give an antibiotic to someone but don't take the full dose → it will kill some of the bacteria (say 70%) but won't kill the rest of the bacteria.
- This means the resistant bacteria will not be surviving and since there is less other bacteria present they can now survive more easily → There is less competition for food o2 etc.
- This means the resistant bacteria can grow, pass on their genes to their offspring and so instead of 30% of the population being resistant, by giving antibiotics you are

artificially increasing the number of bacteria present that are resistant to almost 90% for example.
- This heavily decreases the effectiveness of the antibiotic as more bacteria in the population are resistant
- Also as the bacteria divide they will become more resistant
- Ultimately you get a population of bacteria that is resistant to all antibiotics

→ KEY TAKEAWAY → MAKE SURE TO FINISH COURSES OF ANTIBIOTICS IN ORDER TO PREVENT ANTIBIOTICS RESISTANCE

→ If you take away nothing from this section just remember the key takeaway → it is 70% of what you need to know for this.

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## Why this happened

- Overprescription in healthcare and agriculture → People use more antibiotics for chickens etc to make sure that the animals don't get ill and so won't waste energy fighting infection, but rather for growth in order to make sure that they get the most amount of meat. → By giving antibiotics you get more antibiotic resistance and these bacteria can pass on from animals → humans.
- Overprescribing in healthcare → Antibiotics are given to people with viral infection etc (Heads up if you didn't know antibiotics will do nothing against viruses as they have completely different structures) → Kills non-resistant bacteria but keeps resistant ones → same pathways as before
- 

- Global travel spreading resistant strains → Self-explanatory really. Think about COVID (THIS IS A VIRUS NOT A BACTERIA) and how it spread as well if you want a comparison.

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## Why it matters for interviews

- Shows you can link science to **real-world impact** → It is one of the biggest challenges in healthcare and if you are going into it then you need to be aware of it. You don't need to memorise the whole explanation for why it occurs - maybe for Oxbridge - but in essence just be aware that it is there and **why it is occurring**

- Also nice to link in if you get a graph question about antibiotic resistance → Can link to the mechanism or could link to the part where you mention why the rates have spread so much?
- It is a nice topic to talk about but it is quite niche and probably won't come up unless specifically asked about
- BTW → **Cancer cells become resistant to chemotherapy** in the same way as bacteria do to antibiotic resistance.

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## How to link in interviews

- **To patient safety**: "Routine operations become risky without effective antibiotics." → Will create more demand for an already short-staffed NHS → could mention waiting lists → Could mention how you would overcome the resistance
  qq

- **To ethics**: "Should we limit antibiotic use even if patients demand them?" → Really common concern of GPs → Need to balance **Justice** - Justice for everyone to get medication if they really need it, **Non-maleficence** - doing less harm to not only the patient requesting it but also other people that may catch the resistant bacteria strain as well as **Beneficence** - making sure that the patient is actually being treated and not dying of some other disease

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## Reflection link to your experience

- If you shadowed a GP, mention how doctors balance patient expectations with antibiotic stewardship (Fancy name for not prescribing antibiotics unnecessarily e.g. if they have a virus or a level of infection that doesn't need it)

There is another thing to be **aware** of for throat infections - it is something called the FeverPAIN scale → Doctors use it to assess whether it is worth giving a patient antibiotics or not.

**Fever**: Fever during the previous 24 hours

**Purulence**: Presence of pus (yellow stuff) on tonsils

**Attend** rapidly: Onset of symptoms within 3 days

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Severely **Inflamed** Tonsils: Marked tonsillar inflammation (swollen tonsils)

**No** cough or coryza: Absence of cough or nasal symptoms

**YOU DO NOT NEED TO KNOW THIS OFF BY HEART OR EVEN MEMORISE IT**. I just put it in for interest and to make you sound like a smarty pants in the Interview because you know this and just mention the scale when talking about antibiotic resistance if you want.

# Strikes & Workforce Issues

## Why it matters

The workforce is the backbone of the NHS. Strikes highlight pay, working conditions, and patient safety — all hot topics in interviews. If this doesn't get asked about in some shape or form in your Interviews, I will personally send you 1p to your bank account - thats how sure I am.

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## Key Facts

- Since December 2022, **junior doctor strikes led to over 1 million rescheduled appointments and procedures** (NHS England, 2023)[13]
- About **30% of NHS staff report frequent burnout**, pushing many to leave or move abroad (NHS Staff Survey, 2024)[14]

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## Why this happened

- Pay erosion compared to inflation but that is a great simplification of the whole story. The whole thing has gone on for a while now and it all goes back to **2008 levels**

[13] https://www.bmj.com/content/384/bmj.q556

[14] https://www.statista.com/statistics/1607990/frequency-of-burnout-nhs-england/

[15]which are the most sought after levels in comparison to today. The argument basically is that the DDRB (pay body that decides how much doctors get paid) has decreased their pay in real terms (Remember inflation from before?) as things have gotten more expensive but doctors are not getting increases in pay at the same rate at which costs are increasing.

- Compared to 2008, junior doctors and residents (including F1s) have had pay levels that have eroded by approximately 25-26% in real terms in 2023-2025 due to inflation and repeated pay freezes → as explained before.
- In 2008 the avg F1 pay was £22k → This would basically have the same 'purchasing power' (again remember the inflation thing I mentioned before if you are confused by what I mean) as £35k today[16]. Doctors also feel that they are more burnt out than before with less funding for things like accomodation etc that can also have a burden on them financially.

  Here is the full timeline:

  2008-2022: Doctor pay fell behind inflation due to pay freezes and below-inflation increases. BMA demanded restoration to 2008 real levels.

  2022: Nurses, paramedics, and other NHS staff began strikes over pay and living costs (cost-of-living crisis). BMA prepared for industrial action.[17]

  Jan 2023: Junior doctor strikes began—the first major action since 2016—in protest of over a decade of pay erosion and burnout.

  March-April 2023: Multiple rounds of strikes; walkouts up to 120+ hours. The BMA demanded a 35% pay rise to compensate for lost purchasing power.

  Summer 2023: Strikes paused and negotiations continued between the BMA and the government. However the government pay offers fell short of what the BMA actually wanted (5–7% increases proposed).

  Jan-Jun 2024: Further major strikes as deals were rejected.[18]

[15] https://www.bma.org.uk/media/6134/bma-ia-pay-restoration-methodology-13-september-2022.pdf

[16] https://www.bma.org.uk/media/6134/bma-ia-pay-restoration-methodology-13-september-2022.pdf

[17] https://www.bmj.com/content/383/bmj.p2881

[18] https://www.bma.org.uk/our-campaigns/resident-doctor-campaigns/pay-in-england/resident-doctors-guide-to-industrial-action-in-england

Sept 2024: Dispute ended after junior doctors accepted a deal averaging 22.3% pay rise over two years—still less than requested. Two-thirds voted in favor.

2024-2025: Consultants accepted revised deals; government committed to reviewing pay mechanisms (DDRB reform as mentioned before)

- It's not just the money as well by the way it's also the high workload, long hours and staff shortages - along with a general feeling of underappreciation for doctors.
- Alternative opportunities abroad with better pay/conditions → People leaving for Australia etc as mentioned before

One thing that people don't think about is the comparison between nurses and doctors in this context. You are a part of the healthcare team so this might be a nice comparison for you to use and seem more 'aware' of other issues than different candidates.

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## Why it matters for interviews

- Shows you understand the link between **staff welfare, patient safety** and the **reasons** why resident doctors are striking in terms of pay, conditions etc. Shows you know what you are getting into and not just the fact that you are going in blind.

- Lets you show **balance**: patient disruption vs long-term retention and safe staffing.

  → Nice stat to put in there:

  Consultants will only provide Christmas Day cover with strikes[19]. This means that while emergency care will be provided, almost all routine care will come to a standstill. (BBC news) → Patients are 16% more likely to die if they are admitted on a Sunday compared with a Wednesday with 48% less specialists and a lower number of overall doctors on a weekend (NIHR article)[20] → Can then link to what will happen to patient care if strikes happen (potentially).

[19] https://www.bbc.co.uk/news/health-66217770

[20] https://evidence.nihr.ac.uk/alert/hospital-emergency-care-is-as-good-at-the-weekend-as-on-weekdays/

## How to link in interviews

- **To ethics**: “Doctors balance duty to patients with duty to protect themselves.” → Key point here is to mention:

  *Non-maleficence* in terms of doing no harm to patients by reducing the time that they are spent striking and making sure that patient care isn’t harmed in the process.

  Beneficience → The fact that by striking doctors will get better working conditions → Means that they can be more focused on patient care → More likely to give better patient care → more beneficial to patients.

- **To your experience**: “On placement, I saw how staff shortages impact patient care. → Did the doctors talk to you about this? Did the wards seem overly busy? Did the doctors mention the time that they finished work - was it longer than had been expected for them. Have you heard of any mental health issues for doctors etc.”

