OET

Living the Language

Doctors' edition

Your guide to English usage in British life and work

Introduction

Congratulations – you've passed your English language test and you're ready to begin your new career in the UK healthcare system.

We recognise you may face communication challenges ahead as you begin working in an English-speaking workplace. That's why we've created Living the Language – a resource designed to help overseas nurses working in the NHS develop their English communication skills.

This guide includes practical advice on coping with local accents, working with teams, written documentation and speaking on the phone plus lots more guidance to help new hires adapt and integrate into their workplace and navigate British society outside the workplace.

We're grateful to those who contributed to this guide, including Doc2UK, NHS England Workforce Training and Education Directorate (NHSE WTED) (previously Health Education England (HEE)) and NHS Employers. We also had input from overseas doctors now working in the NHS, who've shared their own experiences to help their peers. You'll read their stories in the quotes throughout this guide.

We are committed to supporting overseas doctors beyond their English test with resources like this guide, supporting their journey to a dream job as a registered doctor in an international healthcare setting.

- The OET UK team

Top tips for new doctors practising in the UK:

"Put your patient at the heart of decisions you make. Do not hesitate to seek help from your seniors or ask a patient to repeat what they have just said if you didn't understand. That could be the most important part of the diagnosis.

Familiarise yourself with the NHS Trust or NICE guidelines in patient management. This will help a lot of decisions become easier."

-Dr Keerthi

Contents

Note for readers

The term ‘patient’ is used to refer to any person receiving care in a UK healthcare setting, such as a care home resident, hospital inpatient, outpatient, individual seeking therapy or any other healthcare service user. While much of the content refers to a hospital context, the material is also relevant to workers in other UK healthcare settings.

Introduction to the NHS

Every day, the NHS provides care for over a million people in England, touching the lives of everyone who calls the UK home. The NHS was established in 1948 as the world's first universal healthcare system that was free to everyone. The creation of the NHS was a landmark moment in both British and medical history, and over the past 75 years, it has become an essential part of British society.

Find out more about the NHS: stepintothenhs.nhs.uk/about-the-nhs

Discover the OET NHS Values course: oet.com/product/nhs-values

> **"The NHS belongs to people. It touches our lives at times of basic human need when care and compassion are what matter most."**
>
> **- NHS England Workforce, Training and Education**

The role of the NHS

The NHS provides support to people throughout their lives. Since 1948, the NHS has continually evolved to meet the needs of each generation, and has often led the way with global medical initiatives, such as:

- The world's first CT scan on a patient in 1971
- The first IVF birth in 1978
- Research leading to the discovery of the first effective COVID-19 treatment, made available in every hospital the same day it was approved

None of these innovations would be possible without the skill and dedication of NHS staff, volunteers, and partners in the social care sector.

Since its inception, the NHS has relied on employees from around the globe, starting with the Windrush Generation of 1948. Today, the workforce is proudly represented by over 200 nationalities.

Understanding the scale of the NHS

In 2023/24, there were an estimated 600 million patient contacts with GP, community, hospital, NHS 111 and ambulance services. This equates to approximately 1.7 million interactions with patients every day.

Learn about the history of the NHS and how it functions today with a free course by The King's Fund: kingsfund.org.uk/leadership-development/courses/nhs-explained-course

How the NHS works

It's important to understand how your patients access their healthcare, especially as it may be quite different from healthcare services in your home country.

Healthcare in the UK is provided by the government and paid for by taxes. The NHS delivers General Practitioner (GP) services, Accident and Emergency care (A&E), hospital services and social care to all UK permanent residents and citizens for free.

Accessing the NHS

To access NHS healthcare and treatment, everyone is required to register with a GP at a GP practice, usually the one nearest to their home. The GP practice, or surgery, is where one or more GPs, as well as other community healthcare professionals (e.g. nurses, midwives, dieticians) deliver their services. Once they have registered, patients receive an NHS number, which entitles them to NHS services for life.

Primary versus secondary care

The first point of contact for all non-urgent healthcare is the patient's primary care provider, e.g. GP or dentist. If necessary, the GP or dentist will refer the patient to a secondary care provider or specialist, e.g. cardiologist, dental surgeon, etc. via a medical referral letter. Once the specialist has provided the necessary treatment and care within the hospital setting, the patient will then be discharged back to their primary care provider.

What is an NHS Trust?

You will hear people refer to a local hospital as an NHS Trust. NHS Trusts act as healthcare providers and provide hospital services, community services and other aspects of patient care, they may also act as commissioners when sub-contracting patient care services to other providers of health care.

Understanding Integrated Care Systems

The NHS is continually evolving to better meet the needs of the population. A significant recent development is the establishment of Integrated Care Systems (ICSs), designed to provide more coordinated and efficient healthcare services. These systems encompass various components, including Integrated Care Partnerships (ICPs), Integrated Care Boards (ICBs), place-based partnerships and provider collaboratives. These groups collaborate to ensure that services are integrated and focused on improving the well-being of communities across the UK.

What are Integrated Care Systems?

Integrated Care Systems (ICSs) are local partnerships that bring health and care organisations together. They create shared plans to connect health and care services to improve people's lives in their area.

What are Integrated Care Partnerships?

Integrated Care Partnerships (ICPs) are groups of different organisations that work together to improve local health, care, and well-being. This includes the NHS, local councils, social care providers, and voluntary groups.

What are Integrated Care Boards?

Integrated Care Boards (ICBs) are the legal NHS organisations that plan how to meet the health needs of the local population based on the integrated care strategy. They manage the NHS budget and organise local health services.

What are Place-Based Partnerships?

Place-based partnerships design and deliver integrated services for specific areas within the ICS. This might be a town, borough or neighbourhood. They involve various stakeholders interested in improving health and care, such as the NHS, local councils, other local organisations and residents.

What are Provider Collaboratives?

Provider collaboratives bring together providers of local health and care services across different areas and sometimes different ICSs. This group includes acute, community, and mental health hospitals and primary care and social care providers.

Watch this short video to discover the key organisations that make up the NHS and how they work together to deliver care:

How does the NHS in England work and how is it changing?

YouTube

Emergency & urgent care

In the NHS, urgent and emergency care services are designed to address varying levels of medical needs.

Call 999 for immediate, life-threatening emergencies requiring urgent medical help. The response may include sending an ambulance or advising you to go to A&E if it's safe. For details on what constitutes a life-threatening emergency

visit: nhs.uk/nhs-services/urgent-and-emergency-care-services/when-to-call-999/

Accident & Emergency (A&E): A&E handles severe and critical conditions needing immediate care, operating 24 hours a day, seven days a week (24/7) for major trauma or serious illnesses that can't wait for a scheduled appointment.

Use 111 for non-emergency medical issues needing immediate advice. This service directs you to the best care options, such as visiting a pharmacy, scheduling a GP appointment, or going to an Urgent Treatment Centre (UTC) or A&E.

Urgent Treatment Centres (UTCs): UTCs treat non-life-threatening conditions needing prompt attention, like minor injuries or infections, providing an alternative to A&E and easing its patient load.

Paid services

In the NHS, most services are free at the point of use, but there are some circumstances where you may need to pay for certain aspects of your care, including prescription charges, dental care, and eye tests.

However, certain groups are exempt from paying for these services. For example, children, pregnant women and new mothers, individuals on low incomes, pensioners, and those with certain medical conditions or disabilities are exempt.

UK-specific health issues

Common causes of death

Understanding the health risk factors and the leading causes of death in the UK will give you a better insight into your patients' needs. The main causes of death in the UK have changed over time and differ between men and women as well as across various age groups. Here is a summary of the key points:

Leading causes of death for men

- Ischaemic Heart Disease (IHD): This has been the leading cause of death for men for many years, although the number of deaths has decreased over time.
- Other significant causes include lung cancer, chronic respiratory diseases and stroke.

Leading causes of death for women

- Dementia and Alzheimer's disease: These have become the leading cause of death for women since 2011, accounting for a significant percentage of female deaths.
- Other significant causes are heart disease, stroke and lung cancer.

Age group differences:

- Older adults (65 years and older): Dementia and Alzheimer's disease have become leading causes, particularly due to the aging population and better diagnosis.
- Middle-aged adults (50 to 64 years): IHD remains a top cause for men, while breast cancer and lung cancer are significant for women.
- Younger adults (20 to 49 years): Suicide and accidental poisoning are leading causes for both men and women in this age group.

Factors influencing trends:

- Aging population: More people are living longer, which contributes to higher rates of age-related diseases like dementia.
- Medical advances: Better treatment and diagnosis have influenced the reported causes of death.
- Lifestyle factors: Smoking, diet and other lifestyle factors continue to impact the prevalence of diseases like cancer and heart disease.

Caring for an ageing population

By 2050, it is projected that one in four people in the UK will be aged 65 years and over.

