

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 you 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.

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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?

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.

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