Assessing Risk, Negotiating for Behavior Change, Respecting Culture

Standardized Patient Case
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The Office on Women's Health

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Project Overview

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Overall Project Goal

To train health professional learners in the area of women's heart disease, and evaluate the effectiveness of the curricula in improving knowledge and awareness of cardiovascular disease risk factors, prevention, intervention and early detection in women.

Targeted Learners

Medical students year 1-4, nurse practitioner students, lay health educators, practicing clinicians. The material can be modularized and level of difficulty adjusted for the appropriate learner type and level.

Case Overview

This case focuses on heart disease risk in women, specifically on risk factor assessment, patient education and counseling around behavior change, and on cultural aspects of the encounter. Students may want to focus on the risk factors, but the most significant learning objective of the case that makes the best use of standardized patients as a teaching modality are negotiating for behavior change and exploring cultural contexts. Standardized patients and facilitators will need to be prepared to fully explore these aspects of the case. The case details may be modified to fit the standardized patient and the teaching context including details of the patient's cultural background.

Case Focus

Heart disease risk factor assessment, negotiating for behavior change, and respect for cultural perspectives in a 43 year-old African American woman.

Major Purposes of Case

After working through this case with the standardized patient (SP), the student will:

1. Assess the patient's cardiovascular disease (CVD) risk
2. Assess the patient's knowledge of her CVD risk
3. Assist the patient in linking her personal risk to her personal values and goals
4. Help the patient identify heart healthy behaviors
5. Help the patient identify heart unhealthy behaviors
6. Use *The Heart Truth* patient education materials in risk assessment and counseling for the patient
7. Help the patient commit to changing at least one "heart unhealthy" behavior
8. Write a summary note
9. Order appropriate screening and/or diagnostic tests
10. Complete a knowledge-based assessment

Case Specific Essential Knowledge, Skills and Behaviors to be Demonstrated:

1. Knowledge of the risk factors for heart disease in women
2. Knowledge of the contribution that specific risk factors have to CVD in women
3. Knowledge that hormone replacement therapy is NOT indicated to reduce CVD risk in women
4. Demonstration of appropriate patient centered counseling techniques (including gender and cultural issues) based on the stages of change and confidence conviction models of behavior change
5. Demonstration of use of *The Heart Truth* patient education materials in risk assessment and counseling for the patient
6. Demonstrated use of the risk calculation tool from the Framingham Heart Study Point Scores
7. Demonstration of the ability to provide individualized counseling to identify and reduce specific risk factors in the case patient

Primary Challenges Presented by the Patient's Behaviors:

1. She is overwhelmed by the need to change so many behaviors at once
2. She has her own beliefs about the role that diet, exercise and medication have in causing and/or treating high blood pressure, diabetes, and heart attacks
3. She has fears about her own health and the meaning of illness based on her experiences with her mother, her husband and her friends
4. She is very concerned about her own children and job situation which adds stress and makes changing behavior more difficult
5. She shares the belief that black women should be strong and be there for others whose needs come before her own

Expected Differential Diagnosis and Problem List:

Significant risk factors for cardiovascular disease (smoking, probably high blood pressure, sedentary life style, overweight, “rule out” diabetes)

Checklist Items

Some of the skills that may be assessed using the SP case are listed on this page. These are provided for you to consider as you construct your own checklist for evaluating student performance.

Risk Factor Assessment
The student:

- Identified the major CVD risk factors in this patient (smoking, family history, overweight, sedentary lifestyle, possible hypertension, “rule out” diabetes, “rule out” hyperlipidemia)
- Used the Framingham risk calculation tool accurately to estimate the 10 year risk specifically for this patient
- Demonstrated the measurement of waist circumference and/or the ability to calculate BMI (body mass index) based on height and weight measurements provided
- Ordered appropriate diagnostic tests (fasting glucose, fasting lipid profile)

Patient Education and Counseling
The student:

- Correctly identified the patients stage of change for each of the following behaviors:
    - Smoking: CONTEMPLATION. The patient knows she should quit, and will commit to cutting down. African American women in this age group generally initiated smoking in their late teens or 20s; African Americans have been less likely than other ethnic groups to begin smoking as younger teenagers (although this may be changing). The learner must address the patient’s sources of stress and work with the patient to identify ideas for managing differently.

    - Exercise: ACTION. The patient is ready to begin exercising. Patient needs encouragement, reward, and a personalized message about health benefits.

    - Diet: CONTEMPLATION. The patient wants to improve, is motivated to work with husband who also needs to lose weight, is interested in “heart healthy” recipes and wants to order a cookbook. She has past experience with successful weight loss from initiating a diabetic diet for husband.

    - Risk reduction for diabetes, hypercholesterolemia: PRECONTEMPLATION. She needs “new information” from lab results.

- Used stage appropriate techniques to negotiate with the patient about the changes she was willing and able to make

- Uncovered the patients health beliefs, values and concerns

- Provided personalized messages for change linked to the patient's lifestyle, goals and values

- Effectively used *The Heart Truth* patient education materials to assist in patient counseling

Cultural Perspectives
These may be modified and customized to fit the details of a particular cultural group or specific patient. This case is designed to highlight major concepts and to serve as one example, and is in NO WAY intended to stereotype any group. All medical care is delivered in the context of the individual. Everyone in influenced by factors such as culture, family, and past experience with the healthcare system in medical encounters. This case serves a way to learn about the influences of this on patient beliefs and outcomes.

The student
- Demonstrated respect for the patient's beliefs about cause and meaning of illness
- Explored patient's concerns about family role and functioning
- Recognized beliefs about body size and image
- Responded appropriately to patient's use of terms and vocabulary
- Negotiated dietary issues in the context of usual and customary dietary practices

Implementation Tips

Use of the Case
The Heart Truth SP case can be used for beginning, intermediate or advanced learner levels. It can be utilized for educational or for assessment purposes to fit the needs of different training institutions. Teaching and reviewing the major case concepts (cardiovascular disease risk and risk assessment in women, patient education and counseling principles, general cultural awareness principles) prior to beginning the session will optimize the learner and standardized patient time for interaction.

Small Group Discussion Tutorial
This format works well for beginning and intermediate learners. Small groups of 3 to 6 learners with a trained facilitator and a standardized patient can work through the learning objectives using a "time in/time out" strategy. Advanced learners (such as fourth year medical students or residents) can be trained to serve as facilitators, thereby increasing their own content knowledge and teaching skills. Specific guidelines for using the case in this manner are included in the facilitators guide section.

Assessment/Evaluation through a Single or Multiple Station Clinical Skills Examination
This format can be utilized for intermediate or advanced learners to assess a broad range of skills in knowledge of CVD risk factors in women, communication skills especially counseling and negotiation, and cultural sensitivity and awareness.

RESOURCES

II RESOURCES

Resources

You may want to provide the students and facilitators with a list of resources they can consult for more information. Some suggested resources are listed below.

Cardiovascular Disease in Women

Schulman, KA, Berlin, JA, Harless W, et al: The effect of race and sex on physician's recommendations for cardiac catheterization. N Engl J Med 1999;340:618-626.

Kannel, WB, Abbott, RD: Incidence and prognosis of myocardial infarction in women: The Framingham study. In Eaker, ED, Packard, B, Wenger, NK, et al (eds): Coronary Heart Disease in Women: Proceedings of an NIH workshop. New York: Haymarket Douma 1987;208-214.

