The Room You're Walking Into

A PLAB 2 candidate's guide to the unwritten rules of the UK consultation

An AMaC performance guide.

Why this guide exists

You did not get this far by being a weak doctor. You passed the written exam. You have examined more patients than most UK graduates your age. If PLAB 2 were a test of medical knowledge, you would walk it.

It isn't. And that is exactly why good doctors fail it.

PLAB 2 marks a **consultation style** — a particular way of being in the room with a patient — and that style is culturally specific to UK practice. It is not taught anywhere explicitly, because the people who designed it grew up inside it and assume everyone shares it. Most PLAB candidates did not grow up inside it. So they walk into the station with excellent medicine and an instinct for how a good doctor behaves — an instinct that served them brilliantly at home — and that instinct quietly costs them marks they never see being deducted.

This guide makes the invisible visible.

How to read this — the only frame that matters

Read this as a **professional register you switch into**, not a verdict on how you were trained.

A British doctor who went to practise in Karachi, Lagos, Cairo or Manila would have to learn an entirely different consultation style to be trusted there — and their UK habits would read as cold, evasive, or strange. They would not be a worse doctor. They would be in a different room with different rules. That is your situation in reverse.

So nothing in this guide says your way is wrong, or that where you come from is a problem. The respected, decisive, family-centred doctor you may have trained to be is a *good* doctor. This guide simply hands you the rules of one specific room — the UK exam, and the NHS it prepares you for — so that your real competence actually shows on the day, instead of being hidden behind a style the examiner wasn't trained to reward.

You are not changing who you are. You are learning the room.

> **A note on how this is written.** We talk throughout about *the instinct a candidate may bring* and *what the UK room rewards* — never about "doctors from country X." PLAB candidates come from dozens of countries that share almost nothing culturally, and the patterns below show up across all of them and in plenty of UK graduates too. Take what rings true for you; ignore what doesn't.

1. From "the doctor decides" to "we decide together"

This is the big one. If you change only one thing, change this.

In much of the world, the respected doctor is decisive. The patient comes precisely *because* you will tell them what is wrong and what they must do. Hesitation or offering choices can read as weakness — as if you don't know. Patients trust the doctor who takes charge.

UK medicine is built on the opposite instinct: **patient autonomy**. The patient is the decision-maker; you are the expert adviser who informs and supports their choice. The whole consultation is a partnership.

In practice the UK room expects you to:

- **Ask for their ideas, concerns and expectations** — what they think is going on, what they're worried about, what they were hoping for. (You will hear this called *ICE*. Examiners look for it explicitly.)
- **Offer options rather than issue instructions** — "there are a couple of things we could do here" not "you will take this."
- **Share the decision** — "how does that sound to you?", "what matters most to you?"
- **Check understanding** — "just so I know I've explained it clearly, what will you tell your wife when you get home?"

What scores zero: confidently telling the patient what is going to happen without ever asking what *they* think or want. To you this may feel like competence and reassurance — you are taking charge, as a good doctor should. To a UK examiner it reads as failing to involve the patient, and it sinks more candidates than any clinical gap in the exam.

> **Say this:**
> "From what you've told me, I'm thinking this is most likely a chest infection. There are a couple of ways we could approach it — can I talk you through them, and we'll decide together what suits you best?"
> **Not this:**
> "You have a chest infection. Take these antibiotics for five days and come back if it's not better."

The second sentence is not wrong medicine. It is wrong *room*.

> **One important exception — the emergency.** Everything above is about the *consultation*. It does not apply when a patient is acutely unwell in front of you. In a genuine emergency — anaphylaxis, sepsis, a peri-arrest, a collapsing patient — decisiveness *is* the marked behaviour. You take charge, you act, you lead the team, and you explain afterwards. The shift from "decide for" to "decide with" is about consultations, not resuscitations. Part of learning the room is knowing which room you're in: the calm clinic where you share the decision, or the emergency where the patient needs you to make it.

