Morning of the Exam — the Non-Negotiables

Don't revise new content today. Read this once, breathe, and walk in trusting your preparation. In every station, these are the marks you must not leave on the table:

Open every station — Wash hands · introduce yourself · confirm name & DOB · gain consent.
Explore the person — Ideas, Concerns, Expectations — early, and weave them into the plan.
Stay safe first — Treat as you go in ABCDE · act before you talk · escalate early with SBAR.
Screen the red flags — Ask them, name them, and safety-net: what to watch for, when and where to act.
Before any drug — Check allergies · the dose, decimal-safe · ‘units’ in full.
For intimate exams — Offer and document a chaperone — every time.
Think out loud — Say what you see, what it means, and what you'll do — visible reasoning scores.
Close kindly — Summarise · check understanding · safety-net · thank the patient.

You are ready. Be structured, be safe, be kind.

PART

A

The Exam Engine

The universal skills every station is built on — structure, safety, reasoning and communication.

11 cards · 8 ★ must-know

★ MUST-KNOW A1 · The Universal Station Blueprint

CORE · ALL PATHWAYS · the spine of every encounter

BLUEPRINT

INTRODUCE → OPEN → HISTORY (+ red flags) → ICE → SUMMARISE → EXPLAIN → PLAN → SAFETY-NET → CHECK → CLOSE

KEY FRAMEWORKS

ICE — Ideas · Concerns · Expectations — ask early, validate, weave into the plan
Safety-net (4W) — What to watch for · When to act · Where to go · if Worse
Managing uncertainty — "At this stage…" · "Based on what we know so far…"

INSTANT FAIL — WHAT LOSES THE STATION, AND THE LINE THAT SAVES IT

✗ LOSES THE STATION	✓ THE LINE THAT SAVES IT
Rambling / no structure	"Let me structure this — your story, your ideas and concerns, then a plan."
ICE not explored	"What do you think might be going on, and what worries you most?"
Anchoring / premature closure	"What else could this be? Let me check the red flags."
No safety-net	"If X happens, go to Y within Z."
Silent reasoning	"Let me talk you through my thinking…"

MUST-SAY SCORING LINES

"What do you think is happening?" · "What worries you most?" · "What were you hoping I could do?" · "Just to check I've understood…" · "Does that make sense? Anything else you'd like to cover?"

KEY RULE

Timing: intro by 0:20 · ICE + red flags by 2:30 · reasoning 2:30–4:30 · management 4:30–6:30 · close by 8:00.

COMMON MISTAKES

Skipping ICE · anchoring on the first diagnosis · stopping the history too early · running out of time · explaining in jargon.

GOLD CLOSING STATEMENT

"I structured the consultation, explored the patient's ideas, concerns and expectations, shared the plan, and safety-netted clearly."

★ MUST-KNOW A2 · ABCDE & the Golden Minute

CORE · RED PATH · INSTANT-FAIL RISK

BLUEPRINT

Golden Minute (Safety → Responsiveness → Call help → Start ABCDE → Attach monitoring) → A·B·C·D·E, treat as you go → Reassess after every step → Escalate early → Transition

KEY FRAMEWORKS

A — Airway — stridor/gurgling → adjuncts, suction, call anaesthetics
B — Breathing — O_2 only if hypoxic (94–98%, 88–92% if COPD risk); treat PTX/asthma/PE
C — Circulation — IV access · bloods · fluids if shocked · reassess response
D — Disability — glucose first · GCS/AVPU · pupils
E — Exposure — temperature · rash · bleeding · dignity

INSTANT FAIL — WHAT LOSES THE STATION, AND THE LINE THAT SAVES IT

✗ LOSES THE STATION	✓ THE LINE THAT SAVES IT
Full history before stabilising	"I'll stabilise with ABCDE first; history once stable."
Silent assessment	"I'll verbalise each step as I go."
Ignoring abnormal observations	Act on them immediately and say so
No reassessment after a step	"I'll reassess after every intervention."
No escalation	"I'm calling for senior help now."

MUST-SAY SCORING LINES

"Treat as I go, not assess then treat." · "15 L/min via non-rebreathe, then titrate to target." · "If the patient deteriorates I return to A." · "Reassess and verbalise the response after every intervention."

