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Session 1: Introduction and Listening

**Date:** Thursday 8/29 & Tuesday 9/3
**Time:** 2:00 – 4:00 PM
**Location:** Queen Lane Seminar Rooms (SPs during the second hour)

**Objectives:**
1. Understand use of the BIC as a template for learning and feedback in the medical interview.
2. Better understand the qualities of active listening.
3. Understand the process of feedback and how it will be used in this course.
4. Understand the components and the skills of taking an HPI.

**DocCom Assignment:**
- Module 07 Open the Discussion
  - Read the module. No need to complete multiple-choice or discussion questions.
- Module 08 Gather Information: Review.
  - Module 08 is also assigned for your next session. The assessment is not due at this time.

**Discussion:**
(60 minutes)
- Introduction of group members
- How the course works
- Use of the BIC
- Principles of feedback
- Listening Exercise
- Overview of interviewing
- Data Gathering
- History of the present illness
- Understanding BIC IA (Opening), IB (Exploration of the Problems), IVA (HPI)

**Standardized Patient Small Group Exercise:**
(45 minutes)
- Eliciting the HPI
  - Facilitator interviews SP
  - Students critique and discuss

**Wrap-up:**
(15 minutes)
What did we learn today? Topics for next session.

**Personal Awareness: Topics for Reflection**
In communicating with a woman who has an abnormal amniocentesis, some of your values and attitudes can affect what you say. For example, what are your attitudes toward abortion? And how will that color your discussions? How would your attitudes toward mental retardation or other birth defects affect your questions and advice to your patient? The patient will probably be dealing with sadness, anger and disappointment. How would that make you feel, and how would you use your own feelings in a therapeutic way for the patient? Attitudes toward certain aspects of
the patient's life may affect your communication. Suppose she is unmarried, or doesn’t know who the father is, or has a same sex partner, or is impoverished and cannot care for another child? Would these issues affect how you might talk with a woman about her abnormal amniocentesis?
Introduction (about 1/2 hour)

Please start by having all group members introduce themselves, and give a little of their backgrounds, interests, how they became interested in medicine, etc. Some students will have already had some experience with patients. Please say a bit about your own background and experiences that you will bring to facilitating these sessions. Make some comments about the nature of co-facilitation with fourth year students, and discuss how you will be sharing (if that is the case) teaching with other faculty and students. Go over the general format of each session (see “Notes on Small Group Facilitation” handout). Emphasize the importance of doing the DocCom assignments on time. Most of the readings are from DocCom, but there are also assigned articles that will be on the course website. Invite questions about the course format.

Discuss the learning goals of this session:

1. Understand the use of the BIC as a template for learning and feedback
2. Better understand qualities of active listening
3. Understand the process of feedback and how it will be used in this course
4. Understand the components and skills of taking an HPI

Introduction to the skills of interviewing

Ask students to discuss the functions of medical interviewing, and the core of skills needed to elicit a history, as delineated in the assigned DocCom modules. Go over the BIC in more detail, and emphasize the skills in IA and IB, used in eliciting a history. Ask students to describe their understanding of these skills. The BIC key will also help in this discussion. You should also go over the elements of the HPI. Briefly review BIC IVA. Go over the notion of how clinicians use closed-ended questions at the end of the open-closed cone in testing hypotheses based on their differential diagnoses.

Understanding feedback and its use in this course

Please go over the nature and purpose of feedback in this course (see “Notes on Feedback in This Course” in your “Notes on Small Group Facilitation” handout). Discuss the usual format of feedback (goals agreed to before the exercise, after the exercise, students who interview do self-evaluation, first saying what they did well, followed by peer and then faculty critique. When appropriate, ask SPs for their feedback.) Also, be sure to invite student feedback to faculty co-facilitators on how the sessions are going in the interest of constantly improving the learning experience.

Listening Exercise (This exercise can be done before or after the SP interview - SPs arrive at 3pm). Otherwise, assign as homework to be discussed at next session.

Active listening is at the heart of medical interviewing and is different from the listening we do in normal conversations. The goal of active listening is to truly understand what the other person is trying to convey, what it’s like to be that person going through the experience that s/he is telling you about.

Active listening can be therapeutic for patients. The following exercise can help clarify what it is like for patients who are talking about personal issues to someone they have only just met. Students can also get a better sense of how doctors listen.

Ask students to form pairs and perform this task: for five minutes, one student will talk while the other listens. The student will say something about what it is like to be here now in medical school, or something meaningful that has happened recently, or something important to them that would help another understand him/her better.
Students should only talk about things that they would feel comfortable in sharing. The student listening may only reply to clarify, or to reflect back understanding of what the other has said, though head nodding, saying “uh-huh,” or other comments to indicate that the student is listening. Please keep time and announce the five-minute mark. At the end of the five minutes, the student who is listening should take about two minutes to say what he or she has heard the other student say and include the facts and feelings about them. During the next five minutes the pair can talk about that experience. If there is time, another student can speak while the other listens. Afterwards there will be a general discussion on the experiences of listening and being listened to. Students have many responses to listening and being listened to - some students find the five minutes flies by while others feel that it is a long time. Some students have said more than they intended. Some students wonder if the listener is interested or cares about what they are saying; some listeners feel awkward because they are always thinking of things they want to say to the other student as a way of connecting, which may get in the way of listening. The many reactions that students have to this exercise can provide a rich discussion about the nature of active listening.

Standardized patient interview demonstration

Your SP will be a patient with new onset asthma, in to see you for an initial visit. Either you or your co-facilitator should demonstrate an interview, focusing on the elements of the HPI and the skills you use in eliciting the HPI. Critique yourself first, and then ask for student critique and questions. Feel free to extend the interview to the PMH, FH, SH, etc. which will give the students a preview of where they will be going in this course. If there is time, you might play a patient with a simple illness story and ask for a student to volunteer taking the HPI, practicing a few skills like greeting, open-closed cone questioning and segment summary.

Wrap-up

Allow 15 minutes to wrap up, review relevant lessons from the day, and plan for next time. Session 2 will focus on students’ reactions to beginning dissection of their cadavers and on how personal attitudes toward illness, vulnerability and death can affect patient care. Please ask students to read Cadaver Stories (there is a link on the syllabus entry for session 2 on the course website) and to bring something they have written for the basis of the discussion. These written pieces can be essays, poems, etc. similar to the Cadaver Stories reflecting their feelings, thoughts, spiritual and religious beliefs about confronting a dead body, dissection and experiences with death.

Debrief

Please meet with your student co-facilitator for about 30 minutes after the session has ended to review your work together, to fill out daily worksheets evaluating student skills and to plan for next time. Discuss which portions of the next session the fourth year student might want to facilitate.
FACILITATOR NOTES

Session 2: Personal Attitudes Toward Illness, Vulnerability and Death

Practicing the HPI

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Objectives:
1. Explore feelings and thoughts in relation to beginning dissection.
2. Expand understanding of how personal attitudes toward illness, vulnerability and death might affect patient care.
3. Review the elements of the opening of an interview and eliciting an HPI.
4. Understand how facilitation skills to elicit a patient's history.
5. Understand the importance of techniques of eliciting patient concerns, beliefs, fears and hidden agendas.
6. Understand what is meant by professionalism and how this session promotes self-reflection as a necessary and healthy habit for professional development.

Module 08 Gather Information

Read: Coulehan, J., Cadaver Stories, Medical Encounter, 14-18. (1994 Fall) and Melinda Moniz: Honorable Name. Also, please read the definition on Professionalism.

Write: A brief piece that expresses your reactions to beginning dissection. This can be a creative piece – a story or poem, or simply your feelings and thoughts. Describe how your awareness of your own feelings and thoughts relates to your professional development as defined in the ABIM definition of Professionalism. Bring this with you to the session and be prepared to share with your group members.

Clinical Framework Issues:
- Further thoughts from last session.
- Reactions to dissecting a cadaver and sharing of written reflections.
- Practice the skills of eliciting an HPI with a standardized patient.
- Include attention to the use of facilitation skills, especially attentive silence, and eliciting the patient's concerns.

What did we learn today? Topics for next session.

What were your apprehensions about dissection? Did the "Cadaver Stories" reflect how you felt when beginning your dissection? Has the prospect of, or experience with dissection, caused you to reflect on your own attitudes about death and dying? How do you feel dissecting a cadaver will influence your attitudes toward death and dying, and your abilities to work with patients with these issues? (Some feel that dissection is the first step in physicians’ increasing familiarity with death, which may lead to becoming distant or insensitive in dealing with the issues of death and dying.) How might your personal experiences with loss and grief affect your ability to work with dying patients? If you were dying, what do you think you would want and need from your physician?
Learning Objectives
1. Students should explore their feelings and thoughts in relation to beginning dissection
2. Students should expand their understanding of how their personal attitudes towards illness, vulnerability and death may affect their care of patients
3. Review the elements of the opening of an interview and eliciting an HPI
4. Understand using facilitation skills to elicit a patient’s history
5. Understand the importance and techniques of eliciting patient concerns, beliefs, fears and hidden agendas
6. Understand what is meant by professionalism and how this session promotes self-reflection as a necessary and healthy habit for professional development.

Discussion for the first hour of this session
Students begin their dissections this week on Wednesday, September 17th at 11:00AM – an “Evaluation of the Cadaver” in the Gross Anatomy lab. Please discuss students’ personal reactions to dissecting the cadaver. Beginning dissection can bring up powerful feelings for students around the issues of illness, vulnerability and death. It is important to discuss these issues since attitudes can greatly affect physicians’ care of chronically ill and dying patients, giving bad news to patients and their families, discussing advance directives with patients, and working with grieving patients and families. Because of their attitudes and beliefs about death, or the emotional pain of losing a patient, physicians may become distant or over-involved, or may under- or over treat their terminally ill patients. It has been said that the cadaver, being the physician’s “first patient,” can begin the process of objectifying patients and their diseases, and can lead to students suppressing their own fears of vulnerability and death. Hopefully, today’s discussion will be a meaningful one that will allow students to understand the beneficial effects of talking about these issues with each other.

The “Cadaver Stories” readings should be a good jumping off point. Also, students should have written their own stories or other creative pieces that they might want to share with the group. You might want to start off the group by reading aloud Melinda Moniz’ poem, “An Honorable Name,” on page 6 of these notes. Then, please give each student a chance to read or present what they have written for today. Invite students to say more about their contributions and ask others in the group to comment.

For this discussion other questions may be useful to consider:

a) What are/were your apprehensions about dissection?
b) What are your feelings, thoughts about your cadaver?
c) How might certain attitudes related to death and vulnerability be likely to affect your patient care in general?
d) How do you think your feelings and personal experiences with loss and grief might affect your ability to work with dying patients?

Also, we would like to enhance students’ understanding of the concepts and behaviors that comprise professionalism. We asked the students to read the ABIM definition of medical professionalism and to reflect how feelings about dissection relate to the development of professional identity. Below is that definition:
AMERICAN BOARD OF INTERNAL MEDICINE
Professionalism in Medicine

Definition and Objectives
Professionalism in medicine requires the physician to serve the interests of the patient above his or her self-interest. Professionalism aspires to altruism, accountability, excellence, duty, service, honor, integrity and respect for others. The elements of professionalism required of candidates seeking certification and recertification from the ABIM encompass:

A commitment to the highest standards of excellence in the practice of medicine and in the generation and dissemination of knowledge.

A commitment to sustain the interests and welfare of patients.

A commitment to be responsive to the health needs of society.

These elements are further defined as:

Altruism is the essence of professionalism. The best interest of patients, not self-interest, is the rule.

Accountability is required at many levels – individual patients, society and the profession. Physicians are accountable to their patients for fulfilling the implied contract governing the patient/physician relationship. They are also accountable to society for addressing the health needs of the public and to their profession for adhering to medicine’s time-honored ethical precepts.

Excellence entails a conscientious effort to exceed ordinary expectations and to make a commitment to life-long learning. Commitment to excellence is an acknowledged goal for all physicians.

Duty is the free acceptance of a commitment to service. The commitment entails being available and responsive when "on call," accepting inconvenience to meet the needs of one’s patients, enduring unavoidable risks to oneself when a patient’s welfare is at stake, advocating the best possible care regardless of ability to pay, seeking active roles in professional organizations, and volunteering one’s skills and expertise for the welfare of the community.

Honor and integrity are the consistent regard for the highest standards of behavior and the refusal to violate one’s personal and professional codes. Honor and integrity imply being fair, being truthful, keeping one’s word, meeting commitments and being straightforward. They also require recognition of the possibility of conflict of interest and avoidance of relationships that allow personal gain to supersede the best interest of the patient.

Respect for others (patients and their families, other physicians and professional colleagues such as nurses, medical students, residents, and subspecialty fellows) is the essence of humanism, and humanism is both central to professionalism, and fundamental to enhancing collegiality among physicians.
A major responsibility of those training internal medicine residents and subspecialty fellows is to emphasize the importance of professionalism in the patient/physician relationship and to illustrate this by example.
The ability to affect attitudes, behavior patterns and ethical conduct in patient care must be recognized and used during residency and fellowship training a time of unique clinical, educational and social experiences for physicians. It must also continue after training and throughout one’s professional career.

**Practice Data Gathering Skills**

Devote the second hour of this session to practicing the skills of data gathering. A standardized patient will be waiting outside your Seminar Room at 3:00PM (you will have to invite him/her in when you are ready to begin the interview). Please quickly review the skills of data gathering and the elements of the HPI and reinforce and highlight the BIC skills I A & B and IVA. Please also introduce the importance of facilitation skills, BIC IIA and understanding the patient’s perspective, BIC IVB.

Review BIC IIA, facilitation skills. Stress that these skills help the patient tell his or her story, that they are skills of active listening. Please stress the importance of attentive silence as a facilitation skill, since this is perhaps the most unnatural skill for beginning medical students to learn. Use of silence means that if the patient stops in the middle of a narrative, or becomes quiet because of an obvious emotional reaction; the interviewer needs to keep silent until the patient begins talking again. (Or, after a respectful silence, the interviewer can ask the patient what s/he is feeling). We specify on the BIC key that silence must be at least three seconds long because our observation is that many students find it difficult to allow silences for that long.

Discuss the importance of eliciting patient concerns, beliefs, fears and hidden agendas (BIC IVF). The fourth year student co-facilitator will have read students’ responses to the optional questions in the assigned DocCom module, and can refer to these in helping to lead the discussion. If possible, give examples from your patients about how these issues colored patients’ perceptions of their illnesses, may have led to more patient (and physician) anxiety and inappropriate testing when not elicited, how misconceptions about their illnesses and treatment may lead to unwarranted fears and noncompliance, etc. (For example, some patients believe that hypertension means that their blood pressure is only raised when they are stressed, so they do not take their medications when they are not feeling tense.) Also, not eliciting patient concerns and hidden agendas frequently leads to the “Oh, by the way...” as the physician is trying to end the visit.

Ask a student to volunteer to interview. You might want to stop and start the interview several times to coach the student, point out effective use of skills and ask the other group members for input. You might ask a second student to practice taking the same history, or starting up where the first student leaves off. Please ensure that students try out BIC skills in eliciting the HPI, especially surveying major symptoms, asking the patient to start at the beginning, focusing using an open-to-close cone, and segment summary.

Encourage them to use facilitation skills including repeating the patient’s last statement, head nod, etc. Make sure that a student asks about the patient’s main concerns and worries.

**Wrap-Up**

Take about 10 minutes to review what we have learned from this session. Also, please plan for the next session, a hospital session in which we will further practice data gathering with a hospitalized patient.
Debrief

Please meet with your student co-facilitator for about 30 minutes after the session has ended to review your work together, to fill out daily worksheets evaluating student skills and to plan for next time.

NOTE TO 4TH YEAR STUDENT CO-FACILITATORS: Please arrive early (at least 1/2 hour) for your next session in order to ensure that your group’s designated patients are still available and willing to be interviewed!

Abington’s patients’ list will need to be personally picked up from Stacey Bolton. Her office is located within the ‘Old Cafeteria’ (in the back and off to the left) on the ground floor of the Rorer Bldg. If she is not in her office, the 4th year is to call her from any white phone, ext 4213.

Hahnemann patients’ lists can be found on the information board next to room 6601 on the 6th floor.
An Honorable Name

Melinda Moniz
Drexel, ‘04’

My hand was on your shoulder
-as if to comfort you.
I wish I knew your name
A comrade suggested we should name you.

I immediately suggested “Gloria,”
a name to reflect my admiration and reverence.
I respect you and I hope to earn yours,
Most of all, I thank you.

I am touched by your gift, beyond words.
I can imagine how difficult it must have been
for you and your loved ones,
to have made this final benevolent decision.

Your bravery made me feel unworthy, yet in awe
of the venerable courage of a noble woman.

As I examined the beautiful fabric of your being, I appreciated
Your body as a familiar friend and teacher
Who invited me into a treasured home.

Guide me, teach me, forgive me
Ever sorry, forever grateful
Glory to you great lady.
Cadaver Stories
By Jack Coulehan

What's the story? One story is: When you get to medical school, you dissect a human body! The professor says, “Your cadaver is a specimen. Here are the rules. Be serious. Be respectful. Maintain your distance.” But the professor also knows that tales begin in that long bright room. A rite of passage. The first step of clinical distance. The beginning of a covenant, a token sacrifice. I recall the last words of Socrates, “Crito, I owe a cock to Aesclepius.” Crito promised to make that sacrifice, to pay the debt. The students, wearing new white coats, walk into the laboratory. They think they are going into that room to learn muscles and arteries, organs and fissures. And it is true. They do not learn the marvel of sameness, the random toss of variation. In the body they find no story, neither drama nor intention. But if they listen, they hear a voice that speaks the word “abomination” one student hears a whisper of abomination. Once when she glances at intestines stored between a cadaver’s legs. One hears it when he peels his body’s face. They begin to question their losses. When they look to the cadaver for help, they find it silent. Resistant.

When they look to themselves for help, for a way of responding to “abomination,” they discover stories, their stories. The students present these tales to their cadavers in gratitude. The cock they offer to Aesclepius is narrative. At SUNY Stony Brook, we ask first year medical students to write the story of their cadaver, either the imagined life of the person whose body they dissect, or the history of their own relationship with that body. The following are three such stories.

Sadie
By Amanda Ratliff

Sadie sat in front of her floral calendar, fixating on a crocus from February, even though it was now May. After several minutes of winter reverie, she slowly stood and made her way to the phone. Slowly, she dialed her sister's number. She sat down as she listened to the repeating ringing. Her sister had bad emphysema and so moved slowly, guarding each breath she took. As Sadie fiddled with her now-too-loose wedding band, she lost her grip and it fell to the floor. Reaching over to retrieve it, her back spasmed. She hung, head close to the stain-proof carpet, grimacing with pain as she struggled to realign herself.

“Do not cut too deep. You may inadvertently damage superficially positioned nerves. Disregard the following instructions for skin incisions if you have already dissected the upper limb...” I had not. I had never imposed any sharp object into flesh except a sewing needle to extract splinters. As we rolled the moist chemical-laden sheet down to expose the cadaver, I was thrilled, petrified, remorseful. She lay on her back; her eyeballs rolled back, her mouth half-opened as if she had one more thing to say. Our first contact involved lifting her and placing her on her stomach so that we could begin by “exploring” the muscles of her back. She was so light, so frail, so unaware that we were there.

There was nobody home, perhaps. She had let the phone ring 22 times, as she always did. Her sister, Blanche, could not possibly require more than 22 rings to walk the 10 feet that separated her TV from her phone. Perhaps she was watching her favorite game show and didn’t dare miss a moment. Sadie was calling to find out what food she needed to bring to the Happy Heart cooking class at the senior center. Sadie had the coronary vessels of a 35-year-old, her long time friend and family physician always said, but Blanche was not so lucky.

She had lived a life filled with lard spread on everything (“to keep her husband and children from shriveling up and disappearing”), two packs of cigarettes a day (since age 17, when she married and was “free to make her own choices”), and devoid of any movement other than climbing the one flight of stairs that lead to her apartment and walking the half a block to the grocer's to buy more lard and cigarettes. The results were three angioplasties, one heart attack and a triple bypass operation.

“Removal of the Heart. The eight great vessels must be severed, but the posterior wall of the pericardial sac should be left intact. Identify the transverse pericardial sinus. Mark it by placing a pencil or probe through it.” By this time, I've been cutting and probing three times a week for several weeks.
Severing the vessels that anchored the heart in the thorax, I've lifted the heart from its cage, identifying and following the paths of the various arteries, exploring the connections between chambers. In between lab sessions, I've carefully placed the heart so that it would stay moist in a plastic bag.