## Reflection link to your experience

- If you saw stretched staff during volunteering, reflect on resilience, teamwork, and the human side of medicine → Doctors are people too, they are not robots. Say you know it is a challenging profession but ultimately we are humans and have needs that also need to be taken care of - we can be the patient too sometimes.

# Physician Associates (PAs)

## Why it matters

The rise of Physician Associates (PAs) has become one of the most debated topics in UK healthcare. With growing NHS staff shortages and increasing patient demand, PAs were introduced to support doctors — but the controversy lies in *how far that support should go*. Interviewers often ask about PAs to see if you understand both their *value* and the *concerns* raised by doctors, nurses and patients.

## Key Facts

- There are over **3,000 Physician Associates** currently working in the NHS (NHS England, 2024)[21], and this number is set to increase at a much higher rate
- They complete a **2-year postgraduate diploma** (they don't do a medical degree) and work under the supervision of doctors.
- PAs cannot **prescribe medication** or **order ionising radiation** (like X-rays or CT scans) however they can take histories from patients, do physical exams, make diagnoses but this is all at a minimum level.[22]

## Key Issues

- **For:** Help reduce pressure on doctors and cut down the waiting times we have seen previously, letting doctors focus on more serious complications and so makes everyone's time more efficient.
- **Against:** Concerns about role confusion from a patients side especially if they haven't seen them before - are they seeing a doctor or not? Patient safety is a key concern as we will see later and lack of clarity about accountability if something goes wrong.

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21 https://healthmedia.blog.gov.uk/2023/11/03/physician-and-anaesthesia-associate-roles-in-the-nhs-fact-sheet/

22 https://www.england.nhs.uk/long-read/nhs-englands-position-on-physician-associates-7-february-2024/

- **Public concern:** These are 2 incidents have raised questions about transparency (e.g. patients not knowing they weren't seen by a doctor) and have been reported in the UK media and are currently being reviewed by the GMC and NHS England→ This includes some deaths as well such as:
    1. **Emily Chesterton**:[23] Patient misdiagnosed by a PA as having anxiety/long COVID and then symptoms of a pulmonary embolism (clot in the lungs) missed. PA did not escalate to a doctor and unfortunately the patient died after not being referred to emergency care.
    2. **Pamela Marking**[24]: The patient presented to A&E with serious symptoms but a PA diagnosed a nosebleed instead of a life-threatening cause and discharged her without informing doctors. The patient unfortunately died.

## How to talk about it

A balanced answer might be:

> "Physician Associates can be valuable in reducing NHS workload and improving access to care, but it's important that their role is clearly defined, with proper regulation and supervision as otherwise unfortunate events could occur (mention one of the things we said before). Patients deserve transparency about who is treating them as without that they cannot give informed consent (more on that later in the guide)"

## Link it to:

→ If you see doctors striking or having a high workload → Link it to this as a solution to try and overcome the long waiting lists etc (link from the previous stats in the document)
→ Negligence in the NHS and some of the other problems e.g. Harold Shipman and Lucy Letby and how they both have led to reforms in the NHS → Will PA lead to reforms?

Some PA reforms have occurred such as:

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[23] https://www.bma.org.uk/bma-media-centre/bma-backed-high-court-case-brought-by-parents-of-emily-chesterton-and-anaesthetists-united-against-gmc-over-regulation-of-pas-begins

[24] https://www.pslhub.org/learn/investigations-risk-management-and-legal-issues/investigations-and-complaints/coroners-reports/prevention-of-future-deaths-report-pamela-marking-24-february-2025-r12819/

- All PA's must register with the GMC (General Medical Council) from December 2026 → They are there to regulate all doctors training and practicing methods → WIll allow PA training to become more supervised[25]
- The Leng Review (2025) recommended changing the title from "Physician Associate" to "Physician Assistant" for greater clarity. PAs must now wear uniforms and badges clearly identifying their role, and all patient-facing materials must explain the distinction between PAs and doctors[26]
- PAs can no longer see "first point of contact" patients in primary care, emergency medicine, or mental health unless there are **clear national protocols** and they are under **direct supervision**.
- Newly qualified PAs must complete at least two years in secondary care prior to working in GP or mental health settings




25 https://www.pulsetoday.co.uk/news/regulation/gmc-sets-out-pa-regulation-start-date-and-two-year-respite-period/

26 https://www.gov.uk/government/publications/independent-review-of-the-physician-associate-and-anaesthesia-associate-roles-final-report/the-leng-review-an-independent-review-into-physician-associate-and-anaesthesia-associate-professions

# Assisted Dying Bill & End-of-Life Care

## Why it matters

This is one of the *most ethically bound* and most emotionally involved issues in medicine in the current climate. With rising public debate and ongoing bills being discussed in Parliament, candidates are expected to know the ethical arguments, not just personal opinions. The question often tests your ability to balance *autonomy* and *non-maleficence* along with the other ethical pillars (look at that from the ethics section)

## Key Facts

- Assisted dying is **illegal** in the UK under the **Suicide Act 1961**[27], which makes it an offence to assist someone in ending their life → However that might be changing now with the advent of the assisted dying bill
- Some countries, such as **Canada**, **Netherlands**, and **Belgium**, allow forms of assisted dying under strict conditions.[28]
- A UK Bill proposing legalisation for terminally ill, mentally competent adults is currently under debate (2025).

## Key Ethical Arguments

- **For:**
    - Respects *autonomy* - allows patients control over their death and lets them do what they want with their body provided that they have capacity → Look at capacity in the ethics section if you need a refresh
    - Could be argued for *non-maleficence* as people might say that if someone has a painful and terminal (means they are going to die) illness then they are doing less harm by allowing them to end their life early with the help of medical doctors in a peaceful way compared to living their life in pain for the next however many years.

    - Can relieve suffering when palliative care cannot → It is important to know what palliative care means and is a key term in this argument.

[27] https://www.legislation.gov.uk/ukpga/1998/42/contents

[28] https://www.europarl.europa.eu/RegData/etudes/BRIE/2025/775914/EPRS_BRI(2025)775914_EN.pdf

→ **Palliative care** - Basically just the treatment of people who are going to die and making sure that they are comfortable and the painful effects of their diseases are minimised.

- **Against:**
    - Risks *abuse* or *pressure* on vulnerable patients → As sad as it sounds, many younger people may abuse their older generations by persuading them take the assisted suicide in order to make sure that they get an inheritance early etc. There may also be people coercing them for malicious intent
    - Could undermine trust in healthcare professionals → Many old people may feel as if they are being treated by someone who also kills people. Trust is a major issue here and you can link to this to topical news → For example Lucy Letby, if she is killing babies, then it is possible that one doctor one day may abuse this assisted suicide → Could link this very nicely to the Harold Shipman case where he took advantage of many elderly patients and caused their deaths for inheritance (more later)
    - Slippery slope — where do we draw the line between assisted dying and making sure elderly people aren't taken advantage of?
    - Could also argue about the fact that

## NHS Context

- End-of-life care focuses on **palliative and hospice support**, helping patients live comfortably and die with dignity.
- Key services include **pain management**, **spiritual care**, and **emotional support for families**.
- The NHS Long Term Plan aims to improve palliative care access and reduce inequalities across regions.

## How to talk about it

"I think assisted dying raises valid points about patient autonomy, but it's equally important to strengthen end-of-life and palliative care so that no patient feels that dying is their only option."

# The Vaccine Scandal

## Why it matters

Vaccines are one of the greatest public health successes in history — yet *trust* can be easily damaged. From misinformation on social media to historical mishandlings (like the MMR controversy), vaccine scandals test your understanding of *ethics, communication, and public health responsibility.*

## Key Facts

- **MMR Scandal (1998):** Dr Andrew Wakefield falsely linked the MMR vaccine to autism in a now-retracted *Lancet* paper[29] (Journal that loads of doctors use to read about research). His research was found to be fraudulent, because he falsely suggested a link between autism and vaccinations. He wanted to do this, because lawyers paid him beforehand as they wanted to sue the vaccine companies - a clear ethical breach. The worst thing about it however is that it caused massive **drop in vaccination rates** [30]and lasting mistrust → People still believe today that vaccinations cause autism. Think about herd immunity if you've done this in A-level biology and think if less people have vaccines → less people are protected against diseases → More can get infected → More people can spread disease → More burden on the NHS → More money spent fighting it etc.

- **Covid-19 Vaccine Hesitancy:** Social media misinformation can lead to lower uptake in some communities, especially in ethnic minorities and younger groups → again very recent and relevant

- **Consequences:** Resurgence of diseases like measles — cases in England reached their highest in over a decade in 2024.[31]

## Key Themes

- **Public trust:** Once lost, takes years to rebuild → Lucy Letby and Harold Shipman broke the public's trust as well

- **Media responsibility:** Regular reporting amplified fear.

