GUIDE TO

ST INTERVIEWS
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SECTION 1

INTRODUCTION
1.1 - INTRODUCTION TO ST INTERVIEWS

Background
ST interviews are structured interviews centred based on a multiple-stations format

‘Structured’ means that the interviews are no longer an assessment tool whereby candidates were asked a few questions and were recruited on the subjective judgement of the interviewers. Instead, each question is targeting one or several skills and candidates are marked according to a strict schedule defined in advance by the interviewers. Previously, SHO and SpR interviews also had a marking schedule but the criteria were not so clearly defined. The move to a structured interview process has several consequences:

- There is more emphasis on questions asking for scenarios or examples of situations where you demonstrated various skills. In some specialties, there is also a greater emphasis on clinical scenarios.
- The interview process has become more of a “tick the boxes” exercise where you are expected to demonstrate the specific skills that are on the marking sheet. This requires a greater understanding of the interview process and of what the interviewers may be looking for.
- There is a greater emphasis on the content of the answers, though obviously the delivery of the answer also matters a lot (for a start it is a good indicator of your communication and teaching skills!)

Stations
The process is based on a series of stations, the length and nature of which varies according to the deanery and specialty that you are being interviewed for. Typically, an interview consists of 3 or 4 stations, each 10 minutes long. The stations will usually deal with different topics such as:

- Station 1: Clinical scenarios
- Station 2: Research, audit and teaching
- Station 3: Motivation and general questions
- Station 4: Risk management & difficult work situations

Usually, each station will deal with a different topic; however there have been numerous exceptions. For example, some candidates (e.g. Anaesthesia in London) have had mostly clinical scenarios in all stations. Others (such as some specialties in Scotland) have only had one big station with a wide range of questions i.e. essentially an old style interview.

In addition to stations based on a questions and answers format, some specialties have introduced role play in many deaneries (e.g. O&G) and even group discussions (e.g. Psychiatry). Others still have introduced practical skills stations (e.g. some ophthalmology interviewers ask you to suture a tomato, whilst in surgical interviews, some candidates have been asked to suture an orange. Some anaesthetics applicants have been asked to intubate a dummy).

THIS BOOKLET

This booklet has been designed to help you think about the answers that you could bring to the most commonly asked questions. In order to avoid a situation where you simply regurgitate a ready-made answer, we have deliberately avoided giving model answers.

However, whenever possible, we have included the main points that you would be expected to raise together with an indication of how you could structure and deliver each answer.
1.2 – HOW TO PREPARE FOR YOUR INTERVIEW

Introduction
When you start preparing for an interview, it is tempting to spend a relatively modest period of time rehearsing quickly the answer to hundreds of questions in front of your mirror or talking to your walls. This preparation method yields very little results as it only helps to reinforce the mistakes that you are making and does not allow you to think carefully about the content of your answers and how to deliver them effectively. In fact, if you do this too closely to your interview it is likely to make you panic and to be counter-productive.

A communication exercise
Interviews are nothing more than a business discussion where one party is trying to gather information about the other. It is in fact a pure communication exercise revolving around a known context and as such it follows the same communication rules as any other meeting.

What makes effective communication? In practice no/ one can listen to anyone for more than a few minutes. Interviewers generally allow up to three minutes per question. Since this includes the time it takes to ask the question and to probe into your answer, you are aiming to produce an answer that is 1.5 to 2 minutes long.

During these 90 to 120 seconds, there is little point in trying to put across too much information as the interviewers will not remember a lot of it and you will make little impact. Ask a friend to read you a list of 20 objects and see how many you can remember after a few minutes. You are likely to remember only 3 or 4 and these will be the more unusual objects. The same applies at interviews. The listener (i.e. the interviewer will only be able to take on board 3 to 5 strong ideas. You should therefore organise your answers on that format.

The PowerPoint format
Many candidates can put together meaningful PowerPoint slides but are unable to organise their information in the same way at interviews. In fact both require the same technique. Rather than writing down all your answers word by word on paper, thereby risking to become inflexible and rehearsed, not counting the real risk of learning your answers by heart and forgetting half of their content at the interview, you should concentrate on gathering the key building blocks in your mind in bullet point format, so that you may recall them more easily on the day.

How to proceed
Although there are hundreds of possible questions (which puts off some candidates from preparing at all), they all relate to a few handfuls of subjects. You should therefore spend an important proportion of your preparation time thinking about each of these subjects using different angles in order to build up some good content that you will then be able to manipulate in different ways to answer dozens of questions.

In order to achieve this, concentrate on one subject at a time and gather 4 or 5 questions relating to it. Spend five minutes or so on each question, simply trying to gather information about yourself, your experience. Constantly query your own answers as if you were a difficult interviewer. Whenever you mention you like something or find something interesting, ask yourself why, etc. Answer the who, what, where, when, why and how questions. This will help you to gather information that you can then use at an interview. Then take the questions again and try to organise all the relevant information under 3 to 5 headings which will form the basis for your answer. You can write these down in the form of 3 to 5 bullet points with a couple of lines under each of them to back up your points.
1.3 – HOW TO FORMULATE YOUR ANSWERS

The right length: Your answers should be no longer than 2 minutes (3 minutes if the subject is broad). Any longer and you will put the interviewer to sleep.

A strong structure: Most answers will be built according to the following format:
(a) Direct answer to the question
(b) Expansion & Substantiation your answer
(c) Broadening & Conclusion

Be direct: Always answer the question in the first sentence, before you expand. This will reassure the interviewer that you will not fob him off and it will add structure to your answer.

Be open: As much as possible try to announce the structure of your answer upfront. This will keep the interviewer interested as he will know what to expect. For example:-
• If asked about your strengths, start with “I feel I have three main strengths”.
• If asked why you went into your specialty, start with “Essentially there are two main reasons that made me choose specialty x over other specialties.”

Be personal and explicit: Use a combination of headlines and expansion statements. Always stay concrete and practical.
• Use “I” rather than “we”, using “we” gives the impression that you do not get involved in the work as much as you say.
• Keep to statements that provide real information about your skills and abilities. Avoid vague statements such as “I find teaching really interesting” or “I went into paediatrics because I like it.” What really matters is why you find it interesting or why you like it.
• Use facts to substantiate your general statements. Use the 5 “w” questions to gain knowledge about yourself and add content.
• If you can, try to use objective measures as much as possible e.g. “My consultants often praise me for the way in which I approach communication with patients when breaking bad news” or “I have received numerous letters from patients, thanking me for the clarity of my explanations”. It sounds much better if others say you are good than if you are the only one to say it.

Conclude and add depth:
• If the question is about a specific skill (teaching, communication, management, leadership, training, research), you could spend 30 seconds discussing the importance of the skill in your role.
• Think laterally and broaden the debate. See if you can identify other skills that you can discuss as part of your answer. E.g. talking about conflict can lead you to discussing how good communication can help prevent conflict.

Sell yourself: Make sure that everything you say relates the answer back to you and the job. If the question is hypothetical e.g. “What makes a good doctor?”, “What skills should a good leader have?” then
• Answer the question
• Conclude by explaining how you match the criteria i.e. why YOU are a good doctor, why YOU are a good leader.

Don’t bore them with spurious detail. Never quote a specific example unless asked. It will make your answer much longer and will create confusion by concentrating on one issue whilst the question may be much broader.
1.4 – QUESTIONS ASKING FOR EXAMPLES

Example questions are used by interviewers to help determine patterns of behaviour that they can use in order to predict how you may react in other situations of the same order. These questions are calling for you to demonstrate your general skills.

In order to satisfy an interviewer and present a picture of yourself which is flattering, you will need to find an example which is complex enough.

The technique to answer this type of questions is simple. It is a common communication well known in the HR circles and interviewers will be expecting to hear all its components.

**Situation** – Explain what the problem was. What was the context?

**Task** – As a result, what did you seek out to achieve?

**Action** – How did you do it? What did you do? Why did you do it?

**Result** – What happened at the end? What did you learn?

The most important part of the answer is the action. This is where you will reveal how you resolved the problem. In order to help the interviewers extrapolate your behaviour in that one example you must not only explain what you did but also why you did it like this.

For example “I let the patient talk for a few minutes” is okay but does not really say a lot about you. However “I let the patient talk for a few minutes to give them the opportunity to express their problem in their own words and let them vent their anger at the delay they had incurred” is much more explanatory and reveals a lot more about how you function as an individual.

**Common Traps**

When you provide an example,

- Do not concentrate too much on the clinical aspect of the scenario. If the interviewers wanted clinical information they would ask for it explicitly. Instead emphasise the skills that you used to resolve the problem.
- Do not provide an example that is too simple, you will not be able to sell any skills through it.
- Do not forget to discuss the outcome and what you learnt from the situation.

**Most commonly asked examples**

- Where you communicated well (or where your communication skills made a difference to the care of a patient)
- Where you showed leadership
- Where you were an effective team player
- Where you showed initiative (i.e. where you used your general skills to resolve a situation that was unfamiliar to you)
- Where you dealt with a difficult colleague
- Where you deal with a difficult or angry patient
- Where you had to prioritise your work.
- Where you dealt with a difficult scenario
- Where you worked under pressure
- Where you handled a stressful situation
- Where you had to ask for senior help
- Where you made a mistake.

Make sure you prepare a good example for each of these and you will cover 90% of possibilities. In this booklet we will address several of these examples so that you can gain a good idea of how to present them.
1.5 – A LOOK AT SOME IMPORTANT SKILLS

Before you can answer interview questions confidently, you must have a good understanding of the skills that you are supposed to.

COMMUNICATION

Communication skills vary from simply listening to people to an ability to influence people, to negotiate etc. In fact communication is such a vast subject that people write books about it. At an interview, your communication skills can be tested in many ways, for example:

- Simply by listening to the way you express yourself, the manner in which you construct your answers to impress interviewers, etc
- By asking you directly about how you rate your own skills, what you can improve etc
- By asking you to discuss a situation where your communication skills played a particular role (as is often the case in application forms).
- Through a role play exercise.

There are a number of areas of communication in which a doctor must excel. They would generally fall under one of the following two categories:

1 - Active Listening Skills

This is closely linked with empathy, which all doctors are required to demonstrate. Empathy is characterised by a personal ability to see a situation from the other person’s point of view and relates to the following behaviours:

- Being attentive and acknowledging – this is usually achieved through simple body language such as an open posture and good eye contact. It also includes nodding at the appropriate time etc.
- Reflecting the other person’s feelings and experiences
- Probing in a supportive manner
- Providing feedback, being supportive, showing warmth and being caring.
- Checking with the other persons whether your interpretation of a situation is accurate
- Knowing when to stay quiet and simply give the other person the time they need.

This applies equally to your dealings with patients and colleagues. The impact of good active listening skills is a better relationship, an ability to build a rapport and generate mutual trust, which is crucial in your dealings with everyone. This results in better care for patients and a better working relationship with your colleagues.

2 – Conveying messages in a clear and effective manner

The skill involved in conveying messages clearly and effectively resides principally in your ability to adapt your communication to your audience. This includes:

- Using clear and unambiguous language;
- Checking the understanding of your audience and adapting your message to it;
- Have a clear idea of what you are trying to communicate;
- Taking account of prior knowledge and personal circumstances of your audience;
- Using the appropriate level of jargon;
- Choosing the most appropriate medium to communicate (written/face-to-face/ email/telephone, diagrams, posters, models, etc).
- Being able to deal with difficult situations diplomatically
- Negotiation and influencing skills.

This applied equally whether you are giving instructions to a junior colleague, presenting issues to a senior colleague, teaching others, giving a presentation to a peer group, breaking bad news, writing notes, handing over, discussing issues with patients, negotiating the admission of a patient onto a ward or a scan with a radiographer.
TEAM PLAYING
The main attributes of a good team player are as follows:

*Understands his role in the team and how it fits within the whole picture*
In order to get on within a team, team players must have a thorough understanding of what they need to achieve and what is expected of them. They must also understand what is expected of others so that they can work with them effectively.

*Treats others with respect. Is supportive.*
Team players treat fellow team members with courtesy and consideration. They show understanding and the appropriate support of other team members to help get the job done. Effective team players deal with other people in a professional manner.

*Is willing to help*
Good team players go beyond any differences they may have with other team members and find ways to work together to get work done. They respond to requests for assistance and take the initiative to offer help.

*Is flexible and adaptable*
Good team players adapt to ever-changing situations without complaining or resisting. A flexible team member can consider different points of view and compromise when needed. He or she doesn’t hold rigidly to a point of view especially when the team needs to move forward to make a decision or get something done. They must strike a compromise between holding on to their own beliefs and convictions whilst respecting and taking on board other colleagues’ opinions.

*Communicates constructively and listens actively*
Teams need people who speak up and express their thoughts and ideas clearly, directly, honestly, and with respect for others and for the work of the team. Good listeners are essential for teams to function effectively. Teams need team players who can absorb, understand, and consider ideas and points of view from other people without debating and arguing every point. Such a team member can also receive criticism without reacting defensively. Finally, a good team member shares information with colleagues and keeps them up to date about progress on his assignments.

*Is reliable. Takes responsibility and ownership of his role.*
A good team member should do everything possible to deliver on his assignments on time and with the level of quality expected of him by the rest of the team. He should get things done and do his fair share to work hard and meet commitments. You can count on him or her to deliver good performance all the time, not just some of the time. He should also be relied upon to admit his mistakes and proactively sorting them out.

LEADERSHIP
A good leader

*Has clear objectives and communicates them effectively to the team*
In order to lead a team, a leader must have a clear sense of direction, and clear objectives. (This is often referred to by candidates as “a vision”, although this term is very business-like and really only applies to the higher management echelons). A good leader is able to communicate those objectives clearly to the rest of the team so that they can take responsibility to achieve their own goals.

*Leads by example*
A good leader is effective only if he is being followed by his team. He must engender respect from his colleagues by showing a good example. A leader needs to be enthusiastic, competent and confident. He needs to demonstrate that he works at least as hard as he expects others to do.

*Understands and motivates his team*
A good leader must understand the strengths, weakness and aspirations of each team member. This enables him to share responsibilities accordingly. He motivates his team towards achievement by:
- Praising and encouraging
- Rewarding colleagues (e.g. by involving team members in specific projects)
- Empowering people & giving them responsibilities and freedom
• Making himself available

Communicates and interacts well with his team
A good leader should listen to the input and ideas of the team and take them on board. Communicating constantly with the team is also important for the leader to have a good idea of how the team functions, grievances, etc which makes it easier to anticipate and resolve conflict.

Recognises the need for change and implements it. Is a decision maker
A good leader is not static and constantly seeks new ways of working and improving. A good leader is able to take on board all the input he receives and to make a decision on that basis. He does not seek short-term popularity at the expense of achievement.

Is flexible
A good leader will adapt his leadership style to the demands of particular situations and the individuals involved. Some situations or individuals will require him to take a hands-on approach whilst other may require him to take a step back and be more hands off.

Throughout your answers you will need to ensure that you demonstrate some of the above qualities.
SECTION 2

MOTIVATION & GENERIC QUESTIONS
2.1 – Why this specialty?

DERIVING CONTENT
Before you can answer this question you must actually sit down and understand why you have applied to the specialty for which you are being interviewed, otherwise you will not be able to present a sensible answer.

Excluding any obvious reason (such as “this is where there are the most number of posts”), your reasons will normally fall into three distinct categories:

Clinical reasons. This could include:
- The technology involved
- The challenge of dealing with difficult patients and sensitive situations (e.g. paediatrics, psychiatry, O&G)
- The analytical nature of the work
- The variety that the work involved e.g.
  - you have to deal with different specialties (e.g. emergency medicine, paediatrics),
  - or it has a nice mix of medicine and surgery (e.g. emergency medicine, ophthalmology, O&G)
  - it has a mix of ward work and clinics (most medical specialties)
  - it deals with chronic and acute patients
  - it involves prevention as well as treatment
- The fact that you get immediate results from your work (e.g. most surgical specialties) – be careful with this reason because in surgery you also handle chronic patients, so a better reason may be that you like the fact that you enjoy that duality.
- The diagnosis is easy to establish, or on the contrary it offers a challenge.
- It has a strong investigation component, or on the other hand, there aren’t many investigations so it offers you a challenge, or it allows you to act on your clinical skills.

Academic reasons. This could include
- The research opportunities that the specialty offers
- The teaching opportunities that the specialty offers

Generic reasons. This could include:
- The strong MDT element
- The holistic nature of the specialty
- The communication challenge (e.g. paediatrics, psychiatry)
- The opportunities to get involved quickly in decision making and responsibilities.
- The nice mix between independent work and team work.

You may have some social reasons (e.g. no on-calls, or flexible lifestyle) but unless these are strong factors in your decision, you would be best advised to leave such social reasons out as they would place the emphasis

Obviously, it is important to remember that many of the candidates against whom you will be competing will be coming up with similar arguments to yours. After all, there aren’t thousands of different reasons for which one would want to go into a specific specialty. However this does not mean that you should shy away from the obvious reasons.

DELIVERING THE ANSWER
You will never find some obscure reason that no one else has thought about and that will give you the job. It is also true that many of your reasons for one specialty are likely to apply to other specialties.

This is why it is important that you make your answer more interesting by bringing your own history, background and experience into the answer. If you just said “I want to do ophthalmology because it is varied”, it would sound rather boring.

Instead, if you said: “When I did my ophthalmology attachment, I really enjoyed the variety that the job offered, between intricate surgery in theatre and clinics. Having to deal with patients who could be routine (for example
for cataracts) or more complex (such as those who could lose their sight and where psychosocial factors mattered most) is also very exciting”, you would come across as much more enthusiastic.

The most important aspect of the answer to this question is that it must feel enthusiastic and passionate. It is not a competition about who will have the best reason or the most reasons, but it is about recruiting those who believe in their future in the specialty. That can only be achieved by talking about what you enjoy in some detail.

2.2 – Why this deanery?

DERIVING CONTENT
It is extremely difficult to answer this question if you know nothing at all about the deanery, and you must ensure that you do a minimum of homework to ensure that you can add substance to your answer. There are several sources of information that you can use, including:

- The deaneries’ website
- The medical school websites (extremely good at providing information about research and teaching opportunities)
- Internet forums and generally, taking to people who work in the deanery already)
- Other internet sites, and particular, individual trusts.

Before you can answer this question, you must identify the reasons that have pushed you to apply to this particular deanery, with a view to presenting a range of possibly two or three of them. If you have already worked in the deanery in question then you will have some obvious arguments based on your experience; if you have not, then you will need to do more research.

Your reasons could be:

- **Clinical reasons** e.g. the types of hospitals involved in the rotations, the type of patients that you will be seeing (e.g. KSS or Peninsula are an obvious choice for Geriatrics), the quality of the training that you will be receiving (which is where it is helpful to have worked there before or to know people who work there).

- **Academic reasons** e.g. the opportunities that the region offers in terms of teaching and research opportunities. This would mostly depend on whether there are some centres of excellence nearby. Note that if you are applying for CMT or Surgery in General, you may want to give an idea of the specialty that you would like to choose at ST3 level so that you can give a more specific answer.

