A STRUCTURED MEDICAL INTERVIEWING COURSE: SEVEN STANDARDIZED PATIENT CASES

INSTRUCTOR'S GUIDE

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A Structured Medical Interviewing Course:
Seven Standardized Patient Cases

Instructor's Guide

Brief Description

The M-1 Interviewing Course at the Medical College of Wisconsin uses six standardized (SP) cases. This is a complete guide for the six cases that are currently being used in the course: acute back pain, first prenatal visit, normal breastfed newborn, depression in an older adult, an unwanted pregnancy, and routine physical for a 60-year-old man as well as a seventh case that has been used in the past: routine physical for a woman in her 40's. The purpose of interviewing the SP is for the first year medical students to practice core interviewing skill in a safe, group-learning, experiential environment. Through these cases students practice establishing rapport, collecting the history for each case, and attending to patient-centered concerns. As the cases progress, student practice additional skills: family and genetic history, birth and newborn history, sexual and menstrual history, smoking cessation counseling, depression and suicide assessment, and diet and exercise history.

The authors would like to acknowledge Tisha Palmer for her contributions to case development.

Intended Learner audience

1st year medical students developing core interviewing and communication skills
2nd year medical students seeking to refine interviewing skills

Course Objectives

At the completion of the interviewing course, medical students will be able to

1. Demonstrate respect for patients by introducing themselves and explaining their role in the interview
2. Initiate the interview with an open-ended question and use focused questions to obtain specific information
3. Value the patient's narrative by giving the patient ample time to speak
4. Comprehend the components of the pertinent history and demonstrate ability to gather it in a variety of patient encounters
5. Respond directly and empathically to patient concerns (agendas, values, emotional state)
6. Incorporate patient values into discussion involving behavior change and decision-making
7. Check information with patient for correct understanding before ending the interview
8. Write a concise chart-style note that accurately portrays the standardized patient encounter

Course Structure

This course consists of six sessions of 1 ½ to 2 hours each. Groups of six students meet with one facilitator and a series of standardized patients. Each week, two students are assigned to interview the standardized patient. By the end of the course, each student has participated in two interviews, observed and discussed four additional interviews, and

completed six chart-style notes. Six of the seven cases provided here can be used to create a combination of cases and learning objectives that meet course needs.

At the completion of the course, an objective structured examination (OSCE) uses the same six cases. All of the students rotate through stations to complete all of the interviews (approximately 15 minutes per interview). The standardized patients use the OSCE checklists to score the students' performances.

Expectations of Students

1. Attendance is required at all sessions
2. All students are expected to prepare for the session by reading the assigned materials
3. As the student interviewer:
   a. Conduct a structured interview in the 15-20 minute timeframe
   b. Address the specific content of the case
   c. Focus on the objectives and challenges of the case
4. As the student observers:
   a. Observe the interview
   b. Provide verbal feedback to interviewers regarding specific aspects of the interviewers' performance (delineated for each case in the student assignment form)
5. All students are expected to write a chart-style note of the encounter

Expectations of Facilitators

Qualifications

1. Facilitator needs working knowledge and understanding of the basic principles of medical interviewing
2. Teaching and organizational skills
   a. Ability to monitor and guide students through the interview process
   b. Ability to promote small group interaction
   c. Ability to provide constructive feedback about the interview and the chart-note

Responsibilities

1. Prepare the students before the interview (use handout: Students Reference Guide)
   a. review required reading assignments as a group before the interview
   b. discuss features and challenges of the interview
   c. encourage students to anticipate challenges and suggest appropriate questions
2. During the interview (use handout: Facilitator Checklist of Content and Communication Skills)
   a. monitor the time of the interview (15-20 minutes)
   b. provide guidance during the interview if requested by the student
3. Upon completion of the interview
   a. ask the SP to give candid feedback about
      - how he/she felt during the interview
      - was he/she listened to
      - was he/she correctly understood
      - any recommendations

   b. facilitate group discussion of the interview and feedback to the interviewers
   c. complete a written review of each student's performance including a checklist of skills and specific comments
   d. provide written feedback on the students' written chart-style notes
4. Evaluation of student skill (use handout: Facilitator Checklist of Content and Communication Skills)
   a. during the interview, facilitator will complete checklist for the the student interviewer
   b. use this checklist in giving verbal feedback about the interviewer in a group discussion format
   c. written chart notes are graded for organization and completeness and returned to the students

      The grading system is a 3-point system:

      Below expectations (1)
      Meets expectations (2)
      Exceeds expectations (3)

      It is very hard to be 'below expectations' unless a student turns it in late, does not take previous feedback into account, or omits *major* sections of the write-up.

      Most reasonable efforts will 'meet expectations.'

      Some write-ups along the way will 'exceed expectations,' and they will be very well-written, without content omissions, with excellent organization, will lack of extra verbage, and be easy to read.

OSCE

If needed, included are additional evaluation forms that are specifically designed for using the case as part of an OSCE.

Preparing for a Medical Interviewing Course

1. Prepare materials
   a. Facilitator's Guide: create a binder with introductory material and a tabbed section for each case including
      - Facilitator Case Reference Guide
      - Facilitator Checklist of Content and Communication Skills
      - Standardized Patient (SP) Case Instructions
      - Student Reference Guide
      - Student Assignment Form
      - Supplemental information/references (case-specific)
      - Student reference; Writing Your Notes
   b. Student Guide: create a course booklet or binder for each student with introductory material with six tabbed sections for each case including
      - Student Reference Guide
      - Student Assignment Form
      - Supplement information/references (case-specific)
      - Student reference: Writing Your Notes

   c. Secure copyright reproduction permission if including selected articles in the binders
2. Train standardized patients (use handout: SP Training Notes; optional: OSCE Checklist)
   a. Contact medical school's department that trains SP's regarding times that patients are needed and locations of student interviews.
   b. Give "SP Training Notes" to trainers of SP's. These specify the specific case content and role (emotional state) the SP's should incorporate into their performances to present the challenges and learning opportunities to the students
   c. If SP's will be scoring the students in an OSCE, give trainers and SP's the OSCE Checklist specific for each case. Consider having SP's watch previously-recorded interviews to learn to use the checklist correctly
3. Train facilitators (use previously-prepared Facilitator's Guide and Textbook)
   a. Review the cases, the questions that are expected to be asked by the student interviewer, and the particular challenges of each case
   b. Explain the tasks related to their role as facilitators (refer to earlier section: Facilitator Responsibilities)

Facilities/Required Resources/Instructional Materials (Equipment, space, room set-up)

Textbook: Coulehan, J. & Block, M. (2006). *The Medical Interview: Mastering Skills for Clinical Practice.* F.A. Davis Co.: Philadelphia, PA. 5th Ed.
Video: ACP/AICM Clinical Skills Series: Counseling for Behavior Change

Room able to accommodate the number of students (typically 6), one SP, and one facilitator.
A conference-type table and enough chairs to accommodate group discussion and set-up of interview. Arrange students desks, table, and chairs as needed for the interview.

- Two chairs at front of room for student interviewer and standardized patient
- Other students and facilitator seated comfortable in room facing the interviewer and SP (ideally around a conference table)

A smoking cessation video accompanies Case #6 and requires a VCR player/monitor.

Teaching Tips – Lessons Learned

Student interview assignments are kept private until the day of the interview. In our experience, students come more prepared to the session (as observers or interviewers) if they *may* have to do the interview.

Throughout the preparation for the interview, the facilitator must speak to the specific challenges that come with each case.

Assign specific tasks to the student observers (see each case for a list of these) before the students do their interviews.

The two students assigned to be interviewers for the session wait in the hall. One student knocks on the room door, enters, and conducts his/her interview. When the first interview is complete, the second student interviewer is signaled to begin. We have found that when the student going second has watched the first student interview, he or she has more trouble with a spontaneous interview. It may be "knowing the answers" to the questions makes it more difficult for him or her.

Selected References

For all cases: (recommended chapters identified for each case)
Coulehan, J., & Block, M. (2006). *The Medical Interview: Mastering Skills for Clinical Practice*. F.A. Davis Co.: Philadelphia, PA. 5th Ed.

Case #1: Acute Back Pain
(no additional references)

Case #2: First Prenatal Visit
Bender, PL. "Genetic Family History Assessment." AACN Clinical Issues. 1998: Vol 9, No. 4, pp 483-490.

Case #3: Breastfed Newborn Feeding Case
Newborn History Sheet. Compiled by Kayleen Papin, MD; reviewed by Medical Interviewing Course facilitators at Medical College of Wisconsin. July 2006.

Gartner LM, Morton J, Lawrence RA, Naylor AJ, O'Hare D, Schanler RJ, Eidelman AI: American Academy of Pediatrics Section on Breastfeeding. Breastfeeding and the use of human milk. Pediatrics. 2005 Feb:115(2):496-506.

http://familydoctor.org/019.xml?printxml Link to Patient Handout on Breastfeeding

Case #4: Having Trouble Sleeping
Gallo, J. Rabins, P. "Depression Without Sadness: Alternative Presentations of Depression in Late Life." American Family Physician. Sept. 1, 1999: Vol 60, No 3. pp 820-826.

Case #5: Unwanted Pregnancy
Case 5 Background Information compiled by Joan Bedinghaus, MD with references.

Case #6: Well Visit
Phase Model of Behavior Change sheets

Assessment of Tobacco Use & Brief Clinical Interventions from Clinical Practice Guideline: Treating Tobacco Use and Dependence. US Department of Health and Human Services, from http://www.surgeongeneral.gov/tobacco/treating_tobacco_use.pdf (page 23 & pages 25-35)

Review of colon cancer genetics at
http://www.cancer.gov/cancerinfo/pdq/genetics/colorectal

Video: ACP/AICM Clinical Skills Series: Counseling for Behavior Change

Case #7: Annual Check-up/High Blood Pressure
Nat'l Heart, Lung, and Blood Institute "Your Guide to Lowering Your Blood Pressure with DASH"
http://www.nhlbi.nih.gov/health/public/heart/hbp/dash/new_dash.pdf (accessed Feb 25, 2008)

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Facilitator Training: Facilitating the Sessions

1. Arrange the room: two chairs placed in front of the group for the standardized patient (SP) and the interviewer. Six chairs around the conference table for the facilitator and the student observers.
2. You may wish to discuss the major issues in the case before starting the interviews.
3. The SP's are kept in another room so that they can "stay in character" for the interviews. When your group has arrived and you are ready to begin, ask the two students designated as interviewers to wait in the hall. Have the SP come in and sit in one of the chair in the front of the room. Then signal the first interviewer. The interviewer should knock, come in, and introduce herself (as a medical student) then proceed to interview the SP as if the student were the main health care provider for that patient.
4. The interview should take about 15-20 minutes. As the interview is progressing, use the checklist (specific for each case) to note whether the interviewer has completed the appropriate interview tasks.
5. The interviewer may call "time out" to ask you or the group for information or guidance. (Occasionally, you as the instructor may also call time out if you think things have really gotten stuck or off track.) When the interviewer is finished, he should make some kind of summarizing or transitional statement to end the interview.
6. Then signal the second student to come in and repeat the interview. The first interviewer can stay and observe the second interviewer.
7. After each interview is done, have the SP give each student some feedback, and allow the group to ask the SP questions if they have them. The SP's can then leave the room and you and the students will continue to discuss the case.
8. All of the students in the group are required to write a chart note-type account of the interview and turn it in within a week of the session. Let you students know how you want them to get the notes to you (e-mail, interoffice mail, etc). You should review the notes for completeness, organization, and clarity (brevity is important, too!) Return the notes to the students at the next session.