[29] https://www.bmj.com/content/340/bmj.c696

[30] https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/conditionsanddiseases/articles/covid19vaccinehesitancy/latest

[31] https://www.gov.uk/government/statistics/measles-confirmed-cases

- **Ethical issue:** Duty of doctors and scientists to communicate clearly, honestly, and with evidence.

### How to talk about it

> “The vaccine scandal shows how fragile public trust in medicine can be. It highlights the importance of ethical research, transparency, and education - because misinformation can have real-world consequences for public health → Link to the stuff we mentioned above to do with NHS burden etc or even link it to another case like Harold Shipman/Lucy Letby etc.”

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# NHS - (Know what you are getting into)

### Why it matters

You'll work in the NHS as a doctor. Understanding how it's structured is essential, even at an interview. It also helps you link answers together and show you know how care is delivered in the UK.

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# 1. Primary Care (the first point of contact of the NHS)

- What you see first usually → **GPs, dentists, pharmacists, opticians** etc. For medicine it is mainly the GP
- You go in with your symptoms (usually not life-threatening) and then get referred (passed onto) to a specialist.

**Example**:
You have chest pain and go to the **GP**. The GP takes a history (asks you questions about it) then does some tests and then finds that you have a heart problem. They then will refer you to secondary care (the hospital) to see a cardiologist.

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# 2. Secondary Care (hospitals)

- After patients are referred and is where they get specialist tests or treatment.
- This includes A&E, outpatient clinics, inpatient wards → basically the whole hospital

**Example**:
The chest pain patient now arrives at **A&E** and is seen by an emergency doctor - probably after a 3 hour wait nowadays :( - they have blood tests done and are admitted to a ward for further monitoring.

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# 3. Tertiary Care (super-specialist centres)

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- These are **highly specialised hospitals** for complex care.

- Examples: cardiac surgery units, neurosurgery centres, cancer centres → Basically anything super specialised → when local hospitals can't provide the specialised treatment we send the patients here.

**Example**:
Tests show the patient had a heart attack and needs **bypass surgery (solves some blood issues with the heart)**. They are then transferred to a **specialist cardiac centre** for an operation which can only be done by a super-specialist.

→ In summary:

- 1° care → First person you see to then send you to the right specialist doctor
- 2° care → Specialist looks at you and does test and treatment
- 3° care → If 2° can't do it or is too complex → They send you here

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## 4. Community & Social Care

- Care provided outside hospitals e.g. district nurses, physios, care homes.

- Supports patients after discharge to keep them well at home.

**Example**:
After surgery, the patient goes home. A **community nurse** visits to check the wound as lots of patients after having a heart attack are really scared and have some sort of PTSD thinking they could have another one at any time. A **physiotherapist** supports their recovery → walking etc.

Ok so we covered the actual journey through the NHS → But who actually runs it?

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## 5. The Organisations Behind the NHS

- **DHSC (Department of Health and Social care)** → NHS England used to be there but as of recently the government has merged it with the DHSC[32]. This was due to the **Darzi review** → Basically it said that there were people doing the same jobs in both so it was a waste of money paying both people. It is also due to the extra pressure on the NHS to try and save money.

- **GMC**: regulates doctors and investigates any claims or wrongdoings (Harold Shipman etc). Sets training standards and pathways as well as maintains what doctors have to do every year and keeps their information up to date.

- **BMA**: doctors' trade union → Will have seen them in terms of the strikes that occurred → They protect doctors and their best interests

- **PCN** → Primary Care Networks → Group of local GPs that come together to ensure that primary care (mentioned before) runs smoothly and makes sure that all the community services like vaccines, diabetes screening etc are working smoothly. Really important during COVID vaccine rollouts etc.
- **ICSs** → Integrated Care systems → make sure hospitals, GPs, and community teams in the same region work together instead of separately → Basically like a large team manager

**Why it matters for interviews**:

- These acronyms will sound weird, but just knowing what they do shows that you have done some research and will be ahead of other candidates.

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## Reflection link to your experience

- If you shadowed a GP, explain how you saw referrals being made → Allows you to mention the teamwork aspect of the NHS (they don't want big headed doctors).
- Could also mention teamwork if you saw this on the wards → Link back to how you've shown teamwork at school playing rugby, hockey, fortnite etc (ok maybe not fortnite)

[32] https://www.nhsconfed.org/publications/abolishing-nhs-england-what-you-need-know

# 7. The NHS Long-Term Plan (NEED TO KNOW)

**What it is**

- A blueprint published in **2019** to guide the NHS over the next 10 years. [33]
- Main aims (know this):
  - Prevention
  - Digital innovation
  - Mental health
  - Reducing health inequalities
  - Shifting from Hospital → Community care

**Key points**

- **Digital-innovation**: More online GP consultations are suggested with more incentives for GPs to train and work in more remote areas.
- **Prevention**: tackling smoking, obesity, and alcohol harm via community campaigns and raising awareness in schools etc. Prevention is so much better than treatment
- **Mental health**: £120 million invested for new mental health centres
- **Community focus**: more care delivered at home to reduce hospital pressure → Building new neighbourhood centres which will have Primary care, mental health pharmacy and social care all in 1 big centre → Will save money and will allow for better communication between these areas of the NHS

**Linkers**

- **To obesity hot topic**: prevention is cheaper than treatment → Show cost to the NHS via stats shown before
- **To AI**: digital-first care links to virtual wards → Great link to combine plans with your own research. Also could mention the other AI advancements

[33] https://www.gov.uk/government/publications/10-year-health-plan-for-england-fit-for-the-future

- **To inequalities**: plan focuses on deprived communities → North south divide and smoothening out funding

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# 8. NHS Funding

**What you need to know (no more no less)**

- Funded mainly through income **tax (tax you pay due to what you earn) but also a smaller portion through National Insurance (NI) - another type of tax for social security → They just increased the rate of NI as well**

- **Budget**: around **£195.6 billion in 2025/26**.[34]

- One of the main pillars of the NHS is that it is **"free at the point of use"** (THIS IS VERY IMPORTANT TO REMEMBER) → but **some charges apply** e.g. prescriptions (England only - £9.90 per item)[35], dental care, eye tests will be chargeable

  Not a funding thing but the Head of the NHS is the **Health Secretary** which is (currently as of writing) **Wes Streeting**

**Why it matters in interviews**

- Know the *"free at the point of use"* quote - it is **VERY important**. But if you know exceptions you'll be ahead of other candidates that haven't done as much research.

- Interviewers may ask: "Should the NHS charge for GP visits?" → Rishi Sunak tried to implement this beforehand and this was not met well at all.

**Linkers**

- **To ethics**: justice → If people can't afford then people should still get care not based on their socio-economic status

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[34] https://www.england.nhs.uk/long-read/financial-performance-update-6/

[35] https://media.nhsbsa.nhs.uk/press-releases/b2f6650c-c901-4d6b-afef-766fcb2eae11/nhs-prescription-charges-frozen-for-2025-26

- **To lifestyle diseases**: should NHS money go on preventable conditions? People choose to smoke so should we treat them? (**Say that smoking is influenced by many factors including things that are beyond people's control such as genetic predisposition, environment they grew up in , whether mum or dad smoked etc**)

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# 9. Patient Safety & Failings → IMPORTANT

**Why this matters**

Scandals determine public trust and medical training, it's important as if people don't trust doctors and healthcare professionals, they won't tell as much of the truth that they need to; potentially leading to worse treatments for them and not getting the care they actually need. You don't need every detail — just know a few examples and what changed afterwards.

**Key examples**

- **Mid Staffordshire (2005–09)**: hundreds of unnecessary deaths due to poor care in the Stafford hospital due to neglect of patients, bad staffing and poor hygiene → Led to almost 1000 excess deaths. Need to know that it led to the **Francis Report (by Sir Robert Francis)**, emphasising openness and patient-centred culture in the NHS → Basically we need to be open about what is going on in all hospitals to make sure that patients are getting the care that they need.

- **Martha's Rule (2023)**: Martha Millis unfortunately died of sepsis in 2021 after her parents' concerns about her health deteriorating were ignored.

  This new rule gives families the right to call for a rapid review if they feel a patient is deteriorating.

  It has 3 parts:

  - Patients being asked regularly about how they feel and whether they are getting better or worse, with this information acted upon in a structured manner.
  - All staff are able to request a review by a different team if concerns about deterioration are unaddressed.
  - Patients, families, and carers having access to this escalation route if they feel concerns are unaddressed

- **Lucy Letby case (2023)**: Neonatal nurse (the nurse who looks after babies just after delivery) convicted of **harming babies**.

