

TEACHING THE BEHAVIORAL SCIENCES: A MANUAL OF TECHNIQUES

by

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Introduction

Why a teaching manual for the behavioral sciences? While biochemical pathways or cardiac physiology are seen as part of the biomedical model concepts like culture or lifecycle may appear separate from the medical curriculum. With the emergence of the biopsychosocial model, however, behavioral science concepts have become better integrated into the medical curriculum; but the inclusion of these concepts has not been easy. Teachers have had to develop learning strategies that authenticate behavioral science concepts within the medical model.

Instruction in medical education generally begins with lecture hall didactics, designed to impart large amounts of information in relatively short periods of time and supplement readings from assigned texts. While there are legitimate criticisms of the lecture/discussion tradition, the fact remains it is the mainstay of medical education, at least in the basic science years. The challenge is how to augment it. The goals of didactic education should be to demonstrate the medical relevance of basic science material from the behavioral and social sciences as well as the biological sciences. Wherever possible, lecture/discussion presentations should be amplified by whatever techniques can be applied. This includes multimedia modalities (e.g., video recordings, slides, PowerPoint), program formats (e.g., lecture, question/answer, panel discussions, workshops), supplementary materials/presentations (e.g., case studies, patient presentations), and experiential learning situations (e.g., role playing, standardized patients, scenarios & vignettes).

This manual is designed to provide the instructor with a compendium of techniques to teach a wide variety of basic behavioral science concepts. The techniques are appropriate at all levels of medical education from undergraduate studies to continuing medical education. Thus, the word “trainee” is used throughout the manual rather than the word student.

Many innovative learning strategies have been developed, making it impossible to present all of them. Similarly, it is not feasible to present a specific learning strategy for each behavioral science concept. Rather, the intent of this manual is to focus on experiential learning strategies associated with selected concepts. Many of these strategies integrate biomedical information with psychosocial information. This approach is most consistent with the “Integrated Sciences Model” outlined in the text, thus providing a bridge between the classroom and the clinic. Selected resources are also provided to aid instructors in developing their own learning strategies and evaluation designs.

As a practical guide to teaching, the manual is divided into seven chapters. Chapter 1 presents the case study method and several examples. Chapter 2 discusses how to

augment the lecture/discussion with actual patient presentations and interviews. Chapter 3 describes the use of “Standardized Patients” in both didactic and clerkship experiences. Chapter 4 discusses how situational scenarios and vignettes can be used to apply behavioral science concepts. Chapter 5 demonstrates the various uses of role-playing in clinical skill development. Chapter 6 presents a further array of task-oriented activities designed to teach specific behavioral science concepts or skills. Chapter 7 reviews some additional resources that can serve as instructional aids.

In each chapter we will present the basic rationale and instructional goal for each technique, the methodology by which it is carried out, and then several selected examples of how to apply the technique. While it is impossible to describe and provide examples of how each technique can be applied to the entire range of behavioral science concepts and research findings applicable to health care, we do point out those techniques that appear to be especially suited to teaching certain concepts. In the end, however, how these supplementary teaching techniques can be used more beneficially depends largely upon the insight and creativity of the instructor. Necessity is still the mother of invention!

This manual is a living document. ABSAME welcomes the comments and suggestions of all readers. We are especially eager to identify other methodologies that have been particularly useful for teaching specific topic areas that have eluded even the many techniques presented here. We are also interested in expanding the listing of helpful resources, most notably on the Internet, that can be easily and inexpensively accessed.

ACKNOWLEDGMENTS

Having taught the behavioral sciences to medical students for over fifteen years, I have been impressed by the innovation and creativity that many colleagues have brought to the art and craft of teaching this important subject area. I want to thank the following individuals for their generosity and willingness to share their work in developing this introductory manual: Jack Carr, Michael Hosokawa, Debra Howenstine, David Mehr, Jeffrey Spike, Tom Vernon, Daniel Vinson, Edward Walker, Eugene Worth, and Elizabeth Garrett. I especially want to thank O.J. Sahler for her superb editing and suggestions, Ora Lindsey for her help in preparing the manuscript, and Mark Vogel for implementing the on-line version of this document.

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CHAPTER 1 CASE STUDIES

Patient cases allow the trainee to appreciate how inextricably linked the biomedical and behavioral sciences are. Patient cases can be used in either large lecture or small group formats to facilitate discussion. In addition, patient cases can be written to use simulated participants (see Chapter 3). The following are selected cases presented in different formats that cover a range of topical issues outlined in *The Behavioral Sciences and Health Care* (note that some cases are presented in intertwined parts to be sequenced over time):

 **KEY TECHNIQUE**
Unfolding Learning

CASE 1: Chronic Pain: Karen Jones

Part I

Karen Jones, a 42-year-old new patient, is on your schedule for evaluation of back pain. On entering the room and asking what you can do for her, she states, "I've had terrible low back pain for over a year. My back is killing me! I hope you can do more than my last doctor. He just wasn't very interested in my problem. He did a couple of tests and gave me some pain pills, but when that didn't help he ignored me. I'm at my wits end, but I've heard you are really good at treating back pain. Please help me!"

Further questioning reveals that the pain is located in the low back with radiation to both buttocks. It began while lifting some boxes (about 20 pounds each) at work 13 months ago. Mrs. Jones gives the pain a score of 9 (10 being excruciating pain) most of the time. It interferes with her daily activities, she can no longer continue her job, and she cannot sleep well. Initially there was radiation of the pain down the right leg, but she no longer has any pain in her legs. She has no lower extremity weakness and no change in her bladder or stool habits.

Mrs. Jones has sought help from three physicians since her injury. She has also seen two physical therapists and a chiropractor. None of them provided relief from her debilitating pain. Consistent with her radicular pain complaints, her initial MRI scan showed a herniated L₄₋₅ disc with minimal right-sided nerve root compression. Rest, analgesics, physical therapy, and steroid epidural injections all failed to provide relief, except for resolution of the pain in the right leg. Her orthopaedic surgeon performed a limited lumbar laminectomy to remove the herniated disk. Since the operation, she has failed pain therapy regimens including several non-steroidal anti-inflammatory drugs

(NSAIDs), several bursts of oral steroids, and a second series of epidural steroid injections. Repeat MRI of the spine was negative for anatomic lesions.

Medication List:	Naproxen 375 mg q.i.d., Carisoprodol 350 mg t.i.d. and at bedtime and acetaminophen 325 mg with codeine 30 mg, two tablets orally as needed. She takes 8-10 per day. She is nearly out of these tablets and wants a refill today.
Allergies:	She has no known drug or other allergies.
Past surgical history:	Appendectomy at age 17 2 vaginal deliveries Right modified radical mastectomy for ductal Carcinoma 4 years ago Limited lumbar laminectomy 8 months ago
Health Habits:	She smokes a pack of cigarettes daily. Mrs. Jones uses alcohol, but "never to excess". She states that she has rarely been drunk and feels that alcohol is not really a problem for her.
Patient History:	She has been married to the same man for 20 years. They have two children, a boy (16-years-old) and a girl (12-years-old). On further questioning about how things are going in her family, she relates that her son had a recent arrest and conviction for driving while intoxicated (DWI) with a blood alcohol level of 0.15 gm/dl. His driver's license has been suspended and his grades are poor in school. No problems noted with her daughter, although they don't "talk" much. Her husband announced yesterday that he is thinking about leaving her.

Physical Examination

Vital signs:	BP 116/64, P 76 reg, R 16 reg, T 98.2°F. Weight 165 lbs and height 66 inches.
HEENT:	Normal head, pupils were equal, round and reactive to light. No nasal discharge, normal teeth and pharynx. Conjunctivae were injected equally

	bilaterally.
Chest:	Normal breath sounds.
Breasts:	Left breast is pendulous, without masses. Right breast is surgically absent with a well-healed mastectomy scar.
CV:	Heart beat regular without murmurs or gallops
Abdomen:	Moderately obese without organomegaly. Mild hepatic tenderness to palpation, but the hepatic borders are smooth and soft.
Back:	Laminectomy scar is present and healed. Limited flexibility, but no pain on flexion. Pain bilaterally with side-to-side bending. Hamstring pain on straight leg raising.
Pelvic:	Normal female genitalia, uterus mildly enlarged with a firm myoma on the left side, ovaries without masses. No adnexal masses.
Extremities:	No pedal edema. Right arm has moderate swelling compared to the left.
Lymphatics:	Some fullness in the right axilla, but no palpable masses noted.
Neurological:	CN II - XII intact grossly. Deep tendon reflexes 2+ at the knees, and 1+ at the ankles bilaterally. Sensation to pinprick, light and deep touch intact over both lower extremities.
Rectal Examination:	Firm muscle tone. No masses palpable. Soft stool in the vault. Hemoccult negative.
Mental Status:	Cognitively intact. Oriented to time and place. Short-term memory 3/3. She appears depressed, but otherwise without gross mental status changes.

Questions for Discussion

1. What active problems can you identify at this point?
2. If the patient had changes in bowel or bladder function, what would that signify?
3. What further information do you need now?
4. How will you evaluate her pain syndrome? Over what period of time?
5. Does Mrs. Jones have “real” pain?
6. Does Mrs. Jones have a drug problem?
7. As of this time, what treatment do you think you will offer at this visit? Will you refill the prescription for acetaminophen with codeine? Why or why not?

Part II

At the conclusion of the first visit, you gave Mrs. Jones a 10-day supply of acetaminophen with codeine until you can evaluate her further. You also mention the possibility of referral to a multidisciplinary chronic pain program. She returns one week later and you obtain additional history. Mrs. Jones concedes that she has been feeling “blue” and has had daily crying episodes for 6 months. She has trouble concentrating, is chronically tired, easily becomes agitated, and frequently has early morning awakening and cannot go back to sleep. The future looks bleak, but she has not considered suicide. Her family situation has deteriorated during this time.

As she describes her feelings, you note that her right hand is clenched in a fist, and she grinds that hand into her other hand. When asked about this behavior, she expresses surprise, but states that she often feels out of sorts. The least deviation from her routine results in angry outbursts. She has been at odds with her previous employer about covering expenses for her back injury. She is now in litigation over the Workmen’s Compensation benefits she will receive.

With regard to her husband, she indicates that they just don’t seem to be communicating well. They have had virtually no sexual relations for 6 months. Mrs. Jones has no interest in sex, and she states that getting into “that position” makes her back flare up for days. Further questioning reveals they use a male superior position for coitus. She believes her husband has been faithful, but is extremely frustrated.

Mrs. Jones cries when asked about her son. Her first response is: "Where did we go wrong?" Her son was a good student until her back problem. He has been sullen and irritable since her injury. He spends an increasing amount of time with friends of questionable character. She says that he has been sneaking drinks, and she is concerned that he is smoking marijuana or worse. On more detailed questioning about her personal alcohol use, you find that drinking more than 10 drinks per week is exceptional, there is no binge drinking, and she has not been intoxicated in years.

A thorough review of her past medical record reveals a ductal carcinoma removed from the right breast. The mass measured 1.5 x 1.0 cm and 6 of 13 axillary nodes were positive at the time of her surgery. Hormone receptor testing, both estrogen and progesterone receptors, were negative, thus putting her at high risk for recurrence. Her oncologist recommended 6 months of chemotherapy (Cytosan, Adriamycin, and 5-fluorouracil) because of the increased risk for metastatic disease. Mrs. Jones was reluctant to accept this recommendation, but did undergo the chemotherapy. Over the next two years, repeated evaluations showed no recurrent disease. She missed her appointment last year for follow-up testing.

