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"My Back Hurts and I Need an MRI Now"

Case Summary and Patient Instructions

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CASE SUMMARY

What is evaluated:

The learner's ability to:

- Facilitate a dialogue with their patient about the value of a diagnostic test or treatment in a clinical setting.

Station format:

A standardized patient will portray the patient, and a faculty or senior resident will observe the encounter in person or remotely to evaluate the learner's performance. The encounter will be recorded. The faculty or senior resident and the patient will provide immediate verbal feedback to the learner.

Station timing:

Learners will have 10 minutes to read the instructions and interact with the patient. After the encounter, learners will have 2 minutes to enter a few questions post-encounter, and then return to room for 5 minutes of feedback.

Brief description of the scenario:

What is the focus of this case? The patient wants a diagnostic test (back MRI) and referral to orthopedics. He/she has their reasons. But they don't volunteer the reasons unless skillfully (nonjudgmentally) asked. The physician does not believe the test is indicated. He/she does not think it will change medical management (diagnosis or treatment), and therefore it is of low value. Also, evidence shows patients who have MRIs often end up having more surgeries and potential for harm. They each have taken a different position. The only way forward is to have an opportunity to discover and share the interests underlying each position. It is really the responsibility of the physician to facilitate this dialogue and seek resolution/consensus.

How does the patient present? The patient has been experiencing back pain for two days. It began after he/she lifted weights in training for a triathlon, which is 6 weeks from now. It is localized to the lower back, off to the R. He/she is walking with a cane, and cannot run or bike because of the pain. The patient describes the pain as a very intense spasm and is very stiff. Slight movement makes the pain significantly worse. There are NO other associated worrisome neurologic symptoms such as weakness of legs, loss of bladder control, or pain radiating into the leg. The patient can get comfortable if they sit or lie down, but any movement triggers the pain.

Instructions to learners:

What information will the learners have about the patient?
They will know his/her age, a short list of their chronic medical conditions, and medications. The conversation begins AFTER the history and examination have been completed (they will have information that the story and exam do not suggest a serious problem). They will know that you have no symptoms or signs of a serious condition. They do NOT know what you want to happen (get an MRI or orthopedic consultation) and why—they need to ask.

They are told NOT to do a full history or physical exam (they will have that information).

What tasks should they perform? Counseling only. Giving the patient their diagnosis/impression and recommendations only, followed by questions about what the patient thinks of their proposed plan. No exam. Highest point areas: A) Ask the patient what they think about the suggested plan, B) Explore how the pain has affected their life (difficult to move or train for triathlon), C) what ideas they have about causes (herniated disc), D) fears/concerns about the pain (inability to train for triathlon, not be able to compete), E) expectations for this visit (get an MRI and/or orthopedic consultation), F) To respond in a way that you can know that they understand or heard your concerns and reasons for wanting the test. They should demonstrate some empathy (a PEARLS statement) when you express your feelings (fear, frustration, anger), and G) Ask the patient what they think about this decision. Can they accept that?

Patient Requirements:

- Acceptable age range: 18-50
- Male/Female/Either--Either
- Physical requirements (height, weight, physical condition). Should be fit, if possible.
- Ethnicity-Any
- Performance requirements (e.g. history, physical exam parameters)-comfort with English language skills.
- Dress- gym clothes

Instructions to standardized patients:

(Provide an overview of the patient and his/her needs.) This patient works as a physician's assistant in a sports medicine clinic. He/she specializes in shoulder and hand injuries. He/she works several hours each day, constantly changing positions as moving from room to room. They are training for their first triathlon after having run several races as wanting to try something new. Training had been going well, but now they can't do anything. Even going to work is very difficult. The back pain started two days ago after a weight training session. They would like the pain to go away as quickly as possible so they can return to training. One of their colleague's mentioned they may have a herniated disc and to get an MRI. This colleague also suggested getting a referral to an orthopedic surgeon, so that if surgery is needed, it can be done as soon as possible. You do not have a serious back problem that requires an MRI at this time, or surgery. These options will not change management or outcomes. If anything, they could lead to financial harm or even physical harm. It is a minor disc injury or simple strain and should improve in a few weeks with conservative therapy such as NSAIDs, Ice, Physical therapy.

Specialized Equipment:

Does the station require any specialized equipment or props? A cane if available.

