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ABOUT FILMING THE VIGNETTES

These vignettes were all filmed with a camcorder set up in a room at the Department of Family and Community Medicine at the University of Toronto. The doctors very gamely volunteered to interview a standardized patient for ten minutes - no takes and retakes. This is far less time than they would normally spend with a patient in "real life". Each doctor had misgivings about what they had or hadn't done or had forgotten to do or would have done differently.

An observation that must be made: video *does not* capture one element vital to doctor/patient communication - the human element, the energy between two people. In fact, as we were filming we began turning our backs to the real thing to watch on the monitor because the flavour was so different.

We decided to use a stationary camera thereby providing as little visual distraction as possible. The sound quality, too, is less than professional but we believe we more than make up for the humble technical side of the video with their fresh, unscripted format.

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VIDEO INDEX

The times listed above are approximations only.

Communication Skills
Advanced Challenges in Interviewing
Introduction to Video

Communication skills are an important part of medical practice, increasingly emphasized as a priority for medical education. Basic history taking and interviewing skills are taught in virtually every medical school. This video assumes some familiarity with the basics of the biomedical interview. Students will likely have completed at least one year of a program in which they have observed and learned to perform the "standard medical interview" including taking a history, past history, review of systems (functional inquiry) and a psychosocial history.

As physicians and medical educators, we recognize that often the "good patients" selected for interviewing courses may not always present some of the challenges encountered by students, residents and physicians on the wards, in offices and in the community. Such problems as confusion, anxiety or extreme talkativeness can challenge the standard approach to history taking. A seductive or angry patient may stir up a whole host of feelings in the interviewer that may challenge them to stay in control of their own feelings. Finally, issues such a breaking bad news and giving information require special skills which may not be taught as part of a standard course in interviewing.

We have created a series of 10 video vignettes, each illustrating an interview between a physician and a patient. Accompanying the scenarios is a checklist which lists the various types of skills that are necessary for a successful interview. This checklist will be familiar to many, and resembles the types of checklist that are used for teaching and evaluating of communication skills throughout North America. The checklist is not created for the purpose of marking students in an examination setting, although with minor modifications this could be achieved. Instead, it is designed for teaching and feedback to students, by experts and peers and for student self-evaluations.

The checklist items are purposely vague in some instances. For example, "Uses silences and transitions appropriately". Whereas long, patient silences are helpful with a depressed patient, they might be filled with unhelpful chatter by a very anxious or talkative patient. While very focused, closed questions may feel intrusive to "good historians" they are essential for a confused or manic patient. We have left it up to teachers and students to discuss among themselves which exact techniques will be most helpful in which situations.

The videos are meant to provide an illustration of communication challenges, but not the "perfect interview". Each interviewer has his or her own style and this must be allowed to develop with years of experience interviewing a wide variety of patients. The interviews shown in the videos are only one approach to the situation and are a good springboard for discussion. While interviewers may demonstrate some of the techniques needed in challenging situations, there are others which students may wish to learn and teachers may wish to demonstrate. One of the main points we hope to convey is that in many interviewing situations that physicians encounter everyday, they must significantly alter the format of the "standard interview" as it is taught to beginning medical students.

For each scenario, we have highlighted portions of the checklist which are particularly important for the scenario demonstrated. At the end, we have included a series of discussion questions, designed to stimulate students to think about how they might experience the same situation and how they might interview the patient. It may be particularly useful to practice role-playing the scenarios before or after viewing the videos to allow students an opportunity to feel for themselves the challenges and the pit-falls of these communication challenges.

We hope teachers and students alike will find this a helpful resource for teaching and learning about communication in challenging situations.

VIGNETTE SUMMARY

VIGNETTE NUMBER	VIGNETTE NAME	ISSUE	SPECIAL SKILLS
1	older sexuality	age difference, sensitive issues	rapport, information giving
2	anxiety	fear of brain tumor	listening, information giving
3	anger	death of relative	listening, rapport, emotional control
4	seductive patient	boundaries	emotional control, closure
5	don't tell	mother has cancer, cultural differences, triadic interviewing	questioning, flexibility, information giving
6	compliance	non-compliant patient	flexibility, information giving
7	confusion	hemoptysis and cognitive impairment	listening, flexibility, emotional control
8	breaking bad news	HIV diagnosis	rapport, listening, information giving
9	mania	lithium toxic manic, agitation	listening, flexibility, emotional control
10	sexual abuse	young woman requesting birth control, very upset	listening, flexibility, rapport

Communication Skills

B Hodges, University of Toronto
J Turnbull, University of Ottawa

Teaching and evaluating communication skills is a priority for medical educators. A recent conference which included medical educators from all 16 Canadian Medical schools as well as licensing and certifying bodies, patients, students and schools of nursing and social work, produced a consensus statement on communication skills in medicine. The group stated that "doctor-patient communication is an integral component of quality medical care" but that "rigorous research has revealed major deficits in communication between doctors and patients". Among their recommendations the group called for the "development of sensitive, reliable and valid methods for evaluating students' competence and performance" in communication skills (Consensus statement 1992).

Defining Communication Skills

While there is little doubt that good communication skills are essential for competent medical practice, it is difficult to describe precisely what constitutes good communication skills. In fact, it is only in the past 30 years that educators have attempted to describe, quantify and measure communication skills in medical students (Woodward and Gerrard, 1985). Certainly it has been recognized for some time that the ability to "get a good history" is at the centre of competent medical practice and that a base of knowledge about medical problems and the symptoms they produce, is essential to obtaining a "good history". However, educators believe that specific communication skills can be defined and evaluated which are important across all clinical problems. These include the physical *structure* of the verbal interaction (clear, concise, language, use of pauses, open ended questions) and the *process* of the verbal exchange (verbal inflection, following patients' non-verbal clues, conveying a sense of warmth). Both affect the degree to which information is volunteered to the physician and understood by the patient as well as patients' compliance with treatment and satisfaction with medical care (Woodward and Gerrard, 1985).

However, communication skills go beyond the structure and process of the verbal exchange and include other qualities of the physician-patient interaction. Hess (1969) emphasized aspects of the doctor-patient relationship called "interpersonal skills", including such things as empathy, warmth and respect. More recently however, educators have begun to realize that it is artificial to separate the qualities of the verbal exchange from broader interpersonal elements of the relationship, because each affects the other. A recent definition of communication skills is: "the interaction between doctors and patients (that) involves the forming of a relationship and the gathering and giving of information ... to promote the physical, social and emotional well-being of patients and their families" (Consensus conference 1992). Such a shift is reflected in the types of evaluation tools that are designed to measure student-patient interactions. Scales such as the Calgary-Cambridge Observation Guide (Kurtz, 1994) contains items such as "uses open ended and closed-ended questions appropriately" and "summarizes at the end of a specific line of inquiry" right along side "empathizes and supports the patient" and "is sensitive to pain, discomfort and embarrassment". Thus current thinking supports the evaluation of clinical skills in the broadest sense, including

"interpersonal skills" in addition to qualities of the verbal exchange.

Psychometric Considerations:
Validity, Reliability and Generalizability

It is well known that certain evaluation methods measure some domains better than others. For example, multiple choice questions are excellent for measuring knowledge, but less helpful for the measurement of skills or attitudes. As in all domains, consideration must be given to the psychometric properties of tools which evaluate communication skills. In the past, evaluation of communication skills has relied heavily on oral examinations and end of rotation evaluations (ward evaluations) which possess very low reliability. Newer techniques such as the use of standardized patients, video taping, standardized checklists and Objective Structured Clinical Examinations (OSCE) are attempts to improve the reliability of assessment. Simply put, more observations and more observers, coupled with decreased variation in the observers and in the patients allows for a more reliable assessment. Validity improves when scales are carefully developed, understandable to raters, and capture a well defined domain effectively. However, scales which are valid in one setting may not be valid in another. What appears "empathic" to a surgeon, for example, may not look so to a psychiatrist and what looks like "maintaining focus" to that same psychiatrist may look like disorganization to the surgeon.