Sadie hung up the phone and carefully reached for the Ziploc baggy that contained her needlepoint. She had enjoyed needlepoint since she was a young girl. Gradually the size of her projects, the needles she used, etc. had increased to compensate for the growing difficulty she had with seeing small, close things clearly. Max, her husband, had had similar difficulties in the years before his death. For the last few months of his life, Sadie saw for Max, tirelessly reading him letters, describing scenes on the television, and leading him through the dark underworld of the subway when he had someplace he needed to go.

“It is recommended that the right orbital cavity be approached superiorly though its roof. The orbital plate of the frontal bone must be removed to reveal nerves, vessels and muscles. In contrast, the left orbital cavity should be dissected using the anterior approach. Eventually, the dissection is concluded with the enucleation of the right eyeball.” Her eyes were deflated and colorless. They were surrounded and protected by an array of bones, muscles and fat. I’ve proceeded to strip all of this protection from her most vulnerable sources of sight. As we identified nerves and vessels, discussing the neural routes responsible for the esoteric act of “seeing,” I wondered what the last thing she had seen before dying was. What would explain the look of horror that we cannot remove from her face?

The needlepoint project on which Sadie was working was the image of a giraffe, to be made into a pillow for her granddaughter who was about to turn ten. Sadie would be unable to celebrate the birthday with her because her son and his family were living in Tanzania, helping to set up a water sterilizing system for a community. The casualness with which her son and his wife had made this decision to go so far from home, for such a long time, and with a young child, to a country drowning in its own misfortune was incomprehensible to Sadie. But she knew that resisting change and new ideas shortened one’s life, so she was careful not to judge (overtly). She was planning to sew a few packs of M&M’s into the pillow to surprise her granddaughter, who must be sorely missing her American drive-thru diet. Sadie imagined dinners boasting reptilian delights and wondered what a nine-year-old girl from the suburbs would find to fill her stomach in Tanzania.

“Next, remove the GI tract together with its three unpaired organs (liver, pancreas, spleen). Tie a string around the esophagus close to the diaphragm. If the thorax has already been dissected, tie the string around the esophagus just superior to the diaphragm.” Once the entire GI tract was freed from attachment to the abdominal cavity, we removed it and, each taking an end, spread it out to confirm its great length. It was beautiful and simple. We held it out like a double-dutch jump rope. We swung it back and forth like a metronome.

The grandfather clock reminded Sadie both that it was noon and time to eat. Since Max died, Sadie found, she had to rely on cues for when to eat, because days could easily pass without hunger. On her way to the kitchen, the phone rang. After a minute of heavy breathing, Blanche identified herself. They took turns recounting the events of their days, made plans for going to the senior center later that day, and hung up. Sadie worried that her sister’s breathlessness was sounding worse. She continued on her way to the kitchen. Suddenly she felt an explosive pressure in her head as if she had been hit with a bat from behind. She fell to the floor, crying for help as blackness obscured the room. An hour later, the phone rang. Blanche calling to advise Sadie to bring an umbrella. The phone rang and rang.

The cadaver’s brain had not been well preserved, so when we removed the top of the skull we were confronted with amorphic tapioca-like tissue. The only thing that we could discern was that a vessel in the occipital region had burst. We have removed her facial skin, the top third of her skull, half of her lip, her eyelids and one of her ears. And yet, the look of horror on her face persists.

n.b. The italicized phrases in quotation are taken from Grant’s Dissector (tenth edition).
Deconstruction
By Jennifer McIntosh

One evening last summer I was sitting atop a rocky cliff on a secluded part of the French Mediterranean at twilight. Enjoying a picnic of fresh French bread, cheese, wine and chocolate, I remarked to my companions that life really couldn’t get better than this. Then I remembered-Gross Anatomy loomed before me!

This wasn’t the first time the anxiety surfaced. It appeared every time I really seemed to be enjoying myself. In order to salvage the rest of my vacation, I decided to find someone who could tell me what to expect in my first year of medical school. Fortunately, my guidebook had a listing—“Relief for Anxiety-Ridden Post-Pre-Meds.” But when I found the two adjacent offices the book suggested, I thought something must be wrong. The placard of one office read “Jacques’ Construction,” while the other “Pierre’s Demolition.” Yet I forged ahead into the first office, hoping that Jacques could tell where the party I was seeking had moved.

“But Mademoiselle, you have come to the right place! I can tell you what to expect during your anatomy class,” Jacques proclaimed. I noticed that the room was bedecked with scientific journals and books. A complete skeleton hung in the corner.

Enthusiastically, Jacques informed me, “In Gross Anatomy you will build, build, build. You will create a body of knowledge. In fact, you have already built the scaffolding during your undergraduate education. To it you will add the many human structures both immense and minute. All, of course, named gloriously in Latin and Greek.

When I replied that the task seemed rather momentous and that my anxiety had not been relieved, Jacques added, “The answer to your worries is more building! You will learn how the body is transformed from one cell to many. This will be the glue which keeps your structure of structures together.”

I told him that I was excited about getting smarter but I was still worried about how I would feel about working with a dead person. In light of this, Jacques referred me next door to his friend at Pierre’s Demolition.

“Mademoiselle, I am glad you came,” Pierre told me. “The key to anatomy is deconstruction! You will start with a whole and reduce it to parts. You will decapitate, amputate, disembowel and castrate. You need to see what every part looks and feels like. You need to separate to define.”

Now, feeling even worse than when I had started, I told Pierre that I had come to him because I wanted to relieve my concern about working on a dead body. In particular, I wanted to know if the recent loss of my grandmother would affect my educational endeavor.

“Again, the solution is deconstruction,” Pierre replied. “You will give your cadaver a humorous name like ‘Bertha’. You will know her first as a back, then as a thorax, etc. You will keep most of her covered. ‘She must be kept moist,’ you will say to yourself. If you remember that your grandmother was a whole, a body and a spirit, then you should have no trouble. Wholes have no place in Anatomy. The parts are the important part.

I told Pierre that I still wasn’t happy. It seemed to me that, in reducing Bertha to parts, I would be loosening my grasp upon the idealism to which I so desperately wanted to cling.

“Again, think in terms of breaking down,” Pierre advised. “You must learn to separate two selves form one. Then your professional self can work efficiently and effectively without interference from your other personal and emotional self. In Anatomy, you will learn this detachment because someday your patients will depend on you to be strong when they are at their weakest.”

I told Pierre that I understood the objective, but that I still needed assurance. After all, it is tough enough to keep oneself in line; two seemed a great challenge.
Pierre suggested that Jacques could help me resolve this matter. I returned to the office of construction.

Jacques informed me, “It is true. In Anatomy, you will begin to build a professional self. Don’t worry, you won’t be alone. Together, you and your peers will come to build a community based on shared experience. You will gain a feeling of self-confidence. You will realize that you can succeed at a task even if it is very unpleasant. You will know that you have what it takes to be a doctor.”

When I felt that I gleaned all that I could from Jacques and Pierre, I departed. I hope that my soon-to-be-separated selves could spend some quality time together before their inevitable wrenching apart.

Now, looking back, I realize that Jacques and Pierre were right. There has been an inherent self-splitting in my anatomy education. Without it, I could not have endured the experience. I am also conscious of the fact that for everything destroyed there is something created.

I leave the laboratory after a day of dissection with the taste of the cadaver smell in my mouth and perhaps apiece or two of Bertha’s fascia in my hair. By now, I am used to it. It is a necessary evil. The more thoroughly I violate Bertha’s body, the more I learn.

I am good at blocking out the image of Bertha as a person. Yet, in some way, I have become strangely attached to her. I am able to get right in there and methodically dismember her, but I always make sure that the parts remain together to be deposited in Bertha’s body bucket for cremation. Bertha has lost her humanness while I have gained ‘detached concern.’

When I invade Bertha with a saw or chisel, I think of myself, “it’s happening. I am becoming callous.” Then I remember, I’m really just learning how to get this job done. I am proud when I do it well.

It helps my comrades feel the same way. We laugh and sing and chastise Bertha for being so fat. Yet, somehow, we know when to draw the line. We are surprised that we can find humor in such a situation. At the same time, we appreciate the necessity of the levity. With Anatomy nearly behind me, I am aware that as a person I have changed. Whether for good or for bad, I don’t know. Perhaps I’ll find out when they let me loose on patients. This is the anxiety that clouds my carefree moments now.

**Leaving Behind a Piece of Myself**
*By Judith Frederickson*

Dear Diary, I finally did it!! I signed the papers today, making it official. I struggled with it for a long time, trying to make the right decision. When New Year’s came and I was making my resolutions, it seemed like the right time to make a commitment. Carl never wanted me to do it-he always said that a body deserves respect, even in death, and a good Christian should have a good Christian burial. I suppose if he were alive today, I wouldn’t have gone through with it. The children don’t really approve of the idea either: they want a fancy funeral with their mother laid out in style. But I’ve wanted to donate my body to science ever since I first saw that news story about the revolutionary attempts to transplant organs. Doctor Simmons says that given my age and the state of my organs, most likely they will use my body for medical students to dissect in their anatomy lab. I must admit that I find that a little disappointing, as it would seem so much more glamorous to have my heart transplanted into a young woman’s body to save her from premature death; but as Dr. Simmons says given the state of my arteries, my heart wouldn’t be much of a gift to anyone! Although it’s much less glamorous, I suppose that by being a part of a medical student’s education I will be contributing to saving the lives of many people in the long run. I like the idea of leaving behind my mark on the world. I guess the next thing I have to do is to let Jimmy and Sarah know; I don’t think I want them to tell Sammy or Carol.
I don’t want them thinking of Grandma as a laboratory specimen, they’re too young for an image like that. But I hope that Jimmy and Sarah will understand and that Carl, wherever he may be, will forgive me.

January 8, 1993

Dear Diary,
I just got off the phone after telling Sarah about my decision. You would have thought I was planning to sell my body on a street corner! Sarah got all upset and cried and said that I was betraying Carl’s wishes and making it impossible for her and her brother to properly mourn their mother’s death. Then she went on and on about how my body would be lying naked on the dissecting table in the laboratory “for all the world to see and laugh at.” She said it wasn’t proper for a woman of my age to even think of doing such a thing. To tell you the truth, Dear Diary, I was trying not to think of such things!! I guess I am a little nervous about the idea of having my body lying exposed on a lab table, maybe being made fun of, and having a bunch of medical students cutting me apart, piece of piece. I tried to explain to Sarah that they wouldn’t be cutting me apart, since once my soul is gone, the body left behind won’t be me any more. I told her that I don’t see the big difference between my body laid out on a lab table with people staring at me and being laid out in a coffin, all made up and unnatural looking with people staring at me. Nothing I said seemed to make much of a difference, and she has made me have some second thoughts. I keep telling myself that medical students will be adult enough to treat my body with respect, but I do feel a little self-conscious. I wish Sarah hadn’t taken the news the way she did; I was all excited about finally having made a decision and was dreaming about how grateful everyone would be to me. She kind of took the shine out of it for me. I think I’ll wait a few days before bringing up the subject with Jimmy.

January 15, 1993

Dear Diary,
I just spoke to Jimmy, and he was much more supportive than Sarah. He said that although it makes him a little uncomfortable, it’s a “noble idea” and he thinks I should “do what I think is right.” He also offered to talk it over with Sarah; I’m glad he offered to do that, because I don’t feel up to talking to her about it again myself.

I can’t help thinking how typical all this is; Sarah is all upset about something I’m doing, she’s yelling at me, and Jimmy is trying to smooth it all over, just as he has always done since he was a little boy. I wish Sarah and I could get along on our own without disagreeing all the time.

January 16, 1993

Dear Diary,
Sarah called me today. She said that Jimmy spoke to her yesterday and bit her head off for upsetting me so much. We had a long discussion, and I felt much better after our talk. It’s not that Sarah has changed her mind and supports my decision; she’s still totally against the idea. But I think she understands more where I’m coming from and why I want to donate my body; in fact, she said that if she could be sure that I would be used for organ donation rather than lab dissection, she wouldn’t mind it as much. I guess I understand her point of view a little more now, too. I always feel like she just criticizes everything I do, but I guess it is selfish of me only to consider what I want to do and not to consider how it will affect those I leave behind me. After all, if I can justify allowing people to cut me apart by saying it will make no difference to me once I’m gone, I suppose I also have to realize that in some ways what happens to my body after my death will affect Sarah and Jimmy more than it will affect me. I don’t think I’ll change the legal papers yet, but I’m going to have to give this more thought.

July 25, 1993

Dear Diary,
I’ve been thinking about dying a lot recently, ever since I had my heart attack last month. I’ve gone back and forth, trying to decide whether I should change my mind about donating my body. Sarah’s accusation that I’m betraying Carl has particularly bothered me. But now that Dr. Simmons says I probably only have a short time to live, I find myself thinking about it more and more. Sarah and Jimmy have been taking the news about my health pretty hard and I don’t like to upset them more, but I think that Sarah has finally accepted how much this means to me. I tried to explain to her my recent desire to leave something behind after I die.
I find it comforting to think that my body will continue on after me. Even after death, I will continue to play a role in the world after I’m gone; it’s almost as if I won’t really be dead yet. And some day, years from now, a doctor will have a flash memory of something she learned from dissecting my body, and I’ll still be alive even then.

A Story in Reverse
By Jane Bahk (first year medical student, Northwestern University, Chicago, IL). Submitted for a writing course entitled “Reflections on Gross Anatomy” conducted by Douglas Reifler, M.D.

Before dusk settles into night, if you want to save time for the doctor who has to make out the death certificate, before they use a rope to pull away from the table, before you are wrapped in plastic, before the medical students open the plastic wrapper, rise up from the table and walk out of the operating room yourself. But do it quietly, mind you, for they may hear...

Too late. They have all turned to you again. Their hands work quickly, pounding and kneading you. You know what the doctor sees under the blindingly white light: chest stitched (knit one, purl two), beer belly, feet tinged with blue. Wait! They’ve turned from you again, huddling together, leaving you alone on the table. Their heads are down, so all the better for you to leave now since no one here seems to be looking.

Just as you wished it, people swathed in blue scrubs and wearing facemasks come in with the gurney. You roll onto it; they take you out of the OR.

They wheel you down the long, brightly lit corridor, turning left, then right. The doors open automatically into the Emergency Room where the nurses take out the IV, then move away to different patients. The resident takes a glance at you, then hurriedly moves away while writing on a clipboard. You can see that an old woman stands by a bed and knits something red, and you are reminded of your mother making your red scarf long ago. The paramedics wearing their dark blue uniforms burst into the room with a stretcher. They push you onto it rudely and take you out of the hospital and into the cramped ambulance.

The siren screams as the ambulance races down the highway, down local streets during rush hour, past the mall, past the local grocery store, Dino’s Pizzeria...There’s the Forrestal place, Ed’s old house, Willow Park and their Fourth of July fireworks, the entrance to your subdivision, the stop sign. Then only a few more houses till you’re...

Home. Red brick, white shutters, geraniums in the front. The paramedics take the stretcher off, and you see a woman standing at the doorway, the tears streaking down her face. Why is she crying? They bring you back into your living room, the old upright piano in the corner. The air mask is taken off. They pound on your chest until you cough and exhale, then inhale. You feel the air coming in. The woman's tears have dried, but she looks confused, wringing her hands by her sides. Doesn’t she realize you’ve come back? They leave, and the woman moves to the doorway and exclaims, “Thank God you’re here.” She goes to the telephone and dials 911. Pacing back and forth, picking nervously at the ends of her shorts, she tells them your address, voice breaking: 55 Newland Drive. She turns away from the phone, comes back to your side, pulls you up, and brings you to the dining room.

Chicken. And potatoes. You put down your fork, then relating to her how the new manager called for cutbacks of employees. The manager was from some hotshot school on the West Coast with a management degree. You were worried, that was all. She threw you an understanding glance, trying to appease your growing anger, saying that shouting won’t help your heart.

Wasn’t that what the doctor had said? That was a long time ago. But here you are again. The doctor's office, plaques and diplomas lined on the wall, pictures of family on the desk, manila folder on the file cabinet. Everything’s going well, the doctor tells you, and you should live a long life now. Happy, ecstatic, the woman gives you her warmest smile as you grin back. The future's bright...

What do they know? You aren’t through, aren’t finished. Yet the lights are still dimming. Dusk is settling. You feel the warmth of a caress, then the scratchy familiarity of something surrounding you.

It’s the warmth of your blankets you feel as you stare out your window at the stars. You’re in the old house again, as is it had arisen phoenix-like from its ashes. The willow tree still stoops in the moonlight. Your mother and sister, though you had last seen their names chiseled in granite, now talk in low voices in the next room. You hear their murmuring, the crickets chirping, the occasional twittering of a bird or two,
breaking the absolute silence of the night. Against the inky blue sky, the moon glows luminously and sheds light on the tops of trees. You can hear your father telling you where the North Star is.

But there were no stars the night of the lunar eclipse. Mom made sure you were bundled up that winter evening, swathing your neck with the new scarf she had knitted. The first and last thing she’d ever make, she said ruefully, for it had taken longer than she expected. You didn’t like it at first; it’s scratchy and horribly bright red, a kind of Christmas red, you complain. Stepping outside, a bitterly cold wind bites your face and nips your nose. “Look,” whispers Dad. Shivering, you look up and watch in awe as the moon...

(He’s gone—shake heads, hold breath, bow heads.)
No. Wait. Watch. Shivering, you watch as the light of the moon...disappears.
Session 3: Data Gathering, Patient Concerns and Facilitation Skills

Date: Tuesday 9/24 & Thursday 9/26 (Off-site)
Location/Time: Hahnemann Hospital: 2:30-4:30 PM
Abington Memorial Hospital: 2:45-4:45 PM

Objectives:
1. Review the elements of the opening of an interview and eliciting an HPI.
2. Understand using facilitation skills to elicit a patient’s history.
3. Understand importance and techniques of eliciting patient concerns, beliefs, fears, and hidden agendas.

DocCom Assignment:
Watch the two videos in the module 5 overview section. Read the Patient-Centered Skills: 1-5 and Doctor-Centered Skills: 6 (HPI). Under the “Assessment Questions” tab, choose “Discussion Questions”, then answer question 2 by 6PM the night before your small group session.

Discussion: (20 minutes)
- Review of BIC: IA, IB, and IVA (Opening, Exploration of the Problem(s), and HPI);
- Understanding BIC IIA (Facilitation Skills);
- Discovering patient concerns, beliefs, fears, and hidden agendas (BIC IVF).

Students break into pairs, role-play, and critique each other.

Role Play (10 minutes)

Inpatient Interview: (60 minutes)

Discussion Following Inpatient Interview (20 minutes) Wrap-up: (10 minutes)
Module 05 Integrated Patient-

1. Use of hypothesis generation and testing.
2. Eliciting patient concerns and other relevant patient issues.
3. What did the patient’s non-verbal behavior reveal about him/her?
4. Feedback

What did we learn today? Topics for next session.
Discussion (about 20 minutes): Please review the learning goals of this session.

1. Review the elements of the opening of an interview and eliciting an HPI.
2. Understand using facilitation skills to elicit a patient’s history.
3. Understand importance and techniques of eliciting patient concerns, beliefs, fears, and hidden agendas.

Please review any issues or questions remaining from last week. Briefly review student answers to discussion question 2 from Module 5. (Fourth year student co-facilitators will have read and commented on these answers and should lead the discussion.) Next, briefly review the essential skills in taking an HPI. Ask for students’ comments about the two interviews in Module 5 of DocCom. What were the major differences in the two interviews? How did the physician's attitudes and skills make a difference the information elicited and the relationship with the patient? What skills were the most effective in eliciting information? How did the interviewer in the second example elicit the sensitive information needed to understand the patient’s major concerns?

Emphasize the importance of asking the patient to start at the beginning of the present illness, facilitating the patient's narrative by asking “anything else” until the patient has no more to add. Then ask questions in BIC IV to characterize the symptoms, and questions related to your differential diagnosis. Briefly review the main facilitation skills in BIC IIA. Remind students of the importance of eliciting patient concerns, beliefs, fears, and hidden agendas (BIC IVF).

Role Play (20 minutes)

If you have time, you might want to have a student play the attached role while another student interviews for five minutes, and have the group give feedback on the skills of eliciting the HPI, use of facilitation skills, and the value of eliciting the patient’s concerns. Another alternative is to divide the students in pairs and have one play the patient and the other the doctor, and after 5 minutes they stop and discuss the use of skills.

Inpatient Interview and discussion (about 60 minutes):

Go to the wards. The fourth year student co-facilitator should obtain the patient assignments before the session at a location to be announced (usually on the door of the chief residents' office on the sixth floor of Hahnemann hospital, or on the bulletin board outside the conference room next to the chief’s office on the second floor at Abington).