Care for the elderly is carried out either informally by family members or formally in residential homes, known as care homes. These are run privately, and depending on the financial situation of the person concerned, may be free. Specialist care homes exist, caring for those with dementia, for example. Recognising the difference between a residential home (with wardens), a care home (with carers) and a nursing home (with nurses) is important. This helps with offering specific services for discharged patients, e.g. a nursing home can offer procedures such as injections, while care homes and residential homes cannot. It is important to ask the right questions early enough to determine and plan the best final discharge destination for the patient.

Obesity

In the UK, obesity is a significant health issue. According to the latest data, 64% of adults in England were overweight or obese in 2021/22. Obesity rates vary by age, with the highest prevalence among those aged 45-84. Additionally, obesity is more common in certain ethnic groups, notably black (34%) and White British (27%) individuals.

Childhood obesity is a critical issue in the UK. About one in three children aged 10-11 years are overweight or obese. The government has developed a plan to tackle this problem by promoting healthier eating and increasing physical activity among children. Measures include reducing sugar in foods and drinks, encouraging daily physical exercise and improving education on nutrition. The goal is to halve childhood obesity by 2030 and to improve the overall health of children across the country.

Alcohol use

Alcohol use in the UK remains a significant public health concern. In 2021, approximately 12% of adults in England reported binge drinking in the previous week, with a higher prevalence among men (15%) compared to women (9%). This trend was similar in Scotland and Wales, where 15% and 13% of adults reported binge drinking, respectively.

Alcohol-specific deaths have also been a critical issue. In 2021, the alcohol-specific death rate in the UK was significantly higher for males (20.1 deaths per 100,000) compared to females (9.9 deaths per 100,000). Most of these deaths were due to alcoholic liver disease, accounting for 78% of alcohol-specific deaths.

Hospital admissions related to alcohol consumption have increased. From 2016/17 to 2019/20, the rate of admissions for alcoholic liver disease in England rose by 18%, with older adults (over 65) experiencing a 7% increase in hospital admissions for alcohol-related conditions during the same period.

These statistics highlight the ongoing challenges faced by the UK in managing alcohol-related health issuesW and the need for continued public health interventions and support services.

Workplace communication

In this section we highlight the different scenarios that you may encounter in an English-speaking healthcare system like the NHS.

This section of the guide will address:

- Understanding the structure of NHS teams
- Working as part of a team
- Understanding medical terms and abbreviations
- Using the Situation, Backgrounds, Assessment, Recommendation method (SBAR) to improve clinical communication
- Participating in meetings
- Ensuring proper documentation
- Preparing for revalidation and continuing professional development

Understanding the structure of NHS teams

When joining the NHS in the UK, it's important to understand the hierarchy within departments. This will help you establish your role and know who to approach for different needs. Here's a simple guide to the structure of medical and nursing teams.

Medical team structure:

Medical students: Medical students typically complete a five-year undergraduate or four-year postgraduate course, with the first two years focused on basic medical sciences, followed by three years of clinical training in hospital wards under consultant supervision.

Junior Doctors: Junior Doctors are qualified doctors undergoing clinical training. They have completed a medical degree and may have up to nine years of working experience as a hospital doctor, depending on their specialty, or up to five years working and gaining experience to become a General Practitioner (GP). All Junior Doctors work under the supervision of a senior doctor.

Common titles for Junior Doctors	Descriptions
FY1	Foundation year one Junior Doctor
FY2	Foundation year two Junior Doctor
ST	Specialty trainee in a hospital specialty - includes StR (Specialty Registrar) or have a number signifying the number of years spent in training, e.g. ST4 psychiatry
SpR	Specialty Registrar in a hospital specialty
GPST	Specialty Registrar in general practice
SHO	Senior House Officer

Consultants: Consultants are senior doctors who have completed full medical training in a specialised area of medicine and are listed on the GMC's specialist register. They have both clinical and administrative responsibilities, including managing Specialist and Junior Doctors.

Specialist Doctors: Specialist (or SAS) Doctors (Specialist, Associate Specialist, and Specialty Doctors) are experienced and senior doctors in permanent posts. They have at least four years of full-time postgraduate training, with two years in their relevant specialty.

General Practitioners (GPs): GPs have overall responsibility for managing patient care outside of hospitals. This includes diagnosing and treating health problems and referring patients for specialist treatment when necessary.

Academic Doctors: Academic Doctors or Clinical Academic Doctors often work in a combination of teaching, research and specialist clinical care. They undertake research to advance the science of medicine and can be at any grade, from a Foundation Year Junior Doctor to a Consultant, GP, or SAS Doctor. Common job titles for academic doctors (from junior to senior) include:

ACF: Academic Clinical Fellow

CL: Clinical Lecturer

CRF: Clinical Research Fellow

CSL: Senior Clinical Lecturer

Reader/Associate Professor

Prof: Professor

To learn more about other common medical titles, please visit: bma.org.uk/advice-and-support/international-doctors/life-and-work-in-the-uk/toolkit-for-doctors-new-to-the-uk/doctors-titles-explained

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Nursing team structure

Healthcare Support Workers (HCSWs) / Healthcare Assistants (HCAs)

HCSWs or HCAs provide essential, compassionate care to patients under the supervision of registered professionals. Their duties include ensuring patient comfort, assisting with mobility and personal hygiene, supporting meals, taking observations and maintaining cleanliness. They also update patient records and help keep departments organised.

Nursing Associate: The Nursing Associate role bridges the gap between healthcare support workers and registered nurses, providing hands-on, person-centred care within multidisciplinary teams across diverse settings. Qualified Nursing Associates have the option to study towards becoming a Registered Nurse.

Registered Nurse (RN): RNs are fully qualified nurses registered with the NMC, responsible for assessing, planning and managing patient care. They administer medications, monitor patient progress and provide specialised care. Registered Nurses can specialise in Adult, Children's, Mental Health or Learning Disabilities Nursing.

Staff Nurse: A Staff Nurse is a specific role within the broader category of registered nurses. The term "staff nurse" typically refers to an RN who works directly on the front line of patient care, usually in a specific ward or department. All Staff Nurses are registered nurses, but not all registered nurses are necessarily in a staff nurse role. The Staff Nurse role is often seen as a starting point for RNs, with opportunities for advancement to senior roles such as Senior Staff Nurse, Charge Nurse or specialised roles like Clinical Nurse Specialist or Nurse Consultant.

Senior Staff Nurse: Highly skilled and experienced registered nurses, Senior Staff Nurses are often team leaders, responsible for the supervision and development of staff nurses, coordinating the ward/unit and deputising for the Sister or Charge Nurse.

Sister/Charge Nurse: This is a ward-based leadership position. A Sister or Charge Nurse is responsible for managing a specific ward or department, ensuring that care standards are maintained. They manage the nursing staff, allocate resources and ensure compliance with policies and procedures.

Clinical Nurse Specialist: Clinical Nurse Specialists have advanced training and expertise in a particular area of medicine, such as oncology or diabetes.

Nurse Consultant: Nurse Consultants provide expert clinical guidance, mentor staff and develop policies to enhance patient care. They lead quality improvement efforts, promote evidence-based practices and offer consultative support for complex cases, while staying updated with advancements through continuous education.

Advanced Nurse Practitioner (ANP): ANPs play a pivotal role in the healthcare system, bridging the gap between general nursing and medical practice. They are highly trained registered nurses with advanced clinical skills and education, often holding a master's degree or higher. They provide a wide range of healthcare services, including diagnosing and treating medical conditions, prescribing medications and performing advanced procedures. Their role involves not only direct patient care but also complex decision-making and case management.

Matrons: Matrons oversee nursing care across multiple wards or departments. They are responsible for ensuring high standards of care, managing budgets and often have a strategic role in the hospital.

Working as part of a team

> **“Sometimes it does come as a surprise when a doctor/nurse challenges a decision made by an overseas doctor. It took time to get acquainted with this approach, which I now feel is the correct way of doing things. Challenging a decision doesn’t imply offending...”**
>
> - Dr Keerthi

> **“On a few occasions my decisions have been challenged by nurses and therapists, which was something very different compared to my home country. I feel it is important to express their opinion for the best patient care.”**
>
> - Dr Prabhu

Doctors from your country may have similar experiences to Drs Keerthi and Prabhu.

However, you’ll notice that in the UK, doctors, nurses and other practitioners function as one team, adopting what is known as a multi-disciplinary, person-centred approach.