Another important consideration is the generalizability of measures (to what degree a finding in one situation can be applied to similar situations). The literature shows that generalizability co-efficients for clinical skills in OSCEs are only in the moderate range. Such moderate generalizability is noted even when cases are derived from the same specialty, when the same diagnosis is portrayed with different complaints or when students encounter the same complaints as a result of different diagnoses (Vu and Barrows, 1994). Limited work has been done with regard to generalizability of communication skills, however, in a specific communications OSCE reported by Hodges et al (1994) inter-station reliability was only 0.17 to 0.20. Vu and Barrows (1994) suggest that while such results seem to suggest the need for improved test development, it may be that performance or competence is specific to content and not a generalizable measure.
There are two ways of understanding why communication skills might be linked to knowledge of content. It may be that increased knowledge of the content area "improves" a student's apparent communication skills or conversely, poor communication skills may impede the gathering of content information, even when the candidate possesses adequate knowledge about the problem. This interaction undoubtedly accounts for some degree of inter-case variability.

We might conclude that if there is no homogeneous set of communication skills, and performance depends on the content of a scenario, that a student might perform well when obtaining an autopsy, but poorly in dealing with sexual abuse. Such a conclusion has implications for both the teaching and evaluation of communication skills because it suggests that each type of clinical problem that a student might encounter should be taught and evaluated separately. A comprehensive assessment of communications skills could not be made based on a few "representative" observations.

Only preliminary work has addressed this issue and indeed other explanations have been suggested to account for poor generalizability, including poor discrimination as a result of low score variance

(Hodges, Turnbull, Cohen et al 1994, Vu and Barrows, 1994). Hodges, Turnbull, Cohen et al (1994) reported a study of 95 final year medical students at 5 Ontario medical schools who participated in six ten-minute encounters which examined students' ability to manage the difficult emotions of fear, anxiety, mania, sadness, confusion and anger. Half the students encountered a patient with moderate emotional symptoms and half an extreme emotional state. For difficult stations, students' scores were lower and standard deviation higher suggesting that manipulating difficulty increases score variance and potentially discrimination. However, a strong interaction was found between difficulty and station content, and communication scores were highly correlated with content. Generalizability remained low. Thus while we should be concerned with adequate reliability and validity, the issue of generalizability of communication skills remains problematic and requires further study.

Measuring Communication Skills

Woodward and Gerrard reviewed the current state of the art of assessment of communication skills in 1985. They examined assessment measures in 5 categories - those which assess: (1) physician attributes and attitudes, (2) ability to generate appropriate responses, (3) actual behaviour in clinical encounters, (4) patient-based information and (5) physician-patient agreement. They reviewed a wide range of assessment instruments and compiled a helpful table illustrating which scales measured which aspects of communication and rated the comprehensiveness, reliability and validity of each measure. The authors came to several conclusions based on their review of the literature. For the first category, they reviewed several measures, mostly paper and pencil self-reports of such student attributes as "treating others with kindness and sympathy" and "self-acceptance". They felt that while such tests were easily administered, there was little evidence of their validity with respect to the doctor-patient relationship. In the second category, papers studied the ability of students to identify appropriate behaviours or responses based on a standardized stimulus. Typically a film was viewed and stopped at critical points when students generated responses. The authors comment that although a student can correctly identify or generate an appropriate response they might not actually make such a response in a real clinical encounter. Thus, although the investigators chose to dismiss this type of assessment because of apparent lack of validity, this represents a judgement of face validity. The validity of these measures has not been demonstrated (or rejected) empirically.

The remaining three categories focused on actual encounters with patients or standardized patients. A large number of scales existed at the time to assess a variety of aspects of communication. Since that time, many more have been published and new scales appear in the literature frequently. Many of the scales that Woodward and Gerrard reported had moderate to high inter-rater reliability and evidence of construct and concurrent validity.

Medical educators have experimented with a variety of methods for evaluating communication skills (Vu and Barrows 1994). Because communication consists of verbal and non-verbal interaction with another person, evaluation methods in this area have focused primarily on direct observation of student-patient encounters. Experimental work has examined many variables related to this encounter such as the patient (live interview, video, audio, transcript) and the means of evaluation (checklist, global rating, self-assessment, patient evaluation).

Given that many existing scales have demonstrable psychometric properties, one might wonder why educators should continue to produce new scales. Part of the answer may be in understanding the

context in which communication is measured. Firstly, practical time constraints affect the feasibility of employing certain scales. While the Calgary - Cambridge scale (Kurtz, 1994) contains 35 items useful for a detailed observed interview, the OSCE of the Pre-Internship Program at the University of Toronto uses only 2 global scales: organization and compassion (Cohen et al 1991).

Another consideration is the generalizability problem raised earlier. As mentioned, communication skills must be interpreted within a clinical context. It is possible to define specific communications skills which are essential to particular clinical scenarios. For example, in dealing with a manic patient, it is important to take firm control of the interview and abandon open-ended questions quickly. While such a technique is essential to a successful outcome with a manic patient, such an approach would be perceived as intrusive and offensive to a depressed patient. Thus, certain communication skills are probably not generalizable because they do not apply equally in all clinical situations.

Despite the proliferation of scales, most comprehensive evaluation instruments sample approximately the same sub-domains. Usually these are initiation of interview, questioning skills, non-verbal communication, organization, attitude or control of own emotions, building rapport, counselling and closing or termination. Within each section are listed specific behavioral items. This is where differences arise for different clinical situations. As discussed above, the style of questioning used in mania and depression would be very different. Including communication skills specific to clinical problems may also be effective because items typically used on communication checklists such as "shows empathy" and "responds to emotional issues" fall prey to a halo effect. Even though examiners are specifically directed to assess these common communication skills, they may be influenced by a student's knowledge. When asked to assess specific communication skills which are not part of every clinical encounter, examiners may be more accurately directed toward specific communication behaviours, independent of content.

The fourth category reviewed by Woodward and Gerrard was assessment by the patient, often called "patient satisfaction". A number of scales were reviewed, many with acceptable psychometric properties. Such scales seem to be particularly useful when focused on patient satisfaction or the quality of the relationship. The authors raise the concern that the nature of a patient's presenting problem might interfere with the quality of their evaluation. While tapping broad aspects of the doctor-patient relationship, they felt that it did not have the same kind of feedback value as direct external observation. Since Woodward and Gerrard's review, a definitive effort was made by the American Board of Internal Medicine to create a Patient Satisfaction Questionnaire. This form was carefully developed and shown to have strong psychometric properties (Webster 1989). This tool is now widely used. Use of patient information is a logical source of important data and will likely expand with increased consumer input into health care and education.

Context of Assessment of Clinical Skills

Clearly, the ward evaluation is an easy and practical means of capturing longitudinal performance, if the same evaluator observes the student throughout a rotation. This can be useful for dimensions of professional behaviour such as responsibility, team work and punctuality. As well, there are several means of making ward evaluation more reliable and to reduce the effect of halo, inflation and reduced variance. For example, the use of "anchors" which specify specific behaviours for each

point given can improve reliability. Nevertheless, for the assessment of communication skills, an end of rotation global rating will never achieve the reliability and validity that multiple individual observations of clinical encounters made with standardized checklists could.

Therefore, to ensure that communication skills are adequately assessed before a student is declared competent, other evaluation methods must be employed. Newer methods of evaluation must ensure both comprehensive assessment of communication skills and adequate reliability. Several formats have been described for this purpose, and the field has expanded since Woodward and Gerrard completed their review. The following sections will discuss two new methods in current usage or investigation: standardized patient interviews and the objective structured clinical exam.

Standardized Patients and the Assessment of Communication Skills

The use of standardized patients (SP) in medical education has been extensively studied. Used in evaluation, SPs have the advantage of presenting different students with a similar challenge, thus reducing one important source of variability. Empirical evidence supports the high credibility of standardized patients which are often indistinguishable from real patients (Norman, Barrows, Gliva et al., 1985). In the area of communication skills, Sanson-Fisher and Poole (1980) demonstrated no difference in blind ratings of empathy between students interviewing real and standardized patients. Norman and Tugwell (1982) found no differences in the number of questions asked, the likelihood of arriving at the correct diagnosis or the number of tests ordered between residents examining a real or a standardized patient. Rethans and van Boven (1987) reported that physicians' performances with SPs were more accurate reflections of actual practice than written simulations.