Dempsey, SJ, Dracup, K, Moser, DK. Women's decisions to seek care for symptoms of myocardial infarction. Heart Lung 1995;24:444-456.

Birdwell, BG, Herbers, JE, Kroenke, K: Evaluating chest pain: The patient's presentation style alters the physician's diagnostic approach. Arch Intern Med 1993;153:1991-1995.

Harrold LR, et al. Narrowing gender differences in procedure use for acute myocardial infarction: insights from the Worcester Heart Attack Study. J Gen Intern Med 2003;18:423-31.

Kwolek DS. Women's health education: progress and promises. J Gen Intern Med 2003;18:490-91.

Chrysohoou C, et al. Gender differences on the risk evaluation of acute coronary syndromes: the CARDIO2000 study. Prev Cardio 2003;6(2):71-7.

Devon HA and Zerwic JJ. Symptoms of acute coronary syndromes: are there gender differences? A review of the literature. Heart Lung 2002;31(4):235-45.

Burke, L, Dunbar-Jacob, J., & Hill, M. Compliance with cardiovascular disease prevention strategies: A review of the research. Annals of Behavioral Medicine 1997;19(3):239-263.

Tecce, Marc. Heart Disease in Older Women: Gender differences affect diagnosis and treatment. Geriatrics Dec 2003;58:12, 33-38.

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Kim C, Hofer TP, Kerr EA. Review of Evidence and Explanations for Suboptimal Screening and Treatment of Dyslipidemia in Women: A Conceptual Model. J Gen Intern Med 2003;18:854-863.

Journal of the American Medical Women's Association Theme Issue: Cardiovascular Health in Women. Vol 58 (4); Fall 2003.

Patient Education and Counseling

Rollnick, S., Mason, P., Butler, C. Health Behavior Change: A Guide for Practitioners; 1999, Philadelphia: Churchill Livingston.

Mundinger, M. O. and R. L. Kane. Health outcomes among patients treated by nurse practitioners or physicians. JAMA 2000;283:2521-4.

Miller WR, Rollnick S. Motivational Interviewing: Preparing People to Change Addictive Behavior; 1991, the Guilford Press, New York

Roter DL, Stewart M, Putnam SM, Lipkin M, Stiles W, Inui TS. Communication styles in primary care physicians. JAMA 1997;277:50-6.

Roter DL, Hall JA. Physician gender effects in medical communication: meta analytic review. JAMA 2002;288:756-764.

Street RL, Krupat E, Bell RA, Kravitz RL, Haidet P. Beliefs about control in the physician-patient relationship: effect of communication on medical encounters. J Gen Intern Med 2003;18:609-616.

Halpern J. What is clinical empathy? J Gen Intern Med 2003;18:670-674.

Prochaska J, Norcross J, DiClemente C. Changing for Good: Avon Books, New York: 1994

Keller VF, White MK. Choices and changes: A new model for influencing patient health behavior. JCOM 1997;4:33-36.

Choices and Change: Clinician Influence and Patient Action: The Bayer Institute for Healthcare Communication: 1996

For more information on the Bayer Institute:

Institute for Healthcare Communication, Inc.
555 Long Wharf Drive
13th Floor
New Haven, CT 06511-5901

Cultural Awareness

Institute of Medicine. Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care. National Academies Press. 2002.

Wyatt SB. Williams DR, Calvin R, Henderson FC, Walker ER, Winters K. Racism and Cardiovascular Disease in African Americans. Am J Med Sci 2003;325:315-331.

Ashton CM, Haidet P, Paterniti DA, Collins TC, Gordon HS, O'Malley K, Petersen LA, Sharf BF, Suarez-Almazor ME, Wray NP, Street RL. Racial and Ethnic Disparities in the Use of Health Services: Bias, Preferences, or Poor Communication. J Gen Intern Med 2003;18:146-152.

Kagawa-Singer M, Kassim-Lakha S. A Strategy to Reduce Cross-Cultural Miscommunication and Increase the Likelihood of Improving Health Outcomes. Acad Med 2003;78:577-587.

Crandall SJ, George G, Marion GS, Davis S. Applying Theory to the Design of Cultural Competency Training for Medical Students: A Case Study. Acad Med 2003;78:588-594.

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Cultural Competency in Women's Health: Training Faculty to Teach about Providing Culturally Competent Care to Minority and Underserved Women: developed by the Harvard, Boston University, University of Puerto Rico, Tulane Xavier and University of Washington Centers of Excellence in Women's Health, funded by the Office of Women's Health, U.S. Department of Health and Human Services.

Gilbert,M. Puebla-Fortier, M.-Principles and Recommended Standards for Cultural Competence Education of Health Care Professionals. California Endowment 2003

Clinical Case Vignette CDC's DES Update.DES Case Studies. Tillman, E. Nunez, A; Donoghue, G. Editors. www.cdc.gov/DES. HHS stock number.99-7408, 2000.

Nunez, A.Transforming Cultural Competence into Cross-cultural Efficacy in 's Health Education. Academic Medicine 2000;75:1071-1080.

Jha, Ashish K. Differences in Medical Care and Disease Outcomes among Black and White Women with Heart Disease. Circulation Sept 2003;108:1089-1094
Cardiovascular Disease in Women

Cross Cultural Medicine edited by J. Bigby. American College of Physicians: 2003.

Patient Education Resources for Cardiovascular Disease in Women

The Heart Truth campaign, funded by the National Heart, Lung, and Blood Institute has a wealth of outstanding patient education resources available on its web site.
http://www.hearttruth.gov

AWOHNN Guide Cardiovascular Health for Women: Primary Prevention, 2nd edition.

Understanding Risk: What Do Those Headlines Really Mean?
http://www.nih.gov/news/WordonHealth/apr2004/risk.htm

The Seven Beliefs: A Step-by-Step Guide to Help Latinas Recognize and Overcome Depression by B Lozano-Vranich and J. Petit. New York: Harper Collins Publishers 2003.

The Association of Black Cardiologists web site: http://www.abcardio.org

The National Asian Women's Health Organization web site: http://www.nawho.org

Clinical Practice Guidelines

JNC 7 Report on Hypertension:
http://www.nhlbi.nih.gov/guidelines/hypertension

Comprehensive guidelines for the evaluation, diagnosis, and treatment of hypertension. Available for download in PDF format.

Management of Risks of Increasing Omega-3 Fatty Acids in the Diet
http://www.cfsan.fda.gov/~dms/admehg3.html

Information from the FDA about mercury levels in fish.

Evidence-based guidelines for cardiovascular disease prevention in women: 2007 update.
Mosca L, Banka CL, Benjamin EJ, et al. Circulation 2007; 115: 1481-1501.
http://circ.ahajournals.org/cgi/content/full/115/11/1481

Smoking Cessation
http://www.surgeongeneral.gov/tobacco/treating_tobacco_use.pdf

Clinical practice guidelines for the treatment of tobacco dependence, downloadable in PDF format.

Absolute CHD Risk Calculator:
http://www.nhlbi.nih.gov/guidelines/cholesterol

This tool, made available by NHLBI, allows the user to calculate Framingham risk scores based on individual patient data.