Questions for Discussion

1. What additional problems can you identify at this time? How will this affect your treatment recommendations?
2. What are the family dynamics occurring in Mrs. Jones' family?
3. What other psychosocial issues are present for her?
4. With the new information from her medical history, what will you recommend now?

Part III

You recommend a bone scan, chest x-ray, and CT of the abdomen to rule-out metastatic disease. Results of the bone scan were positive with several 'hot spots' in her thoracic and lumbar spine. The hottest lesion was in the L₃ vertebrae. CT scan of the abdomen and chest x-ray were negative, with no liver metastases noted. Mrs. Jones was very angry when informed of her diagnosis. After some counseling, she did admit that she was fearful that this pain was a recurrence of her cancer all along. She was comforted when her surgeon found the herniated disk. In fact, she had avoided seeing her oncologist for that reason.

Mrs. Jones was told that there were three options for therapy: external beam radiation

to the affected areas, chemotherapy with Taxol (Paclitaxel) or Taxotere (Docetaxel), and/or narcotics for pain. With further explanation, she accepted the oncologist's prescription of a combination of the three regimens. One area of her back was particularly painful and 3000 rads of external beam radiation was directed to this area. She was started on Taxol (175 mg/m²) administered over three hours and repeated every three weeks. While in the hospital, she was placed on a PCA (Patient Controlled Analgesia) morphine infusion to control her pain. After three days, she was switched to a controlled-release oral morphine tablet (MS Contin), using the PCA for breakthrough pain. Once her pain was well regulated, she was provided a prescription of Acetaminophen with codeine to control breakthrough pain.

Questions for Discussion

1. What are the major complications for external beam radiation and chemotherapy?
2. To what do you attribute her anger when given bad news?
3. What are the common systemic side-effects of chronic narcotic use?

Suggested Responses to Questions

Part I

1. Additional problems noted on the initial history and physical examination include chronic pain, possible dependence on acetaminophen with codeine, family dysfunction, cigarette smoking, depression, uterine mass, and history of breast cancer. Chronic pain syndrome is defined by pain lasting more than six weeks. Frequently, patients with chronic pain have shopped for multiple doctors, finding none who are able to help their pain. These patients have a constellation of psychosocial problems including depression, repressed anger (i.e., a failure to identify and express anger and to assertively communicate personal needs), and suicidal ideations.

Even though this patient has a clear link between lifting a box at work and her pain, there may be other causes of low back and buttock pain which include: nephrolithiasis with intermittent urethral obstruction, sarcomas or other tumors of the retroperitoneum, renal tumors, uterine or ovarian enlargement (prostatic symptoms in the male), or abnormalities of the spine/pelvis. In this case, the trainees should focus on the fact that this patient has had a radical mastectomy for breast cancer, and that metastatic disease should be near the top of the list.

2. Changes in bowel or bladder function point to progressive compression of the cauda equina. Patients with low back pain, particularly with radicular complaints must be questioned and examined with cauda equina syndrome in mind. This is a surgical emergency. Surgeons evaluating low back pain patients feel that every patient with similar complaints should have a rectal examination, particularly noting rectal tone and presence or absence of a “wink” reflex to light pinprick and a bulbocavernosus reflex. However, primary care physicians may not feel so strongly about this evaluation. Part of the difference in approaches may reflect a difference in perception of the severity of disease.
3. Further information needed from Mrs. Jones includes more history about alcohol and substance use. Sometimes a patient is forthcoming about their prescription drug use, but more frequently a series of telephone calls to other health care professionals who have treated Mrs. Jones will be necessary to estimate the prescription drug use. A more history about depressive symptoms is a necessity. It is almost a truism that patients in chronic pain are depressed, however recent articles suggest that repressed anger and suicidal tendencies are much more frequent in patients with chronic pain than feelings of sadness or anhedonia (especially non-malignant pain).

Because of her long history of pain and stated family problems, extended history concerning her relationship with her husband and family is a must. Having children who are ‘acting out’ is a symptom of failure in family coping mechanisms. Also, because of her complicated history, Mrs. Jones needs a complete evaluation for metastatic breast cancer. Results of a bone scan and CT scan of the abdomen would be important. It is important to note that the absence of hormone receptors in her tumor suggest a high probability of metastasis. The spine is one area of affinity for this type of tumor.

4. Chronic pain syndromes are multifaceted and require a multidisciplinary approach to treatment. Commonly psychologists/psychiatrists, physiatrists, physical and occupational therapists, and anesthesiologists function together in a pain clinic to evaluate patients like Mrs. Jones. In this case, Mrs. Jones also needs the expertise of her oncologist. Therefore, a complete and thorough evaluation psychologically and medically is what is necessary for Mrs. Jones.
5. Yes, Mrs. Jones has “real” pain. Chronic pain patients are adamant about their pain, and they frequently feel that physicians do not hear their complaints or write off the complaints as being “in their head.” Regardless of whether a physician feels that a patient is malingering, pain complaints are real to the patient. Mrs. Jones is likely to have a true chronic pain syndrome because of her history.

Another area of contention in this case is her Workman’s Compensation litigation. Only then will the physician and patient be able to agree on common goals. While

the patient and their attorney are battling a workmen's compensation agreement, the patient has little incentive to improve.

There may be a psychological component of pain in Mrs. Jones' case, but true malingering is rare and unlikely here. In the case of metastatic pain, bone destruction and the expanding tumor mass can be a source of pain. It is possible that the tumor mass could be impinging on the spinal cord, although this is less likely.

6. Mrs. Jones may have a drug problem with the use of Tylenol #3 on a regular basis, however we are not given enough information to suppose that this is likely. The physician needs to know whether her use of the medication is stable or increasing. Increasing use of pain medication, in order to maintain pain relief, may be a sign of tolerance to the narcotic and certainly suggests a drug addiction. However, if Mrs. Jones' history is accurate (and we have no reason to believe it is not accurate), her use of narcotics is relatively mild and probably can be successfully approached with tapering if other effective treatment modalities are found.
7. Mrs. Jones may need treatment in a chronic pain program, but it will take time to establish her trust in you. Even if Mrs. Jones is found to have metastatic cancer, her pain may be managed in a multidisciplinary manner. Physicians need to break down the stereotype that referral to psychologists/psychiatrists means that you don't believe the patient's complaints and feel that the pain is all in her head. You need to evaluate Mrs. Jones thoroughly. Continuing Tylenol #3 for a limited period while evaluating pain is appropriate unless you have some reason to believe she is just drug seeking. A few telephone calls will confirm or deny this fact (to other caregivers and local pharmacies).

Part II

1. Mrs. Jones is clearly depressed: major depressive symptoms are identified. She has at least five of the nine hallmark signs of depression defined in the DSM IV. At least five of the following symptoms are present during the same period. At least (1) depressed mood or (2) loss of interest or pleasure must be present. Symptoms are present most of the day, nearly daily for at least 2 weeks.
 - a. Depressed mood (sometimes irritability in children and adolescents) most of the day, nearly every day.
 - b. Markedly diminished interest or pleasure in almost all activities most of the day, nearly every day (as indicated either by subjective account or observation by others of apathy most of the time).
 - c. Significant weight loss/gain.
 - d. Insomnia/hypersomnia.
 - e. Psychomotor agitation/retardation.

- f. Fatigue (loss of energy).
- g. Feelings of worthlessness (guilt).
- h. Impaired concentration (indecisiveness).
- i. Recurrent thoughts of death or suicide.

She also has a component of sexual dysfunction, which appears to be related to body position during intercourse as well as her depressed mood.

Her family situation is deteriorating, so family dysfunction is a major problem to identify and treat. Treatment recommendations will not be affected, but the priority for each of the problems may be changed. For example, if the patient is suicidal, immediate inpatient treatment is required.

Given the positive axillary lymph nodes, and the lack of hormonal receptors in the breast cancer, it is possible that Mrs. Jones' back pain has a component due to metastatic disease. Evaluation of this possibility is best undertaken with a bone scan. Any lytic bone lesions will show up as 'hot spots' or areas of increased uptake of the radiopharmaceutical. Because the liver and lung can also be involved, a CT scan of the abdomen and chest x-ray are indicated. Routine lumbar spine X-rays and CT scan of the spine may miss metastatic lesions unless they are advanced.

2. Evidence of family dysfunction includes poor parental communications problems between the Mr. and Mrs. Jones, sexual difficulties, and poor communication between the parents and children. Risky behavior, such as that demonstrated by the son, is a classic cry for help among adolescents in dysfunctional families. Mrs. Jones' physical difficulties are contributing to family dysfunction as well as poor communication. Typically the child's problem is related to the parental problem. Depressed parents are often less available to their children and less able to engage in adequate care and limit setting.
3. Depression and ongoing litigation are other issues needing to be resolved before the patient can realistically expect improvement in her pain scale ratings. It seems that Mrs. Jones is still in a state of denial regarding her breast cancer, and she will need to address that health issue.
4. First, Mrs. Jones needs to be evaluated for metastatic cancer pain. We suggest that a bone scan, chest x-ray, and CT scan of the liver will be the best indicators of metastatic spread for this tumor type. If no metastasis is found, then our goal is to move her towards a chronic pain program and multidisciplinary treatment plan. Such programs are individualized, are available on an outpatient or inpatient basis, and can include the following components: medication management for pain and depression, including weaning from excessive medication use; cognitive-behavioral therapies to treat depression and increase coping strategies; relaxation training or biofeedback to decrease pain and anxiety; assertiveness training to improve communication skills; physical/occupational therapies; exercise regimens and

behavioral contracting to increase activity level; group psychotherapy with other persons experiencing chronic pain; couples or family psychotherapy.

Smoking cessation assistance should be aggressively pursued. Nicotine has been demonstrated to worsen patients' perception of pain.

Part III

1. External beam radiation and chemotherapy have a bone marrow suppressant effect. This is the major complication from such treatment. In the case of external beam radiation, the bone marrow is destroyed in the path of radiation. Chemotherapy temporarily suppresses the marrow, hence particular attention to bone marrow function will be important.
2. It appears that Mrs. Jones has never come to a level of acceptance with her chronic illness. She undoubtedly has repressed anger at her body for betraying her in middle age. Some of her anger may be due to psychological difficulty due to disfiguring surgery, but, more likely, she recognizes that this disease will ultimately claim her life.
3. Follow-up will be necessary to assess the effects of radiation and chemotherapy, both on tumor progression as well as side effects of the treatment themselves. Mrs. Jones is now taking long-acting narcotics continuously, hence need to deal with side effects from these drugs. There are four systemic effects commonly seen in long-term narcotic use:
 - a. Constipation. Routine use of stool softener is recommended.
 - b. Emesis. Some patients will need to given anti-nausea medication, or change the type of narcotic they are receiving to one they can tolerate.
 - c. Urinary Symptoms. This is more common in older men, but decreased urinary stream can occur at higher narcotic doses, secondary to mu-receptors in the urinary bladder muscle.
 - d. Tolerance. Although many physicians are concerned about tolerance and addictive behavior in patients taking long-term narcotics, this has rarely been demonstrated.

