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Starting a Standardized Patient Program Using a Theatre Model

A Thesis submitted in partial fulfillment of the requirements for the degree of Master of  
Fine Arts at Virginia Commonwealth University

by

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M.F.A., Virginia Commonwealth University, 2012

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Richmond, Virginia  
May, 2012

## Acknowledgement

I had only first heard of standardized patients a little more than a year ago when David Leong and Aaron Anderson suggested I should play an administrative role in the program they were piloting. From the beginning, they have allowed me to play a role in creating a vision for the program's future. I am grateful to have the job, but I am more grateful for the trust of these two men.

Ellen Brock, MD, MPH has also given me more trust and autonomy than I ever anticipated. I am fortunate to work for someone with such a keen understanding of organizational dynamics and a true appreciation for the arts.

Any success the VCU Standardized Patient Program has experienced in its infancy is the result of the SPs themselves. Without their patience, hard work, conscientiousness, teamwork, and dedication, this plane never would have left the gate.

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## Abstract

### STARTING A STANDARDIZED PATIENT PROGRAM USING A THEATRE MODEL

Richard Edward Carter, M.F.A.

A Thesis submitted in partial fulfillment of the requirements for the degree of Master of Fine Arts at Virginia Commonwealth University

Virginia Commonwealth University, 2012

Major Director: Aaron Anderson, Associate Chair, Department of Theatre

The methods used to train actors can be modified to train standardized patients to simulate patient encounters with medical students. With some background in standardized patients and simulation, a member of Theatre Department can start a standardized patient program at their own institution. This is based on the pilot year of the VCU Standardized Patient Program which began in June, 2011.

## **Preface**

The first auspicious use of standardized patients, though they were not called that at the time, was initiated by Howard Barrows, a neurologist, teaching at the University of Southern California in the 1960s. The practice met with immediate skepticism and even hostility by others in medical education. However, when he moved to McMasters University in Hamilton, Ontario, he had more autonomy to expand his program and expand the scope of standardized patient work. He developed a methodology for creating cases for students. He also began sending standardized patients into exams with unsuspecting physicians in order to test their ability to portray their assigned conditions.

Barrows wrote extensively on the topic of standardized patient and served as the chief advocate for their use. Even today, his name is revered within the field, and he is generally heralded as the father of standardized patients. However, it was not until he was appointed associate dean of Southern Illinois University's (SIU) School of Medicine in the 1980s when his attention shifted from using standardized patients to demonstrate neurological conditions expanded to seeing them as a useful tool for medical education in a much broader sense. Standardized Patients began to be used to simulate encounters for students studying Internal Medicine, Ob-Gyn, Pediatrics, Geriatrics, Psychiatry, and many other fields.

Dr. Barrows referred to standardized patients as "simulated patients," but by during the 1980s, they became identified for their ability to provide an identical experience to all students. Adding the "standardized" modifier was also important in stressing their ability to rate students as a group with the same standards and predictable results. By the 1990s, certification groups were beginning to require standardized patient interactions as part of their exams.

In the 2000s, David Leong and Dr. Aaron Anderson from VCU's Department of Theatre began work with Dr. Alan Dow at the School of Medicine conducting research and providing training in communication techniques for those working in the medical field. The VCU School of Medicine had been using Standardized Patients from Eastern Virginia Medical School (EVMS) for several years. EVMS began their program in the

1990s and has grown into one of the most respected programs in the country. However, the VCU administration had considered starting its own program in order to save money and have more control over the curriculum. EVMS offers a set program of teaching and assessment. This means less work for the faculty and staff at their client institutions, but it prohibits the ability to alter the curriculum provided by the standardized patients to suit the desires of the medical faculty.

Mr. Leong and Dr. Anderson were approached about starting a program as a collaboration between the Departments of Theatre and Medicine. They began by recruiting 23 individuals from the area for a pilot program in April 2011. It was envisioned that the pilot program would staff an intern orientation at the end of June and potentially staff a few events throughout the following school year for first and second year medical students.

Dr. Anderson and I went to SIU in May 2011 to attend Standardized Patient Educators Training. The weeklong training was useful in describing the duties of a standardized patient as well as the administrators in a program. The training also provided us the opportunity to practice authoring a case and training a standardized patient in that case. However, the course was designed to suit the needs of those staffing an established standardized patient program. Dr. Anderson and I had a number of gaps to fill in on our own related to the creation of a new program.

This document serves as a recommendation to others based on that experience.



## **What is a Standardized Patient?**

A standardized patient (SP) generally serves four main functions:

1. Teaching Clinical Skills
2. Simulating a patient interaction
3. Providing immediate feedback to learners
4. Assessing learners on clinical skills

Depending on the objectives of the curriculum, a standardized patient might be asked to perform multiple functions in the same encounter. A standardized patient might portray a patient with eye pain during an examination by a first year medical student and immediately afterwards provide verbal feedback and complete a written assessment. He might also teach a student how to conduct an abdominal exam and then give feedback while the student practices administering that same exam on the standardized patient.

The breadth of responsibilities of a standardized patient can present a challenge to a program whose goal is to provide a predictable experience to a large number of learners. Standardized patients may have varied interpretations of the attitude and emotional state of the patient in a case. They may also have differing expectations of the learners. This can have devastating effects on the integrity of feedback and assessments. Standardized patients can even have different attitude towards students in an instructional environment that might range from nurturing to pedantic to terse. However, these potential problems can be addressed in advance by using some basic elements of theatrical training.

Many standardized patients may have backgrounds as actors. Some may have formal training and others may not. Some may not have any theatrical experience, but are partially attracted to the experience through their enjoyment of improvised interactions. Some may be attracted because of the challenge, the ability to make some additional income, or they may be looking for a part-time activity while they are retired.

While being a standardized patient can meet all of these desires, many SPs in our program reported that working with medical students was unexpectedly the most rewarding aspect of their job. SPs found that the overwhelming majority of medical students were extremely conscientious towards their skill development. Students

recognize that they have many things left to learn and are grateful for help. SPs are often struck by how frequently they are thanked by the students after an encounter.

The majority of work standardized patients do centers around communications. Some cynical or ill-informed individuals in the medical field may see these skills as tangential to the work healthcare providers really do. You will, from time to time, see an attitude that seems to say, "I want to make the patient healthy. Why should I devote time to making the patient happy?" This might even be more than an attitude. It could be an explicit question.

The skeptics are not encouraged by being told that patient satisfaction depends upon the emotional well-being of the patient. As far as they are concerned, patient satisfaction should be based on a positive clinical outcome. If you were sick, and now you are better, you should be satisfied. It is a lost cause to defend communication skills on these grounds.

However, it should be recognized that communications skills are vital to a positive clinical outcome. By building rapport with a patient, he or she is more likely to divulge information that may be critical to the diagnosis or influence treatment. A patient who does not feel his doctor relates or attempts to relate to him may be unwilling to admit behavior that might be embarrassing. This might be valuable information that allows the doctor to more quickly identify the cause of the complaint or develop a more effective care plan.

Patients are also more likely to follow the care plans of healthcare providers with whom they feel comfortable. We all know individuals who avoid trips to the doctor or dentist because they fear a scolding for not eating the proper foods or not flossing. Being able to counsel patients in without judgment is key to making sure patients follow their long term care plans.

