PACES Station 2: HISTORY TAKING

Patient details: Mr Daniel Steele, a 63-year-old man
Your role: You are the doctor in the general medical clinic
Presenting complaint: Haemoptysis and suspected bronchiectasis on chest X-ray

Please read the letter printed below. When the bell sounds, enter the room. You have 14 minutes to take a history from the patient, 1 minute to collect your thoughts and 5 minutes for discussion. You may make notes if you wish.

Referral text:

Dear Doctor,

I would be grateful if you would see this patient who has had haemoptysis for the past few weeks. He has been treated for chest infections in the past but has no other respiratory problems. I arranged a chest X-ray which has been reported as showing changes consistent with bronchiectasis.

Please advise on further investigation and management.

Yours faithfully,

Your task is to interview the patient and, based on the history you obtain, construct a differential diagnosis and plan for investigation. You should explain these to the patient and answer any questions they may have.

DO NOT EXAMINE THE PATIENT

Any notes you make must be handed to the examiners at the end of the station.

PACES Station 2: HISTORY TAKING

Your role: You are the patient, Mr Daniel Steele, a 63-year-old man
Location: The general medical clinic

History of presenting symptoms

Information to be volunteered at the start of the consultation

You have been coughing up blood for the past 4 weeks. You are coughing up only small amounts of blood but it is occurring several times each day. Your family doctor arranged for a chest X-ray to be performed and told you it showed a lung condition, the name of which you have forgotten.

Information to be given *if asked*

The blood is mixed with clear or white sputum. You have had a persistent cough for around 2 years but this is the first time you have ever coughed up blood. Your cough is usually productive of clear or white sputum. You feel that you have to clear your chest each morning, and can cough up as much as an egg-cupful of sputum. On numerous occasions, your sputum has turned green, and if this persists for more than a couple of days, you see your family doctor to check if you need a course of antibiotics. You have had six or seven courses of antibiotics over the past 2 years. You do not like to see doctors so you have never spoken to your family doctor about your chronic cough and you have not had any tests before.

You have been breathless on exertion for around 1 year. This appears to be slowly getting worse although this does not often limit you. You might have to stop to catch your breath when walking up hills or walking on the flat briskly. If you take your time when walking on the flat, you do not need to stop. You feel wheezy when you are breathless. You are not breathless when lying flat and do not wake up with attacks of breathlessness.

You do not have any ankle swelling. You have no pain and you have not lost weight.

Before the development of these symptoms, you never had any chest complaints, except for an episode of severe pneumonia when you were a child. You were hospitalised for this but you remember little else given how long ago it was.

Background information

Past medical and surgical history

You have had recurrent chest infections over the past 2 years. You had pneumonia when you were 5 years old.

Other complaints

None.

Medication record

Current medications

None

Relevant previous medications
You have taken six or seven courses of antibiotics over the past 2 years. You cannot remember the names of these.

Allergies and adverse reactions
None known.

Personal history

Lifestyle
You smoke 15 cigarettes per day and you have done since you were aged 17 years. You do not drink alcohol.

Social and personal circumstances
You live with your wife. You are both independent in everyday activities. You have had a pet dog for the past 8 years.

Occupational history
You are recently retired. You worked as a joiner. To the best of your knowledge, you have never been exposed to asbestos.

Travel history
You were in Paris 6 months ago for a short break with your wife; otherwise, you have not been abroad for several years.

Family history
None relevant.

Patient's concerns, expectations and wishes
You do not like visiting doctors and thought your long-standing cough was a simple smoker's cough. Seeing blood in your sputum has alarmed you, as has the urgency with which your family doctor arranged this appointment. You are concerned that you might have lung cancer.

You have some specific questions for the doctor at this consultation:

- What was the condition my family doctor said was on the chest X-ray?
- Why am I coughing up blood?
- Could I have lung cancer?
- What can be done to help my symptoms?

PACES Station 2: HISTORY TAKING

DATE	CYCLE

Examiners should advise candidates when there are 2 minutes remaining (i.e. after 12 minutes). 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 whether they have finished. If they have finished, please remain silent and allow the candidate that time for reflection. The surrogate should remain until the end of the 14-minute period.

A good candidate would be expected to take a history which includes a detailed social history and activities of daily living; and to particularly focus on the questions raised in the referral letter. At the end of the consultation the candidate should have discussed solutions to the problems posed by the case. A good candidate would also give the patient the opportunity to ask any further questions before closure. It is not necessary for candidates to agree a summary with the patient during their interview.

Examiners are encouraged to make a rough record of the candidate's consultation with the patient as it progresses. This may highlight omissions in history taking, ambiguities that remain unresolved, and additional points that were not 'in the script'.

The examiner is expected to ask the candidate whether they have formed a problem list or preferred diagnosis and answer the questions in the family doctor's letter. Following discussion of the answer to these questions the discussion should explore the issues raised.

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

Examiners are reminded that, during the calibration process, the surrogate should be rehearsed and specific aspects of the scenario that require clarification or emphasis should be discussed. 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.

NOT TO BE SEEN BY CANDIDATES

INFORMATION FOR EXAMINERS

Scenario No: Sample 1

Problem: Haemoptysis and suspected bronchiectasis on chest X-ray
Candidate's role: The doctor in the general medical clinic
Surrogate's role: The patient, Mr Daniel Steele, a 63-year-old man

Examiners are reminded the areas 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.

Differential Diagnosis (Clinical Skill D)

Probable diagnosis:

- Bronchiectasis- possibly secondary to childhood pneumonia

Plausible alternative diagnoses:

- Primary lung cancer
- Chronic obstructive pulmonary disease (COPD)

Clinical Communication Skills (Clinical Skill C)

- Elicits a history of haemoptysis in a smoker on a background of chronic productive cough suggestive of bronchiectasis or COPD

Managing Patients' Concerns (Clinical Skill F)

- Sensitively explains to the patient that lung cancer is a possibility and does not offer false reassurance
- Explains that the chest X-ray has shown changes consistent with bronchiectasis and explains to the patient what this is in terms understandable to a lay person

Clinical Judgement (Clinical Skill E)

- Identifies investigating for lung cancer as the most pressing issue
- Recognises that longer history of productive cough is suggestive of COPD or bronchiectasis
- Arranges further investigations including chest X-ray, high-resolution CT scan of chest, bronchoscopy, spirometry
- Is aware of treatment options for bronchiectasis i.e. chest physiotherapy, mucolytics, bronchodilators, antibiotics

Maintaining Patient Welfare (Clinical Skill G)

See marksheet

PACES Station 2: HISTORY TAKING

Patient details: Miss Anne Rogers, a 55-year-old woman
Your role: You are the doctor in the general medical outpatient clinic
Presenting complaint: Nausea and anorexia, associated with abnormal liver function tests

Please read the letter printed below. When the bell sounds, enter the room. You have 14 minutes to take a history from the patient, 1 minute to collect your thoughts and 5 minutes for discussion. You may make notes if you wish.

Referral text:

Dear Doctor,

Thank you for seeing this patient who has recently attended the surgery with a 1-month history of nausea and anorexia. I have found no abnormalities on examination but her routine blood tests show a gamma glutamyl transferase (GGT) of 252 U/L (normal range: 4–35) and an alanine aminotransferase (ALT) of 75 U/L (normal range: 5–35). She is not taking any prescribed medication.

The patient has a past history of depression and is the mother of two teenaged children.

On examination, she seemed very anxious.

Please would you advise on the possible likely diagnosis and immediate management.

Yours faithfully,

Your task is to interview the patient and, based on the history you obtain, construct a differential diagnosis and plan for investigation. You should explain these to the patient and answer any questions they may have.

DO NOT EXAMINE THE PATIENT

Any notes you make must be handed to the examiners at the end of the station.

NOT TO BE SEEN BY CANDIDATES

INFORMATION FOR THE SURROGATE

Scenario No: Sample 2

PACES Station 2: HISTORY TAKING

Your role: You are the patient, Miss Anne Rogers, a 55-year-old woman
Location: The general medical outpatient clinic

History of presenting symptoms

Information to be volunteered at the start of the consultation
You have been feeling unwell for the last 6 months and over the past 4 weeks you have not felt like eating. You have also felt sick in the morning.

Information to be given *if asked*
You have lost a few kilograms in weight but remain overweight. You have no abdominal pain but some mild indigestion. You have no difficulty swallowing and you have not vomited. You have become a little constipated but you are not passing any blood in your stool. You have no urinary symptoms. Your periods stopped 6 months ago.

Background information

Past medical and surgical history
You have had depression in the past, especially following the birth of your second child (a boy). Other than that you have had no major physical illnesses or surgery in the past. You have never been jaundiced or had a blood transfusion.

Other complaints
None.

Medication record

Current medications
Over the past 6 months, you have been taking up to eight paracetamol tablets per day for headaches. You have never taken recreational drugs and you are not currently taking any prescribed medication. You sometimes take some proprietary antacids.

Relevant previous medications
None.

Allergies and adverse reactions
None known.

Personal history

Lifestyle
You do not smoke but you have been drinking two large glasses of gin with tonic water every evening for the past year and you have also taken to drinking at least half a bottle of wine at weekends.

Social and personal circumstances
Your partner works away from home and your eldest child has left home to live with a man of whom you do not approve.

Occupational history

NOT TO BE SEEN BY CANDIDATES

INFORMATION FOR THE SURROGATE

Scenario No: Sample 2

You work as a cashier in a local supermarket

Travel history
None relevant.

Family history
There is no relevant family history. Your parents are both alive although your father had a heart attack a few years ago.

Patient's concerns, expectations and wishes
You realise that you may be drinking more than you should. You feel guilty and do not want anyone else to know. You are worried about your recent symptoms and you are concerned that you might have cancer.

You have some specific questions for the doctor at this consultation:

- What is wrong with me?
- Could I have cancer?
- Should I have further tests to find out what is wrong?
- Will I get better?

PACES Station 2: HISTORY TAKING

DATE	CYCLE

Examiners should advise candidates when there are 2 minutes remaining (i.e. after 12 minutes). 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 whether they have finished. If they have finished, please remain silent and allow the candidate that time for reflection. The surrogate should remain until the end of the 14-minute period.

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Examiners are encouraged to make a rough record of the candidate's consultation with the patient as it progresses. This may highlight omissions in history taking, ambiguities that remain unresolved, and additional points that were not 'in the script'.

The examiner is expected to ask the candidate whether they have formed a problem list or preferred diagnosis and answer the questions in the family doctor's letter. Following discussion of the answer to these questions the discussion should explore the issues raised.

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

Examiners are reminded that, during the calibration process, the surrogate should be rehearsed and specific aspects of the scenario that require clarification or emphasis should be discussed. 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.

NOT TO BE SEEN BY CANDIDATES

INFORMATION FOR EXAMINERS

Scenario No: Sample 2

Problem:	Nausea and anorexia, associated with abnormal liver function tests
Candidate's role:	The doctor in the general medical outpatient clinic
Surrogate's role:	The patient, Miss Anne Rogers, a 55-year-old woman

Examiners are reminded the areas 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.

