STANDARDIZED PATIENT PROTOCOL

Institution/Case Author: EVMS Family Medicine

Case Title:

History _X__ Physical Exam __X__
Communication_____X_____

Anticipated time needed: __25___ minutes

Setting:

PATIENT DEMOGRAPHICS: to be used for recruiting the Standardized Patient

a) **age range …….. 30-50**
b) **gender …….. male/female**
c) **race …….. any**
d) **socioeconomic/ educational level ……..middle class**
e) **specific affect to be simulated ……..flat, upset, depressed affect**

SUMMARY OF CASE

Opening Statement:
"I can't seem to get enough sleep"

Full spectrum of patient concerns:
1. Not sleeping
2. "*My husband/wife is saying that I am depressed"*

History of Present Illness:

For the past 3 months, the patient has been feeling more sleepy and less energetic than usual. Wakes up in the morning feeling tired. It requires a huge effort to get ready for work and complete household and work duties during the day. After coming home at night, crashes on the couch and falls asleep for an hour or two. No appetite. Feels depressed most of the time, but not tearful. Difficulty engaging in usual family and social activities – "I just don't have the energy." Feels useless at work and at home. Can't concentrate on complex tasks. Supervisor at work is starting to notice poor performance and asking what's wrong.

Past Medical History:

No hospitalizations or surgeries. No major injuries or accidents
Allergies: Penicillin, peanuts
Hypertension – ran out of meds a few months ago (was on amlodipine 5mg)
Similar episode as teen, received counseling, "I snapped out of it after a few months"

Up to date with screenings and immunizations
No recent travel

Family History:
Married – spouse
Parents – alive, mother has hypertension, father had MI and has DM, no known psychiatric illness
Grandparents – all died of "old age"
Siblings - none
2 children, both healthy

Social History:

Occupation – middle school math teacher
Marital status – married
Educational background – completed high school and college
Religion – not significant for this case
Alcohol – 1 glass wine/1 beer per night occasionally during the week (1-2 days out of Sun-Thurs), 2 on weekends, CAGE neg
Tobacco – no
Drugs – no
Nutrition – decreased appetite, no restrictions except for peanut allergy, avoids all nuts; increased caffeine over past 3 months – now 5-6 cups coffee throughout morning, diet soda with caffeine at lunch
Sexual history – not currently sexually active – no interest
Physical violence – not a concern during this patient's marriage
Wears seatbelts
No firearms in the house
Hobbies – no interest currently
Daily activities – awakens 30-45 minutes prior to leaving for work, "effort to get out of bed," decreased energy/fatigue throughout day, exhausted by end of work day. Does some grading/planning then goes to bed around 11:00 at night, ends up tossing and turning for 1 hour, falls asleep then awakens after 3-4 hours, awake until needs to get up for work

Review of Systems: (list abnormal only)
Fatigue, 2 pound weight loss, constipation (BM every 2-3 days, takes laxative about once a week), feels depressed, irritable with kids/students, feels "slowed down," has thought it might be easier not to wake up in the morning, but no suicidal intent or plan

Relationships with:

2 children at home – teens, mainly look after themselves, good students "good kids", feels bad lately because she has not felt like taking them to activites and the patient feels guilty about that.
Spouse – usually has good relationship, but spouse beginning to get frustrated by lack of interest
Parents live in Richmond, good relationship, come frequently to see grandkids
Financial – Able to pay bills comfortably with spouse and pt working
Friends at work, including other teacher went to college with – talk frequently at work, but has stopped interacting with them on a social basis
Dropped out of church activities past few months

F – depressed/sad/guilty
I –?anemic or vitamin deficiency
F – effort to complete work duties, has withdrawn a little from kids
E – blood tests for above

Presentation:

Will get teary when discussing suicidal ideation, limited eye contact, occasionally appears slightly distracted

Standard Questions/Challenges to Interviewer:

1. *Why can't I just snap out of it?*
2. *I feel guilty about letting my family down*

Physical Examination Findings:
Psychomotor retardation (moves a little slowly, speaks a little slowly)

List patient EDUCATION OR A COMMUNICATION challenges as applicable

1. Motivation to take meds and follow up is an issue due to depressive symptoms
2. Anxious for a "fix" to the problem – but OK if educated re: expected course of improvement and feels as though learner engaged/caring

OPENING SCENARIO

Christian Smith has come to the office complaining of fatigue.