Clinical Guidelines on Obesity Treatment.
http://www.nhlbi.nih.gov/guidelines/obesity/ob_home.htm

Comprehensive guidelines on the evaluation, diagnosis, and treatment of obesity. Downloadable in PDF format.

DASH Eating Plan for the Treatment of Hypertension
http://www.nhlbi.nih.gov/health/public/heart/hbp/dash

A downloadable PDF file of patient education materials about the DASH eating plan for the treatment of hypertension.

Diagnosis and Treatment of Diabetes
http://www.diabetes.org/home.jsp

The American Diabetes Association has guidelines on the evaluation, diagnosis, and treatment of diabetes. These are available for download in PDF format.

10-year CHD Risk Assessment Tool
http://hin.nhlbi.nih.gov/atpiii/riskcalc.htm

This downloadable Excel spreadsheet, developed by Boston University, uses recent data from the Framingham Heart Study to estimate 10-year risk for "hard" coronary heart disease outcomes (myocardial infarction and coronary death) in adults who do not have heart disease or diabetes.

Third Report of the Expert Panel on Detection, Evaluation, and Treatment of High Blood Cholesterol in Adults (Adult Treatment Panel III):
http://www.nhlbi.nih.gov/guidelines/cholesterol

The complete, comprehensive report on cholesterol management, as well as a quick reference version and supporting materials, all available for download in PDF format.

Tools for Personal Digital Assistants (PDAs)

ATPIII Cholesterol Management Implementation Tool for Palm OS:
http://hin.nhlbi.nih.gov/atpiii/atp3palm.htm

Body Mass Index Calculator for Palm OS and Pocket PC 2003:
http://hin.nhlbi.nih.gov/bmi_palm.htm

JNC 7 (Hypertension Management) Application for Palm OS and Pocket PC 2003:
http://hin.nhlbi.nih.gov/jnc7/jnc7pda.htm

"Act in Time to Heart Attack Signs" Physician Quick Reference for Palm OS:
http://hp2010.nhlbihin.net/haac_palm/haac_palm.htm

Teaching Strategies

Wood DF. Problem based learning. BMJ 2003;326:328-30.

Enarson C and Cariago-Lo L. Influence of curriculum type on student performance in the United States Medical Licensing Examination Step 1 and Step 2 exams: problem-based learning vs. lecture-based curriculum. Med Educ 2001;35:1050-55.

Eshach H and Bitterman H. From case-based reasoning to problem-based learning. Acad Med 2003;78:491-96.

The Heart Truth Professional Education Campaign Website:

http://womenshealth.gov/hearttruth

SP CASE

III SP CASE

Standardized Patient Case

This section contains:
Case Preparation
Standardized Patient Case Summary

Case Preparation

Small Group Tutorial Format

The patient is a 43 year-old woman with CVD risk factors of hypertension, positive family history and smoking. She does not know her cholesterol level and has never been diagnosed with diabetes. Copies of *The Heart Truth* patient education materials[1] should be available in the SP teaching exam room and students should be encouraged to incorporate use of these into the counseling session. The use of these materials will increase the learner's awareness of *The Heart Truth* campaign and the materials available to support patient education and behavior change. The learner's communication and counseling behaviors should be assessed. The standardized patient and/or facilitator should provide personalized feedback to the learner on his/her performance on both the content and on interpersonal, communication, and counseling skills, including gender and culturally specific issues.

Assessment Format

After interacting with the standardized patient, the student will be expected to write a summary note of the visit, order appropriate screening or diagnostic tests, and complete a knowledge based assessment on CVD in women based on the content specific to the case learning objectives.

Suggested Case Props from *The Heart Truth* Website

10 Questions to Ask Your Doctor
Heart Healthy Handbook
Heart Health Cookbook order form
Heart Health for Women: It's Ageless fact sheet
Heart Health for Women: An Action Plan
Heart Health Recipes

Additional Props (see Resources section for paper, web-based, and PDA versions)

CHD Risk Assessment Tool
BMI Calculator

[1] Heart Truth materials available at http://www.hearttruth.gov

Props for the Standardized Patient Examination

- Gown
- Drapes/Covering for the patient
- Tape measure

Standardized Patient Case Summary

Note: Case details may be modified to fit the standardized patient and the teaching context.

Case Name: TBA

1. Patient profile

a. Age	43
b. Gender	Female
c. Race/Ethnocultural background	African American, born in the United States
d. Educational background	Graduated from high school, completed course work to become a certified medical records coder
e. General physical characteristics	Middle-aged female
f. Height	Varies with each SP
g. Weight	Varies with each SP, should be slightly to moderately overweight
h. Physical findings	None, except elevated BMI between 25 kg/m^2 and 30 kg/m^2 (not obese)
g. Other important characteristics	The patient is concerned about her own health following the recent sudden death of a friend from an acute myocardial infarction

2. Reason for encounter : Chief complaint
   - Patient is concerned about her health after the recent sudden death of a close friend from church who died of an acute myocardial infarction (MI) at 53 years of age.
   - Patient cared for her own mother who died of cardiovascular disease at age 57. Her mother had an MI at age 45.
   - Patient has been hearing that heart disease is common in women and thought she needed to be checked.

3. Opening statement
   The statement that the patient uses to begin the encounter.
   - "*I'm a little concerned about my health and I thought I should come be checked out*"

4. Appearance: The way the standardized patient should look
   - Comfortable neat attire

5. Patient's demeanor/affect
   - Makes good eye contact
   - Comfortable discussing her concerns
   - Needs to be encouraged to share her beliefs but will do so with open ended questions and genuine concern from the learner
   - Very proud and does not like to be "talked down to"

6. Presentation of gender/cultural issues
   This case is designed to highlight major concepts and to serve as one example, and is in NO WAY intended to stereotype any group. All medical care is delivered in the context of the individual. Everyone is influenced by factors such as culture, family, and past experience with the healthcare system during medical encounters. This case serves a way for students to explore the effect of these influences on patient beliefs and outcomes. These notes are provided as background for the standardized patient on underlying case assumptions and content, NOT as issues for specific portrayal.

   - Heart disease in women is common and deadly, yet many women, especially African Americans, Latinas, and other minorities don't know they are at risk.
   - Although chest pain is the most common heart attack symptom in both men and women, women are more likely to present with symptoms other than chest pain. Women are more likely to report fatigue and generalized weakness in addition to or in lieu of chest pain.
   - Women value time, information and a caring presence from their physicians.
   - Diabetes, smoking , family history of first degree relatives with premature CVD (age < 55 years for male relatives and <65 years for female relatives) and hypertension are major risk factors for CVD in women.
   - High triglycerides are a more powerful risk factor in women compared to men.
   - Noninvasive diagnostic studies for CVD in women have different sensitivity/specificity and predictive values than in men.
   - Women are less likely to be referred for invasive studies and procedures (i.e. coronary angiography, coronary artery bypass grafting) than men.
   - Words used to describe symptoms may be different depending on cultural/ethnic background.
   - Pain and illness have different meaning in different cultures (African American, Latino, and American Indian cultures value women who are strong, silent, don't complain, care for others and put themselves last, as in "*aguantar*", holding on to the very last)
   - Emotional stress is an important underlying cause for illness amongst women
   - Women are the health care seekers for the family
   - A woman's health habits can have positive effects on others; conversely, poor health habits of other family members (e.g., preference for high fat foods, smoking) may make it harder for her to change

7. Vital signs
    a. Blood pressure 150/95 mmHg
    b. Pulse 80, regular
    c. Respiration 16/minute
    d. Temperature 98.4 degrees F

8. Onset: Why is the patient here?
    - The patient has decided to come in to see the doctor because she is concerned about her health. Her good friend from church recently died unexpectedly from a sudden myocardial infarction. The patient was not with her friend when she became ill, but was told that she began complaining of nausea and fatigue for several hours but refused to go to the emergency room. This has made the patient think about her own risks.
    - The patient will only provide this information if asked an open-ended question (e.g. "*How can I help you today*?", "*What brings you in today*?"). Her initial response should be "*I need to be checked out*". If asked, "*Checked out about what?*" the patient can respond "*I'm worried about my heart*".