With the recognition that standardized patients have the potential to assess more areas of the doctor-patient relationship than any other type of simulation, SPs have become widely used in the teaching and evaluation of communication skills. SPs can easily be trained to provide assessment of communication skills and feedback, in place of or in conjunction with an external observer and SP roles can be created to "stress" particular skills. In fact, the usefulness of a checklist item is affected by whether or not a particular skill is actually required in a given scenario. For example, if an items reads: "keeps interview on track, interrupting tactfully when appropriate", yet the patient answers questions succinctly and briefly, this skill will never be tested. The rating is then meaningless. In creating SP roles to test communication, it is important to create some communication challenges. An angry, confused or anxious patient for example, will tax a student's communication skills more thoroughly than a "good historian". Hodges, Turnbull, Cohen et al (1994) demonstrated that situations which were most effective were those in which a severe emotional problem impeded addressing the clinical problem.

It is also important to utilize different affects because different students react differently depending on the affect. Many students are well informed about depression and abuse and are less anxious when confronted with them. However, while most students are expected to be empathic with sick, abused, or sad people, they may not be taught to deal with an attack such as occurs in mania or rage. Such an encounter may generate a greater communication challenge and more anxiety. Very different psychometric properties can be observed depending on the nature of each complex station (Hodges, Turnbull, Cohen et al, 1994).

Assessing Communications Skills in the OSCE Format

Many settings have begun to use the OSCE format for evaluation. The OSCE has been shown to have better reliability than traditional orals and can test many different domains at one time. In effect, the candidate has a large number of "mini-orals" each in a different knowledge area and each with a different examiner. The clinical content is standardized by the use of a standardized patient, and the evaluation is standardized by the use of a detailed checklist.

Students are observed as they perform a clinical task such as interviewing or performing a physical examination while an examiner rates their communication skills on a standardized scale. In a recent review of the use of SPs and the OSCE format over the past few decades, Vu and Barrows (1994) conclude that "large-scale performance assessment using SP technology is feasible and provides a relatively efficient, valid and moderately reliable method of assessing professional competence."

In most settings however, the assessment of communication skills in the OSCE format, is an "add-on" to a history taking station. To date, most OSCE examinations have not contained stations which specifically examine communication skills in the broadest sense. This may be partly a result of the way OSCE stations are created. Typically, various medical departments are asked to create stations. The resulting stations are content laden and scoring systems factually based. Students are asked to address the required content area as the primary goal (e.g. take a history, perform a physical), and communication skills (rapport, empathy, interviewing technique, control of emotions) are secondary. Rarely have stations been created to specifically test communication skills as the primary objective.

Hodges, Turnbull, Cohen et al (1994) created OSCE stations which specifically tested communication skills in the broadest sense. In a three medical school OSCE, 60 clinical clerks and 36 residents were rated in four ten-minute emotionally charged situations portrayed by standardized patients. Inter-rater reliability was demonstrated ($r=0.59$ to 0.63) and a highly significant effect of educational level provided evidence of validity.

The OSCE format does have several draw-backs. OSCE exams require a large number of personnel (particularly standardized patients) although, the assessors may not need to be professionals. OSCEs are also somewhat expensive to run, based mostly on the cost of personnel (for the most part, a successful OSCE requires the use of professionally trained standardized patients). However, it appears from preliminary work that communication OSCE stations can be created with acceptable reliability and validity. As with SP encounters, difficult cases do appear to better address communication skills however, and a generalizable set of communication skills remains elusive. Thus, to test communication, a number of stations testing a variety of content areas should be used.

Conclusions

The technology of assessing communication skills in the broadest sense is progressing rapidly. Communication checklists and rating scales can now be created with acceptable reliability and validity for teaching, learning and assessment. Newer methods of evaluation such as SP interviews

and OSCEs further increase the reliability of measures. While it appears that increasing the communication difficulty of a clinical encounter may result in improved psychometric properties of assessment tools, it also appears that "communication skills" are highly bound to content. For this reason, it may be necessary to create communication measures for specific settings and clinical scenarios.

Perhaps the most appropriate approach to the assessment of communication skills occurs when students and residents interact with patients, on the ward or in clinic. For this to be a suitable venue for evaluation, multiple observations of student behaviour from different sources will be necessary. This is an important area for future investigation.

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COMMUNICATION STATION BLUEPRINT
VIGNETTE #1

STATION NAME:	Older Sexuality
ISSUE:	Age difference, sensitive issues
SPECIAL SKILLS:	Rapport, information giving
PRESENTING SITUATION:	Older divorced woman presents at doctor's office with concerns about resuming sexual activity after a long period of abstinence. Her concerns include vaginal dryness and AIDS.
ACTIVITIES:	Patient encounter
TIME REQUIRED:	10 minutes

INSTRUCTIONS TO INTERVIEWER

You are a family doctor who is about to see Mrs. Williams, a new patient. She has come to talk about something personal.

PATIENT TRAINING INSTRUCTIONS

PATIENT DEMOGRAPHICS:

Woman in her 60's (or older).

CHIEF COMPLAINT:

I've been seeing a very nice man and I think the relationship is going to become a sexual one. It has been a long time since I've been that close to a man and I'm a little concerned about a couple of things. I'm concerned that I might be too dry inside. Also, I read the papers and I know about things like AIDS. Am I supposed to worry about that?

This information may not come out all at once.

HISTORY OF PRESENT CONCERN:

onset: You have been concerned about this matter for about a month. At that time it became clear to you that the relationship was going to proceed in a more intimate direction.

assoc. symptoms: You are experiencing dry skin more generally also.

PAST HEALTH:

Unremarkable in general. Use own history if appropriate.

SOCIAL/PERSONAL HISTORY:

occupation: retired. *Use any profession.*
marital status: divorced.
children: 2
education level: high school graduate.
accommodation: live in own condominium.
smoking history: non-smoker.
alcohol intake: social drinker.
caffeine: 2-3 cups of tea/coffee a day.
medications: none.
diet: good
exercise: swimming, walking
sleep: good

FAMILY HISTORY:

Generally unremarkable. No major health problems that run in the family.

mother: died 3 years ago in her 80's
father: died 2 years ago in his 80's
grandparents: died of old age.
siblings: brother alive and well, aged 65

REVIEW OF SYSTEMS:

Unremarkable. Use own history if applicable.

PATIENT BEHAVIOUR:

You are a little shy to talk about sexual matters. However, you want this relationship to succeed and are willing to address these personal issues even though you are not used to talking about sex with others. You are well-spoken, well-mannered and dressed in an attractive way.

CHECKLIST		
Initiation • uses own name and patient's name in greeting • uses appropriate opening question	YES	NO
Listening and Questioning • uses open-ended and closed questions appropriately • uses silences and transitions appropriately • uses facilitation techniques (e.g. repetitions of last few words, uh-huh, etc.) to draw out more information • asks one question at a time		
Flexibility and Adaptation • follows patient's cues and leads, not rigidly bound to predetermined set of questions • adapts questions and style of speech to specific needs of the patient • responds to patient's non-verbal cues		
Rapport ***• acknowledges patient's distress*** ***• makes good eye contact*** ***• uses appropriate body posture*** ***• creates a receptive atmosphere which puts patient at ease*** ***• receptive to patient's agenda*** ***• makes affirming/legitimizing statements and, if appropriate, empathic statements***		
Organization • has an organized approach to gathering information throughout the interview • follows a standard interview format • structure of interview reflects an understanding of the basic problem		
Emotional Control • conveys a sense of confidence • does not become angry, frustrated, anxious, embarrassed or impatient		
Giving Information/Checking Understanding ***• gives information in a timely fashion in the appropriate amount*** ***• inquires about patient's understanding of information given***		
Closure • provides a final summary of the situation/problem and follow-up plan for the patient • closes with a social amenity		

BIOMEDICAL CONTENT

- sexual history and sexual functioning in the elderly
- genito-urinary functional inquiry
- sexually transmitted diseases

DISCUSSION POINTS

- How would you feel about doing this interview?
- Does the age difference affect the difficulty of the interview?
- This interviewer weaves the woman's functional inquiry and past health into the interview. Are there any things you would have done differently?
- Might you acknowledge the woman's anxiety?
- How much information would you give about STDs, hormone replacement, etc?
- How different would the interview be depending upon culture or race?