Delivering difficult news to a patient requires skill and practice. This may not be something that comes to the student naturally. Working with an SP can give the student the opportunity to practice their communication skills in a safe environment. They can learn to deliver a devastating diagnosis in a way that will treat the patient with dignity and respect and make them more confident and better informed as they head into an uncertain future.

You will have more success winning over skeptics if you can articulate how the SPs' communications work can assist the students in the clinical skills they have always been cultivating. Attempting to introduce this work as a new dimension may play into the fears many doctors have of being turned into customer service providers rather than healthcare providers. Always be sure to reiterate that communication skills are essential to improving outcomes by increasing compliance and promoting dignity and respect.

## Starting from a Theatre Department

There is a natural tendency to associate the work of standardized patients with actors. Learners, faculty and others will frequently refer to the SPs as “actors.” However, in the world of standardized patients, many programs attempt to separate themselves from the traditional world of acting and theatre. In some programs, actors have even developed a bad reputation. Some program directors and coordinators tell cautionary tales about actors who are too invest themselves too deeply in the drama of the case and distract from the didactic effectiveness of the encounter. There are plenty of stories about a standardized patient who was always playing emotional cases or psychiatric case “over the top” that end with a reveal that the SP was also an actor.

I have no doubt that these stories are true. However, that does not mean that actors are inherently inappropriate to work as SPs. It means that unprofessional actors are inherently inappropriate to work as SPs. Sadly, there are unprofessional actors just as there are unprofessional clerks, carpenters, lawyers, and doctors.

Actors - and all SPs, for that matter - perform best when the structure for their work is clear. By setting explicit parameters for their work, you are giving them the best chance for success. This all begins with the case.

Every time you plan an encounter with faculty that involves the SP portraying a patient, you should have a case. The case is a description of the patient’s condition and goals for the encounter. Cases can be purchased or shared from other programs. However, by authoring their own cases, the faculty at your institution will have far greater control over the experiential learning of their students. The case author can dictate exactly which learning points the case should test and the level of difficulty of the experience.

There are several examples of cases in the Appendix, but there are a few things to keep in mind and pass on to case authors:

- Cases should include demographic information about the patient and specify if there is an age range for the SP.
- Avoid cute or joking names for the patient (e.g. Ben Hurtin, Ima Wheezy, etc.).
- The case should have an opening statement for the SP to recite verbatim.
- The Case should not specify the actual diagnosis for the case.

- Cases should be written in bullet point form to make memorization easier.
- Cases should be free of jargon.

Several programs establish a case review board. Not every case needs to be reviewed. Many cases will be for simple encounters that do not require the learners to be formally assessed. However, there are benefits to a group looking over cases for a summative encounter. A physician should exam the cases for medical accuracy. Someone familiar with the standardized patients should review them to make sure all the details are can be portrayed and the language is appropriate for SPs. Someone with a background in assessments or psychometrics can review the checklists and provide guidance for attaining accuracy.

In addition to the details of the case, you should also discuss the learning objectives the faculty member or case author has. These might be valuable details for the SP as they prepare to either present the case or deliver feedback. You should also discuss the kind of experience they want for the learner. To oversimplify, should the encounter be easy, medium, or hard?

Basic learners may need an easy encounter to serve as a confidence building experience. You can train the SPs to guarantee a positive outcome. These kind of cases are usually simple and structure and allow for the SP to bring the case to some level of closure that validates and encourages the learner. The SP can then give feedback that is candid and constructive but maintains an empowering tone and ends on a positive note. These kinds of cases are usually most appropriate for students in their first or second year of training.

Students who are operating at a more sophisticated level may need a simulation that requires a few specific actions to ensure a positive outcome. They might need to ask the correct question or perform the correct exam to set off these triggers. If students hit these benchmarks correctly, the SP will respond positively. Feedback should be honest and balanced. There is no point in trying to gloss over the failure to hit the appropriate triggers, however, the student may have done other things which were praiseworthy. These cases are most appropriate for students who are in the process of learning how to connect and apply the knowledge of their first years such as M3s and M4s.

Advanced learners may need a challenging encounter. This may be a disorienting experience with factors they had not expected or an encounter that cannot end with a positive sense of closure. In these cases, SPs may have to adjust in the moment to push back against more competent learners and to ease off if the learner becomes flustered. Although all learners need to be challenged at some point, it is rarely beneficial to have a simulation designed to give the student a sense of inevitable failure. Feedback for these events should be detailed and may take longer than easier scenarios. The point is not to give overwhelming criticism to the learner, but to discuss the positive and negative consequences of the nuances of the encounter. These feedback sessions often turn into dialogues between the SP and the learner.

Talk with faculty and case authors about these different options. They may not have articulated to themselves at which level they would like the simulation until you mention it. They may want something between two of the levels, and you will probably be able to accommodate them. Making sure your SP understands the kind of outcome you want the students to have and clearly articulating it will help tremendously with creating a more standardized and reliable product.

Once cases are ready, you may begin training the SPs to act the case.

## Acting the Case

Because the reader may not necessarily have a background in acting and because the training actors get can vary widely, this next section will endeavor to establish and define a common vocabulary for training SPs using techniques commonly used to train actors. Much of the language I will draw upon is based on a Stanislavski style. This is not done to disregard or discredit any other method or school. I choose this route because it is simple and is the basis of actor training for the largest segment of actors today. To those with an extensive background in acting, this may seem elementary, but clearly defining these terms is important.

If you as a teacher would like to utilize other methods or styles, you should feel free to do so. These terms should not preclude you from tweaking training to incorporate whatever technique you prefer. Likewise, your SPs are not prohibited from making use of whatever training they have. These terms create a basic structure and can be incorporated by an SP trained in Meisner as easily as a disciple of Strasberg.

It is important for the sake of your program to restrict these terms to training. Your customers in the medical field may already be skeptical of your expertise. They may be reluctant to accept you as a medical educator if your background is in Theatre. Do not undercut your credibility further by using acting terminology with medical faculty, staff, or students as it applies to the work of the standardized patients. Discourage your SPs from doing so, too.

## Objective

The patient's objective is his/her primary goal over the course of the encounter. That goal may be as simple as wanting to be free from pain or a desire to get drugs. It is the pursuit of this objective that should always be foremost in the patient's mind. It dictates his reactions to the student's questions and behavior. A patient whose objective is to get relief for his shortness of breath may grow frustrated with a student who chooses to counsel him at length on his smoking. A patient who is looking for help caring for his geriatric parent may feel comforted when the student empathizes with his struggle.

The focus on the objective gives life and urgency to the encounter. Without it, the patient is merely a model who recites details of his or her condition. Any patient a healthcare worker sees will have an agenda of some kind. They should become acclimated to this as soon as possible.

In most cases, the patient's objective is related to relief. He or she may desire to be free of pain or discomfort. The SP may desire relief from his or her anxiety. That anxiety may stem from a fear of a bad diagnosis or inability to pay for care or a distrust based on an unrelated experience at a hospital. True, all patients probably want more than one thing at a time, but it is worth identifying which desire is more immediate and important than the others. That is the objective.