9. Setting: Where/what was the patient doing when the problem started?
    - She heard about her friend's death when she was at church the following day.
    - The patient has been hearing on the radio lately some public service announcements about women and heart disease and decided she needed to start to make some changes in her own lifestyle (see details that follow) and to "get checked out".
    - She has no current symptoms.

10. Risk factor assessment: Should include information necessary to calculate the patient's Framingham risk score
    - Family history: The patient's mother had a heart attack at age 45, was diabetic, a smoker and had high blood pressure; the patient cared for her until mother passed away at age 57 of CHF (20 years ago).
    - Blood pressure: Current BP is elevated (150/95). She has had elevated blood pressures at health fairs (140-150/85-95) on several occasions in the last 2 years but never been told she has high blood pressure. Her mother had high blood pressure.
    - Blood sugar: The patient has never had it checked. She denies polyuria and polydipsia. Her mother had diabetes and her husband has had it for the past 10 years.
    - Lipids: The patient has never had her lipid levels checked; she does not know whether any of her relatives have been diagnosed with cholesterol problems
    - Diet: The patient prepares the food for her family. She has been following her husband's diabetic diet for past 10 years, though she herself is not diabetic. She snacks at work often (potato chips, cake, candy).

- Weight: The patient and her husband initially lost 20 pounds when starting the diabetic diet. She has since gained 5 pounds back, after going through menopause
- Exercise: The patient does not exercise regularly, but she and a friend from the neighborhood have just started walking for 15 minutes in the mornings twice in the past week. She would like to continue and increase her exercise routine.
- Climateric: She went through menopause 2 years ago, is not having any symptoms, but is curious about "hormones".
- Smoking: The patient has smoked 1/2 pack per day since age 28. She is trying to cut down, but stress at home and work makes it difficult to smoke less.

11. Past Medical History
    - Generally healthy, rarely gets sick
        - Childhood illnesses: "usual"
        - Adult illnesses: No chronic illnesses diagnosed to date
    - Allergies: NKDA
    - Medications: She is not currently on any medication. She is afraid to start, as she has watched her mother and husband have to take a lot of medication and is concerned about expense and side effects.

12. Family History
    - Her mother suffered an MI at age 45 and then went on to develop congestive heart failure (patient phrases it "*Her heart was never the same after that, it got weak. She was always all swollen up with fluid (she took pills for it) and short of breath with any activity. It was pretty awful to watch. I had to take care of her. She died at age 57*." Mother had high blood pressure, diabetes, and was a smoker (initiated late in life as well).
    - Her father died suddenly from a stroke 6 years ago. He had high blood pressure.
    - She has one sibling, a brother who lives in Baton Rouge. As far as she knows, he is healthy.

13. Social History
    - Born: Baton Rouge, LA
    - Occupation: The patient works as medical records coder at the New Orleans Veteran's Affairs hospital. She has a new supervisor at work who is "reorganizing" the department and this is causing stress. She has been at her current job for 15 years and has no plans to leave. She is basically satisfied with her job situation, and has good job security and benefits. She is currently supporting her husband and herself and tries to help out her daughter, who is a single parent, whenever she can. Patient is under stress due to husband's recent retirement, he is "lonely and bored" at home all day.
    - Marital status: The patient has been married for 20 years, her husband is retired (he is older, just turned 62 and has a pension from working for the postal service for 30 years).

- Children: The patient and her husband have 2 children, ages 24 and 22; son (age 24) is married, 2 children, employed and lives out of state, daughter (age 22) is a single mother with 2 children and lives in Baton Rouge. They see the 4 grandchildren only occasionally. The patient worries about her daughter, who is barely "getting by" financially.
- Education: The patient completed high school and a course to get certified as a medical records coder.

14. Support Systems: Include mention of family, friends, coworkers, and church
    - Husband: He husband is supportive of her, but dependent on her. She is sole wage earner and has to oversee his diabetes care. As well, he is home all day and gets restless and bored.
    - Son: Her son lives in Atlanta, and has his own family (wife and 2 children). The patient talks to him several times a week but does not see him often.
    - Daughter: Her daughter is a single parent, and lives in Baton Rouge. She has 2 children. They have a good relationship, and talk daily. The patient supports her daughter both emotionally and financially. Her daughter relies on her mother for advice and for money whenever she can send some. The patient worries a lot about her daughter.
    - Church: The church is the patient's major source of outside interest. She attends regularly. She is very involved; as an example, she sings in choir. She has many girlfriends from church, and sees them as often as she can. She describes herself as very spiritual and believes "God will provide".
    - Parents: Both parents are deceased, as described above.
    - Co-workers: The patient has several friends within her own and other departments at work. They frequently have lunch together and talk about personal lives.

15. Habits and Lifestyle
    - Smoking: The patient has smoked 1/2 pack per day since age 28. African American women in this age group generally initiated smoking in their late teens or 20s; African Americans have been less likely than other ethnic groups to begin smoking as younger teenagers (although this may be changing). She wants to quit/cut down but feels under a lot of stress and is concerned about how to cope with stress if she stops smoking. The patient will respond to suggestions to increase exercise, keep a diary of smoking triggers, and avoid situations with other smokers or that trigger smoking. Her current environment will support her efforts to quit; her husband quit smoking when diagnosed with diabetes, her kids want her to cut down and she has to go outside to smoke at work. She mostly smokes at night and on weekends when she can go outside.
    - Alcohol: The patient rarely drinks, only on special occasions and never more than one drink at a time.
    - Drugs: None, the patient has never tried or "done" inhaled or intravenous drugs

- Caffeine: The patient drinks 2 cups of coffee in the morning.
- Exercise: The patient does not exercise regularly, but she and a friend from the neighborhood have just started walking for 15 minutes in the mornings twice in the past week. She would like to continue and increase her exercise routine.
- Diet: The patient prepares the food for her family. She has been following her husband's diabetic diet for past 10 years, though she herself is not diabetic. She snacks at work often (potato chips, cake, candy).
- Daily activities/hobbies: The patient works full time, and is involved in church activities, including the church choir, which practices 3 times a week.