COMMUNICATION STATION BLUEPRINT
VIGNETTE #2

STATION NAME:	Anxiety
ISSUE:	Fear of brain tumor
SPECIAL SKILLS:	Listening, information giving
PRESENTING SITUATION:	Young woman presents at doctor's office complaining of very bad headaches (migraines). She is worried because she knows of someone who recently died of a brain tumour.
ACTIVITIES:	Patient encounter
TIME REQUIRED:	10 minutes

INSTRUCTIONS TO INTERVIEWER

Karen Miller is a young woman who presents complaining of headaches. Take a relevant history of this woman's complaint.

PATIENT TRAINING INSTRUCTIONS

CHIEF COMPLAINT:

I'm having really bad headaches. I've had headaches before but they've never been as bad as the last few. I really can't do anything when I've got them.

HISTORY OF PRESENT CONCERN:

onset:	4 months ago
duration:	2-3 hours
frequency:	3-4 in the last 4 months
location:	right side, like a band over eye and temple
quality:	starts slowly, builds up until pounding (constant). It takes over.
intensity:	on scale of 1-10, it's 8 or 9
alleviating factors:	lying down in a dark room with cold cloth over head
aggravating factors:	has noticed some connection with caffeine and chocolate intake. Bending over is awful.
assoc. symptoms:	starts with dullness or heaviness in head, then photophobia, then flashing lights in eyes, also associated with blurry vision and nausea (no vomiting), feels tired after they're over
current meds:	Tylenol (they don't help)

PAST HEALTH:

- unremarkable
- went off pill 2 years ago

SOCIAL/PERSONAL HISTORY:

occupation: has own clothing business, currently having some financial difficulties (working harder lately)
marital status: single
accommodation: lives on own in apartment at Yonge & Eglinton
relationship: has boyfriend who is married
smoking history: smokes one pack a day
alcohol intake: social drinker (drinking more lately - 2 glasses/night)
caffeine: has increased lately
diet: don't want to eat
sleep: sleep erratic, somewhat tired
staying up later, stressed and tired
sexual history: normal, some stress in relationship

- nothing in life has gone well over past few months
- recent stress in her life associated with business

FAMILY HISTORY:

father: (60) alive and well, except for history of migraines
mother: (50) alive and well, had breast cancer (lumpectomy - she's fine)
siblings: none
no other major diseases in family

REVIEW OF SYSTEMS:

unremarkable except for: nausea with headaches
periods are a little irregular
significant negatives: no weakness, no tingling, no numbness, no clumsiness, no fainting
no change in weight

PATIENT BEHAVIOUR:

- not overtly depressed
- needs reassurance
- needs pain relief
- anxious, worried about brain tumour
- might say "I've tried Tylenol but nothing seems to help."
- can talk freely about father
- can admit that boyfriend is married

ADDITIONAL COMMENTS:

- Don't lead doctor to think it's depression. Stress an optimistic attitude.
  Example: If talking about the recession, you could say "Yes, times are tough but this recession should lift soon."

- If asked what you think this is, you could answer:

  "I guess I wanted to make sure it wasn't a brain tumour."
  (A friend of a friend recently died of a brain tumour. This person had been told not to worry - that it was just a migraine.)

CHECKLIST		
Initiation • uses own name and patient's name in greeting • uses appropriate opening question	YES	NO
Listening and Questioning ***• uses open-ended and closed questions appropriately*** ***• uses silences and transitions appropriately*** ***• uses facilitation techniques (e.g. repetitions of last few words, uh-huh, etc.) to draw out more information*** ***• asks one question at a time***		
Flexibility and Adaptation • follows patient's cues and leads, not rigidly bound to predetermined set of questions • adapts questions and style of speech to specific needs of the patient • responds to patient's non-verbal cues		
Rapport • acknowledges patient's distress, but does not downplay its importance or make patient feel belittled • makes good eye contact • uses appropriate body posture • creates a receptive atmosphere which puts patient at ease • receptive to patient's agenda • makes affirming/legitimizing statements and, if appropriate, empathic statements		
Organization • has an organized approach to gathering information throughout the interview • follows a standard interview format • structure of interview reflects an understanding of the basic problem		
Emotional Control • conveys a sense of confidence • does not become angry, frustrated, anxious, embarrassed or impatient		
Giving Information/Checking Understanding ***• gives information in a timely fashion in the appropriate amount*** ***• inquires about patient's understanding of information given***		
Closure • provides a final summary of the situation/problem and follow-up plan for the patient		

• closes with a social amenity		

BIOMEDICAL CONTENT

- differential diagnosis of headache
- psychological factors leading to physical conditions and symptoms

DISCUSSION POINTS

- What is the effect of asking several questions at one time?
- Is it possible to cover the relevant medical and psychosocial aspects in one short interview?
- How much reassurance can or should be given about a major illness after a short interview?
- What is an appropriate way to respond to the anxious patient?

COMMUNICATION STATION BLUEPRINT
VIGNETTE #3

STATION NAME:	Anger
ISSUE:	Death of relative
SPECIAL SKILLS:	Listening, rapport, emotional control
PRESENTING SITUATION:	Young woman presents at doctor's office a week and a half after her father's death from complications following bypass surgery. She is angry and plans to sue the surgeon. She is coming for a second opinion on how the case was handled.
ACTIVITIES:	Patient encounter
TIME REQUIRED:	10 minutes

INSTRUCTIONS TO INTERVIEWER

You are doing a locum for a family doctor who is away on vacation for a month. You are about to see a young woman named Margaret Savard.

PATIENT TRAINING INSTRUCTIONS

PATIENT DEMOGRAPHICS:

Young woman in 20's.

CHIEF COMPLAINT:

I want to talk to someone because I'm really angry about what happened to my father. He died last week after some surgery. I'm planning to sue the surgeon. I think the case was mishandled and I'm here to get a second opinion on how things were handled.

HISTORY OF PRESENT CONCERN:

Your father had cardiac bypass surgery 2 weeks ago. He died of complications (MI) one week after the surgery. The funeral was held last week. As far as you know, your father had been healthy and active before the operation. He liked tennis and cycling. The surgery was recommended as a way of prolonging his life. *In reality, you have very little information about why the surgery was done and whether or not your father was having symptoms.*

About 7 months ago, your father had a routine checkup. Your family doctor recommended a cardiac workup. As a result, bypass surgery was recommended as a means of prolonging his life. It took a long time to schedule the surgery (6 months). You don't have information about why cardiac workup was suggested and why the bypass operation was recommended. Your father was not one to complain about his health. *It is possible that your father was having symptoms of heart disease but didn't want to worry you with details.*

You believe the surgeon did not inform you of the real risks of the operation. Actually the surgeon had mentioned 10% risk but you did not think it applied to your father because you considered him a healthy man. You think if you had been adequately informed, you (and your father) would never have consented to the operation.

PATIENT BEHAVIOUR:

You are assertive and furious. Your anger could turn to sadness (perhaps tears) if interviewer is very empathic. Your anger could subside if you are allowed to ventilate adequately.

You are trying to be strong. Your mother is distraught and barely able to function. Your motivation is that you don't want this to be forgotten (swept under the rug). You were very close to your father and loved him very much.

CHECKLIST		
Initiation • uses own name and patient's name in greeting • uses appropriate opening question	YES	NO
Listening and Questioning ***• uses open-ended and closed questions appropriately*** ***• uses silences and transitions appropriately*** ***• uses facilitation techniques (e.g. repetitions of last few words, uh-huh, etc.) to draw out more information*** ***• asks one question at a time***		
Flexibility and Adaptation • follows patient's cues and leads, not rigidly bound to predetermined set of questions • adapts questions and style of speech to specific needs of the patient • responds to patient's non-verbal cues		
Rapport ***• acknowledges patient's distress*** ***• makes good eye contact*** ***• uses appropriate body posture*** ***• creates a receptive atmosphere which puts patient at ease*** ***• receptive to patient's agenda*** ***• makes affirming/legitimizing statements and, if appropriate, empathic statements***		
Organization • has an organized approach to gathering information throughout the interview • follows a standard interview format • structure of interview reflects an understanding of the basic problem		
Emotional Control ***• conveys a sense of confidence*** ***• does not become angry, frustrated, anxious, embarrassed or impatient***		
Giving Information/Checking Understanding • gives information in a timely fashion in the appropriate amount • inquires about patient's understanding of information given		
Closure • provides a final summary of the situation/problem and follow-up plan for the patient • closes with a social amenity		

BIOMEDICAL CONTENT

- grief
- informed consent
- cardiovascular history
- cardiovascular surgery

DISCUSSION POINTS

- Would you feel threatened or defensive interviewing this woman?
- This physician suggested writing a letter to the woman's father. What other techniques might you employ?
- This patient is using several defenses to deal with her feelings (e.g. denial). Would you try to point this out or try to talk her out of her view of things?
- Note how the woman moves from anger to sadness during the interview. Anger often hides a great deal of sadness. How does knowing this affect your interviewing?
- What do you think of this interviewer's use of the terms "dad" and "mom" for the patient's parents.
- What is the most appropriate technique for dealing with the angry or hostile patient?