It may be that your objective will change throughout the course of the encounter. That is fine, but it is worth exploring the possibility of this in training and discussing these potential changes. Planning ahead for a change in objective will allow you to better standardize the encounters. These changes may be part of the expected course of the encounter. They may not. When you are training, it is worth brainstorming different ways the simulation could change course that might not have been intended by the case author.

You may or may not choose to include the objective as an item explicitly stated in the case when it is written. Often, the objective can be easily inferred by the patient's opening statement. Other times it is in the subtext of that statement. The objective could also be a hidden one that is only alluded to in the special instructions of the case.

## Obstacles

The obstacles of the case are the things that stand in the way of your patient reaching his or her objective. Pain is a frequent obstacle. Addiction to drugs or alcohol may be an obstacle. Denial of an unhealthy lifestyle could also be an obstacle. A patient could have several obstacles. They may be psychological or external.

Clearly identifying the patient's obstacles is valuable. By doing so, you can discuss them during feedback and see which ones the student was able to identify and which ones he or she was not. Generally speaking, the better a student is at addressing a



patient's obstacles, the more successful the encounter will be. In many simulations, a student will be unable to address the patient's pain immediately. However, by empathizing, the learner can gain trust and build rapport with the SP and perhaps get a more favorable outcome.

It is worth discussing the notion of playing pain for a moment. Playing a patient in pain should be a delicate, nuanced process. You must be specific about the location and the nature of the pain. Is it localized to one area or does it radiate? Is the pain a burning, aching, crushing, sharp, or dull sensation? These are questions the SP must know not only because the student will likely ask them, but because the SP needs to know these things in order to properly portray the pain.

Students are often taught to inquire about the intensity of the pain using a numeric scale going from "1" to "10". When asking the patient to rate their pain on that scale, they may specify that "1" is "a slight nuisance" and "10" is "the worst pain imaginable" or words to that effect. In anticipation of this question, the case author should designate a number to the intensity of the pain and additional numbers to indicate the pain level at other times if it changes. As an SP striving for realism, you might feel disinclined to submit to a long line of questioning about your family history if the case specifies that your pain is at a level "9" or "10". In those cases, it is more important to dial back your portrayal of the pain in order to be able to supply useful answers in an interview.

If an SP plays the pain as being too intense, the student might be scared to conduct a full interview or a physical exam. Whenever a student expresses reluctance in such a case, the SP must encourage him or her to continue with the exam. The SP can do this while still in character by thanking the student for his or her concern and expressing understanding that the student has a job to do and should be thorough in those duties.

Standardized Patients must also learn to guard. Guarding is the practice of tensing up the body's muscles in preparation for pain upon being touched. This tensing occurs immediately before the student touches an area where the patient expects the touching to be painful. For example, if the patient has been experience pain in the upper part of his abdomen, he would tense his stomach muscles just before the student began to push into that area of the body. Guarding takes place all over the body. The knees flex. Fingers may grip the chair or bed sheet. Toes curl. It is often accompanied by a sharp, shallow inhalation, too.

## Outer Life vs. Inner Life

In training the case, you should also establish an outer life and an inner life for the patient. The outer life is the visible attitude of your patient. The inner life refers to the interior attitude that only the patient can easily see. Sometimes these two things are the same, and sometimes they are different. They may even conflict with one another. A patient may have a calm, stoic outer life but simultaneously an anxious, terrified inner life. Once again, training these aspects of the case very specifically will help ensure that your SPs are delivering a consistent product even when multiple SPs are portraying the same case.

Many experienced actors will be familiar with this concept. It may help them to think about inner life as subtext. The student should be able to recognize the outer life immediately, but only recognize the inner life if they are paying proper attention to the nuances of the SP's body language and vocal cues.

## Beats

Actors and directors will often break a scene into beats. These are small moments where the action moves in a single direction before shifting to another. You should also break your simulation into beats. Many of these beats will come naturally such as the history of present illness, physical exam, or education and counseling. Identifying these beats will give you and the SPs a more detailed structure for preparing the case. It will also provide them with a natural way to structure the feedback. Once again, do not use this terminology with the students. It is not part of their curriculum, and they must not be held accountable to it.

## Feedback

A standardized patient's ability to provide feedback is just as important as his ability to portray the case. Feedback is generally provided either orally, in written form, or both.

Oral feedback is generally given immediately after a simulation. Asking the student what he or she thought was most challenging about the encounter is a great way to begin an oral feedback session. The SP can address the immediate concerns of the student. It also gives the SP a moment to shift out of the character of the patient and into the feedback character.

Establishing a feedback character for your SP program will contribute to a more consistent product in oral feedback sessions and greater professionalism on the part of the SPs. When playing a character of any kind, it can sometimes be difficult to immediately switch back to one's actual self. However, playing more than one role in a show is common for actors. It is easier for an actor to switch quickly and cleanly into a feedback character than to be themselves. Creating the same feedback character for all the SPs also makes the nature and tone of the oral feedback session more unified and predictable.

The feedback character does not need to be richly detailed or have a lengthy biography. The character can be as simple as, "Your feedback character is encouraging, empathetic, detail-oriented, positive, and professional." You may choose to alter the feedback character based on the level of the learner or the nature of the simulation.

You may find it helpful to establish a feedback character for providing written feedback, too. That feedback character might "always give the student the benefit of the doubt" when filling out the checklist or "insists that every portion of the checklist item must be done perfectly" in order for the student to get credit.

## **Where to House Your SP Program**

There are a number of factors to consider when determining the best place to house your SP program. This includes where it lies organizationally within your larger institution and where you will physically conduct the work of the program. Though the Theatre program may be providing the bulk of the labor and training, most of your budget may well come from your medical school. And since they are likely to be your chief customer, their input and involvement is critical. As with any new organization, the best chance of survival occurs when many people are invested in it.

### **SPs and Simulation**

Medical and nursing students have famously learned IV placement by practicing on everyday items such as oranges or each other. This is still common practice today, but technology has advanced far beyond this, too. Now students can practice placing an IV on a simulated arm with skin that feels real and is connected to a computer that can provide instant, detailed feedback on every aspect of the direction, speed, and force of the needle. There are a wide variety of these kinds of trainers for students to practice every procedure from an eye examination to robotic surgery. Students may also practice full scenarios with high-fidelity mannequins that can simulate conditions such as a collapsed lung, cardiac arrest, and even childbirth. The medical community at large has recognized the advantage of using simulation for teaching at every level. Many institutions have built simulation centers to house trainers and mannequins. Some simulation centers may serve multiple institutions or an institution may have multiple simulation centers to accommodate different schools (i.e. Medicine, Nursing, Dentistry, Veterinary).

If your medical school already has a simulation center, it may be a great place to start building your SP program. There may already be physical and organizational infrastructure that you can use. They may already have rooms for simulation with recording equipment. There are several automated systems designed to assist simulation centers with administrative needs such as scheduling and inventory as well and technical needs such as video recording and archiving or assessment tools. In

addition to space for simulation, you will also need room for training. This does not necessarily have to be done at the same location as your simulations. It can even be done at the Theatre Department.

Though it may not be immediately necessary, you will eventually want space for briefing and debriefing. The room should be large enough to accommodate a large group of people and should have either a large monitor or a projector for reviewing videos of the simulation. This same space can also be used to simulate larger clinical spaces such as an operating suite or an emergency department.