  Consulatants and other doctors had voiced concerns before, however they were shut down by heads of the hospital who dismissed their claims (either too busy or couldn't be bothered). The doctors were also worried about getting pushback from colleagues for raising concerns as well as the fact that senior managers seemed too cold and unapproachable.

  This led to a large debate about **whistleblowing** (the practice of telling a member of the hospital if someone in the hospital is doing something wrong) and safety culture.

**Linkers**

- **To ethics**: duty of candour (being honest when mistakes happen) → Needed in Lucy Letby's case → also link to GMC principle that patient safety is of utmost priority and if something is endangering it, then that issue must be raised immediately.

- **To personal qualities**: courage to raise concerns, empathy for patients etc

## Example Interview Q's

**Q: "What did the Francis Report highlight?"**
**Model Answer**:
"It highlighted that patient safety must always come first. It encouraged openness and honesty when things go wrong, which is now formalised in the duty of candour. It also showed the risks of ignoring patient complaints."

**Q: "Why is Martha's Rule important?"**
**Model Answer**:
"It gives families a safety net if they feel their concerns aren't being taken seriously. It emphasises communication and partnership between doctors and patients, reducing the risk of tragic mistakes. It also ensures that patients are feeling heard by the NHS and not feel abandoned"

**Q: "What does the Letby case show us about the NHS?"**
**Model Answer**:
"It showed that there was a culture where staff fears were ignored and this can put patients at risk - which it so clearly did. Doctors and nurses must feel safe to speak

up in order to fulfill their jobs to their greatest potential and organisations must take whistleblowing seriously to protect patients."

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# 10. Pulling it all together — Patient Journey with Challenges

Imagine this scenario:

1. **Primary care**: GP refers a patient for suspected cancer.
2. **Secondary care**: The hospital wait is long due to staff shortages → patient anxious.
3. **Tertiary care**: Once diagnosed, they're referred to a cancer centre for treatment.
4. **Community care**: After chemo, a district nurse helps at home.
5. **Funding issue**: They pay prescription charges in England.
6. **Safety culture**: If care delays worsen, family could invoke Martha's Rule.
7. **Long-Term Plan link**: More prevention and early screening could have caught cancer earlier.

This example shows how the NHS works together — but also where it struggles.Think about how you might implement some changes **(EXAMINER LOVE THIS QUESTION!!!)**

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## High-Yield Interview Angles

- **"Is the NHS sustainable?"** → Talk about rising demand vs funding.
- **"What would you change about the NHS?"** → Suggest prevention, retention of staff and more implementation of AI.

- **“What have we learned from NHS failings?”** → Importance of openness, communication, and putting patients first.

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### Reflection link to your experience

- If you saw delayed referrals → reflect on the patient’s perspective.

- If you saw MDT teamwork: talk about how it reassured patients and improved outcomes → Link to how you might have had a project meeting in school. Nothing is too small in interviews, it's all how you link your experiences with what a doctor does on a daily basis.

  An example might be the doctor actively listening to a nurse in an MDT and then you listening to the team member involved with actually building the project. Say in both examples how it built a better connection between the team as well as allowing you to listen to their concerns and delegate tasks to the person best suited for the job → In the doctor context this would mean that you give the patient the best quality of care possible

# NHS Core Values:

There are 6 C’s you need to know and just drop them randomly in sentences tbh:

**Care:** Core part of the NHS as the focus is on delivering consistently right care for individuals throughout their lives.

**Compassion:** Means giving care with empathy, respect, and dignity

**Competence:** Means having the skills, knowledge, and expertise to improve an individual’s health.Think about what it means if someone is competent

**Communication:** The key to successful caring relationships and teamwork, includes active listening and involving patients in decisions about their care (allowing them to have autonomy)

**Courage:** Courage enables staff to do the right thing for patients, speak up when there are concerns, innovate, and embrace new ways of working → Remember Lucy Letby’s case?

**Commitment:** The dedication to improving care and patient experience as well as meeting future health and social care challenges.

## Apart from this there are 6 different (but similar) Core values:

**Respect and dignity:** Values every person as their own individual and don't judge people based on beliefs, sex, gender, race etc

**Commitment to quality of care:** Self explanatory

**Compassion:** Same as before

**Improving lives:** Self explanatory

**Working together for patients: Together** → Highlights the teamwork aspect of medicine, working with nurses, physios etc. **For patients** it is also important as it shows that patients are our top priority as doctors

**Everyone counts:** Benefit everyone and can link to the pillar of Justice for medical ethics.

# Medical Ethics

## 1. The Four Pillars of Medical Ethics

**Autonomy**

- Patients have the **right to make their own decisions**, even if doctors disagree → but they **need to have capacity**: This is a crucial topic in medicine and it has changed throughout the years. Whereas before doctors used to adopt a much more **paternalistic approach**, deciding what to do with the patients treatment plan with little input from the patient themselves, now doctors must offer multiple choices of treatments if available and respect the patients decision.

- Example: A competent adult refusing life-saving treatment due to religious beliefs. You must respect their views, even if you disagree as a professional, only if they have capacity at that moment.

**Beneficence**

- Acting in the patient's best interests - Doing what's best for them essentially: (Pretty self explanatory)
- Example: Giving oxygen to a breathless patient and relieving suffering

**Non-maleficence**

- **"Do no harm."** Don't give treatments where harm outweighs benefit: Again, may seem simple, but always add it into your interview answers, it adds a lot of gravitas to your answer!

- Example: Not giving unnecessary antibiotics to avoid resistance: could give unnecessary side effects

**Justice**

- Fairness → distributing healthcare resources **equally**. Being fair in order of treatment. This is crucial as the NHS was built on the foundation of fairness.

Socio-economic, ethnicity, sex alone are not deciding factors when it comes to prioritising patients who need help.
- Example: Deciding who gets limited ICU beds.

**Tip for interviews**: Always bring ethical scenarios back to the four pillars - it shows structure. Even explicitly mentioning the word can be useful and at times gain you marks when used appropriately.

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# 2. Consent and Capacity

## Consent

- **A patient must give permission before any examination, investigation, or treatment.**

- **For consent to be valid, it must be:**

    1. **Informed – the patient understands the nature, purpose, risks, and benefits of the procedure (and alternatives, including doing nothing).**

    2. **Voluntary – given freely, without being forced or undue influence.**

    3. **Given by someone with capacity – the patient must be capable of making that decision.**

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## Capacity

(Defined by the Mental Capacity Act 2005[36])

A patient is presumed to have capacity unless proven otherwise → IMPORTANT FOR EVERY PATIENT. Don't assume that a person with dementia doesn't have capacity → Maybe they do and you don't want to be offensive.

[36] https://www.legislation.gov.uk/ukpga/2005/9/contents?

A person has capacity if they can:

1. **Understand the information** relevant to the decision.
2. **Retain that information** long enough to make the decision.
3. **Weigh up** the information to reach a choice.
4. **Communicate** their decision (by any means).

If capacity is lacking → decisions must be made in the patient's best interests, using the least restrictive option possible.

- ***Patients can have capacity for one thing like whether they want an injection, but may not have capacity to consent to heart surgery etc. You need to check every time for whether capacity is there when you ask a patient questions, as they can regain it and lose it at any point***

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**Special cases**

- **Gillick competence** (children): under-16s can consent if they fully understand what is going on
- **Fraser guidelines**: used for giving contraception to under-16s → Same as Gilick's competence but we mention this when it comes to contraception

## Fraser guidelines (More detail)

- You use Fraser guidelines when a young person <16 wants **contraception / advice on sexual health** and doesn't want parents involved.

A doctor can give contraception **without parental knowledge** if **all** of these are met:

1. **The young person understands** the doctor's advice.
2. **The doctor cannot persuade them** to inform parents / allow the doctor to inform parents.
3. The young person is **likely to have sexual intercourse** with or without contraception.
4. The young person's **physical or mental health is likely to suffer** without contraception/treatment.
5. Treatment/contraception is **in their best interests**.

Alongside Fraser competence, doctors must also be careful to spot any potential sexual abuse or exploitation, e.g sex trafficking

- **Advance directives**: written statement about what future care is wanted by the patient if capacity is lost (e.g. dementia) → Most commonly as to whether they want CPR or would rather not go through that trauma and die peacefully

  I was always confused by the No CPR thing because I thought who would want to die. However, CPR actually takes a large toll on the body and can be really stressful and painful to go through, especially if ribs are cracked etc. If you are really old and frail you might want to prefer to die peacefully and not have this added stress which could potentially injure you or damage your quality of life.

### Example Interview Q

**Q: "What if a child asks for contraception without telling their parents?"**
**Model Answer**:
"Doctors use Gillick competence and Fraser guidelines. If the child fully understands the treatment and risks, they can consent themselves. Confidentiality is kept unless the child is at risk of harm to themselves or other people."