Differential Diagnosis (Clinical Skill D)

Probable diagnosis:

- Non-alcoholic fatty liver disease (NAFLD)

Plausible alternative diagnoses:

- Alcoholic liver disease
- Other causes of primary liver disease
- Gallstones

Clinical Communication Skills (Clinical Skill C)

- Gives the patient advice regarding weight reduction
- Provides advice on where to get help to limit alcohol consumption

Managing Patients' Concerns (Clinical Skill F)

- Addresses the patient's concern about cancer

Clinical Judgement (Clinical Skill E)

- Carries out an accurate assessment of the patient's alcohol intake
- Elicits the history of depression

Maintaining Patient Welfare (Clinical Skill G)

See marksheet

PACES Station 2: HISTORY TAKING

Patient details: Mrs Barbara Cassell, a 52-year-old woman
Your role: You are the doctor in the medical admissions unit
Presenting complaint: Headaches and numbness

Please read the letter printed below. When the bell sounds, enter the room. You have 14 minutes to take a history from the patient, 1 minute to collect your thoughts and 5 minutes for discussion. You may make notes if you wish.

Referral text:

Dear Doctor,

Thank you for assessing this patient. She describes suddenly experiencing a sensation of feeling "strange and unreal" while at work today, followed by the onset of a headache and some numbness.

She is clearly distressed by her symptoms. I would be grateful if you could exclude any serious pathology.

Yours faithfully,

Your task is to interview the patient and, based on the history you obtain, construct a differential diagnosis and plan for investigation. You should explain these to the patient and answer any questions they may have.

DO NOT EXAMINE THE PATIENT

Any notes you make must be handed to the examiners at the end of the station.

PACES Station 2: HISTORY TAKING

Your role: You are the patient, Mrs Barbara Cassell, a 52-year-old woman
Location: The medical admissions unit

History of presenting symptoms

Information to be volunteered at the start of the consultation

You were entirely well earlier today when, while sitting down at work, you suddenly experienced a strange and unreal feeling in your head, followed by a rushing sound. You then felt light-headed and developed some numbness of the right side of your body, along with a throbbing headache affecting the left side of your head at the front. You were also aware of some problems with your vision.

Information to be given *if asked*

You lost the right side of your vision in both eyes – everything on the right side of your visual field is blurry and this has persisted. If the doctor asks if you can read print, say that you have not tried, but that you had trouble finding the correct keys on your computer keyboard.
The headache, which was moderate in terms of pain (about 5 out of 10 if asked) has eased.
The right-sided numbness is also much less than it was.

Background information

Past medical and surgical history

You generally enjoy good health, but have had occasional episodes of migraine over a period of several years. When you get your usual migraine headache, you often feel nauseated and experience sensitivity to light. These headaches are most frequent in the few days before your period or if you are stressed. They can last all day and sometimes you wake up with a headache. Sometimes these episodes have been associated with visual disturbance, but this has always resolved over a period of minutes. You also recall one episode in which you briefly experienced right-sided numbness.

You have not previously been hospitalised, apart from childbirth.

Other complaints

None.

Medication record

Current medications

You are not taking any prescribed medications, but you take vitamins and mineral supplements, which you buy yourself. You take paracetamol as required.

Relevant previous medications

None of relevance. You have never taken any medications to treat or prevent migraine as you only get occasional episodes and have never really complained about it.

Allergies and adverse reactions

None known.

Personal history

Lifestyle

You do not smoke or consume alcohol. You have never used recreational drugs.

Social and personal circumstances

You are happily married with two children, who are at university. Your husband is an architect and you have no financial worries.

Occupational history

You work full-time as the assistant head teacher at a local college for blind people and you enjoy your work. (If this scenario is played in the first cycle you could add that you start work very early in the morning.)

Travel history

You have taken family holidays in southern Europe and the USA only.

Family history

Nothing of relevance. Specifically, there is no family history of strokes, heart disease or blood clots.

Patient's concerns, expectations and wishes

- You have found the symptoms you have experienced today extremely distressing and you are particularly concerned about your prolonged loss of vision.
- You want to know when your vision will return to normal and whether this is something more serious than a migraine attack.
- You would like to have a brain scan for reassurance, but you are not very keen to remain in hospital.

You have some specific questions for the doctor at this consultation:

- Is this just another migraine attack?
- If so, why is it more severe than any previous episodes?
- When will my vision return to normal?
- Can I go home and have any further investigations as an outpatient?

PACES Station 2: HISTORY TAKING

DATE	CYCLE

Examiners should advise candidates when there are 2 minutes remaining (i.e. after 12 minutes). 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 whether they have finished. If they have finished, please remain silent and allow the candidate that time for reflection. The surrogate should remain until the end of the 14-minute period.

A good candidate would be expected to take a history which includes a detailed social history and activities of daily living; and to particularly focus on the questions raised in the referral letter. At the end of the consultation the candidate should have discussed solutions to the problems posed by the case. A good candidate would also give the patient the opportunity to ask any further questions before closure. It is not necessary for candidates to agree a summary with the patient during their interview.

Examiners are encouraged to make a rough record of the candidate's consultation with the patient as it progresses. This may highlight omissions in history taking, ambiguities that remain unresolved, and additional points that were not 'in the script'.

The examiner is expected to ask the candidate whether they have formed a problem list or preferred diagnosis and answer the questions in the family doctor's letter. Following discussion of the answer to these questions the discussion should explore the issues raised.

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

Examiners are reminded that, during the calibration process, the surrogate should be rehearsed and specific aspects of the scenario that require clarification or emphasis should be discussed. 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.

NOT TO BE SEEN BY CANDIDATES

INFORMATION FOR EXAMINERS

Scenario No: Sample 3

Problem: Headaches and numbness
Candidate's role: The doctor in the medical admissions unit
Surrogate's role: The patient, Mrs Barbara Cassell, a 52-year-old woman

Examiners are reminded the areas 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.

Differential Diagnosis (Clinical Skill D)

Probable diagnosis:

- Even with the history of migraine, there are additional features here which should prompt consideration of intracranial haemorrhage or another cerebrovascular event

Plausible alternative diagnosis:

- Severe attack of migraine, in view of the past history; however, the pattern of onset of symptoms and the persistence of the visual field defect, in the face of resolution of other symptoms, make this less likely

Clinical Communication Skills (Clinical Skill C)

- Establishes that the current symptoms are slightly different from the previous migraine
- Establishes the persisting visual symptoms
- Establishes the patient's anxieties

Managing Patients' Concerns (Clinical Skill F)

- Addresses the patient's concerns, avoiding unjustifiable reassurance

Clinical Judgement (Clinical Skill E)

- Considers the potential causes of symptoms, to include an acute cerebrovascular event
- Formulates an appropriate and clear management plan for investigation and treatment of a probable acute cerebrovascular event in a relatively young woman, including urgent brain imaging
- Appreciates that discharge of this patient without further investigation would not be appropriate

Maintaining Patient Welfare (Clinical Skill G)

See marksheet

PACES Station 2: HISTORY TAKING

Patient details: Mrs Betty Drake, a 56-year-old woman
Your role: You are the doctor in the general medical outpatient clinic
Presenting complaint: Weight loss, diabetes mellitus and abnormal liver function tests

Please read the letter printed below. When the bell sounds, enter the room. You have 14 minutes to take a history from the patient, 1 minute to collect your thoughts and 5 minutes for discussion. You may make notes if you wish.

Referral text:

Dear Doctor,

I would be grateful if you would see this patient who was found to have type 2 diabetes mellitus 2 weeks ago. She was previously overweight with a body mass index of 28 kg/m^2 (normal range: 18–25); however, she has been losing weight recently. She is taking bendroflumethiazide, and beclometasone and salbutamol inhalers.

Her urea and electrolyte results are entirely normal. However, her liver function tests are as follows:

serum albumin	35 g/L (normal range: 37–49)
serum total bilirubin	28 µmol/L (normal range: 1–22)
serum alanine aminotransferase	46 U/L (normal range: 5–35)
serum alkaline phosphatase	460 U/L (normal range: 45–105)
serum gamma glutamyl transferase	560 U/L (normal range: 4–35)

Her fasting plasma glucose has remained around 12.0–13.0 mmol/L (normal range: 3.0–6.0) over the past 2 weeks.

I am unsure why this patient has abnormal liver function tests and would value your assessment.

Yours faithfully,

Your task is to interview the patient and, based on the history you obtain, construct a differential diagnosis and plan for investigation. You should explain these to the patient and answer any questions they may have.

DO NOT EXAMINE THE PATIENT

Any notes you make must be handed to the examiners at the end of the station.

PACES Station 2: HISTORY TAKING

Your role: You are the patient, Mrs Betty Drake, a 56-year-old woman
Location: The general medical outpatient clinic

History of presenting symptoms

Information to be volunteered at the start of the consultation

You have noticed that you have been getting very thirsty over the past 6 weeks. You have also been passing a lot of urine and have often had to get up 3–4 times during the night to pass urine.

You were told 2 weeks ago that you have type 2 diabetes mellitus, and were advised about cutting out sugar from your diet. You were shown how to test your blood sugar and given a meter to do this but your blood sugar in the morning has remained high at around 12–13 mmol/L (normal range: 3–6). Your family doctor has just prescribed a drug called gliclazide for you to take for this.

Information to be given *if asked*

If asked, you will say that your urine has looked darker recently. Your vision has been blurred and you have been feeling tired and generally lethargic.
Your weight has gradually been falling over the past 6 months. You have lost about 12 kg over this period. This has occurred despite eating a normal diet.
You have also been troubled by episodes of upper abdominal pain, which often radiates through to your back.
Your stools have tended to be looser than they were previously. You have never seen blood in the stools and there has been no obvious colour change.
You have a cough in the mornings, which is frequently productive of clear or white phlegm.
You have not coughed up any blood.
You have not experienced any chest pain.
You do not have any rashes or joint pains.

Background information

Past medical and surgical history

Your gallbladder was removed when you were 42 years old and at that time you were jaundiced.
You have had high blood pressure for the past 5 years.
You have been told that you have mild chronic obstructive pulmonary disease (COPD).

Other complaints

None.

Medication record

Current medications

You take bendroflumethiazide 2.5 mg daily for hypertension.
You use a beclometasone inhaler, 2 puffs twice daily, and you also have a salbutamol inhaler which you rarely use, for COPD.
You have just started taking gliclazide 80 mg once daily prescribed by your family doctor.

Relevant previous medications

None.

Allergies and adverse reactions

None known.

Personal history

Lifestyle

You have smoked 10–15 cigarettes per day since you were 18 years old. You have been drinking very little alcohol recently because this seems to upset your stomach. However, in the past you tended to drink about a bottle of wine at the weekends.

Social and personal circumstances

You are married and live with your husband. You have one daughter who is married and works full-time as a secretary.

Occupational history

You are a housewife but you also look after your two young grandchildren 3 days per week.

Travel history

You visited Greece 10 months ago but apart from that have not recently travelled overseas.

Family history

There is no family history of diabetes, haemochromatosis or coeliac disease.

Patient's concerns, expectations and wishes

You are worried about the reason you are losing so much weight and it has crossed your mind that you may have cancer. You are concerned that your diagnosis of diabetes might affect your ability to look after your grandchildren. You are also worried that you may require insulin injections.

You have some specific questions for the doctor at this consultation:

- Why do I have this pain in my stomach?
- What has caused the diabetes?
- Will I need insulin injections to control the diabetes?
- Why am I losing so much weight?
- I regularly look after my grandchildren during the day – will I still be able to do this?

PACES Station 2: HISTORY TAKING

DATE	CYCLE

Examiners should advise candidates when there are 2 minutes remaining (i.e. after 12 minutes). 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 whether they have finished. If they have finished, please remain silent and allow the candidate that time for reflection. The surrogate should remain until the end of the 14-minute period.

