Utilizing Standardized Patients to Enhance Health Literacy Communication Skills

A Manual of Cases

Lisa Doyle Howley, PhD

Funded by a grant from the JOSIAH MACY, JR. FOUNDATION
Utilizing Standardized Patients
to Enhance Health Literacy
Communication Skills

A Manual of Cases

Lisa Doyle Howley, PhD

This manual is funded by the Josiah Macy, Jr. Foundation [Grant #S01-16]. All correspondence should be sent to: Lisa Howley PO Box 784 Cornelius, NC 28031-0784; phone (704) 236-6276, fax (704) 894-9948; email ldhowley@bellsouth.net
Originally developed 2004. The development and dissemination of these materials was funded by the Josiah Macy, Jr. Foundation [Grant #S01-16]. This manual is not copyrighted and may be reproduced without permission. However, please acknowledge the author and Foundation when used or modified. If you alter its contents, please acknowledge that it was adapted from *Utilizing Standardized Patients to Enhance Health Literacy Communications Skills*. 
# CONTENTS

Clinical Advisors .............................................. ii  
Author ......................................................... iii  
Acknowledgements ........................................... iv  

## I. INTRODUCTION & DEVELOPMENT

- Background Information ................................ 1  
- The Development Process ................................ 3  

## II. STANDARDIZED PATIENT CASE MATERIALS

- Case 1: Georgia Walker ................................... 16  
- Case 2: Mary Pearson ...................................... 26  
- Case 3: Mildred Roberts ................................... 36  
- Case 4: William Fleisher ................................... 50  

## III. THE HEALTH LITERACY COMMUNICATION SKILLS RATING SCALE

- The Rating Scale ........................................... 62  

References .................................................. 69
CLINICAL ADVISORS

Eugene Barrett, M.D.
Professor of Internal Medicine
Associate Chair for Research & Director of Diabetes Center

Claudette Dalton, M.D.
Director, Office of Community Based Medical Education
Assistant Dean for Community Based Education

John Gazewood, M.D.
Assistant Professor of Clinical Family Medicine

Gregory Hayden, M.D.
Professor of Pediatrics
Director, Center for the Advancement of Generalist Medicine

Suzanne Holroyd, M.D.
Associate Professor of Psychiatry
Director, Geriatric Psychiatry, Department of Psychiatric Medicine

Karen Maughan, M.D.
Assistant Professor of Clinical Family Medicine
Co-Director, Family Medicine Clerkship

Christine Peterson, M.D.
Associate Professor of Clinical Obstetrics and Gynecology
Assistant Dean for Medical Education

William Wilson, M.D.
Professor of Pediatrics
Director, Pediatrics Clerkship
Director, Biochemical Genetics Laboratory

All of the above advisors hold their faculty appointment at the University of Virginia School of Medicine, Charlottesville Virginia
Author

Dr. Howley is an educational psychologist and professional consultant to adult education programs. She has been active in the development and evaluation of adult curricula since 1994. She obtained a Bachelors of Science in Psychology from the University of Central Florida (1994), a Masters of Education (1995) and PhD (1999) in Educational Psychology from the University of Virginia’s College of Education. In 1996 she joined the faculty of the Department of Medical Education at UVA’s School of Medicine where she founded the Clinical Skills Teaching and Assessment Program. In 2002, Dr. Howley joined the University of North Carolina at Charlotte’s College of Education as an Assistant Professor of educational research. She continues to teach and advise students from a variety of disciplines on empirical research methodologies. Currently, Dr. Howley is an affiliated research professor to the College of Education and a professional consultant in educational research, evaluation, and assessment. Her primary expertise and research efforts are focused on adult performance assessment. She has published numerous manuscripts and frequently presents her work at national and international meetings. She is an active member, and previous Board member of an international medical education association (ASPE). She serves as a reviewer for several professional journals and as Associate Editor to Medical Education Online: An Electronic Journal.
ACKNOWLEDGEMENTS

Funding for this project began in May, 2002. We sincerely appreciate and acknowledge the Josiah Macy, Jr. Foundation for providing funds to support the development and dissemination of these educational materials [#S01-16]. Without their support, this project could not have been completed. Sincere appreciation goes to the Clinical Advisors for their time and dedication in drafting the standardized patient cases. Special thanks also go to Anne Chapin, Megan Konizer, and Debbie Starke for their assistance with the recruitment and training of the standardized patients and participants. We also gratefully acknowledge Patti Reynard for her on-going assistance in managing funds and facilitating communications between Advisory Committee members. Finally, we thank the standardized patients, medical students, and residents who provided valuable feedback throughout the development and field testing of the cases and materials.
INTRODUCTION

Low health literacy is a significant barrier to quality medical care for a startling number of patients. In relation to the current project, it is defined as more than a patient’s inability to read written text, but his inability to comprehend information and instructions provided by his healthcare provider. According to the 1992 National Adult Literacy Survey (NALS), conducted by the US Department of Education, nearly one-half of all adults are either functionally illiterate or marginally literate (Kirsch, Jungeblut, Jenkins, & Kolstad, 1992). This means that nearly half of all adult healthcare consumers are unable to interpret information from a graph, such as a growth chart or immunization table, enter information into a medication logbook or keep a dietary journal. Low health literate patients often misunderstand common medical terms, such as colon, lesion, blood in stool, and screening test (Davis, Dolan, Ferreira, et al., 2001). Low health literate patients also have less awareness of preventive health measures and less knowledge about personal medical conditions (Williams, M, Baker, Parker, & Nurss, 1998). In order to better address the needs of low health literate patients, several initiatives are underway. Most notably are the American Medical Association Foundation’s Health Literacy Campaign and Pfizer’s Clear Health Communication Initiative, which include research support and education strategies for both patient and provider.

The purpose of the current materials is to provide additional and supplemental opportunities to improve and/or certify healthcare providers’ skills in addressing low health literacy in their patient population. It is not recommended that these cases be used for didactic purposes without an existing health literacy program, curriculum, or other instructional medium.

It is beyond the scope of this project to provide detailed information or instruction regarding health literacy. Several published programs and continuing medical education materials are available for this purpose, including:

- **2003 Health Literacy Education Kit** by the American Medical Association Foundation and the American Medical Association

  American Medical Association  
  515 N State Street  
  Chicago, Illinois 60610  

- **Easy Does It! Plain Language and Clear Communication, Working with Low-literacy Seniors, and Creating Plain Language Forms for Seniors** by the National Literacy and Health Program

  Canadian Public Health Association  
  National Literacy and Health Program  
  400-1565 Carling Avenue,  
  Ottawa, ON K1Z 8R1  
  [http://www.nlhp.cpha.ca/publications.htm](http://www.nlhp.cpha.ca/publications.htm)
In addition to the above published materials, Dr. Claudette Dalton at the University of Virginia School of Medicine has developed an integrated health literacy curriculum for undergraduate medical education. Detailed instructions for building a similar curriculum, including lecture notes, program descriptions, and support materials can be found at http://www.healthsystem.virginia.edu/internet/som-hlc/

The resources and materials listed above provide several strategies for health care providers to more effectively communicate with low health literacy patients. The general objectives of these materials are to improve patients’ understanding, compliance, and health outcomes.

Although vignettes, multiple choice items, and discussion questions are included in many of the above didactic publications, none of them include standardized patient cases to reinforce and/or certify health literacy communication skills. The materials contained in this manual are intended to offer medical educators sound, practical, and flexible tools for enhancing health literacy skills.

This manual consists of five standardized patient cases addressing prominent low health literacy topics as identified through the recent literature. In addition to the standardized patient cases, training guidelines, measurable teaching objectives, and a health literacy communication skills rating scale for assessing these outcomes are included.

These materials were developed with the intent for flexible use. The user should feel free modify these materials for the needs of his/her individual programs, learners, and objectives. Each standardized case includes the following:

- **Case Summary** including case focus, patient demographics, profile, abbreviated objectives, and information to be provided to the student or resident
- **Educational Objectives & Performance Outcomes**
- **Standardized Patient Case Training Materials** including a case summary, presentation and emotional tone, educational and literacy level information, and relevant case details

Also included in the current manual is a standard *Health Literacy Communication Skills Rating Scale*. This scale was intended to measure student and resident health literacy communication skills and standardized patient attitudes across all cases. Users should feel free to use the scale for instructional and/or evaluative purposes. Although initial evidence has been gathered to support the validity of this instrument, additional research is underway to further investigate its properties.
THE DEVELOPMENT PROCESS

Utilizing Standardized Patients to Enhance Health Literacy Communication Skills: A Manual of Cases was developed over an 18-month period. Based on a review of health literacy communication literature, published educational materials, and standardized patient cases, several guiding principles for the development of these materials were made:

- The materials will require the use of existing instruction in communicating with low health literate patients. The specific incorporation of these materials into this existing instruction will be based on the individual needs of the user.
- Cases will be developed for flexible administration. Users will be free to use the materials as written or revise them as necessary to suit their individual educational needs.
- Individual cases will be intended for instructional and/or assessment purposes, however case specific checklists will not be developed.
- Although users are free to modify cases, each will be written and intended for use in an extended performance encounter (15-20 minute stations).
- All cases will focus on marginally literate and functionally illiterate patients (NALS Levels 1 & 2).
- Direct assessment of the patients’ literacy levels will not be included.
- Cases will represent ranges in gender and age. However, race, ethnicity, and culture will not be prescribed for individual cases.
- All cases will assume English as a first language. Case objectives will be written to reflect this assumption. However, this will not prevent users from modifying the objectives and other materials to reflect more diverse populations.
- All cases will assume an outpatient setting.
- Cases will be developed for use with a range of populations, from undergraduate medical students to residents.
- A standard rating scale will serve as the measurement tool for all cases. This scale will be based primarily on adult learning theories and the work of Doak, Doak, and Root (1996).

CASE CONTENT MATRIX

Figure 1 represents the case content matrix, which was constructed to guide the development process. The decision to include the five general content areas was based on the review of health literacy literature. Specifically, these areas reflect some of the most prevalent health-related patient outcomes of low health literacy.

1. Medication Incomprehension
2. Medication Non-compliance
3. Mismanagement of Chronic Illness
4. Poor Preventive Medical Practices
5. Practice of High-Risk Activities

Specific chronic illnesses were selected based on prevalence and complexity. For example, hypertension and type 2 diabetes were selected for the three cases addressing health-related outcome #3 – Mismanagement of Chronic Illness.
**Figure 1. Case Content Matrix**

<table>
<thead>
<tr>
<th>SP</th>
<th>Gender/Age Range</th>
<th>Medication Incomprehension</th>
<th>Medication Non-compliance</th>
<th>Mismanagement of Chronic Illness</th>
<th>Poor Preventive Health Practices</th>
<th>Practice of High Risk Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Georgia Walker:</strong> 25 year-old woman who is reluctant to have a gynecological examination. She was last seen by another physician three years ago for treatment of a yeast infection. At that time, Ms. Walker experienced pain during her first and only gynecological exam. That negative experience, coupled with her lack of knowledge regarding the importance of regular Pap testing, makes her very hesitant to seek preventive health care.</td>
<td>F, 20-30</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Mary Pearson:</strong> 62 year-old woman who recently attended a free health screening where she was found to be at risk for having type 2 diabetes (casual plasma glucose level of 220 mg/dL). The nurse at the fair suggested that she contact her doctor to follow-up on this positive finding. The nurse gave her some literature on type 2 diabetes; however, Ms. Pearson is unable to understand the information. Follow-up testing, immediately prior to the current visit, confirmed the high glucose level.</td>
<td>F, 57-67</td>
<td></td>
<td></td>
<td></td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td><strong>Mildred Roberts:</strong> 76 year-old woman who comes into the Family Medicine Clinic for a follow-up appointment and a refill of her prescriptions for depression, hypertension, and osteoporosis. Mrs. Roberts has not been taking her medication correctly. She has been having trouble remembering when she last took her medication and will frequently take 2-3 times the daily dosage. Consequently, Mrs. Roberts is complaining of restlessness, insomnia, and headaches.</td>
<td>F, 71-81</td>
<td></td>
<td></td>
<td></td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td><strong>William (Rebecca) Fleisher:</strong> 25 year-old new mother who comes into the Pediatric Clinic requesting a well baby visit for her 4 month old son, William. Will was scheduled for two previous appointments, but the parents failed to make the appointment. Rebecca and her husband are first-time parents who heard from a friend that immunizations were dangerous and could cause autism and cancer.</td>
<td>F, 20-30</td>
<td></td>
<td></td>
<td></td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>


VALIDITY

An Advisory Committee of eight clinical faculty members was formed to assist in the development of the standardized patient case materials (see page ii). Each Advisor consulted on one of the cases and several cases had more than one Advisor. All cases were reviewed and revised several times before being field tested with a small group medical students and residents at the University of Virginia. Results of this field test led to further revision and refinement of the materials.

Several steps were taken to gather evidence of validity. First, the content of each case was based on a review of health literacy communication literature, published educational materials, and standardized patient cases. Second, a diverse group of clinical faculty advisors were surveyed about whether the cases were realistic, relevant, and important.