Vital Signs:

T	**98.2**
P	**62**
R	**14**
BP	**153/72**

TASKS
Target Audience: Family Medicine Clerkship

1. Review patient chart information
2. Obtain a focused and relevant history and physical examination based on chart information
3. Discuss your initial diagnostic impressions with the patient
4. Discuss initial management plans with the patient
5. Counsel the patient
6. Provide appropriate patient education
7. Complete a note in EHR that reflects patient centered care
8. Based on note, document coding rationale

CONTENT CHECKLIST Depression

Patient Compliance

1. Patient Compliance SP – on a scale of 1-10 how compliant would this patient be with the learner's OVERALL plan?
2. What effectively contributed to patient compliance? – Comment box
3. What could enhance patient compliance? – Comment box

ABIM (comment box after each item)

4. Would you do what this student/doctor asks you to do?
5. Would you recommend this student/doctor to a friend who wanted a student/doctor with excellent communication skills?
6. Would you make a special effort to see this student/doctor?

MITI (comment box after each item)

7. MITI – Evocation
8. MITI – Collaboration
9. MITI – Autonomy/support
10. MITI – Direction
11. MITI – Empathy

MIRS (comment box after each item)

12. Spectrum of concerns
13. Eliciting the narrative thread
14. Timeline
15. Lack of jargon
16. Patient's perspective
17. Impact of illness on pt/pt's self image
18. Verbal facilitation
19. Non-verbal facilitation
20. Patient education and understanding
21. Investigations and procedures
22. Achieve a shared plan
23. Overall interview
24. Transitional Statements

Health Literacy (comment box following item)

25. Health literacy assessment – may ask either or both to receive full credit – Yes/no
    a. Have you ever needed help filling out forms? (yes – red flag)
    b. How do you read? (OK or less is red flag)

General Comments:

26. In the comment box below please explain any scoring discrepencies among communication scales

Assessment

27. depression (most likely)
28. possible anemia
29. thyroid disorder
30. Uncontrolled high blood pressure

Plan

31. Testing – TSH (thyroid function)
32. BMP – check kidney function and for calcium abnormalities
33. CBC – check for anemia
34. Initial management plans: start medication (SSRI (e.g. sertraline, citalopram), venlafaxine, bupropion all acceptable treatments)
35. Suggests counseling
36. Restart blood pressure medication
37. Follow up 1-2 weeks
38. Discusses time frame for tests/plans – results will be available at follow up in 1 week
39. Medication takes 6-8 weeks to become fully effective
40. Discusses safety (e.g. call if suicidal thoughts/plans or seek support from friend/family)

Physical Exam

41. Wash hands before examining patient
42. Palpates thyroid
43. Auscultates for carotid bruits
44. Auscultates heart
45. Auscultates lungs (3 pair posterior)
46. Observes gait

Introduction

1. Introduces self to patient
2. Explains role and position
3. Uses patient's name

History of Present Illness

4. Would be better not to wake up
5. No suicidal intent
6. No suicidal plan (important for patient safety
7. No risky behavior
8. Not feeling "high" or "wired" (could point to bipolar disorder which would require different treatment)

Past Medical History

9. Medications for hypertension – amlodipine (certain medications can cause symptoms of depression (beta blockers, thiazides, clonidine)

Social History

10. Occupation
11. Marital Status - married
12. Education background
13. Religion - Christian
14. Alcohol – 1-2 glasses of wine per night

15. Tobacco –never
16. Drugs – never
17. Sleep – disrupted
18. Sexual Satisfaction – not changed
19. Relationships – good with husband
20. Relationships – good with co-workeers
21. Relationships – good with family