References for Small Group Facilitation

Kurtz S, Silverman J, Draper J. _Teaching And Learning Communication Skills In Medicine_ Radcliffe Publishing; 2005.
Chapters 5, 6, and 7

Westberg J, Jason H. _Fostering Learning in Small Group: a practical guide_. New York, NY: Springer Publishing Company, Inc;1996

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Case #1: Facilitator Case Reference Guide

Presenting Complaint: (with setting/vitals)	Work-related back injury problems.
Gender and Age Range:	Male / Female, age 35-50
Name:	Diane Peterson
Opening Statement:	"I have this sharp pain in my back that is just killing me"
Brief Summary:	Patient works as nursing assistant at nursing home. While lifting heavy patient, felt sudden onset of low back pain. No previous back problems. Pain and stiffness worsened over the next few hours until patient had to leave work and come here. Pain is shooting down the right leg to the ankle; it is difficult to walk-partly because moving increases pain and partly because right leg feels weak. The patient's supervisor at work is not sympathetic.
Case Objectives:	1. Students will demonstrate introductions, explanation of their role, and establishment of rapport. 2. Students will demonstrate the appropriate use of open-ended and focused questions. 3. Students will demonstrate the ability to elicit a complete description of the chief complaint, including all dimensions of the symptom. 4. Students will demonstrate closure of the interview and transition to the next stage of the encounter. 5. Students will demonstrate clarification of the patient's agenda for the visit.
Key Challenge(s) of Case:	Introduce self, establishing rapport, open and closed questions, active listening, closing. Obtaining an occupational history, a complete description of pain and functional limitations. Respond to obvious distress.
Differential Diagnosis (actual diagnosis):	Disc herniation Muscle or ligament strain.
Exam Room Needs:	General Clinic Exam Room
Follow-up Station Needs:	None
Activities & Time Req:	Small Group Teaching Format – 15 minutes for encounter
Data Collection Methods:	Facilitator will provide verbal feedback on performance Standardized Patient will give feedback on communication skill Facilitator will fill out written review of each student performance
Course, Student Level:	M1 – Interview Course
Correlations:	Back and spinal cord anatomy, radicular pain and dermatomes in neuroscience
Reading:	Coulehan and Block, Ch. 1,2,3, and 8 (5th Ed.). Introductory sections of syllabus
Case Authors:	Joan Bedinghaus, MD , Tisha Palmer, SP Coordinator
Date (orig. / last revision)	November 20, 2001 / September 22, 2006

Case 1: Facilitator's Checklist of Content and Communication

Student Name: ____________________________
Facilitator: ______________________________

I. Content Checklist- Check if the student asked or did the following:

_____ Asked about pain **location** (lower back, radiating down right leg)

_____ Asked about pain **onset** (started when moving patient)

_____ Asked about pain **quality** (sharp, deep)

_____ Asked about pain **intensity** (best = 7, worst = 8)

_____ Asked about **prior history of back problems** (none)

_____ Asked what makes **pain better** (really nothing)

_____ Asked what makes **pain worse** (movement)

_____ Asked how pain **affects function (** can't work)

_____ Asked about **emotional state** (a little anxious)

II. Communication Skills Checklist- Check if the student:

_____ Introduced self and explained role

_____ Started with open-ended questions

_____ Gave patient time to answer fully

_____ Responded to patient's distress

_____ Checked for understanding

Additional Comments/Suggestions for Improvement:

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Case #1: Standardized Patient (SP) Case Instructions
Diane Peterson -- Work-Related Back Injury

Patient Name	Diane Peterson
Gender/Race/Age (age range)	Female, Age 40 yrs old Some preference to African American SP
Presenting Situation	Diane Peterson, age 40 presents to the clinic today with back pain.
Opening Statement	"I have this sharp pain in my back that is just killing me"
Elaboration of Complaint	You work as a nursing assistant at a local nursing home. While lifting a heavy paralyzed patient who had slumped in bed, you felt a sudden onset of low back pain. The human resources department at the nursing home said you should come to this clinic for your on-the-job injury.
Clinical Content*	Present illness/symptoms: • Sudden onset of back pain. When the injury "happened" it felt sharp and sudden. You describe the pain as DEEP and AWFUL. Your pain and stiffness has gotten worse over the last few hours and you had to leave work and come here. If asked to rate the pain your having now on a 0-10 scale, you would answer an 8. • Pain is shooting down your right leg to the ankle. It is difficult to walk – partly because moving increases your pain and partly because your right leg feels weak. You shift uncomfortably in your chair, often wincing and grimacing in your discomfort. • You took 2 Advil about 30 minutes after the pain started. This had no effect. Pertinent Past Medical History: • You have never had any prior back pain or difficulties with your back. • Other than this injury, you have been in good health. You smoke 1 pack/day and drink alcohol – 6 beers on the weekend. You do not use any other drugs and take no medications. You do not exercise on a regular basis though you do get quite a bit of exercise on the job. Family Medical History: • Your parents are both alive and well, living in Florida. • You had one brother who died several years ago of a drug overdose.

Physical Exam	No physical exam will be performed.
Psychosocial Profile	You have only been working at St. Camillas nursing home for short time. (Bluemound Rd. near the zoo). Your supervisor at work was not at all sympathetic to your injury. You are at the end of your probation period at work and do not have any accrued time off. You are quite worried about how this injury might affect your job status and financial picture. You need a form filled out because of leaving work early today and a doctor's note to take any time off. You are married with 2 children in high school. Your husband is laid off. You will get health insurance though your job if you are there for over 90 days. Right now your family is insured under COBRA and it's very expensive. You are also responsible for caring for your elderly mother-in-law, visiting her most evenings to clean and do laundry.
Scenario Development	You should be sitting, uncomfortably, in a chair when the student(s) start the scenario. In general, let the student(s) set the pace and scope of the interview. You are to remain slightly anxious about work and in quite a lot of pain during the entire session. If the scenario/ communication should come to a stall (more than a necessary pregnant pause). You can use one of the following questions to "jump start" the conversation: • Is this what a slipped disc feels like? • Don't I need a MRI or something? • Can I get something for the pain that won't make me sleepy? I really can't afford to miss any work. • This should all be covered by worker's comp, right?

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Case #1: Student Reference Guide

Instructions:	Please review the following materials in preparation for Interview Session, Case #1 –
Reading Assignment:	Coulehan and Block, Ch. 1,2,3, and 8 (5th Ed) are to be completed before Session #1. Please read the Intro. sections of the syllabus as well.
Patient Information:	Diane Peterson is a 40 year old woman who is here to see you for back pain. She is a new patient to this clinic.
Brief Summary:	The patient is here today at the urgent care clinic to see you for a work related injury.
Your Case Objectives:	1. Demonstrate introductions, explanation of your role, and establishment of rapport. 2. Demonstrate the appropriate use of open-ended and focused questions. 3. Demonstrate the ability to elicit a complete description of the chief complaint, including all dimensions of the symptom: (**P**lace, **Q**uality, **R**adiation, **S**everity, and **T**ime course). 4. Demonstrate clarification of the patient's needs for the visit. 5. Respond to the patient's distress.
Key Challenge(s) of Case:	Introducing self, establishing rapport, open and closed questions, active listening, closing. Obtaining an occupational history, a complete description of pain and functional limitations. Respond to obvious distress.
Activities & Time Req:	Small Group Teaching Format – 15 - 20 minutes for encounter
Data Collection Methods:	Facilitator will provide verbal feedback on performance. Standardized Patient will give feedback on communication skills. Facilitator will fill out written review of each student performance. All students will submit written history to facilitator.
Correlations:	Back and spinal cord anatomy, radicular pain and dermatomes in Neuroscience.

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Case #1: Student Assignment Form

<table>
<tr><td>Interviewer:</td><td>You are charged with obtaining a complete problem history from the patient, Ms. Peterson.

Signal the beginning of your interview by introducing yourself and explaining your role. As instructed, you may call a “Time Out” at any point in the interview to get suggestions from your classmates/facilitator if needed.

You will have 15 –20 minutes TOTAL time to complete the interview. The facilitator will let you know when time is up.</td></tr>
<tr><td>Observers:</td><td>You will be responsible for attuning to the following aspects of the interview and the interviewer’s performance:
1) Did the interviewer ask appropriate open ended / closed ended questions and give the patient ample time to respond?

2) Describe how the interviewer responded to the patient’s distress.

3) Give examples of the interviewer(s) reflecting the patient’s language and summarizing to check for understanding.

4) Has a complete description of the problem been obtained?

* Keep in mind that you will be asked to share your impressions and comments on these criteria following the interview</td></tr>
<tr><td>Written Assignment
(All 6 Participants)</td><td>Each of you will be responsible for writing a medical history for Ms. Peterson which should include:
• Identifying data
• Chief complaint: incorporate the patient’s words
• History of the present illness, organizing the story
• Be sure to include all the important elements of the patient’s problem

The medical history in its entirety should be about a page and should be turned into your Session #1 facilitator no later than 1 week from your Session #1 interview date.
This should be submitted via inter-office mail or e-mail.</td></tr>
</table>

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Case #2: Facilitator Case Reference Guide

Presenting Complaint: (with setting/vitals)	First Prenatal Visit
Gender and Age Range:	Female, 27 years old
Name:	Michelle Holly
Opening Statement:	"I want to make sure that I have nothing about this pregnancy to be worried about"
Brief Summary:	This is a first prenatal visit. The patient is excited yet anxious regarding her first pregnancy; she and her husband have been married just less than a year. Last menstrual period was 8 weeks ago. **The pregnancy is unplanned but welcome**. Patient has a first cousin on mother's side with muscular dystrophy. The patient's husband has a first cousin on mother's side with Down's syndrome.
Case Objectives:	1. Students will demonstrate introductions, explanation of their role, and establishment of rapport. 2. Students will demonstrate the appropriate use of open-ended and focused questions. 3. Students will demonstrate the gathering of family and genetic history. 4. Students will show integration of life cycle issues related to recent marriage and birth of first child into the interview.
Key Challenge(s) of Case:	Introduce self, establish rapport, open and closed questions, active listening, closing. Maintaining rapport with a patient while conducting a structured interview using a standard prenatal intake record. Dealing with patient anxiety about genetic risk; explaining risk. Obtaining a 3-generation family history.
Exam Room Needs:	General Clinic Exam Room
Activities & Time Req:	Small Group Teaching Format – 15 minutes min. for encounter
Data Collection Methods:	Facilitator will provide verbal feedback on performance. Standardized Patient will give feedback on communication skills. Facilitator will fill out written review of each student performance. Students will submit written history to facilitator.
Correlations:	Biochemistry: Genetics, X-linked recessives: muscle biochemistry and physiology Devo: prenatal development, prenatal diagnosis.
Reading:	1) Coulehan and Block, Chapter 4 2) Bender, *Genetic Family History Assessment,* attached 3) http://www.genetics.com.au/ **Fact Sheets:** Genetic counseling Prenatal diagnosis. Muscular dystrophy

	X-linked inheritance Down syndrome 4) http://www.geneclinics.org/profiles/dbmd Overview of muscular dystrophy, oriented to physicians. (optional)
Case Authors:	Joan Bedinghaus, MD; Tisha Palmer, SP Coordinator
Date (orig. / last revision)	November 20, 2001 / August 30, 2004

Case 2 : Facilitator's Checklist of Content and Communication

Student Name: ______________________
Facilitator: _________________________

I. Content Checklist- Check if the student asked or did the following:

_____ Asked about three generations in family history

_____ Was able to generate a complete list of family members

_____ Explained inheritance of muscular dystrophy clearly

II. Communication Skills Checklist- Check if the student:

_____ Introduced self and explained role

_____ Started with open-ended questions

_____ Gave patient time to answer fully

_____ Explained reason for long list of questions

_____ Maintained eye contact with patient while dealing with forms/diagrams

_____ Noticed / Responded to patient's growing anxiety

Additional Comments/Suggestions for Improvement:

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Case #2: Standardized Patient (SP) Case Instructions
Michelle Holly -- First Prenatal Visit

Patient Name	Michelle Holly
Gender/Race/Age (age range)	Female, 27 years old * **Attention to genetic prevalence of Down's/MD in specific racial groups – Specify for SPs used.**
Presenting Situation	Ms. Holly, age 27, presents to the clinic today for her first prenatal visit, her husband is unable to join her due to a work conflict.
Opening Statement	"I want to make sure that I have nothing about this pregnancy to be worried about"
Elaboration of Complaint - Concerns	• You want to believe that you have nothing to worry about.
Clinical Content*	<u>Present condition:</u> • Your last period was 8 weeks ago. • You are in good overall physical health. <u>Pertinent Past Medical History:</u> • This is your first pregnancy. • You had been on taking oral contraceptive pills for the last few years but switched to condoms before your wedding due to some concerns about weight gain. Your periods have been normal and regular up until this pregnancy. • You do not smoke. You do drink alcohol – 6 beers on the weekend but have made a conscious effort to not consume any alcohol since you found out you were pregnant. . You do not use any other drugs and take no medications. You do not exercise on a regular basis. • You regularly drink 3 – 4 caffeinated beverages (Soda) a day. <u>Family Medical History:</u> • Your parents are both alive and well, living in Texas. • You are an only child <u>Genetic History:</u> • Your mother had one brother who died in adolescence- you don't know much about him. (He might have had muscular dystrophy but no one ever talks about it.)

	• Your 1st cousin (your mother's sister's child) has muscular dystrophy. He is now 12 years old and in confined to a wheelchair. He has been in the hospital several times in the past year and almost died from pneumonia. You know that your aunt and uncle agonized for months about whether he should be on a ventilator next time or be allowed to die. • *You don't think this is a problem for you because it's a cousin – besides MD is a disease that only boys get and your husband is FINE.* – Your husband has a cousin with Downs' Syndrome (his mother's side). However when you learn during the interview that your child might be affected you become upset, because your cousin has suffered a lot.
Physical Exam	No physical exam will be performed.
Psychosocial Profile	You have only been working as administrative assistant for a local insurance agency for 14 months. You are concerned that you do not have enough Sick Leave / Vacation Time built up to enjoy a paid maternity absence. You may have to take 2 weeks unpaid. Your husband works long hours in the hotel industry. You and your husband live is a small apartment in West Allis. Both of you were looking forward to building enough savings to make a down-payment on a home in Brookfield, closer to your husband's work. This baby will put a wrench in all of your well-laid future plans. Your husband has expressed his concerns about the baby being placed in a daycare facility. He really wants you to be a stay-at-home mom. You believe that unless he makes manager soon, this will not be a option for your family financially. Besides, you think you would go stir-crazy at home alone with a newborn.
Scenario Development	You should be sitting comfortably in a chair when the student(s) starts the scenario. In general, let the student(s) set the pace and scope of the interview. You are cooperative and forthcoming to all questions. You came here today really needing to hear "everything is just fine" so you become anxious and/or defensive about hearing that you do have some genetic risk. If the scenario/ communication should come to a stall you can use one of the following questions to "jump start" the conversation: • Am I supposed to have morning sickness by now? • You don't really need to know about all my cousins and everything do you? **OR** My baby couldn't inherit something from my cousin, so why are you asking me all this? • Does Downs' syndrome run in families? **OR** I don't have to worry about Downs' since I'm under 35 right?