Keeping your space modular will allow you to simulate a larger variety of spaces. You may wish to set up a space as a dental exam room. When training first responders, you may want to simulate an apartment or part of a house. Other customers may want to simulate a clinic in a nursing home or a doctor's office. As with Theatre, it can be easy to underestimate the amount of space you will need to store furniture, set pieces, costumes, and props.

If space allows, set up a green room for your SPs. The green room is a comfortable space for the SPs to wait and relax when they are not in an encounter. In addition to keeping them comfortable, you will want to keep them segregated from students as much as possible. You do not want the students to overhear SPs discussing the cases. However, there is a larger benefit in keeping these groups separate. Simulations are most effective when all the elements are as real as possible. In theatre terminology, you do not want the SPs to "break the fourth wall" except times when they are explicitly told to do so such as when giving feedback.

The idea of creating the most realistic environment possible for the learners should be a priority in all encounters. You will always have limitations, but anything you do to create a higher degree of fidelity in your simulation will benefit the students. Students should wear the appropriate dress such as scrubs, lab coats, or professional attire. SPs should also have clothing appropriate to the simulation whether that is street clothing, a hospital gown, or something specific to the patient they are portraying. Whenever possible, you should assign SPs who most closely match the age, gender, race, weight or other criteria of the patient in the case. Old-age makeup and wigs or padding may work on the stage, but they are rarely convincing when you are receiving a physical examination.

## The Duties of Your SP Program

### **SPs**

#### Recruitment

Though recruiting requires significant work at the startup of your program, it is an ongoing process. You will probably not have enough work to hire any of your SPs on a full time basis at your program's inception. Few programs nationwide can deliver a consistent forty hour work week to any of its SPs. When you hire a large number of people for part time work, many of them will fall into categories such as students, the retired, the unemployed, and the underemployed. These are all groups which lend themselves to a high rate of turnover. You should keep a contact list of possible SPs.

Choosing the best number of SPs to start the program is a difficult process. It all really depends upon how many customers you will have when you start and what their needs are. If they already use SPs from another program, you can use information from their previous simulations to forecast your personnel needs. However, if your customers are just beginning to use SPs, you can probably start with a small group.

Whatever your initial demands for SPs are, start with the smallest number you can and plan to grow only as needed. Starting out with too many SPs can quickly cause confusion and discontent as SPs do not work as much as they would like. It is best to start with a demographically diverse group. Your customers may want to conduct a larger simulation focusing on geriatric or adolescent patients, in which case, you can recruit specifically that demographic.

There may be local theaters in your community who you cannot contact for recruitment. However, do not limit your program to actors. A diversity of backgrounds will benefit your program. Some of our SPs with nursing experience have played an important role in training SPs for physical exams. Some of our SPs with teaching experience are excellent at delivering feedback. Any job that demands empathy or communication provides great experience for being an SP.

## Marketing

You will want to market your program in order to attract potential SPs as well as new customers. You will probably want to make use of existing marketing departments within your institution for this purpose. And because the concept of teaching actors to play patients is so novel and seems like a fantastic idea to so many people, never leave home without your business cards!

Because the encounters lend themselves so well to pictures and video, you should consider social media sites as a means of promoting your work. It provides a great venue to network with programs from other areas, and most sites are entirely free.

## Contact List

Someone in your program should monitor the contact list. Your contact list should include active SPs, inactive SPs, and people who have expressed interest in becoming SPs. Everyone on the list should have their contact information verified annually. An SP who moved out of the area or got a fulltime job, may never work as an SP again, but he should stay on the list as an inactive SP. Inactive SPs may still be valuable for promoting the program and recruiting new SPs.

## Applications

When recruiting new standardized patients, it is helpful to have a standard application form. Aside from standard items such as contact information and employment history, it is also valuable to find out what kind of availability the person has so you can evaluate how active he could be in the program. You will also need to know if they have any current medical conditions or past surgeries. You should specify that these will not necessarily disqualify them from becoming an SP, but those details may be discovered in the course of an examination.

## Interviews

After identifying a possible candidate for the program, you should first set up an interview. It can be informal in nature, and your chief concern should be to assess the

professionalism of the candidate. As an SP, you may come into contact with scores of students in a single day. One unprofessional encounter could tarnish the reputation of your entire program.

It is also important that you explain the nature of the work and the realities of your program. You do not want to oversell the program to a candidate who is on the fence, and have him leave the program after you have invested the time and funds in the candidate's initial training.

### Day-to-Day Personnel

We started our program with twenty-three standardized patients and nearly doubled in size over the course of the first year. Having a group of even part time employees that large requires some day-to-day maintenance. SPs will occasionally have questions about upcoming events. They may have to schedule events to which they were assigned due to sickness or a family emergency. They may have questions about payment, parking, or email. As with any group, some will require more attention than others. As your program grows, this will become a larger portion of someone's job.

### Payroll

It will behoove you to begin conversations with the personnel and fiscal administration departments in your institutions when you first consider starting an SP Program. Your institution may not be used to hiring a large group of part time employees at once. They may want to make the contractors or they may want to make them hourly employees. You will also want to discuss how to adjust the hourly rate for the SPs. It is customary for SPs to get paid at a higher rate for training students to perform breast or genital exams. Our program also pays them at a higher rate when they staff a high stakes exam. This may be a complex procedure and may require some creative bookkeeping.

### Boot Camp

After reading the applications and interviewing candidates, you will want to select your SPs and put them into a boot camp. All SPs should attend the boot camp as their initial training session. It should be roughly the same experience for all SPs.

Your boot camp should include a few key elements:



- How SPs are different from real patients
- How to portray a case
- How to deliver feedback

The chief difference between an SP and an actual patient has to do with how they answer questions. A real patient will usually offer as much information as they can think of the physician. However, a standardized patient only reveals information one or two pieces at a time. Encounters with SPs are designed to give medical students a chance to practice asking the right questions and that cannot happen if the SP gives them too much information at once.

For your boot camps, you should have at least two practice cases for the candidates to learn. There should be elements of a physical exam in both cases and different kinds of pain to portray. You may be able to find medical students who are available to act as the physician in the cases. Candidates can then be assessed on their ability to:

- memorize information
- answer questions without giving away too much information
- portray the outer and inner life of the patient appropriately
- portray the pain appropriately
- provide detailed oral feedback
- provide correct written feedback

Candidates who fail to properly demonstrate one or more of the above items should be remediated until they can either do so to the coordinator's satisfaction or the coordinator believes they are unable to complete the duties of a standardized patient.

In our program, candidates received a stipend for their time in boot camp. After successful completion, we go about making them full standardized patients, who are paid at an hourly rate.

## Event Training

Passing through boot camp does not qualify an SP to go straight into an actual simulation. SPs receive training specific to each event they are to staff. This is true regardless of how long they have been in the program or how many times they have worked on a case with a similar diagnosis.

Typically, SPs are sent the case documents before training so they can review. They may need to review a case and a checklist. When they arrive at training, they are usually asked to be off-book. This means they should have the case details memorized, and they should have reviewed and physical exams in the textbook. Knowing which textbook the students use is critical. If possible, SPs should be furnished with their own copy so that everyone has the same standards for conducting physical exams.

