MRCPUK

Membership of the Royal Colleges of Physicians of the United Kingdom

MRCP(UK) Guidelines for Station 5 scenarios

A guide to writing and vetting
PACES Station 5 scenarios

Contents

Guidelines for writing Station 5 scenarios

Background

The information in this guide is intended as an aid to Host Examiners and their teams in the preparation of scenarios for Station 5.

Station 5 is the Integrated Clinical Assessment station, designed to examine the candidates' ability to address a clinical problem using a combination of focused history taking, examination, and communication skills with a patient in a way that reflects daily clinical practice.

Candidates will see two cases known as 'Brief Clinical Consultations'. Each case lasts 10 minutes in total, with 8 minutes of candidate interaction with the patient. A brief summary of a clinical problem, as may be encountered 'on the acute medical take' or 'in the medical outpatient clinic' is presented to candidates, enabling them to take a focused history of the presenting complaint, perform a relevant physical examination and construct a reasonable differential diagnosis and a management plan. Candidates are also expected to respond to the patient's questions or concerns about the diagnosis, the importance of the problem, the action plan or any other issues that may arise.

During the consultation the candidate need not necessarily complete the history taking element before examining or discussing the nature of the problem with the patient; the encounter is not intended to be a 'long case'. This is in contrast to the formal assessment of history taking, physical examination and communication covered in other stations.

Selection of cases

Station 5 provides the opportunity to assess a wide range of clinical problems across the core medical training framework (a subsection of the General Internal Medicine (GIM) curriculum – see Appendix 2), including more acute clinical problems encountered by trainees in their daily practice, which cannot be assessed elsewhere. The selection of cases should reflect this.

Suitable scenarios include new symptoms and/or signs in a patient presenting on the ward, medical admissions unit or at the outpatient clinic. The inclusion of patients with acute clinical problems in the exam can be challenging. Many chronic diseases also have acute presentations and complications which can realistically be presented in the exam, either as they stand or with some modification of the patient's own history. Judicious use of surrogates with no physical signs, or stable patients with a physical sign (e.g. a carotid bruit) that can be part of a scenario about transient neurological signs, may be used to simulate acute presentations such as TIA.

Examples of suitable cases/scenarios include:

- an incidental finding, e.g. neck swelling in a patient admitted for cholecystectomy. A complication of a chronic disease, e.g. a patient with rheumatoid arthritis and early signs of interstitial lung disease used in conjunction with a history of increasing breathlessness. Differentials to consider include interstitial lung disease, heart failure, infection, and medication. Similarly, patients with stable cardiovascular signs such as valvular heart disease could be given an acute history of collapse or palpitations
- a transient history in a surrogate with no clinical signs, e.g. TIA, palpitations, pulmonary embolism. Skin, rheumatological, endocrine and eye problems can be included but must be presented as clinical problems rather than 'spot diagnoses'.

Examples of scenarios which do not work well include:

- full new outpatient consultations
- patients with complex histories which involve more than one clinical system
- patients with long-standing chronic conditions presented as if they are newly diagnosed, e.g. rheumatoid arthritis. Consider instead introducing potential complications of the disease or treatments
- unfocused scenarios such as a patient presenting with 'weight loss'. The differential is too wide and a focused history and examination is not possible within the timeframe.

It is unlikely that cases such as these will be accepted by the College appointed vetter.

Cases should be balanced across the whole of the PACES exam, avoiding two Station 5 scenarios where the same clinical system or diagnosis is the main focus in both cases, or where there are close similarities in topic matter with other stations. Complete systems examination that would fully duplicate skills used in Stations 1 and 3 are not required or expected, although physical signs that could be seen in these stations could be part of a necessary focused examination leading on from the history, e.g. a murmur in a patient who has collapsed. Some examples of potential scenarios are included in Appendix 2 and Appendix 3 and illustrate many of the points made above.

Writing scenarios

The generation of scenarios is the responsibility of the Host Examiner.

Your College administrator will send you the current version of the scenario template in plenty of time for you to write and submit the scenarios. A copy of the template can be found in Appendix 1.

If the patient's history is to be modified to produce a credible scenario for the candidate to complete within the allotted timeframe, it is essential when selecting such cases that the patient is capable of delivering the modified history. In all cases, arrangements must be made to fully rehearse the scenario with the patient or surrogate prior to the exam.

The template for Station 5 scenarios includes 'help text' in each section to provide useful prompts when writing the scenarios. You should complete every section of the template. Please do not leave blank spaces or delete sections/headings. If not applicable, please state 'N/A' or 'none'.

The template includes:

Information for the candidate

This provides a brief summary of the clinical problem to be encountered and should provide a clear focus for the consultation. It needs to contain sufficient, but not too much, information to enable an integrated assessment of the clinical problem within the allotted 8 minutes. For example:

> *This woman has been referred by her General Practitioner with a ten year history of rheumatoid arthritis. She is now complaining of tingling and weakness in her hands.*

This encourages the candidate to take a brief focused history of the duration of the problem, including any additional neurological symptoms, the past medical history and relevant medication, along with a focused neurological examination to determine whether there is cord compression, or a local pathology such as carpal tunnel syndrome.