Here are some other differences about working in a UK healthcare setting:

- Being part of a multi-disciplinary clinical and social care team means a variety of specialists contribute their expertise to an individual patient's care – nurses, physiotherapists, nutritionists, pharmacists, occupational therapists and social workers, among others
- Realising nurses are expected and empowered to make decisions independently of doctors' instructions
- A higher level of teamwork between doctors and nurses
- A flatter, more flexible hierarchy

Here are some points to bear in mind as you work in a team:

- Don't be afraid to ask for help or advice from your team members – junior doctors, nurses and other allied healthcare professionals, as well as your seniors.
- Don't assume you know the roles and responsibilities of your team
- Respect the opinions and expertise of the others in your team
- If necessary, explain to patients you are interested in getting a second opinion; patients prefer honesty and appreciate there is a multi-disciplinary team approach to healthcare
- You can question your team member's decision if you feel it is misplaced. Be assertive if you feel you are being taken advantage of or pressured
- Remember you are all working towards a common goal

When it comes to working in a team, it's all about collaboration and trust. So, getting to know your teammates is an important step. Here are some recommendations to build rapport:

- Ask team members about their expectations in the workplace
- Attend multi-disciplinary meetings to understand who's involved and their different roles and responsibilities
- Research the roles within your team so you understand where you fit in
- Observe colleagues as they interact to help you understand appropriate behaviours

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Understanding medical terms and abbreviations

Many overseas doctors are faced with difficulties understanding medical terms and abbreviations used in the NHS.

It is worth asking your employer for a glossary, and you can always ask colleagues to define unfamiliar terms.

Here is a glossary of common medical terms and abbreviations that you might encounter while working in the NHS:

- **Accident and Emergency (A&E):** A 24/7 department providing immediate care for patients with serious or life-threatening injuries and illnesses. It's also known as the Emergency Department (ED) or casualty.
- **Blood Pressure (BP):** The pressure of circulating blood against the walls of blood vessels
- **Body Mass Index (BMI):** A measure of body fat based on height and weight
- **Electrocardiogram (ECG):** A test that records the electrical activity of the heart
- **Full Blood Count (FBC):** A blood test that measures different components of blood, including red and white blood cells and platelets
- **Magnetic Resonance Imaging (MRI):** An imaging technique used to visualize internal structures of the body in detail
- **Computed Tomography (CT) Scan:** An imaging procedure that uses computer-processed combinations of X-ray measurements to produce cross-sectional images of the body
- **Intravenous (IV):** Administration of fluids, medication or nutrients directly into a vein

Abbreviations:

AF: Atrial Fibrillation (irregular heart rhythm)

AMHP: Approved Mental Health Professional

APTT: Activated Partial Thromboplastin Time (a blood test to measure clotting)

b.d.s. (bds, BDS): Twice a day

CSF: Cerebrospinal Fluid

CXR: Chest X-Ray

DNACPR: Do Not Attempt Cardiopulmonary Resuscitation

DVT: Deep Vein Thrombosis (a blood clot in a deep vein, usually in the legs)

ED: Emergency Department

GA: General Anaesthetic

HCA: Healthcare Assistant

LFT: Liver Function Test

MSU: Mid-Stream Urine sample

NAD: Nothing Abnormal Discovered

NBM: Nil By Mouth (no food or drink to be taken orally)

OT: Occupational Therapist

PT: Physiotherapist

Rx: Treatment or Prescription

TFT: Thyroid Function Test

UTI: Urinary Tract Infection

Other useful sources:

Abbreviations commonly found in medical records

NHS Glossary

Healthcare abbreviations

Jargon used in health and social care

Your Trust may produce their own like this Acronym Buster from Southern Health NHS Foundation Trust

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Useful app

Medical Dictionary by Farlex

Reference books

Oxford Concise Colour Medical Dictionary

Oxford Handbook of Clinical Medicine – Ian Wilkinson

Medical Terminology: The Best and Most Effective Way to Memorize, Pronounce and Understand medical terms

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Using SBAR to improve clinical communication

SBAR is a communications tool originally designed for the US Navy and later adapted for healthcare environments.

SBAR stands for Situation, Background, Assessment, Recommendation. Using the following prompts will help you provide the right information in various scenarios.

S (Situation) – Describe what is happening at the present time

B (Background) – Explain what the circumstances are leading up to this situation

A (Assessment) – Articulate what you think the problem is

R (Recommendation) – Define what should be done to correct the problem

Why is SBAR used?

The SBAR approach structures the information-giving process to ensure that:

- Staff can anticipate the information they are about to receive. Roles and responsibilities are clearly understood
- Roles and responsibilities are clearly understood.
- All essential information is conveyed with the appropriate level of detail, eliminating the need for repetition
- Staff can communicate their messages clearly, efficiently, succinctly, and assertively.
- Patient safety is prioritised and maintained.

When is SBAR used?

Here are some instances in which the NHS encourages us of SBAR during the patient journey:

- GP referral letter
- Consultant to consultant referrals
- Movement of patient between areas of diagnosis, treatment and care
- Handovers
- Discharge back to the patient's GP or community care setting

Here is an example scenario and language that can be used to communicate the information required in the SBAR format:

S Situation	I'm (name), I'm the Senior House Officer (SHO) on the ward this evening. I am calling about one of your patients, (patient X). I am calling about ... (patient X's test results). I'm ringing to see if we can ... (arrange for transfer of patient X, discuss ...). The situation is ...
B Background	The background (to the situation) is ... Patient (X) was admitted on (XX date) with ... (e.g. MI / chest infection). He's had (X operation/procedure/investigation). Patient (X)'s condition has changed in the last (XX mins). His obs (nursing observations) were within normal limits / His post op bloods are ...
A Assessment	My assessment is that ... I think the problem is ... I'm worried / concerned about the possibility of ... And I have... (e.g. given O2 / analgesia, stopped the infusion). OR I am not sure what the problem is, but patient (X) is deteriorating.
R Recommendation	I'm considering ... I need to ... Could you come and see the patient in the next (XX mins)? AND Is there anything I need to do in the meantime? (e.g. start IV antibiotics / ask the nurses to repeat the obs)

Participating in meetings

Some overseas doctors struggle with stating their point of view succinctly and effectively in English. This may especially be the case in a larger group during multidisciplinary meetings.

> **“Every day I need to participate in such meetings. Initial days of coming to this country I used to find it difficult to understand accent of some people. But with time it has been easier and now I am very comfortable to speak on the public platform.”**
>
> **- An internationally trained doctor in NHS**

Overseas doctors may also need to learn new skills when they are tasked with leading meetings. When it comes to taking the lead during a meeting or handover, it’s important to be able to manage that situation effectively. Make sure you:

- Make introductions (i.e. to the patient) if necessary
- Avoid dominating the meeting
- Listen carefully and respectfully to others
- Avoid and discourage interruption
- Encourage input from your team
- If the patient is present, take care to involve them where possible
- Obtain patient consent for further continuation, when necessary
- Provide a good role model to medical students and staff members training
- Summarise the key points and highlight the plan of action and/or goals for the day

How to communicate more effectively in meetings and handovers

Indicate a new topic	Now, let's look at (patient's name).
Finish a point	That's all for the (past medical history).
Return to the main point	As I was saying ...
Explain something more clearly	What I mean is ...
Make a suggestion	Can I make a suggestion?
Encourage input from team	(Nurse's name), did you have any input from the nursing side?
Inviting questions	Does anyone have any questions?
Involve the patient	Is there anything you would like to add, (patient's name)?
Check there are no other comments	Any other comments before we finish?
Signal the end of the handover	I think we are coming to the end now.
Summarise	So, to summarise ... / Just to recap ... Let's go over what we've agreed.

Ensuring proper documentation

Good record keeping is vital for effective communication and integral to promoting continuity of care and safety for patients.

In the event of a complaint from a patient regarding their treatment, written documentation serves as key evidence.

Examples of written documentation might include:

- Handover notes
- Care plans
- Admissions paperwork
- Medication and observations charts
- Referral letters/emails
- Discharge summaries/emails

“Documentation is much more detailed in the NHS compared to India. The challenge is that an average patient speaks for five mins conveying at least 20 salient points. We must document all these 20 points irrespective of their pertinence to the diagnosis or management of the patient.

This is hard to document whilst we have hardly 20 mins to spare on a patient.”

- Dr Keerthi

“I have to clerk in patients and do clinic letters. A challenge I faced was that letter must be detailed and it quite difficult to get detailed letter always right.”

- Dr Parmvir

What are some common challenges?

- Writing or typing quickly
- Being clear – can it be read by another doctor, nurse or medical specialist
- Knowing what to write and what not to include
- Knowing how much to write
- Getting the tone right

How to overcome them:

- Familiarise yourself with record keeping templates used in your setting
- Read good examples from other doctors to understand what is expected
- Adopt the writing style of colleagues
- Memorise and employ standardised sentences and phrases
- Practice using best practice templates e.g. OET Referral Letter
- Learn from senior staff or your mentor
- Speed up your typing with a free typing tool like typingclub.com or rapidtyping.com

Understand your responsibilities for record keeping with these resources:

RCP: Generic medical record keeping standards

GMC: Good Medical Practice 2024 LINK

Medical Protection: An Essential Guide to Medical Records LINK

Preparing for revalidation and continuing professional development

What is revalidation?