- **Generic reasons** e.g. the fact that you have worked there before and enjoyed the atmosphere, that you gained substantial support during your previous posts in terms of teaching and supervision, that you know some of the hospitals/systems (particularly important for psychiatry and public health)

- **Social reasons** e.g. your partner/husband/wife works locally, you have children at school there or simply that you enjoy the region (for whatever reason). Most people shy away from the personal reasons but they are a good way of making the answer sound different.

DELIVERING THE ANSWER
There is no miracle reason that will automatically get you the job. Similarly, it is likely that your reasons may apply to other deaneries, but you must not be put off by this. If they want to pursue this particular point, let them ask. Every reason is good; what matters is the combination of these reasons, and the enthusiasm with which you convey them. All you need to do is to list your reasons from the most technical to the most personal (the structure above should help you), explaining at each stage what you mean by each of your arguments.

For example, there is no point in just saying “I want to work in the Eastern Deanery because I worked there before and I enjoyed it”; it sounds lame. You should complement this statement by explaining what you enjoyed during your time there.
2.3 – Take us through your CV

Introduction
This is an increasingly question in view of the fact that candidates are being asked to bring their CV with them. In all likelihood they won’t have time to read it before the interview so you may be asked to take them through it or to point out the facts that you feel make you a suitable candidate.

Most people tend to stick to their clinical background. Remember that your CV or form contains a lot more than that.

Do not speculate about future questions. Often, candidates are worried about divulging too much information “in case interviewers later ask questions relating to something they’ve already mentioned”. For example, many people are reluctant to include their reasons for entering a particular specialty in this opening statement because they are bound to be asked that question next. Although it may the case, you cannot take any chances. Your answers cannot be based on your speculations about future questions but purely on the message that you are trying to convey.

Think carefully about the message that you are trying to convey and use this question to sell your positive points. Do not ask the interviewers to restrict the question to a smaller area (for example by asking “What do you want me to tell you about?” or “Do you want to know about my clinical experience or my personality?”). Instead, exploit the vagueness of the question to address all issues you believe are relevant.

Structure your answer well. The content of your answer should roughly be answering the following questions:
- What is your background?
- Why this specialty, weaving in work experience.
- What experience have you acquired (research, teaching, audit, etc)
- General skills/personality traits (especially if your specialty requires a strong emphasis on team work or communication, or if you are applying for a consultant post (in which case you should mention your leadership experience)
- Where do you see yourself going forward i.e. what are you trying to achieve.
- What are your hobbies. Talk about your life outside medicine

Take the interviewers through your personal story as opposed to simply listing a lot of bullet points. This question is about the content of your life story but also about your enthusiasm for medicine, your specialty and for life. To make it exciting you cannot simply concentrate on facts. You must bring in your personal experience, explain what you observed, what you liked, how it influenced you etc. In a way it is very similar to a personal statement.

Unless your career has been very simple or short (especially at the lower grades), do NOT adopt a chronological approach otherwise you will hear yourself quoting dates and hospital names for a long time. This will bore the interviewers and will contain no useful information. Instead take a thematic approach, concentrating on the experience and skills that you have that may be different to other candidates (whilst obviously reassuring your interviewer that you also have the usual experience).

For example, if you are applying for O&G at ST3 level, you will want to talk about your labour ward experience, your theatre gynae experience and your experience of running clinics, including for subspecialties such as gynae-oncology. If you are going for anaesthesia, you may want to talk about you experience in general anaesthesia, ITU/on-calls, and clinics (e.g. pain).

When you describe your research experience, be specific but not too detailed. “I have a lot of research experience” does not really say very much about you. You can be much more accurate with something along the lines of “Over the past two years, I have done two research projects on <title1> and <title2>. As a result, I have written 3 papers, two of which were published in peer-reviewed journals; I have done 2 presentations, including one at national level.”
2.4 – How would you rate your communication skills?

To answer such question, you must follow a number of rules:

**Be complete in your answer**
Discuss the two main components of communication. “Listening” is often forgotten by candidates (especially on the surgical side).

**Sell yourself**
If asked to rate your communication skills, you must be confident in saying that they are good, or effective. If you do not believe in your own abilities, the interviewers will not either. However, you must also ensure that you do not come across as boastful or arrogant. The way to avoid this is to talk about the feedback that you have received from others. For example, “I feel that I have good communication skills, and I have certainly received a lot of very positive feedback from both patients and colleagues.”

**Address the skill, not just the context**
Most people tackle communication questions by saying that they are good communicators because they can communicate with colleagues and patients alike. Such an answer simply paraphrases the question. It only addresses the context in which you communicate but not the actual skills that you have that would make you a good communicator. The fact that you communicate with someone does not make you good at it.

**Tailor the answer to your personal situation**
As well as the general skills of active listening and conveying messages effectively, you will need to personalise your answer.

(i) **Adapt to the speciality you are applying for**
Different specialities require different levels of communication in different areas. For example,
- Oncology posts will require a strong ability to empathise with patients, good skills in breaking bad news and comforting patients etc
- Histopathology posts will mainly be concerned with relationships with other colleagues and clarity & strengths of report writing.
- Paediatrics will place a strong emphasis on your ability to communicate the same issues at different levels (parents and children), together with communication within an MDT setting, which may include having to deal with conflict.
- Psychiatry posts will demand a strong ability to build a rapport very quickly with patients
- Surgical specialities will allocate strong importance to seeking informed consent and therefore your ability to explain complex procedures in a simple language. At the same time, the surgeon has a strong role in reassuring patients and therefore building a rapport through empathy is also important.

(ii) **Adapt to the grade you are applying for**
At SHO interviews, the emphasis is on finding a candidate who has a good background that will make them a good trainee and someone who is able to get on with the job. There is a particular emphasis on handover and note keeping skills. As well as the arguments above, it therefore makes sense to place a certain emphasis on good note keeping and handover abilities.

At Registrar Interviews and Consultant Interviews, the emphasis is moving away from the basic skills towards the managerial abilities. Depending on the job applied for, the candidate may therefore wish to discuss skills such as presentational skills, negotiation skills, ability to resolve conflicts etc.

(iii) **Explain the relevance of the skill and bring your personal experience into the answer**
Personalise your answer by explaining not only what skills you have but also how relevant they are to you and the job you are applying for. Try to make it personal by talking about your experience (without going into unnecessary detail). For example “I am a good listener” is a fairly bland statement that merely indicates that you think you are good and does not contain much information. The following example statement provides more information and a better understanding of what you mean:

“Throughout the course of my training I have developed some good listening skills by observing my senior colleagues and by spending time with my patients. Listening is an important skill in oncology, where you have to
deal with people who need to be handled carefully, and I feel that it has really helped me develop a better understanding of my patients, to build a good rapport with my patients and therefore to provide better care.

WHAT TO DO AND WHAT NOT TO DO

- **DO NOT** use an arbitrary scale when asked to rate or describe your communication skills (such as I would give myself 8 out of 10). Use proper descriptive adjectives (good, very good, strong, effective).

- **DO NOT** over-sell your communication skills by using words like “outstanding, excellent”. The interviewers will also be assessing your communication skills through the way you behave at the interview. They will not forgive you a discrepancy between what you say and what they observe.

- **DO NOT** under-sell your communication skills. Many candidates say that their communication skills are “okay” or “average” or “satisfactory”. Believe in yourself and project a realistic image of yourself. You are probably better than you think.

- **DO NOT** mention your level of English if you are a foreigner. The interviewers will soon find out by the way you speak whether you have good English. There is no point in telling them that you have a good command of the language or, worse, that you feel it is “average”.

- **DO NOT** mention the number of languages as an indicator of how good a communicator you are. Speaking seven languages does not make you a better communicator by itself. However, you can still mention it but in a different context, for example by explaining how your knowledge of several languages has helped you develop a rapport with people who had poor English. Similarly, having worked in different countries by itself does not make you a better doctor or communicator until you explain why it relevant (for example by giving you exposure to different cultures, which you find useful when dealing with such foreign patients because you are able to understand how they perceive their illness within their own culture).

- **DO** try to talk in terms of experience rather than in terms of subjective judgement. It is more powerful to say “I have acquired strong communication skills” rather than “I am a good communicator”. People can argue about how good you think you are but they cannot argue with your experience.

- **DO** make it personal. Link your message back to your job and experiences, place the skill into context.

- **DO** recognise that your communication skills can be improved, but only if you are prompted to discuss your skills in that way. Otherwise, stick to the positive aspects.

2.5 – Give an example of a situation where you showed empathy towards a patient. What did you do well and what could you have done better?

TYPICAL EXAMPLES
A good example would be a situation where a patient wanted to take a course of action which you felt was obviously against their own best interest. This could include:

- A patient who wanted to self-discharge against your judgement.
- A patient who was scared of surgery or of a procedure.
- A patient who refused to comply with their treatment, condemning themselves to painful consequences.
- A patient who refused to involve relatives but who required strong social and moral support.

Whatever example you choose to describe, you must ensure that it is your communication skills that made a difference. You must also ensure that you do not coerce the patient into making a decision.
DELIVERING THE EXAMPLE
To deliver this example, use the STAR approach described earlier in the booklet.

**Example 1 (INEFFECTIVE ANSWER)**
“As an SHO in Oncology I had to break the news to one of my patients that she had carcinoma of the colon. I approached her sensitively and empathically, making sure that she was fine, and answering all her questions”

This answer is on the right tract but almost tries to cram too much information at the same time. Rather than just stating that you were sensitive and empathic, you should put it into the specific context of this patient. You can see how the above text can almost be used as such for any example – this tends to indicate that a more personal approach is needed.

**Example 2 (EFFECTIVE ANSWER)**
“Whilst working in A&E I saw a young Asian woman who was 6 months pregnant. She was very timid but even so appeared to be quite distressed. Seeing that she was alone and vulnerable, I thought about how I would feel if I were in her situation and about how I would want to be treated. I took her to a cubicle away from most of the bustle of the department. I took my time, did not rush her and started to take a history. She became a little tearful and so I spoke in a softer tone. However I knew by her composure that she wanted to tell me more so I gently asked about why she was so upset. Suddenly she just let out all her emotions. She explained that she had miscarried twice before and that her husband and his family thought she was an unfit wife. I could tell she was relieved to confide in someone. Her medical complaint turned out to be minor and with the good rapport we had built she trusted the diagnosis.

Overall I found that actively listening, preparing the scene and mirroring her pace was useful. Using words that were non-threatening and from her own vocabulary also helped. In hindsight I felt that I could have given her more space to talk and I would also involve another person such as a staff nurse who could also reassure the patient.”

Through this example, you have a complete story which describes in some detail how the doctor approached the patient and how he made a difference to the patient.

Note that the question is asking what you did well and what you could have done better. At an interview, this supplementary question would come as a probing question to test your level of personal insight.

2.6 – Give an example of a recent situation you have participated in where teamwork was important. What role did you play? What did you learn from this experience?

This question is very explicit. The introduction tells you that they are testing your team working abilities. In addition, it is a question asking for an example and they are guiding you through the STAR technique:

**Situation/Task:** Give an example of ...
**Action:** What role did you play?
**Result:** What did you learn from this experience?

Please also take note of the request for a RECENT situation. This usually means in the past 6 to 12 months.

This question is in several parts. At an interview, they may give you the full text all in one go, or they may choose to give you the secondary questions once you have started to answer the first parts. If the text is given to you all in one go you must make sure that you take a second to register all of is so that you do not forget to answer it in its entirety.
FINDING AN EXAMPLE

Recall the attributes of a good team player (since you will need to demonstrate them throughout your answer). From a practical point of view, essentially you want to present the image of someone who:

- Has a good relationship with colleagues and is able to work with them to get the work done. Is willing to take on his/her share of the workload, and to offer his help and support to others.
- Keeps communication going within the team by keeping his/her colleagues informed about what they are doing and shares any other information that may be relevant.
- Takes the initiative to resolve issues and discuss problems with the team. This could include negotiating with colleagues if necessary.
- Ensures that he/she carries out his/her work properly and seeks help if they are encountering a problem.

Identify a situation in your recent past where you have had the opportunity to demonstrate these skills, making sure that the example you choose enables you to demonstrate as many team playing skills as possible. This could be a situation where you:

- Participated in the organisation of an event or project such as organising a seminar, regular teaching sessions, health camps, awareness programmes, etc.
- Had to deal with a complex patient, where team playing was important. In order to make the answer interesting you would need to find an example where you had to deal with a multi-disciplinary team for example. You could then explain how you participated to the debate about the management and ongoing care of the patient, and how you interacted with all members of the team to achieve a safe discharge.
- Had to deal with an emergency by using the resources available on the nurses’ and junior doctors’ side, whilst maintaining constant communication with your seniors at all times so that they could have an input into the process and would be fully briefed by the time they arrived. Note that in order to highlight as many skills as possible, you would need to ensure that the situation is complex enough to show how important YOUR role was too. For examples, if your seniors are there with you and they are managing the situation themselves (e.g. crash call), you are losing the opportunity to emphasise the communication aspect of your role in keeping them up-to-date.

Example 1 (INEFFECTIVE)
“I work every day as part of a team, dealing with colleagues, nurses and other doctors. I am aware of my limitations and seek help when necessary, and I communicate well with everyone in the team. I am willing to help and motivate others.”

This answer is too vague and general. In fact, it does little more than summarising the job description. Also, it does not actually answer the question, which is asking for an example of a recent situation i.e. a specific scenario in which you were involved.

Example 2 (INEFFECTIVE)
“I had an elderly patient who wanted to self-discharge because she was worried about her dog. I talked to the nurse and the consultant, and eventually the patient agreed to stay one more day. The patient left the hospital the next day and was happy with the way she had been handled.”

This answer starts well by explaining the context which will lead to a team action to be started. The main problem is that the “Action” section contains very little information. There are plenty of other aspects that can be exploited.

- Why did you talk to the nurse or the consultant? Most likely because the consultant is responsible for the patient and had to be informed. As for the nurse, it might have been because she had a good relationship with the patient and a good understanding of their psychological issues too through the rapport she had built with that patient. This needs to be explained.
• Did you do anything else that would have made you a good team player? Like taking the initiative to contact social services or ask the patient if the relatives could be involved? (They can become part of the team too).

This answer basically needs more detail about what was done and why it was done.

Finally, the “Result” section is partially addressing the wrong point. As well as highlighting that the problem was satisfactorily resolved, it should emphasise that this was the result of team work.

Example 3 (EFFECTIVE)

Three months ago, I was on-call taking admissions from GPs and A&E. I was the only SHO on-site, with my Registrar being busy in theatre and my consultant being on-call from home. A patient presented with <Emergency> which required admission to theatre. Whilst I was stabilising the patient, I asked the house officer to call the Registrar in theatre as it is protocol to inform my seniors for all such cases. The Registrar informed him that he would be busy for at least two hours and I therefore took the decision to call the consultant as well, who announced that he would come in as soon as he could.

At the same time I asked one of the nurse practitioners to call the anaesthetist and help prepare the theatre so that everything would be ready by the time the consultant arrived. Throughout this time I kept in constant communication with the consultant in order to ensure that he was fully briefed. The patient was taken to theatre within minutes of the consultant’s arrival and made a successful recovery. By coordinating the team at a time that was stressful for all involved (patient and doctors) I helped achieve this result. This taught me how crucial communication is in ensuring that the whole team functions well.

Note the absence of much detailed clinical information (totally irrelevant for the purpose of highlighting team playing), the concise but informative introduction, and the manner in which the main components of team playing are highlighted throughout the example, including:

• Recognising protocol, and your limitations.
• Informing your seniors and keeping them up to date about developments.
• Informing other colleagues about developments that are relevant to them (the anaesthetist).
• Using other team members to help out, based on their skills level.
• Getting things done (stabilising the patient, preparing the theatre, etc.)

Also note how the conclusion keeps the mind of the reader focused on your skills by not only explaining the outcome in a concise manner but also highlighting what you did that made it possible to achieve it, and what you learnt from it.

COMMENTS

This scenario could be adapted with very little work to cover other types of example. For example, it is a good example of a situation where you used your initiative or a situation where you had to work under stress (although you would need to place a slightly different emphasis on each aspect of the answer to achieve the desired impact).

Identifying examples that are complex enough to cover several skills is a good trick to minimise your preparation (although you should ensure that you use different examples for each question in the exam).
2.7 – Describe a time when you were unsure whether what you were being told represented the patient’s true thoughts or feelings. How did you recognise this? What did you do about it?

This question seems more complex than the others since it does not explicitly request information about a given skill. Also the type of example that the question is asking for can be quite tricky to find if you haven’t got much experience.

HOW TO APPROACH THE QUESTION?

Think about a type of situation where this might happen.
The question does not tell you whether it is the patient who is not telling you his true thoughts, or whether it is a relative who is telling you something that is not in agreement with the patient’s thoughts or feelings.

If it is the patient, then it may be because they are frightened of what will happen to them if they revealed their thoughts or feelings. This may be a patient who is scared about their own health problems, a patient who hides part of their history to avoid confronting the reality of their illness, or an elderly patient who is keen to have their health problems resolved but is not keen to be taken into care, or is worried about becoming a burden on their relatives.

If it is a relative, it may be that they are trying to forcibly influence the patient into a position that suits them rather than the patient.

Having thought about the question in a general manner, you should now be equipped to find a real-life example in your own experience.

Identify the skills that you want to demonstrate in this example.
The question is asking you how you recognised that there was an issue and what you did about it. Recognising the issue will come from your own judgement of the situation based maybe on inconsistencies in the story that you are getting from the patient, their body language, the way which they express themselves (for example by being vague), etc. Ultimately this will come from your ability to listen to the patient and probe accordingly – in essence, your communication skills. This is the easy bit!

Dealing with the issue is more complex and essentially requires you to gain the patient’s confidence in order to put them back on the right track. This may involve:

- Communication (empathy, listening skills in order to build trust); there is a reason behind this situation and you must identify it quickly. This requires a lot of diplomacy and sensitivity.

- Team work. You may need to involve:
  - a nurse – they often have a more in-depth relationship with the patient simply by the fact they may be more empathic than doctors and have more time to spend with patients.
  - theGP – if there is time to make decisions and the patient can be helped through counseling or simply by having an opportunity to discuss issues.
  - the relatives, if needed. They may be crucial in reassuring the patient.
  - your seniors (identify your limitations!)

In addition, if the relatives are causing the problem (for example by forcing the patient to adopt a particular attitude against his/her will) you may have to use other tools to minimise their possible negative influence on the patient. This could include involving seniors, showing an assertive but sensitive behaviour, spending time with the relatives (after all there may be a valid reason or fear behind their behaviour), etc.
Because this is likely to be an unusual situation, you will need to demonstrate your initiative and lateral thinking to come up with a creative and effective solution.

Example 1 (INEFFECTIVE ANSWER)

“One of my patients wanted to self-discharge because she felt her dog would be in danger if she did not get back home as soon as possible. I suggested that she called a relative so that they could look after the animal but she was adamant that she needed to do it herself.