The most efficient event training is often when the off-book SPs show up and immediately go into a dry run of the case. The coordinator should either act as the physician or should observe each examination closely. This exam does not need to be done in a realistic manner and can even be conducted with the examiner hold the case and/or checklist in his or her hand to expedite the process.

After the dry run is complete, the coordinator makes a decision of who is has sufficiently memorized the case details and who needs remediation later. The coordinator and educator then sit with all the SPs to go over the case details. Here they should discuss parts of the case such as the objective, obstacles, outer life vs. inner life, and beats. They can also cover questions and make decisions as a group about details left out of the case. Everyone staffing the same case should try to be in agreement on everything possible.

For any kind of high stakes exam, you will also want to establish inter-rater reliability between the SPs staffing the event. You may have the SPs watch a live encounter or a taped encounter and then score it based on the checklist they will be using during the exam. Keep careful track of this data. You will want to review it with a psychometrics expert who can verify that you have established generalizability between all of your SPs.

In training for events that do not require a case, but require the SP to teach a physical exam, the SPs should practice teaching elements of the exam to one another. If possible, have an expert physician who can evaluate them on their accuracy. You should also verify that they are only teaching information from the students' textbook and have not incorporated any shortcuts they may have found while studying on the internet.

## Assignments

There are several software companies that make products designed to help SP program coordinators with the assignment process. The process involves three steps:

1. Notify SPs of an upcoming simulation.
2. Collect availability from SPs.
3. Select which SPs will staff the event.

Although the each step may appear easy, the task can quickly grow confusing if you are not organized beforehand. If you are just starting out, you can take advantage of free or cheap online survey tools (e.g. Doodle, Survey Monkey) to assist in gathering availability. Do not forget to see if the SPs are available for event training time, too.

Once you have selected the SPs you can notify them and send out the relevant case materials. At some point, you will have to make a decision about backup SPs. The unexpected does happen, and you never want to disrupt a simulation because an SP did not arrive. In our organization, anytime we have a simulation that requires more than four SPs, we assign a backup SP. The backup shows up to the simulation and may go home if all SPs show up as expected. At larger, high stakes exams, the backup may stay through exam in case an SP falls ill and cannot complete the day.

Your institution may have a product such as Blackboard or Moodle that can assist you in notifying SPs of their assignments. It may also be able to display a calendar of all events. You may be able to start group for your SPs that can allow you to share case documents and study materials.

Be sure to track the work of your SPs. Knowing what cases they have performed and how often they work can be valuable information. It may contribute to how you select which SPs will work on a case. Do you want to staff the simulation with experienced SPs or use it as an opportunity for some SPs who have not worked lately? Some kind of tracker will help you make those decisions.

## Event Administration

At many events you will need someone to be an administrator. This person could be the coordinator or a designee of the coordinator. He or she makes sure everyone shows up on time, keeps track of time during the event, organizes breaks for the SPs, and manages supplies and equipment such as gowns or fake glasses. The administrator also conducts a tune-up before the start of the exam. This is a quick check of the case details immediately before the event begins to ensure that the SP still has all the information memorized.

The administrator should also make sure case information and checklists are all secure and out of sight of students. He or she should also check in with the SPs throughout the

event to make sure the SPs are comfortable and that nothing out of the ordinary has occurred with the students. The administrator should also debrief with the medical staff and faculty after the event and let them know if there were any problems or cause for concern.

## **Customer Relations**

### Curricular Planning

If your customers have never used standardized patients before, you may need to help them find ways to integrate them into their curriculum. The best way to do so is to begin with workshops that focus on the most basic communication skills such as taking a history of present illness or orienting the patient to the dental clinic. You may find yourself having a larger role in curricular planning than you intended, but I encourage you to embrace that as a chance to advocate for more comprehensive communications training at all levels.

### Simulation Planning

You may also be asked to assist to planning the logistics. This can require a lot of attention to detail when you are trying to get an entire medical school class through a simulation in a matter of a few short days. Knowing your customers needs as far in advance as possible will be essential to successfully pulling this off. There is some scheduling software attached to Simulation Center management suites that can be helpful in planning and scheduling simulations.

Often this same software has the capability to serve as an automated assessment tool. If you only have enough money to budget for one automated product, I recommend purchasing an assessment program. A reliable program of this kind will prevent many of the headaches that are associated with grading paper checklists. It will also allow you to provide your customer with immediate feedback on the performance of their students.

### Pricing

Determining the price of your program's services will require planning. Remember you must recoup expenses that go beyond the hourly rate of the SPs. You may also have to

account for training time, program coordinator time, program educator time, supplies, space, and equipment. Customers will often ask you what the per-hour - in simulation, they do not usually think about training - price of your program is, but it is rarely that simple. A long but simple simulation that requires only a few SPs with little training will cost less per hour, but a short simulation that requires complex work from the SPs will have a higher per hour cost. You may also choose to charge a different rate for customers who want to use SPs for research rather than education.

## **Logistics**

As with any organization you will have logistical needs. You will need access to gowns and sheets. Those gowns and sheets will need to be laundered. You will need to book space for training and simulation. You will need to purchase supplies, and you will need a place to store them once they have been bought. If you house your program in a simulation center, you have a better chance of being able to share some of their logistical assets.

## **A Personal Note**

Since high school I have always been conflicted by a deep desire to be involved with Theatre while simultaneously never feeling at home. I never enjoyed performing in front of an audience, nor have I ever even liked being in the audience. Nonetheless, I loved rehearsals. Upon entering graduate school, I was able to more clearly identify that what I truly enjoyed was coaching, teaching, and directing actors. However, when presented with different communities within Theatre such as commercial, academic, or experimental, I had no desire to be a part of any of them. Once again, I knew what I wanted to do, but I had no home in which to do it.

In the VCU Standardized Patient Program, I have found an artistic home. The encounters I craft with the SPs are primarily didactic in purpose, but they are also engaging scenes. They are full of conflict and drama. Perhaps most exciting is that I get to coach actors on their performances to a level of detail few theatre practitioners even consider. Most coaches and directors work to create moments that will be truthful to an audience ten feet away, but I have to create performances that seem real even when the audience is listening to the performer with a stethoscope.

I have found deep contentment at being an artist on the fringes of theatre. Not a fringe artist in the sense that Karen Finley or Muriel Miguel are outside of mainstream theatre, for they have a community of collaborators and fans who support them. Rather, I am truly at the edge of theatre in a way that stretches its definition and is separate from any other theatre community. I am perfectly pleased to work in such a space. I have always thought of myself as a teacher and an artist. In this job, I get to teach a group of students with whom I never anticipated any interaction, and the art of the SPs is my medium for teaching. Achieving such a sense of being-in-the-right-place professionally has given me a sense of stability in what has been an otherwise tumultuous and unpredictable adulthood. I am extraordinarily grateful for this opportunity.

## Appendix A

### Sample Application

#### **VCU STANDARDIZED PATIENT APPLICATION**

*(Click on the text boxes below and type your answers. The boxes will expand. Then save it as a file in your name and e-mail completed application to the SP Program Coordinator, Ted Carter, at [spprogram@vcu.edu](mailto:spprogram@vcu.edu))*

TODAY'S DATE:

NAME:

DATE OF BIRTH (M/D/Y):

COMPLETE ADDRESS:

HEIGHT:

WEIGHT:

RACE/ETHNIC BACKGROUND:

HOME PHONE:

E-MAIL ADDRESS:

CELL PHONE:

US CITIZEN?  No  Yes      If not, WORK VISA?  No  Yes

OCCUPATION (or former occupation):

Are you currently a VCU employee?  No  Yes

Have you ever been a VCU employee?  No  Yes

If so, please list approximate dates of employment:

What makes you interested in working as a standardized patient?