As a doctor working in the NHS, you will be asked to revalidate your General Medical Council (GMC) license every five years to ensure you are still fit to practice. Your annual appraisal with your supervisor or Responsible Officer is part of the revalidation process. During the appraisal, you will be asked to provide examples of your work and will also have the chance to discuss areas for development over the coming year. This process ensures you're keeping up to date with current practices and policies to ensure safe, accurate and quality care for your patients.

The six types of supporting information you must prepare to discuss at your appraisal over your revalidation cycle are:

- Continuing professional development (CPD)
- Quality improvement activity
- Significant events
- Feedback from patients or those to whom you provide medical services
- Feedback from colleagues
- Compliments and complaints

Read more: Guidance on supporting information for revalidation

What is Continued Professional Development (CPD)?

Continued Professional Development (CPD) is the development of the skills you need to carry out your role effectively. During your annual appraisal, you must demonstrate you have completed around 50 credits/hours of CPD.

What areas and activities should I choose for my CPD?

The skills you choose to develop depend on you and your needs and/or the needs of your team. CPD activities can be a mix of formal learning, e.g. attending courses such as Advanced Life Support, speaking at an international conference, attending a workshop on leadership skills, or informal learning, e.g. reading and online research or reflecting on an encounter with a patient.

Reflective writing

If you chose to reflect on an encounter with a patient, you should do this in written format (using reflective writing) and submit it to your supervisor during your annual appraisal.

For some overseas doctors reflective writing might sound a daunting task, but it doesn't have to be. Samples of reflective writing can be short (150–200 words), and the GMC proposes this series of simple questions that you can use as a guide:

- What's the issue you've reflected on?
- What made you stop and think?
- There are many ways to reflect – how did you do it?
- What did you do?
- Tell us what you took away or learned from this experience
- How did it change your thinking or practice?
- Has it improved your practice and outcomes?

Here are some examples of reflective practice written by NHS doctors from different specialisations.

For more on reflective practice, visit the GMC website.

Patient communication

Doctors tell us that tasks related to communicating with patients and their families present one of the greatest challenges when starting work in a new English-speaking setting.

Difficulties can arise from the 'person-centred care' model, an approach to healthcare that may be new to incoming doctors and different to the accepted model of care in their home country. There are many new communication techniques doctors must learn to take the person-centred care approach.

This section of the guide will address:

- Person-centred care
- Hello, my name is
- Active listening
- Using plain English and paraphrasing
- Asking for consent
- The language of bad news
- Avoiding discriminatory language

Person-centred care

Person-centred care is the primary model of care within the NHS. Some aspects may be familiar, while others may seem new or different from your previous experience.

This approach prioritises the individual needs, preferences and values of patients. It views patients as active participants in their care rather than passive recipients. The focus is on building meaningful relationships between healthcare providers and patients, ensuring care is respectful and responsive to each patient's unique needs and values.

The goal is to empower patients to take an active role in their own health and wellbeing.

Core principles of person-centered approach:

Respect and dignity: Treating patients with respect and valuing their input and choices.

Empathy: Understanding and sharing the feelings of patients, recognising their emotions and experiences

Active listening: Fully concentrating, understanding, responding, and remembering what the patient says

Shared decision-making: Involving patients in decisions about their care, ensuring they understand their options and the potential outcomes

Personalised care: Tailoring healthcare services to meet the specific needs and circumstances of each patient

Watch this helpful video to learn more about personalised care

Comprehensive Model of Personalised Care (short verison)

YouTube

To effectively implement a person-centered approach working in the NHS, focus on the following practical strategies and read the examples of how to apply them.

Effective communication:

Active listening: Pay full attention to patients, showing that you value their input.

Open-ended questions: Use questions that encourage patients to express their concerns and preferences.

Plain language: Avoid medical jargon to ensure patients understand their condition and treatment options.

Example: A patient with limited English proficiency is admitted. Use simple language and visual aids. Arrange for an interpreter to ensure the patient fully understands their diagnosis and treatment options.

Building relationships:

Trust: Establish trust by being honest, transparent and consistent in your interactions.

Empathy: Show empathy by acknowledging patients' feelings and experiences.

Continuity: Strive for continuity of care to build long-term relationships with patients.

Example: During a routine check-up, ask about the patient's family, hobbies and interests. This helps build rapport and shows that you see them as a person, not just a patient.

Patient empowerment:

Education: Provide information and resources to help patients understand their health and make informed decisions.

Support: Offer emotional and practical support, connecting patients with relevant services and support groups.

Shared decision-making: Encourage patients to be involved in their care plans, respecting their choices and preferences.

Example: A patient with diabetes expresses difficulty managing their condition. Provide educational materials, demonstrate how to use insulin and connect them with a diabetes support group. Encourage them to ask questions and be involved in their care plan.

Cultural sensitivity:

Cultural awareness: Be aware of and respect cultural differences in healthcare beliefs and practices.

Personalisation: Tailor your approach to meet the cultural needs and preferences of each patient.

Example: A patient from a different cultural background prefers traditional remedies alongside conventional treatment. Respect their beliefs and discuss how both approaches can be integrated safely.

Environment:

Welcoming atmosphere: Create a welcoming and comfortable environment for patients.

Privacy: Ensure patients' privacy and confidentiality are maintained at all times.

Example: Ensure the consultation room is welcoming and private. Personalise the space with comfortable seating and neutral decor to make patients feel at ease.

Continuous improvement:

Feedback: Regularly seek feedback from patients to improve the quality of care.

Training: Engage in continuous professional development to enhance your person-centred care skills.

Reflection: Reflect on your practice and experiences to identify areas for improvement.

Example: After each consultation, ask for feedback: "How was your experience today? Is there anything we could do better?" Use this feedback to improve your practice continually.

Communication skills

This table provides a description of the core communication and relationship building skills:

Skill	Description
Hello my name is ...	Introduce yourself, your role and set the scene for the conversation.
Open-ended questions	Questions that can't be answered with a simple yes or no. They encourage detailed responses and allow the person to share their thoughts and perspectives. Examples: "Tell me more about...", "How was that...", "When do you notice that?...", "Who supports you in your day-to-day life?..."
Open-focused questions	These start as open-ended but then focus on a specific topic.
Screening	Checking if there is "something else" or "anything else" the person wants to discuss. Useful for exploring important points and setting the agenda.
Reflective listening	Repeating back what the person said to show you heard them. This helps them feel understood and involved in the conversation.
Empathy	Showing that you understand or are trying to understand the other person's feelings. Important principles include taking their perspective, avoiding judgment, recognising emotions and communicating your understanding. Example: "You told me you tried to change before, which shows great determination."

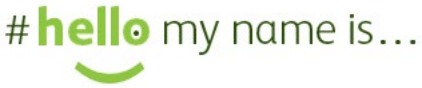
Normalisation	Letting the person know that their feelings or experiences are normal and shared by others. This helps them feel validated and less alone.
Active listening	Fully focusing on the person, making an effort to hear their complete message. This includes giving full attention, making eye contact, nodding and providing feedback like paraphrasing or summarising.
Summarising	Giving a clear verbal summary of what has been discussed. There are two types: 1. Internal summary, focusing on a specific part of the conversation. 2. End summary, covering the entire conversation. Both help consolidate information, review progress and identify next steps.
Clarification	Making sure you understand correctly by asking questions about words, statements or situations.
Signposting	Indicating what you are about to say next. It helps structure the conversation and directs the person to useful resources, services or support organisations. Summarising and signposting are often used together to organise conversations.
Non-verbal / body language	Communicating through body language, such as posture, proximity, touch, body movements, facial expressions, eye contact, vocal cues, use of time, presence, pausing and silence.
Environmental awareness	Being mindful of how the room and its setup affect the conversation. This includes who is involved, where it takes place, and how private it is. Adjusting the environment to make it comfortable for the person.
Ask before advising	Before giving advice, check what the person knows, what they want to know, if they want the information and how they prefer to receive it.

#hellomynameis

The #hellomynameis initiative was launched in 2013 by Dr Kate Granger MBE, who was a doctor and a terminally ill cancer patient. While receiving care, she noticed that many of the healthcare professionals who looked after her didn't introduce themselves.

Dr Granger wanted to remind healthcare workers about the importance of introductions, not just as a courtesy but as a way to establish a human connection between one who is suffering and another who wants to help.

The initiative encourages doctors and nurses to introduce themselves with the brief, repeatable phrase of "Hello, my name is...", so they get in the habit of routinely introducing themselves before beginning a conversation about the patient's care.



Why use #hellomynameis

- Repeatable phrase that is easy to remember
- Helps to quickly establish rapport and build trust
- A confident introduction brings patient comfort and reassurance (I am in safe hands)
- A universal and common phrase

Active listening

Active listening is one of the most important skills in the doctor's toolkit and is the basis of person-centred care. A doctor who listens actively takes responsibility to understand what the patient is saying and how they are saying it, and then acts on what they've heard.