This prompted me to think that there was more to her story and, after much discussion, I concluded that she was worried about the anaesthesia. In order to resolve the situation I arranged for the patient to have a second discussion with the anaesthetist and also arranged for a nurse to sit in with her. After the discussion the patient was happy and went through with the operation.”

This answer is not “bad”. It has a number of positive aspects:

- It deals with a specific situation.
- The introduction is fairly descriptive and effective in setting out the situation.
- It addresses the right type of issue.

On the negative side, it describes what the doctor did, but not really why he thought or acted like this. In other words, the answer needs more depth and needs to highlight how the doctor used his skills to resolve the situation.

What can be improved?

Look at the following statement: “This prompted me to think that there was more to her story and, after much discussion, I concluded that she was worried about the anaesthesia”.

Essentially, it looks as if the doctor has jumped to a conclusion without really explaining how it came about. The whole process has been summarised by “after much discussion”. Since the question is asking how you recognised that there was an issue to be addressed, you would need to go into more detail about that conversation and discuss how you spent time with the patient, discussing the situation and their fears, eventually picking up on parts of the conversation that seemed to indicate that she was in fear of anaesthesia. At the same time you would need to emphasise how you used your listening skills and empathy to gain the patient’s trust and confidence.

Maybe you asked a nurse to have a conversation with the patient instead because you felt she had a good relationship with the patient and that the patient would open up more easily to someone of the same sex. Either way, it does not matter provided you explain how your actions justified your trail of thoughts and provided you address the skills that you used.

Example 2 (EFFECTIVE ANSWER)

“One of my patients wanted to self-discharge because she felt that her dog would be in danger if she did not get back home as soon as possible. I suggested that she called a relative so that they could look after the animal but she was adamant that she needed to do it herself. This prompted me to think that there was more to her story and that maybe she feared the operation she was due to have the next day.

During a quiet period, I asked a nurse to make sure that I would not be disturbed. I sat down with the patient and asked her gently to tell me about her dog. I listened patiently to her, showing an interest in her story and occasionally asking questions. As the patient opened up to me, I felt more comfortable introducing the subject of her own health and the operation. I could feel that she wanted to express her fears but that she was reluctant to admit to the problem, perhaps because she did not want to appear foolish. I gently explained what the operation entailed and reassured her about the anaesthesia. In order to avoid giving the patient the impression that I was pressurising her, I asked the nurse to spend some time with her. To reassure the patient further, I arranged a meeting with the anaesthetist and arranged for the relatives to discuss the care of the dogs with the patient.

After a few hours of concerted team work and sensitive communication, the patient agreed to remain in hospital and the surgery went ahead as scheduled, with a successful outcome.”
Note how the example above combines team work and communication skills in a relatively detailed manner.

COMMENTS
To have an impact, you must make sure that your answers are as personal as they can be by drawing into the relevant detail of the experience that you have accumulated over the years.

It is worth spending time carefully choosing a good example as the detail will flow naturally. If you choose an example that is not appropriate or if you are not addressing the skills explicitly within your answer, you will quickly run out of steam and end up producing vague sentences (if you haven’t run out of words before then).

The above example also shows you how you can transform an “okay” answer into a much more precise answer simply by expanding on one or two ideas that you raised, highlighting how you used your skills in practice to achieve the desired result.

2.8 – Outline a time when a new and different approach to a patient of yours proved beneficial. What did you do and what was the outcome?

The question asks for a different approach. At first glance this could mean either a different way of managing a patient, for example by trying a different type of treatment, or a different way of approaching the patient from a communication point of view.

Bearing in mind that shortlisting questions are not designed to assess your clinical knowledge but your personal skills, you should ensure that you do not fall into the trap of discussing a clinical scenario as it would yield no marks.

HOW TO APPROACH THE QUESTION
Identify the type of situation that the question is targeting & then choose a suitable example from your experience.

Essentially the question is asking you to describe a situation where your first approach was unsuccessful and where you then changed your strategy of approach to achieve your objective. This could include situations where:

- a patient was reluctant to go ahead with one of your recommendations and where you had to take a different approach in your communication to make them get the message.

- a patient with whom you used a first approach that revealed some underlying issues, which then prompted you to choose a different approach. For example, you may have adopted a “standard” approach to the problem but then gained information from the patient that indicated that there were deeper psychological issues at stake, that needed to be resolved as part of the same process.

Identify the skills that you will demonstrate through the scenario.
This question is essentially about testing three skills:

- Your ability to think laterally about a difficult situation, using your knowledge of the patient/the situation and the resources available to you in order to find a solution that will drive you towards a successful outcome. (Note that this could include involving other people such as relatives, other doctors, etc. in which case you may be able to include an element of teamwork in your answer).

- Your communication skills in relation to the patient
The manner in which you are able to build and maintain a rapport with the patient to achieve your desired objective, whilst not compromising your integrity and preserving respect for the patients’ values and choices.

**EXAMPLE 1 (INEFFECTIVE ANSWER)**

An obese 42-year old HGV driver came to my clinic with a high blood sugar level. His GP had referred him to the diabetic clinic twice (he had Type 2 diabetes) and, each time, the patient had failed to attend.

Despite my best efforts to explain the situation to the patient and encourage him to attend, he was not listening attentively and was being uncooperative. I felt a stronger approach would be required to kick the patient into action. I told him that unless he was admitted into hospital and treated, there would be long-term complications to his diabetes, such as loss of eyesight, nerve damage, heart disease and stroke."

The above answer has a lot of good points: it deals with a specific example, the situation is fairly clear and the clinical information is reduced to the bare minimum. However it seems a little harsh. Effectively the candidate is saying “He wouldn’t listen so I scared him to make him comply”. This needs to be softened. In particular the writer should spend more time demonstrating how he approached the patient in the first place, with empathy and sensitivity etc to demonstrate why the second approach was necessary.

Also the candidate has missed out the “Result” part of the answer. This makes it look very odd and even scary to a point. You simply don’t feel that there was a rapport between the patient and the doctor, or any attempt by the doctor to try his very best before escalating his approach. The answer should therefore focus more around the communication aspect and how the doctor interacted with the patient, rather than just about what the doctor felt and what he said.

**EXAMPLE 2 (EFFECTIVE ANSWER)**

An obese 42-year old HGV driver came to my clinic with a high blood sugar level and a urinary tract infection. His history revealed that his GP had referred him to the diabetic clinic twice for Type 2 diabetes and that the patient had failed to attend both appointments. On enquiring about the reasons for his non-attendance, the patient mentioned that he was scared of being prescribed insulin as it would lead to the loss his HGV licence.

My first approach to the patient’s reaction was to listen carefully to his words, explaining that I understood his dilemma, but also emphasising the solutions we could find. I took him through the features of Type 2 diabetes and explained that there were ways in which it could be controlled. In view of his worries, I reassured him that insulin would probably not be an option. I felt that the patient was not listening attentively and was being uncooperative. As he had already missed two appointments and was showing few signs of encouragement, I felt that a stronger approach would be required to encourage him to take appropriate action. After discussing the issue with my consultant, I explained to the patient that, unless he was admitted into hospital and treated, there would be long-term complications to his diabetes, such as loss of eyesight, nerve damage, heart disease and stroke.

"This resulted in a drastic change in the patient’s attitude who very quickly agreed to being admitted. A few months later, the patient thanked me for my empathic but assertive approach as he felt I had saved his life."

This answer is more balanced, showing empathy, discussing with the consultant and then adapting the style of communication to the situation and the patient’s reaction.

**COMMENTS**

Without doing some preliminary ground work, it would be easy to mishandle the question by taking a clinical perspective that would lead you straight to disaster. By doing some preliminary thinking before you launch into an answer, you will quickly identify the skills that you can demonstrate. In turn, this will save you a great deal of time when you are actually writing the answer as you will know exactly what you are trying to say.

There is no harm in presenting clinical information as was done above, but only to the extent that it helps towards the story. In the example above, it was necessary to include some in order to demonstrate the gravity of the patient’s condition and the extent to which the patient was “scared” into compliance.

Finally, beware of words that may sound harsher than you mean them to be. For example “I told” is very directive whilst “I explained” is softer.
2.9 – Describe a time when you had to defend your own beliefs with regard to the treatment of a patient. What did you do and what was the outcome?

Another question following the STAR system, where the question leads you through the structure. The topic is slightly unusual and may scare some people but if you stop one minute to think about it, there is nothing difficult about handling it. The main issue may be for those who are very junior to find an appropriate example.

**HOW TO APPROACH THE QUESTION**

Think about the context in which you may have to defend your beliefs with regard to the treatment of patient. This could be for example:

- A situation where you made a decision that was queried by one of your peers, or seniors or a nurse, and where you had to defend your views.
- A situation where your decision or belief with regard to treatment was queried either by the patient or one his/her relatives.
- A case review meeting where you were asked to justify your actions.
- A disciplinary environment (I would not recommend that you go there!)

Taking this first generalised step should help you recollect situations where this has happened. Once you have come up with an example, try to remember the various steps that were involved in the story.

Think about the attributes that the question is testing and those that you want to present.

- It is a question about defending your beliefs, therefore it will involve a lot of communication. This question is partly about presenting information in a clear manner in order to convince someone.
- Because you are effectively debating with someone over whether your approach was right or not, you will need to take on board their comments to see if they make sense to you. Your answer will therefore involve an amount of listening.
- If you have to defend your beliefs, it is most likely that you are being criticised or are being placed under pressure. This question is partly about coping with pressure and your ability to keep your cool.
- As a doctor, you should have confidence in your own abilities without demonstrating arrogance or being over-confident (in which case you may not be safe as you are unlikely to check your facts and call for help if required). In your answer you should therefore seek to demonstrate that you are safe by taking a logical approach in resolving the issue at stake. That approach really depends on the situation that you are facing.

Think generally speaking about how you would normally try to convince someone that your judgement is correct.

- First you would ensure that you have all the information to hand to be able to present a sensible case.
- Secondly, you would present your logical arguments to the other person and would wait for their reaction. You would then pay attention to what they have to say, giving them the opportunity to express their opinion freely without interrupting. It will make them feel valued and, you never know, they may have a valid point.
- Thirdly, if your first approach did not work, you may want to try a different approach. This could be either a different way of communication (for example by using a diagram rather than words, or by giving someone a...
leaflet to read before you can have your next conversation, etc). In some cases, the alternative approach may be to involve a senior colleague into the debate to give more weight to your argument.

- If none of this works then there may not be an easy conclusion to the problem. If patients are involved, this could involve the complaints procedure, court action etc. For the purpose of answering this question you should ensure that you choose an example where you were successful at defending your beliefs otherwise you will run into trouble, however justified your actions were.

Be careful, in situations of emergency, it may not always be possible to discuss everything for a long time (in fact it may be unsafe and/or negligent to spend too long discussing matters if the patient is not being handled in his best interest. If you discuss an emergency situation, you should ensure that you demonstrate that you have taken every possible step to get input from your seniors if needed, that you acted in line with your best judgement and in the best interest of the patient, and that you have spent time after the event to sort out the conflict.

EXAMPLE (EFFECTIVE ANSWER)

“I had admitted a patient for ketoacidosis who, according to my best judgement, required a high dose of insulin. I asked a staff nurse to administer the treatment, which she refused to do since she would only go ahead with a dose that followed the normal sliding scale. I spent a couple of minutes explaining patiently and in a normal tone of voice to the nurse, that as well as the patient’s blood sugar we needed to deal with the ketosis and the acidosis, which required a high level of insulin. As she refused to go ahead and, in view of the urgency of the situation, I administered the treatment myself in order to ensure the patient was safe at all times.

Once the patient was stabilised, I asked the nurse if she wanted to discuss the matter in a more relaxed setting. Over a cup of coffee in the mess I asked her to explain how she saw the situation and she explained that she had never come across such a situation in the past and did not feel comfortable taking orders without understanding them. I listened attentively to what she had to say, realising that her behaviour could be potentially dangerous for patients. I then spent some time explaining in some detail but in simple terms the facts on diabetic ketoacidosis and why a high dose was necessary. I also explained to her in a non-judgemental manner how her actions may have endangered the patient, emphasising that this should in no way stop her from raising her concerns if she felt she needed to in future.

The nurse felt that she understood the situation better and apologised for her action. This incident enabled us to have a closer relationship and as a result enhanced the standard of care that we were able to provide to all future patient.”

Note the emphasis on the communication aspect of the scenario about listening, being non-judgemental but also assertive. Also note that there is some clinical content, however it has been reduced to what is strictly necessary to understand the context and the actions of the individuals involved.

COMMENTS

Don’t be afraid to go into some detail. Detail and facts will help build up your credibility and will make the example look real. But always make sure that those details are relevant to the question being asked.

You can use the “Outcome” or “Result” section to explain a little bit more than what happened at the end of the story, by adding a sentence about how it helped you become a better doctor. In this example, it is about building bridges with the nurse and enhancing the working relationship. It helps add depth to the answer.

Other questions looking for similar types of answers include: give an example of a situation at work where a patient has not agreed with your diagnosis or management?
2.10 – Describe a situation when you had to use creative thinking to solve a problem at work.

Ask yourself what the word “creative” means.
The word “creative” refers to the fact that you have used your imagination and initiative to come up with a solution. The question therefore relates to a situation with which you were unfamiliar and for which you had to use your brain power to derive a sensible and effective solution.

Identify the type of situations that you have faced, where you were exposed to an unusual problem.
This may include situations where:

- You had to deal with a patient who presented with a condition that you were unfamiliar with.
- Your senior asked you to organise something that you had never organised before (educational meeting, audit project, rota, etc).
- You had to deal with several tasks at the same time, which looked completely impossible to you at the time (for example routine work and several emergencies all at the same time).

Identify the skills that you can demonstrate in your example.
This is a question about what you would do in a situation where you have a problem that has no obvious solution to you. Things you can do include:

- Asking for help from seniors (although this is not really creative by itself!)
- Looking things up in a textbook (already more proactive) or on Medline/Cochrane etc (evidence-based practice is popular at the moment!)
- Discussing issues with colleagues/seniors (team work is always appreciated!)
- Using all the resources available to you, delegating work to the appropriate people (even better!)
- Using a different communication approach (see question 4).

Find an example that suits you best and would enable you to demonstrate your ability to handle unusual situation using several tools. Here are a few examples that should enable you to think of your own:

- You have a patient who looks like he has a particular condition but something tells you that there is more to it than meets the eye. Your creative thinking leads you to do some reading in textbooks and on the internet, before having a chat with your Registrar. You also feel that another doctor from another ward can help, so you contact them and arrange a discussion on the patient’s condition to find a solution to your problem.
- You work in a hospital where the rota is imposing too many constraints on junior doctors (perhaps they have made a mess of implementing the European Working Time Directive). You come up with a solution of your own, discuss it with your colleagues and then arrange a meeting with a consultant to discuss the problems caused by the current system and to offer your own ideas. As a result your proposal is implemented.
- You are running a clinic where you constantly have the same problem with patients. For example there is some simple information that they need to take away with them after the clinic but that information often gets scribbled on a piece of paper, which they lose. You take the initiative to produce a proforma slip which doctors can complete quickly by ticking the right boxes and which patients are less likely to ignore.
You have discovered that members of your team often forget to consider certain points in their history taking, which slows down patient management and may lead to errors. You know that the current system has been implemented by one of the consultants who thinks that it works well and you therefore need to convince everyone that the system needs to be changed. Your creative thinking leads you to use diplomacy and tact to highlight the issue and to offer a counter-solution without upsetting the consultant in question.

You are on-call, facing a difficult case, and none of your seniors are available for help. You can then describe the research you did to find a solution and how you used other resources available (nurses’ advice, other SHOs/seniors from other wards) to solve your problem.

COMMENTS
Conclude on a personal note. In this question you can mention how the situation helped you gain confidence in your own abilities to handle complex situations or how it made you realise how important it was to use the resources available to you and to work as a team.

Questions revolving around this theme include:

- Describe a time when you had to think beyond the obvious to manage a patient’s health.
- Describe a time when you made your workplace more efficient. (Note this could include an example of an audit that you initiated)

2.11 – Describe a situation when you demonstrated professional integrity as a doctor.

INTEGRITY IN YOUR DAY TO DAY WORK
Integrity refers to your ability to do the right thing when faced with a situation that it would be easy to ignore because it makes your life easier. This may be:

- Situations where you have made a mistake, where you would be expected to own up to it and take corrective action.
- Situations where you should know how to handle particular issue but somehow you don’t. Integrity is about admitting your deficiency and working towards addressing it (a lack of integrity would be pretending that you know what to do, which may put your patients and colleagues at risk).
- Situations where you discover that something is wrong and where you take proactive steps to address the situation (for example, if you discover that one of your colleagues has made a mistake, is an alcoholic, takes drugs, has abused a patient or is underperforming/incompetent).
- Situations where you were pressurised into doing something that you knew or felt was wrong and where you resisted the pressure (e.g. a relative, a friend or a colleague encouraging you to breach patient confidentiality).
- Colleague who wants a “favour” that would place you in a difficult position, (covering up for a mistake they made, prescribing them controlled drugs, etc.)

There are other situations where you can demonstrate integrity but they do not always lend themselves well to examples. For instance, finding a wallet in the street and taking it back to its owner would be an example of integrity but

(i) it is not exactly medical;
(ii) it is too basic to be worthy of interest when it comes to writing 250 words on the subject.

STRUCTURING YOUR ANSWER
As ever, since they are asking for a specific example, follow the STAR structure, making sure that you focus on a particular event. Because you need to talk about your integrity, you first need to explain the context that forced you to choose the integrity route.

**Example of the relatives exercising pressure to breach confidentiality.**
- If you want to talk about a relative who wanted you to release information about the patient, you should explain what the patient’s condition was, why they did not want their relatives to know anything, and why the relatives were pressurising you.

- In the “Action” section you can then describe how you handled the relatives (think about the communication skills - listening, showing understanding, empathy) and how you felt you needed to stand up to them. If needed, you can also explain how you called a senior colleague to put more weight on your argument. You can also talk about what was happening with the patient at that time and how you handled the communication with them in that context.

- To conclude, you should explain how through good communication, team playing and gentle assertiveness you managed to resolve a potentially explosive situation.

**Example of the mistake that you made and admitted to.**
- Make sure you choose a situation where the patient wasn’t placed in a dangerous/unsafe situation – there is no need for it in this question since the focus is on how you admitted to the mistake rather than the mistake itself.

- Describe what you had been asked to do (Task).

- Explain the mistake that you made, sticking to the essential (not too much clinical information). Also explain why you made the mistake (is it because you were inexperienced or had misunderstood what you had been asked to do, or some other reason?). Do not be too shy, everyone makes mistakes. Just make sure yours wasn’t a deadly or potentially deadly one!