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## 3. Confidentiality

**What is Confidentiality?**

- Doctors and the wider MDT must keep patient information private. Only those working on the case are allowed to know patient identifying/private details. Staff are permitted to share private information to other specialists if it is in the patient's best interest for treatment (only with the patient's approval).

**When can it be broken?**

- With patient consent.
- If a patient has a STD: any sexual partners of the infected person must be told
- Certain infectious diseases like meningitis (Must alert Public Health protection agencies) - Law
- By law (e.g. notifiable diseases like TB, safeguarding).
- To protect others (e.g. terrorism threats, risk to a child).

**High-yield link**: Confidentiality builds **trust** - without it, patients may not be honest.

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## 4. End-of-Life Decisions

**DNACPR (Do Not Attempt CPR)**

- A medical order saying if a patient's heart stops, doctors will not attempt CPR.
- Used when CPR would not be in the patient's best interest (e.g. frail patients where it would cause more harm than good).

- Patients/families should be involved in discussions, but ultimately doctors make the decision.
- Links to Bawa Gawa Case

## Palliative Care

- Focuses on **comfort, dignity, and quality of life**, not curing disease.
- Aims to **relieve pain and distress** (physical, emotional, spiritual).
- Involves a **multidisciplinary team**: doctors, nurses, social workers, chaplains, etc.
- Central principle: supporting both **patients and families** through terminal illness.
- **Ethically distinct from euthanasia** – palliative care may shorten life as a side effect (e.g. strong opioids), but the **intent** is to relieve suffering, not cause death.

**Example Question:** "What do you think about DNACPR orders?"

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### Model Answer

"DNACPR stands for *Do Not Attempt Cardiopulmonary Resuscitation*. It's a medical decision made when CPR is unlikely to succeed or would cause more harm than benefit - for example, in frail or terminally ill patients.

The aim is to **preserve dignity**, **avoid unnecessary suffering**, and ensure care focuses on the patient's **comfort and wishes**.

These decisions should always involve **honest, sensitive discussions** with the patient whenever possible, and with their family or carers if the patient lacks capacity. Clear documentation and communication with the whole healthcare team are essential to avoid confusion or distress."

---

# 5. Resource Allocation & Justice

## What it means

- The **NHS has finite resources**, so it cannot fund every possible treatment.
- Doctors, managers, and policymakers must make **fair, evidence-based decisions** about how to allocate limited funds.
- The principle of **justice** in medical ethics means **distributing resources fairly** - balancing individual needs with the needs of the wider population.

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## Examples

- **Cosmetic surgery** for non-medical reasons → usually **not funded**, as it doesn't address health outcomes.
- **Expensive new cancer drugs** → may only be offered to patients meeting strict criteria if evidence of benefit is limited or cost-effectiveness is low.
- **NICE** (National Institute for Health and Care Excellence) plays a key role in deciding which treatments provide the best value for the NHS.

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## Example Interview Q

**Q:** "Should the NHS fund obesity surgery?"

**Model Answer:**

> "Obesity surgery is expensive, but it can be **life-saving** and **cost-effective long-term** by reducing complications such as diabetes and heart disease.
>
> I think it's fair to fund it in **selected patients** where lifestyle changes haven't worked and there's clear clinical benefit.
>
> However, the NHS should also focus on **prevention**, promoting healthier diets, exercise, and public health measures to reduce the need for surgery in the first place."

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This link to prevention is so important as you need to think about the NHS 10-year plan. Prevention is at the forefront of the NHS 10-year long plan as it is the healthiest way to help people maintain good health as well as being the most cost effective.

# 6. Famous Ethical & Legal Cases

## Charlie Gard (2017)

- Baby born with a **rare mitochondrial genetic disorder** causing severe brain damage.
- His **parents wanted experimental treatment** in the US, which the NHS would have to pay for
- **Doctors believed** further treatment would only **prolong suffering** with no realistic chance of improvement.
- The case went to **court**, which ruled that treatment should **cease in the baby's best interests**.

**Why it matters:**

- Highlights the **ethical conflict** between **parental autonomy** and **doctors' duty of beneficence and non-maleficence**.
- Shows the role of the **courts** in deciding complex cases involving a child's best interests when families and clinicians disagree.

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## Jehovah's Witnesses (SUPER DUPER IMPORTANT)

- Members of this faith may **refuse blood transfusions** on religious grounds.
- If an **adult has capacity**, their refusal - even of a **life-saving treatment**- must be **respected** (autonomy).
- If the patient **lacks capacity** or is a **child**, doctors must act in the patient's **best interests**, which may involve seeking a **court order** to proceed with transfusion, against a parent's wishes

**Why it matters:**

- Demonstrates the balance between **autonomy** and **beneficence** - autonomy choosing not to have life saving treatment and beneficence in making sure that people are being saved.

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- Emphasises the importance of **capacity assessment** and **respect for individual beliefs** within ethical and legal boundaries.

# Medical Ethics — Key Cases & Patient Safety

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## Harold Shipman (GP Murderer, 2000s)

### What happened

- Shipman was a GP who **murdered more than 200 patients** by giving **lethal doses of morphine** and falsifying records to conceal his crimes. He also made patients give him their inheritance to basically get more money

### What changed afterwards

- **Tighter regulation of controlled drugs** and prescription monitoring.
- Introduction of **the Revalidation system (2012)** - all doctors must regularly demonstrate to the **GMC** that they are **up to date, competent, and fit to practise**.
- Stronger systems for **monitoring mortality patterns (how many people die)** in primary care (GP's)
- Changed the rules so GP practices must have minimum 2 partners - before 1 partner was all that was needed - to ensure at least 1 partner was present that could keep an eye on the other.

### Why it matters

- Exposed how **trust and professional autonomy** can be abused → Link back again to how if patients don't trust doctors → WOnt say everything about diseases → Will be more likely to get more seriously ill and therefore have a greater burden on the NHS etc.

- Led to lasting reforms to improve **accountability, oversight, and patient safety**.

**Example Interview Q**

**Q:** "What did the Shipman case change about the way doctors are regulated?"

**Model Answer:**

> "Shipman's crimes showed how vulnerable patients can be when trust is abused.
> It led to reforms such as **stricter prescription controls** and the **GMC's revalidation process**, ensuring doctors regularly prove they're competent and safe to practise.
> These measures help **protect patients and rebuild public trust** in the profession."

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## Dr Bawa-Garba (2015)

**What happened**

- A **paediatric trainee** convicted of **gross negligence manslaughter** after **Jack Adcock**, a 6-year-old with sepsis (fatal disease), died under her care.
- She thought that there was a DNACPR but actually there wasn't and she left Jack without CPR for 6 minutes after he had a cardiac arrest. If they had given that CPR he would have still been alive.
- Multiple **systemic failures** were involved: IT breakdowns, staff shortages, and lack of senior support.

**Controversy**

- Many doctors felt she was **unfairly blamed for wider NHS failings**.
- Raised concerns about a **"blame culture"** that discourages openness and learning from mistakes → Not helpful to a doctors training is it

**What changed afterwards**

- Recognition that **patient-safety incidents often reflect system errors**, not just individual fault.

- **GMC's handling** of the case was **reviewed**; emphasis shifted toward **a learning culture** rather than punishment.

**Why it matters**

- Highlights the balance between **individual accountability** and **system responsibility**.
- Reinforced the importance of **just culture** in improving patient safety and morale among healthcare staff.

**Example Interview Q**

**Q:** "What did the Bawa-Garba case teach us about patient safety?"

**Model Answer:**

"The case showed that tragic outcomes can result from both human error and systemic pressure.
True patient safety depends on a **learning culture**, not one focused solely on blame.
Supporting doctors to speak up and learn from mistakes ultimately **protects patients and improves care**."

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# Personal Qualities

## Why This Matters

Medical schools are looking for **future doctors**, not just high-achieving students.

They want candidates who are:

- **Empathetic and reflective**
- **Resilient under pressure**
- **Strong communicators and team players**
- **Motivated by genuine reasons**, not prestige or money

You must show **who you are**, **what you've learned from your experiences**, and **how you'll embody NHS values** such as compassion, integrity, and teamwork.

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## 1. Why Medicine?

### What they're really asking

- Do you **understand the realities** of being a doctor - both the challenges and the rewards?
- Are your **motivations genuine**, long-term, and well-informed?
- Have your experiences given you **insight into the profession**, not just admiration?
- How are you suited to taking on this profession?

### How to answer

- Use **specific experiences** (e.g. shadowing, volunteering) to demonstrate understanding.
- Highlight **key skills** that attracted you - e.g. lifelong learning, teamwork, problem-solving.
- Show **balance** - acknowledge challenges such as emotional pressure, long hours, and responsibility.
- Reflect on **how your experiences confirmed** your motivation.

### Examples to use

- GP or hospital work experience → observing continuity of care and doctor–patient relationships.
- Volunteering in healthcare → seeing teamwork and compassion in action.
- Academic interest in science and problem-solving (Very important for Oxbridge!)