Benefits of incorporating active listening:

- You are demonstrating you're listening to the patient, conveying the impression that you are interested in them and their story, and this offers comfort
- You'll get a better understanding the context for each patient
- It will enable you to observe the patient more effectively, picking up on verbal and non-verbal cues
- It will help you avoid making assumptions and premature hypotheses

Benefits of active listening for the patient:

- Allows the patient to feel respected and treated with dignity
- Gives the patient the time to express themselves adequately
- Personalises the experience for the patient
- Enables the patient to participate more fully in the consultation
- Encourages the patient to take greater responsibility for their healthcare

> **“Sometimes a patient will not tell you the history and be ‘rude’ and say ‘it’s in my file’. This is where it is best to explain that yes, they might have to repeat their history again, but you want to listen with fresh ears as to not miss something important or they might remember something important. You’ll definitely see their notes, but a fresh perspective is always good.”**
>
> -An internationally trained doctor in NHS

Practical tips how to practice active listening:

Use open and closed questions: Start with broad, open-ended questions like, “Can you tell me about what brought you in today?” Follow up with specific, closed questions such as, “How often does the pain occur?” This helps gather detailed information and understand the patient’s condition better.

Look and listen for cues: Pay attention to both verbal and non-verbal cues that might indicate discomfort or difficulty in expressing themselves. This could involve noticing body language or changes in tone of voice.

Reflect back: Show you’ve heard what was said by reflecting back, e.g., “It sounds like you’ve been feeling quite exhausted since the treatment. Is that right?”

Positive body language: Maintain an open posture, make appropriate eye contact, and use nodding or small verbal acknowledgments to show you are engaged.

Phrases to help you become a good active listener:

Encouraging the patient's perspective: "I've got an idea why you've come into A&E today, but I'd like to hear the story from your side, if that's OK."

Exploring cues: "You said you're 'not with it'. Can you tell me more about that?"

Screening: "Is there something else on your mind?"

Clarifying: "You said you're 'not with it'. From what you say, it sounds like it's hard to concentrate?"

Reflecting back (echoing): Patient: "I thought I'd bounce back after the surgery, but that hasn't happened." Doctor: "Bounce back?" (pick up on the cue and pause for the patient to say more)

Using plain English and paraphrasing

An important part of person-centred communication is learning how to talk about medical issues using words that a patient can understand and also being confident that you can comprehend what the patient is saying. There are several effective tools for doing this including paraphrasing, summarising, clarifying and checking.

Why is using plan English and paraphrasing medical terminology necessary?

- For having effective conversations with a doctor, patient and family. In this role doctors are often called on to summarise, paraphrase or translate sometimes complex medical scenarios into plain English.
- For gaining consent. Patients and their families must be able to understand the care or treatment to which they are consenting.
- For checking your own understanding of what a colleague or patient has just told you
- For ensuring an accurate diagnosis

Here are some ways doctors can best use paraphrasing and plain English:

- Build up a bank of English words and phrases to complement your existing medical vocabulary, e.g. bruise for haematoma, needle for cannula, 'to lie on one's back' for 'to lie supine'.
- Use common analogies to help the patient understand medical or physiology processes, e.g. 'the heart is like a pump', 'the kidney is a bit like a filter'.
- If you have to use a medical term, explain it immediately in plain English.
- Practice using phrases such as: 'Let me explain it in a different way.' What this means is 'In other words, ...'.

- Check the patient's understanding using expressions like: 'Does that make sense?' 'Do you have any questions at this point?'
- When you paraphrase the patient's words, start by saying 'If I've understood (you) correctly, ...' Then to make sure you have understood completely, ask: 'Is that right?' or 'Is that an accurate summary?'
- Do not move forward if you don't understand or would like others present to help with understanding.

Here are some practical examples to demonstrate how to implement a person-centred approach, enhancing patient satisfaction and care quality within the NHS.

Simon is a medical specialist in a hospital: "I was referred a man who had an enlarged prostate that was causing him some troubling symptoms. At the beginning of our conversation, he said he was very keen to 'get rid of it' as he had two friends with prostate cancer, and he did not want to 'suffer' like them. After hearing about his thoughts, I suggested that we go through the various option available to him. After discussing the pros and cons of each option and what they meant to him, he decided that he would rather watch and wait as the potential risks of surgery might mean a reduction in the quality of life in the areas that were important to him."

Jane is a practice nurse in a local surgery: "The health care assistant had asked me to see a young lady as her home blood pressure (BP) had come back borderline (but normal). We discussed the BP and as part of this I asked about lifestyle- and indeed she smoked a lot. I was tempted to give her a lecture but stopped and decided to take a motivational approach. I asked her how important stopping smoking was to her. She graded it 5/10. I took a step back and we talked about what was important to her. She had a lot of stresses at home (her husband had just been diagnosed as bipolar), and the smoking helped this. We explored further and then decided together that it wasn't the right time to talk about stopping smoking. Instead, she said she would find a plan to manage her stress more helpful."

John is a GP in an inner-city surgery: "I am working with a lady in her early forties with depression/anxiety and substance misuse who is fuelling her partner's drug habits by street begging and daily calls to A&E/999. Rather than criticising her behaviour, I am seeing her weekly to gain a degree of confidence before thinking how we might work with a mental health therapist. The therapist could then help her think how, in the first instance, she can be supported in managing her anxieties rather than calling the emergency services. The mental health therapist would also work with her in exploring what would help boost her self-confidence and self-esteem and to facilitate access to a voluntary self-help group suitable for her circumstance."

Asking for consent

Consent in healthcare means giving someone permission to carry out a specific procedure or treatment. In the NHS, obtaining consent is a fundamental aspect of person-centred care, reflecting respect for the patient and ensuring they are an active participant in their healthcare decisions.

Legal and ethical requirements

Asking for consent is both a legal and ethical obligation. It is essential to document the consent process thoroughly. According to the General Medical Council (GMC), good decision-making involves meaningful dialogue where patients are informed and supported to make decisions that align with their values and preferences.

> **"Although care of the patient is at the heart of every doctor, person-centred care is significantly different in both systems. Emphasis is given to patient consent as one of the important aspects. Patients' approval in decision making is quite important in the NHS whilst it is not so much in the Indian sub-continent. Generally, it is assumed that a doctor would prescribe medicine, and a nurse would give it to them."**
>
> - An internationally trained doctor in NHS

Verbal consent

Verbal consent is required in various situations, such as:

- Setting the agenda for the consultation
- Taking the patient's temperature
- Performing a pelvic examination
- Discussing treatment options
- Agreeing on the presence of a chaperone during an examination
- Moving forward after delivering bad news

Doctors should seek verbal consent multiple times throughout any consultation to ensure ongoing agreement and understanding.

Phrases you can use to ask for verbal consent

- "I just want to ask you a few more questions if that's alright/OK (with you)?"
- "Does that sound OK/alright? / Is that OK/alright (with you)?"
- "Are you OK for me to just ... / Do you / Would you mind if I just...? If you don't mind, I just want to ... (action e.g. listen to your chest)?"
- "Are you happy for me to continue / proceed?"

Written consent

Written consent is often required for more significant procedures to ensure the patient is fully informed about proposed treatment. Before obtaining written consent, it's important to explain:

- The proposed procedure (investigation, operation, treatment)
- The necessity of the procedure
- How it will be performed
- Benefits, risks and possible side effects
- Available alternative treatments
- Likely success of the procedure

Phrases to obtain written consent

"Before we proceed, I want to explain the procedure we're proposing, if that's OK."

"Let me explain what happens during the procedure."

"We recommend this procedure because..."

"The benefits of the procedure are..."

"There are some serious complications with this procedure."

"The most common side effects are..."

"There are alternatives to this procedure, and I can explain their risks and benefits if you wish."

"The decision to proceed with another option is yours."

"Do you have any questions at this point?"

"So, just to summarise, we've talked about..."

"Are there any questions about what we've discussed today?"

"Could you tell me what you understood from our conversation?"

"Are you comfortable with the risks we discussed?"

Consent and age

Consent for patients under the age of 18 has additional considerations and caveats:

Children under 16: Children under 16 can give their own consent if they are believed to have enough intelligence, competence and understanding to fully appreciate what's involved in their treatment. This is known as being "Gillick competent".

Young people aged 16 and 17: Young people aged 16 and 17 are presumed to have the capacity to consent to their own medical treatment and any procedures involved in that treatment, just like adults. However, their refusal of treatment can be overridden by a person with parental responsibility or by a court.

Parental consent: If a child under 16 is not Gillick competent, consent will need to be obtained from a person with parental responsibility. In situations where treatment is deemed essential to the child's welfare and the parents refuse to consent, legal intervention may be sought.

Fraser guidelines: These guidelines specifically relate to contraceptive advice and treatment for those under 16 without parental consent. They ensure that such treatment is provided only if the young person understands the advice, cannot be persuaded to inform their parents, is likely to have sexual intercourse and without treatment, their physical or mental health is likely to suffer.