- Explain how you identified that you had made the mistake and what you did after that. Things you can detail include:
  - Remedying it straight away if it was a simple mistake.
  - Going to your seniors either for help to sort things out, or to report that you made a mistake.
  - Taking every single step possible to sort the matter out.
  - Discussing the issue with colleagues and particularly how you will handle the communication with the patient, if a patient was involved.
  - Apologising to the relevant people (colleagues, patients, relatives, etc)
  - Critical Incident Form if required

- Conclude your story by describing how everyone reacted in the end (patient/colleagues happy, etc) and what you learnt from the example (this could be that you learnt how a simple apology can go a long way, or how admitting your mistake early meant that the problem could be resolved quickly.
COMMENTS
In this case, the word “Integrity” actually featured in the text of the question. Integrity can also be tested as part of a more specific scenario. In particular they could force you to focus on one of the scenarios listed above by asking you the following questions:

- Provide an example of situation where you made a mistake.
- Describe a time where you failed to manage a patient effectively.
- How would you react if one of your colleagues asked you to do something you felt was inappropriate.
- How would you react if you suspected one of your colleagues had a drink or drugs problem? (See question 16 for more details on this)

For the first two questions (example of a mistake, failure to manage a patient effectively), the answer is pretty much as per the above. You need to demonstrate that you recognised that you did wrong, admitted to it and then sought to resolve the matter as swiftly as possible. You also need to discuss the communication implications with both the patient and your colleagues, and what you learnt as a result. If possible, discuss how you also made sure that others learnt from your mistake (e.g. by sending an email to people warning them about a particular problem that you have encountered, or by discussing the case/situation in a team meeting, or even through a critical incident form.

For the others, the question is not actually asking for an example but is asking for a pattern of general behaviour you would demonstrate in a hypothetical situation. These questions are easier to formulate (they don’t need to follow the STAR system since there is no story to tell) but they require you to think carefully about all the issues involved and to present them in a logical manner.

2.12 - Describe a time when you had to obtain informed consent from a patient who was in a vulnerable position. How did you communicate with them, which strategies did you use and what was the outcome?

It looks like a question on how to seek consent so most candidates will rush into describing how they can seek consent. Don’t make the same mistake; the question is more complex than it looks.

The clue is in the second part of the question “How did you communicate with them”. It is a communication question, and more precisely, a question about how to communicate in a challenging situation i.e. where you will have to think carefully about how you will need to approach the problem (clue: creative thinking!). The consent-seeking context is just a platform to make your job easier in finding an example. In your answer, you will need to make a clever mix of the three aspects: seeking consent, communication and creative/lateral thinking.

HOW TO APPROACH THE QUESTION

Identify vulnerable patients you have encountered.
This could include:
- Patients who are elderly, of sound mind but easily influenced.
- Patients who have psychiatric problems.
- Patients who may be making decisions against their own best interest because of some other factors (fear to become a burden on relatives, etc).
- Patients who have just had bad news broken to them.

You can then more easily identify which patient would be a suitable candidate for a good example.
Follow a logical structure, taking the approach chronologically.
Here again (hopefully by now you have got the idea about this!), the STAR system needs to be followed.

- Start by explaining the context. Who was the patient (ensuring you give enough detail to show how/why they were vulnerable) and what did you need to seek their consent for?

- Detail how you sought consent (explaining things slowly, checking their understanding, drawing diagrams if needed etc) but throughout your answer explain how their vulnerability impacted on your actions and how you resolved each problem that this presented you with.

- For example, simply saying “I explained the procedure in simple terms” is too weak because this could apply to anyone, not just a vulnerable patient. Instead you could write something along the lines of “I explained the procedure in simple terms, using a diagram to illustrate my words, but the patient seemed a bit confused about some of the detail and was taking a long time to understand some of the basic information. I therefore asked the nurse and also one of the relatives to explain in their own words what I had described, which helped the patient along.”

- As another example, instead of saying “the patient was crying so I gave her some leaflets and asked her to come back later”, which sounds harsh, you need to explain why you acted in that way and show that you used a sensitive approach that matched the distress of the patient. This could give an answer like “As the patient was crying uncontrollably, I spent some time gently reassuring her that we would do our best for her and asked her if she was okay to continue or wanted to go home. I offered her the opportunity to study some leaflets and come back at a later stage, which she gratefully accepted. She returned three days later etc.”

- Try not to go too technical on the “seeking consent” aspect as it is not really the aim of the question. The only really important aspects for these questions are:
  - Explaining the procedure in detail in a clear manner, including pros, cons, alternatives, risks (no need to go into detail in these questions)
  - Checking the understanding of the patient and answering their questions.
  - Reassuring the patient they can change their mind and can take the time to think about their decision

- In some cases you may need to address the competence of the patient, which you may have assessed by asking a psychiatrist to review the patient or asking for senior advice.

COMMENTS
It is important to recognise when an answer looks as if it is about a given topic when in fact it is asking you to concentrate on totally different skills, simply using that topic as a platform for discussion. In this example, it would have been too easy to consider the consent issue whilst totally ignoring the communication challenges posed by a vulnerable person.

2.13 - Describe a situation when you have used a holistic approach in managing a patient. How did you address the patient’s needs?

The aim of the question is clear: discuss the holistic approach through a real-life scenario. The needs to be identified are also clear since they are part of the holistic approach: physical, social, psychological. No real surprise there.

The key to this question is really to find a good example that enables you to demonstrate your experience of all three aspects, all this with one single patient.
Note: the question asks for a clinical situation. It does not mean you have to go hardcore on clinical information but simply that it must be related to a patient at work, rather than, say, a friend whom you might have dealt with.

HOW TO APPROACH THE QUESTION

Identify a particular patient with whom you had to deal with not only their condition but also their psychological and social needs. This could include:

- An elderly patient who needed to be discharged.
- A patient to whom you broke bad news.
- A homeless patient
- A patient with multiple conditions ranging from psychological to physical.

Use a simple structure for your answer.
This question asks for an example and you should therefore follow the STAR structure. The “Action” section is more or less dictated by the wording of the question.

Situation/Task
Describe what type of patient it was, how they presented to you.

Action
Explain that you understood there were several aspects that needed to be dealt with, from a physical perspective as well as a psychosocial point of view. You can then take all these needs in turn in a very structured manner

- Describe the physical needs of the patients and how you addressed them. In this section try to give just enough detail to give a good impression that you were competent but do not overdo it on the clinical detail – this is not the purpose of the question. In some cases, your answers could even be as simple as referring the patient to a specialist or to a senior colleague. All that matters is that you have addressed the needs in a sensible manner.

- Describe the social needs of the patient. Did they live on their own? Did they have family? Could their family cope with the burden? Did they need care in the community? What about financial aspects? Did they need advice about claiming benefits? Were there charities that could help? Did their home require special adjustments? Did you enlist the help of some members of the multidisciplinary team to sort out some of the issues (care workers, occupational therapist, community nurses, etc)? Did you provide leaflets? Etc

- Describe the psychological needs of the patient. Did they need counseling? Did they require a referral to a psychiatrist? Did you arrange for the patient to get in touch with charities? Did you spend some time counseling them yourself? Did you address this issue with the relatives? Did the relatives need counseling too?

Result
Explain how the patient was helped with your approach (grateful, much improved lifestyle, got a new job and sorted themselves out, etc).

COMMENTS
Don’t be afraid to go into detail in this question. They are asking for it! Make sure you allocate equal weight to the three aspects and, if you can, separate them out so that the reader can quickly identify that you have thought about the whole picture.

Try to be as practical as you can, describing what you physically did to address the patient’s needs. Too many candidates write sentences such as: “I identified the patient’s psychological needs and addressed them appropriately”. This only explains what needs you identified, but it would be nice to know what those needs exactly were and how they were addressed. For example the patient may have had a need for psychological support and consequently you discussed support groups and you gave the patient leaflets to read and website addresses to visit.
2.14 – Give an example of a situation where you showed leadership.

For this question, you should familiarise yourself with the leadership qualities outlined at the start of the booklet (pages 7 & 8). Being a good leader essentially means being able to make decisions and enthuse a team to implement them. This involves clarity and focus on the task at hand, an ability to foresee problems and implement early solutions, delegating effectively to a team and communicating well with it. It can also involve motivating others and taking a hands-on role in difficult situations.

CHOOSING AN EXAMPLE
Examples of leadership can be taken from different sides of your clinical experience. This may include situations such as

A busy on-call where you have limited or no senior support (in which case you must think on your feet and use your team as best as you can (whilst keeping in touch with seniors, even if remotely)

Handling multiple emergencies, where you need to prioritise, allocate responsibilities to various team members, ensure that they are supported in their roles, ensure that you remain approachable to address any issues or concerns they may have, and ensure that you drive your team towards a successful outcome.

Handling a complex patient which requires input from several professionals, some of whom may be reluctant to get involved (e.g. radiographers and other registrars)

A difficult crash call (make sure you do not sure a crash call where you simply had to follow the protocol, otherwise there is nothing interesting to discuss). If you go for the crash call example, you should also prepare another example (as some interviewers explicitly ban candidates from mentioning crash calls (they are the easy options and they hear about them dozens of times each day)).

DELIVERING THE ANSWER
The answer will need to follow pretty much the same pattern as all the previous questions asking for examples, demonstrating through your actions how you exhibited the attributes of a leader.

2.15 – How do you handle stress?

Interviewers need to know that you are able to remain calm under pressure, that you are able to deal with the pressures of stress whilst at the same time delivering safe patient care.

Although most candidates do mention the important issue of hobbies and distressing outside work, few present a broad picture that includes how to deal with immediate stress and how to anticipate and prevent stress. The answer to this question can be presented under four different headings:

1. **General Attitude towards stress**
   - Remain calm
   - Take a step back and try to put things in perspective
   - Identify the cause of the stress

2. **Dealing with immediate stress**
   - Take a break (if convenient)
   - Seek advice from colleagues
   - Prioritise your work, identify resources available and share your workload with others
3. Anticipating/Pre-empting stress
   • Plan your work. Anticipate problems and set up strategies to prevent them.
   • Learn from previous stressful situations. Discuss problems with colleagues and change your strategies.
   • Identify training needs for yourself and others in the team.

4. Destressing/Preparing yourself for stress
   • Relaxation
   • Hobbies
   • Social Life
   • Regular Holidays

Another way of organising the information could be as follows:

1. Recognise that you are stressed
   • Identify that you are stressed and the level of stress (long-term/short-term, does it stop you from performing safely and efficiently?)
   • Ways in which you can identify that you are stressed include for example:
     i. Feeling of tiredness
     ii. Loss of appetite/too much appetite
     iii. Inefficiency, taking too long to do simple tasks.
     iv. Don’t want to get up/go to work in the morning
     v. Becoming irritable (be careful, this is not to be said if you apply for paediatrics where this would cost you the job. In paediatrics, you will need to reassure that you do not externalise your frustration).
     vi. Making silly mistakes
     vii. Becoming forgetful.

2. Identify and resolve the causes of stress
   • Possible causes of stress include:
     i. Exposure to angry relatives or dying patients
     ii. Exposure to underperforming colleagues, conflict with colleague
     iii. Heavy workload, badly organised, not taking proper breaks
     iv. Personal problems (family problems, smoking, alcohol, late nights, etc)
   • Possible ways of resolving stress include:
     i. Taking regular breaks / holiday
     ii. Sharing workload with colleagues / delegating
     iii. Prioritising your work, planning your day
     iv. Asking for help, discussing issues with colleagues
     v. Hobbies, personal interests, relaxation
     vi. Talk to friends & family

3. Prevent stress
   • Learn from past experience
   • Proactive organisation of time and demands / Planning
   • Anticipate difficult periods or potential problems and implement pre-emptive solutions (e.g. training, additional communication, etc)
   • Keep communicating. Manage others’ expectations (for example, if you are prioritising, inevitably someone’s main priority will become bottom of your list. Not managing their expectations would result in a brewing conflict)

PERSONALISING YOUR ANSWER
Whichever way you choose to present your answer, you must make sure that it is personal. It is all too easy to simply state “I prioritise my work and discuss difficult issues with colleagues”; however you can guarantee that many of your competitors will have a similar answer.
To bring a more personal side to the answer, describe some of the situations where you have experienced stress. You do not need to be very specific about the intricate details of such situations, but sentences along the line of “I often have to deal with very busy on-calls which can sometimes become stressful either through lack of immediate senior support or because some of the patients can be very sick. For example, recently I had three patients who were referred simultaneously for xxx, xxx and xxx. The way that I handle such situations is by …”

2.16 – Describe a situation when you had to deal with a patient who was sceptical.

HOW TO HANDLE THE QUESTION

Identify why a patient may be sceptical

- They do not trust you for one reason or another. Maybe they have prior bad experiences with friends or relatives that would make them doubt your word.

- They may have information from the media (for example through TV, newspapers or the internet) that gives them a different perspective.

- They may be medically aware i.e. they are scientists or linked to the medical profession. They require more information than your average patient.

- They may have personal beliefs (against conventional treatment for example) or simply a language problem.

- They have a problem with you (e.g. a male patient being suspicious of a female doctor, a patient trusting older doctors only, etc).

- Your proposed options may be counter-intuitive.

Identify what this question is about.

Essentially there are two factors to consider:

(i) As a doctor you should do your best to ensure that the patient is fully informed. You cannot force the patient to do anything, but you need to demonstrate that you have done everything in your power to act in the best interest of that patient. This means that:

- You should explore the concerns that the patient has and address any underlying issues. For example, if they distrust conventional medicine, you should investigate the reasons behind this concern.

- You should make sure that the patient receives all the information that you can give them. This could be through the involvement of other professionals (for example by involving another colleague, a nurse or referring to a suitable specialist) or by giving a leaflet.

- You should ensure that you address the patient in a way they can understand (basic English if needed, interpreter, diagrams) and that they have time to digest the information and ask questions to you or others.

- If you are getting stuck with the patient, then you always have the option of asking a senior colleague how you should handle the situation (remember – you should be aware of your limitations!)

(ii) The patient has the right to make a decision for themselves. So if your particular patient still disagreed with you at the end, don’t panic but make it clear that you documented their disagreement. It is their right to disagree and your duty to accept that they can do so.

COMMENTS

Once you have found the right example, describing the situation is fairly straight forward using the STAR technique. Do make sure that you address the full question by mentioning what happened at the end.
2.17 – What makes you a good doctor?

A good doctor has many qualities, many of which are well known by all candidates. Most of these qualities are actually listed in the job description, which is curiously similar whatever the grade that you are applying for. Whatever job you are applying for (whether in or outside medicine), all skill requirements are almost always the same. The only differences are the type of technical skills required and the level at which you have to satisfy each competency (for example both an SHO and a consultant would be expected to have good leadership abilities, but obviously at a different level and in different contexts).

Most candidates address this question by listing dozens of qualities at random. This is highly ineffective. Instead you will find that whatever qualities you wish to address can often be classified under the following 5 heading:

1. **Professional competence & behaviour**
   - Sound clinical/surgical background. [Develop in accordance with expectations at the grade you are applying for and for your specialty]
   - Commitment to keeping your skills up to date
   - Aware of limitations. Seek help and refer to seniors when required.
   - Commitment to clinical governance including:
     a. Knowledge and use of guidelines, Evidence Based Practice
     b. Commitment to improving own practice through audit and seeking feedback.
     c. Interest in research (either through personal involvement in trials or through reading in order to maintain Evidence Based Practice)
     d. Commitment to teaching others

2. **Good communication skills** - See previous sections

3. **Good team playing and team leading abilities** – See previous sections

4. **Good managerial and organisational skills**
   - Able to deliver results in accordance with the objectives
   - Able to work well under pressure
   - Good time management skills including prioritisation and delegation skills.
   - Good planning abilities. Can anticipate needs and address them early.
   - Can anticipate conflicts and address issues early

5. **Personal attributes**
   You can use this section to raise any attributes that would not fit easily under the above sections. This would include adjectives such as:
   - Caring
   - Dedicated, Focused, Motivated
   - Enthusiastic
   - Hard-working…. Be careful with this word as its meaning is very vague. If possible try to use more specific words such as “efficient”, “committed”, etc depending on the meaning that you want to attribute to it.

**IMPORTANT**

The above provides a structure to your answer. In order to give a meaningful answer you will need to weave in your personal experience and demonstrate the relevance to the post and grade that you are applying for.

Towards the lower grade the emphasis should be towards organisational skills and team playing. Towards the higher grades, the emphasis should be on leadership with a strong degree of clinical governance.
2.18 – What are your main strengths?

Most candidates answer this question by simply listing a few attributes that they remember from the person specification. This typically gives a litany of the sort: “I am hard-working, dedicated, motivated, focus, empathic, a good listener, a good team player and a good team leader”. Such answer is very vague and provides little information about the candidate.

**HOW TO APPROACH THE QUESTION**

It is important to have an answer that relates to some of the above themes but in order to make an impact, you will need to be more specific. For example, “I am empathic” sounds average because it is very short and, although the candidate may have the quality of empathy, we do not feel that it is their strength. By tightening the wording into something like: “I am very empathic and in particular I am able to build a rapport with distressed patients very quickly” sounds more convincing because it is more specific.

Similarly, “I work well under pressure” sounds fine, but at the same time, it does not feel like anything special. This could be tightened into “I work well under pressure, and in particular I am good at keeping calm and making rational decisions when facing difficult situations or unexpected complications in theatre”.

Ideally you should be able to come up with three strength, which you need to describe explicitly as explained above. You can then expand on your opening statement by explaining why it is a strength and maybe giving an example of when it helped you perform well.

2.19 – What is your main weakness?

When discussing weaknesses, you should avoid the cheesy answers (such as “I am a perfectionist” or “I can’t say no to people”). Nowadays this question is often asked to test how genuine you are rather than to know about your real weaknesses. Here is a wonderful opportunity to prove that you are aware of your limitations.

**HOW TO HANDLE THE QUESTIONS**

As much as possible, you should put your answer into a positive context. If the only thing coming out of your mouth (regardless of how negative it is) it will not leave the best impression. Use the opportunity to sell some positive points.

Many weaknesses are actually acceptable to mention but you need to make sure that they do not impair your chances. The problem most people have is that they try to address the weakness by concentrating it all in just 2 or 3 words in the hope that it will get it out of the way quickly. For example “I can’t say no to people” actually sounds really weak and does not necessarily inspire confidence in you. You need to think about the context in which this weakness occurs so that you can explain in more detail that it is not a permanent flaw of your personality but something which takes places only on occasions and in certain circumstances. You also need to reassure the interviewers that most of time you are actually okay. In the case of “I can’t say no to people” a more positive answer could look like:

“I am someone who is confident and assertive, and always willing to help others. However there are occasions when I am offering to help someone when I know that it will place me in a difficult situation, for example by adding pressure to my workload. In turn this may delay my own work and give rise to stress.”

This answer actually paraphrases “I can’t say no” without actually mentioning the dreaded words. It sounds more personal because it is placed in context and the interviewers are also reassured that in most circumstances you can cope well. You can even make it more personal by giving a brief example.