COMMUNICATION STATION BLUEPRINT
VIGNETTE #4

STATION NAME:	Seductive patient
ISSUE:	Boundaries
SPECIAL SKILLS:	Emotional control, closure
PRESENTING SITUATION:	A recently divorced woman presents at doctor's office requesting medication for anxiety which is related to being in social situations - especially in male company. She is very insecure and needs considerable reassurance. Her sense of the doctor-patient boundary is blurred and she often asks very personal questions.
ACTIVITIES:	Patient encounter
TIME REQUIRED:	10 minutes

INSTRUCTIONS TO INTERVIEWER

You are a family doctor. You are about to see Carole Peters, a 30 year old woman. She has come to see you about feelings of anxiety.

PATIENT TRAINING INSTRUCTIONS

PATIENT DEMOGRAPHICS:

Woman in her 30's.

CHIEF COMPLAINT:

I've been feeling really anxious lately and I wonder if there's something you can give me that might help calm me down.

HISTORY OF PRESENT CONCERN:

onset: approximately 6 months ago
description: you feel a little panicky, hot and sweaty, and your heart beats faster,
assoc. symptoms: you get tongue tied, can't think straight
association to ADL or unusual events:
it happens in social situations, especially when talking to men
course: seems to be getting more and more uncomfortable for you
alleviating factors: removing yourself from the social situation

PAST HEALTH:

In general, your past health has been unremarkable. *Use your own history if appropriate.*

SOCIAL/PERSONAL HISTORY:

occupation:	grade school teacher (focusing more on work since divorce)
marital status:	recently divorced
children:	none
education level:	university
accommodation:	live in own apartment
smoking history:	non-smoker
alcohol intake:	social drinker (drinking more lately to help take the edge off before a social gathering)
caffeine:	2-3 cups per day
medications:	none (not taking birth control pill)
diet:	good
exercise:	very little
sleep:	fair

FAMILY HISTORY:

Unremarkable in general. Use own family history if appropriate.

mother:	alive and well
father:	alive and well
grandparents:	no living grandparents
siblings:	none

REVIEW OF SYSTEMS:

Unremarkable in general. Use own symptoms if applicable.

PATIENT BEHAVIOUR:

You start out answering questions in a straightforward manner. As the interview progresses, you begin to relax and your body language should convey this. As the interviewer demonstrates an interest in your personal feelings, you begin to think s/he is really interested in you - not your problem. You begin to get personal with the interviewer. Comment on their clothes. Ask about their personal life. For example, "Are you married?" "Where do you go when you're out on the town?" Ask for their opinion. For example, "What do you think of this blouse? I'd really like a man's point of view." When describing aspects of your life, such as your loneliness, finish sentences with remarks like "Do you know what I mean?" or "Have you ever felt this way?" When on the topic of marriage, ask the interviewer is s/he is married. Be subtle. Could say that you are surprised at how easy it has been to talk with them. You could ask if they would consider going for coffee of lunch so that you could talk some more.

The interviewer may suggest that you are getting rather personal. If that happens you might say "Oh, I'm sorry, I didn't mean to embarrass you. See what I mean? I just don't know how to behave. I keep putting my foot in my mouth. It's just that I find you so interesting and nice."

You are lonely. Since your divorce papers came through there has been a gap or void in your life. All the men you are meeting now are divorced, in divorce proceedings, or having marital problems. You feel "dangling" - "aimless". Other than your husband you have never really been involved with another man. You met him in high school and dated for several years before you got married.

You have been officially divorced for 6 months. Your marriage lasted 8 years. There were no children. The divorce was a mutual decision - "we grew apart and things just weren't working out". You were separated for a couple of years. During the separation, you were still friends with your husband and continued to see him from time to time. He was someone you could call if you needed to talk. Since the final divorce papers came through you don't think it is appropriate any more.

CHECKLIST		
Initiation • uses own name and patient's name in greeting • uses appropriate opening question	YES	NO
Listening and Questioning • uses open-ended and closed questions appropriately • uses silences and transitions appropriately • uses facilitation techniques (e.g. repetitions of last few words, uh-huh, etc.) to draw out more information • asks one question at a time		
Flexibility and Adaptation • follows patient's cues and leads, not rigidly bound to predetermined set of questions • adapts questions and style of speech to specific needs of the patient • responds to patient's non-verbal cues		
Rapport • acknowledges patient's distress • makes good eye contact • uses appropriate body posture • creates a receptive atmosphere which puts patient at ease • receptive to patient's agenda • makes affirming/legitimizing statements and, if appropriate, empathic statements		
Organization • has an organized approach to gathering information throughout the interview • follows a standard interview format • structure of interview reflects an understanding of the basic problem		
Emotional Control • ***conveys a sense of confidence*** • ***does not become angry, frustrated, anxious, embarrassed or impatient***		
Giving Information/Checking Understanding • gives information in a timely fashion in the appropriate amount • inquires about patient's understanding of information given		
Closure • ***provides a final summary of the situation/problem and follow-up plan for the patient*** • ***closes with a social amenity***		

BIOMEDICAL CONTENT

- depression
- anxiety symptoms and disorders
- marriage, divorce and relationship problems

DISCUSSION POINTS

- This interviewer re-interpreted what the patient's advances as the need for approval. What would happen if he was more aggressive in putting off her seductive behaviour?
- How much personal information should be disclosed to a patient?
- What do you think the interviewer is feeling during this interview?
- Where are the boundaries between what is appropriate and what is not? Should the interviewer be calling the patient by her first name?
- How can a physician tactfully refuse to prescribe drugs when this is what the patient has come for?
- How do you adjust your interview in the face of what turns out to be a seductive patient?

COMMUNICATION STATION BLUEPRINT
VIGNETTE #5

STATION NAME:	Don't Tell
ISSUE:	Mother may have cancer, daughter does not want her to know. Triadic interviewing.
SPECIAL SKILLS:	Questioning, flexibility and adaptation, information giving.
PRESENTING SITUATION:	Mother and daughter are at doctor's office for results of ultrasound. The mother's diagnosis is probably metastatic carcinoma. The mother speaks no English but daughter is there to translate.
ACTIVITIES:	Patient encounter
TIME REQUIRED:	10 minutes

INSTRUCTIONS TO INTERVIEWER

You are a family doctor. You are about to see Mrs. Katalin Sos and her daughter Magdi Sos. Mrs. Sos does not speak English so Magdi has come along to translate.

You met Mrs. Sos and her daughter for the first time two weeks ago. For about two months, Mrs. Sos has not felt well. Your history (through the daughter) revealed that Mrs. Sos has experienced vague pains in her right upper quadrant, lack of appetite and loss of a few pounds. Your physical exam revealed a liver edge that was just palpable, firm, uneven and questionably tender, but the rest of the exam was normal. You arranged for her to have an ultrasound last week.

The ultrasound is reported as showing "multiple echogenic lesions - rule out metastatic cancer".

Mrs Sos and Magdi are now back in your office for the results of the ultrasound and for follow-up.

PATIENT TRAINING INSTRUCTIONS

PATIENT DEMOGRAPHICS:

Two patients to portray mother and daughter. Any age differential.

CHIEF COMPLAINT:

We came to find out about the test my mother had last week.

HISTORY OF MOTHER'S PRESENT CONCERN:

You have not been feeling well for the past two months. You are not very keen on going to doctors but your daughter insisted that you see one. You have been experiencing vague pains in your right upper quadrant. You also have a lack of appetite and you have lost a few pounds.