For more detailed guidance, you can refer to:

NHS England's Decision making and consent: england.nhs.uk/personalisedcare/shared-decision-making/why-is-shared-decision-making-important/decision-making-and-content/

General Medical Council (GMC)'s Professional standards: gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/decision-making-and-consent

NHS UK's Consent to treatment: nhs.uk/conditions/consent-to-treatment/

British Medical Association (BMA)'s Guidance on patient consent: bma.org.uk/advice-and-support/ethics/consent/guidance-for-doctors-on-patient-consent

The language of bad news

Communicating bad news to patients and their families is often cited by doctors as one of the most challenging aspects of their job. This task can be particularly difficult in situations where the doctor does not have an established rapport with the patient or their relatives, such as in the Accident & Emergency (A&E) department. Patients and families may or may not be prepared for bad news, and the information can sometimes be delivered through less personal means such as phone or online consultations, adding to the challenge.

Here are some strategies to help doctors effectively deliver bad news:

Shadow experienced doctors: Seek opportunities to observe doctors who are skilled in delivering difficult news.

Find a mentor: A mentor can provide guidance on best practices and offer support.

Body language: Use empathetic facial expressions and maintain an open posture to convey empathy.

Memorise key phrases: Prepare and rehearse key phrases, especially for use in emergencies.

Tone of voice: Ensure your tone is appropriate and respond to questions and comments with empathy.

Honesty: Be honest about what you know. Honesty builds trust and rapport.

Clear communication: Deliver information in small, clear chunks using signposting and linking words.

Check understanding: Regularly check the patient's understanding and emotional reactions. Pause often to give them time to process the information.

Gauge detail level: Determine the amount and level of detail the patient prefers to hear.

Using a communication framework to delivering bad news

Bad news can vary in severity and context. Using a structured framework like SPIKES can help doctors communicate compassionately and effectively.

SPIKES framework:

Setting up the conversation: Ensure privacy and minimal interruptions.

Assessing the patient's Perception: Understand what the patient already knows about their situation.

Obtaining the patient's Invitation: Ask how much detail they wish to receive.

Giving Knowledge: Provide information in a clear, straightforward manner.

Addressing Emotions: Respond empathetically to the patient's emotional reactions.

Strategy and Summary: Discuss the next steps and summarise the information.

Practical advice for delivery:

- **Warning shot:** Prepare the patient or relative for the news with a brief warning (e.g., “I’m afraid I have bad news...”).
- **Clear and plain language:** Use simple language appropriate to the patient’s understanding, avoiding medical jargon.
- **Empathetic acknowledgment:** Reflect the patient’s emotions and validate their feelings (e.g., “I can see this is very distressing.”).
- **Respond empathetically:** Avoid sympathy that might seem dismissive. Show empathy to connect and validate their feelings (e.g., “I wish the news were better.”).
- **Handling difficult questions:** Be honest if you don’t know the answer and provide realistic responses (e.g., “That’s a difficult question; there are no simple answers.”).

Useful phrases and words for communicating bad news

Preparing someone for bad news:

“The results are not as good as we expected.”

“Yes, it could be serious...”

“We are concerned by the test results...”

“I’m afraid I have bad news...”

“I’m very sorry, I have some bad news to tell you.”

“The news is not good...”

Giving information honestly and sensitively

Use language that is appropriate to your patient's ability to understand, with minimal medical and technical jargon.

"She has had a heart attack" (Instead of "a myocardial infarction")

"He has died" (Instead of "passed away")

"You have cancer" (Instead of "a tumor")

Acknowledging emotions

"Hearing the result of the bone scan is clearly a major shock to you"

"Obviously, this piece of news is very upsetting for you"

"I can see this is very distressing"

"That's not the news you wanted to hear; I know"

Responding empathetically

"I wish the news were better"

"I can appreciate this is difficult news to hear"

Handling difficult questions

"That's a difficult question; there are no simple answers"

"We can hope to control your illness but can't hope to cure it"

"You may have a number of months" or "you may have months rather than years"

Delivering bad news is an inevitable and challenging aspect of medical practice. It requires a combination of empathy, clarityand structured communication to ensure that the patient and their families receive the information in the most supportive manner possible. By using frameworks like SPIKES, seeking mentorship and practicing key phrases, doctors can improve their ability to convey difficult news compassionately and effectively. Continuous learning and reflection on these experiences will help doctors develop their skills and provide the best care possible, even when having the most difficult conversations.

Avoiding discriminatory language

Words are powerful. Certain words and phrases, whether used intentionally or unintentionally, can patronise, discriminate or promote stereotypes. This can be upsetting and offensive, and ultimately cause complications with communication.

On the other hand, using the right words can help to break down barriers, celebrate differences and most importantly treat the other person with dignity and as an equal in our very diverse society.

What is discriminatory language? Discriminatory language includes words and phrases that:

- Reinforce stereotypes
- Reinforce derogatory labels
- Exclude certain groups of people through assumptions, e.g., assuming the male or white population is the norm
- Patronise or trivialise certain people or groups, or their experiences
- Cause discomfort or offence

Who can be affected by discriminatory language?

Language is defined as discriminatory if it relates to nine 'protected characteristics' in the 2010 Equality Act, which are:

- Age
- Disability
- Gender
- Gender reassignment
- Race (this includes ethnic or national origins, colour and nationality)
- Religion or belief
- Sexual orientation
- Marriage and civil partnership
- Pregnancy and maternity

How can overseas doctors avoid using discriminatory language?

- Try to avoid being gender-specific. Use words like “partner” instead of “husband” or “wife”, and “they” instead of “he” or “she”.
- Listen to how patients describe themselves (e.g., British Muslim, Black British) and only refer to a patient’s ethnic background if it is directly relevant to the point you’re making.
- Don’t make assumptions about a patient’s sexual orientation. To gather information related to this that you might need to treat your patient, make your questions as open as possible. This gives people the room to describe and express themselves in a way in which they are comfortable. For example, don’t ask: “Are you straight, gay, or bisexual?” Instead, ask: “How do you describe your sexual orientation?”
- Take the same approach with gender identity. Don’t ask: “Are you male or female?” Instead, ask: “How do you describe your gender?” or “What sex were you assigned at birth?” or “What are your pronouns?”
- Avoid asking: “Are you married?” or “Do you have a boy/girlfriend or wife/husband?” Instead, ask: “What is your relationship status?” or “Are you in a relationship? If so, can you describe the nature of the relationship?”

Employ expressions that emphasise the person, not the disability or condition.

It is okay to say: people living with a disability, or disabled person, people with diabetes, wheelchair user. Here are some examples:

- Say ‘Steven is a child with autism’, not ‘Steven is an autistic child’.
- Don’t refer to ‘the blind’; instead, talk about ‘people who are visually impaired’.
- Use ‘accessible toilets’ not ‘disabled toilets’.
- Do not describe people as mentally ill. It is okay to say: person with a mental health condition, or people struggling with mental health problems.

Referring to older people:

Don’t use the words: elderly, aged, old people, pensioner or senior. Specify ages instead if applicable, e.g., over-65s, over-75s, over-80s. Or use “older person” or “older people”.

Social communication

As a new recruit and a new migrant, you will be socialising or working with people from many different areas of British society in both your professional and personal life. Some overseas doctors say that they find it harder to communicate on a social rather than a professional level. This is because they may be less familiar with general or cultural topics than workplace ones.

In addition, the way people speak English and the words they use vary hugely across the regions of the UK and across social groups.

This section of the guide will address:

- Slang and idioms
- Local accents and dialects
- Manners and etiquette
- Topics and conversational behaviours
- Humour
- Indirect speech and understatement

Slang and idioms

"It's raining cats and dogs out. I think I'm going to need my brolly."

English idioms, proverbs and expressions like this are a key feature of everyday communication. There are so many of them, and it's impossible to know them all (some regions also have their own expressions)! But don't worry, even native English speakers sometimes find themselves puzzled by unfamiliar idioms.

If you suspect you haven't quite grasped what someone is saying, don't be afraid to ask for clarification. People are usually happy to explain what they mean. If you hear an idiom that leaves you scratching your head, just smile and politely ask, "Could you explain what you mean by that?"

Because idioms don't always make sense literally, it's a good idea to familiarise yourself with the meaning of the most popular ones and how they are used.

Here are some idioms you might hear:

"It's raining cats and dogs": This means it's raining a lot. So, if someone says, "Get your umbrella because it's raining cats and dogs," it means it is raining heavily.

"Bob's your uncle": This means something is done easily. For example, if someone gives you directions and says, "Just go down the road, turn left and Bob's your uncle," it means it's that simple!

"Piece of cake": This means something is very easy. So, if you're worried about a task, a friend might say, "Don't worry, it'll be a piece of cake!"

"Once in a blue moon": This means something happens very rarely. So, if someone says they only visit the seaside once in a blue moon, it means they do not go there often.

