A GUIDE FOR WRITING A STANDARDIZED PATIENT CASE

Standardized Patient Program
At the Wilson Centre for Research in Education
University of Toronto

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● STATION NAME: (e.g. chest pain - angina, peptic ulcer disease)

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● SYSTEM OR ISSUE: (e.g. cardiovascular, GI, or breaking bad news)

_____

● SKILLS TESTED:

☐ history taking
☐ physical exam
☐ diagnosis/investigation
☐ management/treatment
☐ management/patient education
☐ other _____

● TYPE OF PATIENT ENCOUNTER: (e.g. follow-up, new patient, emergency, etc.)

_____

● LOCATION OF ENCOUNTER: (e.g. office, out-patient clinic, etc.)

_____

● PATIENT DEMOGRAPHICS:

• age range (please provide as broad a range as possible) _____

• sex (M, F or either) (if this is not critical please circle either) _____

• socioeconomic level (to be simulated) _____

• educational background (to be simulated) _____

PATIENT'S AGENDA

Why has the patient come to see the doctor now? What does the patient (really) want? The patient's agenda might never be verbalized to the candidate but provides a critical framework to guide SP responses, e.g. patient is fed up with pain and wants relief; patient fears surgery and hopes that pills will suffice; patient believes problem must be cancer; patient believes problem is minor etc.

PATIENT BEHAVIOUR

Indicate how the patient feels about his/her illness and how that is manifested in the encounter. What is the general emotional "tone" the patient should display? Provide us with information about the patient's attitude toward the medical interview (he/she is actively seeking help, is reluctant, or is hostile to encounter) and what questions or behaviour on the part of the candidate will trigger a change in behaviour of the patient.

QUESTIONS/CHALLENGES

This will allow us to standardize the patient presentation. Some examples of these are:

"Am I going to die?"

"Will I be able to keep on working with this?"
"I need something for pain right now."

or

"What should I do?"

- **PATIENT'S AGENDA**

- **PATIENT BEHAVIOUR**

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- **ANY QUESTIONS PATIENT WILL CONSISTENTLY ASK, OR CHALLENGES THAT PATIENT WILL PRESENT TO CANDIDATE**

DESCRIPTION OF THE CASE

CHIEF COMPLAINT

This should be very brief and described in the patient's own words.

HISTORY OF THE PRESENT ILLNESS

Please include answers to all applicable items.

Please provide enough detailed information ...

1. Terms such as "occasionally," "frequently," or "a few days" need to be defined. Patients need responses which specify dosages, duration of symptoms and similar information.

2. Descriptions of pain should include a rating on a 1 to 10 scale. "Right upper quadrant pain" is not clear enough. The nature of the pain should be provided (e.g. sharp/dull, intermittent, lasts for only 3-5 minutes at a time, etc.).

   Please use terms or phrases used by real patients you have seen.

PATIENT HISTORY

CHIEF COMPLAINT

HISTORY OF THE PRESENT ILLNESS
onset
duration
progression
frequency
location
radiation
quality
intensity
alleviating factors

HISTORY OF THE PRESENT ILLNESS (continued)
aggravating factors
precipitating event(s)
temporal/environmental/physical considerations
prior episodes
associated symptoms
current meds

RELEVANT PAST MEDICAL HISTORY
past illness(es)
past meds
hospitalizations
allergies
accidents/injuries

RELEVANT SOCIAL HISTORY
marital status
living environment (where & with whom)
habits (drugs, alcohol, tobacco, etc.)
work (type, environment, exposures)
sexual history
RELEVANT FAMILY HISTORY
parents
siblings
other relevant family members

CRITICAL REVIEW OF SYSTEMS		
	PERTINENT POSITIVES	PERTINENT NEGATIVES
HEENT		
skin		
hematopoietic/lymph		
respiratory		
cardiovascular		
GI		
genito-urinary		
menstrual/reproductive		
endocrine		
musculoskeletal		
neurological		

CRITICAL REVIEW OF SYSTEMS (continued)		
	PERTINENT POSITIVES	PERTINENT NEGATIVES
psychiatric		
other (sleep, energy, sense of well-being, etc.)		

INSTRUCTIONS TO STUDENT:
RELATIONSHIP TO PATIENT

The relationship of the student to the patient must be clearly stated. For example:

"You are a clerk in the Family Practice Cinic. You are about to see a new patient to the clinic."

INSTRUCTIONS TO STUDENT:
OPENING SCENARIO

The problem that the candidate is required to deal with must be stated in a clear and concise way. For example:

"This lady has come to your office complaining of shortness of breath."

or

"This patient was brought to the ER by ambulance after falling from a scaffold. He is conscious and complains of severe back pain."

INSTRUCTIONS TO STUDENT:
STUDENT'S TASK

The task that the candidate is required to perform must be stated in a clear and concise way. A time limit must also be given. This time limit is 10 minutes for a history station, and 5 + 5 minutes for a combined history/physical station. For example:

"Obtain a focused and relevant history. You have 10 minutes to complete this task."

or

"Counsel the patient. You have 10 minutes to complete this task."

or

"Take a relevant history of this man's complaint. You have 5 minutes to complete this task. Then, do a focused physical examination relevant to this patient's history. Describe to the examiner what you are doing and your findings. You have 5 minutes to complete this task."

- **INSTRUCTIONS TO STUDENT: OPENING SCENARIO**

- **INSTRUCTIONS TO STUDENT: STUDENT'S TASK**

EQUIPMENT REQUIREMENTS

e.g. cervical collar
IV set up
NG tube
simulation makeup
reflex hammer
BP cuff
X-ray view box
etc.

RELEVANT SOCIAL HISTORY and RELEVANT FAMILY HISTORY

Please provide enough detailed information ...

1. Specify the nature of occupation, parents' health, and lifestyle information that is relevant to the problem. The information given to SPs must go beyond what is given on the Examiner's checklist.

2. Provide information about family members. Describing the patient's brother as hypertensive should be expanded to include details of how long, how managed, (e.g. pills). Whatever the patient would reasonably know about her brother's health should be provided.

... but not too much!

3. Too many details in the peripheral elements of the case create needless memory work for SPs. Names of siblings, birth dates, or employment details are usually left for trainers and SPs to work out. Two good descriptions of employment are "a high pressured office position" or "involves lifting and carrying."

4. If the patient's past medical history and family history are not relevant to the problem, state this. Do not make up an interesting background for the SP.