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The examiner is expected to ask the candidate whether they have formed a problem list or preferred diagnosis and answer the questions in the family doctor's letter. Following discussion of the answer to these questions the discussion should explore the issues raised.

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NOT TO BE SEEN BY CANDIDATES

INFORMATION FOR EXAMINERS

Scenario No: Sample 4

Problem:	Weight loss, diabetes mellitus and abnormal liver function tests
Candidate's role:	The doctor in the general medical outpatient clinic
Surrogate's role:	The patient, Mrs Betty Drake, a 56-year-old woman

Examiners are reminded the areas 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.

Differential Diagnosis (Clinical Skill D)

Probable diagnosis:

- Secondary diabetes mellitus, associated with carcinoma of the pancreas

Plausible alternative diagnoses:

- Alcoholic liver disease
- Gallstone in common bile duct
- Haemochromatosis
- Primary biliary cirrhosis

Clinical Communication Skills (Clinical Skill C)

- Listens to the patient, and takes detailed history of the symptoms and asks about the relevant symptoms
- Is able to take a history to explore some of the causes of the abnormal liver function tests

Managing Patients' Concerns (Clinical Skill F)

- Elicits and addresses the patient's concerns

Clinical Judgement (Clinical Skill E)

- Proposes a plan of investigation including ultrasound scan of abdomen, CT scan of abdomen or MRCP
- Advises smoking cessation sensitively, in view of the possibility of underlying cancer
- Non-judgemental about previous alcohol use

Maintaining Patient Welfare (Clinical Skill G)

See marksheet

PACES Station 2: HISTORY TAKING

Patient details: Mrs Sarah Hay, a 33-year-old woman
Your role: You are the doctor in the medical admissions unit
Presenting complaint: Pleuritic chest pain and breathlessness

Please read the letter printed below. When the bell sounds, enter the room. You have 14 minutes to take a history from the patient, 1 minute to collect your thoughts and 5 minutes for discussion. You may make notes if you wish.

Referral text:

Dear Doctor,

Many thanks for admitting this patient who is experiencing pleuritic chest pain and increasing shortness of breath.

She has recently had a hernia repair and I am therefore concerned that she has had a pulmonary thromboembolism.

Your assessment of her condition and advice on management would be very much appreciated.

Yours faithfully,

Your task is to interview the patient and, based on the history you obtain, construct a differential diagnosis and plan for investigation. You should explain these to the patient and answer any questions they may have.

DO NOT EXAMINE THE PATIENT

Any notes you make must be handed to the examiners at the end of the station.

PACES Station 2: HISTORY TAKING

Your role: You are the patient, Mrs Sarah Hay, a 33-year-old woman
Location: The medical admissions unit

History of presenting symptoms

Information to be volunteered at the start of the consultation

Two weeks ago, you had a groin hernia repair performed. The operation was successful and uneventful. The only problem you had afterwards was pain around the wound site. About a week after the operation, you started to have cold-like symptoms: a sore throat, runny nose, dry cough and aching muscles. As you are asthmatic this meant that your chest became a bit tighter and wheezier over the next few days. You are used to controlling your asthma so you increased your steroid inhaler and took more frequent doses of your reliever. Things appeared to settle down for a few days. You had found it difficult to cough, however, because of the pain from your hernia wound.

Information to be given *if asked*

Two days ago, your cough increased and you started to bring up thick greenish-yellow phlegm. There has not been any blood in the sputum. Again, your chest started to become even tighter and you started to feel shorter of breath when doing your normal activities. You also felt a bit feverish and sweaty especially at night. This morning you felt short of breath even at rest and became aware of some pain in the right side of your chest. This started as a dull nagging pain but about mid-morning suddenly got a lot worse and became a sharp stabbing pain (like someone sticking a knife in your side). The pain got worse every time you took a deep breath so you had to breathe rapidly and in a shallow manner. You took some paracetamol, which only took the edge off the pain.

Background information

Past medical and surgical history

Asthma:

You have had asthma since childhood and spent quite a lot of your early childhood in and out of hospital because of breathing problems. You think you may have had to be ventilated as a child but cannot remember it. Since you were about 10 years old your asthma settled down and you have been able to manage it pretty well by yourself, with only the occasional course of steroids from your family doctor (the last course was 2 years ago). You have not been admitted because of your asthma since you were 25. However, 5 years ago, you did have to come to the emergency department for a nebuliser but you settled quickly and were discharged home within a few hours.

Eczema:

You have had eczema since childhood but this has not troubled you too much in adulthood.

Pneumothorax:

You had a collapsed left lung at the age of 25.

Other:

You also had your appendix removed at the age of 11, and you fractured your left arm playing rugby as a teenager. There is no previous history of a deep venous thrombosis.

Other complaints
None.

Medication record

Current medications

- Seretide® 125 inhaler – 2 puffs twice a day
- Ventolin® inhaler – 2 puffs as required
- Betnovate® cream – topically to areas of eczema as required

Relevant previous medications
None.

Allergies and adverse reactions
You are allergic to ibuprofen; it makes your asthma worse. You have also been told by your mother not to have penicillin as you were given some as a child and it brought you out in a rash. You have been tested for various allergies (for example, dog hair) but nothing was discovered.

Personal history

Lifestyle
You do not smoke and drink only the occasional glass of wine. You like to keep fit and attend a gym regularly.

Social and personal circumstances
You are married with one son who also has asthma.

Occupational history
You work in a bank as a local branch manager. You enjoy your job and do not find it particularly stressful.

Family history
Your mother and an aunt also have asthma, and you think that your mother had a blood clot on her leg when she was young but you are not sure of the details. Your father has had angina since he was 55 and had a heart attack when he was 62.

Patient's concerns, expectations and wishes
Your current pain seems similar to the pain you had when your left lung collapsed. The doctor who treated you at that time had told you there was a chance it could happen again and if you felt a similar pain you should always see a doctor. You went to your family doctor and he sent you to hospital thinking it was a blood clot, and this had really confused you because you had wanted confirmation that it was not your lung collapsing again.

You have some specific questions for the doctor at this consultation:

- Do I have another collapsed lung?
- Why might I have a clot in my lung and is this serious?

- Will I be able to fly overseas for my holidays?

PACES Station 2: HISTORY TAKING

DATE	CYCLE

Examiners should advise candidates when there are 2 minutes remaining (i.e. after 12 minutes). 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 whether they have finished. If they have finished, please remain silent and allow the candidate that time for reflection. The surrogate should remain until the end of the 14-minute period.

A good candidate would be expected to take a history which includes a detailed social history and activities of daily living; and to particularly focus on the questions raised in the referral letter. At the end of the consultation the candidate should have discussed solutions to the problems posed by the case. A good candidate would also give the patient the opportunity to ask any further questions before closure. It is not necessary for candidates to agree a summary with the patient during their interview.

Examiners are encouraged to make a rough record of the candidate's consultation with the patient as it progresses. This may highlight omissions in history taking, ambiguities that remain unresolved, and additional points that were not 'in the script'.

The examiner is expected to ask the candidate whether they have formed a problem list or preferred diagnosis and answer the questions in the family doctor's letter. Following discussion of the answer to these questions the discussion should explore the issues raised.

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

Examiners are reminded that, during the calibration process, the surrogate should be rehearsed and specific aspects of the scenario that require clarification or emphasis should be discussed. 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.

NOT TO BE SEEN BY CANDIDATES

INFORMATION FOR EXAMINERS

Scenario No: Sample 5

Problem: Pleuritic chest pain and breathlessness
Candidate's role: The doctor in the medical admissions unit
Surrogate's role: The patient, Mrs Sarah Hay, a 33-year-old woman

Examiners are reminded the areas 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.

Differential Diagnosis (Clinical Skill D)

Probable diagnosis:

- Pneumonia or infective exacerbation of asthma

Plausible alternative diagnosis:

- Pulmonary embolus (to be excluded)
- (Recurrent pneumothorax is unlikely)

Clinical Communication Skills (Clinical Skill C)

- Focuses on the features of pulmonary embolism such as haemoptysis but also explores the possibility of pneumonia
- Takes a detailed history of breathlessness and explores aspects of the patient's breathlessness and its severity
- Considers possibility of both pulmonary thromboembolism and pneumonia
- Elicits past history of asthma, pneumothorax and eczema
- Takes history of current medication and allergies

Managing Patients' Concerns (Clinical Skill F)

- Elicits patient's perspective of the problem

Clinical Judgement (Clinical Skill E)

- Discusses the management of the patient and mentions appropriate investigations such as D dimer, blood gases, chest X-ray, ECG, ventilation/perfusion scan, CT pulmonary angiogram
- Discusses pulmonary embolism risk scores

Maintaining Patient Welfare (Clinical Skill G)

See marksheet

PACES Station 2: HISTORY TAKING

Patient details: Mrs Linda Hinds, a 53-year-old woman
Your role: You are the doctor in the medical outpatient department
Presenting complaint: Intermittent limb weakness

Please read the letter printed below. When the bell sounds, enter the room. You have 14 minutes to take a history from the patient, 1 minute to collect your thoughts and 5 minutes for discussion. You may make notes if you wish.

Referral text:

Dear Doctor,

I would be grateful if you would see this patient, who has a 6-month history of increasing limb weakness and, in particular, difficulty with climbing stairs. The weakness tends to vary throughout the day.

She has also complained that her mouth is dry and she has found that her speech is sometimes slurred. She has lost a few kilograms in weight but her appetite seems normal.

She is taking an ACE inhibitor for control of her blood pressure.

Many thanks for seeing her

Yours faithfully,

Your task is to interview the patient and, based on the history you obtain, construct a differential diagnosis and plan for investigation. You should explain these to the patient and answer any questions they may have.

DO NOT EXAMINE THE PATIENT

Any notes you make must be handed to the examiners at the end of the station.

PACES Station 2: HISTORY TAKING

Your role: You are the patient, Mrs Linda Hinds, a 53-year-old woman
Location: The medical outpatient department

History of presenting symptoms

Information to be volunteered at the start of the consultation

For the past 9–12 months, you have become increasingly aware of some health problems, mainly with your legs. Initially, you hardly noticed anything, but gradually you became aware that you were having difficulty getting up the stairs in your house.

The weakness in your legs is not always present. It is usually at its worst when you first get up in the morning and then seems to get better after you have been walking about for a while. However, if you undertake housework or walk to the nearby shops, the weakness quickly returns.

You have found recently that you have difficulty getting up from a chair, particularly if you have been seated for several minutes.

Information to be given *if asked*

There may be some mild weakness of your arms but this does not really trouble you. Your grip strength is normal and you have no difficulties with fine movements of your fingers.

You have also noticed that chewing has become difficult. Again, it is difficult to chew at the beginning of your meal and then gets better for a while. However, once you have been eating for 15 minutes or so, the difficulty returns. Your mouth is often dry and this makes eating more difficult. Your husband has noticed that your voice fades from time to time and that your speech can be a bit slurred.

You have no difficulty swallowing your food. You have not noticed any drooping of your eyelids and you have never had double vision. You have had no problems with bladder or bowel function and no alteration in sensation in your limbs.

You have noticed that you are dizzy on standing. There is also a sensation of light-headedness. You have a dry cough, which has been troublesome for the past 3–4 months. You have lost about 4 kg in weight and continue to lose weight despite trying to eat more.

Background information

Past medical and surgical history

You have had high blood pressure and have been on treatment for this for the past 4–5 years.