The Specific questions included:

1. Is the case realistic? Does (case name) represent a “typical” patient or one that you would encounter in your practice?
2. Keeping in mind that the case is meant to supplement instruction in health literacy, are the objectives appropriate for a 3rd or 4th year medical student?
3. Keeping in mind that the case is meant to supplement instruction in health literacy, are the objectives appropriate for a PGY1, PGY2, or PGY3 resident?
4. Keeping in mind that the case is meant to supplement instruction in health literacy, are the objectives appropriate for a practicing generalist physician?
5. Do you feel that the case is measuring important objectives? Are there any that you would add/delete?

The vast majority of responses to questions 1 and 5 were positive. Responses to questions regarding the appropriateness of the materials for varying levels of practice were consistent with one exception. Faculty advisors agreed that 3 out of 4 cases were appropriate for 3rd and 4th year medical students and residents, but not advanced level residents and practicing physicians. The “Fleisher” case was considered “challenging for a 4th year medical student and perfectly reasonable for a family medicine or pediatric resident.” Given that the majority of the cases were considered appropriate only for medical students and residents the field test was limited to these populations.

The field test provided further evidence of validity. A small group of seven medical students (MS) and residents (PGY) were recruited to participate: 2 third year medical students (MS3), 3 fourth year medical students (MS4), 1 first year resident (PGY1), and 1 third year resident (PGY3). Standardized patients were recruited and trained to portray each case. A minimum of five participants completed each of the cases. Following each 20-minute encounter, participants were asked to complete an inter-station questionnaire. Figure 2 displays the results of this questionnaire. The field test also included three additional cases related to cultural literacy and one additional case which is restricted for distribution. This data will not be reflected in this manual.
## Figure 2. Field Test Questionnaire Results

<table>
<thead>
<tr>
<th></th>
<th>Was the SP realistic in his/her portrayal?</th>
<th>Did the case represent a common ambulatory problem?</th>
<th>Do you feel that this case is appropriate for...</th>
<th>Did you find this case challenging for yourself?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mildred Roberts</td>
<td>100%</td>
<td>100%</td>
<td>MS2 = 100%</td>
<td>67%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>MS3 = 100%</td>
<td>[1 PGY1 &amp; 1 PGY3 did not find the case challenging]</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>MS4 = 100%</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>PGY1 = 100%</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>PGY2 = 80%</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>PGY3 = 80%</td>
<td></td>
</tr>
<tr>
<td>Georgia Walker</td>
<td>100%</td>
<td>100%</td>
<td>MS2 = 60%</td>
<td>40%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>MS3 = 100%</td>
<td>[1 MS3, 1 MS4 &amp; 1 PGY3 did not find the case challenging]</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>MS4 = 100%</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>PGY1 = 100%</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>PGY2 = 80%</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>PGY3 = 80%</td>
<td></td>
</tr>
<tr>
<td>Rebecca Fleisher</td>
<td>80%</td>
<td>100% responded “unsure,” “maybe,” “no idea”</td>
<td>MS2 = 20%</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>[1 PGY1 commented that SP was “not very verbal in discussing questions”]</td>
<td></td>
<td>MS3 = 40%</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>MS4 = 80%</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>PGY1 = 80%</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>PGY2 = 60%</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>PGY3 = 60%</td>
<td></td>
</tr>
<tr>
<td>Mary Pearson</td>
<td>100%</td>
<td>100%</td>
<td>MS2 = 50%</td>
<td>67%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>MS3 = 100%</td>
<td>[1 MS4 &amp; 1 PGY1 did not find the case challenging]</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>MS4 = 100%</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>PGY1 = 83%</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>PGY2 = 67%</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>PGY3 = 67%</td>
<td></td>
</tr>
</tbody>
</table>

**NOTE:** Questions were open-ended format. Percentages represent those that provided positive responses.

MS = medical student; PGY = post-graduate year
The Health Literacy Communication Skills Rating Scale was developed to serve as a standard evaluation tool, regardless of specific case focus. This scale, intended to be completed by the standardized patient, contains a total of 19 items: Thirteen items intended to “objectively” measure nine areas of clear communication and six items intended to “subjectively” measure overall attitudes of the standardized patient about the encounter. All items were written in a five point Likert-scale format from strongly agree to strongly disagree. For purposes of the current project, the term “objective” was considered relative to the more subjective items on the scale. In other words, the first 13 items were intended to measure health literacy communication skills or performance and the final six were intended to measure standardized patient attitudes regarding the encounter.

Strategies used to gather evidence of validity for the standardized cases were similar to those used for the Health Literacy Communication Skills Rating Scale. The content of the scale was based on a review of health literacy communication literature, including self-efficacy theory, the health belief model, stages of readiness theory, and adult learning theory. During the field test, the standardized patients completed the original scale immediately following each encounter. Overall, the standardized patients found the tool easy to read, understand, and complete during the brief five-minute inter-station period. Specific feedback was provided regarding two of the original 21 items; these items were re-worded to reflect more consistent language with the rest of the scale.

Individual item characteristics were analyzed by computing descriptive statistics for all items across all cases. The information displayed in Table 1 includes total number of completed rating scales, mean rating scores, standard errors of the mean, and standard deviations. Unfortunately, the small number of participants in the field test did not allow us to make case-specific inferences or to investigate the independence of the nine areas or two subscales. However, further evidence of validity was gathered by correlating the individual items with the overall rating scale score. Individual item and correlational analyses led to the revision of several items. Specifically, the original 21-item scale was reduced to 19: Two items were deleted due to weak internal consistency.

Correlation coefficients between the final 19 individual items, subscale scores, and total scores were strong to very strong (all coefficients were statistically significant). Coefficients between the performance subscale scores and total scale scores ranged from .66 to .87 (M = .80). Coefficients between the attitudes subscale scores and total scale scores ranged from .74 to .90 (M = .82). Further, subscale items were more strongly associated with their respective subscale items than with items across subscales. Specifically, the average correlation coefficient between items on the attitudes subscale with its total subscale score was .87 compared to a correlation coefficient of .77 with the performance subscale. The average correlation coefficient between items on the performance subscale with its total subscale score was .80 compared to a correlation coefficient of .72 with the attitudes subscale.
Table 1. Descriptive Statistics: *Health Literacy Communication Skills Rating Scale*

<table>
<thead>
<tr>
<th>Performance Subscale</th>
<th>n</th>
<th>m</th>
<th>SE</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Open-Ended Questions</td>
<td>26</td>
<td>4.04</td>
<td>.20</td>
<td>1.00</td>
</tr>
<tr>
<td>2. “We” Statements</td>
<td>26</td>
<td>3.58</td>
<td>.25</td>
<td>1.24</td>
</tr>
<tr>
<td>3. Verbal Empathy Statements</td>
<td>26</td>
<td>3.62</td>
<td>.21</td>
<td>1.06</td>
</tr>
<tr>
<td>5. Positive Verbal Reinforcement</td>
<td>26</td>
<td>4.04</td>
<td>.21</td>
<td>1.08</td>
</tr>
<tr>
<td>6. Respectful, Non-Bias Language</td>
<td>26</td>
<td>4.00</td>
<td>.21</td>
<td>1.06</td>
</tr>
<tr>
<td>7. Statements of Support</td>
<td>26</td>
<td>4.15</td>
<td>.21</td>
<td>1.05</td>
</tr>
<tr>
<td>8. Clear Language</td>
<td>26</td>
<td>3.97</td>
<td>.18</td>
<td>.92</td>
</tr>
<tr>
<td>10. Information Delivery</td>
<td>26</td>
<td>4.08</td>
<td>.18</td>
<td>.89</td>
</tr>
<tr>
<td>11. Confirmation of Comprehension</td>
<td>26</td>
<td>3.73</td>
<td>.23</td>
<td>1.19</td>
</tr>
<tr>
<td>12. Instructional Delivery</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13. Confirmation of Instruction</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 2. Reliability Coefficients: *Health Literacy Communication Skills Rating Scale*

<table>
<thead>
<tr>
<th>Reliability</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Performance Subscale (11 items)</td>
<td>0.94</td>
</tr>
<tr>
<td>Attitudes Subscale (6 items)</td>
<td>0.93</td>
</tr>
<tr>
<td>Total Rating Score (19 items)</td>
<td>0.97</td>
</tr>
</tbody>
</table>

**RELIABILITY**

Evidence of reliability was gathered by assessing the internal consistency of the *Health Literacy Communication Skills Rating Scale*. Cronbach’s Alpha coefficients were very high for both subscales and the total rating score. These coefficients are displayed below in Table 2. Assessment of inter-rater agreement was not completed at the time of this publication, but is planned for future study.
GEORGIA WALKER: CASE SUMMARY

CASE FOCUS: Noncompliance with Screening Practices

PRESENTING COMPLAINT: Request for general physical exam (w/o pelvic examination)

PATIENT DEMOGRAPHICS:
- Age: 25
- Sex: Female
- Height: Average
- Weight: Average

CLINICAL ADVISOR:
Christine M. Peterson, M.D.
Assistant Professor of Obstetrics and Gynecology

PROFILE:
Georgia Walker is a 25yo woman who comes into the Family Medicine Clinic requesting a “check-up.” Ms. Walker will be reluctant to have a gynecological examination and will request a general screening exam without the pelvic examination. She has had repeated vaginal infections and one episode of genital warts. Her menses cycles are normal. Ms. Walker was last seen by a physician five years ago for treatment of a yeast infection. At that time, Ms. Walker experienced pain during her first gynecological exam. That negative experience, coupled with her lack of knowledge regarding the importance of regular Pap testing, makes her very hesitant to seek preventive health care.

CASE OBJECTIVES:
The primary objectives of this case are threefold: a) to identify the patient’s stage of change and her rationale for not practicing preventive healthcare, b) to raise the patient’s personal awareness of her risk for cervical cancer and sexually transmitted diseases, and d) to reduce the patient’s anxiety surrounding gynecological examinations and begin to establish trust in order to improve compliance with preventive health practices.

STUDENT INFORMATION:
- Patient Name: Georgia Walker
- Setting: Family Medicine Clinic
- Station Length: 20 minutes
- Patient Summary: Georgia Walker is a 25yo woman who comes into the Family Medicine Clinic requesting a general physical examination. Ms. Walker is a new patient to the clinic. Her New Patient
Survey is attached. The nurse has already taken her vital signs today:

- **BP:** 118/60
- **Temp:** 37
- **Pulse:** 72
- **RR:** 12 unlabored

**Your Tasks:**

- Review the *New Patient Survey* describing Ms. Walker’s past medical history
- Identify the patient’s stage of change and her awareness of preventive health care
- Counsel the patient on the consequences of failing to have regular screening examinations
- Establish a plan for behavioral modifications

**NOTE:** You will not perform a physical exam during this encounter!

***The student will be provided with this patient’s chart before this encounter. This chart will include a new patient survey.***
GEORGIA WALKER:
EDUCATIONAL OBJECTIVES & PERFORMANCE OUTCOMES

The primary objectives of this case are threefold: a) to identify the patient’s stage of change and her rationale for not practicing preventive healthcare, b) to raise the patient’s personal awareness of her risk for cervical cancer and sexually transmitted diseases, and d) to reduce the patient’s anxiety surrounding gynecological examinations and begin to establish trust in order to improve compliance with preventive health practices.

This patient is at the pre-contemplative stage of readiness to change (stage 1 of 5). Specific barriers to compliance include: a) a lack of knowledge about the purpose of Pap smears, b) a negative experience during her first and only Pap test, and c) a lack of awareness regarding her personal risk for sexually transmitted diseases.

Primary Objectives & Performance Outcomes:

1. To identify the patient’s stage of change and her rationale for not practicing preventive healthcare
   1.1 Elicits the patient’s perceived barriers to comply with preventive health care practices
   1.2 Gathers information regarding patient’s level of knowledge surrounding Pap testing
   1.3 Gathers information pertaining to patient’s previous experiences with health care and Pap testing
   1.4 Gathers information regarding patient’s level of knowledge about sexually transmitted diseases

2. To raise the patient’s personal awareness of her risk for cervical cancer and sexually transmitted diseases
   2.1 Uses clear language that is appropriate to the patient’s level of understanding and free of technical and medical jargon
   2.2 Delivers new information in small pieces or organized “chunks”
   2.3 Delivers sufficient information for the patient’s level of understanding and stage of change
   2.4 Provides clear and direct messages about importance of annual Pap testing
   2.5 Provides clear and direct messages about the consequences of unprotected sexual intercourse
3. To **reduce the patient’s anxiety** surrounding gynecological examinations and begin to **establish trust** in order to **improve compliance** with preventive health practices.

