NILE ACADEMY

MEDICINE INTERVIEW SERIES

UK MEDICAL & DENTAL SCHOOL INTERVIEWS · 2026 ENTRY

The Complete MMI Handbook

Every station, framework, ethical principle and NHS hot topic you need to walk into the Multiple Mini Interview circuit prepared, calm and ready to score.

Master Edition

The Multiple Mini Interview, decoded

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WHAT'S INSIDE

Contents

BEFORE YOU BEGIN

How to use this handbook

Read it once cover to cover. Then live in Sections 4, 5 and 12 until the circuit feels like home.

An MMI is not an exam you can revise by memorising answers. It is a test of how you think, how you communicate and how you treat the person in front of you, observed across a series of short, sharp encounters. The good news is that almost everything assessed is a skill, and skills can be built. This handbook gives you the map, the frameworks and the practice material to build them.

STEP ONE

Understand the format

Sections 1 to 3 explain what an MMI is, who uses it and what every examiner is secretly marking against. Skipping this is why most candidates prepare for the wrong thing.

STEP TWO

Learn the stations

Section 4 walks through every station type with a method and a worked example. Section 6 is your communication and role-play deep dive.

STEP THREE

Build the knowledge base

Section 5 (ethics) and Section 8 (NHS) are the two bodies of knowledge you cannot fake. Learn them properly and you can handle anything they throw at you.

STEP FOUR

Drill out loud

Section 12 is a 150+ question bank. Speaking answers aloud, ideally to another person with a timer, is worth ten times more than reading them.

THE SINGLE MOST IMPORTANT IDEA

You need almost no clinical knowledge for an MMI. Nobody expects a sixth-former to diagnose or treat anyone. What they are looking for is a kind, sensible, honest person who listens, weighs both sides of a problem, communicates clearly and shows insight into why they want to do this. Read every station through that lens.

A note on currency. Interview formats, station counts and NHS figures change every cycle. Where this handbook gives specific numbers or a named school's format, treat it as a realistic guide and always confirm against the official email and university web page for your year.

SECTION 01

What an MMI actually is

A circuit of short, independently scored stations that gives you many small chances to shine rather than one big chance to stumble.

The Multiple Mini Interview was developed at McMaster University in Canada in 2004 to fix a known weakness of the traditional panel interview: a single conversation with one or two people is unreliable. A candidate who clicks with the panel, or who happens to get a friendly question, can score far higher than an equally able candidate who does

not. The MMI spreads assessment across many short, structured encounters so that one nervous moment, one awkward examiner or one unfamiliar topic cannot sink you. Researchers found this gave much better "context specificity": it measures how you actually behave across different situations rather than how well you talk about yourself once.

How the circuit works

You rotate through a series of **stations**, arranged like a circuit. At each one you meet a different examiner and a fresh task. A buzzer or bell signals when to move on. Because every station is marked independently, a weak station can be rescued by strong ones, and no single examiner sees your whole performance.

Feature	Typical range	What it means for you
Number of stations	6 to 10 (sometimes 5)	Each is a fresh start. Treat them as separate.
Time per station	5 to 10 minutes	Be concise. You cannot waffle and still cover the ground.
Reading / prep time	1 to 2 minutes before each	Precious thinking time. Always use it to plan.
Examiners	One per station; sometimes a second observing	Both may score you independently.
Scoring	Station-specific rubric, often a 1 to 5 scale plus written comments	Hit the criteria, do not just "have a nice chat".
Actors	Used in role-play and communication stations	They are trained and follow a script. Treat them as real.

HOW A STATION IS SCORED

Examiners use a structured score sheet. It breaks the station into discrete criteria, for example clarity of communication, empathy shown, ethical reasoning, structure, and a global judgement of your suitability. Many schools use a 1 to 5 (Likert) scale per criterion or an overall band, with free-text comments that the admissions panel later uses to separate candidates who scored similarly. This is why **naming the principle and applying it** beats vaguely "being nice": the marker is ticking specific boxes.

MMI versus the alternatives

Format	What it looks like	Used because
Multiple Mini Interview	Circuit of short stations, fresh examiner each time	Most reliable; samples many skills; reduces single-examiner bias. Now the most common UK format.
Traditional panel	One longer conversation with two to four interviewers	Allows depth and follow-up. Still used by some, including parts of Oxbridge.
Group / MMI hybrid	Tasks done with other candidates, observed by assessors	Reveals real teamwork and how you behave around peers.
Problem-based (PBL) task	You work through a problem, sometimes in a group	Schools that teach by PBL want to see you learn this way.

In person or online

Since 2020 many schools have kept an online option, and some run fully online. Two formats to know:

- ✓ **Live online MMI.** The same circuit over Zoom, Microsoft Teams or Blackboard Collaborate. You move between virtual "rooms". Your invitation tells you the platform; test it in advance.
- ✓ **Asynchronous interview.** You record answers to pre-set questions with no live examiner (Imperial has used a two-part format including this, recorded via Panopto). You typically get up to a minute to read and up to five minutes to record. There is no rapport to build, so structure and clarity matter even more.

WHY THIS FORMAT IS GOOD NEWS FOR YOU

A single panel can only see one side of you. The MMI gives you a fresh examiner who knows nothing about your previous station, so a slow start does not follow you around. If a station goes badly, the next interviewer is a blank slate. That structural fairness is your friend, provided you can reset quickly (see Section 10).

SECTION 02

Which UK schools use the MMI

Most do, but the details vary enormously. Prepare for the format, then tailor to your specific school.

The majority of UK medical and dental schools now use an MMI or MMI-style format, but the number of stations, the length of each and what they include differ from school to school, and can change year to year. The table below shows the kind of variation you should expect. **Always confirm against your offer email and the university's current admissions page.**

School (illustrative)	Format reported for recent cycles
Manchester	Five-station MMI, each station eight minutes, two-minute gap, no reading or writing component, in person or on Zoom.
Brighton & Sussex	Five discussions, ten minutes each, one minute between, full circuit around 54 minutes; does not score the personal statement or references at selection.
Birmingham	Six to seven stations, around eight minutes each, including role-play and a calculation station.
Hull York	MMI of around six stations, five minutes each, mixing mini-interviews, group work and individual scenarios.
Liverpool	MMI; face to face for home students, online for international applicants.
Imperial	MMI-style split into two parts including an asynchronous, pre-recorded interview (Panopto).

THE GOLDEN RULE

Two weeks before your interview, build a one-page brief for that specific school: number of stations, time per station, online or in person, platform, whether there is reading time, and any published values or selection criteria. Schools reward candidates who clearly understand and align with their stated ethos, so read their "why us" and course pages closely.