Finally, Mrs. Jones has several other problems of a psychosocial nature. Her depression may need pharmacologic treatment, counseling for family dysfunction, and she will need to monitor pain levels for adjustments in drug therapy.

CASE 2: Impaired Physician: Dr. Smith

Part I

The Problem

You are a physician in Family Practice in a town of approximately 20,000 that has a local hospital. You see a 30-year-old Mrs. Ryan who complains of intermittent abdominal pain, abdominal bloating and irregular periods for the past 6 months. You learn that she has been seeing Dr. Smith for the past 4 months on a monthly basis. She last saw him a week ago. He has been treating her for "fluid" with diuretics and estrogen, but without improvement. She has come to you because she is dissatisfied with Dr. Smith's care and wants another opinion.

Mrs. Ryan was previously well with no major health problems. She is married with two children, 7-year-old twins. She works full-time as a school secretary and has missed a lot of work because the pain. Her husband is a store manager.

Upon examination, you find a large firm pelvic mass with an irregular border. It is moderately tender. What are your initial hypotheses about this case?

Part II

After your examination, you order a diagnostic work up for the following week that includes blood work, a CT scan and a laparotomy. The results indicate that Mrs. Ryan has a large ovarian cancer. She has surgery to remove as much of the cancerous tissue as possible and is now undergoing chemotherapy.

You recall that in the last month you have seen five patients of Dr. Smith who have come to you because they were dissatisfied with his care or because he is frequently out of the office. You also recall that Dr. Smith has missed 3 or 4 monthly medical staff meetings at the hospital over the past years. You remember seeing him fairly intoxicated at a party about a month ago.

- What else do you want to know about this situation?
- What will you tell Mrs. Ryan?

Learning Objectives

1. Knowledge of licensing;
2. Types of state programs that address impairment;
3. Malpractice issues;
4. Handling impaired physicians;
 - What can you do about an impaired physician?
5. Liability issues.

CASE 3: Health Care System: Robert Allen

The Problem

You are an internist in private practice. Robert Allen, a 32-year-old man, comes to you for a physical examination required for a job in the maintenance department of the University.

Vital signs recorded by the nurse are: blood pressure, 200/110; pulse, 80; respiratory rate, 14; weight, 195 pounds; and height, 5'9". During your examination, you obtain additional blood pressures of 190/105 and 192/108 in his right arm and 186/110 in his left arm. His examination is otherwise normal except for a fourth heart sound.

Develop a comprehensive management plan for this patient

- What else do you want to know?
- What actions would you consider at this point?

Learning Resource: Simulated Participant Instructions - Robert Allen

You are a 32-year-old man who has consulted a family physician for an employment physical examination. You were laid off from a construction job 3 months previously and have not worked since then. You have applied for a job as a custodian at the University and the physical exam is required. You consider yourself healthy and you do not like to go to physicians. You were last seen by a physician 6 months ago when you sprained an ankle and were evaluated in the emergency room. At that time you were told that your blood pressure was high and that you should consult a primary care physician. You did not do this. Two years ago when you were seen in a convenience clinic for bronchitis you were also told that you had high blood pressure. However, because you have felt healthy and do not have headaches, dizziness, or visual problems, you do not consider the high blood pressure serious. You are also concerned about the expense of medical care, since your family does not have medical insurance. The only source of family income at the present time is your wife's work as a beautician.

You've been married 8 years and have a 6-year-old daughter and a 4-year-old son. Your father is 55-years-old, has had several strokes, is disabled, receives Medicaid and is currently living in a nursing home. Your mother is 53-years-old, has diabetes, high blood pressure, and heart trouble, she lives with you and your family, takes a lot of medication, and sees physicians frequently. She also receives Medicaid.

Your lack of work has created some stress at home. Your wife has been telling you that you must find a job. You are excited about working for the University.

You have two older brothers both of whom have high blood pressure and have been treated with medication. One brother mentioned several years ago that medication he took for his high blood pressure interfered with his sexual function. You also have a younger sister who is healthy.

You have gained 20 pounds in 5 years. You like pork and beef and salt your food.

You played softball once or twice a week during the summer until you sprained your ankle in a game. Since then you have been relatively inactive.

You have smoked one pack of cigarettes per day for 18 years. You have heard smoking is harmful and have thought about quitting but have not yet tried. Your wife also smokes.

You generally drink one or two six-packs of beer on the weekend and have two or three beers a day during the week. On occasion you drink heavily for a day or two and have been criticized by your wife for this. When you were laid off from work 3 months ago, you went on a three-day binge. Ten years ago, you were arrested for DWI.

You do not chew tobacco or use any illegal substances.

You are a high school graduate. You were in the army for two years after high school. You have held a variety of jobs over the last 10 years.

You are ambivalent about receiving medical care for your high blood pressure. You see your father who is now disabled from high blood pressure but you are concerned about expense and side effects. You also feel good physically.

Your role as a simulated participant is to provide information to the interviewer(s). You should respond to questions using the information above. You should not volunteer information. If you are not specifically asked about certain topics such as alcohol use, exercise, or diet, you should not volunteer this information. You will probably need to improvise at certain times during the interview. Use your own judgment about information you provide when you improvise.

Learning Objectives:

1. Financing outpatient care
2. Effects of lack of insurance
3. Psychosocial and life-style issues and hypertension
4. Family and other social resources
5. Nonpharmacologic treatment of hypertension
6. Making decisions about work-up and treatment when money is tight

CHAPTER 2 PATIENT PRESENTATIONS

A lecture/discussion of behavioral science material is most effective combined with real-life examples of clinical relevance. The most common format is didactic presentation of key biologic-psychologic interactions illustrated with brief case descriptions, which is then combined with a clinical demonstration (e.g., a patient interview/interaction with the class). While some prefer a format in which the instructor questions the patient about his/her condition, others prefer to let the patient present in his/her own words, followed by questions from the audience. The latter format lets trainees test hypotheses about behavioral and biological relationships in the etiology and treatment of disease. Patients enjoy the chance to be “teachers” and trainees invariably appreciate their efforts.

 **KEY TECHNIQUE**

Adding the Spice of Real Life

[Example: Learning, Cognition and Stress: Posttraumatic Stress Disorder](#)

Part 1: A lecture/discussion on Learning, Cognition and the Human Stress Response presents behavioral science research findings on the principles and neuroendocrine mechanisms of learning and cognition, their contribution to adaptation, survival and evolutionary selection, and their role in mediation of the human stress response. Case examples (e.g., somatization, anxiety, mood disorders) also describe treatments based on relevant behavioral science research (e.g. cognitive behavioral therapy).

Part 2: Following the didactic presentation, the patient is introduced and invited to describe the events leading to referral for care to the academic medical center (e.g., a head-on crash in which the patient was the driver of a truck and the driver of the car was killed). The trainees then ask questions that enable them to define the nature of the patient’s problem (e.g., posttraumatic stress disorder), predisposing factors, stressor conditions precipitating the problem, and the biobehavioral mechanisms mediating the etiology. The patient is then thanked by the instructor and receives enthusiastic applause from the appreciative audience.

Part 3: After the patient leaves, the instructor queries the trainees about what they have learned and, given this information, what treatment approach seems most logical. Despite the trainees’ limited clinical knowledge and experience, given the didactic preparation, they are able to apply their knowledge and explore its clinical and treatment implications via their interaction with the patient. The experience is especially affirming for the patient and trainees alike and demonstrates not only the interdependence of behavioral and biological science but also the clinical applicability of behavioral concepts of the “physician-patient interaction”.

CHAPTER 3 STANDARDIZED PATIENTS

Standardized patients (or participants, SPs) simulate a clinical encounter allowing trainees to safely hone their skills. Unlike role-playing, SP encounters use a trained “patient” who has been carefully prepared to observe and “feel” responses given by the trainee. Typically, SPs play the same role in the same scenario multiple times. Thus, feedback is more sophisticated and based on experience, giving a frame of reference for a given trainee’s level of performance. Depending on the context, SPs can provide both formative and summative evaluations. **Note: Rating Scales/Issues for Evaluation for the Instructor and the SP are attached at the end of each case.**

 **KEY TECHNIQUE**

Simulated Real Life

CASE 4: Delivering Bad News: Carol/Carl Adams

Instructions to SP: You are 43 years old and receiving news of a pancreatic biopsy done following a recent episode of pancreatitis. You had been well until this illness and are concerned about cancer, which you fear. Your mother died of breast cancer. You are married and have 3 children ranging from 5 to 12 years old. You are a private person and rarely share your feelings with people; however, you have high regard for physicians. You recently achieved tenure at the University where your spouse also has tenure in a different field. You are fatalistic and petrified about having a life-threatening illness. You are worried about how your family would fare if you died. You may react with a variety of emotional responses (e.g., anger, anxiety) in different interviews.

Instructions to Interviewer: You are seeing Carol/Carl Adams, who presented with pancreatitis and was found to have a large abdominal mass. CT-guided needle biopsy 2 days ago showed pancreatic carcinoma. The 1-year mortality rate for inoperable pancreatic cancer is 90%. Percutaneous or endoscopic placement of a stent may prevent biliary obstruction. Similarly, a bypass procedure may prevent biliary or upper intestinal obstruction. Radiation and chemotherapy are possible but not very effective.

You are to inform the patient that:

1. The biopsy result is positive for cancer; and
2. Based on its appearance on the CT scan, it is inoperable for cure although a palliative procedure is a possibility. You should sensitively communicate needed information at a level appropriate to the patient. You should also provide verbal and nonverbal support and respond appropriately to the patient's emotional reactions.

Standardized Patient Experience: Faculty Member Rating of Trainee Interviewer

Done	Not Done			The Trainee:
<input type="checkbox"/>	<input type="checkbox"/>			1. Disclosed the diagnosis of pancreatic cancer.
<input type="checkbox"/>	<input type="checkbox"/>			2. Indicated that the tumor was likely inoperable.
<input type="checkbox"/>	<input type="checkbox"/>			3. Discussed the possibility of palliation.
<input type="checkbox"/>	<input type="checkbox"/>			4. Indicated he/she would talk with the patient at a specific time in the future.
Always	Sometimes	Never		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	5.	Paused or in other ways provided time for the patient to respond to information.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	6.	Asked about underlying feelings when confronted with hostile, challenging, or unbelieving responses.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	7.	Demonstrated active listening (repeating information back to the patient) or other techniques providing verbal support (e.g., empathic comments, such as "I'm sure this feels overwhelming").
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	8.	Demonstrated non-verbal support, such as affirmative head nodding, eye contact, open posture.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	9.	Avoided being specific about "how much time."
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	10.	Used touch and physical distance to improve rapport.

Additional comments:

Standardized Patient Rating of Trainee Interviewer

Always	Sometimes	Never		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	1.	Explained my situation in language I could understand.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	2.	Allowed time for me to respond.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	3.	Answered my questions satisfactorily.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	4.	Said things that comforted me.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	5.	Conveyed concern by "body language."
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	6.	Used touch in a comforting manner.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	7.	Used decreased physical space to improve rapport.

Additional comments:

CASE 5: Substance Abuse and Stages of Change: Jane/John Becker

Overview: Obtaining Information and Intervening in Substance Abuse

Stages of Change

The stages of change model emphasizes that changing addictive behaviors is a process rather than a single step. Prochaska and DiClemente (*American Psychologist*, 1992) lists five stages of change through which individuals may repeatedly pass in either direction. Although they were writing about addictive behavior, these steps are a good way to think about any behavior change. The five stages are:

Pre-contemplation – Individual has no intention to change behavior in the foreseeable future. Many in this stage are unaware or under-aware of their problems.