1.1 Seeks to understand the patient’s perspective
   1.1.1 Uses reflective empathy statements and non-verbal cues
   1.1.2 Asks open-ended questions
   1.1.3 Listens attentively
   1.1.4 Follows-up on patient’s verbal and non-verbal cues
   1.1.5 Avoids making stereotype judgments

1.2 Provides concrete instructions that are attainable for the patient

1.3 Includes the patient in making decisions and plans regarding her care

1.4 Limits instruction and/or plan to no more than three manageable points

1.5 Checks the patient’s level of understanding by asking her to demonstrate and/or summarize

1.6 Rephrases and/or summarizes the information to ensure clarity and accuracy

1.7 Demonstrates support through verbal and non-verbal reinforcement and feedback
CASE SUMMARY

PROFILE:

Georgia Walker is a 25yo woman who comes into the Family Medicine Clinic requesting a “check-up.” Ms. Walker will be reluctant to have a gynecological examination and will request a general screening exam without the pelvic examination. She has had repeated vaginal infections and one episode of genital warts. Her menses cycles are normal. Ms. Walker was last seen by a physician five years ago for treatment of a yeast infection. At that time, Ms. Walker experienced pain during her first gynecological exam. That negative experience, coupled with her lack of knowledge regarding the importance of regular Pap testing, makes her very hesitant to seek preventive health care.

The primary objectives of this case are threefold: a) to identify the patient’s stage of change and her rationale for not practicing preventive healthcare, b) to raise the patient’s personal awareness of her risk for cervical cancer and sexually transmitted diseases, and d) to reduce the patient’s anxiety surrounding gynecological examinations and begin to establish trust in order to improve compliance with preventive health practices.

Your challenges as the Simulated Patient (SP) include:

- To realistically and accurately reveal facts about Georgia’s complaints.
- To observe the student’s behavior while simultaneously simulating the patient, and
- To accurately recall the student’s behavior and accurately complete the performance checklist.

PRESENTATION/EMOTIONAL TONE

Although you appear healthy with no visual signs of illness, you are anxious about being in the clinic. You hope to be able to just get a general physical exam and leave. You also hope that you will not need to have a gynecological examination and will be very reluctant to do so! You are open and direct, but not rude. You talk openly and honestly to the student/resident about your past medical history, including sexual activities and health.

Beginning of Encounter:

In response the question, “What brings you in today?” you answer in exactly the following words:

“I just need a general physical.”
In response to the question, “I see you recently had a yeast infection. Could you tell me about your symptoms?” you answer in exactly the following words:

“I’m fine now. I was having some discharge and itching. I’ve had this before. I used Monistat and it went away. I’m fine now!”

Throughout the Encounter:

The student/resident will likely explain that you need to have gynecological and breast examinations to screen for and possibly prevent serious medical problems. You will be very reluctant to have this exam! You experienced (what you consider) severe cramp-like pain during and after your last (and only) gynecological examination. You also don’t think this is necessary because you think you are healthy and “know” that you just have yeast infections from time-to-time.

You have very little understanding of the purpose of Pap testing and gynecological examinations. Although you have heard that this exam is recommended, you think that this is only necessary for women who want to get pregnant. You believe that because you are healthy and are in a monogamous relationship, the gynecological exam (and Pap smear) is unnecessary. You have no understanding of the relationship between Pap testing and cervical cancer. You also have no understanding of breast examinations and breast cancer. You think that because you are young, you are not at risk for cancer.

End of Encounter:

If the student plainly and clearly describes the importance of regular gynecological exams and does so in a manner that makes you feel comfortable, you will hesitantly agree to have the exam.

If the student does not discuss the importance of this exam in a manner that is clear, or if he/she presents the information in a manner that is condescending, you will refuse to have the examination.

PREVIOUS EXPERIENCE WITH HEALTHCARE

Your last physical exam was five years ago and included a Pap smear and gynecological and breast examinations. This was your first and only gynecological and breast exam. At that time, you were experiencing similar symptoms (discharge and irritation) and were diagnosed with a yeast infection and genital warts. The physician prescribed treatment for the yeast infection and your symptoms cleared up approximately 7 days later. You were not given anything for the warts. [See below for additional details.]

You experienced (what you consider) severe cramp-like pain during that gynecological examination. You also experienced a small amount of bleeding after the exam. The female physician was pleasant, but was also “rough” during the examination. Because you have no other reference, you think that the
gynecological examination is a painful procedure. This was your first and only contact with that physician. You do not have a regular physician and do not seek regular health care. You do not have a preference for a male or female physician and are not embarrassed or insecure about the procedures.

As far as you know, your Pap smear was normal and you have never had a sexually transmitted disease (STD).

**DESCRIPTION OF YOUR YEAST INFECTION SYMPTOMS:**

NOTE: You are currently not experiencing these symptoms. However, if asked about your yeast infections, you would explain the following symptoms:

- **Vaginal discharge** (offered on *general* questioning):
  - Yellowish to white in color and milky to lumpy in texture
- **Irritation** (offered on *general* questioning)
  - Vaginal itching and redness

**HISTORY OF RECENT ILLNESS:**

You first began experiencing the symptoms about 4 weeks ago. You started taking **Monistat 3**, 1 day after experiencing vaginal itching and discharge. You took the Monistat for 3 days and experienced relief by the end of the treatment (day 3). The Monistat treatment includes a suppository, which you insert like a tampon once per day, and a tube of anti-itch cream, which you apply topically two times per day. The Monistat 3-day is available at drug or grocery stores for $18.00.

The symptoms have not prevented you from conducting your normal daily activities. However, you consider them a nuisance and dislike getting the infections very much.

**PAST MEDICAL HISTORY**

**Overall health:**

You have taken good care of your health. You eat well and try to exercise. You do not smoke. “*I never get sick.*”

**Prior Illnesses:**

**Genital Warts**

You were diagnosed with genital warts five years ago, at the same time you were diagnosed with a yeast infection. Although you were experiencing symptoms of a yeast infection, you did not notice that you
had genital warts. The warts were found internally only. Your physician did not seem overly concerned and stated that this was very common and that they would go away. She also told you to use condoms to protect your partners from the warts, but you have not done this. You incorrectly assumed that the warts were associated with the yeast infection. Therefore, you abstain from sexual intercourse when you are experiencing symptoms of a yeast infection and think that this will prevent your partner from getting infected.

**Yeast Infections**

You have experienced yeast infections somewhat regularly (every 4-5 months). You treat this yourself with Monistat-3 and this clears up the problem within a few days. Symptoms of the yeast infection include vaginal discharge (yellowish to white in color and milky to lumpy in texture) and severe itching.

Hospitalizations: None

Medications: No prescription medications. Monistat 3-day treatments (OTC).

**SEXUAL HISTORY & CURRENT RELATIONSHIP**

You started having sexual intercourse at the age of 14. You have never been in an abusive relationship. You have never been married, but have had multiple male sexual partners (“about 12 or so”). You have had various boyfriends over the years, but none as serious as your current boyfriend - Marcus. You have, what you consider, a good sex life. You met Marcus while working at the diner. He works for the local telephone company as a technician. “He fixes problems with the phone lines.”

You have been with Marcus for about one year. Six months ago he moved in with you, but you do not have plans to marry. You use condoms, but irregularly. Your rationale for not using regular protection and birth control is that you are “monogamous.” As far as you know, he has no history of sexually transmitted diseases, but you have not discussed the matter in-depth. Your boyfriend was married once, and you don’t know what form of birth control he has used with his past partners. Marcus is not aware of your genital warts. He is aware that you experience yeast infections and do not have intercourse during these episodes. Marcus wants you to go on the pill, but you are happy with continuing to use condoms for birth control. You are not interested in going to the gynecologist to get a prescription for alternate birth control. You also don’t want to spend the money on the pills.

You have never used a douche product and use tampons during menstruation.
**LIFESTYLE/HABITS**

You live with Marcus in a one-bedroom/1 bath rental apartment in a lower-middle class neighborhood. You have one car, but it breaks down all the time. When it does, you take public transportation to work or ride with a friend. Marcus drives a truck provided by the phone company. You usually work the breakfast and lunch shifts and finish work by 3 or 4:00 pm. You get up early (4:30am) to be on the job by 5:30am to prepare for the diner to open at 6am. You are in bed early because of the early hour you get up.

**Diet and Exercise:**

You try to exercise several times a week (fill this in according to SP interests: softball, bowling, running). You do not eat any special diet and do not typically watch your weight. You’re happy with your weight and general appearance.

**Alcohol:**

You drink socially on the weekends. If asked for further information about the amount of drinking, reply **“I don’t drink that much. I'll have 1-3 drinks when I'm out with friends.”** You rarely get “drunk” and do not think you have a problem with alcohol.

**Activities/Hobbies:**

You and your boyfriend like to bowl once a week with a league, and you like to go out dancing when you can.

**FAMILY MEDICAL HISTORY:**

**Parents:**

Both your mother (49yo) and your father (60yo) are alive and in good health. They divorced when you were 13. Your mother’s parents are deceased. Her father died of brain cancer when you were very young (2 or 3yo) and her mother died of colon cancer at the age of 60, ten years ago. You don’t recall your grandfather’s age at his death, but you think he was in his 50s. Your father’s parents are alive and healthy (as far as you know). You are not close to your father or his parents.

**Siblings:**

You have one older brother (30yo) who is married with one child. He is healthy.
EDUCATION & LITERACY LEVELS
You graduated from high school when you were 19. You were held back and repeated the fifth grade. “I was never a very good student.”

OCCUPATIONAL HISTORY
You are a waitress at a local diner. You have been working at the diner for three years and enjoy your job very much. You have several good friends that work with you and regular customers that request your section when they come into the restaurant.

You have worked since you were 15 years old in blue collar, service-type jobs (You worked part-time while in high school). You consider yourself a reliable employee. You like to work around people and in a fast-paced environment. You are willing to work long hours when needed. You are hard working and honest. You have minimal health coverage through your employer (no sick pay benefits or medication coverage).
MARY PEARSON: CASE SUMMARY

CASE FOCUS: Education & Management of Diabetes Mellitus

PATIENT NAME: Mary Pearson (Based on the “Mildred Pierce” case)

PATIENT DEMOGRAPHICS:

- Age: 57-67 (Actual age of patient 62)
- Sex: Female
- Weight: Above average
- Height: Below Average - Average

CLINICAL AUTHOR/ADVISOR: Eugene Barrett, MD

PROFILE:

Mrs. Pearson is a 62 year-old woman who has come to clinic today because she recently attended a free health screening where she was found to be at risk for having type 2 diabetes (casual plasma glucose level of 220 mg/dL). The nurse at the fair suggested that she contact her doctor to follow-up on this positive finding. The nurse gave her some literature on type 2 diabetes; however, Ms. Pearson is unable to understand the information.

The current appointment is scheduled 10 days following this fair. When Mary called to make the current appointment, the nurse told her that she should fast for at least 12 hours before the appointment for a more accurate glucose test. Immediately prior to the current encounter, a nurse has taken Mary’s vitals and conducted a fasting plasma glucose test. This test confirmed the previous positive finding that Ms. Pearson has type 2 diabetes (fasting plasma glucose 155 mg/dL).

Mrs. Pearson has been experiencing increasingly annoying (“burning”) pain on the bottoms of both feet. She has experienced nocturia (three times/night) and urinary frequency for 2 months. Over the same time, she has also noted blurred vision, and dry skin. Mrs. Pearson was diagnosed five years ago with hypertension and was placed on hydrochlorothiazide 50 mg/daily. *This information will be referenced in the health fair screening form.*

CASE OBJECTIVES:

The primary objectives of this case are threefold: a) to identify the patient’s current level of understanding about her health status, b) to increase the patient’s level of awareness of type 2 diabetes; and c) to begin to establish a realistic and joint agreement or plan to manage diabetes. A supplemental objective is to teach the patient how to monitor her blood glucose levels with a meter.
STUDENT INFORMATION:

Patient Name: Mary Pearson

Setting: Ambulatory Medicine Clinic

Station Length: 20 minutes (Supplemental objectives requires an additional 20 minutes)

Patient Summary: Mrs. Pearson is a 62 year-old woman who has come to the clinic today because she recently attended a free health screening fair at her work where she was found to be at risk for having type 2 diabetes (casual plasma glucose level of 220 mg/dL). The nurse at the fair suggested that she contact her doctor to follow-up on this positive finding. Her results from the health screening fair are attached. The nurse has already taken her vital signs and repeated the glucose test. She informed Ms. Pearson that her test was positive, indicating that she was diabetic.

BP: 120/60
Temp: 37
Pulse: 72
RR: 12 unlabored
Glucose: 155 mg/dL (fasting)

Your Tasks:

❖ Before entering the room, review the health screening results describing Ms. Pearson’s past medical history and current risk factors for type 2 diabetes
❖ Identify the patient’s stage of change and her awareness of type 2 diabetes
❖ Educate the patient on her condition,
❖ Teach the patient how to test her blood glucose levels (Supplemental Objective)
❖ Establish a plan for management of type 2 diabetes

NOTE: You will not perform a physical exam during this encounter!

***The student will be provided with this patient’s health screening information before this encounter. This chart will include a survey of the patient’s health (test results, current symptoms, and risk factors for DM) completed by a nurse staffing the health fair.
Health Fair: Diabetes Screening Test Results

Patient Name: Mary Pearson  DOB: 2/18/41  Date:

Current/Recent Symptoms (underline all that apply): weakness, dizziness, nausea, sweating, difficulty thinking clearly, increased urination, blurred vision, headaches.