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Case #2: Student Reference Guide

Instructions:	Please review the following materials in preparation for Interview Session, Case #2 –
Reading Assignment:	1) Coulehan and Block, Chapter 4 2) Bender, *Genetic Family History Assessment,* attached 3) http://www.genetics.com.au Genetic counseling Prenatal diagnosis. Muscular dystrophy X-linked inheritance Down syndrome 4) (optional) http://www.geneclinics.org/profiles/dbmd Overview of muscular dystrophy, oriented to physicians
Patient Information:	Michelle Holly is a 27 year old woman who here to see you for her first prenatal visit. This is her first pregnancy and she and her husband have been married for less than 1 year.
Brief Summary:	Michelle has filled out Prenatal Intake Questionnaire (**Attached**). She would like you to reassure her that her baby will be healthy.
Your Case Objectives:	1. Demonstrate introductions, explanation of your role, and establishment of rapport. 2. Demonstrate the appropriate use of open-ended and focused questions. 3. Demonstrate the gathering of family and genetic history. 4. Demonstrate the integration of life cycle issues related to recent marriage and birth of first child into the interview.
Key Challenge(s) of Case:	Maintaining rapport with a patient while conducting a structured interview using a standard prenatal intake record. Dealing with patient anxiety about genetic risk.
Activities & Time Req:	Small Group Teaching Format – 15 - 20 minutes for encounter
Data Collection Methods:	Facilitator will provide verbal feedback on performance Standardized Patient will give feedback on communication skill Facilitator will fill out written review of each student performance
Correlations:	Biochemistry, Genetics, X-linked recessives; muscle biochemistry and physiology; Devo (prenatal development, prenatal diagnosis).

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Case #2: Student Assignment Form

<table>
<tr><td>Interviewer:</td><td>You are charged with conducting a structured interview using a standard prenatal intake record (attached), and obtaining a complete 3 generation family history.

Signal the beginning of your interview by introducing yourself and explaining your role. As instructed, you may call a "Time Out" at any point in the interview to get suggestions from your classmates/facilitator if needed.

You will have 15 –20 minutes TOTAL time to complete the interview. The facilitator will let you know when time is up.</td></tr>
<tr><td>Observers:</td><td>You will be responsible for attuning to the following aspect of the interview and the interviewer's performance:
1) Did the interviewer ask appropriate open ended / closed ended questions and give the patient ample time to respond?

2) Was the patient's distress responded to? Describe how the interviewer maintained responsive contact with the patient while dealing with forms.

3) Did the interviewer(s) reflect the patient's language and ask for clarification / summarize when necessary to check for understanding?

4) Did the interviewer adequately explain why the detailed questions on the form were necessary and was a complete description of the problem obtained?

* Keep in mind that you will be asked to share your impressions, comments on these criteria following the interview</td></tr>
<tr><td>Written Assignment
(All 6 Participants)</td><td>Each of you will be responsible for creating a written medical history for Mrs. Holly which should include:
• Identifying data
• Complete pedigree or genogram (maternal and paternal).
The genogram should be turned into your Session #2 facilitator no later than 1 week from your Session #2 interview date.
This should be submitted via inter-office mail or e-mail.</td></tr>
</table>

Medical College of Wisconsin
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Office of Educational Services/ SP Program

Case #3: Facilitator Case Reference Guide

Presenting Complaint	Newborn visit, breast-fed baby, feeding concerns
Gender and Age Range	4 day old baby with Mother (1st child)
Name	Baby Jacob & Mom Jennifer Schmidt
Brief Summary	The patient is a 4-day-old baby at his first visit to the clinic. He is a healthy, term (40 3/7 week) newborn who was born via uncomplicated vaginal delivery, following a healthy pregnancy to a healthy mother in her mid twenties, her first child. She is motivated to breastfeed, but is worried that he is not getting enough to eat. She has had pressure from her mother-in-law to supplement with formula. Her husband is supportive, but also wonders if the baby is getting enough. "Sometimes he cries like he might be hungry." Baby lost 8 oz during his hospital stay, and has re-gained 3 oz in the last 2 days.
Case Objectives	At the end of this case, students in the M-1 Interviewing course will be able to 1. Demonstrate respect for patients by introducing self and explaining their role in interview 2. Initiate interview with an open-ended question & use focused questions to obtain specific information 3. Comprehend and demonstrate ability to gather the history regarding pregnancy, birth history, newborn feeding, voiding, and stooling patterns 4. Respond directly and empathically to parental anxiety 5. Check information with patient for understanding before ending the interview with a transition to the next step
Key Challenges of Case	Newborn history-taking; newborn feeding history, directly responding to mother's anxiety about caring for her baby
Exam Room Needs	General Clinic Exam Room
Follow-up Station Needs	None
Activities and Time Req.	Small Group Teaching Format; 15 min. for each interview
Data Collection Methods	Facilitator will provide verbal feedback on performance. Standardized patient will give feedback on communication skills. Facilitators will fill out written review of each student performance including a checklist of skills & specific comments. Students will submit a written history to the facilitator. Facilitator will provide written feedback on written history.
Course, Student Level	Medical Interviewing, M-1
Reading	Coulehan and Block: Ch 10 & 18, 5th Ed. Enclosed readings: Newborn history sheet; AAP Policy Statement on Breastfeeding and the Use of Human Milk Link to patient handout on breastfeeding: http://familydoctor.org/019.xml?printxml
Case Author	Kayleen Papin, MD
Date	July 10, 2006

Case 3: Facilitator's Checklist of Content and Communication Skills

Student Name: ______________________
Facilitator: _________________________

<u>I. Content Checklist</u>- Check if the student:

____ Gathered a pregnancy history addressing
Illnesses (DM, HTN/PIH, infections) in the mother

____ Gathered a birth history & newborn hospital stay visit (3 of the following):
Type of birth
Gestational age
Complications – with birth or in hospital stay (oxygen, jaundice, infections, etc)

____ Gathered a newborn feeding history (at least 3 of the following):
How often?
How long?
Is milk in? or Engorgement?
Latching on – not painful?
Swallowing with feeding?

____ Gathered a voiding & stooling pattern history
Stooling: how often, what color/consistency, change in pattern
Voiding: how often

_____ Asked about depression in the mother

<u>II. Communication Skills Checklist</u>- Check if the student:

____ Introduced self & explained role

____ Started with an open-ended question

____ Used focused questions to gather further history

____ Gave patient time to fully answer

____ Directly responded to parent's anxiety

____ Checked information for understanding with the mother

____ Completed the interview with a transition statement
Ex: Thank you. I'll go and get Dr. ___ now.

Additional Comments/Suggestions for Improvement:

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Case #3: Standardized Patient (SP) Case Instructions
Baby Jacob and Mother Jennifer
Newborn Visit, Breast-fed baby, Feeding Concerns

Patient Name	Baby Jacob & Mother Jennifer Schmidt
Gender/Race/Age (range)	4 day old baby boy, mother in her mid-20's
Presenting Situation	Mother brings newborn baby to clinic for 1st visit, 2 days after they are home from hospital.
Opening Statement	"I don't know if he's getting enough to eat."
Elaboration of Complaint --Concerns	This is your first child. Your planned pregnancy was healthy & baby Jacob was born 2 days after his due date. His birth was a vaginal birth and uncomplicated. You and your husband are delighted to have a son, but you had no idea how tired you'd be. You have heard that breastfeeding is good for a baby, and want to do what's best, but you are worried about whether you are making enough milk for him. He seems hungry all the time. Sometimes he wants to nurse/feed "a lot" (every 2 hours). Your mother-in-law, who has come over to help out this first week, has told you that you'd better give him some formula "just to be sure he isn't hungry."
Clinical Content	<u>Present condition</u> Baby is nursing every 2-3 hours around the clock – about 10 minutes on the first breast – then about 5 minutes on the second side when he falls asleep. Last night your breasts became quite full & hard (warm to the touch then – which has gone away now). Your nipples are sore right when baby starts nursing – then it passes, but no cracking or bleeding. Just this morning you started being able to hear him swallow with feeding. There was some milk at the corners of his mouth after he ate. Bowel movements (turning from dark & sticky to yellow & seedy) about every-other feed (4-6 per day) You change his diaper after each feeding & it's always at least wet, if not a bowel movement as well. It's hard for you to tell what's wrong sometimes when he cries – hungry, tired, needs diaper change, too warm or cold, gas?? You are looking for reassurance, as you are worried about your baby and if you are taking good care of him. You do not feel depressed, down, hopeless; even though you are tired, you are able to care for yourself and baby <u>Pertinent Past Medical History</u> Pregnancy was planned & healthy – no infections, no blood pressure problems, and no diabetes.

<table>
<tr><td></td><td>You went into labor at 4 in the morning and had him at 5 the next evening. You had an epidural when you were 5 cm dilated. No other medications during labor. No one told you his APGAR scores. He stayed with you in the hospital room. No yellow skin (jaundice), need for him to be under lights, or other problems at the hospital. He was 7# 9 oz at birth and was 7# 1 oz when you went home 2 days later.
The nurses helped you with breastfeeding while you were in the hospital and said he had a “good latch.” You aren’t entirely sure what that means, but you are worried about being able to feed him.

<u>Family Medical History (relationships are to baby):</u>
Mother in her mid 20’s & in good health
Father of baby is also in good health (late 20’s).
Rest of family is also healthy.</td></tr>
<tr><td>Physical Exam</td><td>No physical exam will be performed</td></tr>
<tr><td>Psychosocial Profile</td><td>You are the first of your close friends who has had a baby. Your mother breastfed you and your younger sister (who is single), but she lives in Florida. Your mother has encouraged you over the phone but won’t be out to see you until the baby is almost a month old.</td></tr>
<tr><td>Scenario Development</td><td>You will be sitting comfortably in a chair holding a baby (doll wrapped in blanket) when the student enters the room. You are feeling excited about your new baby but also tired and worried. You are pleasant and forthcoming with information. You do have a lot of questions and may ask about a number of concerns. If the scenario/communication comes to a stall (more than necessary), you can use one of the following to “jumpstart” the conversation:
Should I give the baby some formula after I try to breastfeed?
How do I know he’s getting enough to eat?
This is all a lot harder than I thought…</td></tr>
</table>

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Case #3: Student Reference Guide

Instructions	Please read the following materials in preparation for Newborn Visit Interview
Reading Assignment	Coulehan and Block: Ch. 10 and 18, 5th Ed. and attached readings: Newborn history sheet; AAP Policy Statement on Breastfeeding and the Use of Human Milk. Link to patient handout on breastfeeding: http://familydoctor.org/019.xml?printxml
Patient Information	Baby Jacob, age 4 days old with mother Jennifer Schmidt.
Brief Summary	Jacob is here with his mother for a hospital follow-up – first visit to the clinic. She is breastfeeding and has some concerns. You are not expected to give breastfeeding advice, but you should respond empathically to mother's concern.
Case Objectives	At the end of this case, students in the M-1 Interviewing course will be able to 1. Demonstrate respect for patients by introducing self and explaining their role in interview 2. Initiate interview with an open-ended question & use focused questions to obtain specific information 3. Comprehend and demonstrate ability to gather the history regarding pregnancy, birth history, newborn feeding, voiding, and stooling patterns 4. Respond directly and empathically to parental anxiety 5. Check information with patient for understanding before ending the interview with a transition to the next step
Key Challenges of the Case	Newborn history-taking; directly responding to a worried, new mom about normal newborn behavior
Activities and Time Req.	Small Group Teaching Format – 15-20 minutes for each interview
Data Collection Methods	Facilitator will provide verbal feedback on performance. Standardized patient will give feedback on communication skills. Facilitators will fill out written review of each student performance including a checklist of skills & specific comments. Students will submit a written history to the facilitator. Facilitator will provide written feedback on written history.