Other complaints

None.

Medication record

Current medications

- ramipril 10 mg daily

Relevant previous medications
None.

Allergies and adverse reactions
None known.

Personal history

Lifestyle
You have smoked since the age of 16 and currently smoke 20 cigarettes per day. You do not drink any alcohol.

Social and personal circumstances
You are married with two grown-up children. They both live away from home. Your husband is an electrician and often works away from home. He can be away on a job for several days at a time

Occupational history
You work in an office as a secretary.

Family history
Your father died at the age of 62 from motor neurone disease. Your mother is 76 and has had two hip replacement operations and is a bit unsteady on her feet. She had an overactive thyroid gland which you remember was treated with radioactive iodine. She is now taking levothyroxine tablets. She is also on treatment for high blood pressure.

Patient's concerns, expectations and wishes
You are very worried that you have motor neurone disease, particularly since you witnessed the distressing decline of your father's health. If you have a wasting disease like your father, you wish to write a living will which will prevent unnecessary prolongation of your life.

You have some specific questions for the doctor at this consultation:

- Do I have motor neurone disease?
- What is going to happen to me?
- Is it going to get worse?

PACES Station 2: HISTORY TAKING

DATE	CYCLE

Examiners should advise candidates when there are 2 minutes remaining (i.e. after 12 minutes). 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 whether they have finished. If they have finished, please remain silent and allow the candidate that time for reflection. The surrogate should remain until the end of the 14-minute period.

A good candidate would be expected to take a history which includes a detailed social history and activities of daily living; and to particularly focus on the questions raised in the referral letter. At the end of the consultation the candidate should have discussed solutions to the problems posed by the case. A good candidate would also give the patient the opportunity to ask any further questions before closure. It is not necessary for candidates to agree a summary with the patient during their interview.

Examiners are encouraged to make a rough record of the candidate's consultation with the patient as it progresses. This may highlight omissions in history taking, ambiguities that remain unresolved, and additional points that were not 'in the script'.

The examiner is expected to ask the candidate whether they have formed a problem list or preferred diagnosis and answer the questions in the family doctor's letter. Following discussion of the answer to these questions the discussion should explore the issues raised.

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

Examiners are reminded that, during the calibration process, the surrogate should be rehearsed and specific aspects of the scenario that require clarification or emphasis should be discussed. 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.

NOT TO BE SEEN BY CANDIDATES

INFORMATION FOR EXAMINERS

Scenario No: Sample 6

Problem: Intermittent limb weakness
Candidate's role: The doctor in the medical outpatient department
Surrogate's role: The patient, Mrs Linda Hinds, a 53-year-old woman

Examiners are reminded the areas 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.

Differential Diagnosis (Clinical Skill D)

Plausible diagnoses:

- Lambert–Eaton myasthenic syndrome
- Myasthenia gravis
- Acute or chronic inflammatory demyelinating polyradiculopathy
- Dermatomyositis/polymyositis and Sjögren's syndrome
- Inclusion body myositis
- Spinal muscular atrophy

Candidates are not expected to suggest all of these differential diagnoses.

Clinical Communication Skills (Clinical Skill C)

- Obtains a history of fluctuating muscle weakness and recognises the likelihood that this is a neuromuscular problem
- Takes the history of dry mouth and postural hypotension, and is alert to the presence of autonomic nerve involvement
- Takes the history of dry cough and weight loss, and is alert to the possibility of an underlying neoplasm

Managing Patients' Concerns (Clinical Skill F)

- Is able to address the patient's concerns

Clinical Judgement (Clinical Skill E)

- Discusses investigations – serum creatine kinase activity, chest X-ray and CT scan of chest, neurophysiological studies, anti-acetylcholine receptor antibodies, anti-voltage gated calcium channel antibodies

Maintaining Patient Welfare (Clinical Skill G)

See marksheet

PACES Station 2: HISTORY TAKING

Patient details: Mr Steve Wright, a 25-year-old man
Your role: You are the doctor in the acute medical admissions unit
Presenting complaint: Acute chest pain and vomiting

Please read the letter printed below. When the bell sounds, enter the room. You have 14 minutes to take a history from the patient, 1 minute to collect your thoughts and 5 minutes for discussion. You may make notes if you wish.

Referral text:

Dear Doctor,

Please would you see this patient, who has developed acute chest pain and nausea after vomiting following a student party last night. He is a temporary resident at my general practice health centre and I have no past medical history for him.

Although he looks unwell, his ECG was normal and general physical examination was unremarkable apart from a tachycardia.

Yours faithfully,

Your task is to interview the patient and, based on the history you obtain, construct a differential diagnosis and plan for investigation. You should explain these to the patient and answer any questions they may have.

DO NOT EXAMINE THE PATIENT

Any notes you make must be handed to the examiners at the end of the station.

PACES Station 2: HISTORY TAKING

Your role: You are the patient, Mr Steve Wright, a 25-year-old man
Location: The acute medical admissions unit

History of presenting symptoms

Information to be volunteered at the start of the consultation
Last night you went to a student party with your girlfriend.

After leaving the party at 02:00 h, you ate some takeaway food and, about half an hour later, vomited a couple of times in the street. After retching, you then noticed rather severe pain in the centre of your chest, which was worse on breathing.

Information to be given *if asked*
Although the chest pain settled a bit, it was still bad enough to stop you sleeping. Despite taking paracetamol and ibuprofen, you are still in pain, which is worse when you take a deep breath. You also feel rather sick and sweaty, and now find it a bit difficult to swallow.

At the party, you drank a bottle of wine, having already consumed four bottles of lager in the pub beforehand. You also took an ecstasy tablet when you arrived at the party and smoked a couple of cannabis joints. You do not take cocaine.

Background information

Past medical and surgical history
None relevant.

Other complaints
None.

Medication record

Current medications
You take no regular medications.

Relevant previous medications
None.

Allergies and adverse reactions
You are allergic to penicillin, which makes you come out in a rash and wheeze.

Personal history

Lifestyle
You smoke 10 cigarettes per day, drink 5–6 bottles of lager at the weekends and use ecstasy and cannabis at parties when you can afford it. You do not take cocaine.

Social and personal circumstances

You live in a flat with your girlfriend, who is a student nurse.

Occupational history
You left school at the age of 17 with no qualifications. You do some manual building work when this is available but recently you have been unemployed and relying on state benefits.

Travel history
None relevant.

Family history
Your parents are divorced and you have very little to do with them although you do see your 14-year-old brother occasionally. All the family seem well although you remember that your dad had a heart attack about 5 or 6 years ago.

Patient's concerns, expectations and wishes
Having taken an ecstasy tablet, you are worried you have done something to your heart because you read that it can affect your blood pressure. You suppose your worries are partly because you are conscious of what happened to your dad, who had heart disease.

You have some specific questions for the doctor at this consultation:

- What is the cause of the pain – could it be a heart attack?
- Is it serious?
- Why am I finding it difficult to swallow?
- Why haven't the painkillers helped?

PACES Station 2: HISTORY TAKING

DATE	CYCLE

Examiners should advise candidates when there are 2 minutes remaining (i.e. after 12 minutes). 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 whether they have finished. If they have finished, please remain silent and allow the candidate that time for reflection. The surrogate should remain until the end of the 14-minute period.

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Examiners are encouraged to make a rough record of the candidate's consultation with the patient as it progresses. This may highlight omissions in history taking, ambiguities that remain unresolved, and additional points that were not 'in the script'.

The examiner is expected to ask the candidate whether they have formed a problem list or preferred diagnosis and answer the questions in the family doctor's letter. Following discussion of the answer to these questions the discussion should explore the issues raised.

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

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NOT TO BE SEEN BY CANDIDATES

INFORMATION FOR EXAMINERS

Scenario No: Sample 7

Problem: Acute chest pain and vomiting
Candidate's role: The doctor in the acute medical admissions unit
Surrogate's role: The patient, Mr Steve Wright, a 25-year-old man

Examiners are reminded the areas 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.

Differential Diagnosis (Clinical Skill D)

Probable diagnosis:

- Oesophageal tear and haematoma

Plausible alternative diagnoses:

- Spontaneous pneumothorax
- Oesophageal reflux/oesophagitis
- Oesophageal rupture

Clinical Communication Skills (Clinical Skill C)

- Obtains a history of the temporal relationship of the pain to the vomiting
- Notes the lifestyle issues relating to drug and alcohol use
- Documents the patient's significant allergy to penicillin

Managing Patients' Concerns (Clinical Skill F)

- Identifies and addresses the patient's concerns
- Is clearly reassuring

Clinical Judgement (Clinical Skill E)

- Develops a management plan focusing on chest X-ray, cautious endoscopy or water-soluble contrast-medium swallow, with the reassurance that an oesophageal tear and haematoma should resolve spontaneously

Maintaining Patient Welfare (Clinical Skill G)

See marksheet

PACES Station 2: HISTORY TAKING

Patient details: Mrs Heba Kamel, a 54-year-old woman
Your role: You are the doctor in the general medical outpatient clinic
Presenting complaint: Progressively worsening dyspnoea

Please read the letter printed below. When the bell sounds, enter the room. You have 14 minutes to take a history from the patient, 1 minute to collect your thoughts and 5 minutes for discussion. You may make notes if you wish.

Referral text:

Dear Doctor,

This patient, who is a retired nurse, has had progressively worsening dyspnoea for the past 18 months. She has a history of recurrent urinary tract infections and is taking long-term antibiotic therapy.

She smokes 20 cigarettes per day and has done so for the past 20 years. She has no past respiratory history.

She has hypertension and examination showed definite bibasal crackles on auscultation of the chest. Full blood count and urea, and electrolytes were normal. Her ECG shows right bundle branch block

I would be grateful if would see this patient and advise on her management.

Yours faithfully,

Your task is to interview the patient and, based on the history you obtain, construct a differential diagnosis and plan for investigation. You should explain these to the patient and answer any questions they may have.

DO NOT EXAMINE THE PATIENT

Any notes you make must be handed to the examiners at the end of the station.

PACES Station 2: HISTORY TAKING

Your role: You are the patient, Mrs Heba Kamel, a 54-year-old woman
Location: The general medical outpatient clinic

History of presenting symptoms

Information to be volunteered at the start of the consultation

You have had progressively worsening breathlessness over the past 18 months. Now you get breathless after walking about 100 m on the flat, or after doing housework such as vacuuming.

Information to be given *if asked*

The breathlessness does not get worse at night and you sleep with one pillow. You have not had any chest pain, palpitations, cough or ankle swelling. Your sputum is normal and you have never coughed up blood. You have had no wheeze.

Background information

Past medical and surgical history

Your past history includes high blood pressure, varicose vein surgery and recurrent urinary tract infections. You have been told that you have an abnormal heart tracing but you do not think you have any heart problems.

Other complaints

Your only other symptoms are nocturnal leg cramps and occasional flushes. You sometimes get constipated but this does not bother you.

Medication record

Current medications

You have been taking bendroflumethiazide 2.5 mg daily and lisinopril 20 mg daily for your hypertension for a few years. Your doctor prescribed an antibiotic for your urinary tract infections 10 years ago and you take this regularly, the dose being 50 mg at night. You cannot remember its name.

Allergies and adverse reactions

You are allergic to Elastoplast®.

Personal history

Lifestyle

You smoke 20 cigarettes per day and have done so for the past 20 years. You do not like the taste of alcohol so you do not drink.

