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: Emily "Emmy" Davis**

**Age: 55**

**Gender: Female**

**Chief Complaint: Severe shortness of breath and chest discomfort for the past 24 hours**

**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: Anxious and distressed**  **Speech: Rapid and slightly labored, may pause to catch breath**  **Body Language: Uses hands to indicate difficulty breathing, shifts position frequently to find comfort**  **Non-Verbal Communication: Sweating, flushed appearance, visible signs of respiratory distress (e.g., intercostal retractions)**  **Verbal Characteristics: Speaks urgently about symptoms, may interrupt to indicate discomfort** |

**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**  **"I can't breathe properly, and my chest feels tight. It's been really bad since yesterday."**  **Response to "Can you tell me more?":**  **"Sure. I started feeling unusually short of breath about two days ago, and it just kept getting worse. Now, even sitting down feels exhausting, and my chest hurts when I try to take deep breaths."** |
| **Other information offered spontaneously (what can be disclosed after any open-ended question)** | **B**  **I've also been coughing a lot, and the cough isn't getting any better. It's making it hard to sleep at night."** |
| **Information elicited when generally prompted (what can be disclosed in response to an open-ended question on a particular topic)** | **C**  **If asked about recent illnesses or infections:**  **"I had the flu a week ago, and I've been trying to recover, but this breathing issue started after that."**  **If asked about exposure to sick individuals or environments:**  **"I work in healthcare, so I've been around a lot of patients lately, including those with respiratory issues."** |
| **Information hidden until asked directly (what should be withheld until specific questioning)** | **D**  **If asked about underlying health conditions:**  **"I have asthma, but it was pretty well controlled until now."**  **If asked about medication adherence:**  **"I've been missing my inhaler doses because I've been feeling too breathless to remember."** |

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

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

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| **Quality/Character** | **Severe shortness of breath, described as feeling unable to take a full breath. Chest discomfort is tightness rather than sharp pain.** |
| **Onset** | **Symptoms began approximately 24 hours ago, progressively worsening.** |
| **Duration/Frequency** | **Continuous shortness of breath with intermittent episodes of increased difficulty, especially at night.** |
| **Location** | **N/A (respiratory symptom)** |
| **Radiation** | **N/A** |
| **Intensity (e.g. 1-10 scale for pain)** | **Shortness of breath rated 8/10, chest discomfort rated 6/10.** |
| **Treatment (what has been tried, what were the results)** | **Used her rescue inhaler (albuterol) a few times with minimal relief. Took over-the-counter cough medicine without improvement.** |
| **Aggravating** **Factors (what makes it worse)** | **Physical activity, lying flat, exposure to cold air.** |
| **Alleviating** **Factors (what makes it better)** | **Sitting upright, using the rescue inhaler provides slight but temporary relief.** |
| **Precipitating** **Factors (does anything seem to bring it on, e.g. meals, environment, time of day)** | **Recent influenza infection, increased exposure to respiratory irritants at work.** |
| **Associated** **Symptoms** | **Persistent cough, wheezing, fever, fatigue, difficulty sleeping.** |
| **Significance to Patient (impact on patient’s life, patient’s beliefs about origin of problem, underlying concerns/fears, hopes/desires)** | **Emily is highly concerned about her inability to breathe properly and fears it may lead to more severe complications. She is worried about missing work and the impact on her family responsibilities.** |

**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: Fever, fatigue, unintentional weight loss (2 pounds)  Respiratory: Severe shortness of breath, persistent cough, wheezing, chest tightness  Cardiovascular: No chest pain radiating, occasional palpitations  Gastrointestinal: No nausea or vomiting, decreased appetite  Neurological: No dizziness or syncope  Musculoskeletal: No significant joint or muscle pain  Psychiatric/Behavioral: Increased anxiety and panic related to breathing difficulties |

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

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| **Illnesses/Injuries (chronic or otherwise relevant)** | **Asthma (diagnosed in childhood)**  **Seasonal allergies** |
| **Hospitalizations** | **None in the past five years** |
| **Surgical History** | **Appendectomy at age 25** |
| **Screening/Preventive (including vaccinations /immunizations)** | **Annual influenza vaccination**  **Up-to-date with mammograms and colonoscopies** |
| **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** | **Albuterol inhaler (2 puffs as needed for asthma)**  **Fluticasone inhaler (once daily for asthma control)** |
| **Allergies (environmental, food, or medication – also list any known reactions) Date of allergy diagnosis** | **No known drug allergies** |
| **Gynecologic History** | **N/A** |

**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 68 from myocardial infarction**  **Mother: Alive, age 85, with chronic obstructive pulmonary disease (COPD)**  **Sibling: Younger brother, age 50, with type 2 diabetes** |
| **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** | **Mother manages COPD with bronchodilators and regular check-ups**  **Brother manages diabetes with metformin and insulin** |