Contemplation – Individual is aware that a problem exists and is seriously thinking about overcoming it, but has not yet made a commitment to take action.

Preparation - Individual is intending to take action in the next month and has unsuccessfully taken action in the past year.

Action - Individual modifies personal behavior, experiences, or environment in order to overcome the problem.

Maintenance – Individual is working to prevent relapse and consolidate the gains made during the action stage.

Studies have shown that, on average, a reduction (at 12-months) of 5 to 7 drinks per week can be accomplished by brief interventions by physicians with problem drinkers. In this exercise, you are to assess the patient's drinking problems and intervene appropriately in a simulated 10-minute clinical encounter.

The Encounter

Instructions to SP: You will play the role of Jane/John Becker. You have stomach discomfort and high blood pressure. These symptoms are associated with excessive alcohol use, but you are unaware of the connection. Furthermore, the results of recent blood tests are also compatible with excessive alcohol use. These are the clues the interviewer should be picking up on to pursue the possibility of an alcohol problem. You have no family history of alcohol problems or of high blood pressure.

There are two variants to this role, the "contemplator" and the "pre-contemplator." The contemplator is thinking about alcohol being a problem and ready to discuss it with the physician. If the interaction is handled appropriately, the contemplator may be helped into taking action to deal with the problem drinking. The pre-contemplator has not seriously considered the possibility that drinking is a problem and is likely hostile to the idea. The remainder of these instructions will be separate for the two variants.

Contemplator: If the trainee asks questions about the quantity and frequency of your drinking, note that you have drunk alcohol for many years, usually one or two drinks a day. If asked about "usual" alcohol consumption, begin with "one or two drinks a day." With any further probing, bring out information about recent changes in that pattern. With all your job and family worries, you've been drinking more, three (if female) or four (if male) drinks most evenings, six (if female) to eight (if male) on weekend days. You've missed four or five days of work in the past two months because of hangovers. Your spouse is nagging you about your drinking, and you've begun wondering if drinking is becoming a problem. You are ready to discuss it with your physician.

If the trainee asks the **CAGE** questions, answer as follows:

- C** = "Have you ever thought you ought to **C**ut down on your drinking?" Maybe. It seems that it might be part of the problem now.
- A** = "Do you ever get **A**nnoyed when someone asks about your drinking?" Well, yes, a bit, when my spouse nags me.
- G** = "Do you ever feel **G**uilty about your drinking? No. You don't think it's a sin, do you?"
- E** = "Do you ever need a drink in the morning (an **E**ye opener) to get going? No. I never drink until after work. Only alcoholics drink in the morning, and I'm not an alcoholic.

If the trainee brings up the adverse consequences of your drinking, be open to discussing alcohol. For instance, the trainee may point out your blood pressure and stomach symptoms, and ask, "What connection do you think there might be between these problems and your use of alcohol?" Your response would be something like, "I've been wondering if there might be a connection there." The trainee may also bring up

changes in your red blood cells and liver function studies, done as part of your last routine physical exam, that are associated with alcohol abuse.

Pre-Contemplator: The basic facts are all the same as for the contemplator, but the reactions are different. As with the contemplator, if the trainee asks questions about the quantity and frequency of your drinking, note that you have drunk alcohol for many years, usually one or two drinks a day. If asked about "usual" alcohol consumption, begin with "one or two drinks a day." With either of these initial approaches, you may want to add something dismissive, such as, "Doesn't everybody?" With further probing, bring out information about recent changes in that pattern. However, the pre-contemplator should get at least somewhat hostile or defensive with continued inquiry into drinking behavior and associated issues. You've been drinking more, three (if female) or four (if male) drinks most evenings, six (if female) to eight (if male) on weekend days. You've missed four or five days of work in the past two months because of hangovers. Your spouse is nagging you about your drinking. You will not willingly link this drinking behavior to your current family and job stresses, but that will be exactly what the trainee will be trying to get you to do.

If the trainee asks the **CAGE** questions, answer as follows:

C = "Have you ever thought you ought to **C**ut down on your drinking?" No. Why should I?

A = "Do you ever get **A**nnoyed when someone asks about your drinking?" I certainly do. It's none of my husband's or anyone else's business what I drink.

G = "Do you ever feel **G**uilty about your drinking? No. You don't think it's a sin, do you?"

E = "Do you ever need a drink in the morning (an **E**ye opener) to get going? No. I never drink until after work. Only alcoholics drink in the morning, and I'm not an alcoholic.

If the trainee brings up the adverse consequences of your drinking, initially say that doesn't apply to you. For instance, the physician may point out your blood pressure and stomach symptoms or your abnormal laboratory findings, and ask, "What connection do you think there might be between these problems and your alcohol use?" Your response would be something like, "I don't think there's any connection."

Despite all of this, if the trainee is skillful, you as a pre-contemplator may move towards being a contemplator. If the physician forcefully makes the connection between alcohol and your symptoms in an empathic way, you should be prepared to think about alcohol as a potential problem. Furthermore, if a good connection is made and the trainee suggests considering if alcohol is a problem as part of an overall plan, the patient should agree to this. In no case, however, would the pre-contemplator be ready to commit to actually change drinking behavior at this visit.

Instructions to Interviewer: Jane/John Becker has been seen at the office twice before. Progress notes record the following information from the two previous visits:

History at Previous Visits: Chief complaints have been insomnia, headaches, no energy, and epigastric discomfort.

Married, but increasingly distant relationship with spouse, many arguments. Two children. Job is in middle management, with little job security or potential for advancement. Employer not satisfied with job performance as of last formal evaluation.

Physical Exam at Previous Visits: The exams were normal except for mildly elevated blood pressure (145/90 and 145/92) and mild epigastric tenderness on palpation.

Labs at Second Visit: CBC normal except for an MCV of 98 (mildly elevated for your lab). Chemistry panel normal except for cholesterol 214; triglycerides, 278; AST (SGOT), 62 (normal, <45; GGTP (gamma glutamyl transpeptidase), 95 (normal, < 65).

At the last visit, you diagnosed:

1. Possible hypertension
Plan: Will watch, recheck in two weeks.
2. Dyspepsia
Plan: Cimetidine 300 mg q.i.d. (before meals and at bedtime)

For today's visit, your medical assistant has recorded a BP of 152/98. Chief complaint today is "Stomach no better. Still sleeping poorly." You are to assess the patient's problems further and intervene appropriately in a 10-minute encounter.

Evaluation Checklist: Faculty Rating of Trainee Interviewer

Note that when SPs play the role of pre-contemplators rather than contemplators, it will be impossible to achieve the highest level ranking on some items, such as item 2. This should not be interpreted as inadequate performance.

The trainee:

1. Inquired about drinking history, pursuing enough to identify the current problem drinking.
 - Identified current increased use
 - Asked about alcohol, but did not identify current use
 - Never asked about alcohol use
2. Helped the patient link alcohol use and his/her symptoms (e.g., pointed out some of the alcohol-related problems and asked a question such as "What connection do you think there might be between these problems and your use of alcohol?")
 - Led patient to the make the connection
 - Made the connection for the patient, but convincingly
 - Connection not made convincingly or made coercively (provoking defensive reaction)
3. Indicated that dealing with the alcohol problem was the patient's responsibility.
 - Patient responsibility clearly indicated
 - Equivocal indication of patient responsibility
 - Patient responsibility clearly not indicated
4. Affirmed the patient's ability to deal with the alcohol problem.
 - Indicated that the patient has the ability to deal with the problem
 - Equivocal indication that patient has the ability to deal with the problem
 - No indication by trainee that patient has ability to deal with the problem
5. Gave specific advice either to reduce or to stop alcohol use.
 - Advice to reduce or stop alcohol use was given
 - No advice to reduce or stop alcohol use was given
6. Provided alternatives for the patient to consider in dealing with his/her problem, such as thinking about the role alcohol might be playing in his/her problems, going to AA meetings, seeing a counselor, coming back for a follow-up visit with the physician to discuss further, etc.
 - At least two alternatives were provided for the patient to consider as a next step
 - One approach was provided for the patient to consider as a next step
 - No specific next step was provided

7. Used verbal and non-verbal communication skills to facilitate the interaction.
 - Always or almost always
 - At times
 - Rarely or never

8. Used verbal and non-verbal skills to convey an empathic approach to the patient and his/her problems.
 - Always or almost always
 - At times
 - Rarely or never

Comments:

Evaluation Checklist: Simulated Patient Rating of Trainee Interviewer

The trainee:

1. Established an open, empathic atmosphere in discussing alcohol issues with me.
 - Always or almost always
 - At times
 - Rarely or never

2. Connected current alcohol use and current problems
 - in a convincing way, leading me to draw that conclusion myself
 - in a convincing way, but making the connection for me
 - less convincingly
 - only by using some coercion or by making me get defensive.

3. Presented management options that realistically fit with the patient I portrayed
 - Options fit well
 - Options were presented but the fit was only fair
 - Options were not presented or the fit was very poor

4. Gave specific advice in a convincing way that was also empathetic.
 - Advice was convincing, specific, and empathetic
 - Advice was given but was not convincing or empathetic
 - Advice was not given or was not convincing or not empathetic

5. Used good verbal and non-verbal communication skills to facilitate the interaction
 - Always or almost always
 - At times
 - Rarely or never

Comments:

CASE 6: Simulated Family: Levonja & James Dixon

Simulated families can help trainees work effectively with various family members as a group. The following is a simulated family scenario with evaluation questions developed by Epstein and Seaburn (*Annals of Behavioral Science and Medical Education*, 1995, Vol. 2 No. 2, 75-82, available through the ABSAME website):

The Problem:

Levonja and James Dixon are a couple in their late twenties who have been struggling with infertility for the past 3 years. They have been through many tests, and now try to avoid talking about the issue, as it is a source of pain and disagreement. They have come in for a routine visit. When the physician inquires about the presenting complaint, the couple begins to bicker about household duties, such as who should do grocery shopping, who gets home too late from work, etc. When the physician probes further, it is apparent that they both suffer from headaches and Levonja also has insomnia. The couple rarely agrees on anything, and each vies for the physician's attention.

Evaluation of Family Interviewing Skills:

Questions for Discussion

Does the interviewer

1. greet and speak with each family member within the first 5 minutes?
2. adapt his/her behavior to the style and affect of the family?
3. act respectfully?
4. acknowledge the family hierarchy?
5. avoid taking sides?
6. obtain the view of the problem from all those present?
7. give appropriate attention to each person's point of view?
8. inquire about family members who are significant, but not present?
9. elicit enough information to evaluate the organization and structure of the family?
10. identify positive qualities of the family and individual strengths?
11. assess cultural, social, and religious affiliations?
12. summarize his/her evaluation of the problem to the family?
13. negotiate a management plan that takes into account family members' perspectives?

CHAPTER 4 SCENARIOS

Brief vignettes or scenarios are faster-paced than patient cases. They can be constructed differently to make the teaching point more explicit. Below are several examples of ways to present the dilemma or point of greatest interest.

Typically, only one or two teaching points are included in a single exercise. Trainees should debate the merits and pitfalls of each course of action before coming to a conclusion about what to do. Encourage them to develop other actions that blend the best of several solutions.