Case #3: NEWBORN HISTORY – Focused on Feeding

Topic in History	Questions	Notes/why we ask
Pregnancy history	Any illnesses in mother: infections, high blood pressure, diabetes, anemia? Group B strep (GBS) status?	Risk factors for baby GBS positive mothers generally get antibiotics in labor in an effort to prevent neonatal sepsis
Birth history	How many weeks gestation? Labor complications – fever infection, medications? Type of birth – vaginal, assisted with forceps/vacuum, cesarean section? Birth weight APGAR scores	Due date = 40 week Full term is 37+ weeks APGAR (**A**ctivity, **P**ulse, **G**rimace, **A**ppearance, **R**espiration) each gets a score of 0-2 for total score out of 10. Scored at 1 & 5 minutes of life. Low APGAR scores increase risk for perinatal complications.
Nursery stay history	Special care needed – oxygen, antibiotics, phototherapy (lights) for jaundice? Home the same day as mom? (2 days for vaginal birth, 4 days for c-section) Weight at discharge	Know if there was a concern during initial nursery stay Babies who stay in hospital longer than mom may have had an early complication Can lose 10% of birth weight – regain to birth weight by 2 weeks (1-2 oz per day)
Feeding	Type of feeding – breast-fed or formula-fed How often? How much? (if formula or expressed breastmilk) How long? (minutes if breastfed) If formula, what type & how is it being prepared	 Every 1-4 hours in first week of life. 2-4 oz per feeding in first week of life 10-25 min Powder is 1 scoop: 2 oz water Pre-mixed – don't add water

Elimination	Bowel movements – how many per day? What do they look like? Wet diapers – how many per day?	Bowel movements – usual is 3-4 per day by 3-5 days old. Usually turning from sticky black (meconium) to yellow-seedy if feeding is going well Wets – usual is 3-5 per day by 3-5 days old Adequate urine and BM's indicate adequate intake.
Maternal depression/coping	How is mother's mood? Is she able to care for child? Does she have help? History of depression?	Screen for post-partum depression vs "baby blues"

Created by Kayleen Papin, MD; Medical College of Wisconsin, Department of Family and Community Medicine, July 2006

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Medical Interviewing
Office of Educational Services/ SP Program

Case #3: Student Assignment Form

<table>
<tr><td>Interviewer:</td><td>You are charged with conducting a structured interview. Imagine you would be presenting the history to your preceptor before you both go on to complete the assessment. During this interview, assess past medical (pregnancy, birth, and nursery stay history) of a newborn, as well as feeding issues (breastfeeding patterns and specifics, voiding and stooling patterns). You will directly respond to the mother's anxiety by responding empathically. You will also check information with the patient as needed during the interview and complete the interview with a transition to let the mother know what will be coming next.

Signal the beginning of your interview by introducing yourself and explaining your role. As instructed, you may call a "Time Out" at any point in the interview to get suggestions from your classmates or facilitator as needed.

You will have 15-20 minutes TOTAL time to complete the interview. The facilitator will let you know when time is up.</td></tr>
<tr><td>Observers:</td><td>You will be responsible for attuning to the following aspects of the interview and giving verbal feedback to the interviewer as his/her performance:
1. Did the interviewer ask appropriate open-ended/closed ended questions and give the patient ample time to respond?
2. Describe how the interviewer reflected the patient's language and summarized when necessary to check for understanding.
3. Did the interviewer directly respond to the mother's anxiety in an empathic way?
4. Did the interviewer maintain a sensitive, supportive attitude while checking for understanding of information with the mother?</td></tr>
<tr><td>Written Assignment:
(entire group)</td><td>Each of you will be responsible for writing a medical history for Baby Jacob which should include:
• Presenting problem/mother's concerns
• Pregnancy, birth, and nursery stay history
• Feeding, voiding, stooling history
The medical history in its entirety should be about 1 page and should be turned into your facilitator no later than 1 week from your interview date. This can be submitted via inter-office mail or e-mail.</td></tr>
</table>

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Case #4: Facilitator Case Reference Guide

Presenting Complaint: (with setting/vitals)	Having Trouble Sleeping
Gender and Age Range:	Female/Male age 70-75
Name:	Naomi (Nathan) Blue
Opening Statement:	"My daughter is worried about me".
Brief Summary:	The patient is here alone, but at the suggestion of her daughter who is worried that patient is "letting herself go." Patient is retired and lives in her own home. Her husband died 2 years ago. They had a fairly active social life as a couple but she has been feeling "like a fifth wheel" at social gatherings since he died. She hasn't been out with her friends for the past two or three months.
Case Objectives:	1. Students will demonstrate introductions, explanations of their role, and establishment of rapport. 2. Students will gather information on functional status in an elderly person. 3. Students will demonstrate the use of the interview to establish the diagnosis of depression. 4. Students will respond supportively to the patient's distress. 5. Student will sensitively discuss the difference between normal grief and depression. 6. Note: Students are not expected to propose a treatment plan.
Key Challenge(s) of Case:	Obtaining adequate information on health, cognition and functional status. (See Coulehan, p 215 in 5th Ed.) Responding to patient's distress. Asking about depression symptoms, and suicidal thoughts and social supports.
Exam Room Needs:	General Clinic Exam Room
Follow-up Station Needs:	None
Activities & Time Req:	Small Group Teaching Format – 15 minutes for encounter
Data Collection Methods:	Facilitator will provide verbal feedback on performance Standardized Patient will give feedback on communication skills Facilitator will fill out written review of each student performance Students will submit written note to facilitator
Course, Student Level:	M1 – Interview Course
Correlations:	Neurobiology of aging, mood: serotonin and norepinephrine receptors.
Differential Diagnosis:	Dementia, hypo- or hyperthyroidism, polypharmacy, alcoholism.
Reading:	Coulehan and Block, Chapter 11, 5th Ed; Gallo JJ, Rabins PV: Depression without sadness: Alternative presentations of depression in late life. American Family Physician 1999; 60: 820-6. (Reprinted in syllabus).
Case Authors:	Joan Bedinghaus, MD and Tovah Bates, PhD
Date (orig. / last revision)	August 1, 2005/January 19, 2006

Case 4: Facilitator's Checklist of Content and Communication Skills

Student Name: ______________________
Facilitator: ___________________

I. Content Checklist- Check if the student asked or did the following:

_____ Asked about at least 2 instrumental activities of daily living (IADL)

Shopping	Transportation
Food preparation	Finances
Housekeeping	

_____ Asked about at least 2 activities of daily living (ADL)

Dressing	Eating
Ambulating/falls	Toileting/continence
Hygiene	

_____ Asked about social supports

_____ Asked at least 4-5 depression symptoms

Mood	Sleep
Appetite	Anhedonia
Guilt	Hopelessness
Fatigue	Concentration
Restlessness	Anxiety
Concentration	Psychomotor slowing

_____ Attempted to explain bereavement/depression difference

_____ Asked about thoughts of death or suicide

_____ Asked about general health and medications

II. Communication Skills Checklist- check if the student:

_____ Introduced self and explained role

_____ Started with open-ended questions

_____ Gave patient time to answer fully

_____ Responded appropriately to patient's distress

Additional Comments/Suggestions for Improvement:

Medical College of Wisconsin
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Case #4: Standardized Patient (SP) Case Instructions
Naomi (Nathan) Blue

Patient Name	Naomi (Nathan) Blue
Gender/Race/Age (age range)	Female/Male, age 70-75
Presenting Situation	“Having trouble sleeping”
Opening Statement	“My daughter is worried about me.”
Elaboration of Complaint - Concerns	You are here alone, but at the suggestion of your daughter who is worried that you are “letting yourself go.” You are retired and live in your own home. Your husband died 2 years ago. You had a fairly active social life as a couple-playing cards with a circle of friends and bowling (or golfing) in a senior league once a week. Since he died, you have been feeling “like a fifth wheel” at these gatherings. “I can’t stand it when people feel sorry for me.” You haven’t been out with friends for the past two or three months. You watch a lot of TV. In fact, you stay up most nights watching old movies on TV until you fall asleep in her chair at 2:00 or 3:00 a.m. Your husband’s health had also been good until he died suddenly of a massive heart attack – there was no warning. It happened when he was out playing golf. “He said she felt a little sick, then he collapsed. By the time the paramedics got there, he was gone.” You had been married for 50 years. You had been planning to travel but “We dreamed of going together. I just don’t feel like going without him.”

<table>
<tr><td>Clinical Content</td><td><u>Present condition:</u>
You describe yourself as being in “good health for your age”
You are able to take care of yourself and have no problems with mobility or activities of daily living.
You drive, clean your own home, manage your own finances.
Nothing seems worth while anymore. You feel your friends would only feel bad to be around you because you’re no fun anymore. You would never consider suicide but you feel sometimes that death would be a relief.
<u>Pertinent Past Medical History:</u>
Your general health has been good. You have “mild hypertension” and take hydrochlorothiazide (“a water pill”) for it, and occasional Tylenol or ibuprofen.
<u>Family Medical History:</u>
Your mother had Alzheimer’s and you had to bear witness to her suffering for years. She passed away at the age of 88.
Your father died “of old age” at 90.</td></tr>
<tr><td>Physical Exam</td><td>No physical exam will be performed.</td></tr>
<tr><td>Psychosocial Profile</td><td>Your grown daughter lives in St. Louis. (The daughter is married but has no children.) Two weeks ago she came to town for a visit and was shocked to see that you had not been keeping up the yard and that the house was piled with newspapers and piles of junk mail that you just didn’t feel like dealing with. Your daughter found some overdue bills that you had overlooked when helping clean up the house. She noticed too that you haven’t been eating much and aren’t keeping the house very clean. The daughter actually called the office to set up the appointment but had to return home a few days ago.</td></tr>
<tr><td>Scenario Development</td><td>Sigh a lot. Speak slowly and be a little vague- as if you’re kind of numb.</td></tr>
</table>

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Session #4: Student Reference Guide:

Instructions:	Please review the following materials in preparation for Interview Session, Case #4 –
Reading Assignment:	Coulehan and Block, Chapter 11, 5th Ed; Gallo JJ, Rabins PV: Depression without sadness: Alternative presentations of depression in late life. American Family Physician 1999; 60: 820-6. (Reprinted in syllabus).
Patient Information:	Mrs. Blue is a 75 year old woman whose daughter made an appointment for her because "she's not taking care of herself."
Brief Summary:	The patient is here alone, but at the suggestion of her daughter who is worried that patient is "letting herself go." Patient is retired and lives in her own home.
Your Case Objectives:	1. Students will demonstrate introductions, explanations of their role, and establishment of rapport. 2. Students will gather information on functional status in an elderly person. 3. Students will demonstrate the use of an interview for the diagnosis of depression. 4. Students will respond supportively to the patient's distress. 5. The student will sensitively discuss the difference between normal grief and depression. 6. Note: Students are not expected to propose a treatment plan.
Key Challenge(s) of Case:	Obtaining adequate information about ability to perform activities of daily living.. Responding to patient's distress. Inquiring about depression symptoms, suicide, and social supports.
Activities & Time Req:	Small Group Teaching Format – 15 - 20 minutes for encounter
Data Collection Methods:	Facilitator will provide verbal feedback on performance Standardized Patient will give feedback on communication skill Facilitator will fill out written review of each student performance
Correlations:	Neurobiology of aging, mood: serotonin and norepinephrine receptors.

Medical College of Wisconsin
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Office of Educational Services / SP Program

Case #4: Student Assignment Form

<table>
<tr><td>Interviewer:</td><td>You are charged with obtaining a complete problem history, briefly assessing functional status and obtaining information about depression symptoms.

Signal the beginning of your interview by introducing yourself and explaining your role. As instructed, you may call a “Time Out” at any point in the interview to get suggestions from your classmates/facilitator if needed.

You will have 15 –20 minutes TOTAL time to complete the interview. The facilitator will let you know when time is up.</td></tr>
<tr><td>Observers:</td><td>You will be responsible for observing the following aspects of the interview and the interviewer’s performance:

1) Did the interviewer ask appropriate open ended / closed ended questions and give the patient ample time to respond?

2) Did the interviewer assess the patient’s functional and health status?

3) Did the interviewer obtain adequate information about depression symptoms, suicidal thoughts and social supports.

4) Describe how the interviewer responded to the patient’s distress.

Keep in mind that you will be asked to share your impressions, comments on these criteria following the interview</td></tr>
<tr><td>Written Assignment
(All 6 Participants)</td><td>Each of you will be responsible for creating a written medical history for Mrs. Blue which should include:
• Identifying Data and Chief Complaint
• History of presenting Complaint including relevant symptoms of depression.
• Past Medical History and Social History including functional status.