Divide up into 2 groups with each co-facilitator taking 4 or 5 students to the bedside. Before going into patients' rooms, ask 1 or 2 students to volunteer to interview. One student might elicit the HPI, and the second student might elicit the BIC IVF (patient’s understanding of the illness, the meaning of the illness to the patient, and the patient’s main concerns.) Please make sure that the other students have specific tasks in observing various aspects of the encounter. Interview the patient for about 15 - 20 minutes. You may want to repeat eliciting details of the HPI that the first year students may have overlooked.

After the interview, please ask the students who interviewed to critique themselves first, starting with what they did well, then how they would improve specific skills in the future. Use the BIC as a basis for feedback. Then invite other students in the group to offer their feedback. You should offer your own comments after the other students in the group have offered theirs. You may also want to comment on your thought processes as the interview progressed, and your thinking about differential diagnoses as the interview progressed. Rejoin the other group and discuss your experiences.
Group Discussion and Wrap-up (about 20 minutes):
Review relevant lessons from the day and plan for next session.

Discussion of Genogram/illness narrative assignment
Please ask students to go to the Physician and Patient Course website to download How to Prepare a Genogram and How to Prepare an Illness Narrative. Ask each student to prepare either a genogram or illness narrative for discussion during next session. Session 4 will be entirely devoted to understanding how attitudes, values and behaviors learned in one’s family of origin can influence patient care.

Debrief (about 30 minutes)
Please meet with your co-facilitator for about 30 minutes after the session has ended to review your work together, fill out daily worksheets evaluating student skills, and plan for next time.
Session 3: Data Gathering; Medical Student; Nielufar Varjavand, MD

AFFECT: Tired, feeling ‘sick’

CHIEF COMPLAINT: “I can’t seem to concentrate on anything. I’m so tired, and my throat hurts so much I can’t even study or read my assignments.”

HISTORY OF PRESENT ILLNESS: You’re a first year medical student. For the past three-four days you’ve been feeling more ill. You’ve had headaches and a severe sore throat, and have tried Tylenol with a little relief. You’ve noticed white patches on the back of your throat, and swollen glands in your neck. You’ve been extremely tired, and have no appetite. For these 3-4 days you’ve been living on broth, Jell-O and ice cream. But it’s so hard to swallow; you can only get down a tablespoon or two. You’ve tried going to class, but couldn’t concentrate. You’ve got exams coming up, but have been too tired to even study.

PAST MEDICAL HISTORY: Chicken pox, age 5. Broken arm, age 12. Two years ago you had Lyme disease. You recognized it by the typical “bulls eye” rash on your chest. You felt like you had the flu. You also had a pretty bad headache, and a fever. You were treated with tetracycline, which you took for three weeks. You felt pretty sick for a few days, but got better within a week after you started the antibiotics.

CONCERNS: You know this illness probably means mono, because you’ve seen college friends get it, or perhaps it is a severe strep throat. But you are worried that it could be something more serious. (You’ve been learning about several serious diseases that can cause fever and lymphadenopathy.) Also, you wonder if this could possibly be a recurrence of your Lyme Disease. Of course, another major concern is falling behind in studies.
Session 3: Data Gathering

Role Play #1: Day Care Worker

By: Nielufar Varjavand, MD

AFFECT: Tired, speaking in a soft voice

CHIEF COMPLAINT: Severe sore throat, high fever, swollen and tender lymph glands

HISTORY OF PRESENT ILLNESS: For the past 2 days, you have had fevers up to 102, your throat hurts such that you can hardly swallow liquids, and the lymph nodes in your neck are enlarged and tender.

THIS IS WHO YOU ARE: You are a 22-year-old day care worker. It is early fall and several children in your day care are sick with upper respiratory infections. You live alone. You have friends of the opposite sex, but prefer to abstain from intercourse. You are trying to eat well, especially now that you are sick, but even drinking soup hurts your throat. You have looked in the mirror and have noticed that your tonsils are swollen and are red. Despite feeling horribly for the past 2 days, you have not taken any medicines.

PAST MEDICAL HISTORY: Chicken pox, age 2. Frequent ear infections treated w/antibiotics. Tonsillectomy, age 5.

CONCERNS: You know that you will get better soon, but want to make sure that your illness is not contagious to the children you take care of at the day care center.
Session 3: Data Gathering

Role Play #2: Medical Student

AFFECT: Tired, feeling ‘sick’

CHIEF COMPLAINT: “I can’t seem to concentrate on anything. I’m so tired, and my throat hurts so much I can’t even study or read my assignments.”

HISTORY OF PRESENT ILLNESS: You’re a first year medical student. For the past three-four days you’ve been feeling more and more sick. You’ve had headaches and a severe sore throat, and have tried Tylenol with a little relief. You’ve noticed white patches on the back of your throat, and swollen glands in your neck. You’ve been extremely tired, and have no appetite. For these 3-4 days you’ve been living on broth, Jell-O and ice cream. But it’s so hard to swallow; you can only get down a tablespoon or two. You’ve tried going to class, but couldn’t concentrate. You’ve got exams coming up, but have been too tired to even study.

PAST MEDICAL HISTORY: Chicken pox, age 5. Broken arm, age 12. Two years ago you had Lyme disease. You recognized it by the typical “bulls-eye” rash on your chest. You felt like you had the flu. You also had a pretty bad headache, and a fever. You were treated with tetracycline, which you took for three weeks. You felt pretty sick for a few days, but got better within a week after you started the antibiotics.

CONCERNS: You know this illness probably means mono, because you’ve seen college friends get it, or perhaps it is a severe strep throat. But you are worried that it could be something more serious. (You’ve been learning about several serious diseases that can cause fever and lymphadenopathy.) Also, you wonder if this could possibly be a recurrence of your Lyme Disease? Of course, another major concern is falling behind in studies.
Session 4: Focus on Families, Family of Origin

Date: Tuesday 10/1 & Thursday 10/3
Time: 2:00-4:00PM (10/1) & 2:30-4:30 (10/3)
Location: Queen Lane Seminar Rooms

Objectives:
Genograms that include family members' personality characteristics and dynamics of family relationships provide instant access to complex, emotionally loaded family material. Understanding how growing up in your family's interpersonal dynamics can reveal issues hindering your ability to be objective towards others and the study of your own personal experience helps develop the professional attribute of "respect for others" giving you the ability to accurately perceive your patient.

1. Better understand how family context might impact a patient's illness.
2. Understand how your own values and attitudes about family might affect your interviewing of patients and their families.
3. Understand the basis of values you may be applying to medical decisions. These may include stoicism, emotional expression, risk aversion, attitudes towards substance abuse, etc.
4. Share (if comfortable) what you have learned from your own background so others can learn from your experiences.

Reading and Writing Assignment:
Read: How to Prepare a Genogram or How to Prepare an Illness Narrative.
Write: Prepare a genogram or illness narrative that you feel comfortable sharing with others in your group. When doing this assignment, focus on family attitudes and behaviors that have shaped your own attitudes, which may play a role in patient care.

While doing this assignment, ask yourselves these questions:
What lessons did I learn from my family about the nature of relationships, about the nature of caregiving, and about acceptable responses to illness?
What kinds of patients might I be likely to associate with family members?
How has my family shaped my views:
• of whether people are basically good or trustworthy?
• of my responsibility toward others?
• of the limits of emotional expression – how expressive I can be, and how much emotional expression can I hear?
• of how much influence can I have on others?
• of how much I need to be right?

Discussion: Students will discuss their own genograms or illness narratives in small groups or with the entire group.

Wrap-up: (15 minutes) What did we learn today? Topics for next session.
Learning Objectives

Please remind students of the objectives of today’s session:

Students will:
1. Better understand how family context impacts a patient’s illness.
2. Understand how their own values and attitudes about family might affect their interviewing of patients and their families.
3. Understand the basis of values they may be applying to medical decisions; these may include stoicism, emotional expression, risk aversion, attitudes towards substance abuse, etc.
4. Share (if comfortable) what they have learned from their own background to enrich their understanding so others can learn from their experiences.

Genograms/Illness narrative discussion

Begin the discussions of genograms/illness narratives. We posted two handouts on the website: How to Prepare a Genogram and How to Prepare an Illness Narrative. Each student was asked to prepare a genogram or an illness narrative for discussion this session. Briefly review with your students the “Family of Origin Group Participation Guidelines” (on the first page of the How to Prepare a Genogram handout). Encourage students to answer questions for themselves presented in the syllabus:

While doing this assignment, ask yourselves these questions:
- What lessons did I learn from my family about the nature of relationships, about the nature of caregiving, and about acceptable responses to illness?
- What kinds of patients might I be likely to associate with family members?
- How has my family shaped my views:
  o of whether people are basically good or trustworthy?
  o of my responsibility toward others?
  o of the limits of emotional expression – how expressive I can be, and how much emotional expression can I hear?
  o of how much influence can I have on others?
  o of how much I need to be right?

It can often be helpful to start these discussions with either the faculty or 4th year co-facilitators presenting his/her own genogram. This presentation and discussion should take 15-20 minutes. If you haven’t already done so, please emphasize that in the discussions to come, all should agree that whatever is said will be held in complete confidence and not be repeated outside of the group. Then, break students up into groups of three. Each student will take a turn at presenting his or her genogram/illness narrative to the others. The others will listen, ask clarifying questions and make comments as suggested by the discussion guidelines. The presentation and discussion of each student’s genogram/illness narrative should take 15-20 minutes to allow all students their turns. Co-facilitators should rotate among the small groups and help out with the discussions. Afterwards, reconvene the group and then go around the room asking each student to say what they learned about themselves, and how these insights might be helpful in their future care of patients.

Wrap-up (15 min)

You might want to summarize your sense of what was learned, and appreciate the thoughtfulness and honesty of all the students. Review the details of the next session, and the learning assignments.
Debrief (about 30 minutes)
Please meet with your co-facilitator for about 30 minutes after the session has ended to review your work together, fill out daily worksheets evaluating student skills, and plan for next time.
How to Prepare a Genogram
Created by Susan McDaniel, Ph.D. and Ronald Epstein, M.D. (used with permission)

A. Family of Origin Group Participation Guidelines

Goal: The goal of family of origin groups is to understand how our family of origin experience informs and influences how we work with patients and families and how we collaborate with other professionals.

1. All presentations are entirely confidential. Please do not discuss others’ presentations outside of your small group. The only exception to this rule is that the faculty may consult with each other if any participant has a serious problem. Other than these exceptions, confidentiality is sacred.

2. Remember that family of origin presentations are vehicles for education and self-awareness, not psychotherapy groups. If this experience generates a desire for more formal family of origin work, your facilitator would be happy to try to refer you to someone skilled in this area.

3. All people find presenting their genograms to be an emotional experience. Respect the power of the experience for yourself and go slowly.

4. Think about your goals and objectives in presenting your genogram. Present your goals at the beginning of your presentation to help focus the group’s feedback.

5. Present only what you wish to present. There is no imperative to be revealing in these groups. Participants should take their cue from the presenter when deciding what type of questions to ask. If you are presenting and someone in the group asks you a question you do not wish to answer, feel free to say that is something that you would rather not explore right now. All group members should be respectful in the way you discuss personal material with the presenter.

6. Present material that is meaningful to you, rather than what you think others may wish you to present.

7. Start with the facts (names, ages, dates, deaths, marriages, divorces, illnesses, etc.). Be sure to present the strengths of your family early in the presentation. This provides listeners with a balanced picture of your family experience.

8. As a participant, ask the presenter questions that are sensitive and designed to help him or her expand the presentation, rather than questions and comments that are overly analytical or critical.

9. Describe the important themes in your family. Watch for repeated patterns across generations - both healthy and unhealthy.

10. At the end of each presentation, the presenter and the group will have time to process the experience. Sometimes people find their own or someone else's presentations activate unexpected thoughts or feelings.

11. Feel free to talk about any concerns with your facilitator at any time.
B. Questions To Think About To Focus Discussions In A Group

1. What do you make of this?
2. What qualities of the encounter were problematic for you?
3. Can you identify a pattern in other encounters you find problematic?
4. How do you think you might respond to such patients? (Avoidance, over involvement, anger, saving).
5. If you had an illness like the patient in this story, how would various family members perceive you? (Mother, father, brothers, sisters).
6. Is there any quality of those relationships that seems familiar? Which one(s)? With whom?
7. Do any family images come to mind?
8. In your parents’ view, what is a good patient?
9. In your parents’ view, what is a good physician?
10. What feelings do you have, having explored this domain?

C. Additional Questions To Broaden The Discussion

1. What are the major recurring themes in your family? In what stage of the family life cycle are you, and what developmental tasks are you facing?
2. How does your family (and how did your family when you were growing up) respond to and cope with illness?
3. What family factors influenced you to go into medicine?
4. How does your being a physician influence your role in the family?
5. How does your own health care seeking behavior affect your expectations of your patients' behaviors?
6. What specific strengths, skills, and insights do you feel that you have gotten from your family?
7. What particular blind spots, difficulties, and avoidances do you have that may be related to your family background?

D. Preparing A Genogram

The genogram is essentially a family map. It usually includes three generations but can include more generations if the patient can provide the data and the practitioner finds it useful. The genogram is also referred to as a family tree.

The use of the genogram has largely developed out of the work of family therapists such as Murray Bowen who realized the value and importance of recurring patterns in a family's history and the influence of one generation on another. The purpose of the genogram is to provide a graphic record of those patterns on both sides of the family. The generations usually included are children, parents and grandparents. The basic procedure is simple and can be done at the first and, if need be, subsequent interviews. It can be done with a single patient acting as informant although more information will emerge if the whole family is present.

The genogram can serve a number of purposes:

1. It can be used solely as a means to collect and record medical and social data for the practitioner's files. The process of doing a genogram is also a useful strategy for developing rapport with an individual or family.
2. Often it is used as a source of learning for the family. Patterns can be identified with them, these can be explored and the family can seek help to restructure their relationships.

3. Increasingly, it is being used as a way to help students learn family dynamics concepts and to help them learn about themselves. The latter is an often underemphasized area for those learning family dynamics. Each of us learns about families first in our own family of origin. We often carry unrecognized assumptions and perceptions about others' families from our initial family experience. This may affect the way we interact with families we see in clinical practice. Doing our own genograms may help us uncover and begin to deal with these perceptions and assumptions before they can impair or interfere in therapeutic relationships with patients. Doing your own genogram can be an exciting voyage of discovery.

A wide variety of data can be simply recorded through the use of symbols and a minimum of words. Information regarding generational relationships, interpersonal relationships (coalitions, cutoffs, triangles), nicknames and characteristics, roles in family (“white knight”) and health-illness data can all be outlined.

A glossary of symbols is provided to start you off. Different practitioners tend to develop their own refinements to a common basic set of symbols. Also provided is a list of questions to think about while developing your genogram and sample genograms of fictitious and real families.

HAVE FUN!
E. Areas To Ask Questions About In Obtaining A Genogram

**Description of Each Nuclear Family:**

- Family members
  - ages
  - places of birth
  - names/nicknames
  - characteristics
  - hobbies/interests/favored activities
  - labels, e.g., Identified Patient
  - present location
  - sibling position

**Dates:**

- All dates of significant events
  - births
  - deaths
  - marriages
  - divorce
  - separation
  - child leaving home
  - illness
  - graduation, etc.

**Health/Illness:**

- All major illnesses - particularly try to identify patterns within families and between generations. Reproduction concerns - e.g., abortions, congenital anomalies, sterility.
  - Cause of death
  - Drugs taken
  - Genetic disease and those which show a familial tendency
  - Health promoting activities, e.g., jogging, weight control

**Socio-economic:**

- Cultural/Ethnic data on each nuclear family
- Economic level of each nuclear family
- Religious affiliation

**Interpersonal Relationships:**

- Who relates to whom
- Conflicts, triangles, cutoffs
- Special issues (i.e., sex, money, religion) which are emotionally laden
- Closest and most distant relationships
- Frequency and mode of communication

The most important things to look for are: a) connections between events, and b) patterns to check out with the family/informant.
F. Genogram Format

1. Symbols to describe basic family membership and structure (include on genogram significant others who lived with or cared for family members—place them on the right side of the genogram with a notation about who they are.)

Male:   Female:   Birth Date: 43-78

Index Person (IP):

Marriage (give date) (Husband on left, wife on right):

Marital separation (give date):

Children: List in birth order, beginning with the

Adopted or foster children:

Fraternal twins:

Identical twins:

Pregnancy:

Spontaneous abortion:

Induced abortion:

Stillbirth:

0.5 mos.
Members of the current IP household (circle them):
Where changes in custody have occurred, please note:

2. Family interaction patterns. The following symbols are optional. The clinician may prefer to note them on a separate sheet. They are among the least precise information on the genogram, but may be key indicators of relationship patterns the clinician wants to remember:

Very close relationship:  
Conflictual relationship: 

Distant relationship:  
Estrangement or cut off (give dates if possible):
Cut off 62-78

Fused and conflictual:

3. Medical History. Since the genogram is meant to be an orienting map of the family, there is room to indicate only the most important factors. Thus, list only major or chronic illnesses and problems. Include dates in parentheses where feasible or applicable. Use DSM-III categories or recognized abbreviations where available (e.g., cancer: CA; stroke: CVA).

4. Other family information of special importance may also be noted in the genogram:

a. Ethnic background and migration date 
b. Religion or religious change 
c. Education 
d. Occupation or employment 
e. Military service 
f. Retirement 
g. Trouble with law 
h. Physical abuse or incest
i. Obesity
j. Alcohol or Drug abuse, symbol=
  
  ![](image)

k. Smoking
l. Dates when family members left home: LH’74
m. Current location of family members

It is useful to have a space at the bottom of the genogram for notes on *other key information*: This would include critical events, changes in the family structure since the genogram was made, hypotheses and other notations of major family issues or changes. These notations should always be dated, and should be kept to a minimum, since every extra piece of information on a genogram complicates it and therefore diminishes its readability.
How to Prepare an Illness Narrative

Goal: To make practical links between one’s cultural background and one’s own view of health and illness.

Please note: You may identify more strongly with certain aspects of your cultural background (e.g., religious, ethnic, or geographic origins) than others. The goal of this assignment is to reflect how your cultural values influence your view of health, illness, and help-seeking. You will also have the opportunity to interview someone who may be more familiar with the values and beliefs of your culture. It is not expected that this person will represent the views of everyone from your cultural background, but this person’s perspective may provide some insight regarding certain values and beliefs of your culture.

1) Type a detailed narrative about an illness that you have had, or that has affected a family member. This need not be something dramatic or catastrophic. In fact, the way you deal with common minor illnesses may be just as illuminating:
   a) Include a description of your feelings and your family’s response to (e.g., medical attention, home remedies) and attitudes towards (e.g., pampering, stoicism, get over it) your illness.
   b) Based on your cultural background, what was your obligation (e.g., actively seeking medical care) and role (e.g., passivity) as a sick person?
   c) Describe the response and attitude of your friends and community to your illness.
   d) To what extent was your family’s response similar to how people from your culture respond to illness?

2) Interview a health expert, i.e., the person whom the family looks to for advice when someone has a physical complaint, for example, grandparent, parent, physician, extended family member, family friend, or community healer. Here are some suggested questions for your family “health expert.” You should include whichever of these seem relevant. Feel free to add others:
   a) What do you do when someone has a cold, diarrhea, constipation, or the flu?
   b) When someone is sick in my culture, are they treated differently depending upon their age and gender?
   c) Do you use home remedies, nutritional supplements, herbs or “unorthodox” treatments? Who taught you about these remedies? Are there cultural roots to these remedies?
   d) What are some of the things that people do in my culture to maintain good health?
   e) What are some of our cultural beliefs about what causes illness?
   f) In general, when people from my culture have sought medical care, how have they been treated (include positive and negative)?
   g) How are doctors viewed in my culture? How does my family feel about going to the doctor?
   h) Are there certain problems for which we would automatically see a doctor? What types of problems would we seek care for through the emergency department?
Session 5: Past Medical History, Observation and Inspection, Non-verbal Behavior

**Date:** Tuesday 10/8 & Thursday 10/10

**Time:** 2:00 – 4:00 PM

**Location:** Queen Lane Seminar Rooms (SPs during the second hour)

**Objectives:**
1. Learn the components of the Past Medical History (PMH).
2. Understand and practice the skills of observation and inspection.
3. Understand the basis of non-verbal behavior.
4. Understand how clinicians incorporate hypothesis testing into the medical interview.

**DocCom Assignment:**

**Module 05** Integrated Patient-centered and Doctor-centered Interviewing - Structure and Content of the Interview. Review PMH section.

**Module 14** It Goes Without Saying: Nonverbal Communication in Clinician-Patient Relationships. Read the module. Answer either discussion question 1 or 2 in Module 14 online by 6PM the day before your session.

**Handout:** Observation and Inspection

**Discussion: (60 minutes)**

BIC IV B (Past Medical History) Understanding non-verbal behavior.