A table is included for the patient's physiological observations at the time of their initial presentation, and can be used to demonstrate pyrexia, hypotension or hypoxia. It is anticipated that 'observations' would generally be used with clinical problems in the acute setting but may also be appropriate in other settings, e.g. to demonstrate the side effect of a drug or the complication of treatment, such as hypotension. If not applicable to the scenario, please write 'N/A' in the boxes but please do not delete the box. If it is not relevant to the scenario then it will be removed during the vetting process. No other additional observation charts should be used.

Information for the patient

This should be clearly written in language that a patient will understand and should not include any medical terminology or abbreviations. In order for the station to run in a standardised fashion, patients are required to give the history as it is set out for them.

Current medications, and doses, should be listed in the scenario but can also be written on a separate piece of paper which the patient can show to the candidate. Please ensure you use generic drug names only.

To avoid confusion, please exclude any drugs which are not relevant if the patient's history has been modified. For example if the scenario focus is on arthritis, and you have modified the history to exclude the patient's myocardial infarction, remove the cardiac drugs from the drug list.

In order to prompt the communication aspect of the encounter you should include two questions for the patient to ask the candidate. These should be phrased as the patient would ask them, e.g. "What is going to happen to me?" rather than "What is my prognosis?"

Information for the examiners

The key issues for all the clinical skills should be completed (with the exceptions of Skill G and Skill F which are standard and have been completed already). During the calibration process, examiners will check the history and physical signs with the patient and agree on the key findings and issues that a candidate must ascertain for each skill, in order to achieve a satisfactory score.

Please note that for Skill A: Physical Examination you should list the nature and extent of examination the candidate must perform in order to achieve a satisfactory score, e.g. assesses tone, power and reflexes in upper limbs, checks for signs of carpal tunnel syndrome. Do not document the physical signs under Skill A here; these should be listed in Skill B: Identifying Physical Signs.

For Skill D: Differential Diagnosis you should provide a probable diagnosis, and any plausible alternative diagnoses. If there are no alternatives you should write 'N/A' or 'none'.

Re-use of scenarios

The re-use of Station 5 scenarios is permitted, however, at least half of your scenarios should be newly written for each diet. Centres must tell their College administrator which scenarios they plan to re-use and any feedback from their previous use will be checked. You may be asked to modify the scenario in accordance with the feedback. Re-used scenarios will not generally need to be re-vetted before use and wherever possible they will retain the same scenario number. Your College administrator will confirm this with you. Any scenario being re-used will, however, be re-vetted every three years to ensure it remains relevant to current clinical practice.

If a scenario is re-used but with a different patient with different physical signs and a significantly different history then this will be classed as a 'new' scenario and will be vetted accordingly.

Scenarios should not be re-used on consecutive days.

Guidance on the use of surrogates

It is permissible to use a patient who cannot converse in English, but who does have abnormal physical signs. The communication aspects of the case will then be undertaken by a relative (or surrogate relative) who speaks English and knows (or learns) the relevant history and can relay this, and who will answer and ask questions, as if they were the patient. They should not act as a translator as this would significantly lengthen communications and make the consultation unachievable within 8 minutes.

Surrogates with no physical signs can, on occasion, be used to play the part of a patient, but this has a direct impact on the candidate's ability to show their competency at identifying physical signs (Skill B). The use of surrogates without physical signs should be minimised and there should never be a situation where both Station 5 scenarios involve surrogates with no physical signs. It is suggested that you make these your 'reserve' scenarios.

Submission of scenarios for vetting

Your College administrator will advise you of when to submit your draft scenarios and will keep you updated as they are vetted. The writing and vetting process is outlined in Figure 1.