KEY RULE

Verbalisation loop, every step: what I'm assessing · what I'm worried about · what I'm doing about it.

COMMON MISTAKES

History before stability · silence · forgetting glucose in D · moving past an unstable step · late escalation.

CURVEBALL

Asked to hand over mid-resuscitation → give a 30-second SBAR without abandoning reassessment, and name who continues A–E.

GOLD CLOSING STATEMENT

"I used the Golden Minute to act on immediate threats, completed ABCDE systematically, treated as I went, reassessed after each step, and escalated early."

★ MUST-KNOW A3 · Consent, Capacity & Best Interests

VERY HIGH · RED PATH · INSTANT-FAIL RISK

BLUEPRINT

Check capacity (URWC) → Benefits → Risks (CMSM) → Alternatives (incl. no treatment) → Teach-back → Confirm voluntary → Document (DISCUSS)

KEY FRAMEWORKS

MCA 2-stage test — 1) impairment of mind/brain? 2) can they Understand · Retain · Weigh · Communicate?

5 MCA principles — presume capacity · support · unwise ≠ incapable · best interests · least restrictive

Risks (CMSM) — Common · Serious · Material (patient-specific, Montgomery) · Mortality

Lacks capacity — best interests via SILVER; only Health & Welfare LPA can decide

Under-16s — Gillick vs Fraser — Gillick competence = a child under 16 with the maturity to understand and consent to treatment in general · Fraser guidelines = the specific criteria for giving contraception or sexual-health advice without parental knowledge

INSTANT FAIL — WHAT LOSES THE STATION, AND THE LINE THAT SAVES IT

✗ LOSES THE STATION	✓ THE LINE THAT SAVES IT
Proceeding without checking capacity	“First, I’ll check you’re able to make this decision today.”
Overriding a capacitous refusal	“You have capacity, so I respect your decision.”
Letting family decide for a capacitous adult	“The decision rests with the patient.”
No risk discussion before a procedure	Give common, serious and material risks (CMSM)
Writing only “consent obtained”	Document benefits, risks, alternatives and teach-back

MUST-SAY SCORING LINES

“Capacity is decision- and time-specific — I assume it but check it.” · “An unwise decision doesn’t mean a person lacks capacity.” · “The risks that matter are the ones important to you (Montgomery).” · “Alternatives include doing nothing.” · “In your own words, what do you understand?” · “For under-16s: Gillick competence for treatment, Fraser criteria for contraception.”

KEY RULE

A capacitous adult (including a pregnant woman) may refuse any treatment.
Children: Gillick for any treatment under 16; Fraser for contraception only (all five criteria).

COMMON MISTAKES

Assuming capacity · jargon · no teach-back · missing the material (patient-specific) risk · accepting a family veto.

GOLD CLOSING STATEMENT

“I obtained valid consent — capacity assessed on the two-stage test, benefits and CMSM risks explained, alternatives including no treatment discussed, understanding confirmed, and the decision documented.”

★ MUST-KNOW A4 · Breaking Bad News & Difficult Conversations

CORE · ALL PATHWAYS · INSTANT-FAIL RISK

BLUEPRINT

SPIKES — Setting → Perception → Invitation → Knowledge (warning shot) → Emotion (NURSE) → Strategy & summary

KEY FRAMEWORKS

NURSE — Name · Understand · Respect · Support · Explore the emotion
Difficult conversation — Acknowledge → Explore → Agree a plan
Duty of Candour — Inform · Apologise (unconditionally) · Explain · Support · Document · escalate + Datix

INSTANT FAIL — WHAT LOSES THE STATION, AND THE LINE THAT SAVES IT

✗ LOSES THE STATION	✓ THE LINE THAT SAVES IT
Bad news with no warning shot	"I'm afraid I have some difficult news to share…"
Conditional apology	"I'm sorry this happened." (never "sorry you feel…")
Ignoring emotion	Use NURSE — name and acknowledge it
"I understand how you feel."	"I can't imagine exactly how this feels."
Detailed prognosis unasked	Chunk and check first; follow the patient's cues

MUST-SAY SCORING LINES

Warning shot · then silence · "This is a huge shock." · "I'm here with you." · "What concerns you most right now?" · "Does that make sense so far?"