MOTHER'S PAST HEALTH:

Generally healthy except for current symptoms.

MOTHER'S SOCIAL/PERSONAL HISTORY:

occupation: homemaker
marital status: widow
children: one daughter
education level: elementary school
accommodation: own home (you live with your daughter)

MOTHER'S FAMILY HISTORY:

Unremarkable.

MOTHER'S REVIEW OF SYSTEMS:

Unremarkable except for symptoms described.

MOTHER'S BEHAVIOUR:

You do not speak English. You only speak Hungarian. You look a little worried. You may look at the doctor but you do not attempt to ask any questions. Once in a while you get curious about what is being said and you ask your daughter (in a language other than English).

DAUGHTER'S BEHAVIOUR:

You are very protective of your mother. You may hold hands throughout the interview. You know how nervous your mother is about doctors so you don't want her to hear anything that may upset her. If told that your mother may have to be investigated for cancer, you refuse to tell her. You love your mother very much and want the best for her. You want her to get the best treatment without knowing she may have cancer. Your body language may show some discomfort, and defensiveness. If your mother turns to you with questions, you try to assure her that everything is fine - that she shouldn't worry.

Some of your reasons for not wanting your mother to know might include:

She's not going to take this very well.
She's going to be hysterical.
She's afraid of hospitals. She doesn't trust them.
That's where people go to die. That's what happened to my father.
She's afraid of illness.
If she finds out something serious is going on, she'll just "stop" living and wait to die.
She won't take the treatment.
I don't want her to give up.

You don't know my mother. I do. I know what she's like.
It's easy for you to say what's best to do. You're with her for 15 minutes. I have to go home and live with her and the decision you've made.
I don't want to ruin her last few years of life.
I want her to spend the time she has left as though she was "living" and not as though she is waiting to die.

CHECKLIST		
Initiation • uses own name and patient's name in greeting • uses appropriate opening question	YES	NO
Listening and Questioning ***• uses open-ended and closed questions appropriately*** ***• uses silences and transitions appropriately*** ***• uses facilitation techniques (e.g. repetitions of last few words, uh-huh, etc.) to draw out more information*** ***• asks one question at a time***		
Flexibility and Adaptation ***• adapts to interviewing a patient through a third party*** ***• follows patient's cues and leads, not rigidly bound to predetermined set of questions*** ***• adapts questions and style of speech to specific needs of the patient*** ***• responds to patient's non-verbal cues***		
Rapport • acknowledges patient's distress • makes good eye contact • uses appropriate body posture • creates a receptive atmosphere which puts patient at ease • receptive to patient's agenda • makes affirming/legitimizing statements and, if appropriate, empathic statements		
Organization • has an organized approach to gathering information throughout the interview • follows a standard interview format • structure of interview reflects an understanding of the basic problem		
Emotional Control • conveys a sense of confidence • does not become angry, frustrated, anxious, embarrassed or impatient		
Giving Information/Checking Understanding ***• gives information in a timely fashion in the appropriate amount*** ***• inquires about patient's understanding of information given***		
Closure • provides a final summary of the situation/problem and follow-up plan for the patient • closes with a social amenity		

BIOMEDICAL CONTENT

- cultural understanding of illness
- Is family aware of details of case? Of your responsibility to inform?

DISCUSSION POINTS

- When is it appropriate to use an interpreter, and how would you adjust your interviewing style?
- What is the role of the physician's own cultural background in interviewing?
- Native Canadians may experience eye contact as very intrusive. Do you know of any other communication issues specific to particular cultures?
- Is there ever a circumstance when you would not tell a patient at the family's request?
- Are you comfortable with the approach taken by the interviewer?
- How do you deal with confidentiality and sensitive issues when you use an interpreter who may or may not be a family member?

COMMUNICATION STATION BLUEPRINT
VIGNETTE #6

STATION NAME:	Compliance
ISSUE:	Non-compliant patient
SPECIAL SKILLS:	Flexibility, information giving
PRESENTING SITUATION:	Middle-aged woman who is being treated for high blood pressure is having trouble cutting down on alcohol.
ACTIVITIES:	Patient encounter
TIME REQUIRED:	10 minutes

INSTRUCTIONS TO INTERVIEWER

Your investigations revealed that Mrs. Corine Cairns has "essential hypertension." You elected to treat her with Lysinopril (a new ACE inhibitor) and a salt restricted diet had been initiated. She now returns after two months for reassessment. Her B/P today is 172/100. Conduct a focused history.

PATIENT TRAINING INSTRUCTIONS

PATIENT DEMOGRAPHICS:

Woman, aged 62.

HISTORY OF PRESENT CONCERN:

You have seen your family doctor from time to time for minor non-specific complaints. These were fatigue-related principally, and investigations at that time did not demonstrate abnormalities. You were found to be borderline hypertensive and salt restriction was suggested. However, this was quite difficult and you did not adhere well to the salt restriction.

In view of persistently elevated blood pressure, your family doctor initiated a medication which you feel has made your tiredness somewhat worse. You also found the medication to be expensive and beyond your modest income. You did get one prescription and took it sporadically (2-3 times/week) but did not have it renewed. You continue to take salt from time to time. You do not like taking medication and frequently forget when to take them. You feel that they make your fatigue worse and that you did not feel immediately better after taking them, so you have not persisted.

You are ill-informed about medications and their use and have a general disrespect for physicians and the medications that they use. You did agree to earlier investigations to look for the cause of the hypertension and all of these were normal. You had blood tests and some form of kidney test that was also normal.

PAST HEALTH:

- You have a longstanding history (> one year) of hypertension. It was never found to be severe and you have had no complications from it.
- You had some occasional chest tightness for which you saw another family doctor a year ago and was prescribed sublingual nitroglycerine, but you have not taken this with any degree of frequency. It has not recurred.
- No history of secondary causes for hypertension such as renal disease, family history, hormonal abnormalities such as thyroid nor adrenal problems.
- Chest pain is only with exertion and has not been a recent problem.
- Gallbladder was removed five years ago.
- No allergies, and you take no other medications other than the one that was recently prescribed.

SOCIAL/PERSONAL HISTORY:

marital status: married
children: 2, both of whom have grown up and left home
occupation: waitress (from time to time)
smoking history: 1 package/day, but have only a slight cough from the cigarettes
alcohol intake: 5 bottles of beer/day, which you do not perceive to be a problem

- You do not have a lot of money, but otherwise have no specific social difficulties or problems.

SUMMARY:

You have a history of hypertension which is "essential hypertension" and is treated with salt restriction and an expensive medication. You do not adhere to your salt restriction diet, nor do you reduce your alcohol intake or cigarette smoking, although you admit that you are not taking salt in your beer anymore. You take your medication only infrequently.

The importance of this station is for the medical student to detect that this lady is not compliant, and therefore not to embark upon further expensive investigations or therapies, but to discuss issues of compliance with her. The student is to ask (a) what she understands of her illness, (b) why she does not take her medications and (c) enter into some form of contact as to how she should do this in the future.

PATIENT BEHAVIOUR:

- somewhat ill-informed
- pleasant, but does not have a great deal of respect for medications
- not dressed affluently
- disinterested in own condition of hypertension

ADDITIONAL COMMENTS:

- Reasons for non-compliance in taking medication:
  you continued to feel tired
  they were too expensive
  you didn't fully understand why they were prescribed

- When asked about symptoms, respond with "since I started on the pills I feel even more tired."