Diabetes Screen
GLUCOSE is the primary energy source for all body tissues. The sugars and carbohydrates you eat are ordinarily converted into glucose, which can be either used to produce immediate energy, stored in the liver or as fat throughout the body. High blood glucose (hyperglycemia) suggests diabetes. Your doctor may want to do further testing. A low glucose level (hypoglycemia) accompanied with symptoms such as weakness, nausea, sweating and difficulty thinking clearly, is suggestive for hypoglycemia. Even if you know you have diabetes, it is important to report any abnormal levels to your health care provider.

Your Screening Results
Screening results that fall OUTSIDE Quest Diagnostics Reference Range (range of expected screening values) are separated from the rest of the report to highlight them. They are printed in a labeled box at the end of the report. If there is no box at the end of YOUR report, all screening values fall within the listed Reference Ranges. The Reference Range for each test is listed on the right side of your blood chemistry report. Screening values that are OUTSIDE Quest Diagnostics Reference Ranges:

1. May show that you had eaten shortly before your blood was drawn
2. May mean there was a problem with drawing your blood
3. May indicate possible problems needing medical evaluation

IT IS NOT POSSIBLE TO DIAGNOSE OR TREAT ANY DISEASE OR HEALTH PROBLEM WITH THIS BLOOD SCREEN ALONE. It can help you learn more about your body and detect potential problems in early stages when treatment or changes in personal health habits can be most effective.

Your Blood Results
You and your healthcare provider can learn a great deal about your health from a sample of your blood.

Laboratory tests help in several ways. Sometimes test results will be abnormal before you have any symptoms. For those times when symptoms have developed, laboratory test results help confirm that a problem does exist. But a normal test result is just as significant as an abnormal result. When a result is normal, it not only helps to rule out disease, but it also establishes a baseline for you. Each person has his or her own baseline “normal”. A person’s own result is the best baseline for monitoring any change that takes place in the future. If any of your values are significantly different than previous health fair results but still normal, contact your health care provider.

Patient’s Glucose Level:

<table>
<thead>
<tr>
<th>Casual Plasma Glucose Reference Range</th>
<th>Your Screening Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>&gt;200mg/dL</td>
<td>220mg/dL</td>
</tr>
</tbody>
</table>
MARY PEARSON:
STANDARDIZED PATIENT TRAINING MATERIALS

CASE SUMMARY

Mrs. Pearson is a 62 year-old woman who has come to clinic today because she recently attended a free health screening where she was found to be at risk for having type 2 diabetes (casual plasma glucose level of 220 mg/dL). The nurse at the fair suggested that she contact her doctor to follow-up on this positive finding. The nurse gave her some literature on type 2 diabetes; however, Ms. Pearson is unable to understand the information (see attached document).

The current appointment is scheduled 10 days following this fair. When Mary called to make the current appointment, the nurse told her that she should fast for at least 12 hours before the appointment for a more accurate glucose test. Immediately prior to the current encounter, a nurse has taken Mary’s vitals and conducted a fasting plasma glucose test. This test confirmed the previous positive finding that Mrs. Pearson has type 2 diabetes (fasting plasma glucose 155 mg/dL).

Mrs. Pearson has been experiencing increasingly annoying (“burning”) pain on the bottoms of both feet. She has experienced nocturia (three times/night) and urinary frequency for 2 months. Over the same time, she has also noted blurred vision, and dry skin. Mrs. Pearson was diagnosed five years ago with hypertension and was placed on hydrochlorothiazide 50 mg/daily. The above information pertaining to symptoms and previous medical history will be referenced in the health fair screening form and will be shared with the student before the encounter.

The primary objectives of this case are threefold: a) to identify the patient’s current level of understanding about her health status, b) to increase the patient’s level of awareness of type 2 diabetes; and c) to begin to establish a realistic and joint agreement or plan to manage diabetes. A supplemental objective is to teach the patient how to monitor her blood glucose levels with a meter.

Your challenges as the Simulated Patient (SP) include:

- To realistically and accurately reveal facts about Mary’s symptoms, as well as her level of understanding about her health status
- To observe the student’s behavior while simultaneously simulating the patient, and
- To accurately recall the student’s behavior and accurately complete the performance checklist
PRESENTATION/EMOTIONAL TONE

You are neatly dressed with your hair done carefully. You make good eye contact with the physician and are cooperative. When asked questions, you respond well, are forthcoming, and are friendly. [***See below under “Attitudes towards health care” for further information.]

RECENT EVENTS LEADING TO THE CURRENT VISIT

You have been experiencing several symptoms that, although not painful, are becoming bothersome. You decided to attend a free health screening at your work to find out what you could do to find relief. The fair took place at your work 10 days ago. While at the fair, the nurses took your blood pressure, weight, and temperature, checked your vision, and took a sample of your blood to test your cholesterol and glucose levels. They also asked you questions about your risk for diabetes. The results revealed that your glucose level was high and you were at high risk for diabetes (all other results were negative). The nurse gave you some literature (which you didn’t understand) and suggested that you contact your doctor as soon as possible and follow-up on the positive glucose test.

ATTITUDES TOWARDS HEALTH CARE

You are comfortable with doctors. However, you frequently have difficulty understanding them. You do not have a consistent health care provider and just see who ever is available in the clinic. You have been good about coming to the doctor every year for your mammograms and pap tests. You are also good about taking your blood pressure medicine. You are concerned about your health, but are more interested in knowing what you are “supposed to do” than in understanding why.

You are not overly concerned about being told that you have diabetes, because you know that you can take a pill for it (much like your high blood pressure). You believe that pills will take care of most ailments and you understand that diabetes is treated with a pill (you remember your mother taking pills).

A “TYPICAL” ENCOUNTER:

Beginning of Encounter:

If at any time during the encounter the student asks how you have been feeling or about your symptoms, you will respond: “My feet hurt and I’ve been really thirsty lately. The nurse said that was ‘cause I probably have diabetes.”

The student will likely begin by asking you what you know about diabetes. You will respond by stating: “I know that means I’ll need to take a pill every day, like my blood pressure medicine. The
You recall your mother having to take a pill to treat her diabetes. In fact, this is all you know about diabetes.

The nurse at the health fair gave you some literature on diabetes that is too difficult for you to understand. You will have this with you during the current encounter and will only refer to the information if the student asked what you know about diabetes. You are able to read most of the words, but are not able to understand or comprehend the information. If the student asks you to read the information, you will say: “Oh there’s too much ‘lingo’ in there. I think it’s written for a medical person.”

The student will likely explain what type 2 diabetes is and how it can be managed to prevent further complications. These methods include: adjusting your diet, losing weight, exercising, and monitoring your blood sugar levels with a meter. If these methods are not effective, then he/she may suggest that they will need to prescribe medication to manage your diabetes.

**During the Encounter:**

The student will likely explain that you will have to test your blood sugar levels and record those levels in a journal or log. **You (incorrectly) assume that if you regularly take a pill for diabetes that you do not have to test your blood.** You will mention this if/when the student/resident brings up the topic of regular blood sugar testing.

**Supplemental Objective:** *To teach the patient how to monitor her blood glucose levels with a meter.*

The student will teach you how to use a blood sugar meter. To test your blood sugar, the student should instruct you to stick your finger with a lancet (a very fine needle to get a drop of blood). Squeeze your finger to get a small drop of blood. Place the drop of blood on a test strip and insert the test strip into your meter. The meter will then give you a number, which is your blood sugar level. The student should explain that you should write this number, date, and time down in your log. The student should ask you to demonstrate these skills. If the student describes the procedures in a clear and non-technical manner, you will be able to perform the tasks appropriately.

You are not opposed to testing your blood, but have concerns about your ability to “get it right.” You do not fear needles. You should only ask questions AFTER the student has had the opportunity to tell you the information. If you are being instructed and the student does not answer all your questions fully, then feel free to ask. In other words, allow the student the opportunity to teach you without prompting. You should not actually prick your finger during the encounter.

Some specific questions you might ask include: **What should my blood sugar levels be? How often do you need to see my log book? How often do I have to do this? What if my levels are too high or low? Where do I get the supplies?**
End of Encounter:

By the end of the encounter, if the student has plainly and clearly explained what diabetes is, what it means to you, and how you can best manage the disease, you will demonstrate understanding. If however, the student/resident does not speak in a plain and clear manner OR if he/she talks in a condescending manner OR if he/she lectures, you will be too embarrassed to tell the student that you do not understand. You will be agreeable to the student’s instructions, even if you do not fully understand them. If the student makes an effort to try to determine whether you really understand what he/she is telling you, only then will you admit the truth.

If the student recommends weight loss, diet changes, or exercise, you will respond: “Oh, can’t I just take pills? I’m not very athletic.” If the student makes an attempt to help you lose weight by suggesting specific strategies that you think are feasible, you will hesitantly agree to try them.

If a follow-up appointment is suggested, you will agree. You are polite, and grateful for any help you’ve received, but will only express understanding if the student/resident has spoken clearly and appropriately.

HISTORY OF PRESENT ILLNESS/COMPLAINT

You first began having pain in your feet four weeks ago. You thought a new pair of shoes might have caused the trouble, but the pain persisted even after you stopped wearing the shoes. The pain is worst at night when you are trying to sleep. Your sleep has also been disrupted by your need to get up several times in the night to use the bathroom, a problem you’ve noticed for about eight weeks. During the same period, you’ve noticed blurred vision and your skin has been unusually dry. You are also thirsty “all the time” because your mouth is so dry.

FURTHER CLARIFICATION OF YOUR SYMPTOMS

1. Burning Pain in Your Feet (OFFERED SPONTANEOUSLY): This started four weeks ago and is getting worse. You blamed it on a new pair of shoes, but the pain has not gone away. You experience it as a burning feeling on the soles of your feet. If asked, “On a 10-point scale, rate the intensity of the pain.” You would reply “Oh, 7 or 8.” Prior to this, you had never had any problem with your feet. Your feet hurt the most at night, when you are trying to sleep.

2. Urinary Frequency (OFFERED SPONTANEOUSLY): For two months you have had to get up more and more frequently to urinate. Currently you are going to the bathroom three times a night. You have never had to do this before.
3. Blurred Vision (OFFERED ON DIRECT QUESTIONING): You have also noticed that your vision is blurrier than before. This began approximately six weeks ago and has gradually become worse. You have not had an eye examination in several years and have been considering having them checked by an optometrist.

4. Dry Skin (OFFERED ON DIRECT QUESTIONING): You noticed about 1 month ago that your skin has become increasingly dry. You recently purchased a dandruff controlling shampoo for your hair and body lotion for the rest of your body. This seems to have helped, but you are frustrated because it is something you have never had to do before. You attribute this to getting older. You have NOT noticed that your skin has been itchy or irritated JUST DRY.

5. Dry Mouth (OFFERED ON DIRECT QUESTIONING): For the last two months, you have noticed that your mouth seems to be dry all of the time ("like cotton"). This has caused you to want to drink a lot of fluids.

6. Dizziness (OFFERED ON DIRECT QUESTIONING): Also for the last two months, you have noticed that you sometimes get dizzy when you stand up. You would describe this as "lightheaded."

Although you have noticed the above changes, you have not made any connection between them. You will only volunteer #3-6 if asked about them DIRECTLY.

**PAST MEDICAL HISTORY**

**Overall health:**

You have been coming to this clinic for years, but do not have a regular physician. You see whoever is available when you come in.

Despite your difficulty controlling your weight, you have always been quite healthy. Five years ago you were diagnosed with hypertension, which is managed well by medication. You do not exercise regularly and lead a very sedentary lifestyle.

**Prior Illnesses:**

High blood pressure diagnosed five years ago. Controlled through treatment ("dyazide" - HCTZ 50 mg/day).

**Hospitalizations:**

You have four children. All births were without complications. You had your gall bladder removed 6 years ago. You were suffering from abdominal pain in your upper right quadrant. This pain was crampy and worsened by fatty foods. After the surgery, you felt fine and can now tolerate any foods.
Medications:
You are currently taking hydrochlorothiazide (HCTZ) for high blood pressure. You take this medication daily (50 mg/day). You call this medicine “dyazide.”

LIFESTYLE/HABITS

Diet and Exercise:
You lead a sedentary lifestyle without a regular exercise routine. You eat an average “American” diet. Your favorite foods include sweets (especially baked goods). You have never tried any formal diet or exercise program. You are comfortable with your weight and are not interested in dieting. However, if the student clearly and plainly explains how important diet and weight reduction are in managing diabetes, AND offers some simple “first steps” to weight management, ONLY then will you hesitantly agree to try the strategy(ies).

Smoking/Alcohol:
You do not drink or smoke.

Caffeine:
You drink 1 cup of regular coffee in the morning.

Occupation:
You are a telephone operator at the University, where you have worked for the past nine years. Your husband, Jim, works for facilities management for the University. “He likes to build and fix things.” You have good benefits through the University, including health insurance.

Living Situation:
You and your husband live in a small two-bedroom home that you own. Your children are all grown.
FAMILY HISTORY:

Mother:

Your mother died at age 68 following a stroke (24 years ago). She had diabetes for ten years before that and was treated with a pill. She did not test her blood glucose levels with a meter. Home testing was not available in 1979.