Exam room staging:

Does the room require any special setup? No. Where should the patient and learner sit?— Near each other beside the desk (both seated). Patient can be seated when learner comes in (or on exam table).

Learner assessment:

The learner will be evaluated by a faculty or senior resident who will observe the interaction and use a behavioral checklist to indicate whether the intern performed the skills "not at all", "incompletely", or "competently". The list has about 10 behaviors/skills.

INSTRUCTIONS TO PATIENT

Patient Demographics

Name: Actor can choose.
Age: Same as actor
Occupation: Physician's Assistant at Sport's Medicine Clinic (specializes in shoulder/hand injuries)
Marital Status/Family: Married, 1 child.
Living Arrangement/City: Living in same town, not far from work.

Opening Statement

(Script the exact wording the patient will use with each learner.)-"My back is really killing me! I hope you can help."

Patient Situation and Concerns

- Who is this patient? (see above).
- Why the patient is here today? Pain in back.
- What does he/she hope to get out of this encounter? 1) Reassurance that they will get better (and be able to return to work soon), and that there is nothing serious going on. 2) pain relief (although this is secondary concern).
- Provide an overview of the patient and his/her chief complaint—e.g. You have come to the clinic today to discuss your back pain.

Characteristics of the Condition

Quality: Spasm, achy (dull, but sometimes sharp). Constant.
Severity: With any subtle movement, becomes 7/10. Otherwise 4-5/10.
Timing: Most intense with any moving, and going from sitting to standing, which is why they need a cane.
Chronology: Began about two days ago. Has become more intense in the past 24 hrs.
Location/radiation: Mid lower back, slightly off to the R. Just above the belt.
Provoked by: Standing, twisting.
Relieved by: lying still.

Patient's understanding and beliefs: Disc is herniated and pinching a nerve. Fear this may prevent them from participating in first triathlon. But you are afraid to speak that out loud for fear possible additional testing and orthopedic referral will end your training. You cannot face that now. Your most important belief is that an MRI and orthopedic surgeon referral will show what is going on so you can be treated quickly resume training. You believe the tests are more reliable than the physician, especially after your colleague at the sports medicine clinic thought an MRI and orthopedic visit was necessary. If the MRI is ok, then you will be relieved/reassured, and be comfortable that you can resume training. However, if the doctor gives a good explanation, and explores your thoughts/concerns/feelings about this, then you will be more trusting and will accept their plan to NOT do an MRI or referral to orthopedics, and watch how things go for at least a few more weeks, especially if other conservative measures are suggested (NSAIDs, Ice, PT, Massage).

Effect on patient's life: Unable to change positions frequently. This interrupts your job seeing patients, but more importantly, is interrupting your training. When pain is severe, you are irritable, have difficulty concentrating. Occasionally it interrupts your sleep.

Associated symptoms: No serious additional symptoms. NO weakness in legs, control of bladder, loss of feelings to suggest serious pressure on a nerve or bone cancer.

Current Medical History

- Does the patient have any other medical problems currently? Hypothyroidism, Taking Synthroid
- How is the patient's overall health? Generally good.
- Does the patient receive routine healthcare? Yes.

Patient Affect/Behavior

How does the patient appear during the encounter? Worried, anxious about not being able to train, and slightly annoyed by how this is limiting his/her life. Somewhat demanding/insistent on obtaining MRI and ortho referral. Do certain learner behaviors impact the patient's affect or behavior? Empathy helps them to calm down, especially acknowledgement of the importance of the triathlon. Also, the learner should acknowledge patient's education and work background. What is motivating the patient's affect and behavior? Being able to participate in triathlon.

Medical History

Has the patient had any prior medical problems, surgeries or hospitalizations? No. Not relevant. Interns were instructed not to ask this.

Sexual History: NA

Medications

Synthroid (Hypothyroidism)

Allergies: None

Lifestyle

Tobacco use: No
Alcohol use: No
Illicit or street drug use: No
Diet: Tries to eat healthy, fruits, vegetables. Has recently gone Vegan.
Exercise: Runs/bikes 6 days a week for >1 hr. Weight training 3 days/wk for 90 minutes. Cross training on day 7.
Leisure activities: Running
Support systems: Spouse

Family History

What family members have, or have had, what illnesses or medical problems? Mother has hypertension

Prompts and Special Instructions
Are there any statements the patient should make at a certain point in the encounter? Are there any behaviors the patient should demonstrate at a certain point in the encounter? Are there any other special instructions for the patient?