Social and personal circumstances

You are a retired nurse (you retired to act as a carer for your son). Your husband is a mechanic and has diabetes mellitus. He also had tuberculosis as a child. You have two sons: the eldest also has diabetes but this is well controlled and he is now at university. Your youngest son has cerebral palsy and still lives at home. You have a dog.

NOT TO BE SEEN BY CANDIDATES

INFORMATION FOR THE SURROGATE

Scenario No: Sample 8

Your eldest son keeps pigeons and you have been looking after them for the past few years when he is away at university or at weekends. This usually involves feeding them and cleaning out their cages a few days each month, several months a year.

Travel history
You have never been abroad.

Family history
Your mother died of breast cancer at the age of 72, and your father had angina and died of a stroke when he was 77.

Patient's concerns, expectations and wishes
Your breathlessness now makes it more difficult to care for your youngest son, which concerns you.

You have some specific questions for the doctor at this consultation:

- What could be causing my symptoms?
- Could it be related to my smoking?
- Will it get worse and interfere with my ability to care for my son?

PACES Station 2: HISTORY TAKING

DATE	CYCLE

Examiners should advise candidates when there are 2 minutes remaining (i.e. after 12 minutes). 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 whether they have finished. If they have finished, please remain silent and allow the candidate that time for reflection. The surrogate should remain until the end of the 14-minute period.

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

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NOT TO BE SEEN BY CANDIDATES

INFORMATION FOR EXAMINERS

Scenario No: Sample 8

Problem: Progressively worsening dyspnoea
Candidate's role: The doctor in the general medical outpatient clinic
Surrogate's role: The patient, Mrs Heba Kamel, a 54-year-old woman

Examiners are reminded the areas 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.

Differential Diagnosis (Clinical Skill D)

Probable diagnosis:

- Nitrofurantoin-induced pulmonary fibrosis

Plausible alternative diagnoses:

- Extrinsic allergic alveolitis
- Chronic obstructive pulmonary disease
- Chronic heart failure

Clinical Communication Skills (Clinical Skill C)

- Obtains sufficient information from the history to draw up a list of differential diagnoses
- Identifies risk factors

Managing Patients' Concerns (Clinical Skill F)

- Addresses patient's concerns

Clinical Judgement (Clinical Skill E)

Plans investigations including:

- chest X-ray
- ECG and echocardiogram
- pulmonary function tests
- high-resolution CT scan of chest
- immunological tests

Maintaining Patient Welfare (Clinical Skill G)

See marksheet

PACES Station 2: HISTORY TAKING

Patient details: Ms Donna Jones, a 47-year-old woman
Your role: You are the doctor in the general medical outpatient clinic
Presenting complaint: Fatigue

Please read the letter printed below. When the bell sounds, enter the room. You have 14 minutes to take a history from the patient, 1 minute to collect your thoughts and 5 minutes for discussion. You may make notes if you wish.

Referral text:

Dear Doctor,

I would be most grateful if you could see this patient, who presented with increasing fatigue over the past year. I checked her full blood count and she has a haemoglobin of 78 g/L (normal range [females]: 115–165; [males]: 130–180) with an MCV of 112 fL (normal range: 80–96).

I would be grateful if you would advise on her investigation and management.

Yours faithfully,

Your task is to interview the patient and, based on the history you obtain, construct a differential diagnosis and plan for investigation. You should explain these to the patient and answer any questions they may have.

DO NOT EXAMINE THE PATIENT

Any notes you make must be handed to the examiners at the end of the station.

PACES Station 2: HISTORY TAKING

Your role: You are the patient, Ms Donna Jones, a 47-year-old woman
Location: The general medical outpatient clinic

History of presenting symptoms

Information to be volunteered at the start of the consultation

You have been feeling increasingly tired, particularly over the past year. As a consequence, you have stopped going out so much and rather than walking to the shops, half a mile (about 1 km) away, you now tend to take the car. There have been times when you have felt rather breathless on walking up even relatively gentle inclines.

Information to be given *if asked*

You have had no headache, dizziness, nausea or vomiting. There is no history of abdominal pain or alteration in bowel habit, and you have not noticed any mouth ulceration or change in your weight.

Background information

Past medical and surgical history

You have never been notably unwell before. In particular, there is no history of any heart or chest problems. You were therefore very surprised when your family doctor told you that you have anaemia (a low blood count).

Medication record

Current medications

You are not prescribed any medication but because your father had a bowel tumour, a nurse friend had suggested taking a small dose of aspirin to prevent the chances of developing something similar. You have been doing this for the past 5 years.

Personal history

Lifestyle

You are a non-smoker. You drink a moderate amount of alcohol (approximately 15 units per week but mainly all at the weekend; equivalent to a bottle and a half of wine over the weekend), and have never drunk any more than that.

Social and personal circumstances

You have a generally good diet. You tend towards being almost vegetarian, with a good intake of fruit and vegetables, and little in the way of red meat.

Family history

Both your mother and grandmother had thyroid problems and you recall that a great-aunt had to wear a wig because of premature hair loss. Your father had bowel cancer.

Patient's concerns, expectations and wishes

You are anxious that your anaemia may be an indication of a more serious problem.

NOT TO BE SEEN BY CANDIDATES

INFORMATION FOR THE SURROGATE

Scenario No: Sample 9

You have some specific questions for the doctor at this consultation:

- What could be causing me to be anaemic?
- Could I have bowel cancer like my father, as I remember he too was anaemic?
- Could it be related to the aspirin I have been taking?
- What tests will I need to have?

PACES Station 2: HISTORY TAKING

DATE	CYCLE

Examiners should advise candidates when there are 2 minutes remaining (i.e. after 12 minutes). 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 whether they have finished. If they have finished, please remain silent and allow the candidate that time for reflection. The surrogate should remain until the end of the 14-minute period.

A good candidate would be expected to take a history which includes a detailed social history and activities of daily living; and to particularly focus on the questions raised in the referral letter. At the end of the consultation the candidate should have discussed solutions to the problems posed by the case. A good candidate would also give the patient the opportunity to ask any further questions before closure. It is not necessary for candidates to agree a summary with the patient during their interview.

Examiners are encouraged to make a rough record of the candidate's consultation with the patient as it progresses. This may highlight omissions in history taking, ambiguities that remain unresolved, and additional points that were not 'in the script'.

The examiner is expected to ask the candidate whether they have formed a problem list or preferred diagnosis and answer the questions in the family doctor's letter. Following discussion of the answer to these questions the discussion should explore the issues raised.

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

Examiners are reminded that, during the calibration process, the surrogate should be rehearsed and specific aspects of the scenario that require clarification or emphasis should be discussed. 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.

NOT TO BE SEEN BY CANDIDATES

INFORMATION FOR EXAMINERS

Scenario No: Sample 9

Problem: Fatigue
Candidate's role: The doctor in the general medical outpatient clinic
Surrogate's role: The patient, Ms Donna Jones, a 47-year-old woman

Examiners are reminded the areas 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.

Differential Diagnosis (Clinical Skill D)

Probable diagnosis:

- Pernicious anaemia

Plausible alternative diagnoses:

- Gastrointestinal disease
- Alcohol excess
- Dietary insufficiency

Clinical Communication Skills (Clinical Skill C)

- Obtains a history of symptomatic anaemia
- Identifies a significant family history of autoimmune disease

Managing Patients' Concerns (Clinical Skill F)

- Addresses patient's concerns

Clinical Judgement (Clinical Skill E)

- Indicates a likely diagnosis and explains further investigations for this (antibody tests and possible Schilling test)
- Indicates likely treatment options with parenteral vitamin B12 supplementation.

Maintaining Patient Welfare (Clinical Skill G)

See marksheet

PACES Station 2: HISTORY TAKING

Patient details: Miss Lily Kwan, a 28-year-old woman
Your role: You are the doctor in the general medical outpatient clinic
Presenting complaint: Diarrhoea and weight loss

Please read the letter printed below. When the bell sounds, enter the room. You have 14 minutes to take a history from the patient, 1 minute to collect your thoughts and 5 minutes for discussion. You may make notes if you wish.

Referral text:

Dear Doctor,

Thank you for seeing this patient who presented to my general practice health centre complaining of a 1-month history of diarrhoea and weight loss.

On examination, she had a soft and non-tender abdomen. Rectal examination was normal. I have taken routine blood tests including full blood count, urea and electrolytes and glucose, which have all been normal. Furthermore, urine culture showed no growth.

She is otherwise well with no past medical history and is not taking any regular medication. She works as an IT consultant.

I would be grateful for any advice on the possible diagnosis and immediate management.

Yours faithfully,

Your task is to interview the patient and, based on the history you obtain, construct a differential diagnosis and plan for investigation. You should explain these to the patient and answer any questions they may have.

DO NOT EXAMINE THE PATIENT

Any notes you make must be handed to the examiners at the end of the station.

PACES Station 2: HISTORY TAKING

Your role: You are the patient, Miss Lily Kwan, a 28-year-old woman
Location: The general medial outpatient clinic

History of presenting symptoms

Information to be volunteered at the start of the consultation

You have been feeling generally unwell for about 3 months. Over the past month you have developed diarrhoea, which is loose but formed stool, with no blood or mucus. If asked, the stool does not float in the pan and is not offensive smelling.

You open your bowels approximately 5–6 times per day and occasionally need to open your bowels once at night. You have no urinary symptoms of any sort.

You have also noticed that you have lost weight unintentionally, having dropped from a UK size 12 to a size 10 in the past 3 months. You do not weigh yourself so you cannot comment on the exact weight loss.

Your appetite has not been affected and, in fact, you feel that, if anything, you seem to be eating more than usual.

Information to be given *if asked*

Your periods have become erratic over the last 6 months with only occasional, scanty blood loss. You feel warm and sweaty a lot of the time and have not enjoyed the recent warm weather, which is unusual for you. Recently, your hands feel somewhat 'shaky', and sometimes your writing has been difficult to read. You have not noticed any problems with your eyes and have not developed any skin rashes. You wonder if your neck has become a little swollen.

Background information

Past medical and surgical history

You have otherwise always been well. You have only been to hospital once before, for a termination of pregnancy at the age of 19. You do not take any prescribed medication, but have been taking vitamin supplements recently. You have no allergies.

Medication record

Current medications

None.

Personal history

Lifestyle

You smoke 5–10 cigarettes a day. If asked, admit to occasionally smoking cannabis. You drink about two gins and tonic a day (if asked, you pour yourself a generous measure).

Social and personal circumstances

You live with your partner and have been trying to start a family recently.

Occupational history
You work as an IT consultant.

Family history
Both your parents died in their eighties. Your father had a heart attack, and your mother had colon cancer. There is no family history of inflammatory bowel disease or coeliac disease.

Patient's concerns, expectations and wishes
You are concerned that you may have cancer because your mother had diarrhoea and lost weight before she was diagnosed with cancer. You also have concerns about your fertility, which is causing some friction between you and your partner.

PACES Station 2: HISTORY TAKING

DATE	CYCLE

Examiners should advise candidates when there are 2 minutes remaining (i.e. after 12 minutes). 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 whether they have finished. If they have finished, please remain silent and allow the candidate that time for reflection. The surrogate should remain until the end of the 14-minute period.

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

Examiners are reminded that, during the calibration process, the surrogate should be rehearsed and specific aspects of the scenario that require clarification or emphasis should be discussed. 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.