A few schools to research individually

Some institutions sit outside the standard MMI pattern or weight things unusually, for example parts of Oxford and Cambridge keep subject-focused panel interviews, and several schools place heavy emphasis on values or work experience. New medical schools have also opened in recent years. None of this changes the core skills in this handbook; it changes the packaging. Map your preparation to the format, then to the school.

SECTION 03

What examiners are really assessing

Behind every station sits the same short list of qualities. Learn the list, and every station becomes legible.

Whatever the task, examiners are checking for the values and attributes that define a safe, trusted, effective doctor. These are not invented per school; they come from three authoritative sources that every UK medical school maps to. Knowing them lets you read what any station is really testing.

1. The GMC: Good Medical Practice

Good Medical Practice is the General Medical Council's core guidance for every UK doctor. Its 2024 edition is organised into four domains. You will not be quizzed on it directly, but your behaviour in stations is judged against its spirit.

Domain	In plain terms
Knowledge, skills & development	Stay competent, keep learning, recognise the limits of your ability and ask for help.
Patients, partnership & communication	Treat patients as partners, communicate well, respect dignity, support autonomy and shared decisions.
Colleagues, culture & safety	Work well in teams, treat colleagues with respect, contribute to a safe and fair culture, raise concerns.
Trust & professionalism	Act with honesty and integrity, maintain confidentiality, be candid when things go wrong, protect public trust.

2. The Medical Schools Council core values

The Medical Schools Council publishes the values and attributes expected of applicants, aligned with Good Medical Practice and the NHS Constitution. In short, schools want evidence that you have:

DRIVE

Motivation & insight

A genuine, reflective reason for medicine, with realistic understanding of the career.

BACKBONE

Resilience & organisation

The capacity to cope with pressure, manage your time and bounce back from setbacks.

CONNECTION

Communication & teamwork

Listening, explaining clearly and working effectively with others.

CHARACTER

Respect, empathy, honesty & integrity

The professional behaviour that underpins patient trust.

Crucially, the Council stresses **evidence over assertion**: showing a quality through a real example beats stating you have it.

3. The NHS Constitution and the 6 Cs

The NHS, founded in 1948, is built on a set of core values. Anchoring your answers to them signals that you understand the system you are joining.

NHS Constitution values	The 6 Cs (care values, widely cited)
Working together for patients	Care
Respect and dignity	Compassion
Commitment to quality of care	Competence
Compassion	Communication
Improving lives	Courage
Everyone counts	Commitment

The transferable competencies, summarised

Every station maps to one or more of these. When you read a prompt, ask "which of these is this testing?" and aim your answer there.

- **Communication** – clear, two-way, jargon-free
- **Empathy** – recognising and responding to feelings
- **Integrity & ethics** – honesty and sound judgement
- **Teamwork** – collaborating and knowing when to seek help
- **Problem-solving** – logical, structured thinking
- **Resilience** – coping under pressure
- **Motivation & insight** – knowing why, and reflecting
- **Professionalism** – reliability, respect, self-awareness

EXAMINER INSIGHT

Mark schemes reward clarity, structure, insight and alignment with guidance such as consent, confidentiality and candour. If you can **name the relevant principle and apply it proportionately to the scenario**, you will score consistently across very different stations.

SECTION 04

The station catalogue

Every station type you might meet, what it tests, a method to attack it, a worked example and the traps to dodge.

No two circuits are identical, but stations fall into recognisable families. Learn the family and you can handle any specific prompt within it. For each type below you get: **what it is**, **what it assesses**, **how to approach it**, and where useful a worked example and common pitfalls.

4.1 Motivation & insight

TESTS Why medicine, why this school, work experience, reflection, realistic understanding of the career.

These are the most predictable stations and the ones most candidates underperform, because they sound easy and so go unprepared. The examiner wants a specific, reflective, evidenced answer, not a slogan.

How to approach

- ✓ **Be specific and personal.** Replace "I want to help people" with a concrete experience and what it taught you. Many careers help people; show what is distinctive about medicine for you (the blend of science and sustained human relationships, the responsibility, the lifelong learning).
- ✓ **Use STARR for experience questions** (see Section 7): Situation, Task, Action, Result, Reflection. The reflection is where marks live.
- ✓ **For "why this school", be authentic.** Tie the course structure (early clinical exposure, PBL, intercalation, dissection, the city) to your own goals and experiences. Do not just recite the prospectus.
- ✓ **Show you understand the hard parts** (long hours, emotional toll, ongoing exams) and that you are still motivated, with eyes open.

AVOID

- × Citing money, status or "my family are doctors" as your driver (explore your own reasons instead).
- × Knowing you want medicine but being unable to articulate why, a classic sign of no reflection.
- × Generic praise of the school that could apply anywhere.

4.2 Personal insight

TESTS Self-awareness, honesty, the qualities of a good doctor, how you handle weakness and setbacks.

Expect "what are your strengths and weaknesses", "what makes a good doctor", "tell me about a time you failed", "describe an achievement you are proud of".

- ✓ **Strengths:** pick qualities relevant to medicine (communication, teamwork, resilience, organisation) and prove each with a quick example.
- ✓ **Weaknesses:** choose a real, non-fatal one and, crucially, show what you are doing about it. Never disguise a strength ("I'm a perfectionist") as a weakness; it reads as a lack of self-awareness.
- ✓ **Qualities of a doctor:** a balanced list, knowledge plus empathy, integrity, communication, teamwork, resilience, then relate one or two back to yourself.

✓ **Failure / mistake:** own it plainly, then focus on the lesson and the change you made. Reflecting maturely on failure is a hallmark of strong candidates.

4.3 Ethical scenarios

TESTS Moral reasoning, balance, awareness of key ethical principles and the law, ability to reach a defensible conclusion.

This is the station family that separates candidates, and the one with the most knowledge to learn (all of Section 5). Ethical stations are often disguised: a task may look practical but carry an ethical core, so the first skill is recognising one.

THE REUSABLE ETHICAL STRUCTURE

1. **Signpost both sides.** Open with "There are two sides to weigh here." Studies show more than two-thirds of applicants fail to address both sides; doing so reliably lifts your score.
2. **Clarify and gather.** What do you not yet know? State the information you would seek.
3. **Apply the four pillars and identify the stakeholders** (patient, family, colleagues, public).
4. **Bring in law and guidance** where relevant (consent, capacity, confidentiality, GMC duties).
5. **Weigh and conclude.** Come down on a reasoned side, acknowledging the trade-off. Sitting permanently on the fence scores poorly.