Father:

Your father died at age 62 in an automobile accident (40 years ago).

Siblings:

You are the oldest child of five. You have three sisters and one brother. Two of your sisters have been on medication for hypertension. Your brother is average weight and in good health.

Children/Grandchildren:

Your four children range in age from 30 to 41. You have five grandchildren among them. All are healthy.

PERSONAL HISTORY

You were a stay at home mother until your youngest child started high school. At that time, you went to work for the phone company as an operator. You have worked at the University as a phone operator for the past nine years. You have a good marriage with your husband, Jim (63yo).

EDUCATION & LITERACY LEVELS

You dropped out of high school when you were 17 to get married to your husband. “I was never good at school anyway.” Jim is a year older than you and had recently graduated from high school.

If asked about your ability to read and/or write, you would respond, “I can read and write: I just don’t like reading.” Actually, you do not read for pleasure at all and avoid reading. You read at a 6th grade level and have difficulty reading articles in newspapers and magazines. You would not admit this to the student. Instead, you would state that you aren’t really interested in anything in the papers.

If the student asks you to read anything, you will be able to read most of the words, but will do so slowly and intently UNLESS the text includes words with 4+ syllables (i.e., opthalmoscope, hypertension, hypercholesterolemia, etc.). You will try to read these words, but will give up quickly and act as though you’re just uninterested in the challenge. See attached literature for a sample of text that is too difficult for you to read and comprehend.
MILDRED ROBERTS: CASE SUMMARY

CASE FOCUS: Medication Noncompliance (overdose of Zoloft® and Dyazide®)

PATIENT NAME: Mildred Roberts

PATIENT DEMOGRAPHICS:
- Age: 71-81 (Actual age of patient 76)
- Sex: Female
- Height: Average
- Weight: Average

CLINICAL AUTHORS/ADVISORS:
- Suzanne Holroyd, MD
- John Gazewood, MD

PROFILE:
Mildred Roberts is a 76yo woman who comes into the Family Medicine Clinic for a follow-up appointment and a refill of her prescriptions. In addition, Mrs. Roberts is complaining of restlessness, insomnia, and headaches. She is a regular patient of the Clinic who has not been seen by her PCP for 5 months. At that time, she was seen for a complete physical examination and was diagnosed with major depression. Labs were normal and included CBC, chemistry panel (including liver function studies). She was prescribed Zoloft® (50mg daily). She was already taking Dyazide® (25mg HCTZ, 37.5mg triameterene once daily) for the treatment of hypertension. She was diagnosed with HTN 3 years ago. Additional past medical history is remarkable for s/p hysterectomy 20 years ago and s/p cataract removal 3 years ago.

Mrs. Roberts has not been taking her medication correctly. She has been having trouble remembering when she last took her medication and will frequently take 2-3 times the daily dosage. She will have two empty prescription bottles and will request that her PCP refill her prescription. Both prescriptions are for a three-month period, but the refill dates will reflect a date one month in the future.

Previously, Mrs. Roberts was able to take her blood pressure medication as prescribed, but the addition of a second medication 5 months ago has made compliance more difficult. In addition, her daughter recently moved out of the state. She used to assist her mother with her shopping, cleaning, and medications.
CASE OBJECTIVES:

The primary objectives of this case are threefold: a) to identify the patient’s somatic complaints as secondary to unintentional overdose due to difficulty taking medications correctly, b) to identify the patient’s actual barrier(s) to taking her medication regularly, and c) to establish a realistic plan for compliance.

STUDENT INFORMATION:

Name: Mildred Roberts
Setting: Family Medicine Clinic
Station Length: 20 minutes

Patient Summary: Mildred Roberts is a 76yo woman who comes into the Family Medicine Clinic for a six month follow-up appointment. In addition, Mrs. Roberts is complaining of restlessness, insomnia, and headaches. She is a regular patient of the Clinic who has not been seen by you, her PCP, for 6 months. At that time, she was seen for a complete physical examination and was diagnosed with major depression. A follow-up appointment was made for one month, but the patient was unable to keep the appointment. Labs were normal and included CBC, chemistry panel (including liver function studies). She was prescribed Zoloft® (50mg daily). She was already taking Dyazide® (25mg HCTZ, 37.5mg triameterene once daily) for the treatment of hypertension. She was diagnosed with HTN 3 years ago. Past medical history is remarkable for s/p hysterectomy 20 years ago and s/p cataract removal 3 years ago. The nurse has already taken her vitals today:

BP: 90/60
Temp: 98.5
Pulse: 65
RR: 10 unlabored

Students will be provided with a chart detailing Mildred’s previous medical history, including her previous “controlled” BP averaging 110/80.

YOUR TASKS:

- Before entering the room, review Mrs. Robert’s chart, which includes her past medical history and pre-existing conditions
- Gather information regarding the patient’s current symptoms
- Establish a plan for follow-up and management

NOTE: You will not perform a physical exam during this encounter!
MILDRED ROBERTS:

EDUCATIONAL OBJECTIVES & PERFORMANCE OUTCOMES

The primary objectives of this case are threefold: a) to identify the patient’s somatic complaints as secondary to noncompliance with medications, b) to identify the patient’s actual barrier(s) to taking her medication regularly, and c) to establish a realistic plan for compliance. Specific barriers to compliance include: a) The fact that she doesn’t understand the relationship between her symptoms and her medications, and b) lack of skills to manage multiple prescriptions.

Primary Objectives & Performance Outcomes:

1. To identify the patient’s somatic complaints as secondary to noncompliance with medication.
   1.1 Seeks to understand the patient’s perspective
      1.1.1 Uses reflective empathy statements and non-verbal cues
      1.1.2 Asks open-ended questions
      1.1.3 Listens attentively
      1.1.4 Follows-up on patient’s verbal and non-verbal cues
      1.1.5 Avoids making stereotype judgments
   1.2 Gathers information regarding patient’s somatic complaints

2. To identify the patient’s actual barrier(s) to taking her medication regularly
   2.1 Gathers information regarding patient’s actual compliance with medications
   2.2 Gathers information regarding patient’s ability to self-manage medications

3. To establish a realistic plan for compliance
   3.1 Uses clear language that is appropriate to the patient’s level of understanding and free of technical and medical jargon
   3.2 Provides clear and direct messages about importance of compliance with treatment
      3.2.1 Delivers new information in small pieces or organized “chunks”
      3.2.2 Delivers sufficient information for the patient’s level of understanding
   3.3 Provides concrete instructions that are attainable for the patient
   3.4 Includes the patient in making decisions and plans regarding her care
   3.5 Limits instruction and/or plan to no more than three manageable points
   3.6 Makes instruction interactive through written or verbal actions (if relevant)
   3.7 Uses instructional media appropriately (if relevant)
3.8 Checks the patient’s level of understanding by asking her to demonstrate and/or summarize
3.9 Rephrases and/or summarizes the information to ensure clarity and accuracy
3.10 Demonstrates support through verbal and non-verbal reinforcement and feedback
MILDRED ROBERTS:
STANDARDIZED PATIENT TRAINING MATERIALS

CASE SUMMARY

Mildred Roberts is a 76yo woman who comes into the Family Medicine Clinic for a follow-up appointment and a refill of her prescriptions. Additionally, Mrs. Roberts is complaining of restlessness, insomnia, and headaches. She is a regular patient of the Clinic who has not been seen by her PCP for 5 months. At that time, she was seen for a complete physical examination and was diagnosed with major depression. Labs were normal and included CBC, chemistry panel (including liver function studies). She was prescribed Zoloft® (50mg daily). A follow-up appointment was made for the following month, but the patient was unable to make the appointment.

Mrs. Roberts was diagnosed with HTN and osteoporosis three years ago. Her long standing prescriptions include Dyazide® (25mg HCTZ, 37.5mg triameterene once daily) for the treatment of hypertension and Evista® (60mg daily) for osteoporosis. Additional past medical history is remarkable for hysterectomy 20 years ago and cataract removal 3 years ago.

Mrs. Roberts has not been taking her medication correctly. She has been having trouble remembering when she last took her medication and will frequently take 2-3 times the daily dosage. She will have (two) empty prescription bottles and will request that her PCP refill her prescriptions for Zoloft®, Dyazide® and Evista®. All her medications are prescribed for six months. Zoloft® was prescribed and filled five months ago. The prescriptions for Dyazide® and Evista® were last filled three months ago. The bottles will reflect these future refill dates.

Previously, Mrs. Roberts was able to take her blood pressure and osteoporosis medications as prescribed, but the addition of a second medication 5 months ago has made compliance more difficult. Additionally her daughter, who used to assist her mother with shopping, cleaning, and medications, moved out of the state three months ago.

The primary objectives of this case are threefold: a) to identify the patient’s somatic complaints as secondary to unintentional overdose due to difficulty taking medications correctly, b) to identify the patient’s actual barrier(s) to taking her medication regularly, and c) to establish a realistic plan for compliance.

Your challenge as the Simulated Patient is threefold:

1. To appropriately and accurately reveal facts about Mildred Robert’s complaints
2. To observe the student’s behavior while you are performing as Mildred
3. To accurately recall the student’s behavior and complete the performance checklist

PRESENTATION/EMOTIONAL TONE

You are a 76 year-old widow and mother of two. You are well groomed and appear healthy with no visual signs of illness. You are cooperative, but not overly forthcoming with answers and questions. You make appropriate eye contact, but you appear tired. Despite your current symptoms, you are feeling much better since your last visit! You are no longer feeling depressed, but the recent relocation of your daughter’s family has been difficult for you: You miss her very much.

A TYPICAL ENCOUNTER

Beginning of Encounter:

In response the question, “How are you feeling?” you answer in exactly the following words:

“I’m feeling much better, but I’ve been having trouble sleeping. I’ve also had headaches lately.”

In fact, you have been having trouble getting to sleep for about three months. In addition, you have also been experiencing increasingly frequent headaches. You have also been feeling a little bit dizzy. These symptoms are different from what you experienced in relation to your depression.

The student will likely follow-up with specific questions regarding your symptoms. These questions should be answered with simple responses to the direct questions. The student should also ask you about your medications.

If the student asks you whether you have been taking the medications, you would respond: “I take my medicine, but sometimes I have trouble remembering if I took it.”

The student will likely follow-up on this statement and ask you to clarify what you mean. If he/she does, you would respond: “My daughter used to help me remember to take my medicine, but she moved away. Sometimes, I forget if I’ve taken my pills and I’ll take them anyway.”

You will have (two) prescription bottles with you, but they will be empty. You took your last pills yesterday. Your prescription was for six months worth of medication. Each of the two bottles will have a refill date several months from the current date. You have taken six months worth of Zoloft® in five months. You have taken six months worth of Dyazide® in three months.
If at any time the student asks about your medication, you will pull these bottles out of your purse and tell your PCP that you need to get them refilled. You are unaware of the refill date and what that means about the amount of medication that you have been taking.

If the student asks you “How many pills do you take every day?” you respond:

“I take 1 red & white pill and 1 blue pill every day.”

If the student asks you “When during the day do you take the pills?” you would respond: “I try to take them when I wake up in the morning, but sometimes I take it in the afternoon. Sometimes I get busy and forget if I’ve taken them or not, but I always take my medicine!”

If the student asks, “Do you ever take too much of your medicine?” you would respond: “Oh… yes I guess I could take too much sometimes, but I always take it!” [See “Details regarding noncompliance” for further details.]

End of Encounter:

By the end of the encounter, if you feel that the student has an understanding of your symptoms and medication compliance, you will be open to specific and attainable suggestions the student makes for better management of your medications. These suggestions should be appropriate for your level of understanding and delivered in a manner where he/she is not “talking over your head.”

Suggestions may include that you take your medication at a regular time each day, and/or that you use a medication reminder device (i.e., medication organizer, electronic pill box, etc.). The student should not overwhelm you with more than 3 points at this visit. In addition, each suggestion should be followed by specific examples or instructions that are agreed upon by both of you. For example, if the student suggests that you use a medication reminder device, he/she should tell you that he/she will show you how to use the device.

DETAILS REGARDING NON-COMPLIANCE

Until two months ago, your daughter would help you remember your medicine by asking if you had taken your pills that day and counting your pills. Now, that she is no longer living nearby and you are taking more prescriptions, you have difficulty remembering to take the medicine.

You are aware of how important it is to take your medicine and frequently take 2-3 times the dosage in a day (not remembering if you already took the medicine that day). You do not take the medicine at any regular time during the day. It has not become a regular routine for you. You were able to manage your HTN and osteoporosis medicines pretty well before you were prescribed the antidepressant.
The additional medication and the loss of the assistance from your daughter have made compliance very difficult. Consequently, you are taking too much of your medication and this is causing you to experience side effects: headaches, insomnia, restlessness, and dizziness. You have had some difficulty with feeling a little lightheaded when you first stand up. You are not overly concerned, because you (incorrectly) assume that taking “a little” too much of the medicine is not a problem. Your PCP has always stressed that you not forget to take your medicine. You are unaware of the relationship between your current symptoms and your medication noncompliance!