KEY RULE

Fire a warning shot, then pause and let silence do the work before any detail.

COMMON MISTAKES

No warning shot · talking over silence · false empathy · info-dumping prognosis · a conditional apology.

GOLD CLOSING STATEMENT

"I warned before telling, delivered the news clearly and compassionately, responded to emotion, checked understanding, and agreed follow-up."

★ MUST-KNOW A5 · Red Flags, Safety-Netting & Risk Communication

CORE · ALL PATHWAYS · INSTANT-FAIL RISK

BLUEPRINT

RECOGNISE (red flags) → ACT (manage / escalate) → COMMUNICATE (safety-net + absolute risk)

KEY FRAMEWORKS

Safety-net — What to watch for · Where to go · When to act (+ dropped-call plan if remote)

Risk — absolute numbers / natural frequency — "out of 100 people, about X…", never relative %

High-yield red flags — headache: thunderclap/neck stiffness · back: saddle numbness/retention · child fever: non-blanching rash

INSTANT FAIL — WHAT LOSES THE STATION, AND THE LINE THAT SAVES IT

✗ LOSES THE STATION	✓ THE LINE THAT SAVES IT
Missing a red flag in the brief	"I'll screen for serious causes before we go further."
Vague safety-netting	"If X happens, go to Y within Z."
Relative risk only	Convert to absolute: "from 2 in 100 to 1 in 100."
No escalation when indicated	"I'm concerned — this needs senior review."
Over-reassurance	Use conditional, safety-aware language

MUST-SAY SCORING LINES

"I need to check for some serious causes — is that okay?" · "Out of 100 people, about X…" · "If anything worsens, seek urgent help." · "I'll document the safety-netting."

KEY RULE

A red flag stated in the brief or by the patient and not acted on is an instant-fail risk.

COMMON MISTAKES

Missed red flag · vague advice · relative risk · silent reasoning · over-reassurance.

GOLD CLOSING STATEMENT

"I screened for red flags, communicated risk in absolute terms, gave clear safety-netting, and escalated appropriately."

★ MUST-KNOW A6 · SBAR & Safe Escalation

CORE · RED PATH · the pass/fail moment

BLUEPRINT

SBAR — Situation (who · where · the problem) → Background (history · meds · obs) → Assessment (findings · concern · differential) → Recommendation (what you need — always)

KEY FRAMEWORKS

Escalate when — unstable · red flags · diagnostic uncertainty · safeguarding · beyond your competence

INSTANT FAIL — WHAT LOSES THE STATION, AND THE LINE THAT SAVES IT

✗ LOSES THE STATION	✓ THE LINE THAT SAVES IT
Not escalating when indicated	"I'll escalate to a senior to ensure safe care."
Handover with no recommendation	State exactly what you need done
Vague, rambling handover	Use the four structured SBAR sections
Not naming who you're calling	"I'll call the medical registrar now."

MUST-SAY SCORING LINES

"I'm concerned about this patient and I need…" · name the person/role · "Please could you review within [time]?" · close the loop: confirm what will happen next.

KEY RULE

Failure to escalate when indicated is an instant fail — the Recommendation is the part candidates omit.

COMMON MISTAKES

No recommendation · no named recipient · escalating too late · an unstructured handover.

GOLD CLOSING STATEMENT

"I recognised the patient needed senior input, escalated promptly using SBAR, and made a clear, specific recommendation."

A7 · Safeguarding, Interpreters & Cultural Competence

VERY HIGH · safety + legal · high fail-risk

BLUEPRINT

Safeguarding — RECOGNISE → RESPOND → REFER → RECORD

KEY FRAMEWORKS

Absolute child triggers — under-13 sexual activity · disclosure of abuse · injury in a non-mobile child · patterned bruising · STI/pregnancy under 16

Adults with capacity — may decline referral unless serious risk to others, coercion, serious crime, or public interest

Mandatory — FGM in anyone under 18 → report to police

INSTANT FAIL — WHAT LOSES THE STATION, AND THE LINE THAT SAVES IT

✗ LOSES THE STATION	✓ THE LINE THAT SAVES IT
Promising confidentiality in safeguarding	"I can't promise to keep this secret if you or others are at risk."
Using a child/family member to interpret	"I'll arrange a professional interpreter."
Not seeing a vulnerable patient alone	See them alone before exploring concerns
Missing a mandatory FGM report (under 18)	Report to police; complete safeguarding referral

MUST-SAY SCORING LINES

"Are there cultural or religious beliefs we should consider?" · "I'll arrange a professional interpreter." · use the patient's affirmed name and pronouns · "Is anyone making you feel unsafe?"

