

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.

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?

NOT TO BE USED IN THE EXAM

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.

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