"Hold your horses": This means be patient and wait. It's like saying, "Wait a moment!"

"Caught between a rock and a hard place": This means being in a tough situation with no easy solution. A friend might say this if they can't decide between two hard options.

"Out of the blue": This means something happens unexpectedly, without warning. For example, if a long-lost friend visits, you might say it came "out of the blue".

"Cost an arm and a leg": This means something is very expensive. So, if you see an expensive antique at a market, you might think it "costs an arm and a leg".

"Under the weather": This means feeling unwell or sick. If someone says they're under the weather, they're not feeling well.

"Break the ice": This means to start a conversation or to make a situation less awkward. For instance, telling a joke can help "break the ice" at a party.

"Hit the nail on the head": This means to describe something exactly right or to be correct. If someone guesses the answer correctly, you can say they've "hit the nail on the head".

"Burning the midnight oil": This means to work late into the night. So, if you're studying for an exam late at night, "you're burning the midnight oil".

"Jump on the bandwagon": This means to join a popular trend or activity. For example, if everyone starts wearing a new style of clothing, you might decide to jump on the bandwagon and wear it too.

"Speak of the devil": This means that someone you were just talking about has suddenly appeared. For instance, if you mention a friend and then they walk into the room, you can say, "Speak of the devil!"

"Cost a pretty penny": This means something is expensive. So, if you see a fancy car, you might say it must have "cost a pretty penny".

"Hit the hay": This means to go to bed or to go to sleep. When you're tired at the end of the day, you might say it's time to "hit the hay".

For further self-study on idioms, you can try the following books:

"English Idioms in Use Advanced Book with Answers" and "English Idioms in Use Intermediate Book with Answers: Vocabulary Reference and Practice," both by Michael McCarthy and Felicity O'Dell.

Slang is also commonly used in everyday English. Here are some examples:

"Knackered": Extremely tired. E.g., "I'm knackered after that long day."

"Gutted": Very disappointed. E.g., "I was gutted when I missed the concert."

"Cheeky": Impudent or irreverent, but often in an endearing or amusing way. E.g., "He made a cheeky comment."

"Mate": Friend. E.g., "How's it going, mate?"

"Quid": Pounds (currency). E.g., "It costs ten quid."

You can learn and practice with these resources:

- List of everyday English phrases EF English Idioms
- Try this free 2-minute online test Cambridge English Idiomatic Language Test
- Follow BBC Learning English BBC Learning English

Local accents and dialects

You will probably be most familiar with the English accent known as 'Received Pronunciation' or 'Queen's English'. This is the accent traditionally described as typically British. However, the UK is made up of more than 50 different accents and dialects!

Accents (the way words are pronounced) and dialects (the local use of specific non-standard words) vary depending on where in the country a person is from, as well as socially.
Here's a guide to just a few of these British dialects: englishlive.ef.com/en/blog/english-in-the-real-world/english-around-britain/

Best practice

When speaking with a patient, they might use their own dialect and include slang or colloquialisms. It is crucial to ensure you fully understand what they are communicating, as this can impact care plans.

Here are some tips:

- **Request local dialect information:** Ask your employer for a list of local dialect terms and common slang you might encounter in your setting.
- **Ask for clarification:** If you don't understand a word or phrase, don't hesitate to ask the speaker to repeat themselves or speak more slowly. For example, you might say, "Sorry, could you say that again?" or "Could you explain what you meant by that?"
- **Rephrase and confirm:** Rephrase what you've understood in your own words to confirm. This helps ensure both parties are on the same page.
- **Use online resources:** If you're unsure about a slang term or local phrase, use online resources or dictionaries to look up meanings.

- **Immerse yourself in local media:** Listening to local radio stations, watching regional TV shows and reading local newspapers can help you get accustomed to the local dialect and slang.
- **Practice with colleagues:** Engage in conversations with colleagues who are familiar with the local dialect. This provides a safe space for learning and asking questions.

  Attend local events: Participating in local community events can expose you to the dialect in a natural setting, improving your understanding through reallife interactions.

Accents and dialects can be tricky, even for those who have been speaking English for a long time. It's important to remember that it takes time for your ear to get used to these variations. Don't be discouraged if you don't understand everything immediately; even native English speakers sometimes struggle with unfamiliar accents and dialects.

Be patient with yourself and continue to practice listening and engaging in conversations. Over time, you will find that your understanding improves. Your efforts will pay off, and your ability to communicate effectively with patients and colleagues will grow stronger.

Manners and etiquette

Please and thank you

New arrivals in the UK, even from other English-speaking countries, are often surprised by the frequency with which people say 'please' and 'thank you' in everyday conversation. It's not unusual to hear these phrases repeated many times in the course of a simple transaction.

Sorry

According to a BBC survey of more than 1,000 Brits, the average person says 'sorry' around eight times per day, with one in eight people apologising up to 20 times a day!

Some nationalities rarely apologise, as it's not part of their culture to do so. However, in English-speaking societies, you are expected to apologise, even if it's not your fault.

General tips:

- You can never say 'thank you' too many times.
- Always say 'please' when you ask for something.
- Say 'sorry' when you bump into someone, even if it's their fault.

Additional insights

Politeness in everyday interactions:

- **Queuing:** The British are known for their orderly queues. Always wait your turn and avoid cutting in line. If you accidentally skip someone, a quick apology will go a long way.
- **Personal space:** Respect personal space, and avoid standing too close to others, especially in public places.

Using titles and names:

- **Formal address:** When meeting someone for the first time, it's polite to use titles and last names (e.g., Mr Smith, Dr Brown). Wait until you're invited to use first names.
- **Professional settings:** In professional settings, maintaining formality in addressing colleagues and patients can show respect and professionalism.

Respecting cultural differences:

- **Understanding cultural nuances:** Recognise that the UK is multicultural, and being aware of different cultural norms and practices can help you navigate social interactions more effectively.
- **Patient interactions:** When interacting with patients from diverse backgrounds, showing cultural sensitivity and respect for their customs can enhance the quality of care.

Conversational topics and behaviours

Preparing for casual social conversations

When meeting people casually whether it's at the school gate, in the supermarket queue or passing a neighbor in the street, it's worth having a few topics ready with opening lines that will help you to confidently start a conversation and 'break the ice'.

Good topics

There are several tried-and-true topics of conversation that can help you to avoid awkward silences, easily get to know someone new and build foundations for deeper friendship.

Here's some good topics and examples of how you might talk about them:

Weather: "This weather is crazy! It was freezing yesterday, but today I'm in a T-shirt. I hope it stays warm, don't you?"

Sporting events: "Did you catch the football at the weekend?"

Holidays: "This time last year I was in Tenerife for my holidays. I'll miss that this year. What plans have you got for the summer?"

Work: "My job is so busy at the moment; the days are really full. Is it the same for you?"

Food/cooking/restaurants: "We got a takeaway from XXX yesterday. Have you been using any good takeout places?"

Arts and entertainment: "Did you watch anything good on TV last night?"

The day/the weekend: "The day is almost over! Do you have any interesting plans for the evening?" or "Do you have any fun plans for the weekend ahead?"

Observations: "I love your shoes today."

Topics to carefully consider

There are certain topics on which people have strong perspectives and beliefs that discussing such might make a conversation difficult for you, or for the person to whom you are speaking.

To avoid potential difficulties like causing an argument, or making people uncomfortable or wanting to leave the conversation, you might consider avoiding these topics:

- Politics
- Religion
- Personal finances
- Age and appearance
- Anything so specific that very few people can relate

There are also topics that are considered especially impolite or inappropriate in British society, so you should consider avoiding these topics entirely:

- Personal gossip
- Offensive jokes
- Topics that are sexual in nature

Humour

A vital element in all aspects of British life is the British sense of humour. The British poke fun at almost everything: themselves, each other, politicians, class, society and you. It is often self-deprecating (putting oneself down), teasing, sarcastic and can be full of puns and innuendo (remarks that suggest something sexual or unpleasant but do not refer to it directly).

Humour is used in British society for a variety of reasons, including:

- To build rapport and informality
- To downplay achievement/appear modest
- To relax a room
- To introduce risky ideas
- To present criticism in an acceptable way

Understanding British humour can be challenging for newcomers, but it can also be a great way to connect with locals.

Tips:

- Don't take it personally: British humour can be direct and may seem harsh at first. Remember, it's often not meant to be taken personally.
- Join in: Once you're comfortable, don't be afraid to join in the humour. It can be a great way to build relationships and show that you understand the culture.
- Ask for clarification: If you don't understand a joke or find something confusing, it's perfectly okay to ask for an explanation. Most people will be happy to explain and appreciate your interest in understanding their humour.

These two books offer valuable insights into understanding British culture and behavior:

Watching the English: The Hidden Rules of English Behaviour by Kate Fox

How to Be a Brit by George Mikes

Indirect speech or doublespeak

Indirect speech, also known as doublespeak, is a way of talking that doesn't always say exactly what it means. The British have a particular skill for using indirect language or doublespeak to express themselves.

