Standardized Patient Form

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| ***Role Player****: Asking someone to imagine that they are either themselves or another person in a particular situation. ​Role Players behave exactly as they feel that person would, thus would not need a case developed.*  ***Structured Role Play:*** *A person who has been provided a prepared script on one element of a scenario which articulates a learning objective.​ Improvisation meets structure.​*  ***Embedded Participant​:*** *An individual who is trained or scripted to play a role in a simulation encounter in order to guide the scenario based on the objectives.​*  ***Simulated Patient:*** *A person who has been carefully coached to simulate an actual patient so accurately that the simulation cannot be detected by a skilled clinician. In performing the simulation, the SP presents the ‘Gestalt’ of the patient being simulated; not just the history, but the body language, the physical findings and the emotional and personality characteristics as well.*  ***Standardized Patient:*** *Individuals who are trained to portray a patient with a specific condition in a realistic, standardized and repeatable way (where portrayal/presentation varies based only on learner performance are trained to behave in a highly repeatable or standardized manner in order to give each learner a fair and equal chance.*  *\*Please consider the lines between the six applications as porous and not as hard lines that prevent movement between applications . Source: Comprehensive Healthcare Simulation; Implementing Best Practices in Standardized Patient Methodology, Chapter 5 The Human Simulation Continuum: Integration and Application.* | |
| **Level of Standardization** | [ ] Standardized Patient  [√] Simulated Patient |
| **Standardized Patient Objectives** | Your challenge as the **Standardized Patient** is multifold:   * To appropriately and accurately reveal the facts about the role being portrayed. * To improvise only when necessary and in a manner that is consistent with the overall tone/content of the case. * Maintain the realism of the simulation i.e., stay in character. * Evaluate learners fairly based on how they performed in this encounter. * Provide patient perspective in feedback. |

**Patient Name: Robert "Robbie" Johnson**

**Age: 65**

**Gender: male**

**Chief Complaint:** **Increased shortness of breath and persistent cough over the past two months**

**Presentation and Resulting Behaviors (e.g. body language, non-verbal communication, verbal characteristics)**

**Examples:**

**Affect: pleasant/cooperative/irritated**

**Speech: verbose/terse/limited**

***Note: include any changes to presentation as case progresses***

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| **Affect: Calm but slightly frustrated**  **Speech: Clear, moderate pace, occasionally breathless**  **Body Language: Uses a hand to support her chest when short of breath, sits leaning forward to facilitate breathing**  **Non-Verbal Communication: Shows signs of mild distress during breathing episodes, maintains eye contact but appears tired**  **Verbal Characteristics: Provides information clearly but may need prompting to discuss emotional aspects** |

**Opening Statement, Open-Ended Questions, and Guidelines for Disclosure**

Note: this section is to give the SP guidance on how to answer open-ended questions. Scripted answer(s) to initial open-ended questions like “what brings you in today?” and “Can you tell me more?” should go in Box A. Further open-ended questions like “anything else going on?” should go in box B below, as well as any information the SP should volunteer at the first given opportunity. Box C is for information that the SP should freely offer, but wouldn’t consider mentioning until the learner introduces a relevant topic. Box D is for information that needs to be withheld unless specifically asked, (e.g. things the patient doesn’t remember until prompted or things the patient may feel shame about).

*Example: let’s say the patient’s roommate is ill. If the patient is having similar symptoms, that information probably goes in box B–it’s highly relevant to the patient and on the top of their mind. If the patient has somewhat differing symptoms, the information might go in box C and could be revealed if the learner brings up living situation, social support, or sick contacts. If the patient would assume the roommate’s illness is unrelated, the information might go in box D and only be revealed when the learner asks about sick contacts.*

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| **Opening Statement(s)** | **A**  **Initial Response to "What brings you in today?":**  **"I've been having this persistent cough and I'm finding it harder to breathe lately."**  **Response to "Can you tell me more?":**  **"Sure. About two months ago, I started coughing more than usual, and over the last few weeks, my breathing has become increasingly difficult, even when I'm just walking around the house."** |
| **Other information offered spontaneously (what can be disclosed after any open-ended question)** | **B**  **After any open-ended question:**  **"** **I've also been feeling more tired than usual and have lost a bit of weight without trying."** |
| **Information elicited when generally prompted (what can be disclosed in response to an open-ended question on a particular topic)** | **C**  **If asked about smoking history:**  **"** **I smoked a pack a day for 40 years but quit five years ago"**  **If asked about exposure to pollutants or occupational hazards:**  **"I worked in construction for most of my career, so I've been around a lot of dust and chemicals."** |
| **Information hidden until asked directly (what should be withheld until specific questioning)** | **D**  **If asked about previous respiratory issues:**  **"I've had occasional bronchitis in the past, but nothing serious."**  **If asked about mental health or emotional well-being:**  **"I've been a bit stressed lately because of my health, but I'm managing."** |