**Standardized Patient Small Group Exercise: (30 minutes)**

Eliciting the PMH

Practice BIC IA, IB, IIA, IVA, IVB, and IVC, followed by feedback (interviewer self-critique, and faculty feedback).

**Discussion Following the Standardized Patient Activity (15 minutes)**

- Feedback on eliciting an HPI and PMH
- Use of hypothesis generation and testing during the HPI.
- What did the patient’s non-verbal behavior reveal about him/her?
- Description of Session 6 (remember 6 is an Extra Credit opportunity).

**Wrap-up: (15 minutes)**

What did we learn today? Topics for next session.
Learning Objectives

1. Learn the components of the Past Medical History (PMH).
2. Understand and practice the skills of observation and inspection.
3. Understand the basics of non-verbal behavior.
4. Gain further understanding of how clinicians incorporate hypothesis testing into the medical interview.

Discussion (Approximately 60 minutes)

Please begin by outlining the objectives for this session (above).
Discuss the elements of a PMH (BIC IVC). Please give examples of how to elicit information in these categories. Discuss any relevant issues from the assigned DocCom exercise.

1. Fourth year student co-facilitator will lead a discussion based on students’ responses to DocCom discussion questions
2. Review the elements of the Past Medical History (Note that we added a question to the PMH about past history of alcohol or drug abuse, since substance abuse can be understood as a disease process. More detailed questions about cigarette, alcohol and drug use are still included in the psychosocial/behavioral history section.)
3. Review the handout on observation and inspection. Students will have read this on the website.
4. Review DocCom Module 14 on non-verbal behavior. You might give examples of how you use your knowledge of non-verbal behavior in evaluating patients.
5. Previously we discussed how clinicians use their knowledge of differential diagnoses to ask closed-ended questions. Please mention how clinicians might also use their observations about patients’ dress, appearance, non-verbal behavior, etc. in their hypothesis testing in medical interviews.

Standardized patient or role play Interview (About 45 minutes)

We are planning to make SPs available for this session, who will play a patient with new onset hyperthyroidism. Occasionally an SP will cancel at the last minute, so if this happens, please role play one of your own patients with a significant past medical history. If you do this role-play, please be aware of your non-verbal and para-verbal behaviors. Either way, ask one student to elicit the HPI, and a second student to elicit the PMH and BIC IVF (patient’s understanding of the illness, the meaning of the illness to the patient and the patient’s main concerns). Please ask other students to observe various aspects of the encounter. Some students should comment on observation and inspection of the patient; other students should comment on nonverbal behaviors both of the patient and the interviewer. Other students should comment on the skills used by the students interviewing the patient. In the discussion after the interview, the students who interviewed should comment first about their use of BIC skills, starting with what they did well, and then commenting on how they might improve next time. The other students in the group can then comment on the interviews and on those aspects of the interview that they were observing. The discussion should also cover the use of hypothesis generating and testing in the interview, the patient’s concerns, and what the patient’s appearance and nonverbal behaviors revealed.

Wrap-up (15 minutes)

Please reconvene and discuss how the interviewing experiences went, and review the major lessons of the day. Please briefly review the format of session 6, a practice
interview with an SP in which the SP gives feedback. This activity will take place in CEAC. A schedule listing student names and times of appointments will be posted on the Physician and Patient Course website and bulletin board along the 2nd floor corridor leading to CEAC.

Students will have ten minutes to speak to the standardized patient, followed by five minutes of feedback from the standardized patient. (Fourth year student co-facilitators are not required to participate in this exercise but may opt to attend and observe in the control room). Feedback will be based on the BIC IA and IB (opening and data gathering), BIC IIA (facilitation skills), BIC IVA and IVB (HPI and PMH), and eliciting patient concerns. **Also, there is extra credit available for doing written self-critiques (2.5 points added to their clinical framework mean score).** Papers must be e-mailed to the course coordinator Beverly Towns at Beverly.towns@drexelmed.edu within one week of session 6 (see “Introduction” to the course for details).

**Debrief**
Please meet with your student co-facilitator for about 30 minutes after the session has ended to review your work together, to fill out daily worksheets evaluating student skills, and plan for next time.
Session 5. OBSERVATION AND INSPECTION; Nielufar Varjavand, MD

During the process of interviewing a patient, a physician learns about his/her patient by obtaining an accurate and complete history as well as a thorough physical exam. However, without even touching the patient, the physician can begin the examination by observing the patient. The following is a checklist of how to do so.

**ALERT AND ORIENTED.** Is the patient conscious? Can you stimulate the patient to awaken? If alert, does the patient understand you and respond appropriately? The levels of consciousness include: normal, drowsy or obtunded, stupor, or coma.

**SIGNS OF DISTRESS.** Upon presentation, you should first note if the patient is in any distress. This can be discerned by looking for an anxious facial expression or body movement like fidgeting, crying, gasping, labored breathing, protecting a painful body part, sweating, flushing, or paleness of the skin.

**POSTURE.** How is the patient positioned? A stooped posture could include osteoporosis. A patient who sits with crossed arms may indicate his/her fright, anxiety, or distrust. A patient who sits upright and refuses to lay flat complaining of shortness of breath may give you clues to his underlying congestive heart failure.

**GAIT.** Does the patient walk easily with self-confidence? Does the patient walk slowly fearful of falling? A patient who is swaying towards one side or one who is dragging his/her foot reminds of one with a stroke. Does the patient have a wide-based gait? A patient who complains of urinary incontinence and worsening memory who you observe walking with a wide-based gait should remind you of normal pressure hydrocephalus. A patient who reports a recent sports injury but has no difficulty walking is quite different from one with an injury but with a limp. A patient with Parkinson’s disease often has a shuffled gait.

**MOTOR ACTIVITY.** Is the patient restless or quiet? Is there a resting tremor or an intention tremor? Are there involuntary motor activities?

**ATTIRE.** How is the patient dressed? This can give you a clue about his/her personality. Is the patient appropriately dressed for the weather? A patient who has hypothyroidism and therefore is intolerant of cold weather might wear an extra jacket even in the 80-degree temperature of summertime. Is the patient clean? Besides learning about the patient’s social status, you can assess if the patient is able to function on his/her own. For instance, is the patient demented and unable to function that he/she needs a caretaker? Is the patient who is already with a caretaker not being cared for, i.e., is there elder abuse? Look at the shoes. Is the patient wearing tennis shoes without the laces tied, indicating profound lower extremity edema? How are the patient’s fingernails? Note the patient’s skin. Is your patient using make-up to cover a bruise? If this is repeated or suspicious, is she trying to hide physical abuse? While talking to the patient, note the patient’s breath. Does the patient tell you he has stopped drinking alcohol, yet you can smell it on his breath? Does the diabetic patient have a fruity breath odor, indicating diabetic ketoacidosis?

**EXPRESSIONS.** How does the patient’s facial expression change during the conversation? You can pay attention to clues regarding depression, nervousness, anger, happiness, embarrassment, and surprise. Observe the elderly patient’s features. Is s/he expressionless, reminding you of the possibility of Parkinsonism?

**MANNER.** Observe the patient’s manner toward you, the staff, or family. Does the mother of a pediatric patient that you are seeing seem caring towards her child or indifferent and neglectful? Is the patient cooperative and agreeable to your suggestions? Is the patient hostile?

**SPEECH.** Does the speech seem pressured, as does the speech of someone in a manic state? Is the speech fluent or is the patient aphasic, as one with a stroke? As you can see, all of the above can give the astute physician more clues about the patient to enhance a history and examination. For more information refer to the Barbara Bates Text, Observation and Inspection.

Please discuss logistics for Session 3 – Data Gathering, this is the first hospital session. Hahnemann
FACILITATOR NOTES

NOTE: FACULTY OR STUDENT CO-FACILITATORS ARE NOT REQUIRED TO ATTEND THIS SESSION

Session 6: SP Practice Interview with SP Feedback

Date: Tuesday 10/15 & Thursday 10/17
Time: 2:00 – 5:30 PM

Check the P&P website and bulletin board outside of CEAC for your specific appointment time and room number.

Location: Queen Lane, CEAC

Standardized Patient Exercise: (15 minute appointment per student)
- 10-minute interview with 5 minutes feedback from standardized patient (sp to give BIC/checklist to student).
- Use BIC IA, IB, IIA, IVA, and IVB skills, and elicit patient concerns (do PMH if time permits).
- Also, use BIC skills IIB (Conveying Empathy).

Note:
- Your appointment time and room number will be posted on the Physician and Patient course website, and on the course bulletin board outside CEAC on the 2nd floor corridor one week prior to your session.
- Arrive 10 minutes before your appointment.

Here is the description of this extra credit opportunity from the course book introduction: You can earn up to 5 additional points on your clinical framework exam final grade (2 1/2 points for each of two exercises) by reviewing your videos of CEAC sessions 6 and 23, filling out a BIC and writing a one-page paper critiquing your use of interviewing skills in the encounters. This critique should include what you did well, and what skills you need to work on. You should also comment on how any personal feelings or discomfort may have interfered with or enhanced your interview. The completed BIC and paper should be emailed to your 4th Year Student Co-Facilitator and the Course Coordinator, Beverly Towns, at btowns@drexelmed.edu. This paper must be submitted by 6:00pm on either 10/21 (for Tuesday groups) or 10/23 (for Thursday groups) to receive the extra credit. (by 6:00pm) after your interview exercise.

InstructionstoAccessRecordedVideo
Video Viewing Instructions for Drexel Med Students

- In order to watch your video you will need to be at a computer connected to the internet and have speakers or headphones.
- Go to this URL http://simcenter.drexelmed.edu/arcadia using your computer’s web browser and log in using your Drexel UserID and password. Internet Explorer is preferred, on a Mac use Firefox.

- On the main page, you should be seeing your UserID and photo. In the main part of the screen is the dashboard. Look under the “Video” heading to see a partial list of your most recent videos. To find all videos from a particular date click “Search.”

- In the “Search Video” tab, leave the Room Number set to “Any Rooms” but change the date range to include the date of your session in the Clinical Education and Assessment Center.
- Then press the Search button to get search results. Similar in the example above, the student would be looking for all videos from Sept. 14, 2009.

~Over~
When results appear, you can click on a video to watch it. Since each room has 2 cameras, you will see 2 links from the same room.

Choose one of the links, if it does not show a good view or if you want to change to the other view, just click on the other link for that room.

Use the navigation controls located below the video window.
To make the video larger, you can left-click on the video image and a menu will appear.
Choose “Zoom,” then “Full Screen.”
NOTE: To get out of Full Screen mode, press the “Esc” key on your keyboard.

If you have any technical problems, please contact the course coordinator, Beverly Towns.
Please discuss logistics for Session 3 – Data Gathering, this is the first hospital session. Hahnemann

FACILITATOR NOTES

Session 7:

Date:

Location/Time:

Objectives:
1. Students will identify how learning skills in developing and rewarding relationships, living a balanced life and taking some time for self-care will positively affect their professional development.
2. Students will focus on issues of balance and self-care in their lives.
3. Students will discuss strategies for coping effectively with stress.
4. Students will learn to ask patients how they approach self-care.

DocCom Assignment:

Module 04 Balance, Self-Care
This is a very rich Module. We invite you to read the entire Module, but we will only discuss the sections “Personality and Study” and “Work and Intimacy” during this session.

Answer, in one or two paragraphs, either discussion question 1 or 2, by 6PM the day before your session.

Also, in preparation for this session please fill out the following Depression/Burnout Questionnaire. This is for self-evaluation only, although you are welcome to share any insights during group discussion.

Personal Awareness/Professionalism Discussion:
(45 minutes)

Each student will come prepared to talk about the answers to these questions:

1. What would be an ideal distribution of time between school, plan, friends and family and personal growth activities
2. What are the barriers to achieving balance in my life?
3. What are some practical strategies and steps I can take to achieve more balance
4. Write a 10-year retrospective dated 10 years from today, listing all of the satisfactions of these past years, the enjoyable times you have spent and the ways you have improved communication with family and friends. List the risks you have taken that have opened up your horizons.

Hospitalized Patient Small Group Exercise:
(60 minutes)

- Interview a patient and practice BIC skills.
- Ask patients about self-care activities, and how they could better take care of themselves in the future.

Wrap-up:
(15 minutes)

What did we learn today? Topics for next session.
Learning Objectives

1. Students will focus on the issues of balance and self-care in their lives.
2. Students will discuss strategies for coping effectively with stress.
3. Students will learn to ask patients how they approach self-care and how that may influence their health and illnesses.

Discussion (45 min)

The reading for this session is DocCom Module 4. As usual, the reading will serve as background for today's discussion. Also, we have asked students to complete a PHQ2 Depression Screen and a question about burnout (attached). Begin by discussing students’ impressions of the assigned sections of Module 4. Emphasize the importance of paying attention to self-care: There is a high incidence of stress, anxiety, depression, substance abuse and burnout among medical students, residents and practicing physicians. Ask students if any are willing to share concerns from filling out the depression/burnout questionnaire. (Please let students know that if they are uncomfortable talking about these concerns they can talk with you in private at a later time or get in touch with student mental health counselor, Diane Gottlieb).

Physicians cannot be effective in their care of patients if they are distracted by personal problems. Furthermore, medical trainees tend to be effective in prioritizing their time when patient care activities are concerned, but rarely take time to prioritize their own balance of work, personal and family time. This next discussion can be a time to think about these issues, and to help each other think about their own self-care and personal growth. Then, divide students up into pairs or groups of three, and ask them to address the following issues. Ask students to take a few minutes to think about these questions and to write down a few thoughts on potential strategies to achieve balance and self care in their lives and/or to reorder their priorities to achieve improved relationships with significant others and friends.

- What would be an ideal distribution of time between school, play, friends and family and personal growth activities?
- What are the barriers to achieving balance in my life?
- What are some practical strategies and steps I can take to achieve more balance?
- Write a 10-year retrospective dated 10 years from today listing all of the satisfactions of these past years, the enjoyable times you have spent and the ways you have improved communication with family and friends. List the risks you have taken that have opened up your horizons.

Ask students to discuss these ideas with each other in their small groups for about 20-30 minutes. Reconvene in the large group and ask students to share their ideas to the extent they feel comfortable. Address how stress management and self-care can contribute to professional development.

Hospitalized Patient Exercise (60 min)

Please focus on the patient's self-care behaviors and how lack of these may have played a role in onset and maintenance of illness. How can the patient improve his or her self-care? Practice the BIC skills.

Wrap-up (15 min)

Review relevant learning from today’s session.

Debrief

Please meet with your student co-facilitator after the session to review your work, fill out daily worksheets, and to plan for the next session.
Depression Questionnaire

PHQ-2
Over the past two weeks, how often have you been bothered by any of the following problems?

Little interest or pleasure in doing things.
0 = Not at all
1 = Several days
2 = More than half the days
3 = Nearly every day

Feeling down, depressed, or hopeless.
0 = Not at all
1 = Several days
2 = More than half the days
3 = Nearly every day
Total point score: ______________

Score interpretation:
PHQ-2 score
<table>
<thead>
<tr>
<th>Probability of major depressive disorder (%)</th>
<th>Probability of any depressive disorder (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>15.4</td>
</tr>
<tr>
<td>2</td>
<td>21.1</td>
</tr>
<tr>
<td>3</td>
<td>38.4</td>
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<td>45.5</td>
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<td>5</td>
<td>56.4</td>
</tr>
<tr>
<td>6</td>
<td>78.6</td>
</tr>
</tbody>
</table>

Patient Health Questionnaire-2 (PHQ-2). This questionnaire is used as the initial screening test for major depressive episode. Information from Kroenke K, Spitzer RL, Williams JB. The Patient Health Questionnaire-2: validity of a two-item depression screener. Med Care 2003; 41:1284-92.

***********************************************************************

Burnout Questionnaire

If burnout is - “Fatigue, frustration, or apathy resulting from prolonged stress, overwork or intense activity,” how well does this describe your current emotional state?

Not at all A little Somewhat That is mostly how I feel Exactly
1 2 3 4 5

After completing this questionnaire, if you have significant levels of depressive symptoms and/or burnout please consider consulting Dr. Diane Gottlieb, of our student counseling services, at (215) 991- 8532 or via email at Diane.Gottlieb@DrexelMed.edu.

Please discuss logistics for Session 3 – Data Gathering, this is the first hospital session. Hahnemann
Session 8: Empathy – Understanding the Patient’s Perspective

**Date:** Tuesday 11/5 & Thursday 11/7 (Off-site)

**Location/Time:** Hahnemann Hospital: 2:30-4:30 PM
Abington Memorial Hospital: 2:45-4:45 PM

**Objectives:**
1. Understand the concept of empathy, and the skills involved in communicating empathy.
2. Students will further understand the importance of exploring patients’ perspectives on their illnesses.

**DocCom Module 06 Build A Relationship**

Read the Module. Answer either discussion Questions 1 or 2 in Module 6 by 6 PM the day before your session.

**Assignment:**
- Review the skills of BIC IIB.
- Review the elements of understanding the patient’s perspective (BIC IVB).

**Discussion:**
(30 minutes)

- Review the skills of BIC IIB.
- Review the elements of understanding the patient’s perspective (BIC IVB).

**Role Play**
(15 minutes)

A facilitator may portray a patient with a serious illness or students may break into pairs and role-play seriously ill patients, to highlight the use of empathy skills.

**Inpatient Interview:**
(60 minutes)

- Do an HPI, PMH.
- Ask about patient concerns
- Use BIC relationship skills.

**Wrap-up:**
(15 minutes)

What did we learn today?

**Personal Awareness/Professionalism:**

Physician empathy is a complex phenomenon. It involves attentive listening, non-verbal expressions of openness and concern, thoroughness of data gathering, asking questions about patient’s life, demonstrating an understanding of the patient’s concerns, addressing these concerns, the skills of BIC IIA & IIB, and much more. Empathy is not a quality that students have or do not have, though some are more naturally able to express empathy than others. Empathy involves a set of attitudes and behaviors that one can acquire and enhance continuously. One of the goals of this course is “getting to” empathy. Personal past history and attitudes will greatly affect a student’s abilities to express empathy. What factors, in the way you have been brought up, in your expectations of other people, fears, and self-doubts might affect your ability to communicate empathy to patients? How can you work on these issues to enhance your ability to communicate empathy?
Objectives

1. Students will enhance their understanding of the concept of empathy, and the skills involved in communicating empathy.
2. Students will further understand the importance of exploring patients’ perspectives on their illnesses.

Discussion (about 30 minutes)

Review the concept of empathy. Ask the students about their perceptions of empathy and the utility of reviewing and reading about it: do they think empathy is innate and cannot be learned, or are there skills and key ways of saying things that promote patients’ perception of physicians’ empathy? Ask students if they have encountered physicians’ empathy during their own illnesses or illnesses in family members. What was that like? What did students think of information covered in the DocCom module? What are other examples of physician empathy aside from the skills in the BIC and mentioned in the text, i.e. reflection, legitimation, support, partnership, respectful statements. (Some other examples include non-verbal communication, attentive listening, respectful silence, and correctly describing a patient’s difficult situation and what he or she may be feeling.)

Empathy in medical interviews has two components: the ability to conceptualize and understand to some degree what a patient must be going through emotionally, and, the ability to clearly communicate that understanding to the patient. The first ability, conceptualization and understanding, grows as the student matures personally and gains experience in patient care. The ability to communicate empathy depends on the student’s use of certain skills, and improves as the student practices using these skills. While many students have the idea that the ability to empathize is innate (which is true to some extent), most students will be able to enhance their abilities to understand patients and to communicate empathy throughout their lives as physicians.

Physicians communicate empathy both non-verbally and verbally. Major skills of communicating empathy are summarized in BIC IIA and IIB. Further explanation of the BIC skills is found in the BIC key. Please re-emphasize the importance of the use of silence to facilitate the patient’s expression of thoughts and feelings. Most students feel awkward about silence in medical interviews. However, silence often conveys respect to patients, and indicates that the student is willing to listen. There is a nice example of the use of silence in DocCom module 6. Dr. Bird is silent for about 6 seconds while a patient cries. Did that seem helpful or did it seem like an uncomfortable silence? What might prevent students from staying silent while a patient expresses strong emotions? In some clinical skills groups, students have already experienced patients crying during interviews. It is not uncommon in these situations for students to try to immediately reassure the patient or to change the subject to a happier topic. It is often more helpful, though, to simply remain silent and pass a box of tissues to the patient. After a respectful period of silence, the student may then gently make a reflective comment such as, “I can see that this is very difficult for you.” You may wish to give further examples of the power of empathic communication from your own experiences with patients. Also, you might want to discuss the implications of expressing empathy for the physician-patient relationship. Does expressing your caring for patients’ conflict with medical professionalism?
ROLE PLAY: Session 8 (about 15 minutes)

If there is time, you may want to do brief role-plays. As usual, there are several ways of doing this. One of the student co-facilitators might want to play a patient with a serious illness. One or more students can take turns interviewing, practicing discrete empathic skills. Stop the role-play after 2 or 3 minutes and ask the student interviewer how he or she was doing and what might be in the way of communicating empathy. Ask for input from other students in the group. The same student can then pick up and try using other skills, especially silence and reflection, or a second student can start over. Doing the role-play in this way can be a compelling and involving exercise.