Examples of indirect speech:

- Instead of bluntly saying "I don't like your idea," they might opt for "That's an interesting proposal, but perhaps we could consider other options."
- When faced with a challenging situation, they might say "It's not exactly ideal" rather than admitting outright dissatisfaction.
- If someone is running late, instead of saying "You're late," they might say "You took your time."
- Rather than directly refusing an invitation, they might politely respond with "I'll have to check my schedule" or "I'll see what I can do."

This way of speaking allows to convey your message subtly, often leaving room for interpretation and maintaining a sense of politeness.

This style of speech can be frustrating if you come from a country where people are transparent about what they think and feel. You'll find yourself having to 'read between the lines' to understand what they really mean.

Some examples:

"I might join you later" often means "I probably won't come."

"With all due respect" usually precedes a statement that will likely contradict or challenge your point.

"We should have a meeting sometime" is often a polite way of saying "Let's discuss this at a later, unspecified date," which might never happen.

"It's quite good", depending on the context and tone, could mean anything from "It's acceptable" to "It's actually not very good."

Tips for navigating indirect speech:

- Practice and patience: Understanding doublespeak can be tricky at first, so don't get upset if you don't get it right away. Just keep practicing and learning from what happens.
- Seek help from friends: If you have a friend or a colleague you trust who knows the language or culture well, ask them for help. They can explain what things really mean.
- Ask for clarification: If you're ever unsure about what someone is saying, don't be afraid to ask questions. It's perfectly okay to say, "Can you explain that again?" or "I'm not sure I understand." Asking for clarification can make things clearer for everyone!
- Be attentive: Pay attention to how indirect speech is used by people around you. Observing and mimicking their style can help you understand and use it more naturally.

Watch this video to have some fun and gain a better understanding of what indirect speech or "doublespeak" is:

Very British Problems: Double Speak YouTube

Conclusion

Transitioning to a new healthcare environment as an overseas doctor can be challenging, but with the right support and tools, it can be a rewarding experience. This guide aims to help you bridge communication gaps and integrate smoothly into the NHS.

Remember, the NHS environment is very supportive, and everyone is here to help you learn and grow. Don't be too hard on yourself; everyone understands the challenges you face. It's okay to ask questions — this is a safe space for you to develop and thrive.

While the journey may be challenging, it offers significant professional and personal growth opportunities. Welcome to the NHS, and best of luck in your new medical career.

Bibliography

Introduction to the NHS

NHS England. “About the NHS Birthday.” NHS England, https://www.england.nhs.uk/nhsbirthday/about-the-nhs-birthday/.
YouTube. “The NHS: A Celebration.” YouTube, uploaded by NHS England, https://www.youtube.com/watch?v=hdiGX52r7mc.
The King’s Fund. “Key Facts and Figures About the NHS.” The King’s Fund, https://www.kingsfund.org.uk/insight-and-analysis/data-and-charts/key-facts-figures-nhs.
NHS England. “New Figures Show NHS Workforce Most Diverse It Has Ever Been.” NHS England, 9 Feb. 2023, https://www.england.nhs.uk/2023/02/new-figures-show-nhs-workforce-most-diverse-it-has-ever-been/.
The King’s Fund. “NHS Activity in a Nutshell.” The King’s Fund, https://www.kingsfund.org.uk/insight-and-analysis/data-and-charts/NHS-activity-nutshell#:~:text=In%202021%2F22%20there%20were,1.6%20million%20contacts%20every%20day&text=The%20King’s%20Fund%20analysis%20of,NHS%20England%20and%20NHS%20Benchmarking.

How the NHS works

NHS. “NHS Services.” NHS, https://www.nhs.uk/nhs-services/.
NHS England. “Overview.” NHS England, https://www.england.nhs.uk/.
Gov.uk. “Health and Social Care.” Gov.uk, https://www.gov.uk/topic/health-social-care.
The King’s Fund. “How Does the NHS in England Work?” The King’s Fund, https://www.kingsfund.org.uk/audio-video/how-does-nhs-in-england-work.
YouTube. “How Does the NHS in England Work and How Is It Changing?” The King’s Fund, https://youtu.be/blapgFKXv0I?si=YfAB-iqaoSu6jL3O&t=145.
NHS. “When to Visit an Urgent Treatment Centre, Walk-in, or Minor Injury Unit.” NHS, https://www.nhs.uk/nhs-services/urgent-and-emergency-care-services/when-to-visit-an-urgent-treatment-centre-walk-in-or-minor-injury-unit/.

UK-specific health issues

ONS. “Leading Causes of Death, UK: 2001 to 2018.” Office for National Statistics, https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/causesofdeath/articles/leadingcausesofdeathuk/2001to2018.
Gov.uk. “Obesity Profile: Short Statistical Commentary, May 2023.” Gov.uk, https://www.gov.uk/government/statistics/obesity-profile-update-may-2023/obesity-profile-short-statistical-commentary-may-2023.
Gov.uk. “Childhood Obesity: A Plan for Action, Chapter 2.” Gov.uk, https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/718903/childhood-obesity-a-plan-for-action-chapter-2.pdf.
Drinkaware. “Alcohol Consumption in the UK.” Drinkaware, https://www.drinkaware.co.uk/research/alcohol-facts-and-data/alcohol-consumption-uk.
ONS. “Alcohol-Specific Deaths in the UK: 2021 Registrations.” Office for National Statistics, https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/alcoholspecificdeathsintheuk/2021registrations.
Alcohol Change UK. “Alcohol Statistics.” Alcohol Change UK, https://alcoholchange.org.uk/alcohol-facts/fact-sheets/alcohol-statistics.

Workplace communication

NHS Careers. “Doctors.” NHS, https://www.healthcareers.nhs.uk/explore-roles/doctors.
NHS Employers. “Nursing Careers.” NHS, https://www.nhsemployers.org/your-workforce/plan/nursing-workforce/nursing-careers.
General Medical Council. Guidance for Doctors: Requirements for Revalidation and Maintaining Your Licence. Retrieved from https://www.gmc-uk.org/-/media/gmc-site/registration-and-licensing/guidance_for_doctors_requirements_for_revalidation_and_maintaining_your_licence.pdf.
General Medical Council. (2012, June). Continuing Professional Development: Guidance for All Doctors. Retrieved from https://www.gmc-uk.org/-/media/documents/cpd-guidance-for-all-doctors-0316_pdf-56438625.pdf.
General Medical Council. (2015, February 15). Reflecting on an Experience: Breaking Bad News. Retrieved from https://www.gmc-uk.org/education/standards-guidance-and-curricula/guidance/reflective-practice/breaking-bad-news.
The CPD Certification Industry. CPD in the Healthcare & Medical Industry. Retrieved from https://cpduk.co.uk/industries/healthcare-medical.

Patient communication

Skills for Health. Person-Centred Approaches Framework. https://www.skillsforhealth.org.uk/images/pdf/Person-Centred-Approaches-Framework.pdf.
NHS England. Comprehensive Model of Personalised Care. https://www.england.nhs.uk/personalisedcare/comprehensive-model.
YouTube. “Person-Centred Care.” YouTube, https://www.youtube.com/watch?v=RXOd-7rn6so.
NHS England. Decision Making and Consent. https://www.england.nhs.uk/personalisedcare/shared-decision-making/why-is-shared-decision-making-important/decision-making-and-content/.
General Medical Council. Professional Standards: Decision Making and Consent. https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/decision-making-and-consent.
NHS UK. Consent to Treatment. https://www.nhs.uk/conditions/consent-to-treatment/.
British Medical Association. Guidance on Patient Consent. https://www.bma.org.uk/advice-and-support/ethics/consent/guidance-for-doctors-on-patient-consent.
Baile, W. F., Buckman, R., Lenzi, R., Glober, G., Beale, E. A., & Kudelka, A. P. (2000). SPIKES—A six-step protocol for delivering bad news: application to the patient with cancer. The Oncologist, 5(4), 302-311.
Buckman, R. (1992). How to Break Bad News: A Guide for Health Care Professionals. Johns Hopkins University Press.
Stonewall Scotland. Inclusive Language in the NHS. https://www.nhsggc.org.uk/media/256045/nhsggc_equalities__inclusive_language_in_nhs.pdf.
NHS. Content Guide: Inclusive Content. https://service-manual.nhs.uk/content/inclusive-content.
NHS. Equality Hub. https://service-manual.nhs.uk/content/inclusive-content.

Social communication

Harzing, A. (2018). British Etiquette: Saying Please and Thank You. Retrieved from Harzing’s Blog.
BBC Future. “Why Do the British Say ‘Sorry’ So Much?” Available at: https://www.bbc.com/future/article/20160223-why-do-the-british-say-sorry-so-much.
Fox, K. Watching the English: The Hidden Rules of English Behaviour. Johns Hopkins University Press.

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