Patient should demonstrate demand and angst about getting MRI and ortho referral. Colleague in sports med recommended this. This is the only way you think you'll be better soon enough to finish training for the triathlon.

Don't initially volunteer why you want the test. Just say you want an MRI and referral to orthopedics, and then be silent (perhaps losing eye contact or looking away). It is very important that the intern take the initiative to explore this with you by asking a question like *"help me understand why that is important?"*.

INSTRUCTIONS TO LEARNERS:

You have 10 minutes to read the information below and complete the patient encounter. A printed version of the information is also available in the room for your use. If you finish the encounter before the 10 minutes are up, you may leave the room and begin your online activity, but you may not re-enter the room.

STATION GOALS:

1) Improve skills for counseling patients on high-value diagnostic testing.
2) Improve skills for managing disagreements about diagnostic testing and how to say "no" respectfully.

SCENARIO:

Mr./Ms _____ is ……..

Reason for visit: "My back is really killing me, I hope you can help."

HPI: This patient developed pain in the low lumbar region (midline) two days ago after a weight lifting session.
Quality: Constant spasm, achy. Mostly dull ache, but sometimes sharp.
Severity: Any subtle movement becomes 7/10, otherwise 4-5/10.
Timing: Most intense with any movement, especially going from sitting to standing, requiring use of cane
Chronology: Began about two days. Has become more intense in the past 24 hours.
Location/radiation: Mid lower back, slightly off to the right, just above the belt.
Provoked by: Standing, twisting.
Relieved by: Lying still.

NO leg weakness, bowel/bladder symptoms, sensory changes. No previous history of back surgery or pain. Taking ibuprofen.
NO significant underlying known medical problems such as cancer or infections.

Exam is without concerning findings. Negative straight-leg raise. Normal neurologic exam. Mild-moderate R Lumbar paraspinal muscle spasm.

Additional information: This is a counseling station. You have interviewed and examined them. The history and exam are normal and without red flags. Your **diagnosis is lumbar strain and additional diagnostic testing is **not** indicated. Experts would agree diagnostic testing should not be done in this situation as it increases costs to the patient and can lead to harm with further unwarranted interventions based on findings. Studies have shown patients who get MRIs have more unnecessary surgeries. Management should be very conservative (ice, analgesics, physical therapy) for at least several weeks. If not improving, return for further evaluation.

TASKS

1. Present your diagnosis (lumbar strain) and plan (Ice, physical therapy, NSAIDs) to the patient in understandable terms.

2. Demonstrate how to facilitate and manage a conversation where you and the patient initially do not agree on the need for a test.
3. Give a respectful “no” regarding the MRI, and negotiate a mutually acceptable course of action

** **Do not perform additional symptom-related history or physical examination.**

Following the patient encounter, exit the room and click STOP ENCOUNTER on the laptop screen. You will then have 3 minutes to complete a short list of questions about the station. You will then return to the room for 5 minutes of feedback from the instructor and patient.
Please close these instructions by clicking the CONTINUE button at the top of the page. You may then knock on the door and enter the exam room.

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"I have a sinus infection. Give me a Z-Pak"

Case Summary and Patient Instructions

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CASE SUMMARY

What is evaluated:

The learner's ability to:

- Facilitate a dialogue with their patient about the value of a treatment in a clinical setting.

Station format:

A standardized patient will portray the patient. The encounter will be recorded. The faculty member will provide verbal feedback to the learner at a later date.

Station timing:

Learners will have 10 minutes to read the instructions and interact with the patient.

Brief description of the scenario:

What is the focus of this case? The patient wants antibiotics for a sinus infection. He/she has their reasons. But they don't volunteer the reasons unless skillfully (nonjudgmentally) asked. The physician does not believe the antibiotics are indicated. He/she does not think it will change the clinical outcome, could potentially have harms, and therefore it is of low value. Also, evidence shows the majority of sinus infections are viral and would not be impacted by antibiotics. Despite recommendations, 80% of outpatient visits for sinusitis result in a prescription for antibiotics, costing $5.8 billion dollars for the 16 million office visits yearly. The patient and physician each have taken a different position. The only way forward is to have an opportunity to discover and share the interests underlying each position. It is really the responsibility of the physician to facilitate this dialogue and seek resolution/consensus.