Briefly describe your past experiences with and opinions about physicians and other medical care providers:

List any conditions you have that could be discovered during a routine physical exam (ie. heart murmur, use of hearing aids, enlarged thyroid, insulin pump, prosthesis, high blood pressure, skin problems, arthritis, reduced lung capacity, etc):

List size and location of any scar(s). (This is important information in regard to the physical exam).

Do you:

Wear glasses/contacts?  No  Yes



Have dentures?  No  Yes

Smoke?  No  Yes

What days of the week will you normally be available for work?

What is the best time to reach you by phone or cell phone?

How long do you anticipate being available to participate?

If you have any friends or acquaintances that may also be interested, please list names, addresses, and phone numbers.

Would you consider having or learning to teach a pelvic/rectal or prostate/rectal exam for educational purposes?  No  Yes  Maybe  Would like more information

Criminal History: Have you ever been convicted of a misdemeanor?  No  Yes

Have you ever been convicted of a felony?  No  Yes

If the answer to either question is yes, please explain:

*A conviction record will not necessarily be a bar to employment. Factors such as age at the time of the offense, seriousness and nature of the violation, and rehabilitation will be taken into account in terms of the position's responsibilities.*

Are you available for initial training on March 19<sup>th</sup> and 20<sup>th</sup> from 12:30-6:30pm?

No  Yes

List any potential conflicts those days:

Are you available for additional training on March 28<sup>th</sup> from 2-5pm? [CSE]

No  Yes

List any potential conflicts those days:

Are you available for additional training on April 2<sup>nd</sup> and 3<sup>rd</sup> from 12:30-6:30pm? [OSCE]

No  Yes

List any potential conflicts those days:

Are you available for work as an SP on April 4<sup>th</sup> from 12-5pm? [CSE]

No  Yes

List any potential conflicts that day:

Are you available for work as an SP on April 5<sup>th</sup> from 12-5pm? [CSE]

No  Yes

List any potential conflicts that day:

Are you available for work as an SP on April 9<sup>th</sup> from 11:30-8:45pm? [OSCE]

No  Yes

List any potential conflicts that day:

Are you available for work as an SP on April 10<sup>th</sup> from 11:30-6:30pm? [OSCE]

No  Yes

List any potential conflicts that day:

Are you available for work as an SP on April 16<sup>th</sup> from 11:30-8:45pm? [OSCE]

No  Yes

List any potential conflicts that day:

Are you available for work as an SP on April 17<sup>th</sup> from 11:30-6:30pm? [OSCE]

No  Yes

List any potential conflicts that day:

Appendix B

Sample Availability Form

**Standardized Patient Availability**

Name: \_\_\_\_\_

Age: \_\_\_\_\_

email: \_\_\_\_\_

Phone: \_\_\_\_\_

Check the following dates/times for which you are available:

- \_\_\_\_\_ Dec. 4 (Sunday), 12pm - 3pm [Training]
- \_\_\_\_\_ Dec. 5 (Monday), 12:30pm - 6pm [Workshop]
- \_\_\_\_\_ Dec. 6 (Tuesday), 12:30pm - 6pm [Workshop]
- \_\_\_\_\_ Dec. 12 (Monday), 12:30pm - 6pm [Workshop]
- \_\_\_\_\_ Dec. 13 (Tuesday), 12:30pm - 6pm [Workshop]

**Return to Ted Carter's mailbox in the Theatre Department no later than 10am on Thursday the 17th.**

## Appendix C

### Sample Agenda for Boot Camp

#### Boot Camp Agenda

##### **DAY 1**

1. Introductions
  2. Overview of Boot Camp
  3. Administrative
    - a. Forms
    - b. Where to Park
    - c. Employment Status
- Introduction
- . History of VCU SP Program
    - a. What is an Standardized Patient?
      - i. What jobs will an SP do?
      - ii. How is an SP different from a real patient?
    - b. How are VCU SPs different?
- What to expect?
- . Different Kinds of Events
    - a. OSCEs
    - b. How to Provide Feedback
- Effective Medical Interviewing
- . FCM Questions
    - . Rubric for Communication
- Pre-SPIKES
- Practice communications w/ peers
- Videos & Rating
- . Review Ratings as Group

##### **DAY 2**

1. Review Cases 1 & 2
    - a. How to answer questions
    - b. Physical Exam Elements
- Practice cases w/ peers
- Dry Run Cases
- Debrief Dry Run
- Remediation (as needed)

## Appendix D

### Sample Event Assignment Matrix

4/4/2012		4/5/2012		4/11/2012		4/12/2012	
Case 1	SP A. A.	Case 3	SP M.R.	Case 5	SP L.S.	Case 7	SP G.E.
Case 1	SP K.S.	Case 3	SP R.M.	Case 5	SP C.M.	Case 7	SP K.W.
Case 1	SP C.V.	Case 3	SP S.R.	Case 5	SP N.C.	Case 7	SP M.J.
Case 1	SP M.B.	Case 4	SP J.W.	Case 5	SP M.B.	Case 8	SP R.B.
Case 2	SP S.R.	Case 4	SP R.B.	Case 6	SP J.B.	Case 8	SP S.R.
Case 2	SP R.B.	Case 4	SP J.B.	Case 6	SP R.W.	Case 8	SP M.R.
Case 2	SP M.R.	Case 4	SP T.N.	Case 6	SP R.B.	Case 8	SP. R.M.
Case 2	SP. R.M.			Case 6	SP T.N.		
Admin	SP J.D.	Admin	SP J.D.	Admin	SP S.R.	Admin	SP J.W.

## Appendix E

### Sample Case 1

Case Name	· Brian / Susan McMahon
Presenting Situation	· Knee pain
Psychosocial Profile	· You are an 18-24 yo College student (male or female)
Opening statement	· <i>“My knee hurts so bad I can hardly walk.”</i>
History of Present Illness	<ul style="list-style-type: none"> <li>· You started having pain in your right knee yesterday while playing football.</li> <li>· The pain began while pivoting on your right leg (there was an outward twisting motion in your right leg as you began to fall).</li> <li>· The pain was severe (8/10) and sharp.</li> <li>· Your knee was swollen last night, but you put ice on it and kept it elevated so the swelling is better today.</li> <li>· You have been taking 2 Extra-Strength Tylenol every 6 hours since it happened.</li> <li>· The Tylenol has helped the pain somewhat (4/10) but when you try to walk the pain is still severe (6-8/10).</li> <li>· While walking your entire knee hurts but especially the inside (medial aspect).</li> </ul>
Past Medical History	<ul style="list-style-type: none"> <li>· You had recurrent ear infections as a child.</li> <li>· You fractured your wrist at age 14 while skateboarding.</li> <li>· You are allergic to Penicillin (the reaction is a rash).</li> <li>· You are on no medications other than the Tylenol (you have taken 2 every 6 hours since the injury).</li> </ul>