Another format would be to have the students role-play in pairs so that students can practice the skills of communicating empathy. Ask the students to role-play a serious illness that they know something about, perhaps a heart attack or cancer, and express what they think a patient's concerns, worries and fears would be with this illness. Alternatively, a student could choose vague symptoms such as fatigue or headaches, but imagine that a major negative life event has occurred in the “patient’s” life: loss of a job, or a loved one. The student playing the patient would express these concerns either verbally or non-verbally and the interviewing student would practice responding, using some of the interpersonal skills in BIC IIA and IIB. These role-plays should last about five minutes, and be followed by five minutes of discussion and feedback. If there is time, students can switch roles and repeat the process.

Inpatient Interview (about 60 minutes)

Go to the wards, and divide into two groups. Before going in to patients’ rooms, ask one or two students to volunteer to conduct the interview. Today, please focus on eliciting an HPI, PMH and BIC IVB, (the patient’s perspective: how the illness has affected the patient’s life, his/her understanding of the illness, its causes and implications, and the patient’s concerns) as well as the interpersonal skills reviewed in the first hour. Please ask students to volunteer to observe various aspects of the encounter. One student could comment on the patient’s expression of emotions and give feedback to the interviewer on his or her communication of empathy; another student could comment on non-verbal behavior, both of the patient and interviewer; a third student could comment on the facilitation and relationship skills used by the student interviewing the patient. All should look for the patient’s perspectives and concerns, and all should comment on the empathic opportunities the patient offered and how the interviewer, facilitator and students in the group responded to those opportunities.

Wrap-up

Allow 15 minutes to get back together in the large group to discuss the lessons of the day.

Discuss Session 9

Session 9 takes place in CEAC on 11/12 and 11/14. This will be a SP exercise on vital signs/heart & Lung exams.

Please remind students to arrive 10 minutes before their appointment time. A schedule listing students’ names and appointment times will be posted on the Physician and Patient course website and bulletin board.

*NOTE TO 4TH YEAR STUDENT CO-FACILITATORS re session 9:
Please arrive no later that 1:45 PM. We start the program promptly at 2:00 PM. There will be folders on the table at the front of CEAC with your room assignment and copies of the BIC.
Debrief

Faculty and student co-facilitators should meet for about 30 minutes after the session has ended to review their work together, to fill out daily worksheets evaluating student skills, and to plan for the next session. Please review co-facilitation issues. Is the fourth year student co-facilitator having enough opportunities to teach and receive feedback on that teaching? How could you work more effectively together as co-facilitators?
Session 9: SP Exercise Vital Signs/Heart & Lung Exams

Date: Tuesday 11/12 & Thursday 11/14
Time: 2:00 – 4:00 PM
Location: Queen Lane, CEAC

Standardized Patient Exercise: (1 hour appointment per 1/2 class)
Your 4TH year student co-facilitator will meet with half of your group from 2:00-3:00, and the other half from 3:00-4:00 in an assigned CEAC room. Your fourth year co-facilitator will review the basics of taking vital signs and performing heart and lung exams on a standardized patient. You will each get a chance to examine the standardized patient and receive feedback.

Note:
- Your appointment time will be posted on the Physician and Patient course website and on the bulletin board outside CEAC, 2nd floor corridor one week prior to the session;
- Arrive 10 minutes before your appointment.

Please bring your stethoscope to this session; if you do not have one, we may provide for this session.

Readings:
Clinical Skills Video
- Log-on at http://webcampus.drexelmed.edu/skills/
- Click Physical Examination link in left pane
- Review Pulmonary, Abdominal, Cardiac and Blood Pressure videos
- View Vital Signs located at the further down the skills’ website

Bates Guide to Physical Examination and History Taking
- Chapter 8: The Thorax and Lungs
- Chapter 9: The Cardiovascular System
(Both can be found in the Queen Lane Library)
Objectives
1. Your 4th year student co-facilitator will meet with half of your group from 2:00-3:00, and the other half from 3:00-4:00, in the assigned CEAC room.
2. Your 4th year student co-facilitator will review the basics of taking vital signs and performing heart and lung exams on a standardized patient.
3. Each 1st year student will have the chance to examine the standardized patient and receive feedback. (Everyone, please bring your stethoscope to this session)

Your appointment time will be posted on the Physician and Patient course website and bulletin board one week prior to the session.

Discuss Session 10

Session 10 takes place in CEAC on 11/19 and 11/21. Please remind students to arrive 10 minutes before their appointment time. A schedule listing students’ names and appointment times will be posted on the Physician and Patient course website and bulletin board one week prior to session.

Session 10 will be a SP practice interview so the students may prepare for their midterm interview in Session 12, which will consist of a 10-minute interview with 5 minutes of feedback from the 4th year student co-facilitator.

*NOTE TO 4TH YEAR STUDENT CO-FACILITATOR re session 10:

Please arrive no later that 1:45 PM. We start the program promptly at 2:00 PM. There will be folders on the table at the front of CEAC with your room assignment and copies of the BIC.
FACILITATORS NOTES
NOTE: FACULTY CO-FACILITATORS ARE NOT REQUIRED TO ATTEND THIS SESSION

Session 10: SP Practice Interview with 4th Year Feedback

Date: Tuesday 11/19 & Thursday 11/21
Time: 2:00 – 5:30 PM

Check the P&P website and bulletin board outside of CEAC for your specific appointment time.

Location: Queen Lane, CEAC

Standardized Patient Exercise:
(15 minute appointment per student)

1. A 10-minute interview with 5 minutes feedback from your 4th year student co-facilitator.
2. Employ all BIC skills and content items acquired thus far (see abbreviated BIC). Your 4th student co-facilitators will provide feedback.
3. While you may not have time to get through all the content on the BIC in 10 minutes, your 4th year student co-facilitators will give you an opportunity to list everything you would have covered had you had sufficient time.

Note:

• Your appointment time will be posted on the Physician and Patient course website, and on the course bulletin board outside CEAC, 2nd floor corridor, one week prior to your session.
• Arrive 10 minutes before your appointment.

Instructions for accessing your recorded video
Fourth Year Student Co-Facilitators: Please arrive at CEAC no later than 1:45 PM, we will start promptly at 2:00 PM

Students will conduct a **10-minute** interview with the standardized patient. A warning bell will sound after 8 minutes to indicate there are 2 minutes remaining of the interview. Students may not bring in notes or copies of the BIC to their interviews.

While observing the student interviews, please fill out the BICs (abbreviated version) that we will provide in your folders.

Following the interview, you will have **5 minutes** to give feedback based upon the abbreviated BIC (copies will be available to you in a folder upon entering CEAC. To optimize this time, 4th year students should remain in the exam room during the interview **(out of the students’ line of vision – we’ll place your chairs in a convenient spot so you won’t be on the student’s video)**.

At the start of feedback, please first ask your student what s/he thinks s/he omitted from the interview. If they respond with sections of the BIC that they did not address during the interview, check off these items on your checklist, giving them credit for the items they mention (including HPI items).

*Please give only the completed BICs to the student to use as a study tool for the Session 12 midterm exam.*
Session 11: Family History / Psychosocial/Behavioral History

**Date:** Tuesday 12/3 Thursday 12/5

**Time:** 2:00 - 4:00 PM

**Location:** Queen Lane Seminar Rooms, w/SPs

**Objectives:**
1. Learn the elements of the Family History (FH) and Psychosocial/Behavioral History (PSBH).
2. Practice eliciting FH and PSBH with a patient.
3. Understand the importance of exploring the patient’s perspective on illness.

**DocCom Assignment:**

**Module 05** Integrated Patient-Centered and Doctor-Centered Interviewing - Structure and Content of the Interview. Review FH and PSH sections.

**Module 09** Understand the Patient’s Perspective

Read the Module. Answer either discussion question 1 or 2 by 6PM the evening before your small group session.

- Review the elements of FH and PSBH (BIC IVD and IVE).

**Discussion: (45 minutes)**

**Standardized Patient Interview: (60 minutes)**

1. Do a FH and PSBH.
2. Focus on using interviewing skills including empathic communication, facilitation skills, attention to content, non-verbal behavior, eliciting the patient’s perspective etc.

**Wrap-up: (15 minutes)**

What did we learn today? Topics for next session.

Taking a psychosocial/behavioral history can help answer the question, “Why is the patient ill now?” Often psychosocial stressors contribute to patient anxiety and depression, and get in the way of patients taking care of themselves. What kinds of questions in the PSBH might be difficult for you to ask? Sometimes it may be difficult to ask patients about very emotional issues, or to press them about their drinking or drug use. What feelings may get in the way of your exploring difficult issues? Sexual history taking raises many issues. Personal fears and biases can greatly affect your approach to patients, especially patients with sexual orientations different from your own. What negative feelings or attitudes do you have in this regard? How could you change certain negative attitudes or at least come to terms with them so that you can offer unbiased care to all your patients?
Learning Objectives:
1. Learn the elements of the Family History (FH) and Psychosocial/Behavioral History (PSBH)
2. Practice eliciting FH and PSBH with a patient.
3. Understand the importance of exploring the patient’s perspective on illness.

Discussion (45 minutes)
Ask the students how session 10 went. Then, outline the objectives for this session. Review students’ answers to multiple-choice and discussion questions in DocCom Module 9. Review the elements of the family history (DocCom Module 5 and BIC IVD), and discuss examples of why it is important to obtain a family history. Discuss the importance and techniques of eliciting the various aspects of the psychosocial/behavioral history. (Please refer to DocCom Module 5 and BIC IVE).

Taking a psychosocial/behavioral history can help answer the question, “Why is the patient ill now?” Often psychosocial stressors contribute to patient anxiety and depression, and get in the way of patients taking care of themselves. Questions in this part of the interview may be particularly sensitive and difficult for beginning students to ask. You might ask the students, “What kinds of questions in the PSBH might be difficult for you to ask?” Sometimes it may be difficult to ask patients about very emotional issues, or to press them about their drinking or drug use. What personal feelings may get in the way of exploring difficult issues? Sexual history taking raises many issues. Personal fears and biases can greatly affect physicians’ approaches to patients, especially patients with sexual orientations different from their own. It is useful to ask the question, “What negative or uncomfortable feelings or attitudes do I have in the area of sexuality? What do I feel when talking with others that have different sexual orientations?” How could students change certain negative attitudes or at least come to terms with them so that they can offer unbiased care to all their patients? You will need to address techniques of eliciting sensitive information about drug and alcohol consumption, sexual activity, and physical and sexual abuse. (Keep in mind that there will be sessions later in this course that will more specifically address sexual history taking (the next small group session) and alcoholism). Introduce the mental status exam (at least those issues presented in BIC IVE).

Also, please discuss the importance of learning the patient’s perspective on his or her illness. How might social or cultural factors affect the patient’s perspective? How might patients’ beliefs and expectations about their illnesses affect the presentation of symptoms, and reactions to testing and therapy? When should students ask about literacy, about culturally based beliefs about illness? What are the benefits of understanding the patient’s perspective for the physician and for the patient?

Standardized Patient Interview (60 minutes)
The standard patient will arrive at 3:00pm. Either ask one or two students to volunteer to conduct the interview, or allow each student in the group to ask one question after another as though all the students in the group were one interviewer. Students will elicit an HPI, PMH, FH, PSBH and the patient’s perspective on his/her illness. If you choose to have one or two students conduct the interview, ask the other students to choose one aspect of the encounter to observe. Students could comment on the possibilities of feelings of embarrassment of the patient and the interviewer. Other students could comment on a variety of interviewing skills including empathic communication, facilitation skills, attention to content, non-verbal behavior, and other aspects of the BIC. After the interview is completed lead the discussion on how the interview would inform the treating physician about all the factors involved in why the patient became ill and what other factors in the patient’s personality and social background might influence the approach to treatment.

Wrap-up (15 minutes)
Allow 15 minutes to get back together in the large group to discuss how the interviewing experiences went, and review the major lessons of the day.
Discuss Session 12
The midterm will take place on January 7 and 9 starting at 1:30pm in CEAC. **Students arrive every 15 minutes.** They have 10 minutes to conduct an interview with a standardized patient followed by 5 minutes of feedback by their faculty co-facilitators. Students should employ all BIC skills and content items acquired thus far. Your feedback should be based upon an abbreviated BIC (following session, and posted on the course website). **This is a graded exercise.** They may not bring notes or copies of the BIC into the interview. We ask that they do **NOT** take notes during their interviews - we want these interviews to be realistic but recognize that students may not be able to get through all the content of the Brown Interview Checklist in 10 minutes. Still, they can do these interviews at a normal pace because at the conclusion of the interviews, faculty co-facilitators will give them an opportunity to list everything they would have covered had they had sufficient time, and they will be given credit for those items. In addition, they will get credit for eliciting all the relevant points of information related to the HPI. Please emphasize to your students that they must arrive ten minutes prior to their appointments. A schedule listing students’ names and appointment times will be posted on the Physician and Patient Course website and bulletin board one week prior to the session.

Students will evaluate their own performances by reviewing their videos, completing BICs, and writing several paragraphs giving both a positive appraisal of their use of clinical skills and areas for improvement. Students will turn in their completed BICs and self-evaluations before session 13. We will send you the students’ adjusted midterm interview scores by session 13. (We need to curve these interview scores to adjust for the “hawks” and “doves” among you) You will then combine the interview scores with your assessments of the quality of students’ self-critiques and use your assessments in filling out your midterm assessment forms for each student.

*NOTE TO FACULTY CO-FACILITATORS about the midterm exam:*
**Please arrive no later than 1:45; we start the program promptly at 2:00 PM.** There will be folders on the table at the front of CEAC with your room assignment and copies of the BIC. Refreshments will be available in the Control Room at the break.

Debrief
Faculty and student co-facilitators should meet for about 30 minutes after the session has ended to review their work together, to fill out daily worksheets, and to plan for next time.
Session 12: Midterm SP Interview with Faculty Feedback

**Date:** Tuesday 1/7 & Thursday 1/9

**Time:** 2:00 – 5:30 PM

Check the P&P website and bulletin board outside of CEAC for your specific appointment time and room number.

**Location:** Queen Lane, CEAC

### Standardized Patient Exercise: (15 minutes per student)

- You will conduct a **10-minute** interview with a standardized patient. A warning bell will sound after 8 minutes to indicate there are 2 minutes remaining of the interview. Students may not bring in notes or copies of the BIC to their interviews.
- After the interview, faculty will give you feedback for 5 minutes.
- Employ all BIC skills and content items acquired thus far.
- While you may not have time to get through all the content on the BIC in 10 minutes, your faculty facilitator will give you an opportunity to list everything you would have covered had you had sufficient time; you will receive credit for those items.
- Afterwards, you will review your video online, complete the BIC (*copy of this BIC exam for students will not be posted on this site for faculty, however, copies will be placed in faculty's folder on day of exam*), and write several paragraphs about your use of BIC skills, elicitation of relevant content areas (BIC IV), as well as your needs for improvement.
- Email these documents to your faculty facilitator, with copies to your fourth year student co-facilitator and the course coordinator, Beverly Towns, by 6:00pm the evening before session 13.
- Your faculty facilitator will use these materials in filling out your Midterm assessment forms, which they will give to you at Session 14.

**Note:**

- Your appointment time and room number will be posted on the Physician and Patient course website and the course bulletin board outside CEAC, 2nd floor corridor one week prior to your session.
- Arrive 10 minutes before your appointment.

[Instructions for accessing your recorded video](#)
PLEASE ARRIVE AT CEAC NO LATER THAN 1:15 PM. WE WILL START PROMPTLY AT 1:30 PM.

Students will conduct a **10-minute** interview with the standardized patient. A warning bell will sound after 8 minutes to indicate there are 2 minutes remaining of the interview. Students may not bring in notes or copies of the BIC to their interviews.

While observing the student interviews, please fill out the BICs (abbreviated version) that we will provide in your folders. Following the interview, you will have **5 minutes** to give feedback based upon the abbreviated BIC. To optimize this time, please remain in the exam room during the interview (out of the students’ line of vision – we will place your chairs in a convenient spot so you won’t be on the student’s video). At the start of feedback, please first ask your student what s/he thinks s/he omitted from the interview. If they respond with sections of the BIC that they did not address during the interview, check off these items on your checklist, giving them credit for the items they mention (including HPI items). Please give the completed BICs to Beverly Towns at the end of the afternoon. She will grade them and return them to you before Session 14. A passing grade is 70.

Before Session 13, students should email **their** completed BICs and self-evaluations (based on their videotaped interviews) to their faculty facilitator, fourth year student and to the course coordinator. These self-evaluations should include several paragraphs about their use of BIC skills, elicitation of relevant content areas, as well as needs for improvement. Please use these, as well as the returned BICs, as the basis for filling out students’ midterm assessments. Give your students the two completed BICs (yours and theirs), the students’ self-evaluations **with** your comments and your completed midterm assessment* (completed by you) at Session 14. Faculty and fourth year student co-facilitators should discuss each student in formulating midterm assessments.

**NOTE:** If there are students in your group who are failing or marginally passing, please forward their names to Beverly Towns at Beverly.towns@drexelmed.edu by Session 14.

* = **Please submit your completed evaluations to me, to copy for students’ file, prior to start of next week’s small group session by:**

1. **Mail:** DUCOM, 2900 Queen Lane, Room 221B, Beverly Towns, Phila., PA 19129;
2. **Fax:** (215) 843-5495 (please note students’ names on second pages);
   or
3. **Email:** btowns@drexelmedu.edu

I will copy accordingly and return to you by the end of next week’s session.
FACILITATOR NOTES

Session 13: Sexual History

Including G/L/B/T Issues

**Date:**
Tuesday 1/14 & Thursday 1/16

**Time:**
2:00 – 4:00 PM

**Location:**
Queen Lane Seminar Rooms (SPs during the second hour)

**Objectives:**
- Review the elements of taking a sexual history
- Enhance understanding of the issues of interviewing gay/lesbian/bisexual/transgendered patients.
- Become aware of personal barriers to asking sexual history questions.
- Become more comfortable in asking sexual history questions.

**Module 18** Exploring Sexual Issues.
Answer either discussion question 1 or 2 in Module 18 online by 6 PM the day before your session.

**Reading Assignment:**
Inclusivity 101: The Benefits of Sensitive Care for L/G/B/T Patients and Something's Missing.

**Discussion: (30 minutes)**
- Discuss readings, elements of sexual history, and personal barriers to asking sexual history questions.

**Role-Play: (30 minutes)**
Students will interview each other in pairs.

**Standardized Patient Small Group Exercise: (45 minutes)**
- Interview Standardized Patient using BIC 1A, 1B and IV A-D.
- Focus on using on using interviewing skills including empathic communication, facilitation skills, non-verbal behavior, etc.

**Wrap-up: (15 minutes)**
What did we learn today? Topics for next session.
Learning Objectives

1. Review the elements of taking a sexual history.
2. Enhance understanding of the issues of interviewing gay/lesbian/bisexual/transgender patients.
3. Become aware of your own barriers to asking sexual history questions.
4. Become more comfortable in asking sexual history questions.

Discussion (approximately 30 minutes)

Please initiate discussion about today's topic, taking a sexual history. Ask students what they learned from DocCom Module 18 and the reading from Medical Encounter (posted on the website), and whether any topics/questions evoked hesitations/concerns from them. Fourth year student co-facilitators might want to lead a discussion about students' answers to DocCom discussion questions. What are their barriers to asking certain questions about sexuality? What are the best ways to ask relevant questions? (A note about the question: “Do you have sex with men, women, or both?” Some feel that this is a good question to ask. Many students and physicians feel uncomfortable asking this question, and if you do not regularly ask this question you might want to tell that to the group. Some heterosexual patients may take offense at this question. Please suggest to students comfortable ways that you have used to ask patients about their sexual orientation. Some of these ways include questions, such as, “Can you tell me something about your sexual partner or partners?” “Have you done any activities that might put you at risk for AIDS, such as IV drug abuse, sex with men, or sex with many women?” Please emphasize the importance of asking about sexuality of all patients, that patients' answers to these questions can give you important information about problems in relationships, sexual orientation, the possibility of a variety of STDs, the risk of AIDS, possible sexual side effects of the medications they are on, etc. Many physicians do not regularly ask about sexuality, while surveys show that the majority of patients expect their physicians to ask about sex and would be comfortable answering these questions.