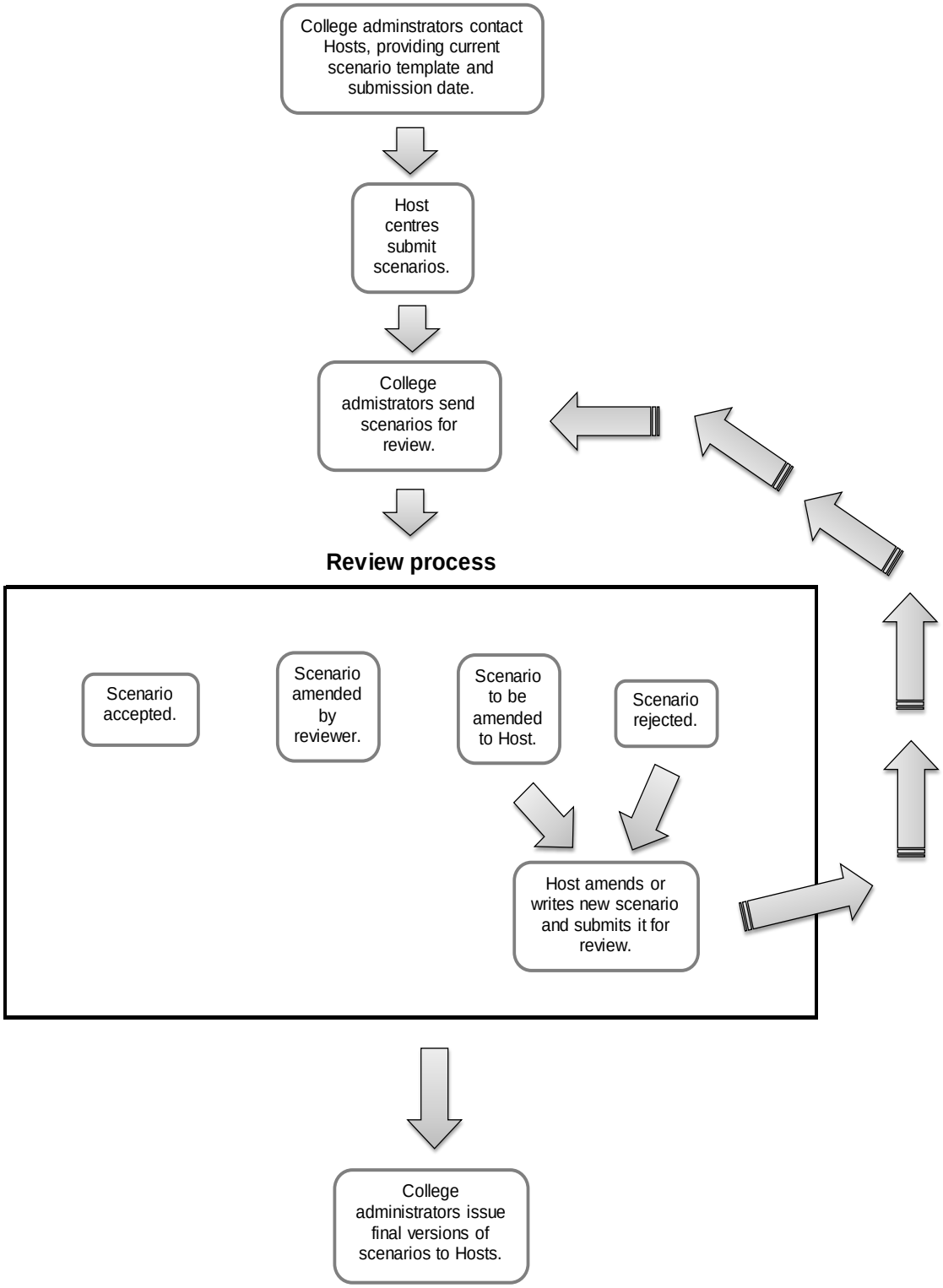

Figure 1: Writing and vetting process

Guidelines for vetting Station 5 scenarios

Introduction

The information in this guide is intended to facilitate the vetting process and ensure a consistent approach to the vetting of Station 5 scenarios across the Federation of Royal Colleges of Physicians. It should be read in conjunction with the writing guide above, and referred to when vetting scenarios. Together, the two guides will help to maintain the high quality of all the scenarios that are produced.

General guidance – scenario content

The scenario should be sufficiently focussed to allow a history taking and appropriate clinical examination to be completed within 8 minutes.

Scenarios which tend to work well include:

- an incidental finding, e.g. neck swelling in a patient admitted for cholecystectomy
- a complication of a chronic disease, e.g. a patient with SLE presenting with pleuritic chest pain
- a transient history in a surrogate with no clinical signs, e.g. TIA, palpitations etc.

Scenarios which do not work well include:

- patients with complex histories which involve more than one clinical system
- patients with long-standing chronic conditions presenting as if they are newly diagnosed
- a simple history which nevertheless involves examination of more than one system, e.g. unexplained weight loss
- a diagnosis which can be spotted “at the end of the bed”, e.g. a new case of acromegaly.

If you feel that a scenario is not going to work well, you should consider the following options:

- a discussion (email or telephone) with the host/scenario writer about how they think the scenario will work, then make any necessary adjustments
- make adjustments with added comments as required
- reject the scenario, preferably with feedback comments for the Host.

You should check and correct the spelling of medical conditions, investigations and treatments etc. Other spelling, grammar and punctuation issues will be corrected by the College administrator.

You should identify any scenarios which involve the same clinical system and remind Hosts that they are not to be used together in the same cycle.

Please remove all the *red, italicised* help-text from the scenario as you carry out your review.

Specific guidance

Information for the candidate:

- check that there is sufficient, but not too much, detail provided in the ‘Clinical Problem’ section. This should be limited to 2 to 5 lines
- check that the table of ‘Physiological Observations’ is relevant, appropriate and sufficient. You should delete the table if you feel it is not appropriate to the scenario.

Information for the patient:

- remind the Host (either directly or through the College Administrator) that if a patient’s history has been altered to fit the scenario then the patient must be sufficiently well rehearsed.
- any medical terminology and abbreviations should be changed to language patients will understand

- check that only generic drug names are used (generic names do not require capitalisation)
- check that the patient's questions are phrased as a patient would ask them. If there are more than two questions given, you should choose the two best questions and delete the others.

Information for the examiners:

- check that it is clear whether a patient or a surrogate is being used
- all text boxes for the Clinical Skills should be completed in accordance with the 'help text' given in the scenario template – see Appendix 1.

Please note that Skills F and G (Managing Patient's Concerns, and Maintaining Patient Welfare) have been pre-populated and should not have been altered by the scenario writer.

APPENDIX 1: Scenario template

Note to hosts & vetters: explanatory / help text in italics should be removed prior to final exam version.

MRCP(UK) PACES

Station 5: BRIEF CLINICAL CONSULTATION

Please avoid scenarios which duplicate cases / examination skills tested in other stations. Ensure the history & examination can be covered in the time available – this may require modification of the patient's history and background details.