Family History	<ul style="list-style-type: none"> <li>· Your maternal grandmother has arthritis.</li> <li>· All your other family are alive and well; your parents are healthy; you have 1 sister who is also healthy.</li> </ul>
Social History	<ul style="list-style-type: none"> <li>· (Acronym for remembering: <b>HEADSS</b>)</li> <li>· Home Situation: you live off campus with 2 roommates, they get along well. <ul style="list-style-type: none"> <li>○ Your family lives in Virginia Beach and you spend summers with them.</li> </ul> </li> <li>· Education: you are a full time college student - a sophomore, doing well.</li> <li>· Activities: You work part-time at Best Buy, play intramural flag football, enjoy hanging out with your friends</li> <li>· Drugs or Alcohol: You do not smoke or use drugs. You drink Alcohol only at parties on weekends.</li> <li>· Support: Your family, girl/boy friend, and friends are all supportive.</li> </ul> <p>Stressors: You are very worried: <i>“I don’t know how I can go to work, or to class like this; can you give me a note?”</i></p>
Physical Exam	<ol style="list-style-type: none"> <li>5. If the student palpates your knee on the inside, it is very tender and makes you wince (the medial joint line is tender). Say “It’s a little sore”.</li> <li>6. If the student slides your knee forward and backward, you should wince (just from the movement - the tests don’t make it any worse, “It only hurts because of moving it”) [Anterior and Posterior Drawer tests negative, Lachman test negative]. <ul style="list-style-type: none"> <li>● If the student bends your knee about 30 degrees and tests the flexion of your knee from inside to outside</li> </ul> </li> </ol>

	<p>(moving sideways to the hinge) you should express diffuse discomfort (“it hurts kind of everywhere in the knee”) [Valgus test - MCL - produces diffuse discomfort].</p> <ul style="list-style-type: none"> <li>● If the student bends your knee about 30 degrees and tests the flexion of your knee from outside to inside (moving sideways to the hinge) you feel no pain (“it hurts kind of everywhere in the knee”) [Varus test - LCL - negative.</li> <li>● If the student hyperflexes your knee (makes it close all the way) and flexes the joint from outside to inside or vice versa while extending it, you feel sharp pain. [McMurrays is positive - meniscus].</li> <li>● If the student asks you to lie face down and presses on your hamstring while twisting your ankle, it causes diffuse pain (“It only hurts because of moving it.”) [Apley distraction test].</li> <li>● If the student asks you to lie face down and applies downward pressure on your knee while twisting your ankle, it causes diffuse pain (“It only hurts because of moving it.”) [Apley grind test].</li> </ul>
Special Instructions	<ul style="list-style-type: none"> <li>· You are worried that you “really messed up” your knee.</li> <li>· You do not think you can go to classes or work.</li> <li>· You want something stronger for pain.</li> </ul>



## Appendix E

### Sample Case 2

Case Name	<ul style="list-style-type: none"> <li>• Mel Flanigan (Depression)</li> </ul>
Presenting situation	<ul style="list-style-type: none"> <li>• Depressed patient coming to see MD for assistance with fatigue, yet inability to sleep at night</li> </ul>
Psychosocial profile	<ul style="list-style-type: none"> <li>• Male or female SP</li> <li>• Age 30s-50s (students will be quoted age of 40 years)</li> <li>• Neatly dressed, well-groomed.</li> <li>• Makes minimal eye contact with student.</li> <li>• Moves slowly and is slow to answer questions.</li> </ul>
Opening Statement	<ul style="list-style-type: none"> <li>• “I’m exhausted, but I still can’t sleep at night.”</li> </ul>
History of Present illness	<ul style="list-style-type: none"> <li>• Patient has had difficulty with both falling asleep and staying asleep at night for the past 4- 6 weeks.</li> <li>• Over past 1 week, has been drinking a glass of wine after dinner to help him sleep - worked for 2 nights, then stopped.</li> <li>• Feels exhausted all the time.</li> <li>• Takes 2 - 3 brief naps during the day as unable to keep eyes open at work.</li> <li>• Over past 1 week, has started to drink energy drinks during work hours to try to stay awake.</li> <li>• Has difficulty concentrating over past 4 weeks – frequently is making mathematic mistakes at work.</li> <li>• Has increased irritability – “snaps” at wife and children “for no good reason.”</li> <li>• No longer interested in hobbies - gardening and playing violin.</li> <li>• Wants to be left alone, not interested in being social.</li> <li>• Increased appetite over past 4 weeks with weight gain (unknown amount) – clothes are fitting tighter.</li> </ul>

	<ul style="list-style-type: none"> <li>• Feels guilty about being a bad spouse, parent, and employee.</li> <li>• Symptoms started after patient was demoted at work due to company’s financial crisis. Patient had option to either be demoted or be laid-off. Patient has always gotten good work evaluations.</li> <li>• No similar symptoms in past.</li> </ul> <p>Suicide Assessment:</p> <ul style="list-style-type: none"> <li>• Feels hopeless.</li> <li>• Trigger – demotion at work.</li> <li>• Has had suicidal thoughts – “I’d be better off dead.”</li> <li>• No plan.</li> <li>• Prohibitors to suicide: doesn’t want to abandon family and religious beliefs.</li> </ul>
Medication s/Allergies	<ul style="list-style-type: none"> <li>• No medications.</li> <li>• No known allergies.</li> </ul>
Past Medical History	<ul style="list-style-type: none"> <li>• No medical illnesses.</li> <li>• No known mental illnesses.</li> </ul>
Family History	<ul style="list-style-type: none"> <li>• Mother – post-partum depression, “but got over it pretty quickly with meds.” Mother hasn’t taken medications for depression in 35 years.</li> <li>• Father – alcoholism, died of cirrhosis.</li> <li>• No family history of suicide.</li> </ul>
Social History	<ul style="list-style-type: none"> <li>• Patient is married with 3 teenage children.</li> <li>• Marriage is stable- no issues. Patient mentions spouse is very supportive.</li> <li>• Employed as an accountant.</li> <li>• Denies tobacco, alcohol, or drug use.</li> </ul>
Physical Findings	<ul style="list-style-type: none"> <li>• Only the general appearance and psychiatry aspects of the physical exam will be addressed. (Patient should be fully dressed – no gown.)</li> <li>• Students should be examining the following during the course of the interview: appearance and behavior, speech and language, mood, thoughts and perceptions, and cognition.</li> </ul>

Special Instructions	<ul style="list-style-type: none"><li>• Asks student if he/she can get a prescription for some pills to help him/her sleep.</li><li>• Answers all questions honestly, doesn't hold back information. However, patient is very slow to respond.</li><li>• Makes little to no eye contact with student.</li></ul>
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## Appendix F

### Sample Event Schedule

#### **M2 FCM Scheduling** **Workshop 8: Mental Health (Grade ID 667)**

#### **Cases**

Case A – Patient with bipolar disorder in manic phase

Case B – Patient with depression

Case C – Adolescent patient with potential drug abuse

Case D – Patient with PTSD

#### **Time**

15 minutes in role

5 minutes feedback (from SP and student)