How does the patient present? The patient will have left a prior message with the clinic's nurse requesting antibiotics for a sinus infection. The patient has had nasal congestion with pressure above the eyes for two days. They have green colored nasal discharge. They also are sneezing. They have not had a fever or chills. They do not have body aches. They do not have a sore throat. There is no cough or shortness of breath.

Instructions to learners:

What information will the learners have about the patient?
They will know his/her age, a short list of their chronic medical conditions, and medications. The conversation will be a telephone encounter, begins AFTER the history has been completed (they will have information that the story does not suggest anything concerning). They will know that you have no symptoms or signs of a serious condition. They do NOT know what you want to happen (get antibiotics) and why—they need to ask.

They are told NOT to do a full history (they will have that information).

What tasks should they perform? Counseling only. Giving you their diagnosis/impression and recommendations only, followed by questions about what you

think of their proposed plan. No exam. Highest point areas: A) Ask the patient what they think about the suggested plan. B) Explore how the sinus infection has affected their life. C) what ideas they have about treatment D) fears/concerns about the sinus infection (want to get better as soon as possible) E) expectations for this call(get antibiotics). F) To respond in a way that you can know that they understood or heard your concerns and reasons for wanting the test. They should demonstrate the use of an appropriate response to your expressed emotion/concerns (fear, frustration, anger) so that you feel understood, or listened to (which could be in the form of a "PEARLS" statement: **P**artnership, **E**mpathy, **A**pology, **R**espect, **L**egitimization, **S**upport)) And G) Ask the patient what they think about this decision. Can they accept that?

Patient Requirements:

- Acceptable age range: 18+
- Male/Female/Either--Either
- Physical requirements (height, weight, physical condition). Any
- Ethnicity-Any
- Performance requirements (e.g. history, physical exam parameters)-comfort with English language skills.
- Dress- any

Instructions to standardized patients:

(Provide an overview of the patient and his/her needs.) This patient works in an elementary school teaching second grade. They have had tenderness above their eyes for the past two days. They also have nasal congestion and yellow-green nasal discharge. They do not have a sore throat, cough, or shortness of breath. They do not have ear pain, fevers or chills. They do feel slightly tired. This situation reminds them of a prior sinus infection that required antibiotics to get better and they want to start those now so that they can feel better as soon as possible. The head pain is making it miserable to go to work with the little kids, especially when bending over to help with arts/crafts.

You do not have a serious infection that requires antibiotics at this time, as it will not change management. If anything, it could lead to financial harm or even physical harm given side effects of antibiotics. It is a viral infection and will get better on its own, without antibiotics.

Specialized Equipment:

Does the station require any specialized equipment or props? No

Exam room staging:

Does the room require any special setup? No.

Learner assessment:

Provide an overview of how the learners will be evaluated.—The learner will be evaluated by a faculty or senior resident who will review the recorded interaction at a later date and use a behavioral checklist to indicate whether the intern performed the

skills "not at all", "incompletely", or "competently". The list has about 10 behaviors/skills.

INSTRUCTIONS TO PATIENT

Patient Demographics
Name: Actor can choose.
Age: Same as actor
Occupation: Second grade teacher
Marital Status/Family: Married, 1 child.
Living Arrangement/City: Living in same town, not far from work.

Opening Statement
(Script the exact wording the patient will use with each learner.)-"I have a sinus infection. I want to get better as soon as possible!"

Patient Situation and Concerns
- Who is this patient? (see above).
- Why is the patient calling today? Sinus infection
- What does he/she hope to get out of this encounter? 1) Reassurance that they will get better (and be able to return to work soon), and that there is nothing serious going on. 2) symptom relief (although this is secondary concern).
- Provide an overview of the patient and his/her chief complaint—e.g. You have called to the clinic today to discuss your sinus infection

Characteristics of the Condition
Quality: Constant, pressure above the eyes.
Severity: With bending over, become throbbing to a 7/10. Otherwise 4-5/10.
Timing: Constant, worse bending over
Chronology: Began about two days ago.
Location/radiation: above eyes
Provoked by: bending over
Relieved by: nothing

Patient's understanding and beliefs: Sinus infections require antibiotics to get better. Fear not getting antibiotics will lead to getting worse and potentially missing school. But you are afraid to say that out loud as you are afraid of sounding unintelligent. Your most important belief is that antibiotics are required for all infections. You believe the quicker you get antibiotics, the better you'll be. The stronger the antibiotics, the better they are. If you get antibiotics, you will be assured to get better the soonest. However, if the doctor gives a good explanation, and explores your thoughts/concerns/feelings about this, then you will be more trusting and will accept their plan to NOT prescribe antibiotics, especially if other conservative measures are suggested (over-the-counter decongestants, nasal sprays, Tylenol, NSAIDs, anti-histamines).

