**Simulated Patient Case**

***Joan/John Blume – Trouble Sleeping***

Adapted from Medical College of Wisconsin Medical Interviewing Office of Educational Services / SP Program. Case modified for Australian allied health audience by Kirrian Steer, Simulation Technician, LaTrobe University.

# Facilitator Case Reference Guide

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| Presenting Complaint:  (with setting/vitals) | Having Trouble Sleeping |
| Gender and Age Range: | Female/Male age 70-75 |
| Name: | Joan (John) Blume |
| Opening Statement: | “My daughter is worried about me”. |
| Brief Summary: | The patient is here alone, but at the suggestion of her daughter who is worried that patient is “letting herself go.” Patient is retired and lives in her own home. Her husband died 2 years ago. They had a fairly active social life as a couple but she has been feeling “like a fifth wheel” at social gatherings since he died. She hasn’t been out with her friends for the past two or three months. |
| Case Objectives: | 1. Participants will demonstrate introductions, explanations of their role, and establishment of rapport. 2. Participants will gather information on functional status in an elderly person. 3. Participants will demonstrate the use of the interview to establish the diagnosis of depression. 4. Participants will respond supportively to the patient’s distress. 5. Participant will sensitively discuss the difference between normal grief and depression.   Note: Participants are not expected to propose a treatment plan. |
| Key Challenge(s) of Case: | Use open ended questioning to allow the patient to describe their chief complaints without interruption.  Use facilitation techniques which encourage the patient to elaborate on presenting complaints without premature closure  Use techniques of surveying to allow patient to describe all of their concerns  Use focused questions to evaluate mood, presence of anhedonia, and current life stresses  Use focused questions to evaluate the impact of the patient’s symptoms on their quality of life  Use focused questions to elicit patient’s expectations of care  Use focused questions to evaluate suicidal ideation  Use rapport-developing skills such as reflection and legitimation to respond to patient’s emotions  Education techniques to explain the diagnosis and management of depression  Use negotiation skills for patients who do not accept the diagnosis of depression |
| Exam Room Needs: | General Clinic Exam Room |
| Follow-up Station Needs: | None |
| Activities & Time Req: | Small Group Teaching Format – 15 minutes for encounter |
| Data Collection Methods: | Facilitator will provide verbal feedback on performance  Simulated Patient will give feedback on communication skills  Facilitator will fill out written review of each participant performance  Participants will submit written note to facilitator |
| Course, Participant Level: | Undergraduate or professional |
| Correlations: | Neurobiology of aging, mood: serotonin and norepinephrine receptors. |
| Differential Diagnosis: | Dementia, hypo- or hyperthyroidism, polypharmacy, alcoholism. |
| Reading: | How physician communication influences recognition of depression in primary care ([Carney, Eliassen et al. 1999](#_ENREF_1)). |
| Case Authors: | Joan Bedinghaus, MD and Tovah Bates, PhD  Modified by Kirrian Steer, Simulation Technician |
| Date (orig. / last revision) | August 1, 2005/January 19, 2006  Modified 17 April 2013 |