NOT TO BE SEEN BY CANDIDATES

INFORMATION FOR EXAMINERS

Scenario No: Sample 10

Problem: Diarrhoea and weight loss
Candidate's role: The doctor in the general medical outpatient clinic
Surrogate's role: The patient, Miss Lily Kwan, a 28-year-old woman

Examiners are reminded the areas 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.

Differential Diagnosis (Clinical Skill D)

Probable diagnosis:

- Thyrotoxicosis

Clinical Communication Skills (Clinical Skill C)

- Collects information regarding the nature of the diarrhoea, specifically history consistent with fast transit and not with inflammatory change or malabsorption
- Elucidates weight loss in the context of increased appetite and neck swelling
- Clarifies diagnosis, noting:
    - Tremor
    - Heat intolerance
    - Oligomenorrhoea
    - Neck swelling
    - Eye problems
    - Skin rashes

Managing Patients' Concerns (Clinical Skill F)

- Explores and addresses the patient's concerns

Clinical Judgement (Clinical Skill E)

- Plans investigations that must include thyroid function tests
- Discusses likely initial management plan: block (carbimazole) and replace (with levothyroxine when euthyroid); β-adrenoceptor blockers for temporary symptomatic relief

Maintaining Patient Welfare (Clinical Skill G)

See marksheet

PACES Station 2: HISTORY TAKING

Patient details: Mr John Davidson, a 25-year-old man
Your role: You are the doctor in the medical admissions unit
Presenting complaint: Fever

Please read the letter printed below. When the bell sounds, enter the room. You have 14 minutes to take a history from the patient, 1 minute to collect your thoughts and 5 minutes for discussion. You may make notes if you wish.

Referral text:

Dear Doctor,

Thank you for seeing this normally fit and well patient whom I have not seen before. He complains of sweats and rigors, headache, sore throat and generalised myalgia. This started abruptly last night.

On examination, he is febrile (39.0°C), sweaty and tachycardic (105 beats per minute). I am concerned because he is mildly photophobic, although I am not convinced he has neck stiffness. There is no rash.

I am concerned that he may have meningitis and would value your opinion.

Yours faithfully,

Your task is to interview the patient and, based on the history you obtain, construct a differential diagnosis and plan for investigation. You should explain these to the patient and answer any questions they may have.

DO NOT EXAMINE THE PATIENT

Any notes you make must be handed to the examiners at the end of the station.

PACES Station 2: HISTORY TAKING

Your role:
Location:

History of presenting symptoms

Information to be volunteered at the start of the consultation

You went to see your family doctor this morning whom you have not seen before. You were well until last night when you became somewhat achey, shivery and tired. You had an early night but awoke this morning with a generalised headache, sore throat and aching all over, especially in your back.

Your family doctor mentioned that you might have meningitis and has referred you.

Information to be given *if asked*

You feel hot and sweaty yet at other times cannot keep warm, and have had some shaking episodes and drenching sweats.
You do not like bright lights which irritate your eyes and head.
You confirm that one or two people in the office have been off with a similar illness recently.

Background information

Past medical and surgical history

None relevant.

Other complaints

None.

Medication record

Current medications

None.

Relevant previous medications

None.

Allergies and adverse reactions

None known.

Personal history

Lifestyle

You are usually well and are an active gym member. You have never smoked but you do enjoy a couple of glasses of wine in the evening.

Social and personal circumstances

You are married; you do not have any children.

Occupational history

NOT TO BE SEEN BY CANDIDATES

INFORMATION FOR THE SURROGATE

Scenario No: Sample 11

You work in IT in the accounts department of a local business.

Travel history
You had a safari holiday 3 months ago in Tanzania. **If asked,** you did not take the malaria pills suggested.

Family history
Your parents are alive and well.

Patient's concerns, expectations and wishes
You feel dreadful and wish to be better and more comfortable. You are naturally very worried at the mention of possible meningitis by your family doctor.

You have some specific questions for the doctor at this consultation:

- Have I got meningitis?
- When will I get some antibiotics?
- What can you do to make me feel better now?

PACES Station 2: HISTORY TAKING

DATE	CYCLE

Examiners should advise candidates when there are 2 minutes remaining (i.e. after 12 minutes). 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 whether they have finished. If they have finished, please remain silent and allow the candidate that time for reflection. The surrogate should remain until the end of the 14-minute period.

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Examiners are encouraged to make a rough record of the candidate's consultation with the patient as it progresses. This may highlight omissions in history taking, ambiguities that remain unresolved, and additional points that were not 'in the script'.

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

Examiners are reminded that, during the calibration process, the surrogate should be rehearsed and specific aspects of the scenario that require clarification or emphasis should be discussed. 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.

NOT TO BE SEEN BY CANDIDATES

INFORMATION FOR EXAMINERS

Scenario No: Sample 11

Problem: Fever
Candidate's role: The doctor in the medical admissions unit
Surrogate's role: The patient, Mr John Davidson, a 25-year-old man

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Differential Diagnosis (Clinical Skill D)

Probable diagnosis:

- Influenza

Plausible alternative diagnoses:

- Meningitis
- Sepsis from another cause; for example, atypical pneumonia, urinary tract infection
- Malaria

Clinical Communication Skills (Clinical Skill C)

- Obtains history of abrupt onset of classic influenzal symptoms

Managing Patients' Concerns (Clinical Skill F)

- Explains the necessary investigations
- Explains carefully the likely diagnosis
- Issues reassurance about treatment and outcome

Clinical Judgement (Clinical Skill E)

- Discusses management and appropriate investigations to include blood tests i.e. full blood count, serum C-reactive protein, urea and electrolytes, liver function tests, blood cultures, thick and thin films; as well as urinalysis and chest X-ray
- Considers whether or not lumbar puncture is really necessary; willing to seek senior advice
- Administers paracetamol or similar, considers fluid balance
- Allows home if satisfied it is not meningitis or sepsis of other cause

Maintaining Patient Welfare (Clinical Skill G)

See marksheet

PACES Station 2: HISTORY TAKING

Patient details: Mrs Erica Phillips, a 30-year-old woman
Your role: You are the doctor in the acute medical unit
Presenting complaint: Night sweats and pyrexia

Please read the letter printed below. When the bell sounds, enter the room. You have 14 minutes to take a history from the patient, 1 minute to collect your thoughts and 5 minutes for discussion. You may make notes if you wish.

Referral text:

Dear Doctor,

Please can you see this patient who has a 4-week history of nocturnal sweats and pyrexia. She has been treated with two courses of antibiotics for a suspected urosepsis but her symptoms are persisting. She has a history of congenital aortic valve disease and is reviewed annually for this.

Please can you review her and organise further investigations.

Yours faithfully,

Your task is to interview the patient and, based on the history you obtain, construct a differential diagnosis and plan for investigation. You should explain these to the patient and answer any questions they may have.

DO NOT EXAMINE THE PATIENT

Any notes you make must be handed to the examiners at the end of the station.

PACES Station 2: HISTORY TAKING

Your role: You are the patient, Mrs Erica Phillips, a 30-year-old woman
Location: The acute medical unit

History of presenting symptoms

Information to be volunteered at the start of the consultation

You have been feeling unwell for the last 4 weeks, with drenching night sweats, and have been to your family practitioner twice. You have taken two courses of antibiotics. Although the last course of antibiotics has made you feel marginally better, you are still having this excessive sweating every night.

Information to be given *if asked*

You have never had symptoms like this before.
You have never felt this unwell.
You feel generally fatigued.
You feel more short of breath.
Your appetite has been reduced and you have lost about 5 kg (about 11 lbs) in weight over the last 6 weeks.
Over the last week, you have started to feel some pain in the upper left side of your abdomen.
You do not have any pain on passing urine and you have not had to pass urine more frequently than usual. However, you have noticed that your urine is darker than normal.
You have not had any cough, headache, sore throat, earache, diarrhoea, or vomiting.
You have not felt any abnormal lumps anywhere.

Background information

Past medical and surgical history

You were born with a defect in the aortic valve (bicuspid valve).
You had a procedure to widen the valve (balloon angioplasty) at the age of 3 years.
You had a mechanical aortic valve replacement 5 years ago.
You get followed up annually and are stable.
You are usually fit and well apart from this heart condition.

Other complaints

None.

Medication record

Current medications

You take warfarin for your valve replacement.
Your blood clotting tests (international normalised ratio or INR) have been well controlled.
You do not take any oral contraception.

Relevant previous medications

Your family doctor prescribed two courses of antibiotics for suspected urinary tract infection:

- trimethoprim (first course)

- cefotaxime (second course)

Allergies and adverse reactions
You are allergic to penicillin.

Personal history

Lifestyle
You do not smoke.
You do not drink alcohol.
You have never used recreational drugs.

Social and personal circumstances
You are married and live with your spouse.

Occupational history
You work in a call centre.

Travel history
You went on holiday to the Algarve last year.
You have never travelled to the tropics or to Africa, South America, or Asia.

Family history
Your father also had an aortic valve replacement.
Your mother is fit and well.

Patient's concerns, expectations and wishes
You are worried about why you are not getting better despite antibiotic treatment.

You have some specific questions for the doctor at this consultation:

- What do you think is wrong with me?
- What tests do you think I need?

PACES Station 2: HISTORY TAKING

DATE	CYCLE

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NOT TO BE SEEN BY CANDIDATES

INFORMATION FOR EXAMINERS

Scenario No: Sample 12

Problem: Night sweats and pyrexia
Candidate's role: The doctor on the acute medical unit
Surrogate's role: The patient, Mrs Erica Phillips, a 30-year-old woman

Examiners are reminded the areas 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.

Differential Diagnosis (Clinical Skill D)

Probable diagnosis:

- Prosthetic valve endocarditis

Plausible alternative diagnoses:

- Lymphoproliferative disorder
- Other infection caused by a multiresistant organism
- Deep-seated infection

Clinical Communication Skills (Clinical Skill C)

- Clearly identifies that endocarditis is the probable diagnosis
- Elicits history which is typical for endocarditis
- Clearly explains to the patient that the possibility of endocarditis needs exclusion as a priority

Managing Patients' Concerns (Clinical Skill F)

- Is able to explain the potential differential diagnoses

Clinical Judgement (Clinical Skill E)

- Understands the link between dental treatment and endocarditis, and the importance of regular dental care
- Understands the link between any infection and possible endocarditis
- Understands the necessity to stop antibiotics and obtain at least three sets of blood cultures
- Expedites echocardiography/cardiology review
- Describes where to obtain local antibiotic guidelines for treatment of prosthetic valve endocarditis
- Knows that prosthetic valve endocarditis will require intravenous antibiotic treatment for at least 6 weeks and probably valvular replacement
- Remembers to obtain a pregnancy test (for female surrogate)

Maintaining Patient Welfare (Clinical Skill G)

See marksheet

PACES Station 2: HISTORY TAKING

Patient details: Mrs Patricia Wilson, a 49-year-old woman
Your role: You are the doctor in the medical admissions unit
Presenting complaint: Chest pain

Please read the letter printed below. When the bell sounds, enter the room. You have 14 minutes to take a history from the patient, 1 minute to collect your thoughts and 5 minutes for discussion. You may make notes if you wish.

Referral text:

Dear Doctor,

This patient presented to the emergency department with a 20-minute history of central chest pain. Examination is unremarkable and her ECG is normal.

Please advise on further investigation and management.

Yours faithfully,

Your task is to interview the patient and, based on the history you obtain, construct a differential diagnosis and plan for investigation. You should explain these to the patient and answer any questions they may have.