Patient details:	*(Preserve anonymity: use gender & age pre-vetting, add name post-vetting for exam use.)* Insert text here
Your role:	*E.g. doctor on call / in the outpatient clinic / in the medical admissions unit.* Insert text here

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

Referral text:

Clinical problem: *Please provide a clear focus for the consultation which must be realistic and believable. Limit it to 2 to 5 lines.* Insert text here

Please add observations to the table below that are relevant to the case. You may write 'normal' or N/A.

Physiological observations for the patient above	Reading on arrival
Respiratory rate (respirations per minute)	
Pulse rate (beats per minute)	
Systolic blood pressure (mm Hg)	
Diastolic blood pressure (mm Hg)	
Oxygen saturations (%)	
Temperature ^{0}C	
Other relevant observation data (units if applicable)	

Your task is to:

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

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

NOT TO BE SEEN BY CANDIDATES

MRCP(UK) PACES

Station 5: BRIEF CLINICAL CONSULTATION

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

Please complete each section, keeping the information provided brief and relevant to the focus of the scenario, using language the patient will understand.

You are: *(Preserve anonymity, use gender & age pre-vetting, add name post-vetting for exam use.) Insert text here.*

History of current problem

If using a patient, you must state whether the history (content, complexity, duration, medications etc) has been modified for the exam or is real. If modified to enable delivery of the scenario in the time available, you must ensure the patient can deliver the modified history.

Information to be volunteered at the start of the consultation
Maximum of 4 lines. Insert text here

Information to be given *if asked*
Include information that expands on the presenting problem. Insert text here

Background information

Past medical and surgical history
Remember to remove any known diagnoses unless the candidate is to be told of diagnoses by the patient. If the past history is complex and not relevant, cut some of it out, ensuring the patient understands the changes. Insert text here.

Relevant family history
Insert text here

NOT TO BE SEEN BY CANDIDATES

Medication Record

Current medications (You may wish to bring a list of your treatment and show it to the doctor if asked.)
Insert text here

Personal history

Relevant personal, social or travel history
Insert text here

Occupational history
Insert text here

Physical examination

Specify the examination to be undertaken and the findings e.g. the doctor will examine your stomach area and you indicate that it is sore when they press under your ribs. Insert text here.

You have 1 or 2 specific questions / concerns for the doctor at this consultation.

Please note them down on a small card to remind you during the exam.
Phrase them as the patient would ask them. Some may be general, e.g. What is wrong with me? Others may be more specific, e.g. How will this impact my lifestyle?
1. Insert text here
2. Insert text here

NOT TO BE SEEN BY CANDIDATES

MRCP(UK) PACES

DATE	CYCLE

Station 5: BRIEF CLINICAL CONSULTATION

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

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

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

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

Continued on next page…

NOT TO BE SEEN BY CANDIDATES

Problem:	*Brief summary (no more than 2 lines) of the problem.* Insert text here.
Candidate's role:	*As noted on the first page.* Insert text here.
Patient details:	*(Preserve anonymity: use gender & age pre-vetting, add name post-vetting for exam use.)* Insert text here.
Patient or surrogate?	Patient / surrogate / patient with surrogate giving history *(you must delete the options NOT applicable).*

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

Clinical skill	**Key issues (please complete each box)**
Clinical Communication Skills (C)	*Include the key points of the history that the candidate **must** establish to achieve a Satisfactory score.* Insert text here.
Physical Examination (A)	*Include the nature and extent of the examination that the candidate **must** do to achieve a Satisfactory score. If further examination is desirable but may not be possible due to time constraints, make this clear. Avoid requiring a full system examination that duplicates those undertaken in Stations 1 and 3. Do not document the physical findings here – use the box below (skill B).* Insert text here.
Clinical Judgement (E)	*List the further assessments, tests, and any other treatment / management e.g. referral, that the candidate must mention in order to achieve a Satisfactory score. Make it clear if there are further items that may be desirable to mention, but not essential to achieve a Satisfactory score.* Insert text here.
Managing Patients' Concerns (F)	Addresses the patient's questions and concerns in an appropriate manner.
Identifying Physical Signs (B)	*List the physical signs (and important negatives) that the candidate must identify in order to achieve a Satisfactory score. Make it clear if there are signs that are 'softer' or less relevant and not essential to identify in order to achieve a Satisfactory score.* Insert text here.

NOT TO BE SEEN BY CANDIDATES

Differential Diagnosis (D)	**Probable Diagnosis:** Insert text here **Plausible alternative diagnoses:** Insert text here or specify 'none'

Maintaining Patient Welfare (G)	See marksheet.

APPENDIX 2: CMT Curriculum

The examples below are based on the 'Top Medical Presentations' as defined in the GIM curriculum (http://www.jrcptb.org.uk/trainingandcert/Pages/ST1-ST2.aspx#cmtcurricassess), and require an integrated approach using many of the skills, attitudes and behaviours that a satisfactory candidate should demonstrate.

Please note it is essential, especially if using a real patient with a modified history, that the patient is fully rehearsed prior to the exam.