Taking the other example of “I am a perfectionist”, think about when you become a perfectionist. Is it all the time? When you are stressed? By going into more detail and speaking about it in simple humble terms you will come across as much more genuine. For example the following answer could be suitable depending on your circumstances whilst not sounding cheesy:
“I am very good at managing my work efficiently and getting things done, although occasionally, when I get very stressed I tend to spend a lot of time dealing with small details when I should really move on to deal with more pressing matters. This usually results in higher levels of stress and some delays. Over the past year or so I have become increasingly able to recognise when this happens and to tell myself to concentrate on other more pressing issues.”

PERSONALISING THE ANSWER
What lets most candidates down is their fear of the question more than the question itself. The more general you remain in your answer, the more cheesy it will sound. Once you have announced and paraphrased the weakness as shown above, it is important that you illustrate through an example how it affects you. By providing an example, you will make it sounds more real and genuine, and less theoretical. You then need to explain what you are doing concretely to get over it.

POSSIBLE WEAKNESSES
Other weaknesses that can be handled in the same way include:
- Tendency to take your work home (which you can resolve with the help of your family and personal will)
- Expect sometimes unnecessary high standards of others (which you can resolve through experience)
- Find it hard to delegate to people you don’t know (especially new juniors), in which case you remedy this by getting to know them as quickly as possible
- Finding hard to cope with some difficult emotional issues at work (especially if working in paediatrics, oncology, elderly care, ITU). This also gets better through experience but also by discussing with other colleagues.

Whatever you say, do not mention poor time management, bad handwriting and not being to stand lazy or stupid people. It just sounds bad!
SECTION 3

ACADEMIC & CLINICAL GOVERNANCE QUESTIONS
3.1 – Tell me about your teaching experience.

In relation to teaching there are several aspects that they will want to test:
- Your experience
- Your appreciation of the various teaching methods
- Your enthusiasm for teaching

Even if the question is not prompting for all of this information, you should try to enrich the content of your answer by weaving in some or all of this information as appropriate.

Describe your experience
Do not mess about with fancy introductions such as “Teaching is very important and is a crucial part of clinical governance bla bla bla” because it just wastes time and will only irritate the interviewers. You have been asked a question; answer it directly.

Describe the various types of people that you have taught (junior/senior colleagues, GPs, peers from other specialties, nurses, medical students). To have a strong answer you should also describe what type of topic you taught them and how often. For example, saying “I teach SHOs on a weekly basis in workshops on topics such as x, y and z” sounds a stronger answer than “I regularly teach junior colleagues”.

This could include presentations (both in and outside the hospital, journal clubs etc) as well as situations where you may have educated patients (if you have nothing else to talk about, it is always a safe thing to mention).

Describe the different methods that you have used.
This could include one-to-one, formal lectures, supervision, workshops, PBL groups (especially if you applying to Manchester), video, mannequins, etc. If it sounds better, you can mix this in with the experience that you described above.

Mention any teaching training courses that you attended.
This would include “teaching the teachers” and any medical education degree that you have taken. If you are booked onto a course then mention it too.

Bring a personal angle to the question.
You can discuss the fact that you make sure that you get feedback on your teaching skills. If the feedback has been good then say so, and explain what people have liked about your teaching. If you want to, you can also mention that you enjoy teaching and explain why. If you are a particular interest in teaching you can also state this and explain what your ambitions are (maybe you want to become an educational supervisor, or get involved at deanery level).
3.2 – Tell me about your worst teaching experience.

Everyone has a bad teaching session at one stage of their career, so there is no point going into denial. The main problem is to find one that is not too embarrassing but is also bad enough to allow you to really sell yourself with some depth.

CHOOSE A GOOD EXAMPLE

Easy examples
The easy examples are those where you made a stupid mistake but one which does not affect the image that you project. This would include practical problems such as forgetting to bring your power cord and the laptop switching off half way through a presentation, or having a font that is too small to read from a distance (particularly if you were expecting a small room and the room turned out much bigger than you thought).

More substantial examples
These are examples where you misjudged the situation; for example a situation where your teaching session was too complicated or too easy for your audience you had to deal with an audience made up of people who had very varied backgrounds you had to deal with disruptive or difficult elements in your audience you failed to prepare adequately (e.g. for questions at the end).

Although these more substantial examples are obviously exposing yourself more, they are also probably the best to discuss in your answer as they allow you to demonstrate a good ability to learn from your negative experience. Whilst the learning process is quite minimal when all you have learnt is to remember to take your power cord next time, it can be much richer when you have failed to adapt your teaching to a diverse audience.

DELIVERING YOUR ANSWER
When you deliver your answer, do not lose track of two things:
- The question is essentially asking for an example therefore you must take the STAR approach.
- The whole point of the question is to make you discuss how you learnt from your mistakes/experience so make sure that this learning process features prominently in your answer.

3.3 – What teaching method do you like the most and which one do you like the least?

There aren’t that many answers that you can give to this question.

LEAST
In practice, no one really like delivering big lectures because:
- It is difficult to target the right level when there are too many people with sometimes a very different background
- You cannot gauge the reactions of the audience, which makes it difficult to then alter your teaching sessions accordingly
- It is mainly a one-way communication process.

Never say that big lectures are “boring” because they might well want you to give some, and, although they may not be your favourite method of teaching you must at least demonstrate that you don’t mind giving them every so often.

MOST
Conversely, you enjoy interactive teaching the most because it offers what big groups can’t offer. Use the opportunity to give an example of a successful teaching session that you gave together with the positive feedback that you gained.
### 3.4 – Why do you enjoy teaching?

There are many things that one can enjoy about teaching and you will most likely be able to come up with your own reasons. Generally speaking, you may want to consider the following points:

- You get personal satisfaction from participating in the development of your colleagues and the feedback that you have been getting certainly shows that people appreciate your input.
- It helps the team bond together. By spending time with your colleagues away from the pressures of your daily routine, you can build better working relationships, which in turn translates into better patient care and a good atmosphere at work (well, sometimes anyway!)
- You can learn a lot from teaching others. Not only do they force you to know your topic in depth (they might ask all sorts of questions at the end of the session) but you also learn through the preparation that you do, reading journals and surfing the net for evidence for example.

### 3.5 – What are the qualities of a good teacher?

The qualities of a good teacher are not always easy to define but essentially you may want to discuss the following:

- Sets appropriate, specific and challenging goals.
- Has a clear plan to achieve his/her goal and has a clear delivery of his/her topic.
- Involves the students, continually assesses the learning and provides feedback.
- Is positive and encouraging.
- Is able to promote enthusiasm in his/her students.
- Is able to adapt to the students and alter his/her methods accordingly.
- Is resourceful and adopts a problem-solving approach
- Respects his/her students.

You can discuss each of these (and more!) in turn, explaining why they are important qualities (i.e. do not just list them). You might also want to discuss how you organise your own teaching, trying to demonstrate as many of the above qualities. This would help personalising the answer.

### 3.6 – How do you know that you are a good teacher?

This question is not about whether you are or not a good teacher but about how you measure your own success. There are several ways in which you can do so:

- From feedback. Discuss the fact that you make a point of getting feedback after each teaching session and mention what your feedback has been (stick to the positive!)
- From the reaction from your students during the teaching. If they interact, ask questions and pay a genuine interest in the topic then you must be a good teacher.
- From the fact that you are being asked to do more teaching.
3.7 – What is the purpose of an audit?

The answer to this is very simple: Audits are a systematic examination of current practice to assess how well an institution or a practitioner is performing against set standards. Essentially it is a method for systematically reflecting on, reviewing and improving practice.

There are several steps in an audit (so-called audit cycle) as follows:

- Choose Subject
- Set Standard
- Collect Data
- Analyse Results Against Standard
- Identify Changes to be made
- Implement Changes
- The phrase “audit cycle” refers to the fact that once the changes have been implemented, you need to check that the practice has improved either closer to or in line with the standard; hence the need to re-audit several months later to check progress.

3.8 – Tell me about an audit that you have done.

The main purpose of this question is to get you to talk about the audit cycle through your own experience. It is therefore important that, as much as you can, you choose an audit which has had an impact on clinical practice (otherwise you will struggle to explain what changes you implemented.

When you describe the audit, you should mention:
- The circumstances that led to the audit (i.e. what problem was identified, which led you or your department to want to look into the matter in more depth)
- The practice that the audit was testing and the standard against which it was tested (If there is no standard then it is not an audit!)
- How you went about collecting and analysing the data (i.e. how many patients were looked at, what your role was and what IT tools you used – for example you can talk about deriving a proforma and entering the data into Excel)
- What the conclusions of the audits were and what recommendations you put forward (after discussions with your consultant of course)
- What changes were implemented
- What the re-audit showed.

Note that many of you will not have done a re-audit for the simple reason that you will most likely have left the job by then. However, you can still signal your understanding of that part of the cycle by saying something along the lines of “Unfortunately I did not have the opportunity to carry out the re-audit because I had left the job before then, but it was planned for 4 months later”. If you know the results of the reaudit (for example because you kept in touch), then mention it.

If you presented the audit, then mention it too.
3.9 – Tell me about your most interesting audit.

Rather than any audit, you may be asked to talk about your most interesting audit. It may be that the most interesting audit did not actually lead to much change in clinical practice. If this is the case, you would be wise to choose an audit that allows you to shine at the interview by giving you the opportunity to discuss the whole cycle, rather than the one that you enjoyed the most. A little white lie, but a worthwhile one!

3.10 – Tell me about your audit experience.

It would just take too long to talk about all your audits if you have several. The main message that you want to give in your answer is that you do have experience of audit and that you know how they are conducted.

The best way to answer this question is therefore to introduce your overall experience by saying:

- How many audits you have done
- What topics they related to

You can then talk in more detail about the audit which you feel had the biggest impact on your practice (see Q3.8)

3.11 – What is the difference between research & audit?

The main differences are as follows:

<table>
<thead>
<tr>
<th>RESEARCH</th>
<th>AUDIT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aims to establish best practice.</td>
<td>Aims to evaluate how close current practice is to best practice and to identify ways in which service can be improved.</td>
</tr>
<tr>
<td>Is designed so that it can be replicated and so that its results can be generalised to other similar groups.</td>
<td>Is specific and local to one particular patient group. Results are not transferable.</td>
</tr>
<tr>
<td>Aims to generate new knowledge and increase the sum of knowledge.</td>
<td>Aims to improve services.</td>
</tr>
<tr>
<td>Is a one-off study.</td>
<td>Is a continuous process.</td>
</tr>
</tbody>
</table>
3.12 – Why are audits important?

Ultimately the main purpose of an audit is to increase the quality of service provided to users (e.g. mainly patients, but also other practitioners, relatives etc).

The benefits of clinical audits are:
- It identifies and promotes good practice and can lead to improvement in service delivery and outcomes for users.
- It helps providing information to relevant institutions about the effectiveness of your service and helps contribute to its development.
- It provides opportunities for training and education.
- It helps ensure efficiency by ensuring a better use of resources.

You can enrich your answer by talking about one your audits, highlighting the impact that it had on clinical practice.

3.13 – What is your research experience?

The answer to this question will very much depend on the extent of your experience and indeed, whether you actually have any at all.

IF YOU HAVE A LOT OF EXPERIENCE
If your experience is substantial, you will need to provide a concise summary of it. The structure of your answer could be as follows:

- **Summarise the extent of your experience upfront** (e.g. I have been involved in four research projects including one randomised controlled trial, two studies and one national trial over the past four years, particularly as part of the PhD that I am currently finishing).
- **Describe the one or two most interesting projects**, setting out clearly the extent of your involvement (including ethical approval, seeking funding, and the role that you played during the actual projects).
- **Mention any courses that you have attended** (e.g. research methodologies, statistics, critical appraisal, etc)
- **Explain what you gained from your research** (research skills and transferable personal skills – see next question)

IF YOU HAVE LIMITED EXPERIENCE
Refer to the section above, summarising all your projects.

IF YOU HAVE NO EXPERIENCE AT ALL
If you do not have any experience, then don’t panic. It may not be a requirement in the first place. Some candidates who have limited or no experience but express a good understanding/awareness of the topic can sometimes be better than candidates with experience who cannot sell themselves well.

You need to demonstrate that you have gained an understanding of research in other ways, for example:
- By attending and/or presenting at journal clubs (where you will have learnt to critically appraise research
- By gaining an understanding of some aspects of research for example by attending courses on research methodology, critical appraisal or statistics, or by attending conferences.
- By doing literature searches as part of an audit project for example or as part of your clinical practice.
Be honest about your lack of practical experience, explain why you have little research experience (for example, you have concentrated on taking your exams, on developing you audit experience or teaching experience instead, etc) and quickly move on to discussing how you have build you understanding of research in other ways.

3.14 – What have you gained from your research?

If you have been involved in a research project, you will have gained at different levels:

**Clinical understanding:** You will have gained a good understanding of the topic that you researched, both through your own research but also by doing a literature search and analysis.

**Research skills:** You will have gained a good understanding of the critical appraisal process, research methodologies, what makes good and bad research, the potential for flaws in research, the difficulty in avoiding bias. You will also have learnt how to organise a research project including seeking funding and ethical approval, an understanding of statistics and of research methodologies.

**Personal skills:** Skills learnt would include how to write a paper, how to manage your time in an environment where the milestones might be distant, how to organise your work, how to negotiate with others and personal discipline. You will also learn about personal/professional integrity.

3.15 – What different types of research do you know?

There are many ways in which this question can be answered but essentially you need to discuss the following:

- Clinical (e.g. drug trials, intervention studies) vs. non-clinical (e.g. research into healthcare provision)
- Individual cases vs. epidemiological
- Hypothesis testing vs. literature review

This should then lead you to discussing the different levels of evidence (see evidence-based medicine questions)

3.16 – Why is research important?

There are many reasons why research is important. In particular:

- It enables them to understand the evidence on which decisions are based. In particular the treatments and procedures they are using in their everyday practice would have greater meaning to them.

- Nurturing a practice founded on evidence based medicine (EBM) involves an ability to critically appraise current medical evidence. Having an insight into what good and bad research is as well as the structure of levels of medical evidence and statistical concepts gained from attendance at journal clubs for example is an excellent basis to develop EBM for the future.

- Since medical practice is constantly evolving it is essential to keep up to date with these changes which are based on research. This would encourage the doctors of the future to keep to continuous professional development (CPD).

- Many trainee doctors may take future roles that could involve using experimental therapies or managing patients who may be involved in clinical trials. So a good grounding and insight into the ethics and procedures of medical research is important.

- Advances in medicine are inextricably linked to research and giving trainee doctors inspiration at an early stage may encourage further advancements in the future.
• It provides good insight a specialty, which may encourage their career development and their motivation for that specialty. This includes hot topics, controversies and differences in practice.

• It enables them to gain a number of skills such as organisational skills (working to deadlines, organising data, planning a project, notation, integrity, etc) and to develop other skills such as writing and presentation skills (assuming the outcome is a presentation or a paper).

If you have been involved in research yourself then you can discuss how you developed your understanding of the above through your projects and the personal skills that you developed as a result of it. You can structure your answer in 3 or 4 points for example:

- Clinical understanding gained through research
- Understanding of research principles gained
- Generic skills gained

3.17 – What do you know about research governance?

This is a very factual question and either you know the answer or you don’t (it’s better if you do). In essence, the word “governance” refers to a set of rules that ‘govern’ the discipline.

The Government has made a strong commitment to improving the quality and integrity of any research which uses NHS resources, staff and patients. The Department of Health now requires any person carrying out research within an NHS trust or medical school to adhere to rules set out in THE RESEARCH GOVERNANCE FRAMEWORK 2005. The main responsibilities of researchers are summarised below:

1. All persons carrying out clinical research within the Trust should possess a Trust substantive or honorary employment contract, within which is a requirement to adhere to Research Governance principles.

2. Approval of the R&D Directorate and the appropriate Research Ethics Committee must be obtained before any research commences, and studies should comply with all legal and ethical requirements throughout their course.

3. All researchers should bear a day-to-day responsibility for the conduct of research, including ensuring that any research they undertake follows the agreed protocol, helping care professionals to ensure that participants receive appropriate care, protecting the integrity and confidentiality of clinical and other records and data generated by the research, and reporting any failures in these respects, adverse drug reactions and other events or suspected misconduct through the appropriate systems. The principal investigator on any project is accountable to their employer and has special responsibilities.

4. Researchers must agree to comply with research monitoring and audit as required by the Trust, funders and sponsors, and provide reports on the progress and outcomes of the work as required to an acceptable standard.

5. Findings from the work should be disseminated promptly and fed back as appropriate to participants.

6. Researchers should make suitable arrangements for the management of financial and other resources provided for the study, including the management of any intellectual property rights.

If you really want to show off, you can talk about the new National Research Ethics Service (NRES) which was created on 1 April 2007 as a replacement for COREC. NRES is under the umbrella of the National Patients Safety Agency and it oversees the various Research Ethics Committees. For full detail about their activities, refer to their website at www.nres.npsa.nhs.uk.
3.18 – What is Evidence-Based Medicine?

Evidence-based medicine (EBM) has been defined as "the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients. The practice of evidence based medicine means integrating individual clinical expertise with the best available external clinical evidence from systematic research."(David Sackett, et al. “Evidence Based Medicine: What It Is and What It Isn't,” BMJ 312, no.7023 (1996).

In 2000, David Sackett revised his definition as follows: “integration of best research evidence with clinical expertise and patient values.” David Sackett, et al. Evidence-Based Medicine: How to Practice and Teach EBM (New York: Churchill Livingstone, 2000), 1

Generally speaking, you should be wary of using ready-made definitions (the same applies to the classic definition of clinical governance) as they simply demonstrate your ability to regurgitate ready-made answers and do not highlight any personal understanding of the issues at stake. The above definition also uses words that are unfamiliar to most people and which are best avoided (for example, few people know that “judicious” means “based on sound judgement”)

Try to build your own practical definition, showing that you have a good understanding of what EBM entails. EBM is essentially the analysis of best available research evidence combined with your own clinical expertise and judgement to determine how it can best applied to a specific case, taking into account patient values.

Definition of key terms

- **Best available research evidence**: clinically relevant research, often from the basic sciences of medicine, but especially from patient-centred clinical research into the accuracy and precision of diagnostic tests (including the clinical examination), the power of prognostic markers, and the efficacy and safety of therapeutic, rehabilitative, and preventive regimens. New evidence from clinical research both invalidates previously accepted diagnostic tests and treatments and replaces them with new ones that are more powerful, more accurate, more efficacious, and safer.

- **Clinical expertise**: the ability to use your clinical skills and past experience to rapidly identify each patient's unique health state and diagnosis, their individual risks and benefits of potential interventions, and their personal values and expectations.

- **Patient values**: the unique preferences, concerns and expectations each patient brings to a clinical encounter and which must be integrated into clinical decisions if they are to serve the patient.

When these three elements are integrated, clinicians and patients form a diagnostic and therapeutic alliance which optimises clinical outcomes and quality of life.

3.19 – What are the different levels of evidence?