DO NOT EXAMINE THE PATIENT

Any notes you make must be handed to the examiners at the end of the station.

PACES Station 2: HISTORY TAKING

Your role: You are the patient, Mrs Patricia Wilson, a 49-year-old woman
Location: The medical admissions unit

History of presenting symptoms

Information to be volunteered at the start of the consultation

Two hours ago, you were walking home after lunch in a restaurant with your daughter when you developed central chest pain with some discomfort in the upper stomach. The pain was associated with a heavy feeling in your left arm, and nausea. You sat down and the pain eased a bit but returned when you started to walk again and you decided to go home. After the first few minutes of severe pain, the pain was constant and unpleasant but not unbearable, and it eased off completely after about 20 minutes. You now feel well and think this might have been your gallstones playing up.

Information to be given *if asked*

You did not feel sweaty or breathless with the pain. Your daughter said you looked pale and insisted on bringing you to the hospital on the way home.

Background information

Past medical and surgical history

About 5 years ago, you experienced similar pain after meals and were found to have gallstones on an ultrasound scan arranged by your family doctor. You did not want to have your gallbladder removed at the time. This has not caused you any recent problems.

You had a varicose vein stripping 15 years ago.
You suffered from pneumonia when you were 23 years old.

Other complaints

Your periods seem to be stopping and you are experiencing quite bad flushing. You have never had hormone replacement treatment.

Medication record

Current medications

You currently do not take any prescribed medications; you do, however, take a vitamin preparation that you buy from the chemist.

Relevant previous medications

You took the oral contraceptive pill on and off for about 10 years between the ages of 25 and 40.

Allergies and adverse reactions

None known.

Personal history

Lifestyle

You smoke 10 cigarettes per day and have done since the age of 25. You drink alcohol infrequently – really only at special events. You have never used recreational drugs. You regard yourself as fairly fit as you walk to school and back every day (a distance of about a mile, or 1 km) and you are on the go all day at school. While you are still able to walk to school, you think you may be experiencing some breathlessness taking the stairs in the school. You do housework and look after a big garden without any difficulty but you do not take formal exercise. You eat a healthy diet. You want to lose weight but are finding it difficult.

Social and personal circumstances

You are married and have two grown-up daughters. In your spare time, you are secretary of the local community council and you run a successful social club. You have no pets. You do not have any particular worries or stresses at the moment.

Occupational history

You are a primary-school teacher. You enjoy your work.

Travel history

You have not travelled out of the country in recent years.

Family history

Both parents are alive: your mother is in her seventies and is prone to chest infections but is otherwise well. Your father, also in his seventies, has high blood pressure and you think he had a heart attack in his mid-fifties. You have two older brothers and have just found out that one of them has high cholesterol.

Patient's concerns, expectations and wishes

You think that this pain is from your gallstones and wonder if you should now consider an operation. However, the nurse in the emergency department said it could have been from your heart, and you are keen to know if the doctor thinks that is the case. You want to know what further tests will be required, and if you will need to stay in hospital.

You have some specific questions for the doctor at this consultation:

- Was this pain from my gallstones? Should I have an operation to remove them?
- I heard someone say it could have been my heart but my ECG is normal so how could this have been a heart attack?
- I feel better now; can I go home?
- What further tests are required?

PACES Station 2: HISTORY TAKING

DATE	CYCLE

Examiners should advise candidates when there are 2 minutes remaining (i.e. after 12 minutes). 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 whether they have finished. If they have finished, please remain silent and allow the candidate that time for reflection. The surrogate should remain until the end of the 14-minute period.

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NOT TO BE SEEN BY CANDIDATES

INFORMATION FOR EXAMINERS

Scenario No: Sample 13

Problem: Chest pain
Candidate's role: The doctor in the medical admissions unit
Surrogate's role: The patient, Mrs Patricia Wilson, a 49-year-old woman

Examiners are reminded the areas 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.

Differential Diagnosis (Clinical Skill D)

Probable diagnosis:

- Angina or non-ST-elevation myocardial infarction (despite the 'normal' ECG)

Plausible alternative diagnosis:

- Biliary disease
- Dyspepsia (gastrooesophageal reflux/spasm)

Clinical Communication Skills (Clinical Skill C)

- Obtains a clear history of events, notes there is no abdominal tenderness to support a gastrointestinal cause of symptoms
- Establishes the vascular risk factors
- Explains the need to investigate for a potentially serious condition

Managing Patients' Concerns (Clinical Skill F)

- Offers a plausible differential diagnosis
- Outlines a reasonable plan of investigation and treatment

Clinical Judgement (Clinical Skill E)

- Investigates further for the possibility of ischaemic heart disease: arranges for cardiac markers (e.g. serum troponin, serum creatine kinase MB fraction etc.) and further ECGs before the patient is discharged (i.e. safe practice)
- Addresses smoking cessation

Maintaining Patient Welfare (Clinical Skill G)

See marksheet

PACES Station 2: HISTORY TAKING

Patient details: Mrs Julia Coles, a 40-year-old woman
Your role: You are the doctor in the outpatient clinic
Presenting complaint: Joint pain

Please read the letter printed below. When the bell sounds, enter the room. You have 14 minutes to take a history from the patient, 1 minute to collect your thoughts and 5 minutes for discussion. You may make notes if you wish.

Referral text:

Dear Doctor,

This patient has pain in her hands on exposure to cold. She also has paresthaesia in her hands and complains of joint pain. Her full blood count and kidney function were normal. Her serum C-reactive protein was 10 mg/L (normal range: <10)

I would be grateful if you can investigate and advise.

Yours faithfully,

Your task is to interview the patient and, based on the history you obtain, construct a differential diagnosis and plan for investigation. You should explain these to the patient and answer any questions they may have.

DO NOT EXAMINE THE PATIENT

Any notes you make must be handed to the examiners at the end of the station.

PACES Station 2: HISTORY TAKING

Your role: You are the patient, Mrs Julia Coles, a 40-year-old woman
Location: The outpatient clinic

History of presenting symptoms

Information to be volunteered at the start of the consultation

For the last 2 years, you have noticed that your hands are painful particularly in the cold weather. Over the course of the last year, your symptoms have become troublesome; for example, simply opening the freezer is triggering your symptoms.

Information to be given *if asked*

Your fingers turn white then blue then red when they are painful. You have not developed any skin damage. Your family doctor advised you to keep your hands warm by wearing gloves, which partially helped, but your symptoms are now worsening.

Over the course of the last year, you have also developed swelling in the fingersand pain in multiple joints. The joint pain started in your ankles and then your knees became painful but not swollen. Then your hands have become swollen and you had to have a new wedding ring made. You struggle to make a fist.

You have 'pins and needles' in your hands waking you up at night occasionally. Your family doctor has prescribed tablets (pregabalin).

You have shortness of breath on mild exertion, You can walk 100 m (about 100 yards) then start to be short of breath. You have no cough or chest pain. You use one pillow at night.

You have not had any sensitivity to light or sunlight, no hair loss, no mouth ulcers, no genital ulcers, no rash, no blood clots in your leg or lungs, and have not had any miscarriages and your periods are normal. You have occasional indigestion but no difficulty in swallowing.

You do not have a history of psoriasis. You have experienced no change in bowel habits, no red eyes or urinary symptoms.

You feel exhausted.

Background information

Past medical and surgical history

You previously had post-viral fatigue.
You also have depression, for which you take citalopram (see below).

Other complaints

None.

Medication record

Current medications

- citalopram 20 mg once daily
- pregabalin 150 mg three times daily (for pain)

Relevant previous medications

None.

Allergies and adverse reactions

None known.

Personal history

Lifestyle

You do not smoke or drink alcohol.

Social and personal circumstances

You live with your husband and two young children.

Occupational history

You teach at a primary school.
You have been off sick for 4 weeks .

Travel history

You prefer to travel to warm places, because of your hands, and last year you went to Egypt and you enjoyed it. Your hands were good during the trip.

Family history

Your parents are well.

Patient's concerns, expectations and wishes

You want to know what is causing these symptoms and whether or not it is a serious problem.

You have some specific questions for the doctor at this consultation:

- Will the hand symptoms get worse?
- Will I be able to continue my work as a teacher?
- What is the cause of my symptoms?

PACES Station 2: HISTORY TAKING

DATE	CYCLE

Examiners should advise candidates when there are 2 minutes remaining (i.e. after 12 minutes). 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 whether they have finished. If they have finished, please remain silent and allow the candidate that time for reflection. The surrogate should remain until the end of the 14-minute period.

A good candidate would be expected to take a history which includes a detailed social history and activities of daily living; and to particularly focus on the questions raised in the referral letter. At the end of the consultation the candidate should have discussed solutions to the problems posed by the case. A good candidate would also give the patient the opportunity to ask any further questions before closure. It is not necessary for candidates to agree a summary with the patient during their interview.

Examiners are encouraged to make a rough record of the candidate's consultation with the patient as it progresses. This may highlight omissions in history taking, ambiguities that remain unresolved, and additional points that were not 'in the script'.

The examiner is expected to ask the candidate whether they have formed a problem list or preferred diagnosis and answer the questions in the family doctor's letter. Following discussion of the answer to these questions the discussion should explore the issues raised.

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

Examiners are reminded that, during the calibration process, the surrogate should be rehearsed and specific aspects of the scenario that require clarification or emphasis should be discussed. 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.

NOT TO BE SEEN BY CANDIDATES

INFORMATION FOR EXAMINERS

Scenario No: Sample 14

Problem: Joint pain
Candidate's role: The doctor in the outpatient clinic
Surrogate's role: The patient, Mrs Julia Coles, a 40-year-old woman

Examiners are reminded the areas 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.

Differential Diagnosis (Clinical Skill D)

Probable diagnosis:

- Raynaud's phenomenon

Plausible alternative diagnoses:

- Limited systemic sclerosis
- Mixed connective tissue disorder

Clinical Communication Skills (Clinical Skill C)

- Listens to the patient, and takes detailed history of the symptoms and asks about the relevant symptoms

Managing Patients' Concerns (Clinical Skill F)

- Addresses the patient's concerns

Clinical Judgement (Clinical Skill E)

- Considers the differential diagnoses
- Requests investigations including: full blood count, urea and electrolytes, liver function tests, serum C-reactive protein, antinuclear antibodies, anti-double-stranded DNA antibodies, anti-neutrophil cytoplasmic antibodies, rheumatoid factor, extractable nuclear antigen antibodies (includes anticentromere antibodies, anti-Scl-70 antibodies and anti–RNP antibodies); pulmonary function tests and echocardiography
- If the diagnosis of systemic sclerosis is proven, vasodilators can be used e.g. nifedipine can be given to alleviate the hand symptoms; considers patient referral to a rheumatologist

Maintaining Patient Welfare (Clinical Skill G)

See marksheet

PACES Station 2: HISTORY TAKING

Patient details: Mrs Caroline Riley, a 30-year-old woman
Your role: You are the doctor in the medical admissions unit
Presenting complaint: Drowsiness

Please read the letter printed below. When the bell sounds, enter the room. You have 14 minutes to take a history from the patient, 1 minute to collect your thoughts and 5 minutes for discussion. You may make notes if you wish.

Referral text:

Dear Doctor,

Please could you review this patient who has metastatic ovarian cancer. She has felt generally unwell and has been drowsier and intermittently confused over the past week. She is struggling to manage at home.

Unfortunately, I think she might be approaching the end of her life.