 **KEY TECHNIQUE**

Filling in a Medical Sketch

Two Scenarios on Professionalism

Scenario 1

You are a 38-year-old physician seeing a 40-year-old patient to whom you have been providing care for the past 8 months. The patient was recently hospitalized for community-acquired pneumonia. The hospitalization was uneventful and the patient is well at today's visit.

At the end of the visit the patient reaches into a pocket and removes a small gift-wrapped box. Leaving the room, the patient places it on your desk and states, "I want you to know how much I appreciate your excellent care and concern." You later open the box and find a \$200.00 Mont Blanc pen.

What would be your initial response to this gift?

1. Write a note or call the patient to express thanks for the gift.
2. Write to or call the patient and explain that you cannot accept the gift.
3. Return the gift to the store and give the money to a local charity.
4. Do nothing presently, but be certain to use the pen at the patient's next visit.

Issues to consider:

- Monetary value of gift
- The context of the gift: implications/hidden agenda/expectations
- The patient's cultural background

Scenario 2

You are a single, resident on an elective rotation at a private practice. You have been providing care to a 27-year-old patient with a minor wound infection following an appendectomy. You are mutually attracted to the patient.

On the day of discharge, you stop by to ensure that the patient has all of the appropriate medications and instructions. When you enter the patient's room to say goodbye, the patient asks you out to dinner for sometime the following week. Your elective ends in two weeks and you know that you will not be returning.

What would be your initial response?

1. Decline the invitation, but suggest that you could have lunch together in the hospital cafeteria next week.
2. Accept the dinner invitation, give the patient your pager number, and ask the patient to contact you to arrange details.
3. Graciously decline the invitation and explain that the code of professional ethics forbids you to socialize with a patient.
4. Diffuse the invitation saying that you aren't available next week, but maybe you could have dinner in the future.

ACP Guidelines:

For current patients:

"It is unethical for a physician to become sexually involved with a current patient even if the patient initiates or consents to the contact."

For former patients:

- Dependency, trust, transference and the inequality of power increase vulnerability
- The impact of the doctor-patient relationship may be viewed differently by the two parties (and both may underestimate the influence)
- It is unethical for the physician to use or exploit the trust, knowledge, emotions, or influence derived from the previous professional relationship

Issues to Consider:

- Recognition of sexual feelings toward a patient
- Stimulate a review of personal unmet physical and emotional needs
- If patient appears to be too aggressive, see patient with a chaperone

Four Vignettes on Rules of Conduct

Instructions: In each case, identify as many responses as possible, and then consider the justification or rationale for each. Rate each one as: (1) poor (too weak or too strong a response to the situation); (2) acceptable but less than ideal (legally acceptable, but ethically timid); (3) preferable (more than what is required by law, meeting all of your professional standards); or (4) supererogatory (above and beyond the call of duty, heroic). Another way of thinking about the rating scale is the “low” road, the “safe” road, the “high” road, and the “heavenly” road.

1. A long-time patient of yours comes to the emergency room asking to see you. He lives in a remote area in substandard living conditions and with inadequate nutrition, but has long valued his independence. He has no family, no neighbors, and as a loner, avoids establishing friendships.

His complaint is that he is cold. He is out of wood, cannot keep warm at night, and fears he will freeze to death. He asks for your help.

On examination, as always, he is unkempt, has poor personal hygiene, smells of tobacco and alcohol, and has one single area of frostbite on his left great toe. He is not intoxicated. His temperature is 98.40 F, BP 146/88, HR 74. He has a right carotid bruit and a gr. II/VI apical pansystolic murmur, both of which you have documented in the past. He has never had, and does not now have, any symptoms referable to these findings. The remainder of his examination is normal.

2. You have practiced internal medicine in an urban community throughout your career. The community has deteriorated economically and your professional income barely covers your office costs and premiums for malpractice insurance. You will be 62-years-old in several months and, financially, can retire comfortably. It is unlikely that another physician can be recruited to the community.
3. You are the principal investigator of a large, federally funded clinical trial in cardiology. You oversee a staff of research assistants, all recent college graduates, who manage the patient visits, medication and the data collected. Extensive data are collected daily from the clinic patients, creating an intense but exciting environment. You ask a newly hired research assistant to develop a database by the end of the day so that you can analyze data regarding the patients' cholesterol levels for a paper you've been working on. You perform the analyses and find a result supporting your hypothesis. Subsequently, the paper is accepted for publication.

Six months later, just before the paper is to appear, a colleague notices a discrepancy between a datapoint from the research assistant's database and the

original raw data. Investigating, you find that about 15% of the numbers are incorrect. You confront the research assistant who reports feeling pressured to get the project done and thought that making up a few numbers in a large database wouldn't affect the results. You correct the data error, re-do the statistical analysis, and find that the results still support the hypothesis, but no longer significantly.

4. An investigator for the state department of health calls you about your patient with a slowly progressive untreatable cancer. You have been providing him with supportive care that includes pain control with narcotic analgesics. The investigator informs you that the patient has received narcotic analgesics from other physicians, an action that the patient has never mentioned to you. You know that about 10 years ago, the patient was imprisoned for 5 years for theft.

A Scenario on Medical Costs

The Problem:

You are medical consultants to a not for-profit dialysis clinic that provides chronic dialysis to 170 patients. The number of new patients requiring dialysis over the last year has increased by 20%. Many of these patients have multi-system, high risk, medical problems, greatly increasing the cost and complexity of care. The cost of dialysis treatments is reimbursed by the federal government. However, the government is concerned about rising costs and wants to put a cap on the reimbursement rate for dialysis.

With the government wanting to control the cost of dialysis, you are to consider what you would advise the clinic administrators to do as they face economic constraints.

Learning Issues:

1. Organization and structure of a not for-profit clinic providing specialized treatment.
2. Understanding how the government's only program for funding a catastrophic disease works, including the interface between public and private financial sectors.
3. Description of the problems confronting physicians faced with government regulation.
4. Ethical issues regarding access to care and development of criteria for patient care.
5. Distinction between cost-benefit and cost-efficiency in delivering patient care.

A Scenario on Culture, Death and Dying

The Problem:

A 67-year-old Hispanic woman presents with lung cancer. She was diagnosed 5 years ago, at which time she was told that the cancer was inoperable. She has since visited a number of alternative practitioners and healers, and now presents with a complaint of increasing shortness of breath and hemoptysis. A CT scan reveals that one lung is almost completely filled with tumor and the other lung is approximately 75% filled with tumor. Various specialists in oncology and radiation therapy have agreed her prognosis is extremely poor. The patient tells you she wants “everything done” and does not want to be a “no code.” She is estranged from her husband, who divorced her when her cancer was diagnosed. She has seven children, all of whom have differing opinions regarding her care.

Questions for Discussion

1. How would you approach discussing the issues of death and dying with her and her family?
2. What options would you recommend to her and her children?
3. What issues may come into play regarding her care?

Sample Response:

You should involve as many family members as possible. Because the patient herself is competent, her wishes must prevail over those of her children, although in her culture, the family is the important unit of support and decision-making. Her religious beliefs need to be considered, and perhaps a *curandero* (folk healer) could be called in if the patient desired. Hospice care or a home hospice nurse should be considered. A full and clear description of what procedures would be done in the hospital under what circumstances must be presented to the patient in order for her to make an informed decision about procedures she does and does not want to have performed.

CHAPTER 5 ROLE PLAYING

Role playing is one of the most effective methods for demonstrating skills, developing technique, and receiving feedback. Using triads, one person plays the patient, another plays the physician, and a third acts as the observer. The first two “actors” assume defined roles (e.g., “frustrated physician”, “angry patient”) or play out a defined scenario (e.g., “ask Mrs. Jones for permission to perform an autopsy on her husband who just died”). Learning to give specific, objective feedback is the important skill highlighted for the observer. The following characteristics of **constructive feedback** are adapted from Bergquist and Phillips’ *Handbook of Faculty Development* (1975):

KEY TECHNIQUE

Actors: “Roll with the Role”
Observers: Good feedback is an **ART** –
Action-oriented, Respectful, Timely

1. It is descriptive rather than evaluative. The observer reports what he/she saw or felt, rather than whether the action was good or bad.
2. It is specific rather than general. The observer comments on a specific action (“You made good eye contact”) rather than a global impression (“I thought you established good rapport”). It is also useful to limit feedback to a few areas rather than overwhelming the person being observed with too much information.
3. It is focused on behavior rather than on the person. “I noticed that you did not introduce yourself to the patient’s wife,” rather than “You were rude.” The former gives direction for change; the latter implies a fixed personality trait.
4. It meets the needs of both the receiver and the giver of feedback. Feedback should be given to help, not to hurt. Feedback should never be destructive or used to give the observer a psychological advantage.
5. It is directed toward behavior that the receiver can change. Frustration is only increased when a person is reminded of a shortcoming over which he/she has little or no control.
6. It is solicited rather than imposed. Feedback is most useful when the receiver has formulated a question that the observer can then answer (“What could I have done when the baby began to cry?”)

7. It is well-timed. In general, feedback should be given as soon as possible. However, the setting should be private or in a small group and the receiver should be ready to hear it. If an encounter has not gone well, waiting a few minutes, or even longer, may be appropriate.
8. It is communicated clearly. Having the receiver rephrase feedback helps ensure the message corresponds to what the sender intended. Regardless of good intent, feedback is often threatening and may be distorted or misinterpreted.
9. It represents a shared impression. When feedback is given in the presence of others, both the giver and the receiver have an opportunity to verify its appropriateness through “consensual validation”.
10. It attends to the consequences of the feedback. The person who is giving feedback will greatly improve his/her helping skills by being constantly aware of the effect the feedback is having on the receiver and modifying tone of voice or list of issues accordingly.
11. It is a step toward authenticity. Understanding how to give and receive constructive feedback can lead to a relationship built on trust, honesty, and genuine concern.

The two role plays below are designed to familiarize trainees with the complex interplay of biologic, psychologic, social, cultural, and economic factors that determine health and illness. ***An example of a process and content feedback form follows the case.***

➤ INSTRUCTIONS FOR: THE MEDICAL INTERVIEW

Although much background is provided for the case below, there are many more details or questions that might arise during the course of the role play. Your ability to stay "in role" is critical to the effectiveness of this learning tool. So, you may need to improvise answers. Become familiar with your role, research the disease process, and try to see the encounter through the eyes and perspective of the character you are playing. Keep in mind the setting (context) of the encounter. Also, feel free to embellish your role, although you should not change its nature. Try to be natural and realistic.

The purpose of the following two cases is for the actor playing the physician to elicit information about each of the pertinent medical and socio-emotional issues presented by the patient. The information in the case titles is all that is provided to the “physician”.