Effect on patient's life: Unable to bend over well to help students. It is disruptive to your job, and leads to decreased concentration and increased irritability, which is not good for a school teacher.

Associated symptoms: Nasal congestion, yellow-green nasal discharge; no fever, chills, cough, sore throat, shortness of breath, ear pain

Current Medical History

- Does the patient have any other medical problems currently? Hypertension; taking hydrochlorothiazide
- How is the patient's overall health? Generally good.
- Does the patient receive routine healthcare? Yes.

Patient Affect/Behavior

How does the patient appear during the encounter? Worried, anxious about missing work if doesn't get better soon. Only has one more sick day to use this year. Willing to do anything to get better.

Medical History

Has the patient had any prior medical problems, surgeries or hospitalizations? No. Not relevant. Learners were instructed not to ask this.

Sexual History

With spouse only

Medications

Hydrochlorothiazide

Allergies: None

Lifestyle

Tobacco use: No
Alcohol use: No
Illicit or street drug use: No
Diet: Tries to eat healthy, fruits, vegetables.
Exercise: Walks 6 days a week for >1 hr.
Support systems: Spouse

Family History

What family members have, or have had, what illnesses or medical problems? Mother has diabetes

Prompts and Special Instructions

Are there any statements the patient should make at a certain point in the encounter? Are there any behaviors the patient should demonstrate at a certain point in the encounter? Are there any other special instructions for the patient?

Patient should demonstrate demand and angst about getting antibiotics. This is the only way you think you'll be better and not miss school.

Don't initially volunteer why you want the test. Just say you want antibiotics and then be silent. It is very important that the intern take the initiative to explore this with you by asking a question like *"help me understand why that is important?"*

LEARNER INSTRUCTIONS

You have 10 minutes to read the information below and complete the patient encounter. A printed version of the information is also available in the room for your use. If you finish the encounter before the 10 minutes are up, you may leave the room and begin your online activity, but you may not re-enter the room.

STATION GOALS:

1) Improve skills for counseling patients on high-value diagnostic testing or treatment.
2) Improve skills for managing disagreements about diagnostic testing or treatment and how to say "no" respectfully.

SCENARIO:

Mr./Ms _____ is ……..

Reason for visit: "I have a sinus infection. I need your help."

HPI:
Quality: Constant, pressure above the eyes.
Severity: With bending over, become throbbing to a 7/10. Otherwise 4-5/10.
Timing: Constant, worse bending over
Chronology: Began about two days ago.
Location/radiation: above eyes
Provoked by: bending over
Relieved by: nothing
Associated symptoms: Nasal congestion, yellow-green discharge.
NO fevers, chills, sore throat, cough, dyspnea, ear pain.

NO significant underlying known medical problems such as cancer or infections.

Additional information: This is a counseling situation. Your nurse has taken the above information from the patient. You are calling the patient back to discuss treatment options. The history is normal and without red flags. Your **diagnosis is viral upper respiratory infection and additional treatment is **not** indicated. Experts would agree antibiotic therapy is not indicated in this situation as most infections are viral in nature and antibiotics have no role in therapy. Also, antibiotics are associated with increased costs and have side effects that can be quite harmful. Despite recommendations, 80% of outpatient visits for sinusitis result in a prescription for antibiotics, costing $5.8 billion dollars for the 16 million office visits yearly. Management should be very conservative (decongestants, anti-histamines, nasal sprays) for the first 7-10 days. If not improving, return for further evaluation.

TASKS

1. Present your diagnosis (viral upper respiratory infection) and plan (decongestants, anti-histamines, nasal sprays) to the patient in understandable terms.
2. Demonstrate how to facilitate and manage a conversation where you and the patient initially do not agree on the need for treatment.

3. Give a respectful “no” regarding antibiotics, and negotiate a mutually acceptable course of action

** **Do not perform additional symptom-related history or physical examination.**

Following the patient encounter, hang up the phone and click STOP ENCOUNTER on the laptop screen. You will then have 3 minutes to complete a short list of questions about the station.