Generally speaking, there are five levels of evidence as follows:

1. Strong evidence from at least one published systematic review of multiple well-designed randomised controlled trials.
2. Strong evidence from at least one published properly designed randomised controlled trial of appropriate size and in an appropriate clinical setting.
3. Evidence from published well-designed trials without randomisation, single group pre-post, cohort, time series or matched case-controlled studies.
4. Evidence from well-designed non-experimental studies from more than one centre or research group.
5. Opinions of respected authorities based on clinical evidence, descriptive studies or reports of expert consensus committees.
For practical purposes, these have been regarded into four categories which are commonly used in the UK.

Cat. A: Consistent Level 1 studies.
Cat. B: Consistent Level 2 or 3 studies, or extrapolations from level 1 studies.
Cat. C: Level 4 studies, or extrapolations from level 2 or 3 studies.
Cat. D: Level 5 evidence, or troublingly inconsistent or inconclusive studies of any level.

Advice
- Because the above would be difficult to remember in normal circumstances, let alone under pressure at an interview, we would recommend against providing all this information at an interview unless specifically asked to recall the different levels.
- If you are requested to list the different levels, it is easier and less convoluted to recall the 5 points in the first box rather than the A-D classification.
- Some of the 5 levels in the first box above are subdivided into two or three more complex levels. We would suggest you ignore this. If you are interested, full details can be found on the following website: http://www.cebm.net/levels_of_evidence.asp

If you can’t remember them all
Many of you may have trouble memorising all this or may have a blank at the interview. If this happens to you then it is wise to memorise at least the top and bottom levels of evidence with a view to present these confidently rather than make a botched attempt to regurgitate the whole lot in a messy fashion.

So it you don’t know or can’t remember, it might be best to simply say; “I am not sure about the full detail but I know that the top level is “systematic review of double blinded randomised controlled trial and that the bottom level is expert opinion, with a graded approach in-between.” It may not be the ideal answer but it may have more impact than a messy one that attempts to give the full information.

3.20 – What are the steps involved in an evidence-based approach?

The steps are as follows:
- A clinical problem arises out of the care of a patient
- Construct a well defined clinical question from the case
- Conduct a search by using the most appropriate resources
- Appraise that evidence for its validity (i.e. closeness to the truth) and applicability (i.e. usefulness in clinical practice)
- Integrate that evidence with clinical practice & patient preferences and apply it to practice
- Evaluate your performance with the patient

If possible, provide an example where you applied those steps (particularly if you are going for an ST3 medical specialty).
3.21 – What are the arguments for and against Evidence-Based Medicine?

<table>
<thead>
<tr>
<th>AGAINST</th>
<th>FOR</th>
</tr>
</thead>
<tbody>
<tr>
<td>EBM is &quot;old hat&quot;. Clinicians have been using the literature to guide their decisions for a long time. The label is new.</td>
<td>The new focus on EBM &quot;formalises&quot; that &quot;old hat&quot; process and filters the literature so that decisions are made based on &quot;strong&quot; evidence.</td>
</tr>
<tr>
<td>EBM is &quot;cook book medicine&quot;. It suggests that decisions are based solely on the evidence, down playing sound clinical judgement.</td>
<td>EBM should be one part of the process. Decisions must be blended with individual clinical expertise, patient preferences and when available good evidence.</td>
</tr>
<tr>
<td>EBM is the mindless application of population studies to the treatment of the individual. It takes the results of studies of large groups of people and tries to apply them to individuals who may have unique circumstances or characteristics, not found in the study groups.</td>
<td>The last step in the EBM process is to decide whether or not the information and results are applicable to your patient and to discuss the results with the patient.</td>
</tr>
<tr>
<td>Often there is no randomised controlled trial or &quot;gold standard&quot; in the literature to address the clinical question.</td>
<td>Clinicians might consider the &quot;evidence pyramid&quot; and look for the next best level of evidence. Clinicians need to understand that there may be no good evidence to support clinical judgement.</td>
</tr>
<tr>
<td>There is often great difficulty in getting access to the evidence and in conducting effective searches to identify the best evidence.</td>
<td>Librarians can help identify the best resources and teach clinicians effective searching skills.</td>
</tr>
</tbody>
</table>

3.22 – What is your experience of Clinical Governance?

Before you can attempt to describe your experience of clinical governance, you must have a good understanding of what it is all about.

**Definition**

The most widely used definition of clinical governance is as follows: "A framework through which NHS organisations are accountable for continually improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish." (G Scally and L J Donaldson, 'Clinical governance and the drive for quality improvement in the new NHS in England' BMJ (4 July 1998): 61-65)

**Warning**: Although you may want to familiarise yourself with this definition, there is no need to memorise it. Under pressure, most candidates remember the beginning and the end, and mess up the middle part. Even if you remembered it perfectly it would only serve to demonstrate that you have a good memory and not that you understand the concept. Interviewers do not treat kindly those who are only able to recall the definition and will expect a good practical understanding of the issues at stake.

**How can you define it?** Clinical governance is the formalisation under one umbrella of several activities in which everyone was involved at different levels in the past, albeit on an ad-hoc basis. This formalised approach ensures that these activities (also called pillars) are practiced consistently throughout the NHS. Essentially Clinical Governance is a quality assurance process designed to ensure that standards of care are maintained and improved and that the NHS is accountable to the public.
What are the different pillars of Clinical Governance?

1. **Clinical Effectiveness & Research**
   Making sure that the treatments offered to people do what they are supposed to do. This means keeping up to date by accessing good quality information and using interventions that have been proven to be effective (Evidence Based Medicine). It also involves supporting and implementing the National Service Frameworks (NSF) and being aware of local priorities for healthcare.

2. **Risk Management**
   Risk Management involves having robust systems in place to understand, monitor and minimise the risks to patients and staff and to learn from mistakes. When things go wrong in the delivery of care, doctors and other clinical staff should feel safe admitting it and be able to learn and share what they have learnt. This includes reporting any significant adverse events via critical incidents forms, looking closely at complaints etc. Once risks are identified, they are assessed for their probability of occurrence and the impact they could have if an incident occurred. Processes are then implemented to reduce the risk and its impact. The level of implementation often depends on budget available and the seriousness of the risk. Risk management also involves day-to-day activities such as complying with protocols (hand washing, discarding sharps, identifying patients correctly etc) and promoting a blame-free culture to encourage everyone to report problems and mistakes.

3. **Education and Training**
   Education and training covers the support available to enable staff to be competent in doing their jobs and to develop their skills so that they are up to date. Professional development needs to continue through lifelong learning. For doctors this involves attending courses, on-the-job training etc. CPD plays an important part in education and training, as do appraisals, which are meant to identify and discuss weaknesses, and opportunities for personal development.

4. **Patient and Public Involvement**
   This means listening to what the public thinks of the services provided, and learning from their experiences. It may mean changing the way you work in order to be responsive to patients needs and involving service users when planning new services, above all putting the patient at the heart of what you do. Institutions like the National Patients Safety Agency, PALS and making appropriate use of complaint procedures all contribute to this process.

   This also includes the concept of openness, which relates to the need for the NHS to be upfront with the public in relation to its own problems. As part of openness, the NHS publicises complaints procedures to patients, deals with problem doctors openly, encourages doctors to admit their own mistakes as part of a blame-free culture etc.

5. **Using Information**
   The NHS holds an enormous amount of information about patients and needs to be able to access it efficiently and make the best possible use of it. For example, audits that monitor quality, measure progress and enable future planning. This means learning how to use computers in readiness for moving to the Electronic Patient Record and understanding how the Data Protection Act relates to your work. This also includes having systems in place to protect confidentiality. The Caldicott Report describes the Standards to be used and how to develop systems and support the process. The “Caldicott Guardian” is the person responsible for ensuring this happens.

6. **Clinical Audit**
   This means measuring practice against standards. Some of the standards are set for us nationally by the National Service Framework (NSF) or NICE, others will be set locally.

7. **Staffing and Staff Management**
   Staffing and staff management includes recruitment, management and development of staff. It also includes effective methods of working and good working conditions.
Talking about your experience (i.e. answering the question)
Many candidates have a tendency to go through each pillar and simply list what they are. Others emphasise the importance of clinical governance. Neither approach actually answers the question.

The question is asking about your experience. Given that there are seven pillars and that it is unlikely that you have contributed in depth to all of them, it would be wise to choose the key pillars where you have actually had some experience.

Out of the seven pillars, you could select the four most relevant ones for your grade and specialty. This could include:

- **Clinical effectiveness** (where you can talk about how you follow guidelines and protocols, your experience of evidence-based medicine and of research)
- **Audit** (See previous questions on your audit experience. In particular you can emphasise how your audits have made a difference to clinical practice)
- **Training and education** (where you can discuss how you keep your skills up to date, exams taken and qualifications obtained, together with your own teaching experience)
- **Risk management** (where you can discuss the fact that you learn from your experience and your mistakes, maybe some situations where you completed a critical incident form, and also the fact that you try to promote a blame-free culture by remaining approachable so that juniors feel free to ask for help if they have problems.

For some specialties which are very patient focussed (e.g. psychiatry, palliative care, paediatrics) you may also want to emphasise Patient and Public Involvement.

Note: all pillars are important to all specialties but in an interview you only have 2 minutes to answer and it is better to have a selective and confident answer covering the major points rather than a superficial answer covering all the points only briefly. Our suggestion would therefore be to address four pillars in depth and simply to mention the other three at the end of the answer so that you can signal that you are aware of them.

When you describe your experience, do not simply say that you have been involved in that particular activity. Try to provide examples from your past. You have two minutes to address four pillars; that makes 30 seconds for each. You have time; use it!

3.23 – How do you keep up to date?
This question is not difficult but it requires you to go into some detail (which many candidates fail to do). There are many ways in which you can keep up to date, including:

- Attending courses (state how many courses you attended over the past 2 years say and explain what type of courses they were. No need to talk about exam preparation courses.)
- Attending teaching sessions and presenting at them (Name some examples)
- Attending conferences (name a few)
- Reading text books and looking up difficult issues on the internet.
- Learning from your own experience and that of others.
- Reading journals (name a few)
- Teaching others (discuss briefly your own teaching experience and how you have acquired knowledge through it)
SECTION 4

NHS ISSUES
4.1 – Appraisals

AIM OF AN APPRAISAL
Appraisal is a professional process of constructive dialogue, in which the doctor being appraised has a formal structured opportunity to reflect on his/her work and to consider how his/her effectiveness might be improved. It is a positive process designed to give doctors feedback on their performance, to chart their continuing progress and to identify development needs. It is a forward-looking essential for the developmental and educational planning needs of an individual. It is not the primary aim of appraisal to scrutinise doctors to see if they are performing poorly but rather to help them consolidate and improve on good performance, aiming towards excellence. However, it can help recognise, at an early stage developing poor performance or ill health, which may be affecting practice. The aims and objectives of the appraisal scheme are to enable NHS employers to

- review the contribution of the individual to education and research
- review the contribution of the individual to leadership of the discipline and to innovation
- review regularly an individual's work performance, utilising relevant and appropriate comparative performance data from local, regional and national sources
- optimise the use of skills and resources in seeking to achieve the delivery of service priorities with respect to research, teaching and clinical practice;
- consider the consultant's contribution to the quality and improvement of services and priorities delivered locally within higher education and the NHS;
- set out personal and professional development needs and agree plans between the sectors for these to be met;
- identify the need for the working environment to be adequately resourced to enable any objectives in the agreed job plan review to be met;
- provide an opportunity for consultants to discuss and seek support for their participation in other activities
- utilise the annual appraisal process and associated documentation to meet the requirements for GMC/GDC revalidation.
- Provide an opportunity to consider the job planning process and to clarify to which organisation the individual is accountable for each element of their appointment

PERSONAL DEVELOPMENT PLAN (PDP)
As an outcome of the appraisal, key development objectives for the following year and subsequent years should be set. These objectives may cover any aspect of the appraisal such as personal development needs, training goals and organisational issues, CME and CPD e.g. acquisition/consolidation of new skills and techniques and any resource implication for training and/or staff development.

ARE APPRAISALS USEFUL OR SIMPLY A PAPERWORK EXERCISE?
Fundamentally the process of appraisal is useful. It forces the trust and the consultant to have an in-depth look at the situation and identify possible improvements. As such the process is difficult to fault. However, it requires commitment from both sides in order to be fully effective. Setting realistic targets as part of the PDP is important otherwise no progress will be possible. Similarly, the consultant will need to be fully committed to achieving those targets and the Trust committed to supporting the consultant in order for the targets to be achieved.

WHAT IS THE DIFFERENCE BETWEEN ASSESSMENT AND APPRAISAL?
The difference can be summarised as follows: Assessment is ticking boxes set by others(e.g. an exam, a viva, etc) – Appraisal is ticking boxes that you have helped to set yourself.
4.2 – Revalidation – Better doctors, safer patients

IMPORTANT NOTE: Revalidation was suspended in March 2005 pending further discussion as a direct result of the damming report issued by Dame Janet Smith on the role of the GMC in the Shipman case. Do not make the common mistake of mentioning that it was “introduced” as a result of Shipman.

The idea of revalidation arose several years ago at the result of several medical scandals. Its aim is to ensure doctors’ fitness to practice.

WHAT IS THE AIM OF REVALIDATION?
Revalidation aims to
- Protect patients from poorly performing doctors
- Promote good medical practice
- Increase public confidence in doctors.

HOW DID THE PROPOSED SYSTEM WORK?
Doctors would have submitted records of appraisals, including personal development plans and feedback. They would also have submitted CPD records. Based on that evidence the GMC would have decided whether to revalidate a doctor or insist on further action.

THE 5TH SHIPMAN REPORT
Following the Shipman affair, an enquiry was conducted by Dame Janet Smith into the various components of the scandal. This included an enquiry into the role of the GMC, which resulted in the so-called 5th Shipman Report. The report essentially criticised the GMC for looking after doctors more than after patients and for not taking reasonable steps to protect patients by revalidating doctors properly. It also highlighted the poor sharing of information on doctors’ performance between the professional, educational and regulatory bodies. The GMC’s role was also criticised, particularly the fact that it sets the rules, investigates doctors and passes judgement on their actions.

WHY WAS REVALIDATION SUSPENDED?
When the GMC was criticised for letting Harold Shipman kill hundreds of victims unnoticed, it defended itself by presenting revalidation as the answer to the problem.

The Shipman case mainly concerned a failure by the NHS to audit Shipman’s activities in a number of areas including:
- Cremation forms (and a second signature more or less applied without checks)
- A high mortality rate amongst his patients (all of whom were elderly and whose deaths were simply dismissed as unlucky or natural)
- A discrepancy in the prescription of diamorphine and other controlled drugs (all the more bizarre since Shipman had already been suspended by the GMC for stealing drugs in the 1970s).

It was established that Shipman was well liked by colleagues and patients, and therefore would have passed appraisals with flying colours. He also kept up to date and would have had no problem being revalidated on the basis of those two criteria only. As a result the GMC has no choice but to suspend revalidation (before it was fully introduced) and to go back to the drawing board.
BETTER DOCTORS, SAFER PATIENTS
On 14 July 2006, Professor Sir Liam Donaldson, the Chief Medical Officer (CMO) published his review into the regulation of the medical profession. The report was designed to address the criticism raised against the GMC in the 5th Shipman Report issued by Dame Janet Smith.

The main recommendations in Good Doctors, Safer Patients include:

- The creation of unambiguous, operationalised standards for generic and specialist practice to give a clear, universal definition of a ‘good doctor’ and to allow patients, employers and doctors themselves to have a shared understanding of what is expected of doctors. These standards would be incorporated into the contracts of doctors.

- Devolution of some of the powers of the GMC, as statutory regulator, to the local level. This would be accomplished through the creation of a network of trained and accredited General Medical Council affiliates.

- The creation of an independent tribunal in order to adjudicate on fitness to practise matters - the GMC would focus on the assessment and investigation of cases.

- A renewed focus on the assessment, rehabilitation and supervision of doctors with performance problems where these problems are not borne of malice.

- Greater public & patient involvement - to ensure public and patients work with GMC affiliates in making decisions around fitness to practice, and with medical Royal Colleges in the process of re-certification.

- A new twin-track system of revalidation - re-licensing for all doctors and re-certification for those on the specialist and GP registers.
4.3 – NICE

WHAT IS NICE?
- Stands for “National Institute for Health and Clinical Excellence” (Don’t forget the “Health bit, even though it does not feature in the acronym).
- Established in 1999
- NICE makes recommendations on treatments and care using the best available evidence. One important aspect to bear in mind is that its recommendations are also based on cost-effectiveness and not purely on “best evidence”
- NICE produces four kinds of guidance:
  a. **Technology appraisals** - guidance on the use of new and existing medicines and treatments within the NHS in England and Wales.
  b. **Clinical guidelines** - guidance on the appropriate treatment and care of people with specific diseases and conditions within the NHS in England and Wales.
  c. **Interventional procedures** - guidance on whether interventional procedures used for diagnosis or treatment are safe enough and work well enough for routine use in England, Wales and Scotland.
  d. **Public health guidance**

WHAT ARE THE PROBLEMS/CONTROVERSIES SURROUNDING NICE?
- Assessing evidence can take time. Guidelines are often issued long after the evidence.
- Some decisions made have been severely criticised. For example:
  a. In October 1999, NICE recommended against prescribing the flu vaccine Relenza but was forced to change its mind following criticism from pharmaceutical companies. It was then agreed that the vaccine should be prescribed to patients at risk only. The “Drug and Therapeutics Bulletin” actually gave advice contradicting the NICE guidance.
  b. In June 2000, NICE altered its recommendation on the MS drug beta interferon following patient pressure. The drug was deemed too expensive and clinically controversial.
  c. In October 2002, NICE rejected photo-dynamic treatment for age-related macular degeneration. This severely upset old age charities.
- NICE makes recommendations based on the efficacy and cost-effectiveness of treatments, drugs or procedures. However it does not take account of budgeting issues within trusts. This problem was raised in 2000 and it was agreed that the NHS should put in place additional funding for the implementation of NICE recommendations. However, with treatments becoming increasingly expensive, the issue resurfaced recently with the problems caused by the funding of the drug Herceptin.
4.4 – National Patient Safety Agency (NPSA)

The role of the NPSA is to coordinate the efforts of the whole NHS to learn from incidents where patient safety was compromised.

Its main role is to prevent accidents/incidents by
- collecting and analysing information on adverse incidents from local NHS organisations, NHS staff, patients and carers
- by taking into account other safety-related information from a variety of existing reporting systems
- by learning lessons and ensuring that they are fed back into health care and treatment is organised and delivered
- by ensuring that where risks are identified, work is undertaken on producing solutions to prevent harm, specify national goals and establish mechanisms to track progress
- encouraging a no-blame culture where doctors are can report problems, mistakes and near-misses so that the system can learn from their experience.

