MRCP(UK) PACES

Station 5: BRIEF CLINICAL CONSULTATION

Patient details:	Mrs Jane Smith aged 52.
Your role:	You are the doctor in the medical outpatient clinic.

You have 10 minutes with each patient. The examiners will alert you when 6 minutes have elapsed and will stop you after 8 minutes. In the remaining 2 minutes, one examiner will ask you to **report on any abnormal physical signs** elicited, your **diagnosis or differential diagnoses**, and your **plan for management** (if not already clear from your discussion with the patient).

Referral text:

Clinical problem: This woman has been experiencing drooping of the right side of her face with slurred speech and weakness in her right arm for three hours. This occurred two days ago. She has made a complete recovery.

Your task is to:

- Assess the problem by means of a brief focused clinical history and a relevant physical examination. You do not need to complete the history before carrying out an appropriate examination.
- Advise the patient of your probable diagnosis (or differential diagnoses), and your plan for investigation and treatment, where appropriate.
- Respond directly to any specific questions / concerns which the patient may have.

Any notes you make may be taken into the examination room for your reference, but must be handed to the examiners at the end of the station.

NOT TO BE SEEN BY CANDIDATES

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Candidates will have a very limited time (8 minutes) with you to gather all the information they require, perform an examination and explain what further tests or treatments they would like to arrange, as well as answer your questions. The scenario below may be based upon your case, however, some aspects of your medical history may have been simplified or left out from the scenario for the purpose of the exam, for example other health problems, previous tests and treatments. It is very important that you stick to the history given below and do not deviate from it. This is essential to ensure that the exam is fair for all candidates. Those organising the exam will contact you beforehand to run through the scenario with you. Please read through the history carefully as you will have the opportunity at that point to raise any questions or concerns you may have.

You are: Mrs Jane Smith aged 52.
You are in: the medical outpatient clinic.

History of current problem

Information to be volunteered at the start of the consultation
Two days ago, while making a cup of tea, you noticed that your face had suddenly started drooping on the right side. Your speech was also slurred. You also noticed that your right arm felt weak.

Information to be given *if asked*
The whole episode lasted for three hours - you now feel completely better. You haven't experienced anything like this before.

You didn't have a headache or experience any visual symptoms during the episode. You didn't notice any weakness in your legs. You didn't call the doctor at the time as you were felt frightened during the episode.

Background information

Past medical and surgical history
Five years ago you were diagnosed with high blood pressure.

Relevant family history
None of your family have experienced anything similar.

Medication record

Current medications (Please bring a list of your treatment with you and show it to the doctor if asked.)
Losartan for high blood pressure. Your blood pressure was checked last month by your GP and was normal.

Personal history

Relevant personal, social or travel history
You smoke 15 cigarettes a day and have done so for the last 20 years.

Occupational history
You are a medical secretary and are right handed.

Physical Examination

The doctor will examine your pulse, and listen to your heart and neck. They may examine your arms and speech.

You have one or two specific questions / concerns for the doctor at this consultation.

Please note them down on a small card to remind you during the exam.

1. Why did I experience this weakness?

2. What can I do to prevent this happening again?

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DATE		CYCLE

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Examiners should advise candidates after 6 minutes have elapsed that "You have two minutes remaining with your patient". If the candidate appears to have finished early remind them how long is left at the station and enquire if there is anything else they would like to ask or examine. If they have finished, please remain silent and allow the candidate that time for reflection.

The examiner should ask the candidate to describe any abnormal physical findings that have been identified. The examiner should also ask the candidate to give the preferred diagnosis and any differential diagnoses that are being considered. Any remaining areas of uncertainty, eg regarding the plan for investigation or management of the problem may be addressed in any time that remains.

Examiners should refer to the marking guidelines in the seven skill domains on the marksheet.

Examiners must fully rehearse the scenario with the patient / surrogate during calibration. The boxes on the next page indicate areas of potential interest in this case which both examiners should consider, along with any other areas they feel appropriate. Examiners must agree the issues that a candidate should address to achieve a Satisfactory award for each skill and record these on the calibration sheet provided. Examiners should also agree the criteria for an Unsatisfactory award at each skill.

Continued on next page…

Problem:	Right sided facial drooping and weakness, TIA.
Candidate's role:	The doctor in the medical outpatient clinic.
Patient details:	Mrs Jane Smith aged 52.
Patient or surrogate:	Patient.
Clinical setting:	The medical outpatient clinic.

Examiners are reminded that the boxes below indicate areas of potential interest, but are not intended as absolute determiners of Satisfactory performance. It is for the examiners to agree and record the specific criteria they will assess the candidate on during the calibration process.

Clinical skill	Key issues
Clinical Communication Skills (C)	Takes a history and establishes the diagnosis of TIA. Identifies risk factors ie smoking and hypertension.
Physical Examination (A)	General physical examination including pulse, heart sounds, excludes murmurs, carotid bruits. Checks reflexes.
Clinical Judgment (E)	Recommends ECG, glucose, Doppler studies and lipids and possibly an ECHO or MRI angiography.
Managing Patients' Concerns (F)	Addresses the patient's questions and concerns in an appropriate manner.
Identifying Physical Signs (B)	There are no abnormal physical signs.
Differential Diagnosis (D)	**Probable Diagnosis:** TIA. **Plausible alternative diagnoses:** Mini stroke.
Maintaining Patient Welfare (G)	Treats the patient respectfully, sensitively and ensures comfort, safety and dignity. Does not cause physical or emotional discomfort or jeopardise safety.