### Reflection prompts

- What moment made medicine feel “right” for you?
- What did you observe about the doctor–patient relationship?
- What difficulties did you see doctors face? How did they handle them?

### Model answer

“I want to study medicine because it brings together my love for science with my desire to make a tangible difference in people’s lives. On my GP placement, I observed a doctor explaining diabetes management in a simple, compassionate way that helped a patient feel empowered rather than judged. That experience showed me how communication can directly affect patient outcomes. I’ve also seen the pressures doctors face - the emotional demands, long hours, and constant learning - but those challenges have strengthened my motivation. For me, medicine is about applying knowledge to real people’s lives and growing through service.”

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## 2. Empathy - Arguably the most important soft-skill

### What it means

- **Empathy**: understanding and trying to see a perspective from another person’s feelings/perspective
- **Communication**: the ability to explain clearly, listen actively, and adapt to different audiences.

Both are essential for building trust and ensuring safe, compassionate care.

### How to answer (e.g How have you shown empathy?)

- Use examples where you **actively listened**, **responded sensitively**, or **adapted your communication style**.
- Reflect on **how empathy or listening improved the situation**.
- Avoid clichés - show how you applied empathy practically.

### Examples to use

- Volunteering with elderly patients → listening and providing comfort.
- Mentoring younger students → simplifying complex information.
- Retail or customer service → staying calm and professional under pressure.

### Reflection prompts

- When did you have to comfort or support someone emotionally?
- When did you explain something complex in a simpler way?
- How do you make sure people feel heard?

### Model answer

"During my time volunteering in a care home, one resident became upset about moving away from her family home. My instinct was to offer solutions, but I realised what she needed most was someone to listen. I sat with her, gave her space to talk, and acknowledged her feelings. That experience taught me that empathy isn't about fixing problems - it's about presence, patience, and understanding. I've since applied that in daily life by practising active listening, which I know will be vital in building trust with future patients."

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## 3. Resilience & Coping with Pressure

### What it means

- **Resilience** means maintaining composure and effectiveness despite setbacks or stress.
- Medicine is high-pressure - resilience allows doctors to learn from mistakes and adapt constructively.

### How to answer (e.g. Why is resilience important?)

- Use examples that show you faced **a genuine challenge** - not something trivial.
- Focus on your **coping strategy** and **growth afterwards**, not just the problem itself.
- Show **self-awareness** and willingness to learn.

### Examples to use

- Overcoming an academic setback or poor exam result.
- Managing multiple commitments (school, work, sport).
- Facing rejection and learning to persevere.

### Reflection prompts

- What's the biggest challenge you've faced, and how did you manage it?
- How do you deal with stress now compared to before?
- What personal qualities help you stay grounded?

### Model answer

"During Year 12, I struggled with time management and underperformed in my first set of exams. Rather than seeing it as failure, I analysed what went wrong - I lacked structure and balance. I built a study plan, asked for feedback from teachers and incorporated short breaks to avoid burnout. My grades and confidence improved significantly. That experience taught me that resilience is not about avoiding setbacks, but about adapting, reflecting, and improving. Medicine is challenging, and I know I'll face pressure again, but I've developed tools to manage it effectively."

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## 4. Teamwork

### What it means

- Doctors work within **multi-disciplinary teams (MDTs)** - effective teamwork means collaborating with others for the patient's benefit.
- Good team players **listen, communicate, adapt, and support** others, not just lead.

### How to answer (e.g. How are you a good team player?)

- Use an example showing both **contribution** and **collaboration**.

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- Highlight communication, respect for different roles, and learning from others.
- Reflect on what makes a team function well.

### Examples to use

- Sports teams or student leadership.
- Group projects or debates.
- Observing MDT meetings during work experience.

### Reflection prompts

- When have you resolved conflict or disagreement within a team?
- Have you supported a struggling teammate?
- What makes a leader effective?

### Model answer

"As captain of my football team, I quickly learned that leadership is about collaboration, not control. In one match, a teammate was struggling after missing a key goal. I encouraged him, adjusted our strategy, and focused on keeping morale high. We ended up winning, but more importantly, the experience taught me that strong teams succeed because members support each other. In medicine, teamwork means recognising everyone's contribution - from nurses to consultants - to deliver the best patient care."

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## 5. Reflection & Self-Awareness

### What it means

- **Reflection** is the ability to analyse experiences, identify strengths and weaknesses, and act on feedback: so crucial for doctors!!
- **Self-awareness** helps doctors recognise limits and seek support when needed - essential for patient safety and lifelong learning.

### How to answer: (e.g. Give a time where you had to reflect)

- Describe a situation that didn't go as planned.
- Explain **what you learned**, **what you changed**, and **how you improved**.

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- Show maturity and openness to feedback.

### Examples to use

- Academic or extracurricular feedback.
- Work or volunteering situations where you adjusted your approach.
- Learning from observing reflective practitioners.

### Reflection prompts

- When did feedback change how you worked?
- What have you learned about your strengths and weaknesses?
- How do you ensure you're improving continuously?

### Model answer

"In a Year 13 presentation, I spoke too quickly and lost my audience. Afterwards, I reflected on my performance and asked for feedback. I realised that nerves made me rush, so I practised pacing and using pauses for emphasis. In my next presentation, I slowed down and received positive feedback. This showed me that reflection is about awareness and action - recognising what to improve and making tangible changes. That mindset is essential in medicine, where reflection drives safer, better care."

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## 6. Integrity & Honesty

### What it means

- Integrity is **doing the right thing, even when it's difficult or unnoticed**.
- Honesty builds **trust between doctors, patients, and colleagues** - it's vital for ethical practice and patient safety.
- Integrity is not just limited to a profession, it is something interviewers may test in a university setting scenario etc: e.g. a 2nd year medic passes down a suspected mark scheme to your friend (1st year) for an exam. What will you do?
- Tips: Cheating is not allowed. Even if you think you may get away with it (which you probably won't) it is wrong to go ahead. Habits at uni pave the way for a career in the hospital. Also, ensure that you maintain empathy and try to find out if your friend is

facing any difficulties which may have led to them asking for a mark scheme etc…

## How to answer (2nd year medic mark scheme scenario)

- Tips: Cheating is not allowed. Even if you think you may get away with it (which you probably won't) it is wrong to go ahead. Habits at uni pave the way for a career in the hospital. Also, ensure that you maintain empathy and try to find out if your friend is facing any difficulties which may have led to them asking for a mark scheme etc…
- Reflect on why honesty matters more than self-protection.
- Link integrity to patient trust and professional standards.

## Examples to use if prompted

- Standing up for fairness or ethical conduct.
- Being trusted with responsibility (e.g. mentoring, money-handling, safeguarding).

## Reflection prompts

- When did honesty make a difference in an outcome?
- How does integrity influence teamwork?
- What would happen if trust were broken in medicine?

## Model answer

"While working part-time in retail, I once gave a customer the wrong change. I realised immediately and admitted the mistake, even though it was uncomfortable. The customer appreciated my honesty, and my manager later commended me for it. That moment reinforced how integrity builds trust and prevents small issues from becoming bigger ones. In medicine, honesty is even more critical - patients place their lives in your hands, and trust is the foundation of every clinical relationship."

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## Final Takeaway

Each of these attributes - motivation, empathy, resilience, teamwork, reflection, and integrity - links back to the **GMC's "Good Medical Practice"** and **NHS core values**.

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When answering, always:

1. **Use real experiences** - even small ones.
2. **Reflect on what you learned.**
3. **Connect it back to medicine** - how it'll make you a better future doctor.

# High-Yield Interview Questions (with Example Answers)

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### Q1: *"What qualities make a good doctor?"*

**Model Answer:**
"A good doctor combines knowledge with compassion. They listen to patients, communicate clearly, and work well in a team. They must also be resilient, because medicine can be stressful, and honest, because patients need trust."

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### Q2: *"Tell me about a time you showed empathy."*

**Model Answer:**
"While volunteering in a care home, I met a resident who felt anxious about losing independence. Instead of rushing, I listened to her worries. I realised empathy isn't just about feeling sorry, but about understanding and supporting without judgement."

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### Q3: *"When have you worked in a team?"*

**Model Answer:**
"In my school science project, our team initially clashed about roles. I suggested dividing tasks based on strengths, which made us more effective. This showed me that good teamwork means recognising others' skills as well as contributing your own."