Its remit also covers:
- safety aspects of hospital design
- cleanliness and food
- ensuring research is carried out safely
- supporting local organisations in addressing their concerns about the performance of individual doctors and dentists, through its responsibility for the National Clinical Assessment Service (NCAS), formerly known as the National Clinical Assessment Authority.
- Managing the contracts with the three confidential enquiries.
  - The National Confidential Enquiry into Patient Outcome and Death (NCEPOD)
  - The Confidential Enquiry into Maternal and Child Health (CEMACH)
  - The National Confidential Enquiry into Suicide and Homicide by people with mental illness (NCISH)
4.5 – Foundation Trusts

WHAT ARE FOUNDATION TRUSTS?
The Health and Social Care Act 2003 establishes NHS foundation trusts as independent public benefit corporations. There are currently approximately 60 Foundation Trusts. They

- are controlled and run locally, not nationally. Local public accountability will replace central state control,
- are accountable to local people who can become members or governors,
- have increased freedoms to retain any operating surpluses and access a wider range of options for capital funding to invest in delivery of new services,
- recruit and employ their own staff,
- have to deliver on national targets and standards like the rest of the NHS, but NHS foundation trusts will be free to decide how they achieve this,
- are not subject to directions from the Secretary of State for Health,
- are not subject to performance management by strategic health authorities and the Department of Health.

HOW ARE THEY MEANT TO BENEFIT PATIENTS?

- NHS Foundation Trusts can improve the level of care for their patients because they have been set free from central government control. To achieve this they have freedom to decide locally the capital investment needed in order to improve their services and increase their capacity. They can also borrow in order to support this investment, as long as they can afford it, without needing to seek external approval.

- NHS Foundation Trusts establish stronger connections between local hospitals and their local communities. Those living in communities served by a hospital of an NHS Foundation Trust are invited to become a member. Members can stand and vote in elections for Governors of the NHS Foundation Trust. This form of public ownership and accountability will ensure that hospital services more accurately reflect the needs and expectations of local people.

HEALTHCARE COMMISSION REPORT 2005
In the summer of 2005 the Healthcare Commission published its first report on Foundation Trusts. The results were as follows:

Positive points:

- Directors enjoyed the greater ability they had to plan ahead and to set priorities for investment.
- The move to trust status also built more confidence in financial management; and faster decision making and funding for developments in services.
- Waiting times have been reduced, but no more than was the case for other “non-foundation” trusts

Negative points:

- Foundation trusts have been limited in their ability to borrow money by their independent regulator through a "prudential borrowing code." Initially, this limited borrowing to only 10% of trusts’ total assets, although this restriction has since been eased by Monitor.
- The government has maintained a cap on private patients which many feel is limiting the potential of their trusts.
- Foundation Trusts have been implemented at the same time as other important changes such as the new consultant contract and a new payment system for hospitals. This has caused some confusion.
4.6 – European Working Time Directive (EWTD)

A directive implemented in 1998 covering ALL employed staff in the EU.

- **Working Time Regulations impose:**
  - A minimum of 11 hours’ continuous rest in every 24-hours period
  - A minimum break of 20 minutes after every 6 hours worked
  - A minimum period of 24 hours’ continuous rest in every 7 day period
  - A minimum of four weeks’ paid annual leave
  - A maximum of eight hours’ work in each 24 hours for night workers

- **Implementation in the NHS over 5 years from 1 August 2004 as follows:**
  - AUGUST 2004 – Average 58-hour maximum working week + rest requirement
  - AUGUST 2007 – Average 56-hour maximum working week
  - AUGUST 2009 – Average 48-hour maximum working week

- **Working time includes:**
  - Any period during which you are working, at your employer’s disposal and carrying out your activity or duty
  - Any period during which you are receiving relevant training
  - Any additional period to be treated as working time under a relevant agreement.

- **Pros**
  - Better work-Life balance
  - Less stressed doctors
  - Forced a total rethink of the system and a drive for efficiency
    - Hospital at night
    - Delegation of responsibilities to other professionals e.g. nurses
    - Competency driven approach as opposed to time based.

- **Cons**
  - Less continuity of care (off for 10 days after nights, doctors admit patients during the night but do not do the follow-up the next morning, etc)
  - Less on-ward training available
  - Need for more doctors (driving the new accelerated training program)
4.7 – Hospital at night

The Hospital at Night was the largest pilot study in the run-up to August 2004 – it was tested throughout 11 acute NHS Trusts. This wide-ranging pilot aimed to redefine how medical cover is provided in hospitals during the out-of-hours period. The project requires a move from cover requirements defined by professional demarcation and grade, to cover defined by competency.

MAIN REASONS FOR INTRODUCING THE HOSPITAL AT NIGHT

- There is significant activity in the evening period but this falls off after midnight
- Activity varies by specialty - medicine in general continues to have activity throughout the night but surgery in general falls to a much lower level
- There are very low levels of activity in trauma and orthopaedics and medical and surgical subspecialties
- Few patients have life threatening conditions
- Around a quarter of junior doctors' time is spent on tasks that do not require medical skills (eg requesting investigations, finding notes or information, some minor procedures)
- Nearly half of junior doctors' time is spent repeating tasks such as clerking or reviews

WHAT IS IT ABOUT?

- Proposes to achieve effective clinical care at night through the use of one or more multidisciplinary teams covering the full range of skills required to meet immediate patient needs.
- Instead of having doctors from every single speciality on call every night, the night team will be composed of a reduced number of doctors who will each be able to handle emergencies from several specialties. The reduced team is led by a senior consultant and a senior nurse.
- It focuses on competencies (i.e. what doctors can do) rather than grades (i.e. how many doctors of each grade should be present).
- It opens up a number of opportunities
  - For non-medical staff to take on a proportion of work traditionally done by doctors at night
  - To move a significant proportion of the work at night into the extended day
  - To reduce unnecessary duplication of work (e.g. through a reduction in multiple clerking)

ADVANTAGES

- Improved handovers required
- Better sense of teamwork – decreases isolation
- Competency levels extended and enhanced (particularly in relation to the identification and management of the acutely ill.
- Drive on efficiency.

DISADVANTAGES

- Ensuring adequate competency can be challenging (for example in doing single clerking)
- Risk of inconsistency of cover from week to week
- Trusts may not be big enough to have all competencies and experiences present at any one time.
- Bureaucracy – competencies will need to be assessed at and after induction
- One of the main advantages should have been to reduce the number of senior doctors hours at night in order to ensure better coverage during daytime, when it is mostly required. However practice has shown that senior doctors get called to the hospital more often than they would like to.
INTRODUCTION TO MMC

- In order to address the shortage of consultants and deal more effectively with the effects of the European Time Directive (and particularly the reduction in training time resulting from its introduction), the Government has introduced a new training programme for junior doctors. This new system became operational early August 2005.

- The “old” system took an approach based on number of years of experience. After one year as a PRHO (Pre-Registration House Officer), doctors would become SHO (Senior House Officer) during which they would be required to gain exposure to a number of specialities, including exposure to emergency work, etc. Once they had satisfied requirements based on their number of years of experience (and subject to passing relevant exams) they could become Specialist Registrars, which essentially consisted of a fixed-term training program sanctioned by a final exam. This would give them a Certificate of Completion of Specialist Training, entitling them to seek work as Consultants.

- The new system is no longer based on number of years of experience. Instead, now, doctors can only proceed to a further stage if they have satisfied a number of conditions based on the skills that they have actually acquired. The new system is made up of the following steps:
  - **Foundation Year 1** (1 year - equivalent to the PRHO year). Curriculum is based on GMC requirement and consists of developing awareness of the important duties of the doctor.
  - **Foundation Year 2** (1 year – equivalent to first year SHO). Curriculum included developing skills in handling common emergencies.
  - **Basic Specialist Training** (Varies according to specialties but typically 2 years). This is an initiation to your chosen Specialty or a General Medical/Surgical training period.
  - **Higher Specialist Training** (Varies according to specialty but typically 3 years). In-depth specialty training.

During each year of training, the doctor will need to satisfy colleagues and assessors that he has acquired the skills required of him, at the level expected of him. This will be achieved through a structured program complemented by regular assessments. Assessments could take different forms, from exams to on-the-job assessment, and could be done by consultants, nurse specialists, communication experts or other relevant professionals.

ALLOCATION OF TRAINING POSTS

Under the Calman system, trainee doctors could choose the posts to which they wanted to apply. Although the maths were such that not every trainee would get a numbered post (after all there are less consultant posts being released than there are medical students coming in), every doctor could try their luck time after time. This system meant that a number of doctors who failed to get onto a training post hovered around at SHO/Clinical fellow/Staff grade level.

The new selection system is such that doctors only get one shot at obtaining a training post through the national recruitment process, failing which the candidate will need to apply locally for a non-training post.

ADVANTAGES

- The new system focussed a lot more on what doctors need to know to be good at their specialty. Doctors therefore need not waste time in learning about issues that may not be relevant to their chosen career.

- A greater emphasis is being placed on training in the workplace. Currently, training is available but is left to the initiative of the consultants, registrars and junior doctors. The new system will force each trust to optimise training opportunities in line with the curriculum.
DISADVANTAGES

- On average, it is expected that the new system will produce consultants in about two years less than the old system. However at the same time, the European Working Time Directive is reducing the number of hours available down to 48 hours. Overall it is estimated that the training time of doctors will be halved as a result of this double reduction in the number of years and the number of hours. Part of this will be offset by a more efficient and targeted training structure. However there are doubts about the ultimate outcome.

- Doctors will need to make up their mind about the specialty they want to enter after only two years’ experience. If they have not had the opportunity to encounter the specialty of their choice during the two foundation years they may find it difficult to make a decision. One-week tasters will be introduced to enable people to make adequate choices but this may not be sufficient time to make a decision.

- Some of the smaller specialties may be under-represented in the foundation program rotations. In addition the rotations where these specialties do appear may be taken up by doctors who want to do other specialties. This may lead to a decrease in the number of doctors taking up these smaller specialties. Under the current system, such doctors have the opportunity to do stand-alone SHO posts to test their interest. This will no longer be possible.

- The implementation of the EWTD has led to the creation of many non-training posts to ensure that there are enough doctors. There is a risk that many people will not have access to the main training posts and will be left in a lurch (see negative publicity in August 2005 about 1000 applicants per training post in some regions).

- There will be difficulty in recognising training undertaken abroad as there will be a need to work out for each degree/post what competencies were acquired and how this fits with the UK system. Reaching an equivalence system could take some time. This affects not only foreign (non-EC) doctors but also UK doctors having spent time abroad.

- Those who are struggling to obtain a number before the termination of the old system will find themselves thrown into the new system at a level which is not yet known.
INTRODUCTION TO PBC

“Practice-based commissioning” refers to the fact that GP practices operate as individual businesses with an independent budget, and must use their budget to purchase the services they need from external providers, whether such providers are NHS or private providers.

Primary Care Trusts (PCTs) are also able to commission services i.e. they authorise various service providers to provide a service required at a local level.

Each service/clinic/procedure is allocated a specific standard tariff. GPs are required to pay the service provider a referral fee for their patients. The PCT covers any additional costs in relation to treatment or investigations. For example, a GP referring a patient to a cardiologist will pay a referral fee (say £130). If the patient required an angiogram then this will be paid by the PCT directly.

The level of the fees paid by the GP and the PCT (the “tariff”) for each specific service is set by the NHS at national level and is calculated as an average across the country of what such service would cost (though there are some allowances made for regional differences in overheads as well as risk factors)

Patients are given the choice between up to four providers, one of which can be private.

ISSUES ASSOCIATED WITH PBC

GPs can retain any unspent money (within certain limits). These profits can either be reinvested for patient care or simply pocketed by GPs as earnings. It is therefore in their interest to minimise their spending for referrals. This stops the GPs from “dumping” patients onto secondary care. On the other hand, one must ensure that GPs appropriately refer patients who do need to be referred. This is taken care of by a clause in their contract that links their overall budget to quality of care.

GPs with many patients who require similar services may prefer to develop their own service/clinic instead of referring their patients to secondary care. This encourages GPs to develop their own special interests (GPs with Special Interests), or to open clinics within their surgeries, which can be run either by subcontracted doctors or by nurse specialists.

GPs have a greater say in the type of services that should be made available in their area and how these should be run. This is good for GPs and to a certain extent for patients too, but hospital managers and consultants may not appreciate the input. Any provider who would not provide services as required by GPs and their patients may find themselves with fewer referrals than expected.

The tariff paid for each procedure/referral is set, meaning that GPs cannot choose to refer a patient on the basis of cost. This avoids the creation of inequalities across the NHS and ensures that the choice of care is made purely on the quality of care provided to the patient.

PBC encourages patients to choose a provider on the quality of care provided (since the tariff is set). In many cases, the private sector will be able to compete favourably, particularly in terms of waiting lists. This may mean the start of the “privatisation” of the NHS.

GPs must pay a referral fee for every patient sent to A&E. To bypass the fee, a practice has developed to simply tell the patient to turn up in A&E or to call 999. The effect is that GPs save the referral fee, which is paid directly by the PCT instead. This has resulted in an increased in “blue light admissions” for non-emergencies.

Inter-departmental referrals have been banned in many hospitals as it does not bring additional funding for that referral. Instead, patients are being sent back to the GP for a new referral. Although this can be inconvenient for the patient, the evidence points to the fact that it is actually a quicker pathway.
4.10 – Payment by results (PBR)

INTRODUCTION TO PBR

PBR is a close cousin to PBC, but viewed from the secondary/tertiary care provider’s point of view. As a service provider, you will receive a fixed tariff for each clinic, each test, each diagnosis and procedure. You will also be placed in direct competition against other NHS trusts, GPs with Special Interests, and private providers.

As a result you will need to ensure that the services that you provide are aligned with PCT and GP requirements and that you deliver a high level of care to ensure that patients choose you from the shortlist offered by the GP.

ISSUES ASSOCIATED WITH PBR

- Simple elective procedures (hysterectomies, hip replacements, cataract operations, etc) will mostly be performed by the private sector (which can do so efficiently and with minimal waiting time). This will cause a training problem and may result in junior doctors being sent to the private sector for training. This, in itself, could cause problems too if the private sector is reluctant to provide that training (In fact there is evidence of trainees failing their RITAs already because of such reluctance)

- The tariff set by the NHS is calculated as an average across the NHS. Therefore, half of the providers are likely to have costs below the tariff and half will have costs above the tariff. Those with high costs will make losses, which will force them to close down, merge with other trusts to create better performing operations or make staff redundant. Although such rationalisation can be welcome in many ways for the benefit of efficiency and cost-savings, it raises serious issues about patient safety (particularly if trusts start cutting corners in order to save money). In addition, closures may put more pressure on other services, who may find themselves struggling.

- PBR requires very accurate coding if each provider is to receive payment for everything that they do. This can be complicated to achieve. There is also an issue of possible abuse, with Trusts coding “more than they should”. There is no real solution to this.

- Complicated and risky patients are handled by the NHS, no the private sector (which is contractually only allowed to deal with simple cases). Whereas on a simple case the tariff is likely to match the actual cost very closely, on a risky patient, the tariff could be way off the actual cost (since there are many levels of risk and complications and the tariff takes an average). The NHS is more exposed to discrepancies than the private factor and more exposed to the risk of making financial losses.
4.11 – Choose and Book

Introduced on 1 January 2006, “Choose and Book” (CAB) is a new electronic booking service which allows GPs to make the first outpatient appointment for their patient at a convenient time, date and location. Instead of relying on an arbitrary choice made by their GP for the referral, patients will now be given the choice between at least 4 hospitals to choose from.

**HOW DOES IT WORK FROM THE PATIENT’S POINT OF VIEW?**

1. Patients will be able to book an appointment using one of four different ways:
   - By calling the CAB appointments telephone line
   - By going to the dedicated CAB website
   - By calling the booking staff and the hospital or clinic they want to use
   - By booking with their GP or a member of the GP practice

2. Before they can book, patients will need to receive an appointment request letter from their GP. The letter will contain an appointment reference number and the list of hospitals and clinics available for choosing. Patients will also be given password to ensure total confidentiality.

3. Patients will be given the choice between 4 or 5 hospitals or clinics that will have been commissioned by the PCT to provide the required services. Patients will also be given information that will assist them in making their choice. The information will relate to:
   - Details on each hospital’s facilities (car parking, local transport, etc)
   - Star ratings, performance standards – i.e. information on local performance versus government targets. This includes information form surveys of patients and staff, etc.

4. Once the appointment is booked, the patient will receive confirmation of the details of the appointment (date, time, details of hospital/clinic and specialist) as well as any special instructions (such as abstaining from eating for a period of time before the appointment, etc)

5. In the meantime, the GP will need to produce a referral letter to be made available to the secondary care specialist. This can be done in two ways:
   - By using a CAB compliant primary care system: the referral is created directly using a ready-made template and patient details are automatically attached using pre-agreed rules. The document is held centrally and can be retrieved, viewed and printed by the specialist.
   - By writing it in MS Word and attaching it to a referral request which is sent via internet route (please note: this is not an email system but a secured web-based application).

6. The Specialist Consultant can then review the referral, confirm the appropriateness of the referral and can, if necessary, alter the priority status. The consultant will also be able to refer the patient to a more appropriate clinic or reject the referral. If the referral is rejected, the appointment is cancelled and the GP is notified of the reasons. If the patient is referred to another clinic then he/she must meet with the GP again in order to discuss further choices.

7. Whenever the priority is altered by the Consultant, the Trust will contact the patient directly to offer different choices of dates and times. The GP will not be informed directly but will be able to view the information on his system.

**ADVANTAGES**

**For patients**
- Greater flexibility for arranging time and date
- Choice of clinic/hospital in relation to location and reputation
- Convenience through the different booking methods.
- Booking may actually be finalised at the end of the GP consultation.
For doctors & trusts

- Better planning ability by being able to track referrals and adapting to local needs
- Referral letter cannot be misplaced and arrives in good time.
- System may allow for prior discussion of cases via the system
- Reduction of “Do Not Attend” (DNA) patients as the appointment will have been chosen at a time that suits them.
- Better audit trail as information is electronically and systematically stored.
- Saving on administrative time

DISADVANTAGES

For doctors/trusts

- CAB is actually (and surprisingly) NOT compulsory! It can also be costly to implement (new computers, new software, etc). Running the new and old systems in parallel could be a nightmare.

- Patients will then be given information on targets etc. Statistics tend to be hospital-specific. A good clinic in an average hospital could therefore be misrepresented

- There is a great fear that this system may force some clinics/facilities to close down if they are not chosen enough by patients.

- Discussing the possible choices with patients will increase consultation time at the GP level. However this may be partially compensated for by a generally reduced administrative burden.

For patients

- Vulnerable patients may find the system difficult to operate. For example, a confused elderly patient who decides to postpone his/her choice until they have spoken to their relatives may forget to make the booking altogether.

- Patients will be required to remember passwords OR to keep them in writing but separately from their reference number (a bit like the bank cards). More confusion for the vulnerable patients!

- GPs will only be able to book services commissioned by the PCT, no matter how good or available other services may be. This could actually increase waiting lists for the popular services whilst also ensuring that non-commissioned services are closed down.