CHECKLIST		
Initiation • uses own name and patient's name in greeting • uses appropriate opening question	YES	NO
Listening and Questioning • uses open-ended and closed questions appropriately • uses silences and transitions appropriately • uses facilitation techniques (e.g. repetitions of last few words, uh-huh, etc.) to draw out more information • asks one question at a time		
Flexibility and Adaptation ***• follows patient's cues and leads, not rigidly bound to predetermined set of questions*** ***• adapts questions and style of speech to specific needs of the patient*** ***• responds to patient's non-verbal cues***		
Rapport • acknowledges patient's distress • makes good eye contact • uses appropriate body posture • creates a receptive atmosphere which puts patient at ease • receptive to patient's agenda • makes affirming/legitimizing statements and, if appropriate, empathic statements		
Organization • has an organized approach to gathering information throughout the interview • follows a standard interview format • structure of interview reflects an understanding of the basic problem		
Emotional Control • conveys a sense of confidence • does not become angry, frustrated, anxious, embarrassed or impatient		
Giving Information/Checking Understanding ***• gives information in a timely fashion in the appropriate amount*** ***• inquires about patient's understanding of information given***		
Closure • provides a final summary of the situation/problem and follow-up plan for the patient • closes with a social amenity		

BIOMEDICAL CONTENT

- hypertension and related symptoms
- alcohol history
- review of cardiovascular system
- hypertension education and compliance issues

DISCUSSION POINTS

- How might the interviewer's style have an impact on the patient's subsequent behaviour and their rapport?
- How much information should be given to the patient?
- How does it feel to work with a patient who apparently does not follow the advice of the physician or the recommended treatment?
- What specific tactics are utilized to improve compliance?

COMMUNICATION STATION BLUEPRINT
VIGNETTE #7

STATION NAME:	Confusion
ISSUE:	Hemoptysis and cognitive impairment
SPECIAL SKILLS:	Listening, flexibility, emotional control
PRESENTING SITUATION:	Older man who lives at "mission" has coughed up blood. He is a heavy drinker and appears confused. It is difficult to get a history.
ACTIVITIES:	Patient encounter
TIME REQUIRED:	10 minutes

INSTRUCTIONS TO INTERVIEWER

You are the doctor on duty in the Emergency Department. You are about to see Ernie Saunders, who has come to Emergency with the complaint of coughing up blood. Collect sufficient information to make a differential diagnosis and management plan.

PATIENT TRAINING INSTRUCTIONS

PATIENT DEMOGRAPHICS:

Man, 60 years of age

CHIEF COMPLAINT:

You have come to the emergency department because you have been coughing up pink frothy blood, about 1 cup per day, for one week.

HISTORY OF PRESENT CONCERN:

- One occasion of coughing yesterday morning led to vomiting. Blood was seen in material "vomited up"
- you have had a cough for years, but it has become worse since last fall
- no change in colour of sputum except for blood this week

PAST HEALTH:

- had appendix removed when you were a teenager
- 2 years ago you were told that you had "bronchitis"
- last chest x-ray was 2 years ago (at the community clinic)
- had one episode of hepatitis "because of alcohol" (nauseated, tired, jaundiced). This was a couple of years ago - had a check-up.
- blackouts over the last year, and one seizure, all related to alcohol
- no shortness of breath, no faintness, no chest pain, no fever
- no black or red stools
- no complaints of nose bleeds or blood in back of throat
- no bleeding elsewhere

SOCIAL/PERSONAL HISTORY:

smoking history:	you've been a smoker all your life. You smoke approx. 1 pkg/day (you cut down when the price went up
diet:	no change in weight/appetite
occupation:	unemployed (were a journalist with McLean Hunter for 5 years)
accommodation:	living at the mission
marital status:	you had been married but are now divorced because of alcohol related problems (10 years)
children:	2 boys
alcohol intake:	you continue to drink heavily - 1 bottle of wine/day

ADDITIONAL COMMENTS:

- do not volunteer amount or description of blood or vomit until asked.
- you do not know your age, but will know birth date.

PATIENT BEHAVIOUR:

- unkempt, yet oriented and alert
- you are bright and answer questions promptly and accurately
- coughing during interview

CHECKLIST		
Initiation • uses own name and patient's name in greeting • uses appropriate opening question	YES	NO
Listening and Questioning ***• uses open-ended and closed questions appropriately*** ***• uses silences and transitions appropriately*** ***• uses facilitation techniques (e.g. repetitions of last few words, uh-huh, etc.) to draw out more information*** ***• asks one question at a time***		
Flexibility and Adaptation ***• follows patient's cues and leads, not rigidly bound to predetermined set of questions*** ***• adapts questions and style of speech to specific needs of the patient*** ***• responds to patient's non-verbal cues***		
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Giving Information/Checking Understanding • gives information in a timely fashion in the appropriate amount • inquires about patient's understanding of information given		
Closure • provides a final summary of the situation/problem and follow-up plan for the patient • closes with a social amenity		

BIOMEDICAL CONTENT

- hemoptysis and respiratory review of systems
- general health review
- alcohol history
- cognitive testing

DISCUSSION POINTS

- Given time demands, how is it possible to interview such a patient without becoming frustrated and impatient?
- When is it appropriate to perform a cognitive assessment?
- Although it seems much longer, this interview is only 10 minutes long. How much time is necessary to properly interview such a patient? What is practical in a busy office or ward?
- Do you use terms such as “barf” and “spit”? What do you think would happen if the interviewer asked about “vomiting” or “hemoptysis”?
- The interviewer uses repetition of questions to get information. What other techniques aid in interviewing this type of patient?
- To what degree do you "come down" to the level of the patient?
- Confused patients can also give useful information. How can this be determined?

COMMUNICATION STATION BLUEPRINT
VIGNETTE #8

STATION NAME:	Breaking Bad News
ISSUE:	HIV diagnosis
SPECIAL SKILLS:	Rapport, listening, information giving
PRESENTING SITUATION:	Young married man presents at doctor's office requesting results of HIV test. His test is positive. His regular doctor is "on leave" and a locum must break the bad news.
ACTIVITIES:	Patient encounter
TIME REQUIRED:	10 minutes

INSTRUCTIONS TO INTERVIEWER

Melvin Purchase is a cook whom you saw for the first time last month. He was concerned that he may have contracted the AIDS virus through homosexual contact. He presents to you today in follow-up to hear the results of his HIV serology. His screening and confirmatory tests are positive. Discuss this with him.

PATIENT TRAINING INSTRUCTIONS

HISTORY OF PRESENT CONCERN:

You are a pastry chef in a hotel. Last month you had blood tests done because of your concern for the possibility of contracting AIDS. You are visiting the doctor today to hear the results of the tests. You have no symptoms and have enjoyed good health. However, you are found to be HIV positive.

PAST HEALTH:

- No history of enlarged lymph nodes, fever, cough, weight loss, shortness of breath, skin abnormalities, arthritis, penile discharge, rectal irritation, sore throat, or visual abnormalities.
- No known allergies to medications and you are on no medications at this time.

SOCIAL/PERSONAL HISTORY:

- You are happily married (3 years)
- Just as your relationship was starting up with your wife you had a brief affair with another woman
- You decided to have an HIV test when you heard that this woman had become very ill - the rumour is she has AIDS.
- You and your wife are planning a family and have not been using contraception.
- Your wife does not know about your visit to the doctor, nor indeed of your fear that you may have been exposed to the virus.
- You do not use drugs or alcohol.

PATIENT BEHAVIOUR:

Well groomed. Somewhat anxious. Concerned you will lose your job if employer learns of your diagnosis. Also concerned about your relationship with partner.

ADDITIONAL COMMENTS:

- I feel like I've been hit with a ton of bricks.
- We're planning a family - my wife will take this very badly. It's not fair. Nobody should have to handle this.

CHECKLIST		
Initiation • uses own name and patient's name in greeting • uses appropriate opening question	YES	NO
Listening and Questioning ***• uses open-ended and closed questions appropriately*** ***• uses silences and transitions appropriately*** ***• uses facilitation techniques (e.g. repetitions of last few words, uh-huh, etc.) to draw out more information*** ***• asks one question at a time***		
Flexibility and Adaptation • follows patient's cues and leads, not rigidly bound to predetermined set of questions • adapts questions and style of speech to specific needs of the patient • responds to patient's non-verbal cues		
Rapport ***• acknowledges patient's distress*** ***• makes good eye contact*** ***• uses appropriate body posture*** ***• creates a receptive atmosphere which puts patient at ease*** ***• receptive to patient's agenda*** ***• makes affirming/legitimizing statements and, if appropriate, empathic statements***		
Organization • has an organized approach to gathering information throughout the interview • follows a standard interview format • structure of interview reflects an understanding of the basic problem		
Emotional Control • conveys a sense of confidence • does not become angry, frustrated, anxious, embarrassed or impatient		
Giving Information/Checking Understanding ***• gives information in a timely fashion in the appropriate amount*** ***• inquires about patient's understanding of information given***		
Closure • provides a final summary of the situation/problem and follow-up plan for the patient • closes with a social amenity		

BIOMEDICAL CONTENT

- HIV, medical, social and community support issues
- sexually transmitted diseases
- reportable diseases
- grief
- suicide risk prevention

DISCUSSION POINTS

- How much information can this man process at this time?
- What can you do if he says nothing and has no questions?
- What sort of follow up would be appropriate for this man?
- How optimistic should/can you be?