WORKED EXAMPLE · ETHICAL SCENARIO

> *A 15-year-old asks her GP for contraception and does not want her parents told. What should the doctor consider?*

Recognise it: this is consent and confidentiality in a minor. **Both sides:** respecting her autonomy and confidentiality versus her welfare and parental involvement. **Apply:** assess *Gillick competence* (does she understand the advice and implications?) and the *Fraser guidelines* (is she likely to have intercourse regardless, is her health at risk without it, is it in her best interests?). If competent, autonomy and confidentiality support providing advice without informing parents. **Safeguarding caveat:** if there were signs of coercion, exploitation or a much older partner, the welfare duty can override confidentiality and a safeguarding referral becomes necessary. **Conclude:** encourage her to involve a trusted adult, but if she is Gillick competent and there are no safeguarding red flags, the doctor can lawfully provide care confidentially.

4.4 Role-play & actor stations

TESTS Communication, empathy, active listening, composure, integrity under pressure.

You interact with a trained actor in a scripted scenario, usually **non-medical** because no clinical knowledge is required. Common themes: comforting an upset friend, an angry customer or relative, a friend asking you to do something dishonest, breaking disappointing (rarely tragic) news, resolving a conflict. The actor reacts to how you behave, so the conversation is the assessment.

Section 6 is the full deep dive. The headline method:

✓ Open warmly, introduce yourself, set a calm tone.

✓ Listen far more than you talk. Use open questions and silence.

- ✓ Explore their **Ideas, Concerns and Expectations** (ICE).
- ✓ Acknowledge emotion explicitly ("I can see this has really upset you").
- ✓ Avoid jumping to solutions; people want to feel heard first.
- ✓ If asked to do something wrong, decline kindly but firmly, explain why, and offer a better route.

EXAMINER INSIGHT

For role-play the marker is watching whether you: react sensibly to the unknown, communicate clearly, build rapport, show genuine empathy, and behave with integrity. You do not need to "solve" everything in five minutes. A candidate who listens and shows they care outscores one who delivers a slick but cold fix.

4.5 Communication & instruction-giving

TESTS Clarity, structure, checking understanding, adapting to the listener.

You explain something to the examiner or instruct them to complete a task they will do *exactly* as told, for example "describe how to wrap a parcel" or "teach me to tie a shoelace" without demonstrating. Or you explain a concept to someone with no background.

- ✓ **Plan the steps** in your prep time; sequence matters.
- ✓ **Check the starting point:** what does the listener already know?
- ✓ **Chunk and check:** give one step, confirm it landed, then continue.
- ✓ **No jargon; be precise.** If they will follow literally, ambiguity is your enemy ("place your right hand" not "put your hand there").
- ✓ **Invite questions** and summarise at the end.

4.6 Data interpretation & calculation

TESTS Numeracy under pressure, accuracy, clear reasoning, composure with numbers.

You might read a graph, interpret a table, or do a simple calculation such as a drug-dosage sum (for example, "a drug is given at 5 mg per kg for a 20 kg child, what dose?"). No advanced maths is needed, only careful arithmetic.

- ✓ **Talk through your working out loud;** the reasoning is marked, not just the answer.
- ✓ **Note the units** and convert carefully (mg vs g, mL vs L).
- ✓ **Sanity-check** the result ("does that dose look sensible?").
- ✓ If you slip, say so calmly and correct it; recovering well is itself a positive.

4.7 Prioritisation

TESTS Judgement, safety-first thinking, distinguishing urgent from important, escalation.

You are given several competing tasks or a situational list and asked to order them, or you face a situational-judgement style scenario familiar from the UCAT.

PRIORITISATION LOGIC

1. **Gather information** before deciding; ask what you would need to know.
2. **Patient safety comes first,** always. Anything that risks immediate harm rises to the top.
3. **Separate urgent from important.** A deadline can create false urgency; the critical thing may be quieter. (An exam you cannot resit outranks a party ticket selling out today.)
4. **Act within your competence, then escalate.** Doing nothing and failing to tell a senior is usually the worst option.
5. **Review** and be willing to re-prioritise as things change.

4.8 Teamwork & collaboration

TESTS Cooperation, listening, leadership without dominance, knowing when to seek help.

You may complete a task with another candidate or an examiner, or reflect on past teamwork. Medicine only works as a collegial team, so this matters.

- ✓ Invite others' input, build on their ideas, and credit them.
- ✓ Lead by coordinating, not steamrolling; share the airtime.
- ✓ If you reflect on a past team, use STARR and be honest about your specific role.
- ✓ Frame asking for help as a strength, not a weakness; it keeps patients safe.

4.9 Problem-solving & "quirky" questions

TESTS Adaptability, calm under surprise, creative and logical thinking.

Examples: "If you were an animal, which would you be?", "How would you design a hospital ward?", "Estimate how many GPs there are in the UK." There is rarely a right answer; they want to see how you think when caught off guard.

- ✓ Pause, take a breath, and think aloud, structure beats a blurted guess.
- ✓ For estimation, state assumptions and reason step by step.
- ✓ Stay composed and even enjoy it; your manner is half the mark.

4.10 NHS hot topics & current affairs

TESTS Awareness of healthcare, balanced analysis, understanding of the system you will join.

You discuss a current issue: doctors' strikes, waiting lists, AI in medicine, NHS funding, an ethics-in-policy topic. Section 8 gives you the facts and talking points. The skill is to show informed, balanced reasoning rather than a hot take.

- ✓ Give a brief factual grounding, then argue both sides, then a measured view.
- ✓ Link back to patients and to NHS values.
- ✓ Know one or two topics in real depth and a broad overview of several.

4.11 Practical, dexterity, reading & portfolio stations

Less common but worth knowing:

- → **Manual dexterity / practical task** – build or manipulate something to test fine motor control and following instructions. Work carefully and narrate.

- **Reading / comprehension** – read a passage in prep time, then discuss or summarise. Note the key points and any bias.
- **Personal statement / portfolio** – questions drawn from your application. Re-read your statement beforehand; be ready to expand on and reflect upon everything in it.

ONE METHOD TO RULE THEM ALL

For almost any station: **use your prep time to plan, signpost your structure, address more than one perspective, show empathy where a person is involved, and finish with a clear conclusion or summary.** That single habit lifts your score in motivation, ethics, role-play, prioritisation and hot-topic stations alike.

SECTION 05

Medical ethics toolkit

The principles, the law and the hot topics, plus a structure that lets you reason through anything they ask.

Ethics is the body of knowledge most likely to win or lose you marks, because it appears in disguised stations as well as obvious ones. You do not need a philosophy degree. You need the four pillars, a handful of legal concepts, both sides of the major debates, and a structure to tie them together.