**HISTORY OF PRESENT ILLNESS/COMPLAINT**

**Timeline:**

3 years ago: You were initially diagnosed with high blood pressure and osteoporosis. You are treated for both with oral medication and you get these medications refilled every six months

1 year ago: You first began to notice symptoms of depression

5 months ago: You were diagnosed with depression. You were given a six-month prescription for your depression. A few weeks later, you began to feel much better!

4 months ago: A follow-up appointment was scheduled, but you did not attend

3 months ago: You first began experiencing your current symptoms at about this time. You had your high blood pressure medicine refilled at this time

Today: You are seeing a new doctor today. You also need refills for your antidepressant and high blood pressure medications

You have been a patient of the Family Medicine Clinic for three years. Your previous doctor recently retired and referred you to the current doctor at the Clinic (the student examiner is your current PCP). Your last visit was 5 months ago. You had an appointment scheduled 4 months ago, but were unable to keep the appointment.
You were diagnosed with major depression at your last visit (5 months ago). At that time, you came into the clinic for an annual physical examination. Your previous primary care physician gave you a six month prescription for Zoloft® and told you to come back in one month. You were unable to make the follow-up visit.

Before you were diagnosed and treated for depression, you had been experiencing several symptoms (for about 12 months before being diagnosed). These are described below. Keep in mind that these symptoms were prevalent prior to your LAST visit. Your current symptoms are described in a separate section of this document.

**Depression Symptoms:**

You first began having symptoms about 1 year ago (6 months prior to your diagnosis). At that time, you began having frequent abdominal pain, headaches and backaches. These symptoms were accompanied by difficulty sleeping. Your appetite also became increasingly poor. You lost approximately 15 pounds over a period of 4 months.

All of the following symptoms began about 12 months ago and continued to worsen until you were diagnosed and prescribed medication. You are still experiencing insomnia and headaches, but these symptoms are much less severe and different from what you experienced in the past. [See description of current symptoms for details].

**Fatigue:**

About 12 months ago you began feeling exhausted. Nothing seemed to help; however, you tended to feel a little better in the afternoon. You felt worse in the morning - *"I couldn’t get out of bed"*

**Pain:**

About 12 months ago you began experiencing pain all over especially in your stomach, back and head. You were unable to locate a specific location of pain and it did not radiate. The pain was there all of the time. If asked, “On a 10-point scale, rate the intensity of the pain.” You would reply “Oh, 7 or 8.”

**Sleeplessness:**

You were able to fall asleep ok *“out of exhaustion”* around 10pm, but you awoke about 2-3am every night and could not get back to sleep. *“I just couldn’t sleep. I would wake up every night about 2 or 3 and couldn’t get myself back to sleep.”* You stayed in bed and tried to sleep. By morning you were too tired to get out of bed.

**Additional Depression Symptoms & Responses to Possible Questions:**

- Loss of appetite:
  
  *“I just wasn’t hungry. In fact, I think I had lost about 15 pounds over that year.”*
• Difficulty with Concentration:
  “I couldn’t even read the paper any more.”
• Mood Changes:
  “Actually, I was feeling depressed. I didn’t even have a reason except for feeling so sick.”
• Energy Level:
  “I didn’t have any!”
• Interest/Changes in Activities:
  “Before I got sick, I would do things with my senior center, but I just didn’t have the energy after I got sick.”
• Suicidal Ideation:
  “Oh no, I wasn’t suicidal. I just wanted to feel better. It felt as though life was just empty.”

**CURRENT SYMPTOMS:**

You are no longer feeling depressed and the associated symptoms listed above are no longer present. You feel much better than you did before your diagnosis and treatment. You began feeling better about 3 weeks after your last appointment (~4 months ago). Your current symptoms are different from what you previously experienced.

**Insomnia:**

For the past few months, you have been having difficulty getting to sleep. “I just can’t get to sleep. I try to get to bed early and I’m tired, but I end up tossing and turning for a long time.” You typically go to bed at 9 or 10 pm, but I don’t fall asleep until 4-5 hours later.

**Headaches:**

You get headaches a lot (every 2-3 days for 3-4 hours). You describe them as throbbing and usually occurring in the front of your head. You take two Tylenol, which sometimes helps. You had experienced this type of headache several years ago (before you were diagnosed with hypertension). You don’t have any other problems or symptoms associated with the headaches (no unbearable pain). You have never passed out or had a seizure. You’ve never lost vision, seen spots (or flashes of light), or had double vision.

**Dizziness:**

For the last 4 to 6 weeks, you have felt lightheaded when you first stand up from a chair or get out of bed. This will last for a minute or so, and then go away. You have not fainted or fallen. You have begun to pause for a minute after first standing to let the dizzy sensation pass.
PAST MEDICAL HISTORY

Overall health:

You have always taken good care of your health. You eat well and try to exercise. However, over the last year you have been less active. You seek regular health care (PCP 1x year, mammogram every 2 years). You were diagnosed with high blood pressure three years ago and, until recently, have controlled it well.

Prior Illnesses:

High blood pressure (or hypertension) diagnosed three years ago controlled by taking oral medication (see below). You were experiencing headaches prior to this diagnosis (see above for description of headaches).

Osteoporosis diagnosed three years ago controlled by taking oral medication (see below). You have a history of osteoporosis in your family. You were not experiencing specific symptoms and do not experience any side effects from this medication (as far as you know).

Hospitalizations:

You have two children. Both births were vaginal without complications.

You had a hysterectomy 20 years ago.

You had cataract surgery 3 years ago.

Medications:  [See above for additional information about medications.]

You are currently taking Dyazide® for high blood pressure (25mg HCTZ, 37.5mg triameterene 1x daily). You are supposed to take this medication once daily. It was first prescribed 3 years ago. You get this prescription refilled every 6 months. The pill has an opaque red cap and white body. One side of the pill is inscribed with “DYAZIDE SB.”

You are also taking Zoloft® for depression (50mg daily). You are supposed to take this medication once per day. It was first prescribed 5 months ago. You also get this prescription refilled every 6 months. The tablet has a light blue coating and is inscribed on one side with “ZOLOFT” and the other side with “50MG.”

You are taking “EVISTA” for osteoporosis (60-mg daily). These tablets are white, elliptical, and film coated. They are imprinted on one side with “LILLY” and the tablet code “4165” in edible blue ink.

Other than occasional Tylenol, you take no over-the-counter medications.

SEXUAL HISTORY

You have not been sexually active since your husband passed away eight years ago. You were in a monogamous relationship with him for 45 years.
LIFESTYLE/HABITS

Diet and Exercise:
See above

Alcohol & Smoking:
You drink about one glass of wine per day. Before you were treated for depression, you were drinking 3-4 glasses of wine per day (for approximately 4-5 months) to help you sleep. The amount did not concern you. However, your PCP suggested that you “cut down” once you were prescribed the medication for depression, which you did. You are a non-smoker.

Caffeine & Stress:
You drink 1 cup of regular coffee in the morning. You consider yourself someone who handles stress well. However, you feel a great deal of stress now that your daughter has moved away and you are not feeling well.

Hobbies/Interests:
You are active with your senior center. You also enjoy reading the newspaper and books and gardening. You had stopped these activities for about 6 months before you were diagnosed and treated for depression, but recently became interested in them again.

Occupation:
You are not working. You worked part-time as a sales clerk in the past. You were a housewife when your children were young.

Living Situation:
You live alone in a single level townhouse. Your daughter used to live nearby, but she moved out of the state two months ago due to her husband’s job relocation. You are beginning to be concerned about your ability to continue living on your own without the assistance of outside support.

You have always thought of yourself as an independent and strong person, but with the recent move of your daughter, you realize that you may not be as self-sufficient as you thought. However, despite these concerns and recent problems with managing your medications, you are still able maintain your home. You routinely cook and clean. You shop for groceries and drive your car without any problems; however, you prefer not to drive after dark. If asked, you are not interested in moving into an assisted living community.
Remember: Other than managing your medication regimen, you are able to perform regular daily activities without much complication. You independently shop, cook, and clean your home and frequently eat lunch at the Senior Center with your friends.

**FAMILY HISTORY:**

**Mother:**

Your mother died at the age of 82 (20 years ago) of “heart problems.” She also had “bone problems.”

**Father:**

Your father died at the age of 83 (22 years ago) of lung cancer. He was a heavy smoker most of his life. You had a good relationship with both parents.

**Siblings:**

You have one sister (Martha) who has had problems with “her nerves.” Otherwise, you assume that she is relatively healthy. She is 68 and lives out of state. You are not very close and rarely see each other.

**Children/Grandchildren:**

You have two children (Sarah and John) and three grandchildren. Both live out of state and call frequently. You are close to your children and they are both concerned about your recent health problems. You have no current plans to see either of them in the near future.

You are very sad about the recent move of your daughter and her family. Her husband is an engineer and was relocated out of state by his company two months ago. Your daughter also has a new job and is very busy. Before the move, you saw your daughter (almost) every day. Now that she has moved, you speak on the phone 2-3 times per week.

**PERSONAL HISTORY**

You grew up in a working middle class family in Maryland. You met your husband while in high school and married soon after. He attended George Washington University and received a degree in Engineering.

You were a stay at home mother while your children were young. You took various part-time jobs over the years (primarily as a sales clerk). You enjoyed working with the public and consider yourself a social person.

Your husband died 8 years ago of heart disease. He was a generally healthy person. His death was sudden and was a very difficult period in your life. You are comfortable talking about him and, although you still miss him, you feel as though you have moved beyond the bereavement stages.
EDUCATION & LITERACY LEVELS

You graduated from high school and married a few months later. You were an average student. You frequently read the local newspaper and you used to like to read romance novels. However, you haven’t read a novel in several years. You just don’t seem interested anymore. If the student asks you to read anything, you will be able to read all the words without any difficulty.

You tend to speak with a simple vocabulary. You do not use medical terminology. For example, you would refer to your hypertension as “high blood pressure” and osteoporosis as “bone disease” or “osteepro-sus.”

You are somewhat naïve about healthcare. You do not understand the relationship between your symptoms and medication. You do what you are told to do by health care providers, but you rarely understand the rationale behind their recommendations.

MENTAL STATUS EXAMINATION

Although you are not experiencing mental status problems, students may question you in detail about your memory. The questions and tasks below are some examples. You will be able to perform all of the following tasks:

- Check for orientation to time and place
- Ask you to recall 3 words
- Spell WORLD backwards or Serial 7's
- Name 2 objects
- Draw a clock
- Repeat "No ifs ands or buts"
- Follow a 3 stage command
- "Close your eyes"
- Write a sentence
- Copy design
CASE FOCUS: Failure to immunize 4 month old infant

PRESENTING COMPLAINT: Well baby visit

PATIENT DEMOGRAPHICS:
- Age: 16 weeks
- Sex: Male
- Length: 25 inches
- Weight: 13.5lbs

CLINICAL ADVISOR:
- Gregory Hayden, M.D., Professor of Pediatrics
- Bill Wilson, M.D., Professor of Pediatrics

PROFILE:
Rebecca Fleisher is a 25 year old new mother who comes into the Pediatric Clinic requesting a well baby visit for her 4 month old son, William. The patient, Will, was born at the local hospital and appeared to be in excellent health and began breast-feeding soon after delivery. The Apgar scores taken at birth were 9 (1 minute) and 9 (5 minute). Birth weight was 7lbs/6oz, and birth length was 20 inches. Will was scheduled for two previous well-baby visits (2 weeks and 2 months), but the parents failed to keep the appointments.

Rebecca breastfed Will for the first three weeks, but switched to formula because it was more convenient and less painful for her. Rebecca and her husband are first-time parents who heard from a friend that immunizations were dangerous and could cause autism and cancer. Consequently, they are reluctant to have Will further immunized (he received a single Hepatitis B vaccine soon after birth). Rebecca is hoping to discuss her concerns with the physician.

CASE OBJECTIVES:

The primary objectives of this case are threefold: a) to identify the patient’s stage of change and her rationale for not practicing preventive healthcare, b) to raise the patient’s knowledge and awareness levels (and dispel misinformation) regarding the importance of childhood immunizations, and c) to improve compliance with preventive health practices.

STUDENT INFORMATION:

Patient Name: William Fleisher

Setting: Pediatric Clinic
Station Length: 20 minutes

Patient Summary: William Fleisher is a 4 month old infant, brought to the pediatric clinic for a well-baby visit. William has not been examined since he was released from the hospital at birth. He was born at the local hospital and appeared to be in excellent health and began breast-feeding soon after delivery. The Apgar scores taken at birth were 9 and 9. Birth weight was 7lbs/6oz. Will received his first hepatitis B vaccine while in the nursery soon after birth. Although scheduled for a well-baby visit at 2 weeks and 2 months, Will has not been seen.

Assume that you have just examined the infant. Your findings are included in the attached patient chart.

Rebecca’s mother-in-law has taken her grandson out of the room, you have finished your examination, but Rebecca has remained in the room because she would like to discuss some concerns.

Your Tasks:

❖ Review the Patient’s medical chart describing Will’s medical history and current examination results
❖ Identify the patient’s stage of change and her awareness of preventive health care
❖ Counsel the patient on the consequences of failing to practice preventive medicine
❖ Establish a plan for behavioral modifications

NOTE: You will not be able to see the patient during this encounter. Instead, you will only be interacting with the patient’s mother, Mrs. Fleisher.