Presentation	**Scenario**	**Suitable for patient/surrogate**	**Patient/surrogate question(s) for candidate**	**Key issues to be identified**
Breathlessness	50-year-old woman with long history of systemic sclerosis presents with increasing breathlessness over several months. Smoker.	Patient with systemic sclerosis (may or may not have chest signs).	Is this due to my scleroderma?	Check obs (HR, BP, SaO2), listen to heart and chest, looks for signs of right heart failure. Identifies pulmonary hypertension/ILD/COPD as differentials. Suggests PFTs, CXR and echo as initial investigations.
Confusion – acute	65-year-old man binge drinking for several years since death of wife. Neighbour found him wandering in the street, confused. Day 3 hospital admission and nursing staff ask you to review the patient as he remains confused and wandering off the ward.	Surrogate for history, patient for examination (e.g. with stigmata of chronic liver disease).	Can I go home?	Checks obs (including temperature, BM), checks for head injury, neuro screen. Appropriate differential including alcohol withdrawal, infection, subdural haematoma, Korsakoffs.
Acute back pain	65-year-old woman, long history of poorly controlled asthma, sudden onset, no neurological symptoms or history of trauma.	Surrogate or patient.	Is this something serious? Is it related to my asthma?	Identifies steroid use as risk factor for osteoporotic vertebral fracture. Palpates spine, screens lower limb neurology. Investigations to exclude secondary causes osteoporosis, arranges DEXAscan.

Presentation	Scenario	Suitable for patient/surrogate	Patient/surrogate question(s) for candidate	Key issues to be identified
Blackout/collapse	70-year-old woman/man presents with several episodes of collapse when golfing. Further questioning reveals worsening chest pain on exertion and exercise induced syncope.	Patient (with aortic stenosis).	Can I still play golf?	Checks obs (asks for postural BPs).Feels pulse, listens to heart, checks medication list. Arranges for ECG, echo etc.
Falls	70-year-old woman admitted with increasing frequency of falls and difficulty getting up from her chair.	Patient has early (not florid) Parkinson's disease.	Why am I falling?	Checks obs (incl. BP) and drug chart, injury screen, neuro screen and identifies features of Parkinson's disease.
Abdominal pain	30-year-old woman presents with several days' history of abdominal pain and vomiting. Had a coil inserted 3 weeks ago.	Surrogate.	Is this something to do with my coil? Can I go home?	Asks re: last menstrual period. Check obs chart, examines abdomen, must ask for pregnancy test. Differential includes gastroenteritis, ectopic pregnancy. Recognises risk factors for ectopic pregnancy.
Headache	65-year-old man with 3-week history of headache. On further questioning he has muscle aches, stiffness in his arms and thighs and some jaw claudication.	Patient or surrogate.	Can you give me any tablets for this?	Look for signs of temporal arteritis, neuro screen upper and lower limbs. Arranges TAB and discusses steroid treatment.
Fits/seizure	50-year-old man, known epilepsy on AEDs. Presents with increasing frequency of seizures. Lives alone and drinks 'more than he should.'	Surrogate.	Why am I having more seizures?	Looks for reasons for increased seizure frequency e.g. recent infection, compliance with meds, any potential drug interactions. Potential alcohol withdrawal. Neuro screen.

Presentation	**Scenario**	**Suitable for patient/surrogate**	**Patient/surrogate question(s) for candidate**	**Key issues to be identified**
Haematemesis and melaena	Patient with long standing RA presents with melaena. Increasing knee pain over several months not helped by painkillers. Medications include naproxen (taking extra tablets on empty stomach) and oral bisphosphonate.	Patient.	Is this related to my tablets?	Takes drug history, establishes NSAID as likely culprit. Checks obs (HR, BP), examines abdomen, offers to perform pr. Further investigations, discuss analgesia.
Jaundice	*Difficult to examine in this station, unless a patient / surrogate with yellow sclerae can be found.*			
Palpitations	25-year-old woman with recurrent episodes of palpitations. Well at present.	Patient (e.g. with goitre) or surrogate.	Am I having heart attacks?	Checks obs, examines for goitre and peripheral thyroid signs. Listens to heart.
Vomiting/nausea	Patient with known AF (digoxin on medication list). Recent chest infection and given clarithromycin by GP.	Patient with AF.	Is this due to my pills?	Checks obs. Listens to heart and lungs. Differential includes potential drug interaction between digoxin and clarithromycin, antibiotic related GI upset.
Weakness/paralysis	50-year-old lorry driver presents with transient symptoms of right arm weakness, smoker.	Surrogate, or patient with a carotid bruit or murmur.	Can I still drive?	Checks obs chart (notes hypertension). Looks for cardiovascular risk factors in history, neuro screen, explains diagnosis, further investigations e.g. carotid doppler.
Management of patients requiring palliative and end of life care	*Not possible to examine in this station.*			