The four pillars of medical ethics

Developed by Beauchamp and Childress, the four pillars are the framework UK doctors and interviewers use to reason through dilemmas. Name them, then apply them.

PILLAR 1

Autonomy

Respect the patient's right to make their own informed decisions about their care, including the right to refuse. Underpins consent and confidentiality. It is not absolute: it can be limited by capacity, by law, or by harm to others.

PILLAR 2

Beneficence

Act in the patient's best interests; do positive good. Example: staying late so a ward is safely covered until your colleague arrives.

PILLAR 3

Non-maleficence

"First, do no harm." Avoid interventions whose harm outweighs benefit. Example: not prescribing antibiotics for a likely viral illness, avoiding harm and resistance.

PILLAR 4

Justice

Fairness: treat people equitably and use limited resources fairly. Especially live in an NHS facing finite budgets and health inequalities.

THE PILLARS IN CONFLICT

The interesting cases are where pillars clash. A patient refusing a life-saving transfusion pits **autonomy** against **beneficence**. Funding one costly treatment for a wealthy patient pits their **autonomy** against **justice** for everyone else. Your job is to name the tension and reason toward a proportionate resolution, not to pretend there is no trade-off.

Three ethical frameworks worth naming

Framework	Core idea	Quick use
Consequentialism / Utilitarianism	Judge an act by its outcomes; greatest good for the greatest number.	Useful for resource allocation, public health.
Deontology	Some duties and rules are binding regardless of outcome (honesty, consent).	Useful where rights or duties are absolute.
Virtue ethics	Ask what a good, compassionate doctor would do.	Useful as a sense-check on any decision.

The legal and clinical concepts you must know

Concept	What it means
Valid consent	Must be **voluntary**, **informed** (risks, benefits, alternatives explained), and given by someone with **capacity**. Consent can be withdrawn at any time.
Capacity (MCA 2005)	Adults are assumed to have capacity. To have it for a decision a person must be able to **understand** the information, **retain** it, **weigh** it, and **communicate** a choice. Capacity is decision-specific and can fluctuate. An unwise decision is not in itself a lack of capacity.
Gillick competence	A child under 16 may consent to their own treatment if they have enough maturity and understanding to grasp what is proposed.
Fraser guidelines	Specific criteria for providing contraceptive or sexual-health advice to under-16s without parental consent (understanding, likely to proceed regardless, health at risk otherwise, best interests).
Confidentiality	A core duty that builds trust. It can be **broken** only with consent, when required by law, or in the public interest (serious risk of harm to the patient or others, for example a credible threat, certain communicable diseases, or safeguarding).
Best interests	When an adult lacks capacity, decisions are made in their best interests, considering their known wishes, values and the views of those close to them.
DNACPR & advance decisions	A DNACPR records a decision not to attempt resuscitation. An advance decision (living will) lets a person refuse specified treatment in advance, should they later lose capacity.
Duty of candour	The professional duty to be open and honest with patients when something goes wrong, to apologise and to put it right.
Whistleblowing	Raising concerns about unsafe or unethical practice. Patient safety overrides loyalty to a colleague; concerns should be escalated appropriately.

Concept	What it means
Safeguarding	Protecting children and vulnerable adults from harm. Safeguarding concerns can override confidentiality.
Equality vs equity	Equality treats everyone the same; equity gives people what they each need to reach a fair outcome. Justice in healthcare usually means equity.

The hot ethical topics, both sides

Have a balanced view on each. Always present arguments on both sides before a measured conclusion.

EUTHANASIA & ASSISTED DYING

For: respects autonomy; relieves unbearable suffering; can be carefully safeguarded. *Against:* sanctity of life; risk of coercion of the vulnerable; impact on the doctor-patient relationship and on palliative care; difficulty defining safeguards. **Status:** assisting a suicide is currently a criminal offence in England, Wales and Northern Ireland (Suicide Act 1961); legislation on assisted dying has been moving through Parliament in recent sessions. Confirm the current legal position before your interview.

ABORTION

For: bodily autonomy; access to safe, legal care; the woman's circumstances and health. *Against:* moral status of the foetus; conscientious objection of some clinicians. **Note:** in Great Britain abortion is lawful within the terms of the Abortion Act 1967; doctors may conscientiously object but must refer on.

ORGAN DONATION

England, Scotland and Wales now operate an **opt-out** ("deemed consent") system for organ donation, with families still consulted. Balances increasing supply against respecting individual and family wishes. Topical sub-issues include allocation fairness and transplant tourism.

VACCINATION & MANDATES

For: protects the individual and the community through herd immunity; a public-health good. *Against:* autonomy and consent; equity of access; trust and hesitancy. Distinguish encouraging uptake from compelling it.

RESOURCE ALLOCATION & RATIONING

Finite budgets force hard choices. **NICE** uses tools such as the **QALY** (quality-adjusted life year) to assess cost-effectiveness. Tension between utilitarian "greatest good" and justice for the individual. Expect scenarios with one resource and two patients.

GENETICS & GENE EDITING

Predictive testing raises questions of consent, privacy, insurance and the "right not to know". Editing (for example CRISPR) raises safety, consent of future generations and "designer baby" concerns versus preventing serious disease.

JEHOVAH'S WITNESS & BLOOD TRANSFUSION

A competent adult may refuse a transfusion on religious grounds even if life-saving, autonomy is respected. With children, the picture differs and best interests and the courts may be involved. A clean illustration of autonomy versus beneficence.

OTHER TOPICS TO HOLD A VIEW ON

- Mental health & sectioning (Mental Health Act)
- IVF and fertility funding

- Surrogacy
- Mandatory reporting of disease
- AI-assisted diagnosis and liability
- Private vs NHS care and top-ups
- Animal research
- Public-health nudges (sugar tax, smoking)

CARRY THIS STRUCTURE INTO EVERY ETHICS STATION

Two sides → clarify → pillars + stakeholders → law/guidance → weigh → conclude. Memorise it. It works whether the topic is assisted dying or a friend cheating on a test.

SECTION 06

Communication & role-play mastery

The frameworks that turn a daunting actor station into a structured, human, high-scoring conversation.

Communication stations reward warmth and structure in equal measure. Below are the core principles, then the four frameworks worth knowing by name, then how to handle the specific difficult conversations you may face.

The core principles

- ✓ **Listen more than you speak.** Aim to talk less than half the time. Silence is a tool; let people fill it.
- ✓ **Open questions first** ("Tell me what's been happening") before closed ones to narrow down.
- ✓ **Acknowledge emotion explicitly.** Name what you see: "This sounds incredibly stressful."
- ✓ **Avoid jargon.** Use plain words and check the person follows.
- ✓ **Chunk and check.** Give information in small pieces and confirm understanding before moving on.
- ✓ **Mind your manner.** Open body language, eye contact, an unhurried pace, sitting at the same level.
- ✓ **Do not rush to fix.** People need to feel heard before they want solutions.