The medical history should be about a page and should be turned into your Session #4 facilitator no later than 1 week from your Session #4 interview date.
This should be submitted via inter-office mail or e-mail.</td></tr>
</table>

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Case #5: Facilitator Case Reference Guide

Presenting Complaint:	Unwanted Pregnancy
Gender and Age Range:	Female, Age 22
Name:	Kelly Morr
Brief Summary:	Kelly is a sophomore at a local college with a steady boyfriend with whom she has been sexually active. She has been taking birth control pills since last September, occasionally forgetting to take one. Her periods are normally regular but she is three weeks late. Kelly is not a pro-choice militant, actually most of her friends and family are animatedly pro-life, but she DOES NOT WANT TO HAVE A BABY! Kelly has told her boyfriend about being late and he stated "Whatever you decide is right" but he is not ready to raise a kid either. Kelly has just been informed by the nurse that her test is positive but doesn't want to believe it.
SPECIAL CASE INSTRUCTIONS	1. **Please instruct the students to act as though they have the major responsibility for this patient's care. i.e., They should talk with her about her options.**
Case Objectives:	1. Students will demonstrate introductions, explanation of their role, and establishment of rapport. 2. Students will demonstrate the appropriate use of open-ended and focused questions. 3. Students will obtain a menstrual, contraceptive and sexual history. 4. Students will inquire about values involved in patient decision-making about sexual activity and unwanted pregnancy.
Key Challenge(s) of Case:	Students will demonstrate the ability to help patient clarify values related to sexual activity and unwanted pregnancy. Menstrual history, ask about sexual activity and contraception, symptoms of pregnancy. Students will respond to emotional distress and be non-directive in their discussion.
Exam Room Needs:	General Clinic Exam Room
Follow-up Station Needs:	None
Activities & Time Req:	Small Group Teaching Format – 15 minutes min. for encounter
Data Collection Methods:	Facilitator will provide verbal feedback on performance Standardized Patient will give feedback on communication skills Facilitator will fill out written review of each student performance Students will turn in written history to facilitator
Course, Student Level:	M1 – Interview Course
Correlations:	Physiology of ovulation
Reading:	Coulehan and Block, pages 97-100 and Chapter 6, 5th Ed. Case 5 Fact Sheet.
Case Authors:	Joan Bedinghaus, MD , Tisha Palmer, SP Coordinator
Date (orig. / last revision)	December 5, 2001 / January 19, 2006

Case 5: Facilitator's Checklist of Content and Communication Skills

Student Name: ______________________
Facilitator: _________________________

<u>I. Content Checklist</u>- Check if the student asked or did the following:

_____ Asked about contraception and sexual activity (at least 2 of following):
LMP Contraception
Planned?

_____ Asked about previous pregnancies

_____ Asked about general health

<u>II. Communication Skills Checklist</u>- Check if the student:

_____ Introduced self and explained role

_____ Started with open-ended questions

_____ Gave patient time to answer fully

_____ Asked clarifying questions about patient's feelings and intentions

_____ Discussed options helpfully, non-directively

_____ Responded with empathy to patient's anxiety and ambivalence

Additional Comments/Suggestions for Improvement:

Medical College of Wisconsin
Medical Interviewing
Office of Educational Services / SP Program

Case #5: Standardized Patient (SP) Case Instructions
Kelly Morr – Possible Pregnancy

Patient Name	Kelly Morr
Gender/Race/Age (age range)	Female, 22
Presenting Situation	Ms. Morr, age 22, presents to the clinic today to determine why her period is three weeks late.
Opening Statement	"I am worried because my period is late"
Elaboration of Complaint - Concerns	• You DO NOT WANT TO BE PREGNANT! • The nurse just told you your pregnancy test is positive. • If you are pregnant, you want an abortion – but you're really conflicted about it.
Clinical Content*	<u>Present condition:</u> • Your last period was 7 weeks ago. • You have been too scared to take a home pregnancy test • You are in good overall physical health. <u>Pertinent Past Medical History:</u> • You had been on "The Pill" since last September. You have tried to stay faithful to taking the pill everyday but have had some "slip-ups" • You do not smoke cigarettes. You do not drink alcohol. • You exercise on a regular basis, aerobics classes at college gym 2-3 times per week and almost daily running when weather permits. • You regularly drink 3 – 4 caffeinated beverages (Soda) a day. <u>Family Medical History:</u> • Your parents are both alive and well, living in Evanston, Illinois. • You are an only child.
Physical Exam	No physical exam will be performed.
Psychosocial Profile	You are a sophomore at Mount Mary College. You are a straight-A student with ambitions of graduating with a 4-yr Nursing Degree. You live in an apartment (which your parents pay for) off campus. You are active in a Jesuit / Catholic civil service organization and your freshman year was relatively uneventful. You met your boyfriend, Scott, at local park – you two shared the same "running route". He is a liberal arts major at UW – Milwaukee. Scott and you have been an item" since last spring – ('I guess opposites attract'). You often drive home to see your parents on the weekends, but your relationship with them has been strained lately, as they disapprove of

	Scott. They say they disapprove of his manners, you suspect it is his religion and ½ Hispanic ancestry that really "gets their goat". Or it could be that Scott is "non-religious" and his mother is Jewish. You told Scott yesterday that your period was late. You guess he must be in shock, he didn't say much and simply stated that "he would go along with anything you decided" if the test came back positive. You can't image him being ready to settle down and help you raise a child and besides, he has no money and loads of college debt. You love him but he has never been the guy you imagined yourself marrying. You are sure your parents would insist that you marry him if you are pregnant. At this point, you feel you simply have no choice but abortion - even in the face of shame and disapproval – if you are indeed pregnant. Your parents would be furious, and you fear they will "ruin your future" (ie. Cut off your financial support and "force you" to move back home.) Besides, your plans for your own future do not include caring for a baby while going to school. The nurse has just told you the pregnancy test is positive, but you don't want to believe it.
Scenario Development	You should be sitting, shifting anxiously in a chair when the student(s) starts the scenario. In general, let the student(s) set the pace and scope of the interview. You are shy and fairly uncommunicative in answering the student's questions. You avoid significant eye contact. You are somewhat embarrassed to be here at all (you feel you should have known better) and are very afraid of the possible outcome (pregnancy). If the scenario/ communication should come to a stall (more than a necessary). You can use one of the following questions to "jump start" the conversation: • Is there something you can give me that will cause me to miscarry? • What is the latest that I can get an abortion? What time frame do I have to make my decision? • Do you do abortions here or will I have to go somewhere else? How much is this going to cost? • (to a woman student) What would you do if you were in my situation?

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Medical Interviewing
Office of Educational Services / SP Program

Case #5: Student Reference Guide

Instructions:	Please review the following materials in preparation for Interview Session, Case #5
Reading Assignment:	Coulehan and Block, pages 97-100 and Chapter 6 5th Ed. ,Case 5 Fact Sheet.
Patient Information:	Kelly Morr, age 22
Brief Summary:	Ms. Morr is a sophomore at a local college with a steady boyfriend with whom she has been sexually active. Her period is late. The nurse has just informed her that her pregnancy test is positive.
Your Case Objectives:	1. Demonstrate introductions, explanation of their role, and establishment of rapport. 2. Demonstrate the appropriate use of open-ended and focused questions. 3. Obtain a menstrual, contraceptive and sexual history. 4. Inquire about values involved in patient decision-making about sexual activity and pregnancy.
Key Challenge(s) of Case:	Demonstrate the ability to clarify and discuss values related to sexual activity and pregnancy. Sensitively inquire about sexual activity, menstrual history and contraception use. Explore patient's options in a non-directive way.
Activities & Time Req:	Small Group Teaching Format – 15 - 20 minutes for encounter
Data Collection Methods:	Facilitator will provide verbal feedback on performance Standardized Patient will give feedback on communication skill Facilitator will fill out written review of each student performance Student will submit written note to facilitator.
Correlations:	Physiology of ovulation, implantation

Case 5: Fact Sheet/Background Information

(Students who piloted this case asked for some basic information to be provided as background to this interview).

Basic Menstrual/Sexual/Gynecologic History

General Health: Ask about recent or chronic illnesses and medications. Many systemic illnesses affect menstrual, sexual or reproductive functions. So do some medications. Some meds, including antibiotics and anticonvulsants, reduce the efficacy of oral contraceptives.

LMP: last menstrual period. Ascertain and record the date of the *first day of vaginal bleeding.* In clinical medicine, unlike embryology, the number of days or weeks of pregnancy (EGA or estimated gestational age) is counted from the first day of the last menstrual period, not from the date of fertilization.

Menstrual cycle: Is it regular? (about the same number of days between the start of one period and the next.) If menses are not regular, describe or date the last 2 or 3 periods.

Cycle length: the interval between one period and the next. About 28-35 days is normal.

Contraception: Some women interpret "birth control" to mean "the birth control pill" i.e., only oral contraceptives. So you may want to ask, "Do you use anything to prevent pregnancy?" Ask which method is used and whether use is consistent.

Sexual activity: "Sexually active" is medical jargon that may sound odd to patients. "Do you have a sexual relationship with someone right now?" is more readily understood. If the patient answers yes, ask about the duration and quality of the relationship (e.g., "Is that a steady relationship? Is your partner involved only with you? How long have you been involved?") If the patient answers no, you may need to ascertain if she has ever been sexually active, and how recently. You can't assume patients are heterosexual- ask whether the patient's relationship is with a man or a woman.

Obstetric History: Has the patient ever been pregnant? What were the results of any previous pregnancies (i.e., term births, preterm births, miscarriages [spontaneous abortions] induced abortions, stillbirths)?

Ask about any **gynecologic problems or surgeries.** Common problems may include sexually transmitted infections, vaginal infections, abnormal Pap smears, uterine fibroids (leiomyomas, which are common benign tumors of uterine muscle), ovarian cysts, premenstrual syndrome or premenstrual dysphoric disorder, dysmenorrhea (menstrual cramps) and endometriosis.

Background Information:

<u>Pregnancy Testing</u>:
The urine pregnancy test becomes positive about 14 days after ovulation, 28 days after the last menstrual period.

<u>Miscarriage (Spontaneous abortion)</u>:
The spontaneous abortion rate in women <20 is 12%; the rate rises with increasing maternal and paternal age; in women >40 it is 26%. Eighty percent of SA's occur in the first 12 weeks of

gestation. Second and third trimester fetal loss is much less common. (Source: *Williams' Obstetrics*)

Emergency Contraception (”post-coital contraception” “morning-after pill”):
Although difficult to estimate, the risk of pregnancy after one episode of unprotected intercourse is about 15%. Estrogen/progestin (Preven) and progestin-only (Plan B) oral contraceptive pills, if taken within 72 hours of unprotected intercourse, reduce that rate to between 0.5% (if taken within 12 hours) and 4% (if taken 61-72 hours after intercourse) Any oral contraceptive can be used for post-coital contraception, though dosage regimens vary from brand to brand. The weight of the evidence is that post-coital contraception works by inhibiting or delaying ovulation. These hormonal regimens cannot disrupt an established pregnancy. In September 2006, the FDA approved sale of Plan B without a prescription.

Medical Abortion:
Mifepristone (RU-486, Mifeprex) was FDA-licensed in September 2000 for use, with misoprostol (Cytotec) for early termination of pregnancy. It is 92% effective up to 9 weeks after the last menstrual period. Mifepristone is a progesterone antagonist that disrupts development of the placenta and embryo. Methotrexate, a folate antagonist used to treat many autoimmune diseases, can also be used in the same way and is 95% effective.

The FDA specifies a protocol for the use of mifepristone. The patient takes an initial dose in the doctor's office. Two days later, she takes an oral dose of misoprostol, a prostaglandin, which induces uterine contractions to expel the products of conception. The FDA mandates a follow-up visit 11 days later and requires physicians who administer mifepristone/misoprostol to have surgical backup (D&C) readily available in the event of method failure or excessive bleeding. In Milwaukee, medical abortion is available at Affiliated Medical Services.

Surgical Abortion:
Cervical dilatation with vacuum aspiration or sharp curettage can be used up to 16 weeks. In Milwaukee, Planned Parenthood and Affiliated Medical Services are the main providers. Late second trimester abortions, most often performed for fetal anomalies, require more complex procedures that may be performed in a hospital or a properly equipped clinic.

Adoption:
Adoption is a complex topic that can only be briefly sketched here. A woman may arrange to have a private or public agency assume care of her newborn and place it with an adoptive parent or parents. The identities of the mother and adoptive parents may be concealed from one another (closed adoption) or known to one another (open adoption). In some open adoptions, the mother selects the adopting parents from applicants to an agency and may negotiate for visiting rights, payment of medical costs, etc. (To actually pay for the baby is illegal.) There is a multi-step process of relinquishing parental rights (maternal and paternal), which varies tremendously by state and county. The birth parent cannot give up parental rights before the child is born and may decide to keep the child at any point until the final stage.

Local Adoption Agencies include: Milwaukee County Adoption Agency (public); Children's Service Society of Wisconsin (private, non-profit, non-religious, local); Lutheran Social Services and Catholic Charities (local, religious) and Bethany Christian Services (Private, religious, national).

Costs:
The medical abortion costs about $500. A surgical abortion costs about $360. Second and third trimester abortions cost about $450 to several thousand dollars, depending on the circumstances and type of procedure. Prenatal care and a normal vaginal delivery cost about $5000. Adoption typically costs the adopting parents $10,000 or more through a private agency; it does not usually cost the birth mother any money to put up her child for adoption. Raising a child to adulthood has been estimated to cost at least $180,000 in direct costs and $100,000 in lost earnings to the mother.

Laws Regulating Abortion:
In 1973, the US Supreme Court's Roe v. Wade decision redefined the extent to which the states may regulate abortion. It declared that in the first trimester, decisions about abortion are a private matter between a woman and her physician; in the second trimester the state may regulate the procedure in ways that are reasonably related to maternal health (such as requiring them to be performed in a hospital;) after fetal viability, states may regulate or forbid abortion except where necessary to preserve the life or health of the mother.

In 1989, the Court ruled (Webster v. Reproductive Health Services) that states could impose restrictions such as waiting periods, special informed consent requirements, parental notification and hospital requirements, though not spousal notification.

You may be interested to know that *contraception* was illegal in most states until Supreme Court decisions in 1965 and 1972.

Wisconsin requires a 24-hour waiting period between pre-abortion counseling and the procedure itself. It also has a law requiring parental notification before a minor can obtain an abortion.