Role-Play (approximately 30 minutes)

There are 3 role-plays: Dyspareunia, a woman with PID, and a man with impotence related to his beta-blocker for hypertension. Some students might want to try playing the role of the opposite gender. It could give students insight into the issues and concerns around sexuality of the opposite sex, and could be fun to do. Ask the students to break into pairs, give the role-plays to the “patients” only, and role-play for about seven to ten minutes. (The students playing the “doctor” roles, in addition to asking about the current problems, should ask a few questions about PMH and psychosocial history as well, i.e. works, relationships, etc.) Then have the “patients” give feedback and have both partners discuss the experience - their feelings, the barriers, why they did or did not ask certain questions, etc. After fifteen minutes, get back into the large group and discuss the issues for another 15 minutes. Students might want to take some role-plays home, and try other roles with their partners or others.

SP Interview (approximately 45 minutes)

During the second hour of this session, an SP will come in whose role will be to have a medical problem, with some sexual dysfunction as part of his or her illness. Please have students take turns interviewing the SP, going through the relevant history, and asking appropriate sexual history questions. Call “time-outs” as necessary to make points, or to ask student interviewers how they are doing, what they are thinking and feeling, etc. Be sure and ask the SP how he or she is feeling responding to the students’ questions.
Wrap-Up:
Ask students what they have learned and reinforce important points.

Debrief

Please meet with your student co-facilitator for about 30 minutes after the session has ended to review your work together, to fill out daily worksheets, and to plan for next time.

Readings for this session:

Readings on the course website:
INCLUSIVITY 101: The Benefits of Sensitive Care for L/G/B/T Patients
Elizabeth J. Rankow PA-C, MHS Oakland, CA
rankow@earthlink.net

Lesbians, gay men, bisexual and transgendered (L/G/B/T) individuals are members of every population seen in the clinical setting. They may have unique health needs that go unaddressed when heterosexuality is universally assumed. An inclusive approach to care, and treatment standards based on a thorough assessment of individual behavior and experience, can optimize the quality of services offered to all patients.

Issues of sexual orientation do not exist in isolation. It is the complex interplay of all the facets of an individual's experience that inform their specific health concerns, the manner in which they present for care, their style of communication, access to medical services, level of trust in the medical system, compliance with treatment plans, and the outcome of their patient encounters. To be most effective, strategies for change must involve both medical education and clinical practice; addressing individual knowledge, attitudes and behaviors, systemic procedures, and institutional policy.

The meaning and experience of homosexual identity or behavior is unique to each person. Individuals may be actively involved in gay and lesbian politics or culture, they may be “closeted” and isolated from valuable support resources, or their sexual orientation may be only a minor part of their personal identity. Often L/G/B/T people feel forced to lie about or hide their same-sex relationships in order to access medical and social services, or to maintain the support of their biological families and their cultural or religious communities. Family members learning that their loved one is not heterosexual may also be in need of support. Parents, siblings and others may enter a “closet” of their own. They may experience feelings of anger, shame, disgust, fear or self-blame. Remember that homosexual identity or behavior carries different significance in different cultural contexts. Issues specific to the ethnic origin, socioeconomic class, and religious background of each person must be considered to adequately address concerns.

An Inclusive Approach
In providing culturally competent care to any individual, clinicians must first refrain from making assumptions. A thorough and non-judgmental history will yield information about a patient’s important relationships, living situation, beliefs about health and illness, use of alternative healing modalities, life stresses, sources of support, sexual and drug use history, and primary areas of concern. They use of inclusive language in medical history forms and the patient interview sends a message of receptivity, and provides the clinician with rich information about the important people in the lives of all his or her patients, gay or “straight.” (See sidebar: An Inclusive History).

Awareness and acceptance can be conveyed through the office environment as well. Brochures, periodicals, and posters or other decorations should reflect the diversity of clients served; offering images and information depicting people of varied ages, ethnicities and family configurations. By creating an atmosphere of safety, and encouraging honest communication addressing the issues of importance to each patient, providers will facilitate the success of treatment plans, education, or other interventions.

Systems and structures
Examine the mission statement, strategic plan, explicit and implicit policies, standards of care, physical environment and images used in marketing. Whose values are reflected? Are they congruent with the values of the communities served? Are the clinicians, staff, management, and boards of directors reflective of the communities served? Is there a mechanism for ongoing in-service education to increase cultural sensitivity? What outcome measures are used to
evaluate the relative success and effectiveness of interventions? Is there a commitment to a common shared vision at the top levels of administration? At the clinician level? At the staff level? How is this communicated internally to employees? How is it communicated externally in messages to the client base and the community?
An Inclusive History

Ask about relationships:

Are you involved in a significant relationship?
Tell me about your living situation. Who shares the household with you?
Tell me about the people who are important to you. Where do you get the most support?
Are your relationships satisfying or are there any concerns you’d like to discuss?

Ask about behaviors:

Are you sexually active?
With men, with women, or with both?
Have your sexual partners in the past been men, women, or both?
Do you have any need to discuss birth control? How are you dealing with the issues of “safer sex”?

Have you had a new partner(s) or change in your sexual activity since your last visit?
Is there anything else I should know about your sexual history in order to give you the best care?

If your client discloses s/he is L/G/B/T:

How does s/he feel about her/his sexual orientation?
What does it mean for her/him?
In her/his cultural context? Family?
Whom has s/he told and what kind of responses has s/he received?
Has s/he ever been the victim of discrimination or violence because of her/his sexual orientation?
Does s/he know how to access lesbian and gay community resources?
What does s/he consider to be her/his major stresses, health risks, and issues of concern?
What services and resources would be helpful?
Something’s Missing

Peaches Bass
Founder, Lesbian Health Project,
Mabel Wadsworth Women’s Health Center in Bangor, Maine
Currently, Estes Park, CO
peachesb@hotmail.com

Donna G, a woman her late thirties, visited her family doctor for an annual exam. She decided it was time to tell him that she was a lesbian. She did so with some apprehension, but he had no particular response and he asked her no questions. The visit proceeded without any remarkable incident, and Donna was relieved, thinking, “Why didn’t I come out to my doctor sooner?” The following year, she again went to this physician for a routine checkup. In the exam room, her doctor asked her, without a hint of humor or irony, “So, are you still a lesbian?” Donna switched to another doctor.

There are a number of things this physician should have attended to in the interest of providing the best care for this patient and keeping her in his practice. Below are a number of suggestions that can act as a guide for making clinical encounters more appropriate for gay men, lesbians, and bisexuals.

Patients need to know about your commitment to privacy and exactly who will have access to their medical records:

“What you tell me is confidential. The only people who will see this information are myself and my office staff. If I need to refer you to another doctor or if I have to consult a specialist, I will ask you to sign ‘release of information’ form.”

Except for a few states and municipalities, people can be fired if they are homosexual. Because so much medical and pharmacy information is in the hands of insurance and managed care companies, you can allow patients to be in control of who gets to have this information by offering to keep certain details from appearing in their chart. While some health care providers may feel uncomfortable about this, remember that patients lie when they are afraid of the consequences of disclosure, as, for example with cigarette smoking, extramarital affairs, and sexual orientation. You will be able to provide better care through patient self-disclosure when you win his or her trust. You can always suggest: “If I refer you to other doctors, you must tell them what you’re telling me because it won’t be included in your file and they need this information to treat you correctly.”

A patient may use common language, slang, street terms, or even vulgarities. Be calm, pay attention to your facial expressions and body language, and when your patient has responded, continue by asking, “What other kinds of sexual activity do you engage in?” until the patient says “That’s all.” If you don’t understand the terms your patient uses, ask for clarification: “I don’t know what that expression means. Can you explain it to me?” Thank the patient for sharing the information, and feel free to explain that you had never heard the word used that way.

A common stereotype is that all gay men have lots and lots of sex partners, and are rarely in long-term relationships, or that lesbians are always monogamous and has sex infrequently.

Our society tends to see gay male sexual activity primarily in terms of anal and oral sex, and lesbian sex as non-penetrative, body-to-body contact or mutual masturbation. By being aware of these common assumptions, you will be able to listen more accurately to what your patient is telling you.
Some clinicians voice concern that a heterosexual (or a deeply conflicted homosexual) patient could voice offense at unbiased, gay-positive practices. Some worry that a patient might say, “Why are you asking me these questions? Don’t you know I’m a married woman?” or “I had no idea some of your patients are those kinds of people. I’d like to see another doctor.” Fear of AIDS, prejudice, or lack of understanding may underlie these remarks. It’s important to do what you can to explain your practice to all your patients, and then let them decide if you are the health care provider they want to see.

If a heterosexual patient tells you that s/he is attracted to people of the same gender, don’t negate the attraction. Offer to refer the patient to a gay/lesbian/bisexual support group, but don’t press it. This is especially important when seeing young people who may be questioning their sexual orientation. The isolation of gay and lesbian youth and the attendant complexities of adolescent sexuality and pressures to conform lead too many young men and women to suicide, substance abuse, risky behavior, and even rape and unplanned pregnancy.

Concerns for adolescents who are lesbian, gay, or bisexual include victimization and violence at home or at school. Many gay youth drop out of school, run away from home, or are kicked out of the house. Like other troubled children, they can end up living in exploitative situations, and they need special support, sensitive referrals, and assiduous follow-up.

Elderly people are sexual beings and just as likely to be gay, lesbian, or bisexual. In addition to the usual medical and emotional needs and referrals for older people, attend to their sexual needs as well.

Treat transgendered patients as you would anyone else. The nature and even definition of transgenderism is a source of fascination, debate, and mystification. Respect their self-identification and acknowledge their physiological reality as a male or female. Seek professional training and information sources that are authoritative and current, have specific referrals for people seeking support or sex change services. The National Lesbian and Gay Health Association (NLGHA) can be a helpful resource. Transgenderism can be a special concern for adolescents. Transgendered people may or may not be homosexual; do not assume anything about the sexual orientation of a person whose gender identification is in flux or transgendered.

What could Donna G’s family doctor have done differently? He could have acknowledged that it was probably stressful for her to come out, and he could have thanked her for being truthful and forthcoming. He could have admitted that he didn’t have much expertise in addressing lesbian health and sexuality issues, but with her advice, he could locate some resources and professional information. He could have suggested that she might want to see a clinician with more training, or someone who was more comfortable with homosexuality. He could have asked her what she felt her specific needs were as a lesbian. If he had, she might still be one of his patients. Don’t try to be perfect or 100% politically correct. It’s okay to admit your limits and what you don’t know, as along as you’re open to learning. Be a good listener and caring professional.
Session 13 – Sexual History
ROLE PLAY- Male Impotence Patient Role

You are here to see your doctor today for a routine follow up of hypertension.

You are 30 years old. You have been married for 8 years and have two beautiful children. Your spouse is an appliance salesperson at Sears and makes a decent salary. You have been working in quality control in the Nabisco plant for the past 5 years. It is a good job with friendly co-workers. (The only drawback is that you get free cookies and know you eat too many of them.) You don't exercise at all, even though you know you should. You smoke - 1 pack of cigarettes per day since age 15. You drink a couple of cans of beer every night—it’s enjoyable when you're watching TV. Otherwise life is fine-no real stressors. Finances are OK - you get by.

Six months ago, you were diagnosed with hypertension. Your hypertension has been in good control for the past four months with 100 mg of atenolol (a beta blocker) and hydrochlorothiazide (a diuretic). You have not seen your doctor in three months. Your doctor was pleased at the last visit since you had managed to lose about five pounds and your pressure was normal at that time. You are here today for a follow-up visit. The nurse just took your blood pressure and told you it was normal at 130/85 and that you had lost another seven pounds.

You have worked on cutting down junk food, have cut down to one beer at night and have started walking at lunch time. You are proud of the fact that you have lost twelve pounds, and are starting to look more like your old handsome self. The only thing that you've been unable to do is quit smoking. You were scared when you first learned you had hypertension, especially because of your mom's early death from a heart attack. You tried quitting smoking but only lasted two days. It was just too stressful to quit. If anything you have increased your smoking to perhaps 1 1/2 packs a day, since your recent troubles with impotence.

You're really embarrassed by this problem and would rather not talk about it but will if specifically asked by your physician. You have been having trouble having full erections and lately haven’t been able to get an erection at all. It all started about four months ago, after your physician raised your atenolol from 50 to 100 mg. You wondered if it might have had something to do with the medication, but your physician never mentioned that impotence could be a side effect of your meds, so you thought it probably wasn't. Besides, the first time it happened you and your wife had just had an argument about money. (There's never enough, and she had just bought several very expensive dresses. It really made you angry.) That night you didn't get a full erection and gave up on sex. After that, your problem with erections was mild and occasional, but a couple of times you couldn’t sustain your erections and it became very embarrassing. At first your wife was supportive and reassuring, saying that it was probably because you’ve been working too hard lately. But you became increasingly worried each time you had sex whether you could perform or not, and soon you weren’t able to have erections at all. You were too embarrassed to mention it at the last office visit, but lately your wife has been insistent that you discuss it with your doctor.
Session 13 – Sexual History
ROLE PLAY- Male Impotence (Physician's Notes)

This is your third visit with this patient whom you diagnosed six months ago with hypertension. At your last visit three months ago, his pressure was well controlled with 100 mg of atenolol (a beta blocker) and 25 mg of hydrochlorothiazide (a diuretic). Atenolol can cause male impotence, but you did not mention this to him when you put him on it. You had advised him to lose weight, begin exercising, and stop smoking. At your last visit, he had lost about five pounds. He is here today for a regular visit. His pressure is normal at 130/85, and he has lost another seven pounds.
Session 13 – Sexual History
ROLE PLAY—Woman Patient
BY: Nielufar Varjavand and Dennis Novack

CC: pain when having sex

HPI: You are a 32 year old female with complaints of dyspareunia (pain on intercourse) for the past few months. You and your husband have been married for 10 years and have been in a loving relationship without any problems. (You occasionally have fights, but they are never physical and you always make up with each other.) You cannot explain why you are having pain now. It is so painful that you want to avoid sex at all costs. Your husband, Jim, has been understanding, but you can see that he is also irritated.

If you are asked to try to think about what was going on in your life when the dyspareunia began, you recollect that your stepdaughter was raped around the same time that the symptoms began. She is 16; it was a date rape and very traumatic for her. When she was raped, you, for the first time in many years remembered the time you were raped by your girlfriend’s brother, which was also the first time you had sex. You were 16 and had suppressed the memories until the news of your stepdaughter’s rape. You didn’t discuss this with anyone then, or now, because you thought the whole incident was past history. It was very painful for you at the time, both the physical event and the emotional aftermath. You felt guilty, at the time, because you had thought your friend’s brother was cute and thought you might have somehow brought on the rape. You never told anyone, since you thought it would have destroyed your friendship with your friend. You thought she wouldn’t believe you anyway. You were also afraid of your parents’ reaction. You simply made yourself never think of it again. You didn’t have sex again until you met your husband five years later. At first, sex was not enjoyable with your husband, who is eight years older than you and divorced. Jim was kind and good—he broke through your inhibitions. You never told him about the rape. Though you and your husband have been doing well together, and sex has been enjoyable (about two to three times a week), recently you have been irritated with little things he does, and find his teasing “male chauvinistic” remarks particularly annoying.

GYN Hx: You started your menses at the age of 14. You have a regular menstrual cycle without any change in the amount of bleeding. You had a tubal ligation after the birth of your second child in 1992, and do not use any other form of protection. You and your husband feel that you don’t need to, since you are in a monogamous relationship. You got gonorrhea from the rape, for which you were treated without lasting medical consequences. You have had two pregnancies (gravida 2) and two vaginal deliveries (para 2).

PMHx: You have iron deficiency anemia for which you take iron. You broke your right ankle while playing basketball in high school.

Medications: You take an iron tablet every morning with orange juice (you are supposed to take three per day, but you don’t because it gives you constipation.) You also take a multi-vitamin.

Fhx: Your parents are alive and healthy. You have two older sisters, one with uterine fibroids and the other with lupus. Both of your children (ages 8 and 6) are healthy, as is your only stepdaughter (age 16).

PSBhx: You are an attorney working with the Department of Labor Board. Your work is intense and usually not overly stressful. Lately, it has been busier than usual, and you find that you have less tolerance for it. You have been working there for the past 3 years. You do not smoke cigarettes, but you have a couple of cocktails every night. You tried marijuana in high school, but never got into any kind of drugs.
Session 13 – Sexual History
ROLE PLAY – Woman patient - RLQ ABDOMINAL PAIN
(THE DIAGNOSIS IS PELVIC INFLAMMATORY DISEASE FROM GONORRHEA)

CC. Right lower quadrant abdominal pain

HPI. You are a 24 year old woman. In the last few days you’ve had onset of RLQ pain that first started out as a dull ache, but has since become persistent and severe. Your periods are usually regular. Now you are in the middle of your cycle, but have been bleeding for the past few days (moderate flow). You’ve also had a fever to 101, and nausea and vomiting for the past 24 hours (you vomited four times). You haven’t eaten anything during that period, because you can’t keep anything down. You had not eaten anything out of the ordinary in the past 4-5 days. You do not have diarrhea or urinary burning or frequency.

PMH. No previous medical or surgical problems.

FH. Parents are alive and well. Father has hypertension. A younger brother and older sister are in good health.

PSH: You are a graduate of Penn State and are working as a reporter at the Philadelphia Inquirer, on the Suburban Section. You smoke a pack of cigarettes per day (for about 5 years), and drink alcohol only socially. You have never done any kind of drugs. You’ve been sexually active for six years. You have had four sexual partners over the years, and even once experimented and had sex with one of your friends who is a lesbian. (It was OK, but you decided you like heterosexual sex better, and you wouldn’t volunteer that information unless specifically asked.) For the last year you’ve been going out with another reporter at the paper. You have been strictly monogamous with him and are confident that he has been faithful to you as well. You use the pill for birth control. You think you should probably ask your boyfriend to use condoms, since you really don’t want to get pregnant, and you’ve heard of some women getting pregnant on the pill. But you know your boyfriend doesn’t like to use them, and you’re afraid of offending him. It makes him feel like you don’t trust him, and it does spoil the spontaneity of the encounter. Your last sexual encounter was ten days ago; you did not use a condom.

You think you probably have a gastroenteritis, but are worried that you might have appendicitis.
FACILITATOR NOTES

Session 14: Focus on Culture

Date: Tuesday 1/21 & Thursday 1/23 (Off-site)
Location/Time: Hahnemann Hospital: 2:30 - 4:30 PM
Abington Memorial Hospital: 2:45 - 4:45 PM

Objectives:
1. Enhance your understanding of the influence of cultural factors on medical care.
2. Enhance your understanding of how personal attitudes may have been shaped by cultural factors, and how these personal attitudes might affect patient care.
3. Practice asking questions about culture with hospitalized patients.

Module 15 Understanding Difference and Diversity in the Medical Encounter: Communication across Cultures.
Answer either discussion question 1 or 2 in Module 15 online by 6 PM the day before session.

Personal Awareness/Professionalism Discussion: (60 minutes)
Students break into small groups, write down the answers to the following questions, and then discuss:

- “To what culture do I belong and/or with what culture do I identify?”
- “What values come to mind that I particularly like and dislike as I reminisce about my cultural heritage?”
- “In reflecting on a cross-cultural interaction with a patient in your Community Educational Experience (CEE), what factors helped me feel a sense of congruence (“in synch”) and/or a sense of dissonance (“out of synch”)?”
- “How has the ‘culture’ of medical training affected my attitudes?”
- “What is the medical school culture, and how does it respond to my needs?”

Inpatient Interview: (45 minutes)
Ask the patient questions about his/her cultural background and its impact on his/her health and illness.

Wrap-up: (15 minutes)
What did we learn today? Topics for next session.
Objectives of this session
1. Enhance your understanding of the influence of cultural factors on medical care.
2. Enhance your understanding of how personal attitudes may have been shaped by cultural factors, and how these personal attitudes might affect patient care.
3. Practice asking questions about culture with hospitalized patients.

Discussion (60 minutes)

Please discuss the objectives of this session and important points in the DocCom Module. The 4th year co-facilitator should lead a discussion about the responses first-year students made to the optional question assignment. Please convey to the students the purpose of today's reflective exercise: In addition to understanding how culture might affect patients' attitudes and expectations, it is important for physicians to be aware how cultural norms might be affecting their own attitudes and behaviors toward patients.