Framework 1 · ICE

IDEAS · CONCERNS · EXPECTATIONS

A fast way to understand any person in front of you. **Ideas:** what do they think is going on? **Concerns:** what are they worried about? **Expectations:** what are they hoping for from this conversation? Asking ICE shows you treat them as a person, not a problem, and it surfaces the real issue quickly.

Framework 2 · Calgary-Cambridge

The standard model for a medical consultation. You will not run a full consultation in an MMI, but its shape makes any conversation flow.

Stage	What you do
Initiating the session	Greet, introduce yourself, establish rapport and the reason for the conversation.

Stage	What you do
Gathering information	Open questions, active listening, explore ICE.
Physical examination	(Clinical only, not usually in MMI.)
Explanation & planning	Share information in chunks, check understanding, agree next steps together.
Closing	Summarise, safety-net, confirm the plan.

Two threads run throughout: **building the relationship** and **providing structure** (signposting).

Framework 3 · SPIKES for breaking bad news

The most widely taught protocol for difficult news. In an MMI the "bad news" is usually mild (a cancelled trip, a lost item, a friend's disappointment), but SPIKES is the structure examiners recognise.

Letter	Step	In practice
S	Setting	Private, calm, sit down, minimise interruptions, give it time.
P	Perception	Find out what they already know or suspect before you tell them.
I	Invitation	Ask how much they want to know; get their permission to proceed.
K	Knowledge	Give a brief warning shot, then the news simply, in plain language, then pause.
E	Empathy	Respond to emotion: observe it, name it, allow silence, validate it.
S	Strategy & summary	Agree the next steps and what support is available; summarise.

Framework 4 · Empathy vs sympathy

FEELING WITH

Empathy

Understanding and sharing another's feelings from their perspective. "It sounds like this has left you frightened and exhausted." This is what medicine needs.

FEELING FOR

Sympathy

Feeling pity or sorrow for someone from the outside. "I'm so sorry for you." Kind, but more distant and less connecting.

A TOOL FOR SHOWING EMPATHY: NURSE

Name the emotion, **U**nderstand it, **R**espect/praise their coping, **S**upport them, **E**xplore further. A simple way to respond when someone becomes emotional.

Handling the specific difficult conversations

The angry or upset person

- ✓ Stay calm and do not match their energy. Lower your voice.
- ✓ Let them vent without interrupting; acknowledge their feelings.
- ✓ Apologise for the situation (not necessarily for personal fault) and find out what they need.
- ✓ Move toward a constructive next step.

The friend asking you to do something dishonest

- ✓ Hear them out and show you understand why they are asking.
- ✓ Decline clearly and kindly; explain the principle (integrity, fairness, consequences).
- ✓ Offer a legitimate alternative or to help them another way.
- ✓ This tests assertiveness and integrity; do not cave to maintain the friendship.

Comforting a distressed peer

- ✓ Create a safe space, listen, and resist the urge to immediately problem-solve.
- ✓ Validate their feelings and gently explore what support they have.
- ✓ Signpost help where appropriate, without overstepping.

Online role-play tips

- → Look at the camera to "make eye contact"; check lighting and framing.
- → Slow down and pause more, video adds lag and removes body-language cues.
- → Nod and verbally acknowledge ("I see", "go on") so the other person knows you are engaged.

ROLE-PLAY PITFALLS

- ✕ Talking over the actor or rushing to a solution.
- ✕ Trying to act like a doctor or offer a medical diagnosis (not required, often penalised).
- ✕ Forgetting to show emotion because you are focused on "getting it right".
- ✕ Being so soft you never address the actual issue.

SECTION 07

Answer frameworks

A small toolkit of structures. Internalise them so that under pressure your answers organise themselves.

STARR · for any experience or "tell me about a time" question

SITUATION · TASK · ACTION · RESULT · REFLECTION

Situation	Set the scene briefly.
Task	What needed doing, your responsibility.
Action	What *you* specifically did.
Result	The outcome.
Reflection	What you learned and how it shaped you. **This is where the marks are.**

The ethical structure · for any dilemma

Two sides → clarify what you'd need to know → apply the four pillars and name the stakeholders → bring in law and GMC guidance → weigh the trade-off → reach a reasoned conclusion.

Prioritisation logic · for ranking tasks

Gather information → patient safety first → urgent vs important → act within competence then escalate → review.

A reflection model · for "what did you learn"

A short version of Gibbs' reflective cycle keeps reflection from sounding shallow: **what happened → how it felt → what was good or bad → what you make of it → what you would do differently next time.**

Signposting language bank

Signposting tells the examiner your structure and keeps you on track. Keep a few of these ready:

To open

"There are a few angles here; let me take them in turn." · "Before I answer, I'd want to know…" · "There are two sides to weigh."

To sequence

"First… Second… Finally…" · "On one hand… on the other…" · "Building on that…"

To show empathy

"I can see this matters a great deal to you." · "That sounds really difficult." · "Help me understand how you're feeling."

To conclude

"So, weighing both sides, I'd lean towards… because…" · "To summarise the key steps…"

WHY FRAMEWORKS WIN

Under pressure, memory fails but habits hold. If "ethics question" automatically triggers "two sides first", and "tell me about a time" automatically triggers STARR, you free up mental space to actually think, and you never freeze on where to start.

SECTION 08

NHS & healthcare knowledge

How the system works, what it stands for, and the current debates, with balanced talking points for each.

You are applying to work within the NHS, so examiners expect a working knowledge of it. You do not need to be a policy expert; you need the essentials and an informed, balanced view on the big issues.

The essentials

✓ **Founded in 1948** by Aneurin Bevan, on the principle of healthcare **free at the point of use**, funded through general taxation, available to all based on need not ability to pay.

- ✓ **Structure (England):** the Department of Health and Social Care sets policy; NHS England oversees the system; **Integrated Care Systems** and their boards plan and fund care locally. Care is delivered across **primary** (GPs, the usual first point of contact and "gatekeeper" to specialists), **secondary** (hospitals) and **tertiary** (specialist centres) levels.
- ✓ **Values:** the NHS Constitution's six values and the 6 Cs (see Section 3).

1948	~7.4m	15,000
Year the NHS was founded	Elective waiting list, mid-2025, far above pre-pandemic levels	Medical school places targeted by 2031/32 under the Long Term Workforce Plan

Figures move every cycle. Use these as orientation and refresh the exact numbers from a recent source (NHS England, The King's Fund, BBC Health) shortly before your interview.