16. Open-ended Inquiry:
    What does the patient say when confronted with an open-ended inquiry without giving the whole case away?
    - She is more than willing to talk IF she feels the provider is sincerely interested and asks questions that show she is valued as a person. Some examples of phrases which will cause the patient to tell more about herself:
        i. "*Tell me about yourself*," or "*Tell me about your life*."
        ii. "*How are things going for you?*"
        iii. *"I'd like to know a bit more about you and your life*."
    - She will respond very positively to empathetic comments and to reflection. Some examples:
        iv. "*It sounds like that was tough*." (in response to mother's situation or friend's sudden death)
        v. "*Seems like you've got a lot going on in your life*." (in response to husband's situation, daughter's issues, job issues)
        vi. "*I can tell that choir and church are very important to you. I'm glad you've got support and activities you enjoy."*

17. Physical Exam
    All normal except:
    - BP: On chart, noted to be high.
    - Waist circumference/BMI: BMI on chart, student may measure waist circumference.

18. Laboratory Tests:
    The learner should order a metabolic panel, fasting lipid profile and fasting blood glucose ordered at the end of the visit. The learner should explain what he/she is ordering and why.

19. Patient Education and Counseling:
    Students will be trained on the Procheska and Diclemente transtheoratical model (stages of change) and on the Keller and White "confidence/conviction" model of assessing and counseling for behavior change. The key to this case is learning/demonstrating correct use of this model and the associated techniques for the specific stage of change identified in relationship to each one of her health

behaviors. Studies have shown that EMPATHY, RESPECT, UNCOVERING PERSONAL VALUES AND HEALTH BELIEFS, LINKING CHANGE RECOMMENDATIONS TO LIFE STYLE/VALUES/SUPPORT SYSTEMS, NEGOTIATING FOR DOABLE CHANGE, and ALLOWING THE PATIENT TO TAKE THE LEAD are critical to effective practice and outcomes.

This case is designed to highlight major concepts and to serve as one example, and is in NO WAY intended to stereotype any group. All medical care is delivered in the context of the individual. Everyone is influenced by factors such as culture, family, and past experience with the healthcare system during medical encounters. This case serves a way for students to explore the effect of these influences on patient beliefs and outcomes.

There are specific concerns this patient has as an African American woman that reflect both gender differences and cultural values and practices. Specifically,

- Although chest pain is the most common heart attack symptom in both men and women, women are more likely to present with symptoms other than chest pain. Women are more likely to report fatigue and generalized weakness in addition to or in lieu of chest pain.
- Risk factors are weighted differently in women than in men.
- Family role and dynamics are key to women's lives.
- Body image and weight are viewed differently in different cultures.
- Food has a very significant social role in all cultures though specific foods/events may differ among cultures.
- Access to power differs between cultures and within different families.
- The perceived meaning of illness and symptoms varies between cultures and within different families.

The patient is in the following stages of change with respect to each risk factor for CVD and related issues:

- Smoking: CONTEMPLATION. She knows she needs to quit and she wants to quit. Successful counseling/negotiation strategies include:
  - Asking about how long/where/why she smokes: She did not start smoking until she was 28. African American women in this age group generally initiated smoking in their late teens or 20s; African Americans have been less likely than other ethnic groups to begin smoking as younger teenagers (although this may be changing). She mostly smokes in the evenings and on weekends.
  - Asking about triggers for smoking: She identifies stress and boredom
  - Asking about support systems for quitting (family, coworkers): Her husband, coworkers, children, friends ALL want her to quit and have encouraged her to stop smoking. She has one other friend who smokes (the one who recently started walking with her).

- Asking about previous quit attempts: She has quit once before for several years. She started again 4 years ago when her daughter got pregnant the second time.
- Negotiating about what the patient thinks might help her quit: She does not want to try nicotine replacement, bupropion, and varenicline (though learner should mention and offer these options). She thinks she can do it on her own as she did before. The learner may mention that a person who quits smoking is "strong" (which appeals to patient's self image as a strong woman who can handle anything).
- Strategizing about the patient's support system for quitting: She and her friend both want to quit. Can they do it together and support each other?
- Discussing alternatives to smoking: Exercise is a good alternative to smoking; she and her friend have recently started to walk, and both want to quit smoking.

- Weight: CONTEMPLATION. She is not happy about gaining back 5 pounds since menopause. She is confident she can lose it, which is why she started walking with her friend. Successful counseling/negotiation strategies include:
  - Asking what the patient thinks FIRST (before dispensing advice)
  - Finding out what she thinks her ideal body weight would be. African Americans and Latinos often describe women who are "heavy" as normal and attractive. As a result, many African Americans and Latinos would identify a woman who is medically overweight as being at a healthy weight, even though her weight puts her at risk for CVD and other complications. The patient identifies BMI 25 kg/m^2 as her ideal weight (SPs should be told the weight this approximates based on their height in order to give this weight if asked by the learner). In the patient's family, all the women are "big"
  - Inquiring about what changes the patient thinks she can make

- Diet: ACTION. She has been trying to avoid snack foods and is carefully following her husband's diabetic diet (for both of them). Successful counseling/negotiation strategies include:
  - Asking about her usual diet
  - Supporting her with positive reinforcement for the changes she has made
  - Inquiring about triggers for snacking/relapse

- Exercise: ACTION. She and her friend have started walking in the mornings before work. Successful counseling/negotiation strategies include:
  - Asking about her current efforts
  - Supporting her with positive reinforcement for the changes she has started
  - Inquiring about obstacles and discussing how best to overcome them

- Blood Pressure: PRECONTEMPLATION. She knows many people with high blood pressure and it runs in her family. She is very reluctant to take medication. She is scared about this because she knows some people from

church whose family members are on dialysis from "high blood". She is willing to continue to work on diet and exercise and will need careful discussion of the risk this poses to her heart and brain. Successful counseling/negotiation strategies include:
  - Finding out what she knows about high blood pressure ("high blood")
  - Finding out what her experiences are (family, friends)
  - Inquiring about her thoughts about medication
  - Uncovering her fear of the consequences of high blood pressure
  - Linking her blood pressure to a SPECIFIC risk for heart attack/stroke (use Framingham/JNC 7 criteria)
  - Supporting her continued efforts with diet and exercise
  - Negotiating agreement to continue to monitor and discuss at next visit

- Lipids: PRECONTEMPLATION. She has heard something about "fat in the blood" but doesn't know much about it. Successful counseling/negotiation strategies include:
  - Asking her what she knows
  - Asking her if she would like to know more
  - Linking "high fat in the blood" to a SPECIFIC risk for heart disease (Framingham risk assessment)
  - Explaining "good and bad" cholesterol
  - Explaining why he/she is ordering the test, how and why to fast before the test, and when to expect results

- Risk for Diabetes: ACTION. Her husband has diabetes, her mother had it, many friends, and coworkers have it. She wants to get her blood sugar checked and want to avoid getting diabetes if she can. Successful counseling/negotiation strategies include:
  - Asking her what she knows
  - Exploring her fears about diabetes and its complications
  - Linking diabetes to a SPECIFIC risk for heart disease (single greatest risk factor for women)
  - Getting agreement to be tested
  - Explaining the test, how and why to fast, and when to expect results
  - Supporting her diet, exercise and weight loss efforts as ways to prevent diabetes