Yours faithfully,

Your task is to elicit a history, assess the person's views of their problems and clarify what matters most to them. You should construct a differential diagnosis and plan for investigation. Discuss your assessment and the medical options with the person and agree how best to proceed, answering any questions that are raised.

DO NOT EXAMINE THE PATIENT

Any notes you make must be handed to the examiners at the end of the station.

PACES Station 2: HISTORY TAKING

Your role: You are the patient, Mrs Caroline Riley, a 30-year-old woman
Location: The medical admissions unit

History of presenting symptoms

Information to be volunteered at the start of the consultation

You were found to have ovarian cancer about 5 years ago. You initially had an operation (to remove the ovaries and womb) and then you were given lots of cycles of chemotherapy. You were recently told that your disease has progressed and that further chemotherapy will not help. Your oncologist is looking for any trials that you can be involved in, but you have not had any chemotherapy for the past month. Despite this, you normally manage to take your children to school, do the housework and cooking, and care for yourself.

Over the past week, your health has significantly deteriorated and you have experienced progressive fatigue. You are now struggling to get out of bed and look after your children. You are sleeping during the day which is not normal for you. Your husband has told you that you have been sleepier and less communicative at times and you are finding it difficult to concentrate. You have become weaker.

Information to be given *if asked*

- You have felt nauseated at times. You have also vomited once or twice over the past week.
- You are not passing as much urine as usual.
- You have had some jerking of your hands and have spilled some drinks as a result of this.
- Your abdomen has been getting more swollen for a while, and your oncologist told you that this might be because of a build-up of fluid. He has talked about inserting a drain if this worsened.
- You have been constipated and have not opened your bowels for about 3 days.
- You were having pain in your abdomen as a result, and your family doctor prescribed naproxen twice daily 2 weeks ago. This pain has now improved. Usually, you need about 4 doses of morphine sulfate oral solution (Oramorph®) per day, but you have not taken any Oramorph® at all over the past 3 days.

Background information

Past medical and surgical history

You had a total abdominal hysterectomy and bilateral salpingo-oophorectomy (womb and both ovaries removed) 5 years ago. You have had five different chemotherapy medications since then.

Other complaints

None.

Medication record

Current medications

- paracetamol 1 g 4 times daily
- naproxen 500 mg twice daily
- morphine sulfate modified-release capsules 80 mg twice daily
- morphine sulfate oral solution (Oramorph®) 20 mg as needed

Relevant previous medications

You have not taken anything else since your last cycle of chemotherapy about 5 weeks ago.

Allergies and adverse reactions

None known.

Personal history

Lifestyle

You drive a car and need this to take your children to school.

Social and personal circumstances

You live with your husband and two young sons. You are normally independent and self caring but, as you have become more unwell over the past week, you have spent more time in bed and have been less able to manage at home. Your husband has taken time off work to look after you.

Occupational history

You are no longer working; before your cancer diagnosis, you worked as a secretary.

Travel history

None.

Family history

- Your mother had ovarian cancer and died at the age of 40.
- Your maternal aunt had breast cancer but was cured.
- Your father is alive and well.
- You have been tested for the *BRCA* gene mutation (a familial cause of breast and ovarian cancer) and found to be positive.

Patient's concerns, expectations and wishes

Your family doctor has told you that he thinks that your disease is progressing. You understand that you might be dying, but you are keen that everything possible is done to allow you more time with your children. You are concerned about your family and how they will manage if you die. You were managing well before last week, so this has happened quite quickly and you are shocked at the speed of your deterioration. You are easily fatigued and lethargic and would like to feel brighter and be able to look after your children. You are concerned about your nausea and constipation and would like these to be managed. You are pleased that your pain control is better than it had been.

NOT TO BE SEEN BY CANDIDATES

INFORMATION FOR THE SURROGATE

Scenario No: Sample 15

You have some specific questions for the doctor at this consultation:

- Am I dying?
- Can you make me feel better?
- Why have I deteriorated so quickly?

PACES Station 2: HISTORY TAKING

DATE	CYCLE

Examiners should advise candidates when there are 2 minutes remaining (i.e. after 12 minutes). 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 whether they have finished. If they have finished, please remain silent and allow the candidate that time for reflection. The surrogate should remain until the end of the 14-minute period.

A good candidate would be expected to take a history which includes a detailed social history and activities of daily living; and to particularly focus on the questions raised in the referral letter. At the end of the consultation the candidate should have discussed solutions to the problems posed by the case. A good candidate would also give the patient the opportunity to ask any further questions before closure. It is not necessary for candidates to agree a summary with the patient during their interview.

Examiners are encouraged to make a rough record of the candidate's consultation with the patient as it progresses. This may highlight omissions in history taking, ambiguities that remain unresolved, and additional points that were not 'in the script'.

The examiner is expected to ask the candidate whether they have formed a problem list or preferred diagnosis and answer the questions in the family doctor's letter. Following discussion of the answer to these questions, the discussion should explore the issues raised.

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

Examiners are reminded that, during the calibration process, the surrogate should be rehearsed and specific aspects of the scenario that require clarification or emphasis should be discussed. The sections 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.

NOT TO BE SEEN BY CANDIDATES

INFORMATION FOR EXAMINERS

Scenario No: Sample 16

Problem: Drowsiness
Candidate's role: The doctor in the medical admissions unit
Surrogate's role: The patient, Mrs Caroline Riley, a 30-year-old woman

Examiners are reminded that the sections 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.

Differential Diagnosis (Clinical Skill D)

Probable diagnosis:

- Opioid toxicity as a result of renal impairment – risk factors are a new NSAID and disease progression causing possible obstructive uropathy

Plausible alternative diagnosis:

- Hypercalcaemia
- Entering terminal phase of illness

Clinical Communication Skills (Clinical Skill C)

- Establishes a clear trajectory of rapid deterioration
- Explores the patient's understanding of her illness

Managing Patients' Concerns (Clinical Skill F)

- Explores the patient's wishes and expectations
- Explains the need to rule out reversible causes of deterioration

Clinical Judgement (Clinical Skill E)

- Suggests appropriate investigations including urea and electrolytes and serum calcium, and considers ultrasound scan of renal tract
- Plans management of potentially reversible causes of deterioration, and explains the next steps in a clear and concise manner
- Discusses referral to palliative care team and support available for family

Maintaining Patient Welfare (Clinical Skill G)

See marksheet.

PACES Station 2: HISTORY TAKING

Patient details: Mrs Janice Miller, a 30-year-old woman
Your role: You are the doctor in the general medical outpatient clinic
Presenting complaint: Fatigue and exhaustion

Please read the letter printed below. When the bell sounds, enter the room. You have 14 minutes to take a history from the patient, 1 minute to collect your thoughts and 5 minutes for discussion. You may make notes if you wish.

Referral text:

Dear Doctor,

I would value your opinion on this patient who recently presented to me complaining of exhaustion over the past 18 months.

Physical examination was normal except for her blood pressure, which was around 145–150/90 mmHg. Her serum urea and electrolytes were all normal, as were her liver function tests. The only abnormalities I found were a mild normocytic anaemia with a haemoglobin of 110 g/L (normal range: 115–165).

She is not taking any prescribed medication but has taken paracetamol from time to time.

I would value your opinion as to what is going on here.

Yours faithfully,

Your task is to elicit a history, assess the person's views of their problems and clarify what matters most to them. You should construct a differential diagnosis and plan for investigation. Discuss your assessment and the medical options with the person and agree how best to proceed, answering any questions that are raised.

DO NOT EXAMINE THE PATIENT

Any notes you make must be handed to the examiners at the end of the station.

PACES Station 2: HISTORY TAKING

Your role: You are the patient, Mrs Janice Miller, a 30-year-old woman
Location: The general medical outpatient clinic

History of presenting symptoms

Information to be volunteered at the start of the consultation

You have been troubled by increasing fatigue and exhaustion. You are not sleeping well, often waking early.

You have been crying quite a lot recently and have lost some weight – you think about 3 kg (6–7 lbs). You have been very worried about your symptoms. Your family doctor has examined you, carried out some blood tests and has referred you to the outpatient clinic. You are also aware that your blood pressure is slightly high.

Information to be given *if asked*

You have experienced numerous aches and pains, particularly in the smaller joints of your hands and feet, intermittently for the past 6 months. More recently these pains have increased. The pain is at its worst when you wake and lasts until lunchtime.

You have had a troublesome red rash affecting the bridge of your nose and your cheeks. This was most obvious last summer and has presently resolved. There was also a hint of a similar rash on the backs of your hands at that time. You have recently had recurring problems with mouth ulcers.

Last year you became pregnant, but lost the baby after about 10 weeks.

Background information

Past medical and surgical history

As a child you had measles, chickenpox and mumps. Eighteen months ago, you had a deep venous thrombosis or blood clot in your right leg, which required warfarin therapy for 6 months. A year ago you had a painful right elbow for about 2–3 weeks, which your doctor treated with painkillers.

Other complaints

None.

Medication record

Current medications

You are not using any contraception. You take paracetamol and occasional ibuprofen (Brufen®).

Relevant previous medications

None.

Allergies and adverse reactions

None known.

Personal history

Lifestyle

You have been married for 2 years. You do not smoke and you drink only at weekends (about three vodkas and a glass or two of wine). (The alcohol history should only be used if culturally appropriate.)

Social and personal circumstances

You have no money worries.

Occupational history

You have worked in a bank since leaving school. Your job occasionally involves moving files and boxes, which is sometimes painful, and your fingers hurt after a day of operating a keyboard.

Family history

You have one sister and both your parents are alive and well. There are no known illnesses in your family.

Concerns, expectations and wishes

Your symptoms are getting worse and you feel as though everything is going wrong. You sense your husband is becoming fed up with you and you are getting fed up with yourself too.

You have some specific questions for the doctor at this consultation:

- Why am I developing all these symptoms?
- Why do I feel so tired?
- Did I have the miscarriage because I am so run down?
- Is it ok for me to try to become pregnant again when I feel so low?

PACES Station 2: HISTORY TAKING

DATE	CYCLE

Examiners should advise candidates when there are 2 minutes remaining (i.e. after 12 minutes). 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 whether they have finished. If they have finished, please remain silent and allow the candidate that time for reflection. The surrogate should remain until the end of the 14-minute period.

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NOT TO BE SEEN BY CANDIDATES

INFORMATION FOR EXAMINERS

Scenario No: Sample 16

Problem:	Fatigue and exhaustion
Candidate's role:	The doctor in the general medical outpatient clinic
Surrogate's role:	The patient, Mrs Janice Miller, a 30-year-old woman

Examiners are reminded the areas 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.

Differential Diagnosis (Clinical Skill D)

Probable diagnoses:

- Systemic lupus erythematosus
- Other connective tissues disorders (e.g. primary antiphospholipid antibody syndrome)

Possible additional diagnosis:

- Depression

Clinical Communication Skills (Clinical Skill C)

- Obtains a history of fatigue and arthralgia
- Also obtains the relevant past history of hypertension, previous venous thrombosis, photosensitive rash, mouth ulcers and previous miscarriage

Managing Patients' Concerns (Clinical Skill F)

- Addresses the patient's concerns about their symptoms and explains the need for further investigation
- Advises avoidance of pregnancy until a clear diagnosis and management plan are in place

Clinical Judgement (Clinical Skill E)

- Proposes an appropriate plan of investigation and management that includes relevant autoantibody tests, lupus anticoagulant, and urine dipstick

Maintaining Patient Welfare (Clinical Skill G)

See marksheet.