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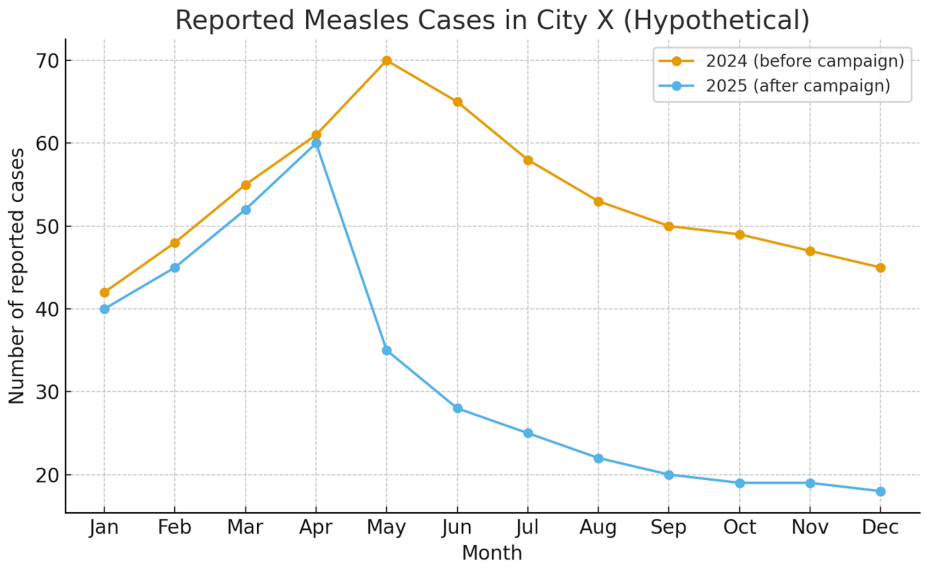
## Q4: *“How do you deal with stress?”*

**Model Answer:**
“I manage stress by breaking tasks into smaller goals and keeping active with exercise. For example, during A-level mocks, I felt overwhelmed, but daily gym sessions helped me stay balanced. This taught me resilience and the value of healthy coping strategies.”

# Graph Question Example:




(*Public health campaign)

**1. Describe** the trends in measles cases for both years.

2. What likely public health intervention happened in **May 2025**? Justify your answer using the data.

**3. Calculate** the percentage reduction in cases from **May 2024** to **May 2025**, and comment on its significance.

4. Give **two reasons** why cases do **not** fall to zero even after the campaign.

5. If you were a public health doctor, what **one further measure** would you recommend to sustain/improve these results?

6. How could this data be **misleading** if presented to the public without context?

## Graph Question guidance:

**1. Describe the trends in measles cases for both years.**

In 2024, cases start fairly low in January (around the low 40s) and steadily rose, peaking in May at about 70 cases. After May, they gradually fall but stay in the 40–50 range for the rest of the year. So 2024 shows a classic "build-up → peak → slow decline" pattern.

In 2025, the pattern is similar at first - Jan to April climbs from about 40 to 60 - but from **May 2025** onwards there is a sudden and marked drop, from about 60 down to the 30s and then into the low 20s by late summer/autumn. After that, the numbers stabilise at a much lower level than 2024. So the key message: **2025 follows 2024 until May, then dramatically improves.** That's what you should say out loud.

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**2. What likely public health intervention happened in May 2025? Justify your answer using the data.**

The most likely explanation is **a targeted measles vaccination / MMR catch-up campaign** starting around May 2025. We know this because the fall is:

- sudden (right after May),
- large (almost halved),
- and sustained (stays low for months).

Random variation doesn't usually give you that clean a drop. A public-health intervention - e.g. school-based MMR drive, calling in under-immunised children, outbreak control measures - does. So you justify it by saying: "The timing of the fall directly follows May 2025, so the intervention must have been introduced then."

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**3. Calculate the percentage reduction in cases from May 2024 to May 2025, and comment on its significance.**

May 2024: **70 cases**

May 2025: **35 cases**

Change = 70 − 35 = **35 fewer cases**

Percentage reduction = (35 ÷ 70) × 100 = **50%**

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That's a **very** clinically and public-health significant fall: halving monthly cases in one year suggests the intervention was effective and worth continuing/funding. In an MMI, add one sentence like: "A 50% reduction in one month for a vaccine-preventable disease is a strong indicator of successful outbreak control."

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**4. Give two reasons why cases do not fall to zero even after the campaign.**

First, **no vaccine programme reaches 100%** - some children miss appointments, some parents refuse, some are migrants/new arrivals without records. That leaves a small susceptible pool.

Second, **measles is highly infectious**, so even imported/sporadic cases can still cause small numbers, especially in households or schools with pockets of low coverage.

You could also mention waning immunity, delayed effect in certain age groups, or under-immunised communities - any of those would be acceptable.

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**5. If you were a public health doctor, what one further measure would you recommend to sustain/improve these results?**

A good answer links to **coverage**. For example:

"I would introduce an ongoing recall-and-reminder system through GP practices and schools for unvaccinated or partially vaccinated children, focusing on high-risk postcodes."

That's good because it's targeted, realistic and explains **how** you'd keep numbers low. You could also say community outreach to groups with lower uptake, but make it concrete - not "raise awareness" in the abstract.

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**6. How could this data be misleading if presented to the public without context?**

Several ways. If you show just the post-May 2025 line, people might think "measles is over" and stop vaccinating — but the lines show it's **reduced, not gone**. Also, it's one city, so it can't be generalised to the whole UK. And we don't know about changes in **testing/reporting** - if reporting got stricter in 2024 and more routine in 2025, part of the change could be artefact, not biology. So you'd say: "Without context on population, testing, and vaccine uptake, the graph could overstate success."

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### Quick guidance (what examiners want on graph/data MMIs)

1. **Describe before you explain.** Start with: “In 2024… in 2025…” - don’t jump straight to “vaccines worked”.
2. **Reference the actual numbers.** Saying “it went down a lot” is weaker than “from 70 to 35 - a 50% reduction.”
3. **Name the most plausible public-health intervention.** For vaccine-preventable infections, say “vaccination / catch-up MMR”.
4. **Show you understand real life = imperfect.** “Doesn’t go to zero” is a nice public-health maturity signal.
5. **Mention limitations.** “Single area”, “possible reporting bias”, “seasonality” - that’s higher-level thinking.

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### Extra Top tips for graph questions

- **Say what you see.** One sentence per axis: “X-axis is months, Y-axis is case numbers.”
- **Compare, don’t just list.** “2025 follows 2024 until May, then diverges.”
- **Offer a reasonable hypothesis, not a wild one.** Vaccination > weather (Simple I know)
- **Finish with impact.** “This matters because sustained low numbers reduce outbreaks and pressure on paediatric doctors in the NHS.”

# General advice on graph/ application questions

Universities might throw you a curve ball, including not only graphs, but diagrams, photos, statements, or questions you may have never prepared for.

But there are certain ways you can improve your chance of giving a better response:

→ Describe what you see in a photo (Stick to basics first)

→ Then gradually build up your response, linking topics you are aware of (example later on)

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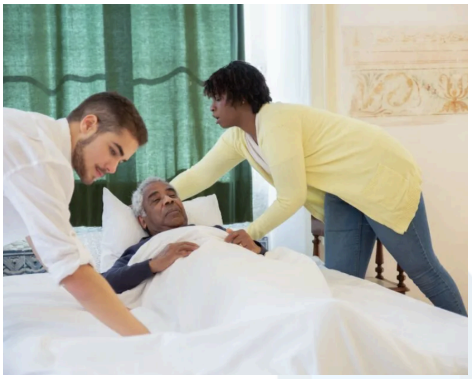
→ Always use key phrases where appropriate (4 pillars etc)

→ Do not jump to conclusions (e.g. a photo of someone with a rash MUST be measles: NOT appropriate, even if you are correct)

→ Always explain your reasoning, even if you are mentioning simple or obvious points

*Example: Describe what you see in the photo. Can you link this to any themes in the NHS?*



**Describe what you see:**

- "There is an older male patient in a hospital bed."
- "Two members of staff (likely healthcare assistants/nurses) are helping him sit up/adjust in bed."
- "It looks like a ward setting in the NHS, based off the bed etc"

**Interpret what's happening:**

- "This looks like supportive/care work for a frail or dependent patient."
- "He may have mobility issues or be recovering from illness/surgery."

**Link to NHS themes (pick 2–3, not all):**

- **Caring for an ageing population / bed blocking:** "Older, dependent patients often stay longer → pressure on beds and flow."
- **MDT value:** "Two staff working together safely - shows that good care isn't just doctors, HCAs/nurses are essential to achieve optimum patient care."
- **Staffing / lack of doctors:** "This is care that doesn't need a doctor, so using the wider workforce is efficient."

- **BAME health / diversity:** “The workforce appears diverse - reflects NHS as an inclusive employer and improves cultural competence.”
- **Resource allocation / efficiency:** “Hands-on care like this takes time → highlights pressure on wards when staffing is low.”
- **Innovation / AI:** “Some of this lifting/monitoring could be supported by tech/AI/assistive devices to reduce staff injury and free time for clinical work.”