Presentation	**Scenario**	**Suitable for patient/surrogate**	**Patient/surrogate question(s) for candidate**	**Key issues to be identified**
Chest pain	35-year-old woman with known SLE. Presents with pleuritic chest pain and SOB on exertion.	Patient.	Is this to do with my lupus?	Checks obs, listens to chest, examines calves, differential includes PTE, pleurisy, pericardial effusion. Arranges appropriate investigations e.g. ECG, CXR, echo, V/Q or CTPA, lupus anticoagulant etc.
Acute and chronic kidney disease	Patient with ESRF attends for regular dialysis complaining of fever and pain in fistula arm.	Patient with ESRF and AV fistula.	Is my fistula still working? Will I still be able to get dialysed?	Check obs, including temperature. Examine fistula site for evidence of infection, assess for signs of ischaemia in distal limb. Appropriate management including U&Es, CRP, blood cultures, renal review.
Fever	55 year old admitted with ACS develops temperature of 38.5°C and chest pain on day 3 of admission. Patient with known valvular heart disease presents with fever. Recent soft tissue infection of great toe but didn't complete course antibiotics.	Patient or surrogate. Patient with heart murmur.	Am I having another heart attack? Is this related to the infection in my toe? Do I need more antibiotics?	Checks obs. Auscultates heart and lungs, looks for signs of infection e.g. cannula site. Differential – Dressler's, hospital acquired infection, soft tissue infection from cannula. Checks obs (temperature, HR, BP, urinalysis). Looks for stigmata of subacute bacterial endocarditis.

Presentation	Scenario	Suitable for patient/surrogate	Patient/surrogate question(s) for candidate	Key issues to be identified
Rash	30-year-old man with psoriasis attends for review in clinic. Incidentally complains of pain in his hands and feet (PIPs, DIPs). Increasing stiffness in his back first thing in the morning.	Patient with psoriasis and nail changes but no clinical synovitis.	Is this related to my psoriasis? What can I take for the pain?	Looks for nail changes, examines hands and feet for synovitis/dactylitis. Assesses range of spinal movement and SI joint tenderness. Recognises nail changes increase likelihood of developing PsA. Advises NSAIDs, arranges X-rays hands, feet and SI joints.
	35-year-old woman with RA well controlled on anti-TNF therapy and methotrexate, attends Rheumatology clinic for routine review. She mentions her 6-year-old son has got chickenpox and she can't remember having it herself. She has a new cough and feels generally unwell.	Patient with RA.	Will I get chickenpox? Is there anything I can do to stop myself catching it?	Checks obs (including temperature). Listens to chest, looks for vesicles. Advises patient to stop anti-TNF and methotrexate. Check varicella antibodies if not immune and administer VZ immunoglobulins.
	30-year-old presents to the Emergency department with rash which developed in a restaurant 4 hours ago. Rash has resolved but they feel itchy and wheezy.	Surrogate.	Can I go home? How can I stop this happening again as it's terrifying?	Establishes potential allergen from history. Checks obs (HR, BP, SaO_2). Examines skin for rash, auscultates chest. Management – antihistamine, period of observation then send home if improving, referral for allergen testing etc.

Presentation	Scenario	Suitable for patient/surrogate	Patient/surrogate question(s) for candidate	Key issues to be identified
Limb pain/swelling	30-year-old pregnant woman presents with 'faint.' Further questioning gives history of increasing SOB on exertion and a painful tender calf.	Surrogate or patient.	Will this harm my baby? Will I need any tests and will they be safe for my baby?	Checks obs (HR, BP including postural drop), examines calves, auscultates chest. Differential includes DVT / PTE, postural hypotension in pregnancy, muscular pain. Explains investigations – U/S leg, liaise with obstetrics.
Poisoning	30-year-old patient has taken 16 paracetamol tablets over a 24 hour period in an attempt to cure a headache. The headache has now gone, but a friend advised him that he could have liver damage. Further info: patient drinks 40–50 units of alcohol per week	Surrogate with feigned epigastric tenderness	Have I damaged my liver? What can be done about it?	Establishes risk factors for suicide, other toxins and liver damage. Checks obs. Examines for liver disease and feels epigastrium. Arranges bloods (U&E, LFT, FBC, clotting, paracetamol level). Knows of guidelines for treatment of paracetamol poisoning.
Cough	52-year-old man with recent STEMI. Further info: newly commenced on ACE inhibitors.	Surrogate.	Can you give me something to stop this cough?	Check medication list. Assess for signs of heart failure.
Diarrhoea	65-year-old patient recovering from CAP. Been on a cephalosporin.	Patient or surrogate.	Is this caused by my tablets? Do I need to go into a single room?	Check obs (HR, BP, temperature), medications, examines abdomen, looks for evidence of dehydration. Demonstrates knowledge of appropriate infection control measures.

APPENDIX 3: Examples of suitable Station 5 scenarios

1: Postural hypotension

2: Infective discitis

MRCP(UK) PACES

Station 5: BRIEF CLINICAL CONSULTATION

Patient details:	Mrs MI aged 45.
Your role:	You are the doctor on duty in the medical admissions unit.

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

Referral text:

Clinical problem: Please will you see this woman who had an uncomplicated myocardial infarction five weeks ago. She now feels rather lethargic.

Please will you rule out a further myocardial infarction.

Physiological observations for the patient above	**Reading on arrival**
Respiratory rate (respirations per minute)	22
Pulse rate (beats per minute)	56
Systolic blood pressure (mm Hg)	105
Diastolic blood pressure (mm Hg)	65
Oxygen saturations (%)	96
Temperature ^{0}C	36.8
Other relevant observation data (units if applicable)	

Your task is to:

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

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

NOT TO BE SEEN BY CANDIDATES

MRCP(UK) PACES

Station 5: BRIEF CLINICAL CONSULTATION

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

You are: Mrs MI aged 45.