The current hot topics

1. RESIDENT (JUNIOR) DOCTOR STRIKES

What: resident doctors in England (renamed from "junior doctors") have taken industrial action over pay restoration and, increasingly, a jobs and training bottleneck; action that had paused resumed in 2025. *Both sides:* the right to fair pay and safe conditions, and long-term workforce sustainability, versus disruption to patients and cancelled care. *Talking point:* note the ethical tension between collective action and the duty to patients, and that emergency cover is maintained during strikes. *Sample Q:* "Is it ever ethical for doctors to strike?"

2. WAITING LISTS AND THE ELECTIVE BACKLOG

What: the waiting list for planned treatment rose to record highs after the pandemic and remains very large. *Why it matters:* long waits cause harm and anxiety; recovery needs more capacity, better flow and prevention, not just more staff. *Sample Q:* "How would you reduce NHS waiting times?"

3. A&E PRESSURE AND "CORRIDOR CARE"

What: emergency departments and ambulances face sustained demand; four-hour A&E performance and ambulance response times remain below target. *Why it matters:* delays risk harm in time-critical conditions; bottlenecks often stem from bed availability and delayed discharge, so solutions span the whole system including social care. *Sample Q:* "What causes A&E delays and how would you fix them?"

4. WORKFORCE: TRAINING MORE, KEEPING MORE

What: the NHS Long Term Workforce Plan commits to a major expansion of training, including roughly doubling medical school places. *Both sides:* ambitious and necessary, but delivery depends on funded placements, educators and clinical capacity, and **retention** (wellbeing, flexible careers) matters as much as recruitment. *Sample Q:* "Is training more doctors the answer to NHS staffing?"

5. FUNDING

What: demand rises faster than budgets; analyses (for example by The King's Fund) have highlighted real-terms pressure and growing provider deficits despite funding boosts. *Talking point:* the NHS must deliver more with constrained resources, forcing choices about prevention, efficiency and where money goes. *Sample Q:* "Why is NHS funding always described as in crisis?"

6. THE 10 YEAR HEALTH PLAN AND ITS THREE SHIFTS

THE THREE SHIFTS TO KNOW

- **Hospital → community** (care closer to home, the "neighbourhood" model).
- **Analogue → digital** (a more digital NHS, the NHS App, data and AI).
- **Sickness → prevention** (stopping illness before it starts).

These three shifts are a clean, memorable way to frame almost any "future of the NHS" question.

7. AI AND DIGITAL HEALTH

What: AI is being used for diagnostics (for example imaging), triage and administration, alongside the NHS App and electronic records. *Both sides:* potential to speed diagnosis, cut workload and improve access, versus questions of data privacy, accuracy, bias, accountability when AI errs, and the need to keep the human relationship central. *Sample Q:* "Will AI replace doctors?"

8. THE REST OF THE LANDSCAPE

- **Mental health** demand, especially in young people
- **Ageing population** & social-care integration
- **Health inequalities** (the Marmot agenda)
- **Prevention & public health** (obesity, smoking, vaping)
- **Antimicrobial resistance**
- **Climate & the net-zero NHS**
- **Pandemic legacy** & long COVID
- **Health and the cost of living**

HOW TO DISCUSS ANY HOT TOPIC

Brief facts → both sides → link to patients and NHS values → measured conclusion. Know one or two topics in depth (enough to handle follow-ups) and a sentence or two on each of the rest.

SECTION 09

Your preparation roadmap

What to do, in what order, over the weeks before your interview, so that you peak on the day.

A six-to-eight week plan

When	Focus
Weeks 1–2	Learn the format and the frameworks. Read this handbook fully. Master the four pillars, ICE, SPIKES, STARR. Re-read your personal statement and list every experience you can draw on.
Weeks 3–4	Build the knowledge base. Work through the ethics topics and NHS hot topics. Start a one-page note on each, in your own words. Begin answering questions aloud.
Weeks 5–6	Drill stations. Do timed practice across every station type from Section 12. Record yourself. Practise role-play with a partner. Get feedback and act on it.

When	Focus
Final week	Polish and taper. Build your school-specific brief. Refresh the latest NHS figures. Do a few light mocks, sort logistics, and rest. Do not cram new material the night before.

Wider reading and listening

- BBC News Health
- The King's Fund (NHS explainers)
- NHS England news
- GMC: Good Medical Practice
- Medical Schools Council guidance
- BMJ / Student BMJ
- Quality broadsheet health coverage
- A reputable medical-ethics podcast

How to practise so it sticks

- ✓ **Out loud, always.** Reading answers feels productive and is nearly useless. Speak them.
- ✓ **To a person, with a timer.** Recruit a friend or family member to play the examiner or actor and to keep time.
- ✓ **Record and review.** Watching yourself reveals filler words, pace and body language you cannot feel in the moment.
- ✓ **Build an example bank.** Map your experiences to qualities (teamwork, resilience, leadership, empathy) so you always have a story ready.
- ✓ **Practise the reset.** Deliberately rehearse moving on after a station you feel went badly.

QUALITY OVER QUANTITY

Ten questions answered aloud, reviewed and re-attempted will improve you more than a hundred read silently. Depth of practice beats breadth of reading every time.

SECTION 10

On the day

Logistics, mindset and the small habits that protect your performance when it counts.

Logistics

- ✓ **Arrive early** (or log in early). Bring any required ID and documents.
- ✓ **Dress smartly and comfortably,** as you would to meet a patient.
- ✓ **Online:** test your platform, camera, microphone and internet beforehand; choose a quiet, well-lit, tidy space; have water and a backup plan if tech fails.

Mindset and the reset

- ✓ **Treat each station as a fresh start.** The next examiner knows nothing about the last one. A bad station only damages you if you carry it forward.
- ✓ **Use the gap between stations** to take a breath, drop the previous task, and read the next prompt with fresh eyes.
- ✓ **Approach it as a conversation,** not an interrogation. Be genuine, use common sense and compassion.

Inside the station

- ✓ **Read the prompt carefully** and use every second of prep time to plan a structure.
- ✓ **Watch the clock** loosely; be concise so you cover the ground before the buzzer.
- ✓ **Body language:** open posture, eye contact, calm pace, a warm opening.
- ✓ **If you go blank,** pause, take a breath, and think aloud; silence to gather yourself is fine.
- ✓ **If you misspeak,** correct yourself calmly; recovering well is a positive signal.