**Sample Healthcare Interview & Physical Exam Format:**

**History of Present Illness (HPI):**

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| **Quality/Character** | **Cough is chronic, initially dry but has become more productive with occasional clear sputum. Shortness of breath is progressive and not relieved by rest.** |
| **Onset** | **Cough began two months ago, shortness of breath developed gradually over the past six weeks.** |
| **Duration/Frequency** | **Cough is persistent throughout the day, worsening in the mornings and evenings. Shortness of breath occurs during minimal exertion, such as walking a few steps.** |
| **Location** | **N/A (respiratory symptom)** |
| **Radiation** | **N/A** |
| **Intensity (e.g. 1-10 scale for pain)** | **Cough discomfort rated 5/10, shortness of breath rated 6/10 during activities.** |
| **Treatment (what has been tried, what were the results)** | **Tried over-the-counter cough suppressants with no significant relief. No previous use of inhalers or respiratory medications.** |
| **Aggravating** **Factors (what makes it worse)** | **Physical activity, exposure to cold air, and presence of dust or smoke.** |
| **Alleviating** **Factors (what makes it better)** | **Rest, use of inhalers, avoiding triggers like dust and smoke.** |
| **Precipitating** **Factors (does anything seem to bring it on, e.g. meals, environment, time of day)** | **No specific precipitating event; gradual onset related to chronic lung condition.** |
| **Associated** **Symptoms** | **Fatigue, occasional wheezing, chest tightness, mild weight loss.** |
| **Significance to Patient (impact on patient’s life, patient’s beliefs about origin of problem, underlying concerns/fears, hopes/desires)** | **Robbie is concerned about the persistent nature of his symptoms and their impact on his daily life and independence. He fears that it might be a serious condition given his long history of smoking and occupational exposures.** |

**Review of Systems: (list any additional pertinent positives and negatives from these systems: Constitutional, Skin, HEENT, Endocrine, Respiratory, Cardiovascular, Gastrointestinal, Urinary, Reproductive, Musculoskeletal, Neurologic, Psychiatric/Behavioral)**

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| Constitutional: Fatigue, unintentional weight loss  Respiratory: Increased shortness of breath, chronic cough, occasional wheezing  Cardiovascular: No chest pain, occasional palpitations  Gastrointestinal: No nausea or vomiting, decreased appetite  Neurological: No dizziness or syncope  Musculoskeletal: Mild joint pain  Psychiatric/Behavioral: Mild anxiety related to health status |

**Past Medical History (PMH): (fill in any relevant fields)**

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| **Illnesses/Injuries (chronic or otherwise relevant)** | **Hypertension**  **Former smoker (40 pack-years, quit 5 years ago)** |
| **Hospitalizations** | **None in the past five years** |
| **Surgical History** | **Appendectomy at age 30** |
| **Screening/Preventive (including vaccinations /immunizations)** | **Annual influenza vaccination**  **Up-to-date with colonoscopy and prostate screening** |
| **Medications (Prescription, Over the Counter, Herbal/Dietary Supplements)**  **Include: medication name, dosage strength, dosage form, route of administration, frequency of administration, duration of therapy, indication** | **Lisinopril 10 mg orally once daily for hypertension**  **Occasional use of over-the-counter ibuprofen for headaches** |
| **Allergies (environmental, food, or medication – also list any known reactions) Date of allergy diagnosis** | **No known drug allergies** |
| **Gynecologic History** | **N/A (Male patient)** |

**Family Medical History: (fill in any relevant fields)**

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| **List all relevant and appropriate family members and their age and health status, or age at and cause of death** | **Father: Deceased at 70 from lung cancer**  **Mother: Alive, age 92, with osteoarthritis**  **Sibling: Younger sister, age 60, with asthma** |
| **Instructions for SP on how to answer questions about any family members not listed above:**  **(i.e. do not add any additional family members, any other family is alive and well, unsure about paternal grandparents, etc.)** | **Do not add any additional family members.**  **Any other family members are alive and well.**  **Unsure about paternal grandparents’ health status.** |
| **Management/Treatment of any relevant conditions and/or chronic diseases in family** | **Sister manages asthma with inhalers and regular check-ups**  **Mother takes NSAIDs for arthritis** |