Name the safety-net — out loud. Notice that the good example above ends on a quiet but heavily marked move: *"come back if it's not better."* That's **safety-netting**, and the UK room rewards it explicitly — so don't let it slip out as an afterthought. Tell the patient what you expect to happen, what would be reassuring, and exactly what should bring them back or prompt urgent help. Be specific: not "come back if you're worried," but "if the breathlessness gets worse, or you start coughing up blood, or the fever climbs again, I want you to call us or come straight back." It shows the examiner you've thought past this moment to what happens next — which is precisely what a safe junior doctor does.

> **Say this:**
> "I'm not expecting this to happen, but if you develop a severe headache, neck stiffness, or a rash that doesn't fade when you press a glass against it, don't wait — call 999 or come straight to A&E."

2. The patient is the centre — not the family

In many cultures, serious news goes to the family first. You protect the patient — especially an elderly patient, or a woman — by speaking to the husband, the son, the parents. Doing so is an act of respect and kindness.

In UK practice this instinct, applied unchanged, becomes a serious error.

The competent adult patient is the centre of their own care:

- **You tell the patient, not the family.** Breaking bad news to relatives before a competent patient knows is a real failure, not a kindness.
- **You do not disclose to a spouse, parent or adult child without the patient's consent.** "Is there anyone you'd like to be with you when we talk?" is the right move — offered to the patient, their choice.
- **Confidentiality belongs to the patient.** A worried daughter on the phone is not automatically entitled to her father's results.

The capacity exception — don't over-correct. All of the above assumes a patient who *has capacity* to make their own decisions. When a patient genuinely lacks capacity — through dementia, delirium, unconsciousness, severe learning disability — the rules change, and involving the family becomes correct rather than a breach. Here you act in the patient's **best interests**, and that explicitly includes consulting those close to them about what the patient would have wanted. So the skill is not "never involve the family" — it is knowing *which* patient is in front of you. A competent adult: the patient decides, and you protect their confidentiality. A patient without capacity: you make a best-interests decision *with* the family's input. PLAB 2 tests both, and it tests whether you can tell them apart.

This one genuinely catches people out, because doing the warm, respectful thing you were raised to do is the wrong thing here — and it can be an **instant fail** in a confidentiality or breaking-bad-news station.

> **Say this (to a relative asking for information):**
> "I can completely understand why you want to know, and it's clear how much you care about him. I'm sure you'll appreciate that I can only share his medical details with his permission — but I'd encourage you to talk to him directly."
> **Not this:**
> quietly telling the daughter the diagnosis because she seems sensible and worried.

3. Use an interpreter — not the family

If a patient's English isn't strong enough for the consultation, the instinct in many settings — and the kind, efficient one — is to let the adult son or the husband translate. They're right there, they care, and it's quicker.

In UK practice this is the wrong move, and it's one the exam looks for directly.

You offer a **professional interpreter**:

- **A family member is not a neutral channel.** They may soften bad news, edit what the patient says out of love or shame, answer *for* the patient, or have their own view of what should happen. The patient may also hold things back — a symptom, a fear, a disclosure — precisely *because* their relative is the one translating.
- **It's a confidentiality issue too.** Routing a diagnosis through the worried daughter is the same failure as section 2, just wearing different clothes — the cancer result reaches the family before, and instead of, the patient hearing it cleanly themselves.
- **Children should never interpret.** Asking a child to translate serious or intimate information for a parent is a clear safeguarding and professionalism failure.

The right move is simple: offer the interpreter, and frame it as the patient's right, not an inconvenience.

> **Say this:**
> "I want to make sure we understand each other properly, and that you can say everything you need to — so I'd like to arrange an interpreter for us. Would that be alright? It means nothing gets lost between us."
> **Not this:**
> "Can your son tell me what's been happening?"

The same principle runs underneath this as everywhere else in the guide: the consultation is between *you and the patient*, and the interpreter exists to keep that line clear — not to add a third decision-maker into the room.