Managing nerves

- → Some adrenaline is useful; reframe nerves as energy.
- → Slow, steady breathing before you enter resets your voice and pace.
- → You earned the interview, the school already rates you on paper. Now they just want to meet you.

THE ONE HABIT THAT MATTERS MOST

Reset between every station. The candidates who fall apart are usually not the ones who had a weak station, but the ones who let it bleed into the next three. Close each door behind you.

SECTION 11

The mistakes that cost marks

Examiners see the same errors again and again. Knowing them is half of avoiding them.

ETHICS

Only arguing one side

The most common and costly error. Over two-thirds of candidates fail to address both sides. Always signpost both before concluding.

TIMING

Not using prep time

Walking in without a plan leads to rambling. Plan a structure in your reading minute.

DELIVERY

Robotic, memorised answers

Pre-scripted speeches sound hollow and collapse under a follow-up. Learn structures, not scripts.

INSIGHT

No reflection

Describing an experience without saying what you learned wastes the question. Always reflect.

TONE

Putting down other applicants

Never compare yourself favourably to others or generalise about the profession. Speak only to your own qualities.

MOTIVATION

Money, status or "family of doctors"

Weak or second-hand motivators. Give your own, reflective reasons.

ROLE-PLAY

Playing doctor / diagnosing

No clinical knowledge is expected; attempting a diagnosis often loses marks. Focus on communication.

EMPATHY

Rushing to fix, talking over

Failing to listen or to acknowledge feeling. Let people be heard first.

PRIORITISATION

Ignoring safety and escalation

Forgetting that patient safety comes first, or failing to escalate, undermines the answer.

STRUCTURE

Waffling, no signposting

Long, shapeless answers lose the examiner. Signpost and stay concise.

RESILIENCE

Carrying a bad station forward

One weak station infecting the next few. Reset each time.

INTEGRITY

Caving to do the wrong thing

In integrity scenarios, being agreeable is not the goal. Decline the wrong thing, kindly but clearly.

SECTION 12

The practice question bank

Over 150 questions across every category. Answer them aloud, to a timer, ideally to another person. Model approaches follow the trickier ones.

Motivation & insight

1. Why do you want to study medicine?
2. Why this medical school specifically?
3. What appeals to you about being a doctor, and what worries you?
4. What did you learn from your work experience?
5. Tell me about a time work experience challenged your view of medicine.
6. Why not nursing, or another healthcare career?
7. What have you done to find out whether medicine is right for you?
8. What would you do if you did not get into medical school this year?
9. Where do you see yourself in ten years?
10. What specialty interests you and why? (No commitment expected.)
11. What recent medical development have you found interesting?
12. How do you know you can cope with the demands of medicine?
13. What does a doctor's typical day actually involve?
14. What is the difference between a good doctor and a good person?
15. What have you read or listened to recently about healthcare?

Personal insight

1. What are your greatest strengths? Give evidence for each.
2. What is your biggest weakness, and what are you doing about it?
3. What qualities make a good doctor? Which do you have?
4. Tell me about a time you failed. What did you learn?
5. Describe an achievement you are proud of.
6. How do you handle stress and pressure?
7. Tell me about a time you showed leadership.
8. Tell me about a time you worked in a team.
9. How do you manage your time?
10. Tell me about a time you received difficult feedback.
11. What would your friends say is your worst trait?
12. Describe a time you had to adapt to a new situation.
13. What do you do to look after your own wellbeing?
14. Tell me about a time you showed empathy.
15. What is the most difficult thing you have ever done?

Ethical scenarios

1. A 15-year-old asks for contraception and does not want her parents told. What do you consider?
2. A competent patient refuses a life-saving blood transfusion on religious grounds. What should the doctor do?
3. One donor organ, two suitable recipients. How should the choice be made?
4. A patient demands antibiotics for a likely viral illness. How do you respond?
5. Should the NHS fund a very expensive treatment that extends life by a few months?
6. A colleague comes to work smelling of alcohol. What do you do?
7. You see a senior make a drug error. What do you do?
8. A friend asks you to sign them into a lecture register. How do you respond?
9. Is it ethical for doctors to strike?
10. Should obese patients or smokers be deprioritised for certain surgery?
11. What are your views on assisted dying?
12. What are your views on abortion?
13. Should vaccination ever be mandatory?
14. A patient tells you something that suggests they may harm someone. What do you do?
15. Should patients be able to pay privately to top up NHS care?
16. An elderly patient lacks capacity and the family disagree about treatment. How do you proceed?
17. Is it ever acceptable to lie to a patient?
18. What do you think about the opt-out organ donation system?
19. Should parents be able to refuse vaccination for their child?
20. A wealthy donor offers your hospital money in exchange for faster treatment. What are the issues?

MODEL APPROACH · "IS IT ETHICAL FOR DOCTORS TO STRIKE?"

Two sides. For: doctors have a right to fair pay and safe working conditions; sustainable pay and morale protect patients in the long run; emergency cover is maintained so the most urgent care continues. Against: striking disrupts care and cancels operations, causing harm and anxiety now; there is a duty to patients that can feel at odds with industrial action; public trust may suffer. **Pillars and stakeholders.** Weigh non-maleficence and justice for current patients against beneficence for future patients and fairness to staff; stakeholders include patients, doctors, the NHS and the public. **Conclusion.** A defensible line: striking can be ethical as a last resort when other routes are exhausted and emergency care is protected, but the harm to patients means it should never be undertaken lightly. Avoid taking a one-sided political stance.

MODEL APPROACH · "A COLLEAGUE SMELLS OF ALCOHOL AT WORK"

Recognise: patient safety and a colleague's welfare. **Gather:** approach them privately and non-judgementally; you may be wrong, so check the facts. **Act on safety first:** an impaired colleague should not be treating patients, so they must step back from clinical duties now. **Escalate:** inform a senior or supervisor; this is not "telling tales", it is protecting patients and ultimately the colleague. **Support:** show compassion; there may be an underlying problem needing help. **Principle:** patient safety overrides loyalty, and the GMC duty to raise concerns applies.

Role-play prompts

1. A friend is upset because they failed an important exam. Talk to them.
2. A customer is angry that their order arrived broken. You work there. Resolve it.
3. Tell a friend that you accidentally lost the expensive item they lent you.
4. A teammate keeps missing group meetings and the project is suffering. Address it.
5. A friend asks you to lie to cover for them. Respond.
6. A relative is anxious about a delayed appointment. Reassure them. (No clinical detail needed.)
7. A younger student is being bullied and confides in you. Support them.
8. Tell your sports team that a planned trip has been cancelled.
9. A friend is making an unhealthy choice and you are worried. Talk to them.
10. Apologise to a colleague after a misunderstanding you caused.