**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, 15 pack-years, quit 10 years ago** |
| **Alcohol Use** | **Occasional wine, 1-2 glasses per week** |
| **Home Environment** | **Home type** | **Two-story townhouse** |
| **Home Location** | **Urban area** |
| **Co-habitants** | **Lives with spouse and two teenage children** |
| **Home Healthcare devices (for virtual simulations)** | **None** | |
| **Social Supports** | **Family & Friends** | **Strong support from spouse and children, a few close friends** |
| **Financial** | **Stable income from employment and savings** |
| **Health care access and insurance** | **Employer-provided health insurance** |
| **Religious or Community Groups** | **Active member of a local church** |
| **Education and Occupation** | **Level of Education** | **Bachelor’s degree in Nursing** |
| **Occupation** | **Registered Nurse** |
| **Health Literacy** | **High; understands medical terminology and instructions** |
| **Sexual History:** | **Relationship Status** | **Married** |
| **Current sexual partners** | **Spouse** |
| **Lifetime sexual partners** | **Married once, no significant extramarital relationships** |
| **Safety in relationship** | **No concerns** |
| **Sexual orientation** | **Heterosexual** |
| **Gender identity** | **Pronouns** | **She/Her** |
| **Identifies as (e.g. transgender, cisgender, gender queer)** | **Cisgender Female** |
| **Sex assigned at birth** | **Female** |
| **Gender presentation (any notes about body language, style, or dress that may signal gender identity)** | **Professional attire, minimal makeup** |
| **Activities, Interests, & Recreation** | **Hobbies, interests, and activities** | **Enjoys gardening, reading, and yoga** |
| **Recent travel** | **Vacationed last summer, no recent travel** |
| **Diet** | **Typical day’s meals** | **Balanced diet with emphasis on vegetables, lean proteins, and whole grains** |
| **Recent meals** | **Regular eating habits, no significant changes** |
| **Avoids eating (e.g., fried foods, seafood, etc.)** | **Avoids high-sugar foods due to minor diabetes concerns** |
| **Special diet (e.g., vegetarian, keto, dietary restrictions, etc.)** | **None** |
| **Exercise (activities and frequency)** | **Exercise activities and frequency** | **Practices yoga twice a week, walks daily** |
| **Recent changes to exercise/activity (and reason for change)** | **Reduced walking frequency due to shortness of breath** |
| **Sleep Habits** | **Pattern, length, quality, recent changes** | **Pattern, Length, Quality: Sleeps approximately 7-8 hours per night, disturbed by coughing and difficulty breathing**  **Recent Changes: Increased difficulty falling asleep and staying asleep due to respiratory symptoms** |
| **Stressors** | **Work** | **Increased workload leading to fatigue** |
| **Home** | **Balancing work and family responsibilities, concern about health impacting ability to care for family** |
| **Financial** | **Stable, no significant financial stress** |
| **Other** | **Managing chronic health conditions and recent acute symptoms** |

**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 female appearing anxious and in moderate respiratory distress, sitting upright and leaning slightly forward  Vital Signs:  Temperature: 38.0°C (100.4°F)  Blood Pressure: 130/85 mmHg  Heart Rate: 110 bpm  Respiratory Rate: 28 breaths per minute  Oxygen Saturation: 89% on room air, 93% with supplemental oxygen via nasal cannula  HEENT:  Throat: Slight erythema, no exudates  Lungs: Bilateral wheezing, reduced breath sounds in the lower lobes  Cardiovascular:  Regular rhythm, tachycardic, no murmurs  Abdomen:  Soft, non-tender, no hepatosplenomegaly  Extremities:  No edema, no cyanosis  Neurological:  Alert and oriented, anxious but cooperative |

**Prompts and Special Instructions:**

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| **Questions the SP MUST ask/ Statements patient must make** | **Must Ask:**  **"What is causing my sudden difficulty in breathing?"**  **"How serious is my condition?"**  **"What treatments are available to help me breathe better?"**  **Must Make:**  **"I can't catch my breath, and it's really scary."**  **"I'm worried this might be something life-threatening."** |
| **Questions the SP will ask if given the opportunity** | **"Will I need to be on a ventilator?"**  **"Are there any side effects to the medications you’re prescribing?"**  **"How long will it take for me to recover?"** |
| **What should the SP expect by the end of this visit? (e.g., diagnosis, plan, treatment, reassurance)** | **Diagnosis: Acute Respiratory Distress Syndrome (ARDS)**  **Plan: Initiation of appropriate therapies (e.g., supplemental oxygen, mechanical ventilation if necessary), administration of corticosteroids, possible antibiotics if infection is suspected, recommendations for intensive monitoring, referral to a pulmonologist, scheduling follow-up appointments**  **Treatment: High-flow oxygen therapy, possible intubation and mechanical ventilation, medications to reduce inflammation**  **Reassurance: Understanding of the severity of ARDS, explanation of treatment plan, support resources for managing the condition** |
| **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 lab results indicating hypoxemia (e.g., low PaO₂, elevated PaCO₂)**  **Detailed imaging studies (e.g., chest X-ray or CT scan showing bilateral infiltrates)**  **Comprehensive blood work (e.g., elevated inflammatory markers)**  **SP Does Not Know:**  **Exact lab values and their interpretations**  **Detailed medical terminology beyond general understanding**  **Specifics of imaging results unless the learner explains them** |