- Impact of Family History on CVD Risk: CONTEMPLATION. She is afraid to end up like her mother. She does NOT know that her mother's early heart attack poses a risk to her own health. Successful counseling and negotiation strategies include:
  - Asking her what she knows
  - Exploring her fears about ending up like her mother
  - Linking her family history to a SPECIFIC risk for heart disease
  - Supporting her lifestyle efforts as ways of preventing heart disease

- Stress: CONTEMPLATION. She recognizes she is "stressed" but accepts it as part of her life. Her boss and her daughter are constantly "working on my nerves". She has no symptoms of depression (sleeping well, good appetite, overall positive mood, interest in usual activities). Successful counseling and negotiation strategies include:
  - Exploring the patient's current life situation, e.g., "*How things are going in your life?"*
  - Listening to her concerns with respect
  - Acknowledging her concerns with empathetic response, e.g. "*That sounds tough, how are you coping?*
  - NOT jumping in to provide solutions
  - Exploring symptoms of depression (sleep, mood, appetite, pleasure/interest, thoughts of suicide)

- Menopause: CONTEMPLATION. She went through menopause 2 years ago. She did not have many symptoms, and currently feels well. She and her husband are satisfied with their sex lives, though he sometimes has difficulty with erections (a common problem for diabetics). She has heard about hormones and wonders if she should be taking hormone therapy. Successful counseling and negotiation strategies include:
  - Exploring her symptoms/experiences with menopause
  - Inquiring about her current sex life (satisfaction, etc)
  - Providing information that "hormones" are not indicated for her (explaining recommendation for limited use for severe menopausal symptoms only)

20. Previous Experience with Physicians: She is somewhat leery about physicians. She has had previous unpleasant experiences; feeling that doctors were not listening to her, and not feeling respected, understood or valued. She has felt rushed and "talked down to". She will be very receptive to respectful listening, inquiries about her as person, interest in her life and family, willingness to explain risks and procedures, asking for her ideas about change, and not using medical jargon.

21. Other Relevant Notes: She has good health benefits through her job. Her insurance provides a tiered pharmacy benefit; generic drugs are cheapest.

STUDENT MATERIALS

IV STUDENT MATERIALS

Student Materials

These materials should be given to the learner(s) prior to seeing the standardized patient.

This section contains:
Student instructions
Patient education and counseling handout (for both students and tutor)

Suggested Reading:

Bello N, Mosca L. Epidemiology for Coronary Heart Disease in Women. Progress in Cardiovascular Diseases 2004. 46:287-295.

Suggested Case Props from *The Heart Truth* Website (available at http://www.hearttruth.gov)

10 Questions to Ask Your Doctor
Heart Healthy Handbook
Heart Health Cookbook order form
Heart Health for Women: It's Ageless fact sheet
Heart Health for Women: An Action Plan
Heart Health Recipes

Additional Props (see Resources section for paper, web-based, and PDA versions)

CHD Risk Assessment Tool
BMI Calculator

Student Instructions

Ms _____ is a 43 year-old woman who has come to the clinic to see a doctor about her health.

Your office assistant has already taken Ms _____ vital signs. You should not repeat them.

Blood Pressure	150/95 mmHg
Pulse	80 regular
Respiration	16/minute
Temperature	98.4 degrees F

PATIENT EDUCATION AND COUNSELING HANDOUT

Patient Education and Counseling Handout (for both students and tutor)

Patient Education and Counseling

One need only to consider the leading causes of death in the United States (heart disease, cancer, stroke) and their relationship to lifestyle choices and behaviors (smoking, diet, exercise, medication adherence) to appreciate the importance of patient education and counseling skills to the health of our patients. Studies have shown that physicians overestimate the amount of time that they spend counseling and negotiating treatment plans and options with patients, and that patients want more attention paid to this area. This has been validated by focus group studies performed as part of *The Heart Truth* professional education campaign project. The number one concern of the female patients of all cultural and ethnic backgrounds who participated was the way doctors shared information and provided discussion around health behaviors.

Like all skills, the more practice and experience you have with them, the less time they take to do reliably and consistently. This session is intended to give you a chance to practice these skills with a standardized patient and a trained facilitator.

Patient education and counseling for behavioral change are related but distinct skills. There are a few common sense practices in each area that underlie these skills and that can be learned and demonstrated.

Counseling and Negotiating for Behavioral Change

This can be a very rewarding area for both patients and physicians, if physicians have the necessary skills. Consider yourself the patient's coach, not the expert. It is important to remember:

1. Behavior change only occurs by the person responsible for it. If it doesn't happen, it is not your fault and you should not become frustrated and resentful towards the patient.
2. Behavior change usually occurs incrementally and success begets success. Losing 1 pound in 2 weeks can add up to 25 pounds a year and is a lot less overwhelming than considering the whole amount up front. We also know that even small changes (5 or 10 pound weight loss or exercise for 20 minutes three times a week) can have beneficial effects on health.
3. It is easier to link a new behavior to an old habit than to create a new habit from scratch. Medication adherence is greatly enhanced if it is linked to a daily behavior and place such as tooth brushing or shaving.
4. When working with a patient to decrease or cease a negative health behavior, such as smoking or drinking, it is important to work with him/her to develop strategies to avoid or ameliorate triggers that lead to the negative behavior (such as stress, influence of peers).
5. Relapse is an expected part of the process of behavioral change, and can lead to learning and growth.

Techniques

- Assess readiness to change. Remember the stages of change and the confidence/conviction model.
    - *"Have you ever thought about quitting smoking?"*
    - *"How convinced are you that it is important for you to lose weight?"*
    - *"How confident are you that you can begin an exercise program?"*

- Tailor the technique to the stage. See the model and the glossary attached. This part takes the most practice.

- Beware of how you provide information. Don't "drown" the patient. Ask for permission and tailor your answer.
    - *"What information do you think would be the most helpful to you?"*

- Solicit the patient's ideas
    - *"What do you think would work best for you?"*
    - *"What ideas do you have about what might help?"*

- Make sure your suggestions are consistent with the patient's goals and values.
    - *"How does this fit in with what is most important to you about your health?"*
    - *"Will this work with your daily life?"*

- Assess the patient's support systems for behavior change and possible barriers to change.
    - *"How do you think your family will react?"*
    - *"How do you think your co-workers might help you?"*
    - *"What obstacles or barriers are you concerned about?"*
    - *"How might you overcome obstacles or barriers?"*

- Negotiate a realistic and achievable plan with the patient.
    - *"I know we talked about a lot of things. It is hard to do many changes at once. Of the things that we talked about, which do you think is most achievable/realistic for you?"*

- Support any and all small steps and good health habits.
    - *"It is great that you were able to cut down on your drinking."*
    - *"I'm so glad you were able to quit smoking for two weeks."*

- Reassure the patient who relapses that it is natural and OK. Use the relapse as a learning opportunity and brainstorm with the patient possible alternatives next he/she may be in a similar situation.
    - *"Next time you have a fight with your daughter, is there anything you can think of that might help you calm down besides smoking?"*

- Check for the patient's understanding and review the plan each visit. Reassure the patient that obstacles and barriers are common and that it is OK for them to tell you about their failures as well the successes.
    - *"What problems have you encountered with the weight loss program?"*

Patient Education Skills

- Assess the patient's current level of understanding.
    - *"What do you think is causing your symptom/problem?"*
    - *"What do you know about your condition?"*
    - *"What kinds of information would be most helpful/useful to you?"*
    - *"What is bothering you the most about your condition?"*

