Clinical Interview Workshop

Academic Foundation Programme
Application Evening

DISCLAIMER

- The advice contained herein has been compiled by current AFP trainees based on their subjective experiences of the AFP application process. It is not designed to substitute other guidance provided via other official channels.

- The information is, to the best of our knowledge, current and accurate as of 23rd September 2015.

- If there is any discrepancy between the advice provided here and other official guidance, you are advised to follow the official guidance (*e.g.* UKFPO website, AUoA website, UKFPO applicants' handbook)

Learning Objectives

- To introduce the format of the clinical interview
- To go through interview scenarios in a systematic way
- To prepare you for the clinical interview

Clinical interview format

- 3-4 clinical scenarios
- **30 minutes** pre-interview to prepare for both interviews
- **10 minute** interview
- They will ask you to prioritise these
- Then discuss how to manage each scenario in order of priority

What are they looking for?

- Logical task prioritisation
  - ABCDE approach
- Structured assessment
  - Important history + examination
  - Bedside tests + Ix
  - Management
- Knowledge of common management pathways
- Appropriate escalation

- Structured Answer!

Clinical Scenario 1 [1]

- You are an FY1 in Trauma and Orthopaedics. You are clerking in a 28 year old man who has just been admitted following an assault 16 hours before, in which he sustained broken ribs, a broken wrist and a head injury. He is very upset and you ask if there is anything else troubling him. He tells you that he was also anally raped by the four assailants and is concerned about his health and his relationship with his girlfriend.
- During your conversation you are called by a nurse on the ward, who asks you to see a 19 year old woman at the other end of the ward urgently. The woman was admitted the day before with a fracture dislocation of her elbow following a fall, and has become very short of breath and is finding it difficult to speak. Observations carried out by the nurse show pulse 120/min, blood pressure 110/70, temperature 37.5^{o}C
- A police officer has come onto the ward and wants to ask you about the first patient's injuries. Your consultant is in clinic and your SpR in theatre.

Shortness of Breath (1)

- On the phone
  - ask for **sats** + **RR** to be measured + **ECG** + start **15L O2**
  - PMHx - ? Asthma/DVT/FHx of thrombophilia
- Differential
  - Asthma
  - Pulmonary Embolus
  - Pneumothorax - ? tension
  - Pneumonia
  - Anaphylaxis
  - Iatrogenic pulmonary oedema

Shortness of Breath (2)

- Assessment
  - How acutely unwell - ? Crash call
  - Hx – pain? Cough? Allergies?
  - CV + Chest examination – percussion, auscultation
  - Fluid status and JVP
  - Examine leg for signs of DVT
  - ? Urgent senior review
- Management
  - Ix: ABG, Bloods, CXR +- PEF (if asthma background) +- CTPA (gold standard)
  - Rx: 5mg Salbutamol + 500micrograms ipratropium nebulisers, steroids + antibiotics
  - Consider treatment dose dalteparin if need to exclude PE
  - Consider senior review/escalation to ITU

Management of assault

- **Discuss with consultant!**
- Ensure **explicit consent**
  - For further investigation, discussion with other members of clinical team, police etc.
- History
  - Ensure bleep free, minimal interruptions
- Forensic specialist examination
  - Chaperone needed for examination
- Offer psychological input
- Clear documentation
  - History
  - Injury: type, location, number, size

Confidentiality[2]

- Need patients express consent for discussion with others regarding any aspect of their care
  - Includes relatives, friends, police
- Before discussion with police – always discuss with seniors
- EXCEPTION – if in public interest
  - e.g. communicable disease
- If lack capacity
  - Consider if temporary/permanent
  - Consider if in best interest

Clinical Scenario 2

- You are an FY1 on General Surgery. You have been bleeped by a nurse on the ward, who asks you to see a 40 y/o man with severe abdominal pain, BP 90/60, HR 120bpm and 500ml of fresh haematemesis.
- 65 y/o male with worsening leg weakness – unable to mobilise from bed and urinary retention. PMHx: myeloma
- Nurse calls you regarding a 40 y/o Type 1 diabetic with a blood sugar level of 30.

Haematemesis (1)

- Differential diagnosis
  - Variceal bleed, peptic ulcer, Mallory Weiss tear, oesophageal/gastric malignancy
- Ask nurse up to date obs
- ABCDE approach
- O/E: stigmata of liver disease, cachexia, asterixis
- Assessment: Rockall Score

Rockall Score[3]

Risk analysis of acute upper gastrointestinal bleeding: Rockall scoring

	Scores 0	1	2	3
Age	<60 yrs	60 - 79 yrs	>80 yrs	
Shock	None systolic BP > 100mm heart rate < 100/min	Tachycardia systolic BP > 100mm heart rate > 100/min	Hypotension systolic BP < 100mm	
Co-morbidity	None		cardiac failure, ischaemic heart disease, other major comorbidities.	renal failure, liver failure, disseminated malignany
Diagnosis	No major lesion Mallory Weis tear	All other diagnoses	Upper GI malignancy	
Recent haemorrhage	None		blood in Upper GI tract, Clots adherent or visible spurting.	

Haematemesis (2)

- Management
  - ? Senior help early
  - High flow O2
  - Ensure venous access – IVF, bloods (FBC, INR, U&E, LFTs, crossmatch 4 Units, ABG
  - ? Blood transfusion
  - IV fluid resuscitation (500ml boluses)
  - IV terlipressin 2mg over 5 minutes
  - Drug chart review - ? Warfarin/NSAIDs etc.
  - **Gastro referral**
  - **Urgent OGD –** NBM pre OGD
  - Consider antibiotics if variceal for SBP prophylaxis
  - IV pantoprazole infusion
  - Correct coagulation abnormality

Cauda Equina Syndrome

- MEDICAL EMERGENCY
- Risk factors:
  - Myeloma, malignancy, epidural abscess, haematoma
- O/E: flaccid paralysis, areflexia, saddle anaesthesia, loss of anal tone on PR
- Mx:
  - Ix: MRI of whole spine URGENT
  - Mx: 8mg dexamethasone IV BD, urgent referral to neurosurgical/orthopaedic spinal team, consider catheterisation

Hyperglycaemia (1)

- Consider DKA or HONK
- Ask nurse:
  - GCS, Urine dip
  - ? PRN insulin prescribed
- Assessment
  - Hx: missed insulin doses, infective or osmotic symptoms, steroids
  - O/E: volume status, source of infection, tachypnoea
- Investigations
  - Bloods – FBC, U&E, osmolality, glucose, CRP, ABG
  - Urine dip (? Ketonuria, ? Nitrites/leucocytes)
  - ? ECG
  - ? CXR

Hyperglycaemia (2)

- Management:
  - DKA/HONK
    - 15L O2
    - IV access + IV fluid resuscitation (KEY)
    - Sliding scale Insulin
    - Ensure VTE prophylaxis
    - Senior review!
    - Consider + treat cause
  - No evidence of DKA/HONK
    - PRN novorapid/short acting insulin + monitor closely
    - Consider and treat cause e.g. missed insulin, sepsis, MI

Summary

- 3-4 clinical scenarios
- Consider your differential diagnosis
- Task prioritisation and explain logic
- ABCDE approach
- Consider some ethics and law
- Review national/local guidelines
  - Antibiotics, DKA, hyperkalaemia etc.
- Consider appropriate escalation

References

1. STFS AFP handbook RE: scenario

2. http://www.gmc-uk.org/guidance/ethical_guidance/confidentiality.asp

3. http://www.jmedicalcasereports.com/content/supplementary/1752-1947-4-44-s1.jpeg