- Health data will effectively start being centralised, a consequence unwanted by some.
WHAT ARE ISTCS?
ISTCs are private companies set-up as a result of government policy to reduce waiting lists for patients awaiting elective procedures.

Although they are private companies, they do not form part of the “private care” system as commonly encountered previously (e.g. private BUPA or PPP patients). They are companies that are commissioned by the PCT to receive NHS patients in accordance with a specific contract. Although they are private entities, they operate under the banner of the NHS (i.e. they are providing NHS-funded care in a private setting). They are in fact even obliged to use the NHS branding and logo.

WHAT DO THEY DO?
- ISTCs are often set up to provide a single elective service or a range of agreed elective services as defined in their contracts with the PCT.
- They tend to recruit doctors from abroad (one reason is that they can choose to pay these doctors at the price that they choose; the second reason is that until recently, ISTCs were not allowed to employ NHS staff, so their only possible source of recruitment within the UK was unemployed doctors, or doctors not working for the NHS). Under the new rules (2006), for services that are being transferred from NHS trusts, NHS staff can be seconded to the ISTCs in question to ensure continuity.
- ISTCs have contracts that only allow them to carry out procedures on simple patients (i.e. with no real risk of complications). They provide services ranging from MRI scanning and x-rays to surgical procedures such as cataract operations, hip replacements, hysterectomies and other simple procedures.
- They can only employ doctors who are registered with the GMC. They have an obligation to follow the same standards of care as the NHS as set out in their contracts.
- Originally, when fully rolled out, ISTCs were meant to be in charge of 10% of the total number of NHS elective procedures. The target is now increased to 15% by 2009.

ISSUES CAUSED BY ISTCS
- ISTCs are dealing with simple elective procedures and are therefore taking away training opportunities from the NHS. Contracts are now being renegotiated to include the provision of training to NHS doctors, though ISTCs are reluctant to get involved as it would obviously reduce their efficiency and increase their waiting time (which are the main factors for which they were introduced).
- Contracts between the PCTs and the ISTCs contain guaranteed levels of income for the ISTCs (since no one would want to invest in setting one up if they could not guarantee a viable amount of business). So, for example, an ISTC could have a contract to provide 5000 cataract operations to the local PCT every year. Contracts are valid for a period of five years at a time. If the number of procedures actually carried out is less than the guaranteed amount of procedures in the contract then the ISTC can keep the income. This results in an increased cost to the NHS. However if the ISCT provides more than the contract then it gets additional payments. The contract is therefore very much one sided.
- Because of the point made above, it is important that the full capacity of ISTCs is utilised (otherwise the money is simply wasted). As a result, PCTs must find ways to push patients towards the ISTCs. In the context of patient choice, the only real way to achieve this is to stop commissioning NHS hospitals for a range of elective procedures. Therefore, NHS hospitals in the vicinity of an ISTC providing a specific elective procedure may be asked to stop providing that service until the ISTC has reached its full capacity. In many cases, they can actually be asked to stop providing the elective service altogether.
- ISTCs which encounter complications may send the patients to the NHS for further care. This increases the burden on the NHS, which may have been avoided or better controlled if the patient had remained within NHS care all along.
There are employment issues for staff being seconded from the NHS to an ISTC. For example, if a consultant is being sent by the NHS to an ISTC to perform two operating sessions per week, there are ambiguities as to where the employment responsibility lies. For a consultant this raises the following problems:

a. What happens if things do not work out, for example the consultant does not like the working environment and wants to return to the former role in the NHS?
b. What happens if there are disciplinary problems? How does the ISTC/NHS relationship work?
c. How does the appraisal and job planning process work?
d. What happens at the end of the provider’s five year contract? Is there an NHS job to go back to?

There are current doubts as to whether ISTCs really represent value for money. This has been queried by the House of Commons Health Select Committee.
SECTION 5

CONSENT & CONFIDENTIALITY
In this section we will discuss the issues of consent and confidentiality. These issues often come up in scenarios and you will be expected to show an understanding of the main issues.

### 5.1 – Gillick competence / Fraser guidelines

Any competent young person, regardless of age can independently seek medical advice and give valid consent to medical treatment. Competency is understood in terms of the young person's ability to understand the choices and their consequences, including the nature, purpose and possible risk of any treatment (or non-treatment). Parental consent to that treatment is not necessary.

It is obviously preferable for young people to have their parents’ support for important and potentially life changing decisions. Often, however, young people do not wish parents to be informed of medical consultations or their outcomes, and the health professional should not override their view. Establishing a trusting relationship between the young person and the health professional at this stage will do more to promote health, than if he/she refuses to see the young person without involving parents.

#### THE LEGAL POSITION FOR OVER 16S

The legal age of consent for medical, surgical or dental treatment is 16 years or over, as determined by Section 8 of the Family Law Reform Act, 1969. In such cases, there is no legal requirement to obtain consent from a parent or guardian. However, in cases where major or potential life threatening surgery is contemplated, persons aged 16 or 17 years should be encouraged to discuss this with their parents, and it is wise for the health professional to discuss these issues with the parent, if the young person agrees.

#### UNDER 16S

The question of the rights of children under 16 years of age to consent to treatment on their own behalf was reviewed by the courts in 1985, in connection with contraception (the Fraser Ruling). That judgement has relevance not only to decisions about contraceptive treatment, but is also essential to decisions made about other surgical, medical or dental treatments. If in the health professional's opinion, they are capable of understanding the nature and possible consequences of the procedure, then a child under 16 may consent.

The Law Lords ruling (often referred to as the Fraser ruling as Lord Fraser was the leading Law Lord for the review) stated that health professionals should consider the following issues before giving contraceptive advice / treatment when seeing young people under 16 years of age:

- Whether the young person understands the potential risks and benefits of the treatment and any advice given.
- The value of parental support should be discussed, and health professionals must encourage the young person to discuss their consultation with their parents. It may also be important to explore the reasons if the young person is unwilling to do so. Although the health professional is legally obliged to discuss the value of parental support, he / she will respect confidentiality.
- The health professional should take into account whether the young person is likely to begin or continue having sexual intercourse with or without contraception or treatment.
- The health professional should assess whether the young person's physical and/or mental health will suffer if they do not receive contraceptive advice or supplies or treatment.
- The health professional should consider whether it is in the young person's best interests to receive contraceptive advice and/or treatment without parental consent.

The Law Lords do not specify an age below which a health professional cannot give treatment or contraceptive advice, but Lord Fraser stated that if the health professional felt that the young person could understand the advice given, there would be no question of him/her giving advice to very young girls.

The ability of young people under 16 years of age to give consent to treatment will vary with age, the individual child and the nature of the treatment under consideration. The evaluation of competence is based on an objective assessment of a young person's understanding, and not whether it is desirable for a 12 year old to begin a sexual relationship. During this assessment, information may be shared which is relevant to child sexual abuse.

A young person under 16 years of age deemed to be competent to give consent should be referred to as “Fraser ruling competent”. This is now the correct term as opposed to "Gillick competent".
NB: In England and Wales, the Fraser ruling does not apply to unreasonable refusal by a child to receive treatment which is in the child's interest (e.g. Heart Transplant). Parental consent may be given. A Court Order may be advisable. In Scotland however, children may refuse treatment provided they are competent.

ABORTION
In the case of abortion, the Medical Defence Union advises that when a girl under 16 is requesting an abortion, her parents should be consulted, unless the girl forbids the health professional to do so. Both the patient's consent and the written authority of the parents should be obtained.

Their refusal, however, should not be allowed to prevent a lawful abortion to which the patient herself consents, if the health professional is satisfied that the patient is mature enough to understand the nature of the operation, complications and the issues involved. An approach similar to that addressed in the Fraser ruling, when the health professional is satisfied with the girl's capacity to understand, he/she may proceed in her best interests. Although every effort should be made to involve the parents, it may be appropriate to seek a second opinion and the Medical Defence Union/Medical Protection Society are always available to discuss individual circumstances. In certain circumstances, the clinician may wish to refer the matter to the Court for an order which could be obtained urgently and in the privacy of chambers.

PARENTAL REFUSAL TO TREATMENT
When a child is not considered to be Fraser ruling competent, it may be unlawful for a health professional to proceed with treatment against the wishes of the child's parent or guardian, e.g. immunisation. Occasionally, parental wishes conflict with reasonable medical practice and are not in the best interest of the child's welfare. Careful consideration is required to decide whether treatment should be administered despite the parent's dissent. A second opinion is strongly advised, and an application to the Court may be required.

Health professionals undertaking a life saving procedure on a child in the face of parental refusal are unlikely to be subject to legal censure, although it is important that in assessing the child's best interests, health professionals give due regard to significant factors, e.g. in the case of blood transfusion in a child of Jehovah Witness parents. Early consideration should be given to making an application to the Court.
5.2 – Breaching confidentiality

It is important to consider that the confidentiality of a child is on a par level to the confidentiality of an adult. Confidentiality can be breached in the following cases:

*Implied consent has been given by the patient*

For example, a patient will understand that you need to provide information about them to other members of your team in order to care for them (for example nurses, or a hospital consultant if you are referring). However if a patient explicitly mentions that they do not wish you to share information with a colleague, you must comply with their request and work around it if possible.

Other forms of implied consent include a patient who visits your surgery with a family member and openly discusses their situation with you. However you must be careful when it comes to disclosing important information. For example a patient may have brought their husband along, but if you feel that you have to break bad news or deal with a sensitive issue, you will need to check with the patient first.

*Clinical Audit*

Safe care requires auditing. Patient data may be used for audits provided patients have been informed that their data may be used and that they have not objected to it.

*Information required by a court/judge*

*In the public interest*

This should be weighed against the possible harm to the patient if the information is released and only if every possible effort has been made to anonymise the data or seek consent.

*To protect the patient or others*

This includes the prevention, detection or prosecution of a serious crime, especially crimes against the person, such as abuse of children.

If you believe a patient to be a victim of neglect or physical, sexual or emotional abuse and that the patient cannot give or withhold consent to disclosure, you must give information promptly to an appropriate responsible person or statutory agency, where you believe that the disclosure is in the patient’s best interests. If, for any reason, you believe that disclosure of information is not in the best interests of an abused or neglected patient, you should discuss the issues with an experienced colleague. If you decide not to disclose information, you must be prepared to justify your decision.
5.3 – CONSENT SCENARIOS

Scenario 1: Adult refusing to give consent for a non-urgent procedure or a treatment
- Check the competence of the patient.
- If the patient is competent, he is entitled to exercise his right to autonomy and to make decisions for himself. The fact that the decision seems irrational to you does not mean that the patient is incompetent.
- If the patient is not competent, then you must seek consent from their legal guardian or seek a court order.

Scenario 2: Adult refusing to give consent for a life saving procedure
- If the patient is competent then there is nothing you can do.
- If the patient is not competent (e.g. unconscious) then you must do what you feel the patient would have wanted you to do if they had been competent. In most cases this is very difficult to determine (except if there is an advanced directive) and you will need to do what you feel is in the best interest of the patient. In many cases, it is advised that you discuss the situation with the family, though the final say will be yours alone.

Scenario 3: Adult refusing to give consent for a life saving procedure for their child.
- If the child is competent in his own right then he can make the decision.
- If the child is not competent then in normal circumstances the consent should be given by the parents. However they are not entitled to make adverse decisions in cases of life and death and you will therefore need to overrule their no-consent approach. In practice it would be wiser to get a court order if you have time to do so, but if you can’t then you must go ahead with what you feel is in the best interest of the patient.
SECTION 6

HANDLING CONFLICT & DIFFICULT COLLEAGUES
6.1 – Give an example of a situation where you had to deal with a conflict at work.

Since the question is asking for an example, you will need to follow the STAR approach described earlier. The difficulty with the question is to find an example which is interesting enough to help you sell yourself, without risking to present yourself as someone who is causing trouble.

Note that the question is not asking for a conflict in which you were involved personally but generally with a conflict that you dealt with. In this case, you will therefore be able to choose an external conflict; however for the purpose of the interview you will be wise to prepare for all eventualities and to have an example of a conflict in which you were personally involved too.

Possible examples of conflict
Examples that you can mention include:
- Conflict with a nurse who disagreed with your approach
- Conflict with an SHO/SpR from a different ward (e.g. ITU) about the possible admission of a patient.
- Conflict with a GP about the follow-up of a patient
- Conflict with a relative about the management of a patient

Skills that you need to sell
Whatever your example, it will need to be strong enough to allow you to present a wide array of skills. These would include:
- Communication skills – you must be able to listen to the arguments presented by all parties involved. You must also be confident in expressing your own views clearly and concisely.
- Empathy – you must understand how the other person is feeling about the problem. If they are angry then you need to allow them an opportunity to calm down before you can progress further.
- Negotiation and initiative – you must demonstrate that you are not simply arguing with the other party but that you are actively trying to find a resolution to the problem.
- Team work – in some cases, you may need to involve other colleagues in resolving the problem (either a senior, or a nurse or some other colleague).

Whichever example you wish to choose, make sure that you take the interviewers through the story, explaining how the conflict originated, how you went about resolving it (highlighting the skills above) and how it concluded (make sure you find an example with a happy ending, and not one which ends with a complaint!)

This is a classic interview question that calls for your common sense as well as your understanding of your duties and responsibilities. The main problem is that the question does not clearly state whether you are to address it in a hospital or a GP context. You can either choose one that you prefer or do both, it does not really matter. The answer is roughly the same either way.

Note the final statement “Justify your actions”. This is to stop you simply saying what you would do without explaining what you were trying to achieve by doing it. It is something that you should aim to do without being asked anyway.
6.2 – You suspect that one of your colleagues is working whilst under the influence of alcohol. How would you approach the problem?

How to approach the question

1 – Think about the skills that the question is testing.

- This is about a colleague who is drunk either now or at times. One aspect is therefore the issue of patient safety both immediate and long-term.

- Alcoholism is a serious problem that could lead the doctor to practice with serious consequences. As a junior doctor, you would be wise to ensure that someone senior knows about the problem.

- You colleague has a health problem that may be linked to a sensitive personal situation. You must make sure you handle the situation sensitively and provide him with support if necessary (and/or arrange for him to receive support).

2 – Remind yourself of your duties

According to the duties of a doctor written by the GMC, you have a duty to act quickly to protect patients if you have good reasons to believe that a colleague is not fit to practice. It means you can’t wait too long! On the other end, “act quickly” is not really explicitly defined, but you should be able to use your judgement appropriately.

Good medical practice (for those of you who have read the booklet) also says that you should be “willing to deal openly and supportively with problems in the performance, conduct or health of team members”. This is an invitation to discuss the situation both with your colleague and with seniors. Beware of the term whistle-blowing. It is rather extreme and does not sound terribly endearing when you are looking to recruit someone who should be able to handle such delicate situation in a sensitive manner.

Read paragraphs 43-45 of “Good Medical Practice”. This will give you a clue about the right course of action. Essentially:

- You should share your concerns with an appropriate senior person such as the clinical director, following the Trust procedures.

- If you are still concerned about patient safety (for example because you feel the problem is not being addressed) then you should report the matter to the relevant regulatory body (e.g. royal college).

- If, at any time, you are unsure, seek help from a defense union or the GMC.

As you can see you will find it difficult to answer the question confidently if you have no knowledge of all this. Having said that, you should be able to reproduce most of it through common sense.

3 – Structure your answer

The above information will give you a clear idea about how the answer should be worded and a clear structure.
Dealing with the immediate patient safety issue

Your main concern should be the safety of the patients.

- If your colleague is working under the influence of alcohol, you should approach him to make sure you are correct. You should be able to detect it without too much problem.

- Explain to your colleague that you feel he has been drinking and that this compromises patient care. Discuss with him the possibility that he should take the rest of the day off. If he accepts then there is no issue, if he refuses then you should contact someone who could convince him, such as your Registrar or Consultant.

- Once your colleague has been sent home, ensure that all the patients he has already seen are reviewed if need be (either by yourself or a colleague) to ensure that that have been dealt with safely.

- You should also liaise with a manager to ensure your colleague’s absence is being covered.

Involving seniors

Once you have handled the immediate aspect of patient care, you should ensure their long-term safety and ensure that the problem is in the hands of people who can act and make a difference.

- Look up the procedures in place in your Trust to see what you should do next. They will most likely ask you to contact a senior colleague (as per GMC guidelines). The most obvious person to contact will be your consultant, but you could also go to the Clinical Director if necessary. In a GP practice, this could be a senior GP or the practice manager.

- If you feel that the situation is not being addressed successfully and that patients are still in danger then you should act further to protect patients by going to the relevant authorities such as the deanery if it is a junior colleague or the relevant Royal College.

- If you have any doubt about how to proceed, then you can get help from the GMC, or your defence union (MDU, MPS, etc).

Your colleague

- Your colleague may have personal problems and, despite the fact that he has been endangering patients’ lives (potentially), you should avoid being too judgemental and should offer your support. The level of support that you provide will of course depend on how well you know him and could range from simply being nice and helpful to spending time with him to help him overcome his problem. In any case it will require some flexibility within the team, particularly if the colleague is required to take some time away from clinical duties to sort his problem out.

Comment

This question is easy once you have the structure clear in your head. There are easy marks to be picked up provided you can justify your actions.

Make sure you familiarise yourself well with the Good Medical Practice issued by the GMC. You can access it on their website at www.gmc-uk.org. It deals with many aspects of a doctor’s responsibilities and often provides valuable information to answer questions on all sorts of topics.
6.3 – One of your consultants is managing a patient against the recommendation of a NICE guideline. How do you handle the situation?

In this question, you must avoid jumping to conclusions. The consultant is probably very experienced and there may be a good reason why he is acting in this way.

Why would a consultant deviate from a guideline?
Ask yourself why he may be acting in this way:

- The guideline may be out of date. New guidelines take a long time to write up and your consultant may feel that his experience dictates a new approach.
- The evidence on which the guideline is based may not be fully applicable to the patient. Maybe the guideline is most relevant for a certain age group which the patient does not fall into. Maybe the patient has comorbidities which make him fall outside the guideline.
- The patient may have refused to go along the route offered by the guideline. If the patient is refusing the proposed treatment, your consultant may have been forced to consider an alternative.
- The consultant may simply feel that in his experience the recommended treatment will not be the best for the patient.

Remember: guidelines are only guidelines. Although a consultant would need to have a good reason to deviate from it, the chance is that your consultant will be taking the best approach.

How to approach the situation?

- In view of the above arguments, you should approach the consultant from an education point of view and ask him if he could explain why he is acting in this way. He will most likely give you a sensible explanation that should satisfy your curiosity and alleviate your fears.
- If you are still puzzled, tell him and he might explain it in a different way.
- If you feel that you still do not understand or you worry that he may not be acting in the patient’s best interest then you should seek a second opinion. This may be from your Registrar or even another consultant. But you must do so diplomatically as you do not want to undermine the consultant in question. By raising the issue with a senior you are satisfying your duties.

At all times, you must make sure that the patient is safe.