4. Say the empathy out loud

This one surprises people most.

In many cultures, empathy is shown through *action* and *presence* — you stay, you help, you carry the burden quietly. Announcing your feelings can seem theatrical, even insincere. A doctor who says "I can see this is upsetting for you" might sound like they're performing.

UK marking expects you to **name the emotion explicitly, in words**:

- "I can see this has come as a real shock."
- "That sounds like it's been incredibly hard to live with."
- "It's completely understandable to feel frightened by this."

Then — crucially — **pause and let it land.** Silence after acknowledging emotion is not awkward here; it is the intervention.

What scores zero: feeling deep compassion and showing it only through your manner, while saying nothing that names the patient's emotion. The examiner cannot mark what you feel. They can only mark what you *say and do*. Silent empathy, however genuine, won't be visible to the examiner unless you also name it.

This is not about faking feeling. It is about translating real feeling into the spoken form the room recognises.

> **Say this:**
> *(patient becomes tearful)* "Take all the time you need. I'm not going anywhere." *(then stop, and wait.)*
> **Not this:**
> ploughing straight into the management plan because you want to be helpful and fix the problem.

5. Softer is safer — the UK register

UK professional speech is **indirect and softened**. To ears trained on direct, efficient clinical communication, it can sound almost evasive — but in this room, directness reads as brusque, and softness reads as respect.

- **Ask permission, don't instruct.** "Would it be alright if I examined your tummy?" not "Lie down."
- **Soften requests.** "I wonder if we might…", "Would you mind if…", "Is it okay if I…"
- **Signpost what you're about to do.** "I'm just going to ask you a few questions about your background, if that's okay."
- **Offer a chaperone for intimate examinations.** Before any intimate examination — breast, genital, rectal — offer a chaperone, explain what the examination involves and why, and get explicit consent. "For an examination like this I'd normally offer to have a chaperone present — a member of staff who

stays with us. Would you like one?" Offering it is the marked behaviour; it reads as safe, professional practice, and its absence is felt even when the patient declines.

- **Use the patient's name, and check how they'd like to be addressed.**

None of this is grovelling. It's the texture of a respectful UK consultation, and examiners feel its absence even when they can't quite name it.

> **Say this:**
> "I'd like to listen to your chest, if that's alright — would you be able to pop your top off for me?"
> **Not this:**
> "Remove your shirt."

The exact words matter less than the two things underneath them: softness and permission. Find a version that feels natural to you.

6. "I don't know" is a safe answer here

In settings where a doctor admitting uncertainty is shameful — a loss of face in front of the patient — the instinct is to always have an answer. Never look unsure. Bluff if you must.

In UK practice, the opposite is true. **Honest uncertainty is good, safe medicine** — and bluffing is dangerous.

- "I'm not certain what's causing this yet, but here's how we'll find out" is a *strong* answer.
- "That's a really good question — I'd want to check with my senior before I give you a definite answer" shows you know your limits, which is exactly what a safe FY doctor does.
- Inventing a confident answer you can't stand behind — a prognosis, a guarantee, a dose you're unsure of — reads as unsafe, and unsafe is the fastest route to a fail.

The UK exam is testing whether you are a *safe* junior doctor, not an all-knowing one. Knowing when to escalate is a competence, not a weakness.

> **Say this:**
> "I don't want to guess at something this important. Let me discuss it with my senior and we'll come back to you properly."
> **Not this:**
> offering a confident timeframe or guarantee to fill the silence.

7. Decoding what patients actually say

This is the half nobody warns you about: not how you speak, but what you have to *understand*. UK patients describe symptoms in lay idiom that may be completely opaque under time pressure — and you can know the medicine perfectly and still miss the symptom because you missed the phrase.