The following exercise is designed to sensitize students to the related issues of how our own culturally-based attitudes and beliefs may affect our care of patients. Ask students to form subgroups of three or four; then each student should take five minutes to write down answers to the following questions (some students will have answered one of these questions for their DocCom assignments): To what culture do you belong and/or with what culture do you identify? What values come to mind that you particularly like and dislike as you reminisce about your cultural heritage? In reflecting on a cross-cultural interaction with a patient in your Community Educational Experience* (CEE), what factors helped you feel a sense of congruence ("in synch") and/or a sense of dissonance ("out of synch") that you would be open to sharing with your small group. How does the 'culture' of medical school affect attitudes that might have relevance to patient care? What is the culture of medical school, and how does it respond to your needs? After students have written down their answers, they should take turns discussing them. Allow about forty minutes for these discussions, and then reconvene as a large group to talk about the major issues raised in the small groups.

Inpatient interview (50 minutes)

Interview a hospitalized patient and ask students to spend part of the interview focusing on gaining an understanding of the patient's cultural identification, how certain cultural norms might be affecting the patient's attitudes toward illness, toward understanding the role of the physician in caring for him/her, and toward expectations of care.

Wrap up (10 minutes)

Compare notes from the different patient interviews, review relevant learning from the day, and plan for next session. Please give students their completed midterm assessment forms with your comments and graded midterms from Session 12.

NOTE: * = Community Educational Experience (CEE) is a required community service learning course.
FACILITATOR NOTES

Session 15: Alcoholism

**Date:** Tuesday 1/28 & Thursday 1/30

**Time:** 2:00 – 4:00 PM

**Location:** Queen Lane Seminar Rooms

**Objectives:**
1. Enhance your understanding of patients’ experiences of alcoholism.
2. Better understand how understanding alcoholism as a disease can enhance your communication with people with alcoholism, and improve your care.
3. Learn the basics of interviewing patients with a suspected diagnosis of alcoholism.
4. Enhance your understanding of your own attitudes and emotional reactions to patients with alcoholism, and how these might affect your interactions with patients.

**DocCom Module 29** Alcohol: Interviewing and Advising

**Assignment:** Answer either discussion question 1 or 2 by 6 PM on the day before your small group session.

**Discussion:** Members of Alcoholics Anonymous will join our small groups. AA Members will tell their stories and respond to questions.

**Wrap-up:** (15 minutes)

**Personal Awareness/Professionalism:** What did we learn today?

**Topics for Reflection:**

Many physicians have negative attitudes toward alcoholism. How do you feel about alcoholics? Some residents on inpatient wards call alcoholic patients by derogatory names. Could you ever see yourself doing this? People with alcoholism often downplay the extent of their consumption to physicians. Suppose you suspect a patient is drinking much more than he/she is willing to admit, or, suppose their alcohol level is very high when they admitted to only one drink. What feelings would you have about that? How could you react in a way that would be helpful to the patient? Physicians need to confront patients with addictions with their denial and behaviors. How comfortable are you with confrontation? Suppose your patient develops alcoholic hepatitis and dies? How much responsibility/guilt would you feel? What would you do with those feelings?
Learning Objectives:

1. Students will enhance their understanding of alcoholism as a disease, appreciating the roles of family and genetics in disease onset, the impact of alcoholism on patients' health, common co-morbid medical condition, and the role of denial in the progression of alcoholism.
2. Enhance your understanding of patients' experiences of alcoholism.
3. Better understand how understanding alcoholism as a disease can enhance your communication with people with alcoholism, and improve your care.
4. Learn the basics of interviewing patients with a suspected diagnosis of alcoholism.
5. Enhance your understanding of your own attitudes and emotional reactions to patients with alcoholism, and how these might affect your interactions with patients.

Format of this session:

We are fortunate to have committee members from Alcoholics Anonymous join us for this session.

Faculty to meet with the guests from AA at the beginning of the session, introduce themselves and the group members and present the format of the session. (Please take an active role to ensure this format is followed.)

The AA members should begin by talking, for about 20 minutes, about the AA program. After that, they should tell "their stories" of their experiences with alcoholism. We are especially interested in how physicians communicated with them: in what ways were they helpful, in what ways not helpful? How did the patients prevent their doctors from recognizing the extent of their drinking? We ask them to advise us as to how doctors could better communicate with their alcoholic patients and how doctors can motivate them to cooperate and comply with their recommendations.

An open session (approx 45 minutes) will follow between students and the AA members. Students and faculty co-facilitators will ask questions of our guests. Please keep in mind the above objectives when guiding the discussion. Also, please keep in mind the major points of our DocCom module. How would students apply the information learned in the module to interact with an alcoholic patient? Hopefully, the AA members can comment on this as well. Please emphasize the disease model of alcoholism. Even though they learn that alcoholism has genetic and physiologic underpinnings, many students still see alcoholism as a moral issue or a failure of will power. These misunderstandings can lead to unhelpful attitudes and judgments that will undermine their future care of people with alcoholism.

Wrap-Up: (15 minutes): Review learning from today's session.

Debrief

Faculty and student co-facilitators should meet for about 30 minutes after the session to review the session, give each other feedback, fill out daily worksheets, and plan for the next session. The next two sessions will be auditorium sessions on Addictions and Communicating with Patients with Chronic Illness. You will all meet again next as a small group for a session on Patient Education (hospital session) on 2/19 or 2/21.
Session 16: Communication with Young People with Chronic Illness

**Date:** Thursday 2/13 Entire Class (Both Tues & Thurs Groups) Meets
**Time:** 2:00 – 4:00 PM
**Location:** Queen Lane, Aud A (A7 Overflow)

**Objectives:**
1. Understand the basics, as well as the special communication issues in interviewing and caring for adolescents.
2. Understand how adolescents' life stage issues affect their reactions to their illnesses and their caregivers.

**DocCom Module 22** Communicating with the Adolescent Patient

**Assignment:** There is no assignment to complete for this module aside from reading the module.

**Format**
Dr. Dan Schidlow, the Chairman of Pediatrics at St. Christopher's Hospital for Children, will interview a family coping with chronic disease in the children.

**Note:** MANDATORY SESSION - ENTIRE CLASS MEETS ON THURSDAY IN AUDITORIUM A (A7, OVERFLOW) FOR TWO HOURS.

We invite faculty to attend as your comments are always helpful in the class discussions, however, this will not be an honorarium session. **Fourth year student co-facilitators assigned to this session are required to attend.**
Session 17: Patient Education

Date: Tuesday 2/18 & Thursday 2/20 (Off-site)

Location/Time: Hahnemann Hospital: 2:30 - 4:30 PM
Abington Memorial Hospital: 2:45 - 4:45 PM

Objectives:
1. Understand the process of patient education.
2. Understand the principles of optimizing patients' adherence to medical regimes.
3. Enhance abilities to perform the skills that make patient education successful.

Module 10 Share Information

Assignment: Read the module and then answer either discussion question 1 or 2 online by 6 PM the day before your session.

Discussion: (20 minutes)
- Determinants of patient adherence and the principles and skills involved in patient education, as presented in the reading below.
- Details of patient education exercise next session.

Role Play: (25 minutes)
In pairs, practice giving information about new onset hypertension.

Inpatient Interview: (60 minutes)
Ask about patient's perceptions of how much they understand of their doctor's instructions, and what would help them better understand their illness and its treatment.

Wrap-up: (15 minutes)
What did we learn today? Topics for next session.

Personal Awareness/Professionalism: Topics for Reflection
Patient education and counseling are arguably the physician’s most important skills. Though you have made an accurate diagnosis and prescribed effective therapy, it will count for little if the patient rejects your advice. How can you be the most effective educator for your patients? What personal qualities help you enhance patient motivation? How will your empathy, optimism, and encouragement be important to your effectiveness? Are there personal attitudes that get in the way of your being maximally effective as an educator and counselor? Since many patients do not adhere to therapeutic advice, how will you deal with frustration and anger when patients fail to follow your advice and get sicker as a result?

How responsible are you for your patients’ actions? What might be your approach to relating to patients around patient education and counseling (i.e. some physicians are paternalistic, some authoritarian, some see themselves as advisors, some treat their patients as equal partners in medical care, etc).
Objectives of this session:

1. Understand the process of patient education.
2. Understand the principles of optimizing patients' adherence to medical regimes.
3. Enhance abilities to perform the skills that make patient education successful.

Discussion (20 minutes)

Discuss the assigned DocCom module and how the skills on the patient education checklist promote a successful encounter (give out the patient education checklist). You might want to illustrate some of these skills items with examples from your own patient care. Include in your discussion your thoughts on the responses students made to the DocCom discussion question assignment. You might want to include in the discussion the Personal Awareness/Professionalism reflection questions listed in the student syllabus:

How can you be the most effective educator for your patients?

What personal qualities help you enhance patient motivation?

How will your empathy, optimism, and encouragement be important to your effectiveness?

Are there personal attitudes that get in the way of your being maximally effective as an educator and counselor?

Since many patients do not adhere to therapeutic advice, how will you deal with frustration and anger when patients fail to follow your advice and get sicker as a result?

How responsible are you for your patients' actions?

What might be your approach to relating to patients around patient education and counseling (i.e. some physicians are paternalistic, some authoritarian, some see themselves as advisors, some treat their patients as equal partners in medical care, etc).

Role Play (25 minutes)

Ask students to pair up and distribute to each pair one physician and one patient role. We have included copies of the role-play and information about hypertension. "Physician" students can interview the patient for about 5 minutes to elicit the history, and then do self-evaluation and receive feedback from the "patient" about the interview. The "physician" should have elicited not only the "patient's" HPI, PMH, FH, and PSH, but also the "patient's" concerns and attitudes that are likely to affect cooperation with therapy. The "physician" will then begin the process of patient education about hypertension, lifestyle change, etc., again do self-evaluation, and receive feedback from the "patient" about use of the skills on the checklist. The group should then come together as a large group and discuss what they have learned. Alternatively, you can have two students do a role-play in front of the group, one playing the physician and the other the patient, with contributions and feedback from the rest of the group. Use the patient education checklist as a template for doing the patient education and for feedback.

Patient Interview (60 minutes)

Go to the wards, have one or more students interview a patient, including asking questions about the patient's understanding of the illness and its treatment, the patient's informational
Please discuss logistics for Session 3 – Data Gathering, this is the first hospital session. Hahnemann needs, barriers to compliance and lifestyle changes, and what would help in self management of his/her illnesses.

Wrap-up (about 15 minutes)
ummarize and review today's lessons and discuss Session 18, which will take place on February 27 (Thursday’s group) and Tuesday’s group is March 4 in CEAC (see next section). The "Patient Education Skills Checklist" (enclosed) should be distributed today and used as a basis for your discussion.

How 18 Works: The 4th Year Student Co-facilitator will observe each student in a 10-minute patient education appointment with an SP. Students will know the patient’s history (on the P&P website); they should not spend time obtaining the HPI. This exercise helps them learn to give patient information at a level comfortable to the patient. Fourth year student co-facilitators will have 5 minutes to give immediate feedback using the same checklist you will review today. The session 18 SP role will be attached to the reminder notice for session 18, for your review. PLEASE DO NOT SHARE THIS WITH THE STUDENTS! Instead, remind students to read “Session 19: Patient Education Exercise, Student Guidelines” on the website. It advises them how to prepare for the SP encounter.

NOTE: When observing the students, please remain out of the students’ line of vision – we’ll place your chairs in a convenient spot so you won’t be on the student’s videotape).
Sessions 17 & 18 - PATIENT EDUCATION Skills Checklist

- elicit patient's understanding of the problem
- elicit patient's motivation to change
- elicit patient's concerns
- offer explanations in clear language, avoiding jargon
- use educational aids to explain procedure (e.g. drawing pictures, pamphlets, etc.)
- check patient's understanding of your explanations solicit questions
- address patient's concerns
- explore barriers to adherence
- explore strategies for overcoming barriers
- come to an agreement about what you and the patient will do

Throughout the encounter, respond appropriately to emotions:

- name the emotion patient expresses or inquire about the patient's emotional reactions
- legitimation: offer understanding of the emotions expressed
- offer partnership, reassurance, support or praise
Session 17 - PATIENT EDUCATION ON HYPERTENSION
PHYSICIAN ROLE

The goal of patient education is to give patients information they need to understand their illnesses and also to motivate them to work with you in resolving their problems. Some recommendations are quite difficult to implement, such as asking patients to change their behaviors or lifestyle. Hence, helping them understand and motivating them to participate in their care is a most crucial aspect of care giving; often as important as diagnosing the illness itself.

During the patient education part of the medical encounter, the physician employs a number of skills to make the process effective, including eliciting the patient's concerns, understanding of the illness and recommended treatment, and barriers to adherence. The physician must give factual information in a clear and organized way, avoiding jargon. For instance, in the role-play today, the patient needs to understand what hypertension is, what its complications are, and how hypertension can be controlled. Physicians need to be careful to not scare the patient about the disease and its course. Raising too much anxiety will prevent the patient from listening and understanding. On the other hand, raising some anxiety about potential complications of not treating a disease can be a good thing, as long as you make clear that there are things that the patient can do to effectively treat the illness and prevent complications. (See the patient education checklist for more details of the patient education process.) The physician can then work with the patient as a partner, giving appropriate reassurance and suggesting strategies to overcome difficulties with compliance.

Hypertension indicates high blood pressure. It is often idiopathic (essential); that is, no cause can be identified. Since patients cannot feel that they have hypertension, it is commonly called the "silent killer." Its complications can be severe: after many years of uncontrolled hypertension, patients may have damaged organs, which can lead to strokes, heart attacks, or kidney failure. Hypertension can often be controlled easily, though. Mild hypertension can often be alleviated (and the risk of complications decreased) by instituting lifestyle changes: blood pressure can be decreased by losing weight, exercising, eating less salt, stopping tobacco and alcohol usage, and decreasing excessive caffeine. Some medicines, such as non-steroidal anti-inflammatories like Advil or Motrin and decongestants can raise the blood pressure somewhat. Be sure to ask patients if they are taking these medications. If lifestyle modifications are not sufficient to decrease blood pressure, hypertension should be treated with medication. There are many anti-hypertensives available, each with their own side effect profile. For example, although diuretics are inexpensive, they increase urination, which can be bothersome. On the other hand, one drug class of choice for patients with hypertension and risks for heart disease is a beta-blocker. These sometimes have the side effect of causing sexual dysfunction and decreased exercise tolerance. Often, lower doses of two drugs can be combined, minimizing side effects. There are many different drugs, and physicians can often find the right combination of drugs to effectively lower blood pressure while minimizing side effects.

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Session 17 - PATIENT EDUCATION ON HYPERTENSION

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Session 17 - Patient Education on Hypertension

Physician Role

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Session 17 - PATIENT EDUCATION ON HYPERTENSION

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FACILITATOR NOTES
NOTE: FACULTY CO-FACILITATORS ARE NOT REQUIRED TO ATTEND THIS SESSION

Session 18: Patient Education Exercise with 4th Year Feedback

**Date:** Thursday 2/27 & Tuesday 3/4
**Time:** 2:00 – 5:30 PM

Check the P&P website and bulletin board outside of CEAC for your specific appointment time.

**Location:** Queen Lane, CEAC

**Preparation:** To prepare for this exercise, please read the handout entitled Patient Education Exercise - Student Guidelines.

**Standardized Patient Exercise:**
- 10 min interview, with 5 minutes feedback from your 4th year student co-facilitator.
- Review the lab findings. Educate the patient about diet modification and exercise.
- Your 4th year co-facilitator will provide feedback.

**DocCom Assignment:**
**Module 10** Share Information
To help you prepare for this exercise, you may want to review DocCom Module 10.

**Module 16** Promoting Adherence and Health Behavior Change
Read Module 16. No need to answer the multiple-choice or discussion questions.

**Reading Assignment:**
**Modifying Lipids through Lifestyle Changes** This will help you prepare for giving specific information to your SP

**Note:**
- Your appointment time and room will be posted on the Physician and Patient course website, and on the course bulletin board outside CEAC, 2nd floor corridor.
- Arrive 10 minutes before your appointment.

Instructions for accessing your recorded video
Fourth Year Student Co-facilitators, come to CEAC no later than 1:45 PM. We will start promptly at 2:00 PM. You will be given a folder containing checklists you'll use to evaluate your students. You'll be observing and giving feedback inside the exam room (out of the students’ line of vision – we’ll place your chairs in a convenient spot so you won’t be on the student’s videotape).

Students conduct a **10-minute** interview with the standardized patient. A warning bell sounds after 8 minutes to indicate there are 2 minutes remaining of the interview. Students **may not** bring in notes or copies of the Patient Education Skills Checklist to their interviews. When students finish the interview, you have **5 minutes** to give feedback,
based on the patient education checklist below. You *may give* the completed checklist to the student.
Session 18 instructions for students:

You will have pre-assigned 15-minute sessions during which you will be evaluated and given immediate feedback by your 4th year student co-facilitator on your ability to educate your patient. Your 4th year will use the same checklist that you reviewed in Session 18, below:

We want to reinforce the goals of Session 17.

They are:

a) Understand the process of patient education.
b) Understand the principles of optimizing patients’ adherence to medical regimes.
c) Enhance abilities to perform the skills that make patient education successful.

In addition, during this session, the specific goals are:

a) To practice skills of giving information.
b) To practice communicating in ways appropriate to the individual patient.

DOOR INSTRUCTIONS ABOUT THE PATIENT:

This is your second visit with this patient. During the last encounter, (he/she had changed doctors because of insurance), you ordered screening lipid levels. You found that the total cholesterol is 280 and the HDL is 30. You review the chart and recall that the patient has an FHx significant for a father who had a myocardial infarction at age 52. The patient’s own PMHx is non-contributory. Your patient is an ex-smoker. He/she started smoking at age 18, but quit 2 years ago. Otherwise, the patient has an active job, which he/she does without any difficulty, but does not have a specific exercise regimen. He/she often grabs lunch at fast-food restaurants, drinks a lot of soda during the hot summer weather, and eats a hearty meal at home with spouse every night. The patient confided in you during the last visit that he/she realizes his/her eating and exercise habits are not ideal, but does not know how to make such changes in his/her lifestyle. He/she does not take any medicines, but has thought of buying “diet-drinks,” but has never actually done so. During the last encounter, you immediately discounted that idea, as the patient appeared to be the average weight for his/her height. However, you ordered the screening lipid profile.

The patient now returns to review the lab findings. You plan to educate him/her on diet modification and exercise. There is an article on Modifying lipids through lifestyle changes in Patient Care to help you prepare for this exercise. You can find this article on the course website.
Sessions 17 & 18 – PATIENT EDUCATION

Skills Checklist

- elicit patient's understanding of the problem
- elicit patient's motivation to change
- elicit patient's concerns
- offer explanations in clear language, avoiding jargon
- use educational aids to explain procedure (e.g. drawing pictures, pamphlets, etc.)
- check patient's understanding of your explanations; solicit questions
- address patient's concerns
- explore barriers to adherence
- explore strategies for overcoming barriers
- come to an agreement about what you and the patient will do

Throughout the encounter, respond appropriately to emotions:

- name the emotion patient expresses or inquire about the patient's emotional reactions
- legitimation: offer understanding of the emotions expressed
- offer partnership, reassurance, support or praise
Session 19: Understanding Communication Issues in Patients with Terminal Illnesses

**Date:** Tuesday 3/18 (Entire Class, both Tues & Thurs groups, Meets

**Time:** 2:00 – 4:00 PM

**Location:** Queen Lane, Aud A, and A7 (Overflow)

**Objectives:**
1. Understand core issues and skills in communicating with patients with terminal illnesses.
2. Understand how personal attitudes toward vulnerability and death might affect your ability to communicate with patients with terminal illnesses.

**DocCom Assignment**

**Module 34 Communication Near the End of Life**

Respond to any one of the first four questions in Discussion question 2, by 6PM the evening before this session.

**Supplementary Reading**

Novack, D. (1993) *Adrienne*. Annals of Internal Medicine, 119, 424-425. (Dr. Novack will read this story in class.)

**Discussion:**

- Dr. Novack will play an audiotape of Adrienne Lockhart’s presentation at the beginning of a panel discussion in 1974.
- Following the audiotape presentation, a panel will discuss the issues raised and the experiences of caring for patients with terminal illnesses.

**Note:**

MANDATORY SESSION - ENTIRE CLASS MEETS ON TUESDAY IN AUDITORIUM A (A7, OVERFLOW) FOR TWO HOURS.

We invite faculty to attend as your comments are always helpful in the class discussions, and fourth year student co-facilitators assigned to this session are required to attend.
Learning Objectives:

1. Students will understand core issues and skills in communicating with patients with terminal illnesses.
2. Students will better understand how their own attitudes toward vulnerability and death might affect their abilities to communicate with these patients.

Format

Dennis Novack will be presenting an audiotape from a panel discussion 30 years ago with Adrienne Lockhart, a friend who died of metastatic breast cancer. A panel discussion will follow.

