PACES: CONSULTATION

Patient details: Miss Anne Rogers, a 45-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 below. When the bell sounds, enter the room. You have 15 minutes with the patient, followed by 5 minutes for discussion with the examiners. You may make notes if you wish; any notes you make must be handed to the examiners at the end of the encounter.

Dear Doctor,
Thank you for seeing this patient who has recently attended the surgery with a 1-month history of nausea and anorexia. Her routine blood tests show a Bilirubin of 35 umol/l (normal<20) 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 teenage children. On examination, she seemed very anxious.
Please would you advise on the possible likely diagnosis and immediate management.

Yours faithfully,

Physiological observations	Reading on arrival
Temperature (°C)	37.1
Pulse (beats/min)	102
Systolic BP (mmHg)	108
Diastolic BP (mmHg)	68
Respiratory rate (breaths/min)	14
Oxygen saturation, breathing air (%)	98
Other relevant observation data	

Your task is to:

- Assess the problem by eliciting a clinical history and 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.
- Discuss your assessment and the medical options with the patient and agree how best to proceed, answering any questions that are raised.
- Assess the patient’s views of their problems and clarify what matters most to them.

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PACES: CONSULTATION

Please read the following scenario carefully.

Your medical history may have been modified for the examination. This may mean that some details (e.g. your current diagnosis, other health issues, past tests and treatments) have been changed or removed.

Please use the details given in this scenario to answer the doctor's questions – this ensures that the exam is fair for all candidates.

The doctor will perform a physical examination, explain any further tests or treatment they would like to arrange and will answer your questions.

If you have any questions or concerns before the examination, please let the examiners know and they will help you.

You are: Miss Anne Rogers, a 45-year-old woman
Location: You are in the medical outpatient clinic

Presenting complaint

At the beginning of the examination, please give the doctor the following information:

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.

If the doctor asks about the following details, please answer using the information below

Further information about your current symptoms:

- 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.

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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.

Family history:

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

Current medications (bring a list with you if needed):
No regular medication

Allergies, adverse reactions and relevant past medications:
none

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.

IF ASKED: 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.

Travel history:
You were in Greece in the summer

Occupational history:

You work as a cashier in a local supermarket

Physical examination

- The doctor will examine your hands and eyes. They will feel your abdomen

Your concerns, expectations and wishes:

You are worried about your recent symptoms because your doctor said there was something wrong with your liver. You are concerned that you might have cancer.

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You have some questions you would like to ask the doctor

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

Make sure you ask the following two questions:

- What is wrong with me?
- Could I have cancer?

You might also like to ask the following questions:

- Should I have further tests to find out what is wrong?
- Will I get better?

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NOT TO BE SEEN BY CANDIDATES

INFORMATION FOR THE EXAMINERS
Scenario N°***

PACES: CONSULTATION

DATE	CYCLE

Examiners should advise candidates when there are 2 minutes remaining with the patient (i.e. after 13 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 patient or surrogate should remain in the room until the end of the 20-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.

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 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’.

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

Examiners are reminded that, during the calibration process, the patient/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 that 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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INFORMATION FOR THE EXAMINERS
Scenario N°***

Presenting complaint: Nausea and anorexia, associated with abnormal liver function tests
Candidate's role: The doctor in the medical outpatient clinic

Patient's details: Miss Anne Rogers, a 45-year-old woman

Patient or surrogate: Choose an option.

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.

Physical Examination (A)

- Looks for signs of chronic lever disease
- Examines abdomen for organomegaly

Identifying Physical Signs (B)

- Not jaundiced. Palmar erythema. Tremor, no falpping
- Hepatomegaly 2FB

Clinical Communication Skills (C)

- The candidate must take a history which adequately explores all areas relevant to the differential diagnoses – it is not sufficient to take a history which confirms a suspected diagnosis without adequately exploring other possibilities or relevant personal history
- The candidate should agree a management plan with the patient

Differential Diagnosis (D)

- Alcoholic liver disease
- Other forms of primary liver disease

Clinical Judgment (E)

- Non-alcoholic fatty liver disease (NAFLD)
- Gallstones

Managing Patient's Concerns (F)

- Addresses the patient's questions and concerns in an appropriate manner
- Provides advice on where to get help to limit alcohol consumption

Maintaining Patient Welfare (G)

- Treats the patient respectfully, sensitively and ensures comfort, safety and dignity
- Does not cause physical or emotional discomfort or jeopardise safety

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