KEY RULE

Interpreters: professional only — never a child, and avoid family for sensitive topics; speak to the patient, not the interpreter.

COMMON MISTAKES

False promise of confidentiality · family interpreter · not seeing the patient alone · missing a mandatory report.

GOLD CLOSING STATEMENT

"I recognised the safeguarding concern, saw the patient alone with a professional interpreter, referred appropriately, and documented clearly."

A8 · Remote & Telephone Consultations

HIGH · INSTANT-FAIL RISK

BLUEPRINT

Opening Golden Minute: ID → location → privacy ("are you alone and able to speak freely?") → connection / dropped-call plan → consent → then SAFE-CALL

KEY FRAMEWORKS

SAFE-CALL — Situation · Assessment (probe + red flags) · Findings · Explanation (limits) · Contingency · Advice (+ safety-net) · Loop (consent · follow-up · GP)

Exam proxies — breathless? → "full sentences?" · rash → "press a glass — does it blanch?" · pain → "can you walk?"

INSTANT FAIL — WHAT LOSES THE STATION, AND THE LINE THAT SAVES IT

✗ LOSES THE STATION	✓ THE LINE THAT SAVES IT
No ID / location / privacy / consent / dropped-call check	Do all five at the very start
Keeping an unsafe patient on the phone	"Based on [red flag], you need a face-to-face review."
Remote prescribing of controlled / high-risk drugs	Avoid; defer to face-to-face
Vague safety-net / no dropped-call plan	Use the four-part remote safety-net

MUST-SAY SCORING LINES

the five opening checks · "I can take a history and advise, but if I'm concerned you'll need to be seen." · "If we're disconnected I'll call back; if you can't reach me, call 999."

KEY RULE

Remote = more risk → more structure → more safety-netting → more documentation.

COMMON MISTAKES

Skipping the opening checks · no exam proxy · managing an unsafe patient remotely · no dropped-call plan.

GOLD CLOSING STATEMENT

"I confirmed identity, location, privacy and consent, used exam proxies, recognised the limits of remote care, and safety-netted including a dropped-call plan."

A9 · Exam-Day Technique & Recovery

CORE · performance, not perfection

BLUEPRINT

The 8-minute station: 0:00–0:20 intro/verify/agenda → 0:20–2:30 open + ICE + red flags → 2:30–4:30 summarise + think aloud → 4:30–6:30 explain + plan + safety-net → 6:30–8:00 check + close

KEY FRAMEWORKS

Read the brief — TASK (what am I doing?) · PERSON (who's in the room?) · TWIST (what's the challenge?)

Kill words — "angry" → de-escalate · "relative" → confidentiality · "refuses" → capacity · "sudden" → red flag · "distressed" → acknowledge emotion

Reset — 3-breath reset before each station · STOP-RESET-GO after a bad one

INSTANT FAIL — WHAT LOSES THE STATION, AND THE LINE THAT SAVES IT

✗ LOSES THE STATION	✓ THE LINE THAT SAVES IT
Rushed communication	Slow down — mark each word; lower the pitch
Loss of structure under nerves	Fall back on the 8-minute map
Visible panic	3-breath reset; "Safety first."
Silence or rambling	Think aloud, but signpost and stay structured

MUST-SAY SCORING LINES

intro in the first 10 seconds · set an agenda · think aloud · safety-net before closing.

KEY RULE

After a bad station: "That station is over — I can't change it." Reset and walk in as if it were station 1.

COMMON MISTAKES

Re-living a bad station · dropping structure under pressure · complacency by station 18 · rushing the close.

GOLD CLOSING STATEMENT

"I read the brief for task, person and twist, held my structure under pressure, reset between stations, and performed station 18 like station 1."