- Explain your view/ideas using concrete, non-medical terms appropriate to the patient's level of understanding.
    - *"I think I can help you feel better with this medication that works by…(lowering your blood pressure, blood sugar, etc.)"*
    - *"In my experience, people with your condition frequently respond to...(an exercise program, watchful waiting, etc.)"*

- Link your treatment plan to the symptom or problem of most concern to the patient.
    - *"It seems you are most bothered by the cough, which I believe is caused by smoking. Quitting or cutting down should help it resolve."*

- Be realistic and practical.
    - "*This medication takes several days to work effectively. Don't give up if you aren't better by tomorrow, but please call me if you are not better in a week."*

- Tell the patient what to expect and what to worry about with side effects.
    - *"This medication sometimes causes nausea. Taking it with food can usually control it, and it is not a serious side effect. If you get a rash, however, this is potentially serious and you should stop the medication and call me the same day."*

- Write down important bullet points. Yes, it takes time, but it is worth it in terms of increased adherence, fewer relapses, and less return visits for unresolved problems/symptoms or side effects. It helps to have handouts with the frequently seen conditions/medications in the office.

- Ask about unanswered questions.
    - **DON'T** ASK: "*Do you have any questions*?" Many patients are embarrassed to answer “yes” to this question, and will just say “no”.
    - **DO** ASK: *"What else would you like to know about your condition that we have not discussed?"*
    - *"Is there anything else you were wondering about?"*

- Check for understanding. The best way is by asking the patient to relay his/her knowledge and plans about the condition to you in his/her own words.
    - *" Let's review. Sometimes I forget important information so it helps me if you can tell me what you plan to do about/for your (name of condition or symptom) when you leave here."*

Theory

The patient education and counseling skills utilized in this case are based on two complementary models. The first, the "transtheoretical model" of Procheska and Declemente describes six "stages of change". An individual will be in a certain stage in relation to a specific behavior and is quite likely to be in different stages for different behaviors. The stages of change can be thought of like a spiral staircase, with people going up and down over time, sometimes skipping stages as one can skip steps. Relapse, or going down the steps, is EXPECTED and common. Relapse is part of the process. Relapse can be used as tool for learning rather than for causing guilt and feelings of failure.

Different strategies for counseling and negotiating for change work best at different stages.

Keller and White proposed another useful model for understanding behavior change that complements the transtheoretical model and that can be used in actual practice with patients. They propose that change requires two essential components: ***confidence***, the skills and knowledge of what to do and ***conviction***, the desire or motivation for change. People are in different "quadrants" of change for different behaviors at different times.

Regardless of which model you apply, the most important tools for success are

- EMPATHY
- RESPECT
- UNCOVERING PERSONAL VALUES AND HEALTH BELIEFS
- LINKING CHANGE RECOMMENDATIONS TO LIFE STYLE/VALUES/SUPPORT SYSTEMS
- NEGOTIATING FOR DOABLE CHANGE
- ALLOWING THE PATIENT TO TAKE THE LEAD

The individual models are further explained below.

STAGES OF CHANGE:

Precontemplation: The patient has never thought about changing the behavior. This is equivalent to "unaware" in the confidence/conviction model. The patient may simply need new information. Some patients are actually resistant to change based on past experience or deeply held beliefs. These patients are cynical in the confidence/conviction model and may be difficult to move forward. Accepting these patients and going along

with their resistance (rolling with resistance) may be necessary until a dramatic event occurs. Getting people to "agree to think about it" on the first visit represents success at this stage.

Contemplation: Many patients are in this stage of change. They know they are doing things that are not good for their health, yet believe the benefits of maintaining the behavior outweigh the energy required for change at this point in time. These patients may be stuck/frustrated (don't know what to do) or stuck/skeptical (aren't convinced of the need to do it) on the confidence/conviction model. Working on linking behavior change to current health issues, personal risk, and past experience and current health beliefs is a good strategy. Change has to be acceptable to the patient, and doable. Small steps at first are easier.

Preparation: At this stage, patients are ready for change. These are patients who have set a quit date to stop smoking, for example, and have thought about strategies to avoid triggers that might cause them to relapse. Working through strategies to implement change with the patient is a good strategy.

Action: Change is occurring. Diets have started, cigarettes are gone, etc. They are moving/changing in the confidence/conviction model. These patients require lots of ongoing support and encouragement.

Maintenance: Patients in this stage have experienced successful change. However, the maintenance stage is an active stage that requires ongoing support and planning for relapse. Patients need help overcoming obstacles and coming up with alternatives to relapse.

Termination / Identification: Patients in this stage have achieved sustained change. Relapse, while possible, is much less likely. These are reformed smokers, regular exercisers, etc. Physicians and other health care providers should offer ongoing support and acknowledgement of the patient's success.

CONFIDENCE/CONVICTION MODEL:

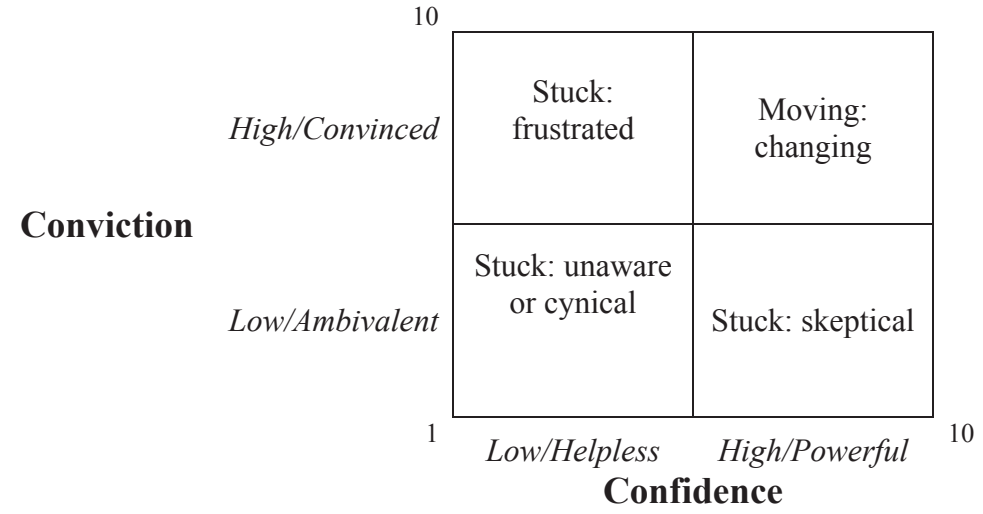
This model can be used to both think about approaching behavior change and as a counseling tool. When discussing health behaviors with patients, ask,
"*On a scale of 0 to 10, with 0 being not at all important and 10 being very important, how important is it to you to change your diet in order to better manage your blood sugars?"*