CASE 7: New Patient Complaining of Chest pain; Mr. or Mrs. Abbott

Setting:	Office visit with your new family physician whom you are meeting for the first time. You are a little apprehensive about discussing your concerns.
Chief Complaint:	Sudden chest pain, sweating, and shortness of breath.
History of Present Illness:	For 5 years you have had episodes of rapid pounding heart beat, feelings of impending doom, hot flashes, feelings of fear and fear of death. They occurred monthly until 2 weeks ago when you began having them daily. You fear the attacks and avoid situations where attacks have occurred (e.g., since you had an attack while driving, you have avoided that route). You cannot stay in situations where escape isn't easy, (e.g., shopping mall). You now feel of traveling any distance from home and are even "scared in my own house."
Past Medical History:	Mitral Valve Prolapse. Diagnosed 3 years ago.
Hospitalizations:	Brief hospitalization for a fractured leg, resulting from a fall when you were a high school senior.
Immunizations:	Up to date.
Allergies:	Allergic to shellfish.
Medications:	Take only acetaminophen for occasional headaches.
Psychiatric History	Saw a psychotherapist approximately 10 years ago for 1 visit because of "worries." No medications were given.
Health Habits:	Drinking several beers a day over the past 5 years "makes me feel better." Do not use tobacco or recreational or illicit drugs.
Sexual History:	Prefer not to discuss this area, except to say things are going well. You have had a vasectomy if a man or a tubal ligation if a woman.
Social History:	If a man, you are a 44-year-old truck driver and your spouse is 38. If a woman, you are a 38-year-old executive secretary and your spouse is 44. You have one daughter, age 16 who is doing well in high school. Your work takes you out on the road frequently and there are at least 2 nights/week when you are not home. This has led to some conflict between you and your spouse, but there are

	no other acceptable job opportunities. You witnessed the tragic pedestrian death of a very close friend and co-worker 8 years ago and frequently have nightmares about him/her.
Family History:	Father died 10 years ago of lung cancer, he smoked and drank excessively. Mother has hypertension and has never been the same since your father's death. There is an older sister, age 50, who is well, and an older brother, age 48, who is an alcoholic.
REVIEW OF SYSTEMS	
General:	More tired than usual and have frequent colds.
Skin:	Negative
HEENT:	Negative
Cardiovascular:	Aside from chief complaint, have occasional palpitations.
GI:	Abdominal cramps and diarrhea during attacks.
GU:	No history of kidney problems, no history of STDs.
GYN:	If female - uncomplicated pregnancy. Periods regular.
Endocrine:	No problems but you wonder about hyperthyroidism as you mother's sister had that condition.
Musculoskeletal:	Stiffness in muscles and joints occurring more frequently after long distance hauling (or working at your computer).
Psychiatric:	Feel stressed with pressures at work and conflict with spouse over work. Get depressed from time to time especially following attacks, which you fear are due to coronary disease.
DIAGNOSES: Panic attacks; Adult Child of an Alcoholic; also Mitral Valve Prolapse-probably not relevant, although could contribute to palpitations; At-risk drinker who needs further assessment.	

CASE 8: New Patient Who Can't Sleep: Mr. or Mrs. Baker

Setting:	Appointment with your new primary care physician. You only see a doctor when you feel something is wrong.
Chief Complaint:	"I just can't sleep."
History of Present Illness:	You have had increasing sleep problems for the past 3 years. At present, you sleep only 2-3 hours per night. You have trouble falling asleep and staying asleep, and you awaken early in the morning. The problem began when your spouse died suddenly from a stroke. You grieved intensely for 6 months and felt you had come out of it. You also have trouble with attention and concentration, and get little pleasure from hobbies/activities. Your appetite is decreased and you have lost 25 lbs in 2 years. You are nervous and tense most of the time, and feel there is "nothing worth living for."
Past Medical History:	No serious illnesses. You have Type 2 diabetes.
Surgical History:	None.
Accidents or Injuries:	None.
Immunizations:	Receive a flu shot and Pneumovax yearly.
Allergies:	None.
Medications:	Estratest daily (if a woman). Ibuprofen when needed for joint pains.
Health Habits:	Smoke 1 pack of cigarettes per day since you were in your 20's and have 1-2 glasses of wine in the evening.
Sexual History:	No sexual desires.
Exercise:	Used to walk daily but have stopped over the past 6 months because of lack of energy.
Social History:	If a woman, you are 77 years old. You have devoted your life to taking care of your husband and doing volunteer work. Your husband was a University professor and you were married for 42 years before he died 3 years ago. If a man, you are a 77-year-old ex-University professor. Your wife took care of you for 42 years before she died 3 years ago. There are no children from this union, a serious regret. You had a "wonderful" marriage and did everything together.

Family History:	Your father died at age 80 from pneumonia. Your mother committed suicide at age 70. You did not know your grandparents who never immigrated to this country, but you do know that your maternal grandfather was depressed. You are an only child. You have no other family medical information.
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REVIEW OF SYSTEMS

General:	Feeling well until the difficulties above.
Skin:	Hyperpigmented spots on your arms and legs.
HEENT:	You think your hearing is getting less acute. You have small cataracts in both eyes.
Cardiovascular:	No chest pains or shortness of breath, but your fatigue easily with any exercise.
Respiratory:	Early morning nonproductive cough.
GI:	Constipated frequently during the past year.
GU:	No problems.
Endocrine:	Negative Review.
Musculoskeletal:	Stiffness in fingers, elbows and knees especially when weather is damp.
Psychiatric:	No past history.

DIAGNOSIS: Depression; smoker; weight loss-This could be secondary to the depression, but with his/her smoking history and changes in bowel habits, a malignancy should also be evaluated.

Following are examples of evaluation forms that might be used in assessing interviewing skills (note that the criteria for assessment is in the judgment of the observers):

INTERVIEW PROCESS FEEDBACK FORM

Interviewer's Name _____ Date ____/____/____
Observer's Name _____

PROCESS INTERVIEWING SKILLS	Unsatisfactory Performance	Needs Improvement	Good Performance	Not Applicable
1. Introduces self and explains purpose of interview				
2. Establishes rapport with patient				
3. Provides an appropriate level of structure				
4. Allows patient to describe the illness				
5. Uses following techniques effectively:				
a. Clarification				
b. Summation				
c. Open-ended and direct questions				
d. Avoids jargon				
6. Responds in accepting, supportive manner, including empathetic statements				
7. Follows up on cues and vague statements				
8. Makes appropriate transitions				
9. Closes the interview appropriately:				
a. Provides summation				
b. Discusses plan with patient				
c. Ends appropriately				

Level of interview difficulty (uncooperativeness, intrinsic complexity): 1 2 3 4 5 (most difficult)

Comments:

INTERVIEW CONTENT FEEDBACK FORM

Interviewer's Name _____ Date _____
Observer's Name _____

CONTENT INTERVIEWING SKILLS	Unsatisfactory Performance	Needs Improvement	Good Performance	Not Applicable
1. Defines the "Chief Complaint" including major symptoms and chronology				
2. Obtains patient's perspective about illness				
3. Obtains information about past medical history				
4. Obtains information about social history				
5. Completes Review of Systems, emphasizing potential contributors to chief complaint				
a. General				
b. Skin				
c. Hematopoietic				
d. Eyes, Ears, Nose, Throat				
e. Respiratory				
f. Cardiovascular				
g. Gastrointestinal				
h. Genitourinary				
i. Musculoskeletal				
j. Endocrine				
k. Psychologic/Psychiatric				

Level of interview difficulty (uncooperativeness, intrinsic complexity): 1 2 3 4 5 (most difficult)

Comments:

In addition to learning basic interviewing skills, trainees need to have more advanced training in interviewing skills that demonstrate their ability to apply specific behavioral science concepts as outlined in the text. For example, trainees need to be able to practice taking a sexual history, obtaining information about and intervening in cases of domestic violence, and delivering bad news. The following are examples of role-playing cases that could be used to help trainees improve their skills in these important areas:

➤ INSTRUCTIONS FOR: TAKING A SEXUAL HISTORY

This role-playing exercise focuses on taking a sexual history with emphasis on: determining if a patient is sexually active; clarifying sexual orientation; assessing the patient's risks for sexually transmitted diseases; and assessing for risk of pregnancy.

CASE 9: Sexual History: Mr. or Ms. Wilson

Physician Role

Mr. or Ms. Wilson, a 24-year-old patient whom you have not previously met, presents to clinic complaining of burning with urination and vaginal discharge (urethral discharge if male). Clarify risk of STDs, sexual orientation, and risk of pregnancy (if patient is male, clarify risk of pregnancy in a partner).

Patient Role

Note: In your role, refer to your boyfriend or girlfriend as your "partner" so that the physician needs to specifically question you about sexual orientation.

You are 24 years old and have had burning with urination for 1 week. You also have vaginal discharge (urethral discharge if male). You are concerned about sexually transmitted disease. You have had one partner for 4 months, and believe this relationship is monogamous, but are not sure. You have had two other sexual partners in the last year and five sexual partners in your lifetime. If male, you sometimes use condoms. Two years ago, you were treated for epididymitis. If female, you take birth control pills regularly and have not missed any pills. Two years ago, you were treated for chlamydia. You believe your partner is asymptomatic. You tested HIV negative 2 years ago. You are being seen by a doctor whom you have not met before. All the doctor knows is that you are having burning with urination and discharge.

Observer Role

Consider the following in your discussion of the interview.

QUESTIONS FOR DISCUSSION

1. Did the physician clarify the patient's risk for STDs by asking about: Sexual activity? One partner or more than one partner? Monogamy? Duration of relationship? Use of condoms? Previous STDs? Partner with symptoms?
2. Did the physician clarify the patient's or partner's risk of pregnancy by asking about: Use of birth control? Compliance with birth control method?
3. Did the physician clarify the patient's sexual orientation?
4. Was the physician nonjudgmental and respectful? Did he/she make the patient feel comfortable during the interview? What parts of the interview worked well? Which parts of the interview might have been conducted more effectively?

➤ **INSTRUCTIONS FOR: OBTAINING INFORMATION
AND INTERVENING IN DOMESTIC VIOLENCE**

The following role-playing situations are related to domestic violence. Gathering information is only part of the purpose of this exercise; intervention is also a major emphasis. For the purposes of this role play, the trainee should focus primarily on the information needed for the clinical encounter. In ambulatory care for a specific problem, collecting a complete database is often a lower priority than addressing the immediate problem. Additional clinical data can then be collected over a series of visits.

CASE 10: Domestic Violence: Claudette Jones

Physician Role

Setting: Primary Care Clinic

Situation: Mrs. Jones brought her 15-month-old son, Tim, to the clinic for immunizations. The nurse noticed that Mrs. Jones has a black eye. You asked the nurse to watch Tim in the waiting room while you talk privately with Mrs. Jones, whom you've never met before. She has told you that her injury resulted from accidentally walking into a door. You are concerned that she may be a victim of domestic violence.

Intervention Goals:

1. Express your concern for her medical condition and personal safety.
2. Assure her that you and the health providers at the clinic are resources for her.
3. Let her know of other local resources for victims of domestic violence.
4. Encourage her to establish an on-going relationship with your or another health provider to strengthen her support system and facilitate further communications.

Patient Role

Setting: Primary Care Clinic. You have brought your 15-month-old son, Tim, in for immunizations. He is in the waiting room with the nurse.

Situation: You are Claudette Jones, a 25-year-old mother. You have been married to your current husband for 3 years, and the relationship has become progressively more violent. He has struck you with his fist, usually on your face, numerous times during the last 18 months, including while you were pregnant. To date, he has never been violent toward Tim. You are socially isolated and have never sought police help. After this most recent episode of violence, things have "gotten better". You don't want to cause problems at home and want the physician to believe that your injury is accidental. You have been telling people that your black eye is the result of walking into a door.