Communication & explaining

1. Explain how to make a cup of tea to someone who has never done it.
2. Teach me to tie a shoelace using words only.
3. Describe how to wrap a present; I will do exactly as you say.
4. Explain the rules of your favourite sport to a complete beginner.
5. Explain what a vaccine is to a worried child.
6. Give me directions from the station to your house.

Prioritisation

1. You have four tasks due today and cannot do them all. Here they are; order them and justify.

2. It is a busy shift; rank these competing requests by priority.
3. You have an exam tomorrow, a shift, a friend in crisis and a family event. What do you do?
4. Several people need attention at once (non-clinical judgement of urgency). How do you decide?
5. You are leading a group project running behind. What do you tackle first?

Teamwork

1. Tell me about a successful team you were part of and your role in it.
2. Tell me about a team that did not work well. What went wrong?
3. How do you handle a team member who is not pulling their weight?
4. What makes a good team leader?
5. Complete this task with the other candidate. (Observed collaboration.)

NHS & hot topics

1. What do you know about how the NHS is structured?
2. What are the biggest challenges facing the NHS today?
3. How would you reduce NHS waiting lists?
4. What causes A&E delays and how would you address them?
5. Will AI replace doctors? Should we be worried?
6. What are the arguments for and against more private involvement in the NHS?
7. What is the difference between the NHS being "free" and being "free at the point of use"?
8. What are the NHS values, and why do they matter?
9. How should the NHS tackle health inequalities?
10. What role should prevention play in the NHS?
11. What do you understand by the 10 Year Health Plan's three shifts?
12. Should the NHS be funded differently?
13. How has the COVID-19 pandemic changed the NHS?
14. What is the role of a GP, and why is primary care important?
15. What do you know about the medical workforce shortage?

Data & calculation

1. A drug is dosed at 5 mg per kg. Calculate the dose for a 24 kg child. (Talk through your working.)
2. Here is a graph of waiting times over five years. Describe the trend and what might explain it.
3. A medicine comes as 250 mg in 5 mL. What volume gives a 400 mg dose?

Problem-solving & quirky

1. If you were an animal, which would you be and why?
2. How many GPs do you think there are in the UK? Reason it out.
3. How would you design the ideal hospital ward?
4. What is your favourite organ and why?

5. If you could solve one global health problem, which and how?
6. Sell me this pen. (Composure and persuasion.)
7. What would you do with a year and unlimited funding to improve public health?
8. Is it better to be respected or liked as a doctor?
9. What invention has had the biggest impact on medicine?
10. If you were the Health Secretary for a day, what would you change first?

HOW TO GET THE MOST FROM THIS BANK

Pick a category, set a timer for the relevant station length, and answer aloud without notes. Record it. Watch it back against the relevant section of this handbook. Re-attempt the ones that felt weak. Rotate categories so no single type catches you off guard on the day.

SECTION 13

Quick-reference cards & glossary

Every framework on a page, and the terms you must be able to define on demand.

The framework cards

ETHICS

Four pillars

Autonomy · Beneficence · Non-maleficence · Justice.

ETHICS

Dilemma structure

Two sides → clarify → pillars + stakeholders → law/guidance → weigh → conclude.

EXPERIENCE

STARR

Situation · Task · Action · Result · Reflection.

CONSULTATION

Calgary-Cambridge

Initiate · Gather · (Examine) · Explain & plan · Close, with relationship and structure throughout.

UNDERSTANDING

ICE

Ideas · Concerns · Expectations.

BAD NEWS

SPIKES

Setting · Perception · Invitation · Knowledge · Empathy · Strategy/Summary.

EMOTION

NURSE

Name · Understand · Respect · Support · Explore.

PRIORITIES

Prioritisation

Gather → safety first → urgent vs important → act then escalate → review.

GMC

Good Medical Practice domains

Knowledge/skills · Patients & communication · Colleagues & safety · Trust & professionalism.

NHS

The three shifts

Hospital → community · Analogue → digital · Sickness → prevention.

Glossary of must-know terms

Term	Definition
Autonomy	A patient's right to make their own informed decisions about their care.
Beneficence	The duty to act in the patient's best interests and do good.
Non-maleficence	The duty to avoid causing harm ("first, do no harm").
Justice	Fairness in treatment and in the use of limited resources.
Capacity	The ability to understand, retain, weigh and communicate a decision; decision-specific and can fluctuate (Mental Capacity Act 2005).
Consent	Agreement to treatment that is voluntary, informed and made with capacity; can be withdrawn.
Gillick competence	A child under 16 with sufficient understanding can consent to their own treatment.
Fraser guidelines	Criteria for giving contraceptive/sexual-health advice to under-16s without parental consent.
Confidentiality	The duty to keep patient information private, breakable only with consent, by law, or in the public interest.
Duty of candour	The duty to be open and honest with patients when something goes wrong.
Whistleblowing	Raising concerns about unsafe or unethical practice through appropriate channels.
Safeguarding	Protecting children and vulnerable adults from harm; can override confidentiality.
DNACPR	"Do Not Attempt Cardiopulmonary Resuscitation"; a recorded decision not to attempt CPR.
Advance decision	A legally binding refusal of specified treatment made in advance, in case of future loss of capacity.
Ceiling of care	An agreed limit on how aggressive treatment will be for a particular patient.
QALY	Quality-adjusted life year; a measure combining length and quality of life, used to assess cost-effectiveness.
NICE	The National Institute for Health and Care Excellence; advises on which treatments the NHS should fund.

Term	Definition
GMC	General Medical Council; the regulator that registers UK doctors and sets standards.
NHS Constitution	The document setting out the NHS's principles, values and the rights of patients and staff.
Integrated Care System	Local partnerships that plan and fund NHS and care services for a population.
Primary / secondary / tertiary care	First contact (GP) / hospital care / specialist centre care.
Herd immunity	Protection of a population when enough people are immune to limit a disease's spread.
Empathy vs sympathy	Feeling *with* someone (sharing their perspective) versus feeling *for* them (pity from outside).
Health inequalities	Avoidable, unfair differences in health between groups in society.

FINAL WORD

You will not be a perfect candidate, and you do not need to be. Examiners are looking for someone they would trust with patients: someone kind, honest, thoughtful and self-aware, who listens, weighs both sides and keeps their head. Master the frameworks in this handbook, practise out loud until they are second nature, and then let your real character do the rest. You have got this.

Go and earn your offer.

This handbook gives you the map. The work is yours: read it, drill the question bank out loud, and walk into that circuit knowing exactly what each station wants from you.

Want a mock MMI circuit, tailored feedback or one-to-one interview coaching? That is what we do.

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