Please close these instructions by clicking the CONTINUE button at the top of the page. You may then knock on the door and enter the exam room.

CONFIDENTIAL

"My Head Hurts and I Need a CT"

Case Summary and Patient Instructions

Authors:
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Craig Roth MD

CASE SUMMARY

What is evaluated:

The learner's ability to:

- Facilitate a dialogue with their patient about the value of a diagnostic test or treatment in a clinical setting.

Station format:

A standardized patient will portray the patient, and a faculty or senior resident will observe the encounter in person or remotely to evaluate the learner's performance. The encounter will be recorded. The faculty or senior resident and the patient will provide immediate verbal feedback to the learner.

Station timing:

Learners will have 10 minutes to read the instructions and interact with the patient. After the encounter, learners will have 2 minutes to answer a few questions post-encounter, and then return to room for 5 minutes of feedback.

Brief description of the scenario:

What is the focus of this case? The patient wants a diagnostic test (head CT). He/she has their reasons. But they don't volunteer the reasons unless skillfully (nonjudgmentally) asked. The physician does not believe the test is indicated. He/she does not think it will change medical management (diagnosis or treatment), and therefore it is of low value. Also, evidence shows almost all scans done for classic migraine symptoms and normal neurological exam are normal. The patient and physician each have taken a different position. The only way forward is to have an opportunity to discover and share the interests underlying each position. It is the responsibility of the physician to facilitate this dialogue and seek resolution/consensus.

How does the patient present? The patient has had migraines for many years. Symptoms typically include an aura about 30 minutes prior to the onset. It is then followed by a throbbing 7/10 pain behind the R eye, and accompanied by photophobia, phonophobia, and nausea. The patient currently has been experiencing symptoms for 3 hours. The patient is visiting from out of town and forgot to bring their Imitrex. This typically will relieve symptoms. The migraines occur once every two months. This headache is slightly worse than the others. They have a normal neurological exam. There are NO other associated worrisome neurologic symptoms such as seizure, changes in vision, weakness of an extremity, dysarthria. This is NOT the worst headache of their life. The patient is most comfortable in a darkened room.

Instructions to learners:

What information will the learners have about the patient? They will know his/her age, a short list of their chronic medical conditions, and medications. The conversation begins AFTER the history and examination have been completed (they will have information that the story and exam do not suggest a serious problem). They will know that you have no symptoms or signs of a serious condition. They do NOT know what you want to happen (get a CT scan) or why—they need to ask.

They are told NOT to do a full history or physical exam (they will have that information).

What tasks should they perform? Counseling only. Giving you their diagnosis/impression and recommendations only, followed by questions about what you think of their proposed plan. No exam. Highest point areas: A) Ask the patient what they think about the suggested plan. B) Explore what concerns they have about this headache (concerned about brain tumor, in town because uncle just passed away from a brain tumor), C) what ideas they have about causes (brain tumor) , D) fears/concerns about the pain (concern they have a brain tumor too), E) expectations for this visit (get a CT scan or MRI). F) To respond in a way that you can know that they understand or heard your concerns and reasons for wanting the test. They should demonstrate some empathy (a PEARLS statement) when you express your feelings (fear, frustration, anger). And G) Ask the patient what they think about this decision. Can they accept that?

Patient Requirements:

- Acceptable age range: any age
- Male/Female/Either--Either
- Physical requirements (height, weight, physical condition). None
- Ethnicity-Any
- Performance requirements (e.g. history, physical exam parameters)-comfort with English language skills.
- Dress- casual clothes

Instructions to standardized patients:

(Provide an overview of the patient and his/her needs.) This patient is in town for his/her uncle's funeral. He/she is from Iowa where they work as a lawyer. He/she has a family member that is seen in this clinic. He/she has migraines every couple months. This current migraine started like all others, with an aura about 30 minutes before. The pain is a throbbing 7/10 behind the R eye, with sound and light making it worse. This is slightly worse than the usual migraine, but this is NOT the worst headache of his/her life. There are no other symptoms. Most of the time, the patient takes Imitrex and the symptoms resolve. However, he/she left their medicine at home. He/she is very upset about this migraine as they are concerned about a brain tumor. The uncle who just passed away died of a brain tumor, something that starts with "G." The patient and his/her family are concerned this migraine could also be a brain tumor. He/she would like to have a CT scan done to confirm there is no tumor. If a CT cannot be done, they would like to have an MRI.