CASE 11: Domestic Violence: Judy Lake

Physician Role

Setting: Out-patient clinic

Situation: Judy Lake is a 35-year-old woman who recently transferred her care to your practice. She has had chronic pelvic and abdominal pain and multiple other chronic conditions, including headaches, insomnia and intermittent depression. Her primary pain has been extensively evaluated by numerous physicians. You have reviewed her outside records and have performed some additional testing. However, you can find no underlying anatomic or physiologic cause for her symptoms. You wonder if some underlying psychosocial issues (e.g., history of childhood physical or sexual abuse, history of sexual assault, an abusive current relationship) are causing her condition.

Intervention Goals:

1. Communicate to the patient that medical conditions and physical symptoms are often closely related to emotional issues (e.g., headaches and ulcers related to stress).
2. Communicate to the patient that chronic pelvic pain and other problems for which no clear cause can be found can be related to past trauma, such as physical or sexual abuse as a child, sexual assault, or a violent relationship with a partner.
3. Let the patient know that discussion of such issues in the clinic setting is appropriate. Often patients feel they need permission to discuss issues that are not clearly "medical."

4. Encourage the patient to receive counseling. Facilitate referral, or where appropriate, schedule the patient back to clinic for further follow-up.

5. Continue to provide treatment for the patient concerning any related issues, such as pharmacotherapy for depression. *Note: in most cases in primary care, counseling referrals are to counselors, social workers, or psychologists rather than psychiatrists.*

Patient Role

Setting: Out-patient clinic. You have come in for follow up of chronic pelvic pain and headaches.

Situation: You are a 35-year-old patient, Judy Lake. Over the last 10 to 20 years, you have had on-going problems with pelvic and abdominal pain that have been extensively worked up. No clear cause for your pain has been found. You have seen numerous physicians and most recently transferred your care to this current physician, whom you have seen several times. He/she has reviewed your outside records and has done some additional testing but has not been able to find any underlying cause for your symptoms. Additionally, you also have suffered intermittently from headaches and have had problems with insomnia. Several times in the past you have been treated for depression. You are frustrated that no one can seem to find the cause of your many symptoms, which have often been severe enough to keep you from working.

You have been married for 5 years. This is your second marriage. Your first marriage occurred when you were 19 years old and eloped with a college classmate. You both decided it was a mistake and were divorced in less than a year.

At age 15, you were raped by your brother's school friend. The incident was never reported to law enforcement and you have never received any counseling. In fact, you have been unable to talk about it with anyone. You have not told either of your husbands or any members of your family. You never discussed it with any of your physicians in the past and are hesitant to do so now even with direct questioning. However, none of your physicians has ever asked you about previous physical or sexual abuse.

➤ **INSTRUCTIONS FOR: DELIVERING BAD NEWS**

Patients receiving news about a serious illness or poor prognosis experience many emotions, including fear, confusion, grief, guilt and anger. The delicate and necessary task of breaking bad news is difficult for most physicians to accomplish. In this exercise the physician role may include a variety of information such as lab data and diagnoses. The trainee playing the physician role will have the opportunity to select the information he/she wishes to present to the patient. The trainee playing the patient role will be given the opportunity to select among the following types of reactions: denial, fear, confusion, guilt, anger or a combination.

The Bad News “Sandwich”: The “Sandwich” technique consists of three parts—(1) the good news (e.g., what was found to be normal), the bad news (e.g., what was abnormal), and (3) more good news (e.g., working together to manage the problem).

CASE 12: Bad News: Robert Spar

Physician Role

History of Present Illness:	This is the first admission for this 29-year-old man referred for evaluation of possible Lyme disease. He was in his usual state of good health until about 6 weeks ago when he began to experience numbness and paresthesias in his right upper lip. This problem continued and 3-4 weeks ago he had the new onset of severe generalized headaches. One week ago he started having temperatures as high as 39°C with generalized body aches, and night sweats but no rigors. Two months prior to the onset of these symptoms he was bitten by a tick. No rash was noted around the bite. He had no other complaints. Three days prior to admission he was seen in Neurology clinic. At that time physical exam was normal, as were his labs except for a WBC of 27,400 (with atypical lymphs) and an LDH of 900. He is now admitted because of persistent fevers and worsening headache.
Past Medical History:	Herpes zoster 4 years ago.

Social History:	Postal worker, lives with his wife and two children. No pets, and no exposure to wild or domestic animals in the past 2 months. He denies tobacco, alcohol, or street drug use.
Medications:	Acetaminophen, as needed.
Allergies:	None known.
Review of Systems:	Negative other than HPI
Physical Exam:	Temp, 38°C, BP, 120/80, pulse, 84; resp, 18; alert, oriented, in no acute distress.
HEENT:	Normal
Lungs and Heart:	Normal
Abdomen:	Soft, non-tender, spleen tip palpable on deep inspiration
Lymphatics:	2 cm cervical node, 2-3 cm axillary nodes
Neurologic:	Slight decrease to fine touch on the right lower face. Otherwise no focal deficits
Lumbar Puncture:	CSF: RBC,0; WBC,1; protein, 37; glucose,55
MRI of Head:	Normal
SMAC:	Uric acid, 11.0; alk phos, 170; AST, 67; ALT, 27; LDH, 4135.
CBC:	Hgb, 12.9; platelets, 135,000; WBC, 41,700; PMN, 24%; Bands, 18%; lymphs, 25%; monos, 10%; Meta, 8%; myelo, 6%; promyelo,1; blast ,8%. Internal Medicine was consulted to evaluate for tick-borne or other infectious processes. Upon review of the peripheral blood smear, a bone marrow aspiration was recommended. It was performed that afternoon, stained and examined.
Findings:	Acute lymphoblastic leukemia
Prognosis:	25% survival at 5 years; 80% chance of remission

Patient Role

You are a 29-year-old man referred for evaluation of possible Lyme disease. You have been in good health until about 6 weeks ago when you began to experience numbness and paresthesias in your right upper lip. This problem continued and 3-4 weeks ago you had the onset of severe generalized headaches. One week ago you started having temperatures as high as 102 with generalized body aches, night sweats but no rigors. Several months prior to the onset of these symptoms you were bitten by a tick but no rash was noted around the bite. You had no other complaints. Three days prior to admission, you were seen in Neurology clinic. At that time, your physical exam was normal, you are now admitted because of persistent fevers and worsening headache.

Past Medical History: Herpes zoster 4 years ago.

Social History: You are a postal worker who is married with two children. You do not use tobacco, alcohol, or street drugs.

In this role you may select among the following types of reactions to the news the physician has to tell you: denial, fear, confusion, guilt, anger or a combination of reactions.

CASE 13: Bad News: Bobby Ferguson

Physician Role:	A 2-year-old child is brought to the Hospital ED in shock. He had been well until the day before when he developed a fever of 41°C late at night; however, the fever defervescenced and he continued to act normally. His mother and his physician decided he could be seen in the morning because he commonly ran high fevers when ill. One hour before his appointment he collapsed while playing with toys on the floor. He was taken to the ED by ambulance.
Past Medical History:	Other than ordinary respiratory illnesses, his history is unremarkable.
Physical Exam:	Admission vital signs: very weak thready pulse of 180. Blood pressure detected by Doppler at 40 mm Hg systolic. He is unresponsive. Prominent liver and spleen. The patient is intubated, begun on parenteral antibiotics and fluids, and admitted to the Pediatric Intensive Care unit.
Laboratory:	WBC is 2,000 with 30% polys and 70% bands. Gram stain of CSF shows numerous pleomorphic gram negative rods.
Social History:	The patient was intensively supported for 9 hours with fluids and vasopressors, but has just died after attempted resuscitation from his third cardiac arrest. You have to tell his parents, who are waiting in the visitors' lounge, that he has died.
Diagnosis:	Meningitis

Parents' Role

Your son collapsed this morning while playing at home and has been critically ill all day. He is now in the Pediatric Intensive Care Unit. You are waiting to hear how he is after his most recent cardiopulmonary arrest. Both of you were asked to leave the room for the resuscitation effort.

Your son always ran high fevers when ill, so you had not taken this illness particularly seriously until his collapse. He was scheduled to see the doctor the morning he collapsed.

You and your partner have two toddler-aged children in common, but have decided not to get married as you don't want "the state" involved in your personal lives. There is also an older child in the household from the mother's previous marriage.

None of your children has been immunized because of your beliefs about the dangers of the various vaccines and their possible role in causing autism.

The father is a cabinet maker and the mother is a housewife who stays home and home schools the older child. You may select among the following types of reactions to the news the physician has to tell you: denial, fear, confusion, guilt, anger or a combination.

CHAPTER 6 TASK-ORIENTED ACTIVITIES

In this chapter, several small group task-oriented activities are presented that focus on specific behavioral science concepts.

 **KEY TECHNIQUE**

Focused Learning

ACTIVITY 1: Task Force Deliberations: National Health Care Reform

Instructions: This activity is designed to illustrate current issues that apply to planning a national health care program. Some trainees may be present as observers, which provides another opportunity to learn to give feedback.

The Problem

You are all part of a task force appointed by the current Administration to work on health care reform. According to the minutes of your last meeting, you have all agreed on the following principles to guide you in your deliberations:

1. Health Care reforms should preserve successful aspects of our present system.
2. Comprehensive reform may need to be achieved in stages.
3. Reform should not raise the federal deficit.
4. Federal leadership in shaping the system is appropriate, but the system must be allowed to adapt to state and local realities.
5. Detailed regulation of the provider-patient relationship is undesirable.
6. Consumers should be informed of costs and given incentives to make cost-effective choices.
7. Americans value making choices about the kind of health care they receive.
8. Primary care should be available in accessible, friendly settings to lower barriers to timely care.
9. More resources must be devoted to wellness promotion and preventive care.
10. Everyone should have basic health insurance coverage.

Your responsibility is to begin writing a national health care plan and set an agenda for next week's meeting. In your drafting of a plan consider the following components:

1. "Inclusiveness" of coverage

- a. Will all citizens be covered or only certain groups?
 - b. On what basis will a person qualify for coverage?
 - c. Will experience or community rating be used?
2. "Comprehensiveness" of coverage
 - a. Which are the covered benefits?
 - b. What decision rules are used?
 3. Incremental or large scale reform
 - a. Which aspects of the current system will be retained?
 - b. Over how many years will the program be phased in?
 4. Financing the reform effort
 - a. Will current dollars be reallocated?
 - b. Will taxes or premiums be used?
 - c. Will there be patient cost-sharing?
 - d. How will health providers be paid?
 - e. Will there be single or multiple payers?
 5. Assessing the reform effort
 - a. How will quality be assessed?
 - b. How will efficiency of using resources be assessed?
 - c. How will the allocation of resources/technologies be controlled?
 6. Planning the reform effort
 - a. Will planning be centralized or decentralized?
 - b. Plan/control which aspects of the reform effort?
 7. Political feasibility
 - a. Will there be public support?
 - b. How will the plan be publicized?
 - c. Which interest groups will be opposed?
 8. Philosophical base of the reform
 - a. Will the managed care philosophy be adopted?

Learning Objectives:

1. Understanding universal health programs
2. Financing strategies and incentives
3. Rationing, access to health care and the uninsured
4. Delivery systems and system administration
5. Changing patterns of disease

Observers' Role

Questions for Discussion

1. Who assumed responsibility for discussion?
2. What kind of decision-making style (authoritative, democratic) was used?
3. Did anyone dominate the discussion?
4. Did anyone not participate? Was anyone not heard? Why?
5. How fast was the process?
6. What would have made the process more efficient?