A working glossary you should recognise instantly:

- **"I've been feeling rough / under the weather / not myself"** — generally unwell.
- **"I'm off my food"** — reduced appetite.
- **"My waterworks" / "passing water" / "spending a penny"** — urinary symptoms.
- **"Down below" / "my privates"** — genital/pelvic area.
- **"I've been having a funny do / a funny turn"** — an episode, often collapse, dizziness or a blackout.

- **"My tummy" / "my belly"** — abdomen.
- **"I've come over all dizzy / light-headed"** — dizziness/presyncope.
- **"I've been bringing it back up"** — vomiting.
- **"My waterworks are playing up"** — urinary trouble.
- **"I've gone off my legs"** — reduced mobility, often in an older patient.
- **"He's not right in himself"** — non-specific deterioration (classic in elderly and carers' descriptions).
- **"I feel washed out / done in / shattered"** — fatigue.
- **"It's been giving me gyp"** — it's been causing pain/trouble (more common in older and regional patients).
- **"My heart's been racing" / "I've been having palpitations"** — palpitations.
- **"I feel like I'm going to pass out"** — presyncope (feeling faint).
- **"It came out of the blue"** — sudden onset.
- **"I've been coughing up phlegm / gunk"** — sputum production.

When you don't understand a phrase, **the safe move is to ask** — gently. "When you say a funny do, can you tell me exactly what happened?" Clarifying is good practice and scores well. Guessing wrong does not.

8. The NHS team — and your place in it

The UK has a flat, named professional hierarchy, and how you move within it is marked.

- **Know who's who:** FY1 and FY2 (foundation doctors — your level), then registrars, then the consultant. When you escalate, you escalate to your **senior / registrar / the consultant on call** — name it.
- **Nurses are colleagues, not subordinates.** Speaking down to nursing staff, or ignoring them, reads very badly. "Could I ask one of the nurses to help me with…" is the right register.
- **Escalate early and explicitly.** "This patient is sick — I'd like to call my registrar now" is a strength, not an admission of failure.
- **Duty of candour:** if something has gone wrong, UK practice requires you to be open about it, apologise, and explain what will be done. In cultures where admitting error invites blame or shame, the instinct is to minimise or defend. Here, **a clear, early apology is the professional move** — and concealment is the serious failing.

> **Say this (after an error):**
> "I'm very sorry this happened. I want to be honest with you about what went wrong and what we're going to do to put it right."

9. The signals you're not saying out loud

The non-verbal layer carries marks too, and its norms are specific:

- **Eye contact** is expected and reads as honesty and attention. Avoiding it — even out of respect, as is correct in some cultures — can read here as evasive or disengaged.
- **Personal space:** don't stand too close; ask before you touch; warn before you examine.
- **Sit down** to talk where you can, especially for bad news. Standing over a patient reads as rushed and dominant.

- **Names:** introduce yourself by name and role ("I'm Dr ___, one of the doctors looking after you today"), and ask the patient how they'd like to be addressed rather than assuming.
- **Don't bring assumptions about gender or age into how much you involve the patient** — the quiet elderly woman is still the decision-maker about her own care.

The one principle underneath all of it

Every rule in this guide is really the same rule wearing different clothes:

In this room, the patient is an equal partner, and your job is to inform, involve, and support them — not to take charge of them.

Paternalism vs partnership, family vs patient, silent vs spoken empathy, instruction vs permission, certainty vs honesty — every one of these is the same shift from *the doctor decides for the patient* to *the doctor decides with the patient*. Hold that single idea and most of the specific behaviours follow naturally.

You are not being asked to abandon the doctor you trained to be. You are being asked to step, for the exam and the NHS, into a room with different conventions — and to let your real ability show inside them.

Learn the room. Then walk in and pass.

This is an AMaC performance guide — it teaches how the UK consultation is marked, not the medicine itself. The UK professional standards it describes (autonomy, confidentiality, consent, capacity and best interests, duty of candour) follow GMC Good Medical Practice (2024) and standard UK consultation models.