Physician Ethics around Abortion:
From *Resolving Ethical Dilemmas: A Guide for Clinicians, 2nd ed.* (Bernard Lo, Lippincott, Williams and Wilkins.)

"Provision of Information Regarding Family Planning and Abortion: Some physicians have strong moral and religious objections to these interventions. They believe it would violate their conscience not only to write a prescription for birth control or perform an abortion, but also to discuss these options with patients. Physicians are not obligated to carry out actions that would violate their fundamental moral beliefs or their conscience. Physicians are free to withdraw from the care of a patient as a last resort if a mutually acceptable plan cannot be negotiated. However, it is problematical if physicians provide care without informing patients of options that are medically acceptable. In other clinical settings, physicians have an affirmative duty to disclose all medically appropriate options with the patient, even if they would not personally recommend them. Thus respecting the physician's conscience may conflict with respecting the patient's autonomy.

"How can this dilemma be resolved? At a minimum, physicians should tell patients that there are options for care they will not discuss for religious or moral reasons, but that other physicians are willing to discuss. For the sake of continuity of care, physicians should inform patients at the onset of their moral objections to abortion or family planning. It is ethically problematical for physicians to use their role to impose their moral or religious views on patients." (Pp303-4)

From the AMA Code of Ethics: H-5.995 Abortion

"Our AMA reaffirms that: (1) abortion is a medical procedure and should be performed only by a duly licensed physician and surgeon in conformance with standards of good medical practice and the Medical Practice Act of his state; and (2) no physician or other professional personnel shall be required to perform an act violative of good medical judgment. Neither physician, hospital, nor hospital personnel shall be required to perform any act violative of personally held moral principles. In these circumstances, good medical practice requires only that the physician or other professional withdraw from the case, so long as the withdrawal is consistent with good medical practice." (Sub. Res. 43, A-73; Reaffirmed: I-86; Reaffirmed: Sunset Report, I-96; Reaffirmed by Sub. Res. 208, I-96; Reaffirmed by BOT Rep. 26, A-97; Reaffirmed: CMS Rep. 1, I-00)

H295.911 Medical Student Education on Termination of Pregnancy Issues
"The AMA encourages education on termination of pregnancy issues so that medical students receive a satisfactory knowledge of the medical, ethical, legal and psychological principles associated with termination of pregnancy, although observation of, attendance at, or any direct or indirect participation in an abortion should not be required." (Res. 304, I-96)

The American College of Obstetrics and Gynecology (ACOG) has published statements supporting the legalization of mifepristone, opposing "gag rules", and advocating that emergency contraception be made available without a prescription. The AMA has also stated its support for OTC availability of emergency contraception, and its opposition to the harassment of providers and patients at facilities that provide abortions.

More information:
www.ama-assn.org
www.acog.org
www.naral.org
Glasier A. Emergency postcoital contraception.
N Engl J Med 1997; 337: 1058-64.
Williams' Obstetrics textbook

Medical College of Wisconsin
Medical Interviewing
Office of Educational Services / SP Program

Case #5: Student Assignment Form

<table>
<tr><td>Interviewer:</td><td>You are charged with conducting a structured interview, obtaining a menstrual, contraceptive and sexual history. During this interview, attune to the patient's values and decision-making about possible pregnancy.

Signal the beginning of your interview by introducing yourself and explaining your role. You should act as though you have the major responsibility for this patient's care. You may call a "Time Out" at any point in the interview to get suggestions from your classmates/facilitator if needed.

You will have 15 –20 minutes TOTAL time to complete the interview. The facilitator will let you know when time is up.</td></tr>
<tr><td>Observers:</td><td>You will be responsible for attuning to the following aspect of the interview and the interviewer's performance:
1) Did the interviewer ask appropriate open ended / closed ended questions and give the patient ample time to respond?

2) Describe how the interviewers responded to the patient's anxiety and emotional conflict.

3) Did the interviewer(s) reflect the patient's language and ask for clarification / summarize when necessary to check for understanding?

4) Did the interviewer maintain a helpful, non-judgmental attitude throughout the session?
Keep in mind that you will be asked to share your impressions, comments on these criteria following the interview</td></tr>
<tr><td>Written Assignment
(All 6 Participants)</td><td>Each of you will be responsible for creating a written medical history for Ms. Morr which should include:
• Identifying data:
Reason for visit
Essential health information:

Date of menstrual period
Any previous pregnancies
Contraceptive Use
Any active health problems
Summary of psychosocial issues</td></tr>
</table>

Medical College of Wisconsin
Medical Interviewing
Office of Educational Services / SP Program

Case #6: Facilitator Case Reference Guide

Presenting Complaint: (with setting/vitals)	Well Visit
Gender and Age Range:	Male, Age 60
Name:	Walter Jackson
Opening Statement:	"I am just here for a check up"
Brief Summary:	Patient has no main complaint. He is here at the insistence of his wife, as he has not been to the doctor for years. He is a smoker (2pk/day for 40 yrs). He is a machinist who does not exercise much and has a poor diet. He reports no health complaints and is not sure if he is ready to quit smoking. His family history includes colon and rectal cancer.
Case Objectives:	1. Students will demonstrate skill in obtaining a family history relevant to this group. 2. Students will demonstrate the assessment of smoking status and motivation to quit. 3. Students will demonstrate skill in negotiating a plan for behavior change. 4. Students will attune to patient's increased cancer risk.
Key Challenge(s) of Case:	Assessing and influencing motivation to quit smoking. Assessment of patient's familial cancer risk.
Exam Room Needs:	General Clinic Exam Room
Follow-up Station Needs:	None
Activities & Time Req:	Small Group Teaching Format – 15 minutes min. for encounter
Data Collection Methods:	Facilitator will provide verbal feedback on performance Standardized Patient will give feedback on communication skills Facilitator will fill out written review of each student performance Students will turn in written history to facilitator
Course, Student Level:	M1 – Interview Course
Reading:	1) Attached reading: Assessment of Tobacco Use & Brief Clinical Interventions, U.S. Department of Health and Human Services, from: www.surgeongeneral.gov/tobacco/ 2) Review of colon cancer genetics at www.cancer.gov/cancerinfo/pdq/genetics/colorectal 3) Attached Phase Model of Behavior Change.
Case Authors:	Joan Bedinghaus, MD , Tisha Palmer, SP Coordinator
Date (orig. / last revision)	November 20, 2001 / August 30, 2004

Case 6: Facilitator's Checklist of Content and Communication Skills

Student Name: ______________________
Facilitator: ___________________

I. Content Checklist- Check if the student asked or did the following:

_____ Asked about triggers in addiction behavior

_____ Inquired about smoking-related illness

_____ Assessed the patient's motivation to quit

_____ Advised and encouraged quitting

_____ Obtained 3-generation family history

_____ Noted cancer risks, suggested some further evaluation

II. Communication Skills Checklist- Check if the student:

_____ Introduced self and explained role

_____ Started with open-ended questions

_____ Gave patient time to answer fully

_____ Facilitated patient's commitment to behavior change

_____ Incorporated patient factors into cessation plan

Additional Comments/Suggestions for Improvement:

Medical College of Wisconsin
Medical Interviewing
Office of Educational Services / SP Program

Case #6: Standardized Patient (SP) Case Instructions
Walter Jackson

<table>
<tr><td>Patient Name</td><td>Walter Jackson</td></tr>
<tr><td>Gender/Race/Age (age range)</td><td>Male, Age 60</td></tr>
<tr><td>Presenting Situation</td><td>Mr. Jackson, presents to the clinic today for an annual exam.</td></tr>
<tr><td>Opening Statement</td><td>“I am just here for my check- up”</td></tr>
<tr><td>Elaboration of Complaint - Concerns</td><td>You have no specific complaints. You are here at the insistence of your wife who has “been on your case about not having gone to the doctor for a check up for years” You smoke (2pk/day for 40 yrs)</td></tr>
<tr><td>Clinical Content*</td><td><u>Present condition:</u>

Cough, sputum production worse in the a.m. Phlegm is gold tone. Mild shortness of breath with exertion (climbing 2 flights of stairs).
Poor diet – high sodium, high fat.
No regular exercise.

<u>Pertinent Past Medical History:</u>

Last winter was diagnosed with pneumonia and were laid up at home for two weeks and felt lousy for a month after that. If the student addresses this you should share that it was really scary, you were unable to catch your breath most of the time, and yet felt unable to quit smoking.
Haven’t been to a doctor for 15 years except visit to urgent care during illness last winter.
Never had any screening for colon cancer (no stool sample, flex-sig or colonoscopy)

<u>Family Medical History:</u>

Mother died 2 yrs ago at age 80 of “old age”
Father died when you were in high school of rectal cancer at age 42
Your father had two sisters (your aunts) and one of them you know died at 45 of some form of “female cancer”
You have one brother and he was diagnosed with colon cancer when he was 50 (5 yrs ago). He had surgery and is doing ok. If the student addresses your family history you should share that “It is kind of scary that your brother is younger than you and dealing with cancer especially after what happened to your father.”
</td></tr>
</table>

Physical Exam	No physical exam will be performed.
Psychosocial Profile	You are married and live in the West Allis area. Your wife is a real estate agent. She also smokes though much less than you do (approx. 1 pack/day) You also have a daughter (32) who lives in Brookfield and also smokes. You are a machinist at Allen Bradley. Still enjoying an active social life, you play cards with "the guys" on Friday nights. Quitting smoking would be particularly difficult to you in that: • All of your friends and family smoke • You are very addicted (You have a cigarette within 20 mins of waking, You get antsy if you are in a restaurant/movie theater and you can't smoke, & **You still smoke when you are ill**) • You have been smoking for longer than you have NOT been smoking. You started smoking when you were young and in the army. You have tried to quit a couple times. When your daughter was born you gave it a try, but were only able to make it a couple days. You also tried to quit when cigarettes went up to $3.00/pk a couple of years ago, but you didn't make even one day.
Scenario Development	You should be sitting comfortably in a chair when the student(s) starts the scenario. In general, let the student(s) set the pace and scope of the interview. **You should be cooperative in answering the student's questions and receptive to their ideas while still maintaining a sense of realistic hesitancy about quitting**. If the scenario/ communication should come to a stall (more than a necessary). You can use one of the following questions/statements to "jump start" the conversation: • After 40 years, it is probably too late to quit smoking now right? I mean would it really make a difference? • Is my family just "Cancer Prone"?

Medical College of Wisconsin
Medical Interviewing
Office of Educational Services / SP Program

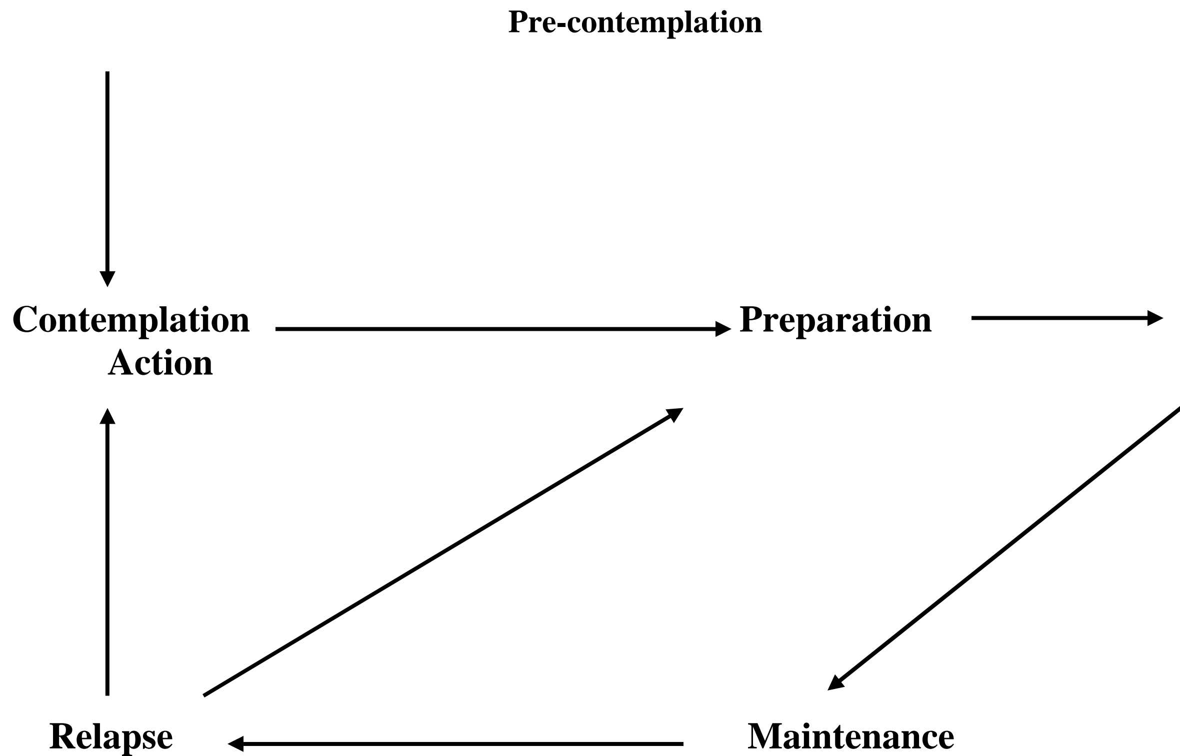
Case #6: Student Reference Guide

Instructions:	Please review the following materials in preparation for Interview Session, Case #6 –
Reading Assignment:	1) Assessment of Tobacco Use & Brief Clinical Interventions, U.S. Department of Health and Human Services, from: http://www.surgeongeneral.gov/tobacco/treating_tobacco_use.pdf (pgs 25-35); 2) "Phase Model of Behavior Change" (attached) 3) Review genetics of colorectal cancer and familial colorectal cancer syndromes at www.cancer.gov/cancerinfo/pdq/genetics/colorectal.
Patient Information:	Walter Jackson, 60 year old male
Brief Summary:	Mr. Jackson has no main complaint, he is here today for "a physical". He is a smoker.
Your Case Objectives:	1. Demonstrate skill in obtaining a family history relevant to this age group. 2. Demonstrate the assessment of smoking status and motivation to quit. 3. Negotiate a plan for behavior change that is appropriate for this patient. 4. Assess this patient's cancer risk.
Key Challenge(s) of Case:	Introduce self, establish rapport, open and closed questions, active listening, closing. Maintaining rapport while assessing and influencing motivation to quit smoking. Obtaining a complete family history and discussing cancer risk.
Activities & Time Req:	Small Group Teaching Format – 15 - 20 minutes for encounter
Data Collection Methods:	Facilitator will provide verbal feedback on performance Standardized Patient will give feedback on communication skill Facilitator will fill out written review of each student performance Students will submit written note to facilitator