**The student will be provided with this patient’s chart before this encounter. This chart will include information about Will’s current examination.**
INFORMATION TO BE INCLUDED IN CHART
GENERAL PEDIATRICS

4 Month Assessment

AGE 4 mos. ROOM TIME

VITAL SIGNS
Temp: 37.2°C WT: 6.13 kg Length: 63.5 cm
Pulse: 100/bp Resp: 48/10 Head:

HISTORY:
Parental Concerns:
Illness:
Diet:
Sleeping:
Social Situation:
ROS:

ATTENDING NOTE
I have examined the patient today and I agree with the history and physical findings
as documented in Dr. _____'s note.

PHYSICAL EXAM GENERAL:
Head:

Eyes:
Pupils, tear ducts, red reflex,

Nose:
Patency,

Mouth:

Neck:

Chest:
Clavicles, B.S., shape,

C-V:
Murmur, femoral pulses

Abd:
H's megalu, masses

Back:
dermatomes

Extrem:

Skin:
Birthmarks, diaper rash

Neuro:
Tone, posture, moro

Devel:
Lifts head and chest,
Rolls over,

PE:

G-U/R:

Extrem:

IMMUNIZATIONS:
DtaP HIB IPV PCV7

EDUCATION:
Breathing, feeding, safety-home, car, and care plans

ASSESSMENT:
1. Well 4 month-old
2. Behind on immunizations

PLAN:
1. Parental guidance
2. Suggest routine vaccines: Pedvax
(DtaP/IPV/Hepl B)

RETURN VISIT INTERVAL: Age 6 mos. FOR: Well visit

PHYSICIAN'S SIGNATURE:

Attending Signature
The primary objectives of this case are threefold: a) to identify the patient’s stage of change and her rationale for not practicing preventive healthcare, b) to raise the patient’s knowledge and awareness levels (and dispel misinformation) regarding the importance of childhood immunizations, and c) to improve compliance with preventive health practices.

This patient is at the contemplative stage of readiness to change (stage 2 of 5). She reads at a 6th grade level and is marginally literate (NALS level 2). Specific barriers to compliance include: a) a lack of knowledge about the purpose and importance of childhood immunizations, and b) a misunderstanding of the risks associated with immunizations.

Primary Objectives & Performance Outcomes:

1. To identify the patient’s stage of change and her rationale for not practicing preventive healthcare
   1.1 Elicits the patient’s perceived barriers to comply with preventive health care practices

2. To raise the patient’s knowledge and awareness levels (and dispel misinformation) regarding the importance of childhood immunizations
   2.1 Uses clear language that is appropriate to the patient’s level of understanding and free of technical and medical jargon
   2.2 Delivers new information in small pieces or organized “chunks”
   2.3 Delivers sufficient information for the patient’s level of understanding and stage of change
   2.4 Provides clear and direct messages about importance of childhood immunizations
   2.5 Provides clear and direct messages about the consequences of failing to immunize

3. To improve compliance with preventive health practices.
   3.1 Seeks to understand the patient’s perspective
       3.1.1 Uses reflective empathy statements and non-verbal cues
       3.1.2 Asks open-ended questions
       3.1.3 Listens attentively
       3.1.4 Follows-up on patient’s verbal and non-verbal cues
3.1.5 Avoids making stereotype judgments
3.2 Provides concrete instructions that are attainable for the patient
3.3 Includes the patient in making decisions and plans regarding her care
3.4 Limits instruction and/or plan to no more than three manageable points
3.5 Checks the patient’s level of understanding by asking her to demonstrate and/or summarize
3.6 Rephrases and/or summarizes the information to ensure clarity and accuracy
3.7 Demonstrates support through verbal and non-verbal reinforcement and feedback
CASE FOCUS: Failure to immunize 4-month-old infant

PRESENTING COMPLAINT: Well baby visit

SETTING: Pediatric Clinic

PATIENT DEMOGRAPHICS:
- Age: 16 weeks
- Sex: Male
- Length: 25 inches
- Weight: 13.5 lbs

MOTHER (SP) DEMOGRAPHICS:
- Age: 20-30 (Actual mother’s age is 25)
- Sex: Female

CLINICAL ADVISOR:
Bill Wilson, M.D.
Professor of Pediatrics

PROFILE:
Rebecca Fleisher is a 25 year old new mother who comes into the Pediatric Clinic requesting a well baby visit for her 4 month old son, William. The patient, Will, was born at the local hospital and appeared to be in excellent health and began breast-feeding soon after delivery. The Apgar score taken at birth was 9 (1 minute) and 9 (5 minute). Birth weight was 7lbs/6oz, and birth length was 20 inches. Will was scheduled for two week and two month well-baby visits, but the parents failed to make the appointments.

Rebecca breast fed Will for the first three weeks, but switched to formula because it was more convenient and less painful for her. Rebecca and her husband are first-time parents who heard from a friend that immunizations were dangerous and could cause autism and cancer. Consequently, Will has not received any immunizations except for the hepatitis B vaccine that was administered after birth.

CASE OBJECTIVES:
The primary objectives of this case are threefold: a) to identify the patient’s stage of change and her rationale for not practicing preventive healthcare, b) to raise the patient’s knowledge and awareness levels (and dispel misinformation) regarding the importance of childhood immunizations, and c) to improve compliance with preventive health practices.
Your challenges as the Simulated Patient (SP) include:

- To realistically and accurately reveal facts about Rebecca’s feelings about preventive healthcare,
- To observe the student’s behavior while simultaneously simulating the patient’s mother, and
- To accurately recall the student’s behavior and accurately complete the performance checklist.

PRESENTATION/EMOTIONAL TONE:

Although you are a first-time mother, you are quite confident about your new role. At first, you were a bit apprehensive, but over the last few months, you have become increasingly confident in your ability to care for your son. You are a new and dedicated mother and you have very little understanding about health care. You have missed your son’s first and second pediatrician appointments that were scheduled 3.5 and 2 months ago. You aren’t very concerned because you assume that there is no real need to visit the doctor when Will is not sick. Your mother-in-law has urged you to bring Will in for the current visit. She is concerned about Will’s health and thinks you should have him immunized.

You appear healthy and happy, but a little over tired. You are pleasant to the student physician, but aren’t very interested about being in the pediatrician’s office. You are cooperative, but not forthcoming with answers. You give brief answers to any questions and do not volunteer much information at first.

You are skeptical and mistrustful about doctors and medical care. This stems, in part, from your experiences with your mother’s cancer: Her cancer was found very late and “they” were not able to help her. You are very naïve about the healthcare system. You will be forthright and assertive, but not rude or dismissive. You want the best care possible for your son, but you believe that certain treatments and medicines are more harmful than helpful. You tend to believe people you trust and a close friend (who you admire) told you that immunizations were harmful.

BELIEFS REGARDING IMMUNIZATIONS:

Before you left the hospital and after your delivery, the nurse gave you a lot of information to read about taking care of your new baby. However, the information she gave you about immunizations was too difficult for you to read and understand (see attachment A). Instead of trying to figure out what the flyer said, you asked your friend Lynnette about immunizations.
Lynnette is your best friend. She is a yoga instructor and (as far as you know) very knowledgeable about healthcare and exercise. She told you that immunizations were harmful to babies and caused autism and cancer. She also said that the likelihood of babies getting “those” diseases that the shots are meant to prevent is highly unlikely. She said the risk wasn’t worth it and you agree with her.

PERSONAL/FAMILY HISTORY:

You grew up as an only child in a working lower middle class family. You have been married for 6 years and have a good relationship (married at 19yo). You grew up in this area and met your husband, Jeff, when you were 16 years old. You dated monogamously for three years before getting married.

You dropped out of high school when you were 16 years old, 6 months after your mother died of colon cancer (and soon after meeting Jeff). Your mother’s death was very sudden. She died 3 months after her diagnosis.

You live with your husband and Will in a two bedroom/two bath rental apartment in a middle class neighborhood. You and your husband are trying to save money to buy a house. You have two cars, but both are on their “last legs.” You take public transportation to work or get a ride from your husband when one of the cars is in the shop.

You have worked full time as sales clerk at a local department store since you were 16 years old. You took 6 weeks off when you had the baby and returned to work part-time. You go to work during the evenings (5:00-9:30pm) and you stay home with Will during the day while your husband works. Most of the time your husband is home during the evening to take care of Will, but sometimes your friend Lynette or your mother-in-law watch him for you. You enjoy your work and like the people you work with. Over the years, you have been promoted from stocking the floors to sales. You have good health coverage and benefits through your husband’s employer. Although you would like to be home during the evenings to spend time with your husband and son, you feel that you need to work to make “ends meet.”

SUPPORT SYSTEMS

Your mother died of colon cancer when you were 15 years old at the age of 55. Your father (68yo) is in good health and living in a small town in South Carolina. You are not close to your father and rarely see him. You have no siblings. Your closest support is from your best friend, Lynette. Your mother-in-law is also living nearby and helps you with the baby from time-to-time. She is a waitress and no longer married to your husband’s father (divorced 15 years ago).
Your Husband

You would consider your husband, Jeff, a good husband and father. However, he is not very engaged with the baby and leaves Will’s healthcare to you. He works as a construction supervisor and is very busy. He was able to take three days off when you had the baby.

Your Best Friend

Your best friend, Lynette, has been very helpful. You went to high school together and have been close ever since. Lynette is single with no children and works as a part-time yoga instructor and full-time secretary. You admire Lynette very much. She graduated high school and has taken a few courses at the local community college. She is a certified yoga instructor and reads a lot about health (herbal remedies, nutrition, alternative therapies, etc.). Although you have never been particularly interested in these topics, you respect Lynette’s opinion very much and you have been taking her advice regarding Will’s health care.

MEDICAL HISTORY (Will)

Your son, William (“Will”), was born four months ago at the local hospital in the obstetrics and delivery department. Although the birth was “difficult,” you did not have any complications. You had a “normal” delivery after being in labor for about 12 hours. You delivered Will 4 days prior to the expected delivery date on _________.

Will weighed a healthy 7lbs and 6ozs at birth (20 inches long). You (and Will) remained in the hospital for 36 hours after delivery. He has been quite healthy – he is eating well, sleeping regularly, and has never “appeared” sick (no yellowish skin, no rashes, or redness). He has been urinating regularly and has had regular bowel movements (no vomiting).

Feeding & Voiding

You first began breast feeding Will a few hours after birth. At first, Will only wanted to nurse about 3-5 minutes on each breast and would fall asleep. After the about 36 hours, you left the hospital and went home. Will began feeding about 15 minutes per breast and wanted to eat every couple hours. He urinated and had his first bowel movement the day after his birth.

Will’s umbilical cord fell off 8 days after birth. Before it fell off, you kept the cord clean and dry because the nurse told you that it could get infected if you didn’t. His belly button looks fine now. Will was circumcised after birth and before leaving the hospital. A light gauze dressing with petroleum jelly was placed over the top of the penis. You and your husband had to change this dressing every day for one week after coming home from the hospital.

You breast fed for about three weeks and then switched to formula over a few days. You didn’t like the inconvenience of breastfeeding and heard that it was “only important to
breast feed for the first few weeks anyway.” Will took to the bottle pretty well and wanted to feed less often (about every 4 hours). He has been feeding from the bottle ever since: He typically drinks about 5 ounces every four hours. The formula that you feed Will is called Similac Advance® and you use the powder formula because it is less expensive than the ready to feed formula. You do not sterilize the bottles and nipples. You clean them in the dishwasher. You also heat the bottle in the microwave for 20 seconds before feeding Will. You typically will burp Will after his feedings by holding him upright against your shoulder and gently patting his back. You have not fed Will any cereal or solid foods yet, but you plan to start doing so in the near future.

You change Will’s diaper “all the time.” He is urinating about 12 times per day and passing stools about 2-3 times per day. You use disposable diapers: Will is currently wearing “step 1” diapers. When he was born, he wore Huggies® Newborn, but when he grew out of those you started buying “step 1” (about 6 weeks after birth). The nurse showed you how to change Will’s diaper at the hospital and then helped you with your first attempt.

Bathing

You and your husband first bathed Will the day after returning home from the hospital. It was a little tricky because of the umbilical cord and circumcision dressing, but you managed to give him a full bath in his baby bathtub. Again, the nurse at the hospital showed you how to do this before you went home. You give him a full bath every 4-5 days, but sponge bathe him every other day.

Sleeping

During the first two months after birth, Will would sleep “almost all the time” for a total of about 18 hours throughout the day. He would wake up to eat every couple hours, until you switched to the formula (then he would eat every 4 hours). About two months ago, he began to follow a more regular sleep schedule: He started sleeping a full 8 hours per night and off-an-on for total of 5-6 hours during the day. He sleeps on his back in his crib (in his own room).

Overall Health

Your overall health is excellent. You have never had a major illness or surgery, including HIV and hepatitis B.