You do not have a serious headache that requires imaging at this time. There are no red flag symptoms. Imaging will not change management or outcomes. If anything, they could lead to financial harm or even physical harm. It is a simple migraine that should improve with conservative therapy such as NSAIDs or Imitrex.

Specialized Equipment:

Does the station require any specialized equipment or props? None

Exam room staging:

Does the room require any special setup? No. Where should the patient and learner sit?— Near each other beside the desk (both seated). Patient can be seated when learner comes in (or on exam table).

Learner assessment:

Provide an overview of how the learners will be evaluated.—The learner will be evaluated by a faculty or senior resident who will observe the interaction and use a behavioral checklist to indicate whether the intern performed the skills "not at all", "incompletely", or "competently". The list has about 10 behaviors/skills.

INSTRUCTIONS TO PATIENT

Patient Demographics
Name: Actor can choose.
Age: Same as actor
Occupation: Lawyer in Iowa
Marital Status/Family: Married, 1 child.
Living Arrangement/City: Lives five hours away

Opening Statement
(Script the exact wording the patient will use with each learner.)-"My head hurts. Please help me."

Patient Situation and Concerns
- Who is this patient? (see above).
- Why the patient is here today? Headache
- What does he/she hope to get out of this encounter? 1) Reassurance that they will get better and that there is nothing serious going on. 2) pain relief (although this is secondary concern).
- Provide an overview of the patient and his/her chief complaint—e.g. You have come to the clinic today to discuss your headache.

Characteristics of the Condition
Quality: Throbbing, behind R eye. Constant. Currently 7/10 pain.
Severity: With exposure to light, the pain is worse.
Timing: Slowly intensifying since onset
Chronology: Began about three hours ago. Slowly becoming more intense.
Location/radiation: Mid lower back, slightly off to the R. Just above the belt.
Provoked by: Bright light, loud sounds
Relieved by: Rest, imitrex (but this was left at home in the haste of packing for funeral)

Patient's understanding and beliefs: This headache is similar to prior migraines, but perhaps slightly more intense. Fear this may be a brain tumor as your uncle has just passed away from a brain tumor, and he had headaches. But you are afraid to speak that out loud for fear possible testing will lead to a diagnosis of brain cancer. You, and your family, cannot face that now in the wake of your uncle's death. Yet, maybe if the cancer is caught soon enough, treatment will be available. Your most important belief is that an image of your head will either provide the reassurance you need, or the diagnosis you need to take the next steps forward. You believe the tests are more reliable than the physician, especially as your law practice leads you to needing to see the evidence. If the head imaging is ok, then you will be relieved/reassured and satisfied with a prescription for Imitrex. However, if the doctor gives a good explanation, and explores your thoughts/concerns/feelings about this, then you will be more trusting and will accept their plan to NOT do any imaging and monitor the migraine over the next few days especially if other conservative measures are suggested (NSAIDs, Imitrex).

Effect on patient's life: Can't eat because of nausea, difficult to think clearly, can't be in bright light right now

Associated symptoms: No serious additional symptoms. NO seizures, no changes in vision, no weakness, difficulty speaking

Current Medical History

- Does the patient have any other medical problems currently? None
- How is the patient's overall health? Generally good.
- Does the patient receive routine healthcare? Yes.

Patient Affect/Behavior

How does the patient appear during the encounter? Worried, anxious about the cause of this headache and what it means for them in terms of life expectancy. Do certain learner behaviors impact the patient's affect or behavior? Empathy helps them to calm down, especially acknowledgement of the fear and emotional stakes of this visit (uncle's funeral, grief in uncle passing, upsetting diagnosis of uncle). Also, the learner should acknowledge patient's education and work background. What is motivating the patient's affect and behavior? Having knowledge of the truth behind this headache.

Medical History

Has the patient had any prior medical problems, surgeries or hospitalizations? No. Not relevant. Interns were instructed not to ask this.