History of current problem

Information to be volunteered at the start of the consultation

You have felt really lethargic over the last week, and have felt unable to do your normal activities. You are disappointed because you felt you were starting to make a recovery after your recent heart attack. You had a heart attack five weeks ago and you are very worried that this could be another one. You could ask your first question here if you get the opportunity.

Information to be given *if asked*

The lethargy started about one week ago. You tried the angina spray but it did not help, it just gave you a bad headache and made you feel very dizzy.
You have noticed dizziness when getting up out of a chair over the last week. You almost fell over the first time, but have now learned to get up carefully.
You have not had any further chest pains or discomfort.
You have wondered whether your tablets are responsible for making you feel like this.

Background information

Past medical and surgical history

You had a heart attack five weeks ago. It all happened so quickly – you were rushed into hospital and had an angiogram immediately. The doctors opened up the heart artery with a balloon (angioplasty) and put a stent in. You were told all your other heart arteries were fine and that the stent and tablets should help to stop further problems. You were told that smoking was at least partly to blame and that you must stop if possible. You were in hospital four days and went home with lots of tablets. You have been on the cardiac rehabilitation programme for three weeks, but felt too lethargic to go this last week. You were going to ask them about your symptoms, but now feel too worried, hence you came back to hospital.

Relevant family history

NOT TO BE SEEN BY CANDIDATES

Your father had a heart attack in his fifties but he is still alive (now aged 70).

Medication record

Current medications (You may wish to bring a list of your treatment and show it to the doctor if asked.)
Aspirin 75 mg once daily, ramipril 10 mg once daily, bisoprolol 5 mg once daily, clopidogrel 75 mg once daily, atorvastatin 80 mg at night, GTN (glyceryl trinitrate) spray as needed.
All this is new, you were not taking any regular medication before the heart attack. You don't like taking all these tablets and you wonder if they are causing some of your current symptoms. Your family doctor increased the ramipril from 5 mg to 10 mg two weeks ago, as per the hospital's advice.

Personal history

Relevant personal, social or travel history
You are married, and have two children aged 12 and 16.
You stopped smoking (20 cigarettes a day) at the time of your heart attack – you are determined never to start again!
You do not drink alcohol.

Occupational history
You are a saleswoman in a car showroom.

Physical examination

The doctor will want to feel your pulse and listen to your heart. They may want to take your blood pressure with you lying down and then standing up. If you do stand up, you feel a bit dizzy and stagger a bit - hold onto something (such as the bed) but do not fall over. After a minute you feel OK.

You have 1 or 2 specific questions for the doctor at this consultation. Please note them down on a small card to remind you during the exam.

1. Have I have had another heart attack?
2. Is this a side effect of the tablets I've been taking since my heart attack?

DATE	CYCLE

MRCP(UK) PACES

NOT TO BE SEEN BY CANDIDATES

Station 5: BRIEF CLINICAL CONSULTATION

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

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

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

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

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NOT TO BE SEEN BY CANDIDATES

Problem:	Patient with a recent MI, presents with lethargy and low BP following an increase in the ACE inhibitor dose.
Candidate's role:	Doctor on duty in the medical admissions unit.
Patient details:	Mrs MI aged 45.
Patient or surrogate?	Surrogate.

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

Clinical skill Key issues (please complete each box)

Clinical Communication Skills (C)	Establish nature of lethargy, excluding recurrent angina, heart failure and GI bleed symptoms. Obtain detail of recent myocardial infarction. Review drug treatment, note recent increase in ramipril.

Physical Examination (A)	Check to assess severity of illness – airway, breathing, circulation. Asks for / looks at the observations. Offers to do lying and standing BP. Feels pulse, listens to heart and lungs.

Clinical Judgement (E)	Immediate tests: U&E, FBC, ECG to exclude AKI, bleed, MI. Would probably not need a troponin. Would advise withholding ACEI and then restarting lower dose. Probably does not need to stay in hospital once AKI and GI bleed excluded – could go home with instructions for GP follow-up.

Managing Patients' Concerns (F)	Addresses the patient's questions and concerns in an appropriate manner.

Identifying Physical Signs (B)	Identifies that the patient is stable, not shocked, but has postural hypotension. No other abnormal physical signs.

NOT TO BE SEEN BY CANDIDATES

Differential Diagnosis (D)	**Probable Diagnosis:** Postural hypotension related to increased ramipril dose. **Plausible alternative diagnoses:** Lethargy induced by β-adrenoceptor blocker. Dehydration secondary to AKI induced by ACE inhibitor.

Maintaining Patient Welfare (G)	See marksheet

MRCP(UK) PACES

Station 5: BRIEF CLINICAL CONSULTATION

Patient details:	Mrs ID aged 72.
Your role:	You are the doctor on call.

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

Referral text:

Clinical problem: This woman has been referred by her family doctor with severe back pain. She lives on her own and is struggling to cope at home. She is known to have osteoporosis and her family doctor is concerned she may have had another vertebral fracture.