2 minutes for case change

#### **Schedule**

- 4 days: Feb 20, 21, 27, 28
- 3 or 4 sessions per day: 12:30, 2:00, 3:45, 5:15 (if needed)
- 4 rooms per day: Rooms 309, 311, 312, 313
- # of students per room: 3 or 4
- # of SPs per day: 4
- Event administrator needed.
- Actual student enrollment by date and time is as follows:
  - Feb 20
    - Schedule 3
      - 12:30 – 16 students, 2:00 – 16 students, 3:45 – 16 students, 5:15 – 6 students
      - 54 total
      - 1 open slot in Room 309 at 5:15, 1 open slot in Room 311 at 5:15
    - Feb 21
      - Schedule 4
        - 12:30 – 16 students, 2:00 – 16 students, 3:45 – 13 students
        - 45 total
        - 1 open slot in Room 311 at 3:45, 1 open slot in Room 312 at 3:45, 1 open slot in Room 313 at 3:45
      - Feb 27

Schedule 1

- 12:30 – 16 students, 2:00 – 16 students, 3:45 – 16 students, 5:15 – 6 students
- 54 total
- 1 open slot in Room 309 at 5:15, 1 open slot in Room 311 at 5:15

Feb 28

Schedule 2

- 12:30 – 16 students, 2:00 – 16 students, 3:45 – 15 students
- 47 total
- 1 open slot Room 313 at 3:45

**2011-2012 M2 Mental Health  
Room Schedule**

Room	<b>309</b>	<b>311</b>	<b>312</b>	<b>313</b>
Case	A	B	C	D
Case	D	A	B	C
Case	C	D	A	B
Case	B	C	D	A

## Appendix G

### Sample Instructions for Event Administrator

## Administering an SP Event

### Prior to Event

1. Acquire all materials from Sim Center (as needed)
    - a. Gowns
    - b. Sheets
    - c. Checklists
    - d. Timesheets
    - e. Simulators (eg. Ventrilosopes, Dual-head stethoscopes, moulage kits, etc.)
- Check in all SPs  
Brief SPs on setup and logistics of event  
Assign breaks (as needed)

### During Event

1. **Keep time** (as appropriate)
  2. Monitor SPs
    - a. Encourage slower SPs
      - b. Provide bathroom breaks as needed
      - c. Troubleshoot emergencies - SP related only
- Monitor Students - **Only as relates to logistics of event**  
Maintain communication with customer point of contact

### After Event

1. Make sure rooms are clear of SP materials
2. Make sure all SPs sign time sheets
3. Collect any feedback to report
4. Check in with SP coordinator

## Appendix H

### Sample Checklist

#### M1 Fall Skills Exam Case 2 (2011)

#### MD Scoring (MD) – 10 items- 9.0 points

VCU Faculty Name:			
1. Greeting the Patient	() Excellent	() Average	() Poor
2. Opening the Interview: the Patient's Story	() Excellent	() Average	() Poor
3. Non-Verbal Communication Skills	() Excellent	() Average	() Poor
4. Verbal Facilitaion Skills	() Excellent	() Average	() Poor
5. Adaptive Questioning-Continuing the Patient's Story	() Excellent	() Average	() Poor
6. Empathetic Responses & Acknowledging Emotional Cues	() Excellent	() Average	() Poor
7. Questioning skills: Lack of Jargon	() Excellent	() Average	() Poor
8. Pacing of Interview	() Excellent	() Average	() Poor
9. Transitional Statements	() Excellent	() Average	() Poor
10. Summarization	() Excellent	() Average	() Poor
11. Demonstrates Professionalism-Feedback Only	() Excellent	() Average	() Poor
12. Comments from MD			

**History of Present Illness (Hx)**  
**MD/SP Scoring – 13 items – 5.85 points**

<b>SP Name:</b>		
	<b>.45</b>	<b>0</b>
14. I feel the pain halfway between breastbone and belly button	<input type="checkbox"/> Yes	<input type="checkbox"/> No
15. The pain is a dull ache that is sometimes sharp and more severe	<input type="checkbox"/> Yes	<input type="checkbox"/> No
16. I would rate the pain at a level of 3-8 out of 10	<input type="checkbox"/> Yes	<input type="checkbox"/> No
17. This first started about 1 year ago	<input type="checkbox"/> Yes	<input type="checkbox"/> No
18. I usually notice this before meals, lasting up to an hour	<input type="checkbox"/> Yes	<input type="checkbox"/> No
19. Milk or small snacks makes the pain better, and not eating makes it worse	<input type="checkbox"/> Yes	<input type="checkbox"/> No
20. I have no other pain or symptoms	<input type="checkbox"/> Yes	<input type="checkbox"/> No
21. This is bothersome to my day-to-day life	<input type="checkbox"/> Yes	<input type="checkbox"/> No
22. I am concerned that I am less productive at work	<input type="checkbox"/> Yes	<input type="checkbox"/> No
23. I take Prozac and Albuterol	<input type="checkbox"/> Yes	<input type="checkbox"/> No
24. I take Prozac: 20 mg daily and use my Albuterol inhaler: 2 puffs as needed	<input type="checkbox"/> Yes	<input type="checkbox"/> No
25. I am allergic to Penicillin	<input type="checkbox"/> Yes	<input type="checkbox"/> No
26. Penicillin causes shortness of breath and wheezing	<input type="checkbox"/> Yes	<input type="checkbox"/> No

**Past Medical History (Hx)**  
**MD/SP Scoring – 5 items – 1.70 points**

	<b>.34</b>	<b>0</b>
27. As a child, I had chicken pox and "lots of ear infections"	<input type="checkbox"/> Yes	<input type="checkbox"/> No
28. As an adult, I have mild asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> No
29. I had my gall bladder removed	<input type="checkbox"/> Yes	<input type="checkbox"/> No



30. I was diagnosed with depression, saw a counselor, but was never hospitalized	<input type="checkbox"/> Yes	<input type="checkbox"/> No
31. I am up to date regarding colonoscopies, mammographies (if female and age appropriate), paps (if female), and cholesterol checks. I received a Tetanus shot 4 years ago	<input type="checkbox"/> Yes	<input type="checkbox"/> No

**Physical Exam (PE)**  
**MD Scoring - 3 items – 1.45 points**

		<b>0</b>	
32. Washing hands (before assessing vital signs)	<b>.45</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
33. Blood pressure	<input type="checkbox"/> Correct Technique <b>.50</b>	<input type="checkbox"/> Incorrect Technique <b>.25</b>	<input type="checkbox"/> Not Done
34. Obtain BP within 4 mm Hg (high or low)	<input type="checkbox"/> Correct Technique <b>.50</b>	<input type="checkbox"/> Incorrect Technique <b>.25</b>	<input type="checkbox"/> Not Done

## Vita

Richard Edward “Ted” Carter was born in Charlottesville, Virginia on April 24, 1980. He graduated from Western Albemarle High School in 1998. Ted received his B.A. in Theatre Arts with a minor in Philosophy from the University of Richmond in 2002. He served as an officer in the U.S. Army Quartermaster Corps and commanded soldiers in Operation Iraqi Freedom and Operation Enduring Freedom. Ted received an honorable discharge at the rank of Captain and is the recipient of two Meritorious Service Medals. He taught middle and high school Drama in Charlottesville for two years and became the Coordinator of the VCU Standardized Patient Program in 2011.