COMMUNICATION STATION BLUEPRINT
VIGNETTE #9

STATION NAME:	Mania
ISSUE:	Lithium toxic manic, agitation
SPECIAL SKILLS:	Listening, flexibility, emotional control
PRESENTING SITUATION:	Manic patient presents at doctor's office requesting medication for nausea and vomiting. Patient has been overdosing on lithium.
ACTIVITIES:	Patient encounter
TIME REQUIRED:	10 minutes

INSTRUCTIONS TO INTERVIEWER

You are about to see Janet Cross, a patient you have been following for many months because of bipolar mood disorder (manic depressive illness). You have been prescribing lithium at a dose of 1200 mg per day. She has made an emergency appointment to see you today. Find out why she came, but do not perform a physical examination at this time.

PATIENT TRAINING INSTRUCTIONS

CHIEF COMPLAINT:

I want you to give me a prescription to stop me from vomiting.

HISTORY OF PRESENT CONCERN:

You are a woman with a long history of bipolar mood disorder. As such you have periods of illness a couple of times per year, usually lasting for a few months. You have been admitted to hospital almost every year for several years. Sometimes it is for a severe depression and sometimes for mania.

Currently, you have been feeling different for about 2 weeks. You feel better than you have ever felt. You have so much energy that you feel you could do anything. You don't need to sleep and haven't for days. Nor are you eating much. You have many new and exciting thoughts coming into your head and you are currently writing your autobiography because you feel you have been chosen to save the world. You attribute this change in your life to the lithium which you have discovered has the ability to make you feel even stronger. You believe that lithium has the ability to make everyone feel this way and that the drug company must reveal their secret files and stop preventing people from using it in the correct dosage.

Therefore, you have been taking twice as much as prescribed for about a week (was taking 4 x 300 mg, now taking 8 x 300 mg). Yesterday you started to feel very nauseated and have vomited several times in the past 24 hours. This is interfering with the work on your book which you urgently want to return to. You have absolutely no idea that you might be having a manic episode.

SOCIAL/PERSONAL HISTORY:

education level:	high school
occupation:	work as a bookstore stock clerk, family gives money to survive, also on welfare
accommodation:	live alone
sleep:	currently maybe 1-2 hours - not sure

REVIEW OF SYSTEMS:

- vomiting
- slight abdominal pain
- no tremors, diarrhea, dizziness

PATIENT BEHAVIOUR:

While you are having all of the difficulties described above, you are able to talk about them freely with the interviewer. If there is any silence of pauses in the interview you will fill them in with talk about your book and your theories on lithium and the drug company conspiracy to hide the truth. So long as the interviewer asks clear questions you will be able to answer them and stay on topic.

- Clothes are bright, inappropriate, but not unkempt (e.g. leopard skin or unmatching combinations), bright makeup

CHECKLIST		
Initiation • uses own name and patient's name in greeting • uses appropriate opening question	YES	NO
Listening and Questioning ***• uses open-ended and closed questions appropriately*** ***• uses silences and transitions appropriately*** ***• uses facilitation techniques (e.g. repetitions of last few words, uh-huh, etc.) to draw out more information*** ***• asks one question at a time***		
Flexibility and Adaptation ***• follows patient's cues and leads, not rigidly bound to predetermined set of questions*** ***• adapts questions and style of speech to specific needs of the patient*** ***• responds to patient's non-verbal cues***		
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Emotional Control ***• conveys a sense of confidence*** ***• does not become angry, frustrated, anxious, embarrassed or impatient***		
Giving Information/Checking Understanding • gives information in a timely fashion in the appropriate amount • inquires about patient's understanding of information given		
Closure • provides a final summary of the situation/problem and follow-up plan for the patient • closes with a social amenity		

BIOMEDICAL CONTENT

- symptoms of mania
- alcohol and drug use and drug toxicity

DISCUSSION POINTS

- While this patient has mania, patients are often encountered who are very difficult to interrupt. How does an interviewer adapt their style to cope with this?
- Sometimes it is necessary to interrupt patients. What is the effect of this on the interview and on rapport?
- Was it appropriate to “coerce” this patient into hospital? Did the interviewer take too much/too little control?
- How would you feel interviewing this patient?

COMMUNICATION STATION BLUEPRINT
VIGNETTE #10

STATION NAME:	Sexual Abuse
ISSUE:	Young woman requesting birth control, very upset
SPECIAL SKILLS:	Listening, flexibility, rapport
PRESENTING SITUATION:	Anxious young woman presents at doctor's office requesting birth control pill. She is worried about getting pregnant by her abusive father.
ACTIVITIES:	Patient encounter
TIME REQUIRED:	10 minutes

INSTRUCTIONS TO INTERVIEWER

You are about to see Suzanne Penner, a 17-year-old girl, for the first time. Address her concerns, but do not perform a physical examination.

PATIENT TRAINING INSTRUCTIONS

CHIEF COMPLAINT:

I want to go on the pill.

HISTORY OF PRESENT CONCERN:

You have come to the doctor to get a prescription for birth control pills. You have never used birth control before - no pills, no condoms, no IUD, etc. Your sexual orientation is heterosexual and you have had a couple of boyfriends. Your sexual activity with them has never progressed beyond kissing and some fondling through clothing. You have, however, been sexually abused (intercourse) by your father for several years. It happens when your mother goes out and she appears not to be aware. You have never discussed this with anyone, but recently saw a movie in which a woman was raped and got pregnant and you are now afraid it might happen to you. You have not missed any periods and finished your regular cycle last week.

You are not a smoker and do not take any other medications. You do not have any medical problems and have never been seen by a psychiatrist or counsellor of any kind for a psychological problem, including the sexual abuse. You are not suicidal or homicidal and are sleeping, eating and able to do school work adequately.

FAMILY BACKGROUND:

You grew up in the city where you are currently living. You have a younger brother, 11, who is not sexually or physically abused as far as you know. Your mother works part-time in a jewellery store on weekends and some evenings. It is at these times when you may end up alone with your father. You try to make excuses to get out of the house but he has very strict rules about where you go and with whom. Your father works as a supervisor for the hydro company during the day.

Your younger brother is the favourite child. You clean his room, make his bed, and prepare his lunches for school.

You don't think your mother wants to know about the abuse. You are afraid that if she finds out, she will blame you. On one level, you blame yourself. Your father has threatened to kill you if you tell anyone.

PATIENT BEHAVIOUR

You are afraid to disclose the abuse, but will do so if the interviewer asks about your sexual activity and why you need the birth control pill. When talking about the abuse you will be downcast but able to answer questions "fairly easily." So long as the interviewer is reasonably understanding you will disclose the whole story when asked.

ADDITIONAL COMMENTS:

You have few friends. You have only one friend with whom you are close. You have not told anyone about the abuse.

You are more angry at yourself than your parents. You really do hate what your father is doing. But there are other aspects to your father-daughter relationship.

Your marks have been slipping. It's often hard to concentrate.

Generally, any physical contact disgusts you. You go out with boys and you let them kiss and fondle you. With your father, you believe it's the girl's duty to give sex when a man asks. If you think there is no escaping sexual contact, you will stimulate him to get it over with. You find the whole thing disgusting and want to get it over with as soon as possible.

CHECKLIST		
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BIOMEDICAL CONTENT

- sexual history
- sexual abuse
- resources for abused women
- depression and suicide
- sexually transmitted disease

DISCUSSION POINTS

- How would the situation be different if the girl was less than 16?
- How do issues of gender of the patient and the interviewer affect the interview?
- Should the interviewer have been more forceful about pressing charges?
- Would you spend more time inquiring about drugs and alcohol?
- Should a family physician necessarily inquire about suicide or guilt in the first interview?
- How does your own perception of sexual abuse/sexuality influence the interview?
- How would you interview the abuser?