Physiological observations for the patient above	**Reading on arrival**
Respiratory rate (respirations per minute)	18
Pulse rate (beats per minute)	90
Systolic blood pressure (mm Hg)	150
Diastolic blood pressure (mm Hg)	85
Oxygen saturations (%)	98 on air
Temperature ^{0}C	38.0
Other relevant observation data (units if applicable)	

Your task is to:
Assess the problem by means of a brief focused clinical history and a focused relevant physical examination. You do not need to complete the history before carrying out appropriate examination.
Review any observation charts that are supplied.
Advise the patient of your probable diagnosis (or differential diagnoses), and your plan for investigation and treatment where appropriate.
Respond directly to any specific questions which the patient may have.

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

NOT TO BE SEEN BY CANDIDATES

MRCP(UK) PACES

Station 5: BRIEF CLINICAL CONSULTATION

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

You are: Mrs ID aged 72.

History of current problem

Information to be volunteered at the start of the consultation

One week ago you noticed a dull pain in the middle of your back which has not gone away and is getting steadily worse. It is now there all the time and any movement is now painful. You just don't feel right in yourself and as you live on your own, daily activities such as washing and dressing are becoming increasingly difficult. You have had a fracture in your back in the past and are concerned that this may be related.

Information to be given *if asked*

You have not fallen recently.
The back pain has not come on suddenly; it started gradually one week ago and is now present constantly. It wakens you from sleep at night.
You have also been feeling feverish and sweaty and a bit shaky at times.
You feel washed out, tired and just not right.
You haven't felt like eating much over the past week and may have lost a little weight (a few pounds) over that time, but you haven't noticed a significant loss of weight.

You did have a small cut on your toe about one month ago which oozed pus. The family doctor gave you a course of antibiotics but you didn't complete the course as they made you feel sick.
You have no cough, breathlessness or sputum. You have not coughed up any blood.
Your bowels are working fine with no change in habit or blood from the back passage / in the stool. You are not going to the toilet more frequently and have not had any episodes of bowel or urinary incontinence.

Background information

Past medical and surgical history

You have osteoporosis and have had a fracture of a bone in your back as a result of this.

NOT TO BE SEEN BY CANDIDATES

Relevant family history
Your mother broke her hip after a minor fall in her early seventies.

Medication record
Current medications *(You may wish bring a list of the treatment and show it to the doctor if asked.)*
Alendronate 70 mg once a week.
Calcichew D3 Forte, 2 tablets daily.

Personal history

Relevant personal, social or travel history
You are widowed. You have never smoked but enjoy the occasional glass of sherry.

Occupational history
You are a retired primary school teacher.

Physical examination
The doctor will want to examine your back. If they press down the middle of your spine, please tell them that it is painful just over your spine in the middle of your back. They may wish to examine the power in your legs and test your reflexes. You have normal power in your legs and normal sensation.

You have 1 or 2 specific questions for the doctor at this consultation.
Please note them down on a small card to remind you during the exam.

- Have I had another fracture in my back?
- Why am I feeling generally unwell?

INFORMATION FOR EXAMINERS

Scenario N°

NOT TO BE SEEN BY CANDIDATES

MRCP(UK) PACES

DATE	CYCLE

Station 5: BRIEF CLINICAL CONSULTATION

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

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

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

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

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NOT TO BE SEEN BY CANDIDATES

Problem:	Woman with a history of osteoporosis and vertebral fracture presents with gradual onset constant and worsening back pain and fever, preceded by cutaneous infection ?discitis.
Candidate's role:	Doctor on call.
Patient details:	Mrs ID aged 72.
Patient or surrogate?	Surrogate.

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

Clinical skill Key issues (please complete each box)

Clinical Communication Skills (C)	Establishes symptoms of gradual onset constant back pain with fever, not in keeping with osteoporotic fracture. Establishes risk factors for discitis in history (preceding soft tissue infection, failure to complete antibiotics and probable bacteraemia with seeding in previously fractured vertebrae). Establishes no symptoms suggestive of acute cord compression.

Physical Examination (A)	Looks at the observations and assesses severity of septic shock. Palpates spine looking for spinal tenderness, conducts focal neurological examination of lower limbs, assessing tone, power and reflexes. Indicates the wish to formally check sensation and perform rectal exam to assess anal tone and perianal sensation. Indicates the need to look for signs of endocarditis (skin lesions, murmur etc).

Clinical Judgement (E)	Immediate management – close observation, assess for signs of sepsis syndrome, fluid balance. Commence empirical antibiotics e.g. IV flucloxacillin based on likely staphylococcal infection after several sets of blood cultures. Immediate tests: X-ray of spine and if abnormal MR scan of spine looking for evidence of discitis, cord compression. Blood cultures, FBC, U&Es, CRP. Discusses the need for discussion with senior on call and liaison with microbiology and surgical colleagues re: appropriate antibiotic therapy and surgical drainage. Recognises that abnormal bone e.g. previous fracture acts as a nidus for infection.

Managing Patients' Concerns (F)	Addresses the patient's questions and concerns in an appropriate manner.

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Identifying Physical Signs (B)	Identifies pyrexia, hypotension and sepsis. Identifies spinal tenderness and establishes no signs of acute cord compression.

Differential Diagnosis (D)	**Probable Diagnosis:** Infective discitis presumed secondary to bacteraemia following incompletely treated soft tissue infection. **Plausible alternative diagnoses:** Osteoporotic fracture, alternative source of sepsis.

Maintaining Patient Welfare (G)	See marksheet