**Add a safety/patient-centred note:**

- “I’d make sure the patient is told what we’re doing and that consent is gained.”
- “Safe moving & handling protects both patient and staff.”

THe best way is think about it is from MACRO to micro → THis way look at the outer most obvious things in the picture and then hone in on the smaller details like facial expressions, clothe stains, light, scars etc.

# Mathematical Skills (Exact Steps & Worked Examples)

### Why it matters

Interview stations often test your ability to calculate **accurately** under time pressure. The test isn't testing your speed and it's more about:

- **Method** (can you set it up correctly?)
- **Units** (mg vs micrograms, mL vs L)
- **Safety** (does the answer make clinical sense?)

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## A) Unit Conversions & Ratios (the foundation)

**Must-know conversions**

- 1000 micrograms (ug) = **1 mg**
- 1000 mg = **1 g**
- 1000 mL = **1 L**
- % solutions = **g per 100 mL** (so 1% = 1 g/100 mL = **10 mg/mL → Think 1g = 1000mg. So 1g/100mL = 1000ug/100mL → divide both sides by 100 → 10ug/mL**)

**"1 in X" solutions (classic interview trap)**

- "1 in 1000" adrenaline = **1 g in 1000 mL = 1 mg/mL**
- "1 in 10,000" = **0.1 mg/mL**

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## B) Dose by Weight (mg/kg)

**Template (always do this order)**

1. Required dose = **(mg/kg) × (weight in kg)**

2. Compare to the maximum **dose** (if given) - this is basically the largest dose that can be injected into a person FULL STOP, no matter the weight.
3. If a liquid: convert mg → **mL** using the stock concentration.
4. **Sanity-check** (does the volume look reasonable?).

**Worked example**
Order: **7.5 mg/kg** for a **32 kg** child. Max single dose **300 mg**. Stock: **100 mg/5 mL**.

- Step 1: Dose = 7.5 × 32 = **240 mg**
- Step 2: Max is 300 mg → **240 mg is below max ✔**
- Step 3: Stock 100 mg in 5 mL ⇒ **20 mg/mL (20mg per 1mL essentially)** → Volume needed = 240 ÷ 20 = **12 mL**
- Step 4: Sanity-check: 12 mL is a reasonable oral volume.

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# C) Dilutions & Reconstitution

**Template**

1. Find the **concentration** after reconstitution (fancy word for dissolving powder into water to then make a solution)
2. Use **Volume = Required dose ÷ Concentration**.

**Worked example**
Vial: 500 mg, reconstituted to 10 mL → **50 mg/mL**.
Required dose: **250 mg** → Volume = 250 ÷ 50 = **5 mL**.

**% solution example (% indicated how much of solution is the dissolved solid → 2% is comparing it to 1g → 2% of 1g is 0.02g = 20mg)**
Lidocaine 2% = **20 mg/mL**. Need **50 mg** → 50 ÷ 20 = **2.5 mL**.

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# F) Percentages, Ratios & Changes

**Percentage change**

- % change = (Final - Original)/Original x100

Easy way to remember this is:

For % increase → Put the higher number first (in the place of the 'Final')

For % decrease → Put the lower number first (in the place of the 'Final')

**Worked example**

Admissions rose from **250** to **300**:

- Change = 300 − 250 = **50**
- % change = 50 ÷ 250 = 0.2 = **20% increase**

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# GMC Qualities of a Doctor

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### Why it matters

The main guidance comes from **Good Medical Practice.**
Every doctor must follow these principles to maintain trust, deliver safe care, and protect patients.

There are 6 sections. You don't need to memorise the whole thing rather, what I'd recommend is look at what is there, be familiar for it and for each section memorise one sentence that you could link really nicely to a couple of things that you would mention in other answers → e.g. Doctors need to take prompt action if patients safety is at risk → Something that was not done in the case of Lucy Letby etc.

Doctors know these values like the back of their hand, so if you know a few they will be really impressed!

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## 1. Knowledge, Skills, and Performance

**Meaning:**
Doctors must keep their medical knowledge and skills up to date and work within their competence.

**What this means for students:**

- Admit when you don't know something - it's safer to ask for help than to guess.
- Always aim for continuous improvement through reflection.
- Build habits of lifelong learning - mention as a reason why you want to be a doctor as well

**Link for interviews:**
If asked about mistakes, reflection, or resilience — mention that the GMC expects doctors to learn from experience and seek guidance when needed.

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## 2. Safety and Quality

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**Meaning:**
Doctors must take prompt action if patient safety is at risk.

**What this means for students:**

- If something doesn't seem right, speak up.
- Reflect and learn from incidents to prevent repetition → so important

**Interview tip:**
This directly applies to **ethical and SJT-style questions** like the drunk consultant, confidentiality breaches or unsafe care. Always show that **safety comes first.**

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## 3. Communication, Partnership, and Teamwork

**Meaning:**
Doctors should listen, communicate clearly, and work collaboratively with colleagues and patients.

**What this means for students:**

- Listen actively and respect every patient's perspective - religion, gender etc
- Communicate at the right level (avoid fancy words).
- Value every team member - nurses, porters, receptionists all contribute to patient care.

**Interview tip:**
Use this section when answering **teamwork, empathy, or roleplay** questions.
Show you can balance authority with respect and kindness.

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## 4. Maintaining Trust and Professionalism

**Meaning:**
Doctors must act with honesty, integrity, and treat patients with dignity.

**What this means for students:**

- Always maintain patient confidentiality.

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- Never falsify records or attendance (ties into scanning friends into lecture scenarios).
- Be aware of your behaviour on social media - it still reflects professionalism → By this I mean don't share patient identifiable information (name, DOB, address, description of appearance etc)

**Key GMC principles to remember:**

- **Do not abuse your position of trust.**
- **Be honest if something goes wrong.**
- **Respect cultural, social, and personal differences.**

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## 5. Leadership and Accountability

**Meaning:**
Every doctor is a leader in some capacity - taking responsibility for decisions, supporting colleagues and improving services.

**What this means for students:**

- Take ownership of your learning and behaviour.
- Support your peers and contribute positively to group work.
- Reflect on how your actions impact the wider team.

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## 6. Reflective Practice

**Meaning:**
Reflection is at the heart of professionalism - learning from experience to improve.

**What this means for students:**

- Reflect after volunteering, mistakes, or feedback.
- **Don’t just describe what happened - explain what you learned and how you’ll change next time → GOLD DUST RIGHT HERE!!!**

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**Interview link:**
If asked *"Tell me about a time you learned something about yourself,"* always use **reflection** and link to growth.

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## How to Use GMC Qualities in Interviews

When answering **ethical, SJT, or reflection questions** try to base your response on GMC values.

**Example Q:** "How would you handle a disagreement with a senior?"
**Model Answer Starter:**

> "I'd remain respectful but prioritise patient safety. The GMC advises that if you believe a patient is at risk, you should raise your concern through appropriate channels, even if it's uncomfortable ...."

# Last bit of advice from us:

Use this guide as a reference when practicing interview questions. It is not intended to tell you verbatim what to say, but instead give a framework which allows you to structure and articulate a full, genuine answer at any given time, no matter what the question may be.

We have interviewed countless students and know what qualities of an answer are required for entrance into med/dental school.

So do the work, use this guide to help you, and ensure you do mock practice interviews, not just with your buddies, but with interviewers who know what is required. If you are interested in doing a mocks with us, led by students with medical school offers from Oxford, Cambridge, UCL, Newcastle, Birmingham and many more, then go to our socials (TikTok, Instagram) and DM or simply email us.

The best of luck to anyone embarking on this journey! Do the work and have the confidence.

Aftab Baquer and Ammar Soni (Co-founders BaqsonMed)

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***Some sections of this guide were drafted or refined using AI writing assistance under human supervision. All factual content has been independently verified by the BaqsonMed editorial team.***

***Extra references***

# References

【3】NHS Digital. *Statistics on Obesity, Physical Activity and Diet, England 2024.*
【4】Public Health England. *Health matters: obesity and the food environment.* 2021.
【5】ONS. *Adult mental health statistics, 2024.*
【6】NHS England. *CAMHS waiting time data.* 2024.
【7】McKinney et al. *International evaluation of AI for breast cancer screening.* Lancet 2020.
【8】NHS England. *Virtual wards: delivering hospital-level care at home.* 2023.
【9】Marmot Review 10 Years On. *Health Equity in England.* 2020.
【10】MBRRACE-UK. *Mothers and Babies: Reducing Risk.* 2022.
【11】WHO. *Global antimicrobial resistance report.* 2019.
【12】O'Neill, J. *Tackling Drug-Resistant Infections Globally.* 2016.
【13】NHS England. *Impact of industrial action: cancelled appointments.* 2023.
【14】NHS Staff Survey. *National results 2024.*