Simulated Patient (SP) Case Instructions

Joan (John) Blume

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| **Patient Name** | Joan (John) Blume |
| **Gender/Race/Age (age range)** | Female/Male, age 70-75 |
| **Presenting Situation** | “Having trouble sleeping” (difficulty getting comfortable) |
| **Opening Statement** | “My daughter is worried about me.” |
| **Elaboration of Complaint – Concerns** | You are here alone, but at the suggestion of your daughter who is worried that you are “letting yourself go.” You are retired and live in your own home. Your husband died 2 years ago. You had a fairly active social life as a couple-playing cards with a circle of friends and bowling (or golfing) in a senior league once a week. Since he died, you have been feeling “like a fifth wheel” at these gatherings. “I can’t stand it when people feel sorry for me.” You haven’t been out with friends for the past two or three months.  You watch a lot of TV. In fact, you stay up most nights watching old movies on TV until you fall asleep in her chair at 2:00 or 3:00 a.m.  Your husband’s health had also been good until he died suddenly of a massive heart attack – there was no warning. It happened when he was out playing golf. “He said he felt a little sick, then he collapsed. By the time the paramedics got there, he was gone.” You had been married for 50 years. You had been planning to travel but “We dreamed of going together. I just don’t feel like going without him.” |
| Clinical Content | Present condition:   * You describe yourself as being in “good health for your age” * You are able to take care of yourself and have no problems with mobility or activities of daily living.   + You drive, clean your own home, manage your own finances. * Nothing seems worthwhile anymore. You feel your friends would only feel bad to be around you because you’re no fun anymore. You would never consider suicide but you feel sometimes that death would be a relief.   Pertinent Past Medical History:   * Your general health has been good. You have “mild hypertension” and take hydrochlorothiazide (“a water pill”) for it, and occasional paracetamol or ibuprofen for arthritis in the hips and lower back.   Family Medical History:   * Your mother had Alzheimer’s and you had to bear witness to her suffering for years. She passed away at the age of 88. * Your father died “of old age” at 90. |
| **Physical Exam** | No physical exam will be performed. |
| **Psychosocial Profile** | Your grown daughter lives in Sydney. (The daughter is married but has no children.) Two weeks ago she came to town for a visit and was shocked to see that you had not been keeping up the yard and that the house was piled with newspapers and piles of junk mail that you just didn’t feel like dealing with. Your daughter found some overdue bills that you had overlooked when helping clean up the house. She noticed too that you haven’t been eating much and aren’t keeping the house very clean. The daughter actually called the office to set up the appointment but had to return home a few days ago. |
| **Scenario Development** | Sigh a lot. Speak slowly and be a little vague- as if you’re kind of numb. |

# Participant Reference Guide:

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| **Instructions:** | Please review the following materials in preparation for Interview Session. |
| **Reading Assignment**: | Improving the recognition and management of depression: Is there a role for physician education? ([Gerrity, Cole et al. 1999](#_ENREF_2))How physician communication influences recognition of depression in primary care ([Carney, Eliassen et al. 1999](#_ENREF_1)). |
| Patient Information: | Mrs. Blume is a 75 year old woman whose daughter made an appointment for her because “she’s not taking care of herself.” |
| Brief Summary: | The patient is here alone, but at the suggestion of her daughter who is worried that patient is “letting herself go.” Patient is retired and lives in her own home. |
| Your Case Objectives: | 1. Participants will demonstrate introductions, explanations of their role, and establishment of rapport. 2. Participants will gather information on functional status in an elderly person. 3. Participants will demonstrate the use of an interview for the diagnosis of depression. 4. Participants will respond supportively to the patient’s distress. 5. The participant will sensitively discuss the difference between normal grief and depression.   Note: Participants are not expected to propose a treatment plan. |
| Key Challenge(s) of Case: | Obtaining adequate information on health, cognition and functional status. Responding to patient’s distress. Asking about depression symptoms, and suicidal thoughts and social supports. |
| Activities & Time Req: | Small Group Teaching Format – 15 - 20 minutes for encounter |
| Data Collection Methods: | Facilitator will provide verbal feedback on performance  Simulated Patient will give feedback on communication skill  Facilitator will fill out written review of each participant performance |
| Correlations: | Neurobiology of aging, mood: serotonin and norepinephrine receptors. |

# Participant Assignment Form

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| **Interviewer:** | You are charged with obtaining a complete problem history, briefly assessing functional status and obtaining information about depression symptoms.  Signal the beginning of your interview by introducing yourself and explaining your role. As instructed, you may call a “Time Out” at any point in the interview to get suggestions from your classmates/facilitator if needed.  You will have 15 –20 minutes TOTAL time to complete the interview. The facilitator will let you know when time is up. |
| **Observers:** | You will be responsible for observing the following aspects of the interview and the interviewer’s performance:   1. Did the interviewer ask appropriate open ended / closed ended questions and give the patient ample time to respond? 2. Did the interviewer assess the patient’s functional and health status? 3. Did the interviewer obtain adequate information about depression symptoms, suicidal thoughts and social supports. 4. Describe how the interviewer responded to the patient’s distress.   Keep in mind that you will be asked to share your impressions, comments on these criteria following the interview |
| Written Assignment (All 6 Participants) | Each of you will be responsible for creating a written medical history for Mrs. Blume which should include:   * Identifying Data and Chief Complaint * History of presenting Complaint including relevant symptoms of depression. * Past Medical History and Social History including functional status.   **The medical history should be about a page and should be turned into your facilitator no later than 1 week from your interview date.**  **This should be submitted via inter-office mail or e-mail.** |