Phase Model of Behavior Change

It can be useful to think about behavior changes like quitting smoking or losing weight as processes that move through several phases:

Pre-contemplation: the person has not thought about changing their behavior
Contemplation: considering change
Preparation: makes a decision, plans strategies to overcome barriers and promote change.
Action: Carries out the plan and changes behavior
Maintenance: settles into new routines, avoids triggers for relapse



A person may move forward or back among the phases. The technique of "motivational interviewing" consists of noticing which phase your patient is in, and if possible helping him/her move closer to the Action phase.

Table 1. THE PHYSICIAN'S TASKS IN RELATION TO THE PATIENT'S PHASE OF BEHAVIORAL CHANGE

Patient's Phase	Examples of Physician's Tasks
Precontemplation	Raise concerns about the patient's health. Help patients understand how smoking is affecting their health.
Contemplation	Explore the risks and benefits of smoking versus not smoking or reduced smoking. Provide feedback about the disadvantages of smoking in a way that enhances the patient's perception or the risks. Acknowledge the benefits of smoking and suggest alternative ways of achieving the same benefits. Try to tip the balance toward modifying smoking habits.
Preparation	Affirm and enhance patient's determination to modify smoking habits for the sake of his or her health. Acknowledge that the patient may still feel ambivalent about change. Negotiate a short-term goal (e.g., reading pamphlets about quitting) and a timetable for a long-term goal (abstinence).
Action	Identify barriers to modification of smoking habits. Negotiate with the patient about what steps must be taken to deal with these barriers and to initiate a change.
Maintenance	Identify at-risk situations for relapse, and develop strategies to prevent relapse.
Relapse	Praise the patient for having gone through these phases. Normalize relapse as a learning experience leading toward eventual success, and encourage the patient to go through these phases again.

Adapted from: Botelho R, Novak S: Dealing with Substance Misuse, Abuse, and Dependency. Primary Care 20:1 51-69, 1995.

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Medical Interviewing
Office of Educational Services / SP Program

Case #6: Student Assignment Form

<table>
<tr><td>Interviewer:</td><td>You are charged with conducting an interview oriented to health screening and prevention. This includes obtaining a complete medical history as well as negotiating a smoking cessation plan.

Signal the beginning of your interview by introducing yourself and explaining your role. As instructed, you may call a “Time Out” at any point in the interview to get suggestions from your classmates/facilitator if needed.

You will have 15 –20 minutes TOTAL time to complete the interview. The facilitator will let you know when time is up.</td></tr>
<tr><td>Observers:</td><td>You will be responsible for attuning to the following aspect of the interview and the interviewer’s performance:
1) Did the interviewer ask appropriate open ended / closed ended questions and give the patient ample time to respond?
2) Describe how the interviewer used the “Five A’s” and/or the “Five R’s”.
3) Describe the patient’s phase of behavior change and the strategies the interviewers used in counseling.
4) Did the interviewer obtain an accurate and complete family history?

Keep in mind that you will be asked to share your impressions, comments on these criteria following the interview</td></tr>
<tr><td>Written Assignment
(All 6 Participants)</td><td>Each of you will be responsible for creating a written medical history for Mr. Jackson which should include:
• Identifying data
• Smoking history
• Other active problems, health maintenance issues.
• Past medical history
• Family history using genogram
• Patient Profile (social history)
• Review of systems: record significant positives and negatives (if obtained during interview)
• Assessment: Readiness to quit, cancer risk.

The medical history in its entirety should be about one page and should be turned into your facilitator no later than 1 week from your interview date. It should include a genogram.
This should be submitted via inter-office mail or e-mail.</td></tr>
</table>

Medical College of Wisconsin
Medical Interviewing
Office of Educational Services / SP Program

Case #7 (alternate): Facilitator Case Reference Guide

Presenting Complaint:	Annual Checkup, High Blood Pressure
Gender and Age Range:	Age 49
Name:	Rhonda Richards
Brief Summary:	The patient is here for his/her "regular checkup." At a health fair in his/her neighborhood a few weeks ago, she had her blood pressure and cholesterol measured and was told they were high. Her blood pressure was 142/90 today. Ms. Richards has a sedentary clerical job and gets no regular exercise. She may be overweight. She eats fried food or pizza 2 or 3 times a week and usually has coffee cake, danish, or donut for breakfast. Her menstrual periods are irregular, but she has no hot flashes. Her mother had a stroke at age 69 and died 2 years later. Her father died suddenly at 66, from an apparent heart attack.
Case Objectives:	1. Students will demonstrate knowledge of life cycle issues related to early middle age. 2. Students will demonstrate knowledge of recommendations for this age group. 3. Students will demonstrate skill in obtaining a diet and exercise history. 4. Students will negotiate a diet and exercise plan.
Key Challenge(s) of Case:	Students will demonstrate the ability to obtain a diet history to discuss lifestyle changes and to negotiate a plan for behavior change. Discuss health maintenance issues (your agenda vs. the patient's)
Exam Room Needs:	General Clinic Exam Room
Follow-up Station Needs:	None
Activities & Time Req:	Small Group Teaching Format – 15 minutes min. for encounter
Data Collection Methods:	Facilitator will provide verbal feedback on performance Standardized Patient will give feedback on communication skills Facilitator will fill out written review of each student performance Students will submit a written history to the facilitator
Course, Student Level:	M1 – Interview Course
Correlations:	Regulation of blood pressure and lipid metabolism.
Reading:	Coulehan and Block: Ch 5, 7, and 18, 5th Ed. Nat'l Heart, Lung, and Blood Institute "Your Guide to Lowering Your Blood Pressure with DASH" http://www.nhlbi.nih.gov/health/public/heart/hbp/dash/new_dash.pdf (accessed Feb 25, 2008)
Case Authors:	Joan Bedinghaus, MD , Tisha Palmer, SP Coordinator
Date (orig. / last revision)	January 15, 2002 / September 10, 2003/January 19, 2006

Case 7 (alternate): Facilitator's Checklist of Content and Communication Skills

Student Name: ______________________
Facilitator: ___________________

I. Content Checklist- Check if the student:

_____ Discussed screening recommendations appropriate for this patient.
(Must touch upon mammogram, pap smear & cholesterol to receive credit)

_____ Discussed patient's menopausal status

_____ Assessed patient's heart disease risk

_____ Discussed diet-hypertension connection.

_____ Encouraged patient to incorporate exercise into daily routine.

II. Communication Skills Checklist- Check if the student:

_____ Introduced self and explained role

_____ Started with open-ended questions

_____ Gave patient time to answer fully

_____ Acknowledged patient's difficulties and incorporated them into recommendations.

_____ Maintained a supportive, sensitive attitude throughout the interview

Additional Comments/Suggestions for Improvement:

Medical College of Wisconsin
Medical Interviewing
Office of Educational Services / SP Program

Case #7 (alternate): Standardized Patient Case Instructions
Rhonda Richards -- Well Visit

Patient Name	Rhonda Richards
Gender/Race/Age (age range)	Female, 49
Presenting Situation	Mrs. Richards, presents to the clinic today for her annual exam.
Opening Statement	"I am just here for my check- up"
Elaboration of Complaint - Concerns	• This is a new doctor for you – your insurance changed. A few weeks ago you attended a health fair at a church in your neighborhood. Someone there measured your blood pressure, told you it was high and recommended you see your doctor. Someone else had a little machine that measured cholesterol in a drop of blood from your finger- they said that was high too. • You feel generally well. Sometimes you have pounding headaches – these have been more frequently lately. You've always thought "hypertension" meant being very tense and you don't think you're tense at all. When you feel burdened or worried, you pray about it, and you feel that your relationships with God and your church are supportive.
Clinical Content	Present condition: • Menstrual periods are irregular – No hot flashes • Poor diet – low calcium, high sodium, high fat. • Lactose intolerant. • No regular exercise Pertinent Past Medical History: • Had your gall bladder removed 5 years ago, no complications. • Only other hospitalizations were for deliveries (uncomplicated vaginal) of 2 children. • Had one mammogram two years ago that was normal. • Have had Pap smear each year, each has been normal. Family Medical History: • Mother and father both deceased. Your mother died 2 years ago after having a stroke at age 69. She had struggled for years with her diabetes (eye disease). Your father died of a heart attack at age 66 (about 10 yrs ago). • You have two younger sisters with no health problems.
Physical Exam	No physical exam will be performed.

Psychosocial Profile	You are a proud and private individual. You work full time as a clerical assistant for a local M & I bank for over 15 years. Your husband Dick is a machinist for Harley Davidson. You and your husband have worked long and hard hours to ensure that you would be able to send your two children to college. You have a 15 year old daughter, and a 14 year old son who attend Riverside High School. Dick's mother lives in town and is in failing health. The task of caring for your mother-in-law has fallen on your shoulders. You spend 1-3 hours after work every day caring for her in her apartment (cleaning, shopping, laundry, cooking, etc.)
Scenario Development	You should be sitting comfortably in a chair when the student(s) starts the scenario. In general, let the student(s) set the pace and scope of the interview. You are pleasant and cooperative in answering the student's questions. If the scenario/ communication should come to a stall (more than a necessary). You can use one of the following questions to "jump start" the conversation: • I thought I should maybe get my sugar checked. • How can my cholesterol be high? I never eat eggs. • I've heard that once you start taking blood pressure medicine, you can never stop. • They told me I have hypertension, but I don't think I'm either hyper or tense.

Medical College of Wisconsin
Medical Interviewing
Office of Educational Services / SP Program

Case # 7 (alternate): Student Reference Guide

Instructions:	Please review the following materials in preparation for Interview Session, Case # 3 –
Reading Assignment:	Coulehan and Block: Ch 5, 7, and 18, 5th Ed., Nat'l Heart, Lung, and Blood Institute "Your Guide to Lowering Your Blood Pressure with DASH" http://www.nhlbi.nih.gov/health/public/heart/hbp/dash/new_dash.pdf (accessed Feb 25, 2008).
Patient Information:	Rhonda Richards, age 45
Brief Summary:	Mrs. Richards is here for her annual check up. At a recent community health fair, she was told her blood pressure and cholesterol were high.
Your Case Objectives:	1. Demonstrate knowledge of life cycle issues related early middle age. 2. Demonstrate knowledge of prevention and screening recommendations for this age group. 3. Demonstrate skill in obtaining a diet and exercise history. 4. Negotiate a diet and exercise plan with the patient. 5. Try to form an alliance with the patient supporting behavior changes.
Key Challenge(s) of Case:	Students will demonstrate the ability to obtain a diet and exercise history, and to negotiate a plan for change in a diet and exercise habits.
Activities & Time Req:	Small Group Teaching Format – 15 - 20 minutes for encounter
Data Collection Methods:	Facilitator will provide verbal feedback on performance Standardized Patient will give feedback on communication skill Facilitator will fill out written review of each student performance
Correlations:	Physiology of blood pressure, regulation of lipid metabolism, menopause.

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Medical Interviewing
Office of Educational Services / SP Program

Case #7 (alternate): Student Assignment Form

<table>
<tr><td>Interviewer:</td><td>You are charged with conducting a structured interview. During this interview, assess health maintenance and hypertension issues, and discuss diet and exercise as outlined in your readings.

Signal the beginning of your interview by introducing yourself and explaining your role. As instructed, you may call a “Time Out” at any point in the interview to get suggestions from your classmates/facilitator if needed.

You will have 15 –20 minutes TOTAL time to complete the interview. The facilitator will let you know when time is up.</td></tr>
<tr><td>Observers:</td><td>You will be responsible for attuning to the following aspect of the interview and the interviewer’s performance:
1) Did the interviewer ask appropriate open ended / closed ended questions and give the patient ample time to respond?