**Social History: (fill in any relevant fields)**

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| **Substance Use (past and present)** | **Drug Use (Recreational, medicinal and medications prescribed to other people)** | **No current recreational drug use** |
| **Tobacco Use** | **Former smoker, 40 pack-years, quit 5 years ago** |
| **Alcohol Use** | **Social drinker, 2-3 beers per week** |
| **Home Environment** | **Home type** | **Single-story detached house** |
| **Home Location** | **Suburban area** |
| **Co-habitants** | **Lives with spouse** |
| **Home Healthcare devices (for virtual simulations)** | **None** | |
| **Social Supports** | **Family & Friends** | **Lives with spouse, has a few close friends** |
| **Financial** | **Stable income from pension and Social Security** |
| **Health care access and insurance** | **Medicare and supplemental insurance** |
| **Religious or Community Groups** | **Attends community center activities monthly** |
| **Education and Occupation** | **Level of Education** | **High school diploma** |
| **Occupation** | **Retired construction manager** |
| **Health Literacy** | **High; understands medical terminology and instructions** |
| **Sexual History:** | **Relationship Status** | **Married** |
| **Current sexual partners** | **Wife** |
| **Lifetime sexual partners** | **Married once, no significant extramarital relationships** |
| **Safety in relationship** | **No concerns** |
| **Sexual orientation** | **Heterosexual** |
| **Gender identity** | **Pronouns** | **He/Him** |
| **Identifies as (e.g. transgender, cisgender, gender queer)** | **Cisgender Male** |
| **Sex assigned at birth** | **Male** |
| **Gender presentation (any notes about body language, style, or dress that may signal gender identity)** | **Casual attire, no notable indicators** |
| **Activities, Interests, & Recreation** | **Hobbies, interests, and activities** | **Enjoys woodworking, fishing, and golfing** |
| **Recent travel** | **None in the past six months** |
| **Diet** | **Typical day’s meals** | **Balanced diet with emphasis on proteins, vegetables, and whole grains** |
| **Recent meals** | **Regular eating habits, no significant changes** |
| **Avoids eating (e.g., fried foods, seafood, etc.)** | **Avoids excessive salt due to hypertension** |
| **Special diet (e.g., vegetarian, keto, dietary restrictions, etc.)** | **Low-sodium diet** |
| **Exercise (activities and frequency)** | **Exercise activities and frequency** | **Walks daily for 30 minutes, occasional golfing** |
| **Recent changes to exercise/activity (and reason for change)** | **Reduced walking duration due to shortness of breath** |
| **Sleep Habits** | **Pattern, length, quality, recent changes** | **Pattern, Length, Quality: Sleeps approximately 6-7 hours per night, occasionally disturbed by coughing**  **Recent Changes: Slight difficulty falling asleep due to persistent cough** |
| **Stressors** | **Work** | **Retired, minimal work-related stress** |
| **Home** | **Managing new health diagnosis, slight concern about dependence** |
| **Financial** | **Stable, no significant financial stress** |
| **Other** | **Adjusting to lifestyle changes due to health condition** |

**Physical Exam Findings: (may also include instructions on simulating/replicating/reporting findings, e.g., physical simulations, verbal prompts, findings cards, moulage, hybrid technology)**

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| General Appearance: Middle-aged male appearing slightly distressed due to breathing difficulty, sits leaning forward  Vital Signs:  Temperature: 37.2°C (99°F)  Blood Pressure: 135/85 mmHg  Heart Rate: 88 bpm  Respiratory Rate: 20 breaths per minute  Oxygen Saturation: 90% on room air  HEENT:  Throat: Slight erythema, no exudates  Lungs: Prolonged expiratory phase, mild wheezing in both lower lobes  Cardiovascular:  Regular rhythm, no murmurs  Abdomen:  Soft, non-tender, no hepatosplenomegaly  Extremities:  No edema, no cyanosis  Neurological:  Alert and oriented, no focal deficits |

**Prompts and Special Instructions:**

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| **Questions the SP MUST ask/ Statements patient must make** | **Must Ask:**  **"What exactly is COPD, and how will it affect my daily life?"**  **"Are there treatments or lifestyle changes that can help manage my condition?"**  **"What can I do to prevent my symptoms from getting worse?"**  **Must Make:**  **"I'm worried about how this diagnosis will impact my ability to enjoy my hobbies and activities."**  **"I want to understand everything I need to do to take care of my health moving forward."** |
| **Questions the SP will ask if given the opportunity** | **"Are there any support groups or resources for people with COPD?"**  **"What signs should I watch for that indicate my condition is worsening?"**  **"Can you recommend any exercises or therapies to improve my lung function?"** |
| **What should the SP expect by the end of this visit? (e.g., diagnosis, plan, treatment, reassurance)** | **Diagnosis: Newly Diagnosed Chronic Obstructive Pulmonary Disease (COPD)**  **Plan: Initiation of appropriate pharmacotherapy (e.g., bronchodilators, inhaled corticosteroids), recommendations for smoking cessation support if applicable, advice on lifestyle modifications (e.g., exercise, diet), referral to pulmonary rehabilitation, scheduling follow-up appointments**  **Treatment: Prescription for inhalers (e.g., albuterol, tiotropium), possible starting of inhaled steroids, patient education on proper inhaler technique**  **Reassurance: Understanding of COPD as a manageable chronic condition, strategies to maintain quality of life, encouragement to adhere to treatment and follow-up plans** |
| **Is there anything the learner knows from the door info that the SP does not? (e.g., symptomatic vitals, pregnancy, lab results, imaging)** | **Learner Knows:**  **Specific spirometry results indicating reduced FEV1/FVC ratio**  **Detailed imaging studies (e.g., chest X-ray or CT scan findings)**  **Comprehensive lab results (e.g., blood gas analysis)**  **SP Does Not Know:**  **Exact spirometry values and their interpretations**  **Detailed medical terminology beyond general understanding**  **Specifics of lab and imaging results unless the learner explains them** |