Facilitator’s Checklist of Content and Communication Skills

Participant Name:

Facilitator:

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

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

Shopping Transportation

Food preparation Finances

Housekeeping

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

Dressing Eating

Ambulating/falls Toileting/continence

Hygiene

\_\_\_\_\_ Asked about social supports

\_\_\_\_\_ Asked at least 4-5 depression symptoms

Mood Sleep

Appetite Anhedonia

Guilt Hopelessness

Fatigue Concentration

Restlessness Anxiety

Concentration Psychomotor slowing

\_\_\_\_\_ Attempted to explain bereavement/depression difference

\_\_\_\_\_ Asked about thoughts of death or suicide

\_\_\_\_\_ Asked about general health and medications

II. Communication Skills Checklist- check if the participant:

\_\_\_\_\_ Use open ended questioning to allow the patient to describe their chief complaints without interruption.

\_\_\_\_\_ Use facilitation techniques which encourage the patient to elaborate on presenting complaints without premature closure

\_\_\_\_\_ Use techniques of surveying to allow patient to describe all of their concerns

\_\_\_\_\_ Use focused questions to evaluate mood, presence of anhedonia, and current life stresses

\_\_\_\_\_ Use focused questions to evaluate the impact of the patient’s symptoms on their quality of life

\_\_\_\_\_ Use focused questions to elicit patient’s expectations of care

\_\_\_\_\_ Use focused questions to evaluate suicidal ideation

\_\_\_\_\_ Use rapport-developing skills such as reflection and legitimation to respond to patient’s emotions

\_\_\_\_\_ Education techniques to explain the diagnosis and management of depression

­­­­\_\_\_\_\_ Use negotiation skills for patients who do not accept the diagnosis of depression

**Additional Comments/Suggestions for Improvement:**

**Simulated Patient feedback**

How well would you rate the practitioner?

Telling you everything, being truthful, upfront and frank; not keeping things from you that you should know?

Poor 1 2 3 4 5 Excellent

Greeting you warmly; calling you by your preferred name, being friendly, never crabby or rude?

Poor 1 2 3 4 5 Excellent

Treating you like you’re on the same level; never “talking down” to you or treating you like a child?

Poor 1 2 3 4 5 Excellent

Letting you tell your story, listening carefully, asking thoughtful questions, not interrupting you while you’re talking?

Poor 1 2 3 4 5 Excellent

Showing interest in you as a person; not acting bored or ignoring what you have to say?

Poor 1 2 3 4 5 Excellent

Discussing choices with you; asking your opinion; offering choices and letting you help decide what to do/ asking what you think before telling you what to do?

Poor 1 2 3 4 5 Excellent

Encouraging you to ask questions; answering them clearly; never avoiding your questions or lecturing you?

Poor 1 2 3 4 5 Excellent

Explaining what you need to know about your problems, how and why they occurred, and what to expect next?

Poor 1 2 3 4 5 Excellent

Using words that you can understand when explaining your problems and treatment; explaining any technical medical terms in plain language?

Poor 1 2 3 4 5 Excellent

**References**

Carney, P. A., M. S. Eliassen, et al. (1999). "How physician communication influences recognition of depression in primary care." Journal of Family Practice **48**(12): 958-964.

Gerrity, M. S., S. A. Cole, et al. (1999). "Improving the recognition and management of depression - Is there a role for physician education?" Journal of Family Practice **48**(12): 949-957.

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