All faculty and student co-facilitators are welcome to come to this session, and we very much appreciate your comments during the discussion. In past years, fourth year student co-facilitators and faculty members have added a great deal by relating their experiences and feelings related to communication with patients at the end of life.
ON BEING A DOCTOR

Adrienne

Dennis H. Novack

1 September 1993 | Volume 119 Issue 5 | Pages 424-425

I met Adrienne as an intern, when I admitted her to the hospital. She was an attractive, engaging woman, a junior faculty member at a nearby liberal arts college. She spoke with an Australian accent in a low voice that was serious, earnest, and playful all at once. She had done some camping a few weeks before and strained her back. She was sure that carrying heavy packs had caused the strain, but since it hadn't gotten any better, her physician felt that she should come into the hospital.

I guess I wasn't a very good interviewer back then. Somehow I had failed to elicit the fact that she had a mastectomy.

I was still at a stage when I felt uneasy examining young women. When it was time for the breast exam, I raised her gown to below her ribs and hesitantly began to examine her breasts. I was shocked that her left breast was missing. "Oh that," she responded cheerfully, "I had cancer a few years ago but the mastectomy cured it. I don't give it much thought anymore." I was instantly saddened, knowing that the cause of her back pain might be a metastatic lesion. I stumbled through the rest of our conversation. I agreed with her that the heavy pack had probably caused her back strain and that with a little conservative care, she would be better in no time.

The following afternoon I looked at her spine films with my resident. I remember him saying, "She's got it, all right. She'll need to be checked for other mets. She'll need castration, radiation, chemo, the works." I didn't go back to see her. She was a private patient, after all, and I was superfluous to her care. Besides, I couldn't face her. I knew she would ask me about her prognosis. I knew she would be afraid of death. I couldn't talk to her about it. So I spent the next couple of days being angry with myself for not going back and talking to people about how you talk to patients with metastatic cancer. Finally one of my psychiatric colleagues gave me the best advice.

"Why don't you just go in and say, ‘Hello’?"

"Damn," I thought, "he's right," and went up to her room. She had been discharged.

I didn't see Adrienne again for about 6 or 8 months. Then, her oncologist approached me.

"Do you remember Adrienne S?" she asked. "She has quite a lot of feelings about what it's like to have cancer and is very articulate. She wants to speak to a small group of physicians to help them understand how to better care for their patients with cancer." I said that I would be glad to organize such a conference and called Adrienne, arranging to meet her for lunch.

That lunch was extraordinary. We spent a couple of hours talking, about her experiences mostly. I felt moved and told her that her insights and feelings were too precious to share with only a few
physicians. She agreed to be part of a panel discussion that also included her oncologist, a nurse, a minister, and me. I advertised it for all hospital personnel.

About 200 people attended. There was a good deal of anger in Adrienne's initial remarks, mostly about physicians' lack of empathy and avoidance of her and about the hospital's lack of attention to the little things. (For example, she couldn't wash her hair in the hospital and, for a woman who cared about her appearance, she found this degrading). She talked about how the cancer had done to her and for her, about her feelings of disconnectedness from her past and from normal life. She talked about how hospital personnel simply called her "Adrienne" without asking how she preferred to be addressed. She talked with appreciation about the student nurse who had naively inquired about her life. She spoke about her prognosis. Clearly her oncologist's honesty and respect had helped her cope. "What a remarkable woman," a friend said later. "It's hard to understand how people believe there is a just and merciful God out there. If there were, how could He let a woman like this die?"

I saw Adrienne often after that. My wife and I had dinner with her; I met her for lunch a couple of times; but mostly I saw her during her repeated admissions to the hospital.

I remember one Saturday, when I was on call and having a slow night. I had been feeling sad about Adrienne's increasing disability. Around 9 pm, I brought my guitar up to her room. She was sharing the room with another young woman about her age who I had cared for when she was in the ICU. Karen had been septic and quite sick but was now on the mend. I remember thinking about the contrast between the two young women, one getting better and one getting worse. I played my guitar and we all sang folk songs. Adrienne sang all of the lyrics to "On Top of Old Smokey." I had never actually heard all of the verses before or realized until then that it was the song of a jilted lover. It has been hard for me to sing that song ever since. As I left to go, Adrienne called me over and gave me a friendly kiss.

On another occasion I passed by her room around midnight and saw that she was awake. I walked in and sat and talked with her for awhile. Adrienne spoke with me about her former husband. Not wanting to take care of an invalid, he had left her after her cancer was diagnosed. We talked about her social life, which had been pretty drab recently. I remember her comment: "Doctors don't pay attention to your real needs." We sat in silence after that and then changed the subject.

Inevitably her cancer spread to her brain. She had trouble walking. I had lunch with her one day before she went to radiation therapy. Adrienne was infuriated with her Dean who had canceled her teaching for that semester. She was too weak to go to class but not too weak to hold class in her apartment, which she had fully intended to do. "Damn it. I'm alive until I die," she said, and had resumed teaching.

On another occasion, I asked her why she cared for me, as she had been recently telling me. I felt I hadn't really done anything for her. She told me she cared for me not for what I was able to do but for who I was. "But," I thought, "isn't who you are assessed by what you do?" Still, I was touched that she cared for me and felt I had made a difference in her life.

Near the end of my residency, she was admitted just as I was leaving for a vacation. I went up to see her before I left and stood beside her while her sister, who had flown in from Australia, sat by. I held her hand and talked with her a bit. She was now somewhat confused. She talked in medical terms about her disease and I remember saying sadly, "So many words you have had to learn."

I wanted to tell her I loved her, and kiss her goodbye, but I didn't, not wanting to admit to her, and myself, that she was dying. I left for the sun. When I came back, Adrienne was gone, her body shipped back to Australia, the memorial service days earlier. I had missed it all.
Adrienne was the first—and the last—patient to become my friend, although a number of patients have called me "friend" since. I never again became so emotionally involved with a patient but, in the end, I was grateful for the experience. Adrienne deepened my understanding of patients’ experiences of terminal illness and helped me overcome my fears of relating to these patients. She also made me aware of the potential for love between doctors and patients: What are the meanings and implications of attraction and caring between doctor and patient? How do clinicians work out the conflicting emotions that sometimes arise?

Author and Article Information

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Session 20: Coping with Severe Disability

Date: Thursday, 3/20 & Tuesday 3/25 (Off-site)
Time: 2:30 – 4:30 PM
Location: Inglis House, 2600 Belmont Avenue
Philadelphia, PA 19131
Meet at Founders’ Hall

DRIVING DIRECTIONS:
Exit campus, make right on Queen Lane. At next corner, make right onto Wissahickon Ave. Continue to 2nd light (Clapier). Make right onto entry ramp of I-76. Continue toward Central Phila. Take exit #341/ West River Dr/Montgomery Drive, and turn right onto Montgomery Drive. In 0.4 miles, turn right on Belmont Avenue, and Inglis House will be on your left (0.9 miles). Street parking will available.

We recommend that you car pool to this session.

Objectives:
1. Enhance the abilities to understand the issues involved in caring for patients with severe disabilities
2. Enhance the abilities to communicate with patients with severe disabilities
3. Better understand personal attitudes and emotional reactions to patients with severe disabilities and how these may inhibit and/or enhance future care of these patients.

Reading

Assignment: We will interview residents of Inglis House, a home for severely disabled residents, a few miles from the Queen Lane campus.

Format:

Wrap-up: (25 minutes)

Patients with severe chronic disabilities often have informational needs that the physician cannot answer. The physician’s inability to answer questions may increase patient anxiety, contribute to demoralization, raise doubts about the physician’s abilities, and may shut down future questions. How should you react when you do not know the answers to questions? How can you deal successfully with the patient’s and family’s reactions to the limits of your knowledge?

Patients with severe chronic disabilities invariably arouse many emotions in their caregivers: pity, a sense of helplessness and/or hopelessness, frustration, fear, repulsion. Because of these emotions, many caregivers would rather not deal with patients with chronic severe disabilities, and may give them less than adequate care when they do have them as patients. What feelings do these patients arouse in you? How would you cope with these feelings if you had a patient with severe chronic disability? What can you look for in these patients that will help you connect with them? How can you appreciate these patients’ personality strengths? Can you find inspiration in their outlooks on life and their abilities to cope, and convey your positive feelings to them?
Learning Objectives:

1) Enhance abilities to understand the issues involved in caring for patients with severe disabilities.

2) Enhance abilities to communicate with patients with severe disabilities.

3) Better understand personal attitudes and emotional reactions to patients with severe disabilities, and understand how these may inhibit and/or enhance future care of these patients.

Format

Enter Inglis House through the front door and proceed to Founders’ Hall, which is behind the front desk. In Founders’ Hall, students will be given a visitors badge and shown to their group’s table. Each student will be given an index card, which will detail the name and room number of an Inglis House resident they have been chosen to interview.

The Medical Director of Inglis House will give a brief introduction to the students and faculty student co-facilitators. An Inglis House resident will also speak about her/his experiences and perspectives. Dr. Novack will also introduce the session and have a brief discussion about the kinds of questions to ask the residents.

The students will then exit from Founders’ Hall and go in pairs to the room detailed on their index card where they will find their assigned resident. Each co-facilitator should go with one of the pairs of students. Please focus upon the goals of this session when interviewing the residents. At 4PM, students and faculty co-facilitators should meet back their small groups at Founders’ Hall. Faculty co-facilitators should discuss the students’ experiences in their interviews. Discuss student perceptions of the challenges of interviewing persons with severe disability. Please ask each of the students about their experiences: What was the hardest thing for them? How did it make them feel? What emotional and social resources have helped their patient cope? What did they learn that was surprising? What is the most important thing they learned from the interview?

Wrap-up

Review learning from today’s session.

Debrief

Faculty and student co-facilitators meet after the session to review the session, to fill out daily worksheets, and to plan for the next session.
Session 21: Addictions

Date: Monday 4/7 Entire Class (Both Tues & Thurs Groups) Meet
Time: 1:00 – 3:00 PM
Location: Queen Lane, Aud A (A7 Overflow)

Objectives: Students will gain a richer understanding about patients’ experience of addiction and the issues involved in interviewing patients with addictions.

DocCom Module 30 Drug Abuse Diagnosis and Counseling.

Assignment: Please read the module. No need to complete multiple-choice or discussion questions.

Format Dr. Barbara Schindler will bring several participants from her “Caring Together” drug addiction treatment program. They will share their experiences with the class and answer questions. These sessions have always been very compelling and moving.

Note: MANDATORY SESSION - ENTIRE CLASS TO MEET ON MONDAY IN AUDITORIUM A (A7 OVERFLOW) FOR TWO HOURS.
Objective: Students will gain a richer understanding about patients’ experience of addiction and the issues involved in interviewing patients with addictions.

Notes: We invite faculty to attend as your comments are always helpful in the class discussions, however, this will not be an honorarium session. It is very helpful to the group discussions to have fourth year students share their experiences of caring for patients with addictive disorders, and the personal struggles they may have encountered in this care.
FACILITATOR NOTES

Session 22: Engaging Patients’ Spirituality/ Medicine as a Spiritual Path

Date: Tuesday 4/8 & Thursday 4/10
Time: 2:00 – 4:00 PM
Location: Queen Lane, SAC A

Objectives:
1. Enhance your understanding of how spirituality may play a role in patients’ lives and in coping with illnesses, and appreciate how that understanding can inform your care.
2. Connect with and share the core values, meanings and purpose that will guide you in becoming a physician, and relate these to the values and traditions of the profession of medicine.

Assignment:
Read: Module 19 Exploring Spirituality and Religious Beliefs

Self-reflection: Consider these questions:
- What gives my life meaning?
- What gives my life purpose?
- What are the values that guide my actions?
- What is my connection to others and to the world?
- What kind of person do I aspire to become?

Each student and faculty member will prepare a representation of his or her personal response to these questions. This may be an image or photograph or magazine clipping or art or word art. This representation should be 6”x6”. (Don’t worry if the image doesn’t convey the entirety of your answers to the questions above.) Bring this image to the session.

Format of the Session:

Students will sit with their groups at designated tables

I. 15 minutes: Initial remarks by Drs. Novack and Rosenzweig:
II. 60 minutes: Small group discussions at tables:
   - A poster board (28”x22”), paste, and colored markers, and extra blank 6x6” squares of paper will be on each table.
   - Each student and faculty member will show and talk about the symbol they brought (4-5 minutes each). During the discussion please focus your description of your image on questions related to the above questions, but which relate to your professional development:
     - What gives meaning or purpose to my work as a medical student and future physician?
     - What are the values that will guide my work as a medical student and physician?
     - How might my work as a medical student or physician deepen my sense of connection with others and the world?
     - What kind of physician do I aspire to become?
• Each group member will put their symbol down on the poster board at the end of sharing. In the end, the group will decide on the final spatial of symbols, and paste them down.
• The group will reflect on the values that are represented on the poster board, and write those values in the margins of the poster board.
• One member of the group will write the list of values on a separate sheet that is provided that will be collected. A visual depiction of the words used by all groups in both sessions will be generated and posted on the Physician and Patient Course Website.
• One member of the group will take a photo of the poster so it can be emailed to Beverly Towns and to each member of the group.
• The group will then answer these questions, with one student acting as scribe:
  o What was surprising about this exercise?
  o What was appreciated about the contribution of other members of the group to the montage?
  o How might students support each other next year and beyond to stay close to their values and the values of Medicine?

III. 10 minutes: Large group debrief

IV. 35 minutes: Discussion/Closure of Physician and Patient Course: Students and faculty express appreciation to one another as the course ends, and say something they each got out of the course that they will take with them into their clinical work in the future.

Background of this Session: Much of medical science addresses the physical body. Our science is a powerful tool for studying the material world – the world that can be observed with physical senses, measured and quantified. To be a human being is to experience more than the material world. We also experience meaningfulness and life purpose. Meaning or meaningfulness is not a physical property of the world. It is a spiritual (non-material) dimension of our life experience.

Life’s meaning and purpose flows out of an experience that we are in relationship to something greater than ourselves (something that is self-transcendent). For followers of certain religions, that something may be called God. For others it may be the greater good, or truth, or family and community, or the whole of humanity, or the ecosystem of the planet, or life itself.

Spirituality points to the domain of life’s meaningfulness and purpose, and a relationship with that which is greater than (transcendent to) one’s self. In the medical literature, we use the word “spirituality” differently than we use the word religion. Religion refers to a particular set of shared beliefs, doctrines and practices that address spiritual questions. Spirituality asks:

• What gives my life meaning?
• What gives my life purpose?
• What are the values that guide my actions?
• What is my connection to others and to the world?
• What kind of person do I aspire to become?

Exploring our patients’ spirituality and religious values and beliefs is an important therapeutic tool. It can create an opportunity for a patient to reaffirm or reconnect with psychological, social and spiritual sources of comfort, strength and personal meaning during times of medical crisis.
and suffering. This aspect of physician patient communication is presented in DocCom Module 19: Exploring Spirituality and Religious Beliefs.

Of equally great importance is our own spirituality as physicians. Becoming a doctor means joining a profession that for centuries has bound itself to timeless values of compassion, altruism and healing. The practice of medicine requires us to be in relationship with these values. We are called to be compassionate even when it is hard to do so, to be trustworthy even when honesty is difficult, and to be committed to a vision of greater relief, wellness and wholeness for our patients even in the presence of great suffering and limitation. The practice of medicine continually calls us to reach beyond ourselves: to be empathic, to cultivate greater wisdom, compassion and love, and to encounter ultimate questions of the meaning and mystery of suffering, healing, life and death.

In this session we explore the relationship between our own, individual spirituality, and how our core values, meanings and purpose bind us to the timeless traditions and values of the profession of medicine.
FACILITATOR NOTES
NOTE: FACULTY CO-FACILITATORS ARE NOT REQUIRED TO ATTEND THIS SESSION

Session 23: SP Practice Interview with 4th Year Feedback

Date: Tuesday 4/29 & Thursday 5/1
Time: 2:00 – 5:30 PM

Check the P&P website and bulletin board outside of CEAC for your specific appointment time and room number.

Location: Queen Lane, CEAC

Standardized Patient Exercise: (15 minute appointment per student):

- 10-minute interview with five minutes feedback from faculty co-facilitator (4th year to give BIC/Checklist to student).
- In this exercise, student will focus on obtaining the patient’s history, conducting the interview as you would conduct the first ten minutes of an interview with a new patient.
- Your appointment time and room number will be posted on the Physician and Patient course website, and on the course bulletin board outside CEAC, 2nd floor corridor.
- Feedback will focus on student’s use of BIC Skills. You will use an abbreviated BIC to give feedback. (Note: This is the same checklist that will be used in the final exam, thus the link will not be posted here but will, however, be available to you on exam day).
- In the final, 70% of the grade will focus on student’s use of the BIC Skills and 30% on the specific information you elicit. If student use the skills well, student should elicit all the information needed (including data from the HPI, PMH, FH and PSH).
- We assume that the student know all the BIC core content areas. Student will not need to tell you what questions they would have asked if there had been adequate time.

Note: Remember, this is an Extra Credit opportunity.

Here is the description of this opportunity from the course book introduction: Students can earn up to 5 additional points on their clinical framework exam final grade (2 1/2 points for each of two exercises) by reviewing the videos of CEAC session 23, filling out a BIC and writing a one page paper critiquing their use of interviewing skills in the encounters. This critique should include what you did well, and what skills you need to work on. You should also comment on how any personal feelings or discomfort may have interfered with or enhanced your interview. The completed BIC and paper should be emailed to the Course Coordinator, Beverly Towns btowns@drexelmed.edu no later
than one week (by 6:00pm) after your interview exercise. 
Instructions for accessing your recorded video
**Please arrive at CEAC no later than 1:45 PM, we will start promptly at 2:00 PM**

Students will conduct a **10-minute** interview with the standardized patient. A warning bell will sound after 8 minutes to indicate there are 2 minutes remaining of the interview. Students may not bring in notes or copies of the BIC to their interviews.

Please **remain in the exam room during the interview** (out of the students’ line of vision – we will place your chairs in a convenient spot so you will not be on the student’s videotape). While observing the student interviews, fill out the BICs (abbreviated version) that we will provide in your folders. This includes skills and content checklists. Note that on the skills portion, you can give points anywhere on the continuum of the scales. The SPs have been trained so that if students use BIC skills well, they should elicit all the information on the case content checklist.

Following the interview, you will have **5 minutes** to give feedback based upon the abbreviated BIC. The focus of feedback will be on their proper use of BIC skills, so students will not need to recite the core content questions they would have asked if there were adequate time. (In the final exam, use of BIC skills will account for 70% of the score and 30% will be for the information elicited.) When the student has completed the interview, spend 5 minutes going over the skills and content checklists and make any general additional comments about their use of skills and what they need to continue to work on. **Please give the completed BICs to the student to use as a study tool for the Session 24 final exam.**
### FACILITATOR NOTES

**NOTE:** STUDENT CO-FACILITATORS ARE NOT REQUIRED TO ATTEND THIS SESSION

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**Session 24: Final SP Interview with Faculty Feedback**

**Date:** Tuesday 5/6 & Thursday 5/8  
**Time:** 2:00 – 6:00 PM  
Check the P&P website and bulletin board outside of CEAC for your specific appointment time.  
**Location:** Queen Lane, CEAC

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| Standardized Patient Exercise: (20 minute appointment per student): | 1. 12-minute interview with eight minutes feedback from faculty.  
| 2. In this exercise, students will focus on obtaining the patient's history, conducting the interview as they would conduct the first 12 minutes of an interview with a new patient.  
| 3. Your appointment time and room number will be posted on the Physician and Patient course website, and on the course bulletin board outside CEAC, 2nd floor corridor.  
| Feedback will focus on students' use of BIC Skills. You will use an abbreviated BIC to give feedback. This is the same checklist that was used in Session 23. Again, as this is the students' exam, it will not be posted but will be available to you on exam day.  
| In this final, 70% of the grade will focus on students' use of the BIC Skills and 30% on the specific information students elicit. If the students use the skills well, they should elicit all the information needed (including data from the HPI, PMH, FH and PSH).  
| **We assume that the students know all the BIC core content areas. Student will not need to tell you what questions they would have asked if there had been adequate time.**  

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**Instructions for accessing your recorded video**
This final session will take place in CEAC at Queen Lane on May 6 and 8. Students will have a 12-minute interview with the standardized patient (you will be in the room with the student), followed by an 8 minute feedback session from you. Feedback will be based upon reviewing the elements of interviewing skills we have touched upon all year. You should use BIC skills categories in giving feedback. Please keep the BICs that you review with students during the feedback and pass them to Beverly Towns at Beverly.towns@drexelmed.edu at the end of the afternoon. Also, please use the feedback time after each interview to offer students your comments and appreciation of their individual efforts during this course.