2) Did the interviewer maintain a sensitive, supportive attitude with the patient while discussing health habits?

3) Describe how interviewer(s) reflected the patient’s language and summarized when necessary to check for understanding.

4) Did the interviewer obtain a useful picture of the patient’s diet?

Keep in mind that you will be asked to share your impressions, and comments on these criteria following the interview.</td></tr>
<tr><td>Written Assignment
(All 6 Participants)</td><td>Each of you will be responsible for writing a medical history for Mrs. Richards which should include:

• Presenting problem
• Other active problems
• Past medical history
• Family history
• Social history
• Review of systems

The medical history in its entirety should be about 1 page and should be turned into your facilitator no later than 1 week from your interview date.
This should be submitted via inter-office mail or e-mail.</td></tr>
</table>

Student Reference: Writing Your Notes

"Reading maketh a full man, conference a ready man, writing an exact man."

-Francis Bacon, 16th century

Required Reading: Coulehan and Block, 5th Ed, pp140-157.

The textbook describes four functions of the written medical record. Written notes serve a fifth function in medical education: instructors use them to judge the knowledge and reasoning ability of medical students and residents. A clear, concise, organized note lets your understanding of the patient's illness shine through. A poorly organized note gives the impression of incompetence.

Chapter 8 gives a good discussion of the process of constructing a "clinical narrative" from the diverse data gathered in an interview, and the Student Guide for each case specifies what the written assignment should include. However, previous students requested more guidance in writing notes, so here it is:

General Tips:

- Use direct clear language,
- Convey the "patient's voice" by using the patient's own words when possible.
- Avoid passive voice and jargon
  (e.g. "The patient stated he had difficulty with ambulation." Do you think the patient really said, "Doc, I'm having difficulty with ambulation?" Or did he say, "I'm unsteady when I walk?")
- Try to group all the descriptors of a symptom (location, severity, quality, radiation, etc.) together.
- Similarly, state the development of the problem over time in consecutive sentences.
- All kinds of history related to the focus of the visit should be included in the HPI. For example, your patient is a man with chest pain. His previous heart attack, his smoking and his family history of heart disease should be in the HPI, not scattered in the Past Medical History, Social History and Family History sections, because they are all very relevant to the current problem.
- Use the traditional headings (Table 8-1, p144) to sort out and organize patient data.
- It is not necessary to open every sentence with "The patient states that…." You and your readers can assume that unless stated otherwise, the HPI is based on the patient's statement.

The key to writing notes that are complete without being too long is to select the *key elements* to include: those that distinguish one illness from another and that convey the severity and urgency of the situation. The examples following are included to demonstrate what we mean.

Example 1:

Ms. Klass is a Caucasian female in her late forties who complains of lower back pain. Ms. Klass reports that she injured her back at the nursing home where she works as a nursing assistant. The pain started approximately three hours prior to her appointment as a result of bending down and lifting a patient from bed. The onset was sudden and very acute.

These 3 sentences tell the time course of the problem.

Ms. Klass reports that the pain is very severe (an 8 on a scale of 1 to 10 with 10 being most severe), concentrated on the lower right side of her back, with sharp, shooting pains radiating down her right leg. She reports that she is not able to perform her daily duties, that any form of movement makes the pain worse, and that "even sitting is uncomfortable". Ms. Klass has been self-medicating with over-the-counter ibuprofen. She reports that the ibuprofen has not been helpful.

Here are the descriptors-location, radiation, severity, quality, and effect on function, what makes it better or worse.

Ms. Klass has no prior history of back problems or chronic illness. She is not on any other medications currently. Ms. Klass smokes cigarettes and reports that she gets no regular exercise.

Summarizes past history quickly.

Ms. Klass' social history is significant in that she is extremely worried about the effect her injury will have on her work. She does not have health insurance, and she is still in her probationary period at the nursing home, and thus any time off is unpaid. Ms. Klass is recently divorced and has just moved to Milwaukee with her two teenage daughters of whom she is the sole financial supporter. She lacks a support system, and has a great amount of anxiety about losing her job.

Puts psychosocial issues in separate paragraph after the biomedical description

Example 2:

Chief Complaint:

The patient's name is George Gohman. He is a janitor who says he hurt his shoulder on the job. His supervisor noticed he was having a hard time doing his job so she told him to go to the doctor's office and have his shoulder checked out. The patient said he was lifting a heavy box down from a high shelf when his shoulder started hurting. When asked what the pain was on a scale of 1 to 10 he said it was an 8. This is the first time he's ever had shoulder pain. He has worked at the same job for over 30 years and has never had any shoulder pain before. He says he has trouble raising his arm and any kind of lifting makes his shoulder pain worse. He said the pain would prevent him from doing pretty much everything he needs to do at work.

-Chief complaint should be in the first sentence.
-"Who says he hurt his shoulder" gives the impression the writer doesn't believe him.
-The interaction with the supervisor is a sidetrack and doesn't belong here. Almost always, the biomedical story comes first in the note.

This paragraph jumps from chronology to description and back again. As a result, neither is clear.

Background:

The patient has no relatives with chronic shoulder pain. He has two daughters who he is paying child support for. He is divorced and under a court order to pay child support. He is worried about missing work because he thinks he won't have enough money to pay his bills. He wants the doctor to prescribe a pill so he can continue working. He has only been working in this place for a little while and doesn't yet have any sick leave or vacation time.

He took 2 Advil 30 minutes after it happened and he said they didn't help at all. He is not taking any other medications. The patient does not exercise outside of work but had a support network that could help support him through this he said he had none because he was new to the area. The last time he saw a doctor was for a routine physical two years ago and there were no abnormal findings then.

It's not necessary to keep repeating that "The patient says," You can assume the history is the patient's statements unless circumstances dictate that you get the history from someone else.

Notes should use the conventional format and headings outlined on page 117.

Redundant and rambling.

Suddenly the writer has started describing the pain and risk factors again, in the middle of a paragraph about psychosocial issues. Then he hops back to discussing support systems

As you have probably figured out by now, Example 2 is a poorly organized note.

Example 3:

Ms. Natalie Klass, a 50-year-old female nursing assistant at St. Camilla's with no prior history of major health problems, came to the clinic complaining of sharp stabbing pain to the lower right back just above the hip. In addition, the pain radiates down her right leg to the ankle; she is fearful that her leg will not be able to support her when she stands/walks.

Ms. Klass stated that two hours prior to her visit, she was at work where she noticed a patient lying in the hall. She was bending down to lift the patient when she felt the onset of back pain. She took Advil a half hour later, but the pain persisted.

Ms. Klass is on probation at St. Camilla's with no sick leave and is fearful that she may lose her job as a result of this incident. She requests documentation to confirm that her pain resulted from a work-related injury and, thus, should be eligible for workers compensation.

Packs a lot of important, relevant information into the first sentence.

Notice the organization of paragraphs:

Paragraph 1 describes the problem.

Paragraph 2 gives the chronology.

Paragraph 3 summarizes the psychosocial issues and the patient's related agenda.

The grading system for notes in this course is by a 3-point system:

Below expectations (1)
Meets expectations (2)
Exceeds expectations (3)

It is very hard to be ‘below expectations’ unless a student turns it in late, does not take previous feedback into account, or omits *major* sections of the write-up.

Most reasonable efforts will ‘meet expectations.’

Some write-ups along the way will ‘exceed expectations,’ and they will be very well-written, without content omissions, with excellent organization, will lack of extra verbage, and be easy to read.

SP Name: ______________________ Student Label: _________________

Case #1: M1 Interview OSCE
Work–Related Back Injury

I. Skills Checklist:

1. ____ Introduced self
2. ____ Explained role
3. ____ Started with open-ended question
4. ____ Gave you time to answer fully
5. ____ Acknowledged your pain and discomfort
6. ____ Summarized history of back problem
7. ____ Checked with you whether the summary was correct and complete

II. Content Checklist:

Asked About

8. ____ Where pain is
1. ____ Does it radiate
2. ____ How it started
3. ____ What if feels like (sharp, dull, electric)
4. ____ How bad it is
5. ____ Past back problems
6. ____ What makes it better
7. ____ What makes it worse
8. ____ Effects on your functioning
9. ____ Effects on your job

TOTAL _____ of 17.

SP Name: ______________________ Student Label: _________________

Case #2: M1 Interview OSCE
First Prenatal Visit, Genetic History

I. Skills Checklist:

1. ____ Introduced self
2. ____ Explained role
3. ____ Started with open-ended question
4. ____ Gave you time to answer fully
5. ____ Maintained eye contact with you while dealing with forms and diagrams
6. ____ Explained reason for long list of questions
7. ____ Acknowledged your anxiety
8. ____ Explained X-linked recessive genes
9. ____ Summarized

II. Content Checklist:

Asked About

10. ____ Was pregnancy planned/wanted?
11. ____ Three generations of family medical history
12. ____ Complete list of family members – all cousins, etc.
13. ____ Alcohol
14. ____ Smoking
15. ____ Last menstrual period

TOTAL _____ of 15.

SP Name: ______________________   Student Label: _________________

Case #3: M1 Interview OSCE
Newborn feeding

I. Skills Checklist:

1. ____ Introduced self, explained role
2. ____ Started with open-ended question
3. ____ Used focused questions to gather further history
4. ____ Gave you time to answer fully
5. ____ Directly responded to your anxiety
6. ____ Checked information with you for understanding
7. ____ Completed the interview with a transition statement (Ex: Thank you. I'll get the Dr. now)

II. Content Checklist:

8. ____ Gathered a pregnancy history
9. ____ Asked about the type of birth
10. ____ Asked about gestational age
11. ____ Asked about complications (at birth, hospital stay, oxygen, jaundice, infections)
12. ____ Asked about how often the baby is feeding
13. ____ Asked about how long each feeding is
14. ____ Asked about whether the mother's milk is in (or engorgement)
15. ____ Asked about voiding (wet diapers)
16. ____ Asked about stooling patterns (coloring, consistency, change in pattern)
17. ____ Asked about depression in the mother

TOTAL _____ of 17.

SP Name: ______________________ Student Label: _________________

Case #4: M1 Interview OSCE
Depression

I. Skills Checklist:

1. ____ Introduced self, explained role
2. ____ Started with open-ended question
3. ____ Gave you time to answer fully
4. ____ Showed sympathy for your sadness
5. ____ Explained how depression is different from grief

II. Content Checklist

Asked About:

6. ____ Managing money
7. ____ Bladder or bowel control
8. ____ Housework
9. ____ Driving
10. ____ Relationships
11. ____ Social support
12. ____ Sleep
13. ____ Sadness
14. ____ Worrying
15. ____ Memory
16. ____ Thoughts of death or suicide

TOTAL _____ of 16.

SP Name: ______________________ Student Label: _________________

Case #5: M1 Interview OSCE
Unwanted Pregnancy

I. Skills Checklist:

1. ____ Introduced self
2. ____ Explained role
3. ____ Used open-ended question
4. ____ Gave you time to answer fully
5. ____ Non-judgmental demeanor
6. ____ Did not push any particular option
7. ____ Responded to emotional conflict/ambivalence

II. Content Checklist

Asked About:

5. ____ Contraception
6. ____ Partner
7. ____ Last menstrual period
8. ____ Previous pregnancies
9. ____ General health
10. ____ Asked about social support

Gave Information on Options:

11. ____ Abortion (or offered to refer to source of information)
12. ____ Adoption
13. ____ Single Parenthood

TOTAL _____ of 16.

SP Name: ______________________ Student Label: _________________

Case #6: M1 Interview OSCE
Smoking and Colon Cancer

I. Skills Checklist:

1. ____ Introduced self
2. ____ Explained role
3. ____ Used open-ended question
4. ____ Gave you time to answer fully
5. ____ Made statement of encouragement to quit
6. ____ Negotiated some kind of smoking behavior change (appropriate to your level of readiness to quit)
7. ____ Helpful, non-judgmental attitude
8. ____ Acknowledged barriers to quitting

II. Content Checklist:

Asked About:

9. ____ Family history of rectal / colon cancer
10. ____ Three-generation family medical history (including grandparents & cousins)
11. ____ Cough
12. ____ Shortness of breath
13. ____ Smoking; how long or how much
14. ____ Desire to quit
15. ____ Previous attempts to quit

TOTAL _____ of 15.

SP Name: ______________________ Student Label: _________________

Case #7 (alternate): M1 Interview OSCE
Hypertension

I. Skills Checklist:

1. ____ Introduced self
2. ____ Explained role
3. ____ Used open-ended question
4. ____ Gave you time to answer fully
5. ____ Asked about barriers to exercise
6. ____ Recommended exercise
7. ____ Asked about barriers to changing your diet
8. ____ Recommended appropriate dietary changes

II. Content Checklist

Asked About:

9. ____ Mammogram
10. ____ Pap smear
11. ____ Cholesterol
12. ____ Menstruation
13. ____ Menopausal symptoms like hot flashes
14. ____ Your eating habits
15. ____ Family history of high blood pressure
16. ____ Family history of heart disease

TOTAL _____ of 16.