★ MUST-KNOW A10 · Visible Clinical Reasoning & Safe Verbalisation

CORE · HIGH YIELD · silence = no marks

BLUEPRINT

GATHER → ORGANISE → PRIORITISE → JUSTIFY → SYNTHESISE → PLAN → SAFETY-NET. Golden 30 seconds (by minute 3–4): "Let me organise my thoughts. Most likely is X because Y. I must not miss Z."

KEY FRAMEWORKS

Five core steps — Most likely (because) · Must-not-miss · Justify tests (BECAUSE rule) · SIPS synthesis · Escalate + safety-net

3-tier differential — most likely · life-threatening · other possibilities

Safe verbalisation (the rules) — reason aloud TO THE EXAMINER, not alarmingly AT the patient · don't voice an unconfirmed serious diagnosis to the patient · signpost ('let me think this through') · keep patient-facing language plain and reassuring

INSTANT FAIL — WHAT LOSES THE STATION, AND THE LINE THAT SAVES IT

✗ LOSES THE STATION	✓ THE LINE THAT SAVES IT
Unsignposted silence over 10 seconds	"Let me organise my thoughts…"
Ordering a test with no reason	BECAUSE rule: "…because it would change management."
No life-threatening differential	"I must not miss [X] because…"
Voicing a scary differential at the patient	Reason for the examiner; keep patient-facing words measured
Anchoring / premature closure	State alternatives; update the differential aloud

MUST-SAY SCORING LINES

"Most likely is X because Y." · "I must not miss Z." · "I'd request [test] because it would change management." · "Putting this together, the pattern fits…" · "This new finding changes my thinking…"

KEY RULE

Examiners score visible reasoning — say what you see, what it means, and what you'll do.

COMMON MISTAKES

Silent excellence (reads as absence) · tests without justification · no must-not-miss · failing to update aloud.

CURVEBALL

You realise mid-station your diagnosis was wrong → say so: "I'm revising my impression because of X." The correction scores more than the original.

GOLD CLOSING STATEMENT

"Most likely is X because Y; I must not miss Z; I'd request [test] because it would change management — putting it together, the pattern fits X, and I'll safety-net and escalate if needed."

★ MUST-KNOW A11 · Prescribing & Calculation

CORE · numeracy · INSTANT-FAIL RISK

BLUEPRINT

Read the order → identify what to calculate (dose by weight, infusion rate, concentration, conversion) → calculate → double-check (units, decimal, order of magnitude) → state the working aloud → sanity-check against the patient

KEY FRAMEWORKS

Core calculations — dose by weight (mg/kg × kg) · infusion rate (mL/hr = volume ÷ hours) · concentration (mg/mL) · unit conversion (mg ↔ mcg ↔ g, always ×/÷ 1000)

Decimal & unit safety — leading zero, no trailing zero (0.5 mg, not .5 mg or 5.0 mg) · 'units' in full for insulin · double-check the order of magnitude

Worked example — 1 L over 8 h = 1000 ÷ 8 = 125 mL/hr · a drug at X mg in Y mL → mg/mL, then the volume needed for the dose

Always — show the working, state the units at every step, and sanity-check — 'does this dose or volume make sense for this patient?'

INSTANT FAIL — WHAT LOSES THE STATION, AND THE LINE THAT SAVES IT

✗ LOSES THE STATION	✓ THE LINE THAT SAVES IT
A decimal / order-of-magnitude error	Double-check; leading zero, no trailing zero
A wrong unit conversion (mg / mcg)	×1000 carefully, units at every step
Not showing the working	State each step

MUST-SAY SCORING LINES

"I'll show my working with units at each step." · "Leading zero, no trailing zero." · "Let me double-check the order of magnitude." · "Does this dose make sense for this patient?"

KEY RULE

An unchecked decimal point is a tenfold error — re-read the number and sanity-check the answer against the patient.

COMMON MISTAKES

A decimal error · a wrong conversion · not showing the working · no sanity check.

GOLD CLOSING STATEMENT

"I identified the calculation needed, worked it through with units at each step, double-checked the decimal and order of magnitude, and sanity-checked the answer against the patient before prescribing."