Sexual History

NA

Medications

Multivitamin
Imitrex as needed

Allergies: None

Lifestyle

Tobacco use: No
Alcohol use: 1-2 beers per month
Illicit or street drug use: No
Diet: Tries to eat healthy, fruits, vegetables.
Exercise: Bikes 5 days a week for >1 hr. Weight training 3 days/wk.
Support systems: Spouse

Family History

What family members have, or have had, what illnesses or medical problems? Uncle just passed away from brain cancer

Prompts and Special Instructions
Are there any statements the patient should make at a certain point in the encounter? Are there any behaviors the patient should demonstrate at a certain point in the encounter? Are there any other special instructions for the patient?

Patient should demonstrate demand and angst about getting head imaging (CT scan or MRI). Having the image is the only way to know the truth (good or bad) behind this headache.

Don't initially volunteer why you want the test. Just say you want a CT or MRI and then be silent (perhaps losing eye contact or looking away). It is very important that the intern take the initiative to explore this with you by asking a question like *"help me understand why that is important?"*.

INSTRUCTIONS TO LEARNERS:

You have 10 minutes to read the information below and complete the patient encounter. A printed version of the information is also available in the room for your use. If you finish the encounter before the 10 minutes are up, you may leave the room and begin your online activity, but you may not re-enter the room.

STATION GOALS:

1) Improve skills for counseling patients on high-value diagnostic testing.
2) Improve skills for managing disagreements about diagnostic testing and how to say "no" respectfully.

SCENARIO:

Mr./Ms _____ is ……..

Reason for visit: "My head really hurts, I hope you can help."

HPI: This patient is visiting from out of town. They get migraines every 1-2 months. They forgot their Imitrex at home.
Quality: Throbbing, behind the R eye, constant.
Severity: 7/10; Slightly worse than other headaches. This is NOT the worst headache of their life.
Timing: Constant, slowly intensifying
Chronology: Began about three hours ago. Had an aura 30 min prior to onset.
Location/radiation: Behind the R eye
Provoked by: Bright light, loud sounds
Relieved by: Resting in a dark room

NO changes in vision, no seizures, no weakness, no dysarthria.
NO significant underlying known medical problems such as cancer or infections.

Exam is without concerning findings. Normal pupils. EOMI. CN II-XII are intact. Normal neurologic exam.

Additional information: This is a counseling station. You have already interviewed and examined the patient. The history and exam are normal and without red flags. Your **diagnosis is a classic migraine and additional diagnostic testing is **not** indicated. Experts would agree diagnostic testing should not be done in this situation as it increases costs to the patient and can lead to harm with further unwarranted interventions based on findings. Evidence shows head imaging for a headache without warning symptoms almost never show a brain tumor. Imitrex could be prescribed if this has helped in the past.

TASKS

1. Present your diagnosis (migraine) and plan (rest, NSAIDs, Imitrex) to the patient in understandable terms.
2. Demonstrate how to facilitate and manage a conversation where you and the patient initially do not agree on the need for a test.

3. Give a respectful “no” regarding head imaging, and negotiate a mutually acceptable course of action

** **Do not perform additional symptom-related history or physical examination.**

Following the patient encounter, exit the room and click STOP ENCOUNTER on the laptop screen. You will then have 3 minutes to complete a short list of questions about the station. You will then return to the room for 5 minutes of feedback from the instructor and patient.

Please close these instructions by clicking the CONTINUE button at the top of the page. You may then knock on the door and enter the exam room.

HVC Communication Performance Checklist	**Not done**	**Partially**	**Completely**
Patient greeted in a manner that is personal and warm.			
Tells/Gives a diagnosis and plan			
Information stated clearly with little or no use of jargon.*			
Pauses after giving information with intent of allowing the patient to react absorb it.*			
Respectfully explores patients feelings by identifying or labeling them.*			
Respectfully **explores** the patient's underlying interests/concerns (i.e. why do they want this test?)			
Respectfully **summarizes** what they've heard: *"An MRI might help you…".*			
Responds to patient's expressed emotion with a statement of understanding			
Clearly/fully **explains the rationale behind NOT doing tests** (e.g., doing the test may cause harm).*			
Explanation makes sense and is congruent with what has happened in this visit, and would likely be reassuring/acceptable to most patients.*			
Seeks a mutually acceptable solution (e.g. *"No MRI now, but reconsider this if pain is significantly worsening, or not improved in 4 weeks*.)			
Asks the patient if they can agree to the suggested plan?			
Encourages and asks for additional questions from the patient.*			
Effectively tests for patient's comprehension.*			

* From the Four Habits model