Pregnancy

You had no complications during pregnancy. Although you smoked cigarettes prior to your pregnancy, you stopped smoking during the pregnancy for the health of your baby. Your
diet was average, but you did attempt to eat better than usual (more fruits and vegetables). You
did not exercise during your pregnancy. You gained a total of 25 pounds.

You saw your obstetrician somewhat regularly throughout your pregnancy. During the
first seven months you saw your obstetrician 4 times (you missed three appointments). During
the last two months, you saw her six times (you missed two appointments). During these visits
the doctor took your weight, your blood pressure, and checked your urine. Your stomach was
measured during the latter part of the pregnancy and the fetal heartbeat was checked with an
ultrasound machine. Blood tests and pelvic examinations were performed throughout your
pregnancy. You did not have an amniocentesis or any other special tests.

Medications
You took pre-natal vitamins during your pregnancy. You began taking these because
your doctor told you to (you also heard from Lynnette that this was a good idea to help the
baby). You currently take no medications.

EDUCATION AND LITERACY LEVELS:
You dropped out of high school when you were 16. You were having trouble
dealing with your mother’s death: “I was never good at school anyway.” You have thought about
getting your GED, but haven’t found the time. You read at a 6th grade level.

If asked about your ability to read and/or write, you would respond, “I can read fine,
but I’ve never been a good writer.” You do not read regularly, but you do enjoy looking at
fashion magazines. You never read the articles because they are usually too difficult for you to
read and comprehend. You are able to use the touch screen computer (cash register) and
scanner at work, but it took a long time for you to become comfortable and familiar with the
technology.

If the student asks you to read anything, you will be able to read all the words, but will do so
slowly and intently UNLESS the text includes words with 4+ syllables (i.e., immunization, hepatitis,
umbilical, gestational, hypercholesterolemia, etc.). You will try to read these words, but will give up
quickly and act as though you’re just uninterested in the challenge. You are embarrassed by your
inability to read and understand the information, but will hide this embarrassment.
Refer to the following online document for an example of a document that is too difficult for you to
read and comprehend. Recall that this document was provided by a nurse at the hospital before you
were discharged and soon after delivery.

Health Literacy Communication Skills Rating Scale
**Health Literacy Communication Skills Rating Scale**
Lisa Doyle Howley, PhD
University of North Carolina at Charlotte

Instructions: Please assess the student examiner or “interviewer” as the patient and according to the scale below. Circle the appropriate number (5-1) for each of the behaviors.

|--------------------|-----------|-------------|--------------|-----------------------|

**PARTNERSHIP - “As the patient, I felt that the interviewer was a partner in my care.”**
The interviewer seeks to understand the patient’s perspective. The interviewer uses open-ended questions to facilitate communication and better understand the patient. The interviewer includes patient in joint decision-making.

1. **Use of Open-Ended Question:**

|--------------------|-----------|-------------|--------------|-----------------------|

|  | The interviewer sought to understand the patient’s perspective by asking open-ended questions and seeking clarification or additional details. | The interviewer attempted to understand the patient’s perspective, but asked few open-ended questions and rarely sought clarification. | The interviewer made no attempts to understand the patient’s perspective and asked no open-ended questions. |

2. **Use of “We” Statements:**

|--------------------|-----------|-------------|--------------|-----------------------|

|  | The interviewer facilitated a discussion with the patient and used “we” statements when speaking of future management issues. (“Once we’ve talked about some of your complaints, let’s work together to arrive at some solutions or options that will work for you.”) | The interviewer attempted to facilitate a discussion, but spoke AT the patient more than he/she spoke WITH the patient. | The interviewer did not attempt to facilitate a discussion, but spoke AT the patient - telling him/her what to do. (“After I ask you some questions about your complaints, I will provide you with some solutions that will work for you.”) |

**EMPATHY - “As the patient, I felt that the interviewer understood, appreciated, and accepted how I was feeling.”**
The interviewer demonstrates an understanding of the patient’s emotional state from his/her point of view. The interviewer uses reflective empathy statements and non-verbal cues to appropriately convey his/her understanding of the patient’s perspective.

3. **Use of Verbal Empathy Statements:**

|--------------------|-----------|-------------|--------------|-----------------------|

|  | The interviewer demonstrated empathy by verbally acknowledging his/her emotional state or reaction. (“I can see that this is a difficult topic for you to discuss.”) | The interviewer attempted to demonstrate empathy by occasionally verbally acknowledging his/her emotional state or reaction. | The interviewer failed to demonstrate empathy and never verbally acknowledged his/her emotional state or reaction. |
4. Expression of Non-Verbal Empathic Language:

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>The interviewer’s <strong>bodily gestures were always congruent</strong> with the patient’s emotional state (i.e., Leaning forward and maintaining eye contact while the patient reveals difficult or personal information).</td>
<td>The interviewer’s <strong>bodily gestures were somewhat congruent</strong> with the patient’s emotional state.</td>
<td></td>
<td>The interviewer’s <strong>bodily gestures were not congruent</strong> with the patient’s emotional state. (i.e., Casually sitting back in his/her chair, clearly distracted or focused on getting out of the room and on to his/her next patient.)</td>
<td></td>
</tr>
</tbody>
</table>

**RESPECT** - “As the patient, I felt that the interviewer was respectful towards me.”

The interviewer explicitly acknowledges the patient’s efforts and achievements, whether successful or not. The interviewer provides the patient with positive verbal and non-verbal reinforcement and feedback. The interviewer shows respect towards patient, does not talk down, or demean the patient. The interviewer suspends critical judgment of patient and his/her behaviors and avoids making stereotype judgments.

5. Use of Positive Verbal Reinforcement:

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>The interviewer demonstrated respect for the patient by explicitly acknowledging the patient’s efforts and providing positive verbal reinforcement (“Despite feeling poorly, I’m impressed with your ability to carry on at home and work.”)</td>
<td>The interviewer attempted to demonstrate respect for the patient, but failed to explicitly acknowledge the patient’s efforts or he/she failed to provide positive verbal reinforcement.</td>
<td></td>
<td>The interviewer failed to demonstrate respect for the patient: Never explicitly acknowledged the patient’s efforts and never offered positive verbal reinforcement.</td>
<td></td>
</tr>
</tbody>
</table>

6. Use of Respectful Language:

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>The interviewer demonstrated respect for the patient by <strong>never speaking down</strong> or demeaning the patient. The interviewer <strong>never made assumptions</strong> based on education level, gender, race, etc.</td>
<td>The interviewer attempted to demonstrate respect for the patient, but <strong>spoke down</strong> or demeaned the patient. However, the patient <strong>did not feel overly demeaned</strong> by these assumptions. The interviewer <strong>made some assumptions</strong> based on education level, gender, race, etc.</td>
<td></td>
<td>The interviewer <strong>frequently spoke down or demeaned</strong> the patient. The patient felt demeaned by his/her actions/behaviors. The interviewer <strong>made assumptions</strong> based on education level, gender, race, etc.</td>
<td></td>
</tr>
</tbody>
</table>
**SUPPORT** - “As the patient, I felt that the interviewer was supportive of me and my health needs.” The interviewer provides direct, concrete, personal statements of support to reassure and encourage the patient.

### 7. Statements of Support:

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>The interviewer demonstrated support for the patient by making explicit statements of help (“I want to help and will be available to support you.”)”</strong></td>
<td>**The interviewer **attempted to demonstrate support <strong>for the patient, but did not make explicit statements of help.</strong> The patient felt that the interviewer would support him/her even though specific statements were not made.</td>
<td><strong>The interviewer failed to demonstrate support for the patient and made no explicit statements of help.</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### CLEAR & PLAIN VOCABULARY - “As the patient, I felt that the interviewer used clear and appropriate language for my level of understanding.”

The interviewer uses clear language, free of technical and medical jargon. Any medical terms that are used are immediately explained in basic terms without prompting from the patient. The language used is appropriate for the patient’s level of understanding.

### 8. Use of Clear Language

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>The interviewer used clear language throughout the session.</strong> Any technical terms used were immediately translated into terms that the patient could understand.</td>
<td><strong>The interviewer used clear language throughout the majority of the session.</strong> However, some technical terms used were not translated into terms that the patient could understand.</td>
<td><strong>The interviewer failed to use clear language throughout the majority of the session.</strong> Technical terms were frequently used and were not translated into terms that the patient could understand.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### IDENTIFICATION OF BARRIERS - “As the patient, I felt that the interviewer understood my motivation level and/or my barriers to change.”

The interviewer identifies the patient’s current stage of change and/or his/her barriers to motivation or understanding.

### 9. Identification of Barriers

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>The interviewer identified all relevant information about the patient in order to assess his/her ability to comply with treatment, make appropriate choices, and/or follow-up with recommendations.</strong></td>
<td><strong>The interviewer attempted to identify some information about the patient, but failed to identify all relevant information.</strong></td>
<td><strong>The interviewer failed to identify any relevant information about the patient and did not assess his/her ability to comply with treatment, make appropriate choices, and/or follow-up with recommendations.</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
INFORMATION DELIVERY - “As the patient, I felt that the interviewer delivered an appropriate amount of information and at an appropriate level of understanding. In addition, the interviewer, placed the information in a context that I could understand.”

The interviewer provides sufficient information about patient’s illness, but does not overwhelm the patient with complex medical information. The interviewer presents the context first when he/she delivers new information. Delivers the new information in small pieces or organized “chunks.” Delivers sufficient information for the patient’s stage of change.

10. Information Delivery


The interviewer delivered an appropriate amount of information at an appropriate level for the patient’s level of understanding. The patient was clear and not overwhelmed by the information.

The interviewer attempted to deliver an appropriate amount of information, but failed to do so. The patient was somewhat overwhelmed by the information.

The interviewer failed to deliver an appropriate amount of information at the patient’s level of understanding. The patient was overwhelmed with information.

CLARIFICATION & SUMMARIZATION - “As the patient, I was asked to clarify what the interviewer had conveyed. In addition, the interviewer summarized what I had conveyed.”

The interviewer rephrases and/or summarizes the information to transition between individual areas and/or the end of the encounter. The interviewer asks the patient for feedback to confirm understanding by demonstration or summarization.

11. Confirmation of Comprehension


The interviewer explicitly sought clarification by summarizing information. In addition, he/she confirmed comprehension by asking the patient to confirm what had been discussed by restating, explaining, summarizing or demonstrating.

The interviewer attempted to seek clarification, but failed to summarize all information. The interviewer asked the patient if he/she understood, but failed to confirm understanding.

The interviewer failed to seek clarification and did not summarize information. The interviewer failed to ask the patient if he/she understood and never confirmed understanding.
INSTRUCTION—“I was able to demonstrate that I understood the instruction. In addition, the objectives or goals of instruction were manageable for my level of motivation and comprehension.”

The interviewer limits instruction to no more than 3 manageable points. The interviewer makes instruction interactive through written or verbal actions. The interviewer uses instructional media appropriately (if relevant).

12. Instructional Delivery

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>The interviewer <strong>delivered no more than three manageable points</strong> while instructing the patient. He/she did so <strong>at a level appropriate for the patient</strong>. If visual media were used they were appropriate for the literacy level of the patient.</td>
<td>The interviewer <strong>delivered an appropriate number of manageable points</strong> while instructing the patient, but <strong>did so at a level inappropriate for the patient</strong>. If visual media were used they were appropriate for the literacy level of the patient.</td>
<td>The interviewer <strong>delivered more than three manageable points</strong> while instructing the patient and <strong>did so at a level inappropriate for the patient</strong>. If visual media were used they were not appropriate for the literacy level of the patient.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

13. Confirmation of Instruction

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>The interviewer checked with the patient to ensure he/she understood instruction by <strong>asking the patient to write, re-state or act-out behavioral actions</strong>. In addition, the interviewer provided <strong>appropriate feedback</strong> to the patient on his/her ability to perform.</td>
<td>The interviewer checked with the patient to ensure he/she understood instruction by <strong>asking the patient to write, re-state or act-out behavioral actions</strong>, but failed to <strong>follow-up with feedback</strong>.</td>
<td>The interviewer checked with the patient to ensure he/she understood instruction by <strong>asking the patient to write, re-state or act-out behavioral actions</strong>, but failed to follow-up with feedback.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**OPTIONAL: Only appropriate for sessions that include patient instruction.**
React to the following statements as the patient by circling your level of agreement with each. In addition, feel free to make comments regarding your rating below each item.


1. As the patient, I felt that the interviewer understood my level of health literacy.  
   COMMENT: 
   SA  A  N  D  SD

2. The interviewer elicited sufficient information about my level of comprehension or my ability to understand information.  
   COMMENT: 
   SA  A  N  D  SD

3. My overall satisfaction with this interviewer’s ability to provide care for me was very high.  
   COMMENT: 
   SA  A  N  D  SD

4. My overall satisfaction with this interviewer’s ability to educate me about my condition was very high.  
   COMMENT: 
   SA  A  N  D  SD

5. As the patient, I would be willing and able to comply with the interviewer’s recommendations.  
   COMMENT: 
   SA  A  N  D  SD

6. As the patient, I would want to continue seeing this interviewer for future healthcare.  
   COMMENT: 
   SA  A  N  D  SD
REFERENCES