ACTIVITY 2: The Genogram

Instructions: Construct your own family of origin genogram to present to a small group. Focus particularly on life cycle transitions, significant family events, family health beliefs, and how your family influenced your decision to become a physician. Each presentation and discussion should take about 15 minutes.

ACTIVITY 3: Health Beliefs

Instructions: List health beliefs or health rules you have learned from family members. Then discuss the origins of these health beliefs and their scientific merit. For example:

- Chicken soup is good for almost anything
- Feed a cold and starve a fever
- Dress warmly or you will catch a cold
- Good people die young
- Maternal dreams mark a baby

ACTIVITY 4: Epidemiology

Instructions: We often gain a greater appreciation of the work epidemiologists do by analyzing a major disease outbreak or epidemic such as TB, food poisoning, influenza, the spread of HIV, cholera, Lyme disease, mad cow disease, or SARS from a local, state, national or global level. Small groups of 6-8 trainees will each analyze and report on a specific disease outbreak. The emergence of infectious disease may be from man-made or natural changes in the environment (e.g., Lyme disease), demographic shifts in populations (e.g., HIV), international travel (e.g., cholera), technological and industrial changes (e.g., hemolytic uremic syndrome in the Northwest in 1993), adaptation of microbes (e.g., antibiotic resistant organisms), or from lapses in the public health system (e.g., food-borne infections). The analysis may involve an historical or current situation and should demonstrate the use of descriptive and inferential statistics. Qualitative data from diaries (e.g., diaries of victims the 14th century bubonic plague in Europe) or first-person accounts (e.g., interviews with local public health officials) regarding the disease outbreak could also be used to appreciate the importance of studying the distribution and determinants of diseases in human populations.

ACTIVITY 5: Critical Thinking

Instructions: Reviewing a current research article facilitates critical appraisal of medical research and increases appreciation of the benefits of medical interventions. Read and critique an article in a medical journal of your choice according to the following steps outlined in Greenberg et al. (*Medical Epidemiology*, 1996):

Step 1. Research Hypothesis

Is there a clear statement of the research hypothesis? Does the study address a question that has clinical relevance?

Step 2. Study Design

Does the study use an experimental or an observational design? Is the study design appropriate for the hypothesis? According to the author(s), does the design represent an advance over prior approaches?

Step 3. Outcome Variable(s)

Is the outcome being studied relevant to clinical practice? What criteria are used to define the presence or absence of disease? How accurate are these criteria?

Step 4. Predictor Variable(s)

How many exposures or risk factors are being studied? How is the presence or absence

of exposure determined? Is the assessment of exposure likely to be precise and accurate? Is the amount or duration of exposure quantified? Are biologic markers of exposure used?

Step 5. Methods of Analysis

Are the statistical methods used suitable for the types of variables (e.g., nominal versus ordinal versus continuous)? Have the levels of type I and type II errors been discussed adequately? Is the sample size adequate to answer the research question? Have the assumptions underlying the statistical tests been met? Has chance been evaluated as a potential explanation of the results?

Step 6. Sources of Bias (Systematic Errors)

Is the method of subject selection likely to have biased results? Is the measurement of either the exposure or the disease likely to be biased? Have the investigators considered whether confounders could account for the observed results? In what direction would each potential bias influence the results?

Step 7. Interpretation of Results

How large is the observed effect? Is there evidence of a dose-response relationship? Are the findings consistent with laboratory models? Are the effects biologically plausible? If the findings are negative, was there sufficient statistical power to detect an effect?

Step 8. Application to Practice

Are the findings consistent with other studies of the same questions? Can the findings be generalized to other human populations? Do the findings warrant a change in current clinical practice?

ACTIVITY 6: Adherence to Medical Regimens

Instructions: Patients are less likely to comply with a treatment regimen if it is excessively complicated. Give trainees a week-long mock medication regimen consisting of different colored “pills” each in a separate pharmacy container. Have the regimen include two or three medications that must be taken several times per day. Have trainees keep a log of when they remember to “take” their medications. At the end of the week, have trainees report on their degree of adherence, what they did to remember their doses, and what made the regimen easy or hard to follow. As an alternative, trainees could follow a diabetic diet for a week.

CHAPTER 7 RESOURCES

Interpersonal Relations/Teamwork

An interactive experience that has been used in many teaching and business settings is a survival challenge. Participants in a group are asked to discuss their opinions of the relative priority of fifteen items that they possess while stranded in the desert on a mountain range. The design of the exercise allows people to problem solve a survival situation and receive feedback on their style of interacting with the group. It is a useful tool to prepare trainees for team-oriented patient care settings. [Information on the mountain survival situation can be obtained from Human Synergistics, 39819 Plymouth Rd., Plymouth, Michigan 48170.](#)

KEY TECHNIQUES

**Problem Solving
Multimedia Events
Computer Applications**

Video

Many useful teaching tapes are commercially available, such as the series of vignettes to teach cultural sensitivity developed by the American Academy of Family Practice and the Encounters in Primary Care series developed at the University of Missouri. These are often referred to as “trigger” tapes in that the video vignette is used to generate discussion around one or two basic concepts.

Hylar and Chou have developed a video casebook of Psychiatry that contains eight video cases of actual patients, designed to teach psychopathology and psychiatric diagnosis. [The video casebook is available from the American Psychiatric Association.](#)

A video tape by D’Onogrio, Berstein and Berstein that contains useful clinical vignettes regarding **substance abuse**, “The Emergency Physician and the Problem Drinker: Motivating Patients for Change” was produced by the ER of Boston University and [Yale University \(800-548-9491\).](#)

Homemade videotapes are useful if their quality is good. The cases and scenarios presented in Chapters 2 and 3 could be scripted into a video taped clinical encounter. At times, the demonstration of how not to do something (e.g., **the wrong way** to deliver bad news) facilitates the learning process as well as tapes that demonstrate appropriate behaviors.

Aside from using video to illustrate a case, trainees could, for example, **analyze commercials** to discover how the content motivates people to use a product to see how this could be applied to medicine.

Another way that videotape can be used is **evaluation**. In this context, trainees watch a scripted scenario or a series of scenarios and then are asked specific questions to critique the videotaped encounter(s).

Film

Only relevant portions of a film need be selected out and shown to trainees. The following is an example of two films that show adolescent behaviors and the questions that could be used for discussion:

BRIGHTON BEACH MEMOIRS

This film is an adaptation of the quasi-autobiographical play by Neil Simon about being gifted and Jewish while coming of age in Brighton Beach (Brooklyn) in 1937. While each adolescent cohort can be identified by the characteristics of its time, this film provides an excellent opportunity to identify issues that have changed in importance and those that have remained a consistent part of the adolescent experience over time.

Questions for Discussion

1. Characterize each of the different roles portrayed in the film. In what ways are these roles stereotyped? In what ways do the teenaged characters reflect different aspects of adolescent development?
2. How do the pressures facing today's adolescents compare with pressures facing adolescents in 1937?
3. The film depicts a variety of interpersonal family dynamics. How do these dynamics impact adolescent development? How do culture and ethnicity affect health behavior?
4. How do the adolescents in the film view the adult world they will be entering?
5. Adolescents experience pressures to both conform and perform. How are these pressures represented in the film?
6. As a health care provider, what issues portrayed by the adolescent characters would you need to be aware of in order to provide quality care?
7. How does your own adolescent experience compare with those portrayed?

THE BREAKFAST CLUB

This film has been praised by some critics as a serious and sensitive depiction of "genuine undergrad anguish". Other critics view the film as an "encounter-session movie" that strips a group of high-school students to their most banal longings to be accepted and liked. Still other critics regard the film as "overstated": the characters are too stereotyped and the setting is too unrealistic.

Questions for Discussion

1. From the perspective of adolescent development and your own experience, how would you assess the quality of representation in the film? Which parts of the film can you and can you not identify with?
2. How would you characterize each of the different roles portrayed in the film? In what ways do these roles seem stereotyped? In what ways do the five main characters reflect different aspects of adolescent development?
3. How are the five main characters defined by what they eat? What developmental issues do they have in common?
4. The picture opens with the epigraph, "And these children that you spit on/as they try to change their world/are immune to your consultations. They're quite aware of what they're going through". How does this epigraph relate to the developmental issues portrayed in the film?
5. How do the adolescents describe their parents? Some critics regard the film as being too anti-parental. Is the characterization of parents overstated or too negative? If so, in what way? Midway in the film, the Jock makes the comment, "If you really liked your parents, you'd never leave home". How do you interpret this comment?
6. Describe the role of the teacher and his relation to the characters in the film. Describe the role of the janitor and his relation to the characters.
7. How is the use of drugs and alcohol portrayed?
8. What are the most important health care issues raised by the film?

Concepts Portrayed in Selected Films:

Disabled Child

My Left Foot

Death and Dying

Terms of Endearment
Ordinary People

Aging

On Golden Pond

The Alcoholic Family

Hannah and Her Sisters
The Great Santini

Doctor/Patient Relationship

The Doctor
Patch Adams

Epidemiology

The Horseman on the Roof (Cholera)
Miss Evers Boys (Tuskegee Study)
Outbreak

Web Sites

Medical education and health-related web sites offer the instructor a wide, rich resource of educational opportunities. There are even web sites, for example, devoted to teaching the art of delivering bad news. *Bookmark favorite sites for future use.*

Courses:

Many medical schools have developed their own web pages for teaching. The University of Oklahoma College of Medicine, for example, has developed a web-based medical school education system called Hippocrates (<http://hippocrates.ouhsc.edu/>), which has about a dozen medical school courses available online. Trainees can view online lectures, examine complex structures, or test their knowledge with a quiz.

Virtual Sites:

- **The Virtual Hospital** (<http://indy.radiology.uiowa.edu/>)
A free digital health sciences library that has information by specialty, by organ system (e.g., neurology/psychiatry), and by type (e.g., patient simulations).
- **The Virtual Health Care Team** (<http://www.hsc.missouri.edu/~shrp/vhctwww/>)
A collection of interdisciplinary cases sponsored by the School of Health Related Professions and the School of Medicine, University of Missouri, Columbia. Many of these online cases explore psychosocial issues relative to, for example, kidney transplant, geriatric assessment, and special needs children.
- **The Virtual Clinic System** (<http://courses.washington.edu/hubio516/attendings/>)
This offering provides an opportunity for the trainee to apply classroom material to the evaluation and treatment of medical patients. Trainees view a case and interactively identify the patient's problem, make suggestions to their colleagues (other trainees in the group) regarding the patient's problems, develop hypotheses, and decide what to do. Trainees are given a new case each week during the course in behavioral science. Each trainee's contribution to the group is anonymous. Group members are identified by their password. Tracking by ID numbers permits faculty to evaluate how information is processed by individual trainees.

Other Useful Web Resources:

Tile.Net – (medicine related Listserv index)
<http://tile.net/lists/medicine.html/>

Health Risk Assessment
<http://www.youfirst.com/>

Annual Statistical Abstract of the United States
http://www.census.gov/stat_abstract/

Bioethics Discussion Pages
<http://www-hsc.usc.edu/~mbernste/index.html/>

Digital Library – (online index of biomedical and health related journals)
<http://galen.library.ucsf.edu/kr/jnl/>

Centers for Disease Control
<http://www.cdc.gov/>