Or

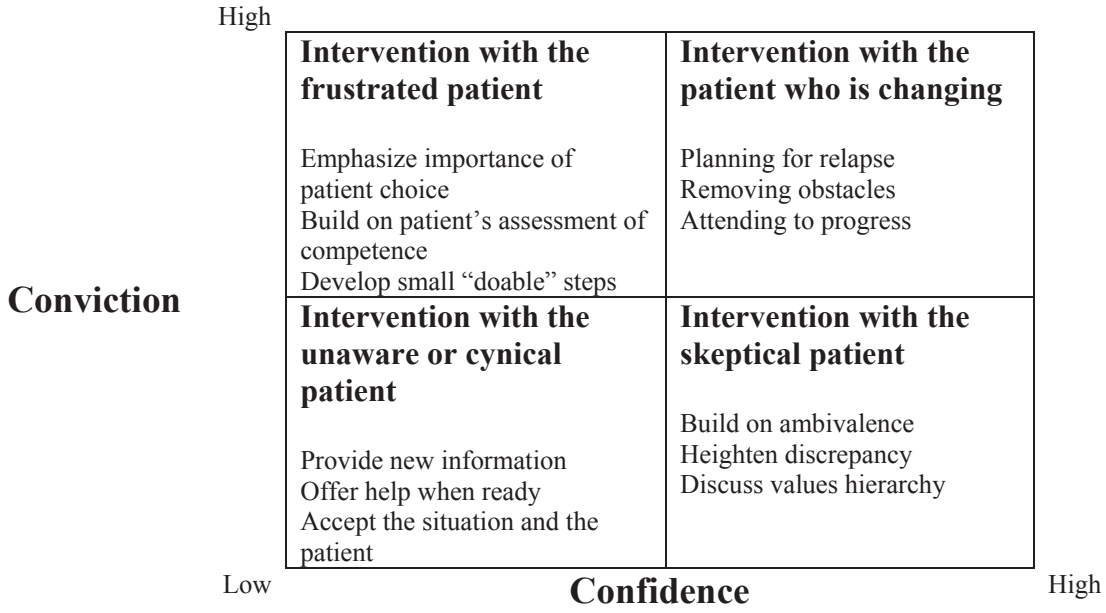
"*On a scale of 0 to 10 with 0 being not at all confident and 10 being very confident, how confident are you that you can make the dietary changes we've been discussing in order to better control you blood sugars?"*

Knowing the patient's level of conviction and confidence can help tailor the counseling strategy you use. Patients who are unaware or cynical need information (if they want it)

and acceptance, as well as lots of patience from the health care provider. Patients who are frustrated need help building skills, using past success as a tool. People who are skeptical need to be convinced that making a change is important for their OWN goals and lifestyle. Moving/changing requires ongoing support and encouragement.



Some techniques and strategies for facilitating change include:



Techniques for Facilitating Behavior Change

ENVIRONMENT

- Attend to the interpersonal environment between the clinician and the patient and the patient's context.

- Establish a supportive clinical relationship to promote change.
    - Use open-ended questions
    - Use reflective listening
    - Use empathic messages
    - Avoid arguments
    - Accept and roll with resistance

- Establish a collaborative clinical relationship to promote change.
    - Acknowledge and support a patient's right to make autonomous choices
    - Recognize and respect the patient's competence

- Assess the patient's understanding of the resources s/he needs to change.
    - What resources does the patient have?
    - What does the patient believe is needed to make the change?
    - What access does the patient have to resources?

ASSESSMENT

- Use the patient's behavior and statements to assess the stage of change for a given behavior:
    - Pre-contemplation
    - Contemplation
    - Preparation
    - Action
    - Maintenance
    - Termination/identification

- Ask, "How ready do you feel at this point in time to 'change' this behavior?"

- Assess both the patient's conviction and confidence. Each factor requires different approaches and techniques.
    - Discover and discuss the patient's convictions:
    - *"How important is this change to you?"*
    - *"How committed are you to making this change?"*

- Discover and discuss the patient's confidence:
    - *"How confident are you that you can make this change?"*
    - *"How likely do you think it is that you will make this change?"*

- Ask the patient to quantify:
  - *"On a scale of 1 to 10, how important is it to you to make this change?"*
  - *"On a scale of 1 to 10, how confident are you that you can make this change?"*

- Does the patient lack conviction (is ambivalent) and confidence (feels helpless) and is therefore unaware or cynical about changing?

- Is the patient convinced that change is necessary but lacks confidence and is stuck in a state of frustration regarding change?

- Is the patient confident in his/her ability to change but lacks conviction about the need to change and is skeptical about changing?

- Is the patient both convinced that change is necessary and confident that she or he can achieve the desired change and is motivated into action?

INTERVENTION

- Enhancing confidence
  - Assist the patient to recall times in the past when she/he has been successful making changes.
  - Assist the patient to make a conscious, deliberate choice to make the change; support the patient's autonomy.
  - Assist the patient to move away from an either/or frame of mind; emphasize the cyclical nature of change.
  - Assist the patient to define action steps that have a high likelihood of being taken.
  - Assist the patient to attend to progress and to perceive slips as occasions for problem solving rather than self-flagellation.

- Enhancing conviction
  - Provide *new* information when it is relevant; ask the patient's permission.
  - Assist the patient to illuminate the discrepancies between goals and actions.
  - Assist the patient to discover the normal conflicts of values, which lead to ambivalence and remaining on the horns of the dilemma.
  - Assist the patient to clarify a values hierarchy and to establish linkages between actions and values.
  - Assist the patient to clarify optional and comparable reward systems that are experienced as beneficial and pleasurable.

- Decreasing cynicism or increasing awareness / increasing confidence and conviction**:** Intervention with a patient who is unaware of the need to change or is cynical about the need to change, reflecting both a lack of conviction and confidence. The task is to increase both in the patient. This can be achieved by:
    - Providing new information
    - Offering your help when the patient is ready to work on increasing knowledge and change
    - Accepting the situation and the patient even though you disagree with the behavior

- Decreasing frustration / increasing confidence: Intervention with a patient who is convinced of the need to change but lacks confidence in his/her ability to achieve success requires building, supporting, and increasing the patient's self confidence. This can be achieved by:
    - Emphasizing the importance of the patient making choices
    - Building on the patient's self assessment of competence
    - Developing small "doable" steps
    - Rewarding achievement with praise

- Decreasing skepticism / increasing conviction: Intervention with the patient who is self-confident and feels powerful in his or her ability to make change, but lacks conviction that anything needs to be done. The task is to help the patient recognize their ambivalence and decide what is most valuable for him or her.
    - Building on any ambivalence (e.g. *You say you don't think smoking is hurting your health, but your children want you to stop. Do you think you might consider stopping smoking because of how they feel?)*
    - Heightening discrepancies (e.g. *You say you don't think smoking is hurting your health, but your children want you to stop. Why do you think they feel so strongly about this?)*
    - Discussing the patient's values hierarchy *(e.g. Your children think it is important for you to stop smoking so you will live longer and spend more time with your grandchildren. What do you think about that?)*

- Maintaining confidence and conviction: Intervention with the patient who is both convinced of the need to change and in his or her ability to change requires ongoing support and plans for dealing with obstacles. This can be done by:
    - Planning for relapse. It is likely to happen and is a common part of the behavioral change process
    - Identifying and removing obstacles or suggesting replacement behaviors
    - Recognizing and supporting progress

RESISTANCE

Resistance is an indication to the clinician that she or he has:

- Not established rapport with the patient
- Lost rapport with the patient

- Chosen an intervention strategy that is inappropriate for this patient

When a clinician encounters resistance, the best approach is to shift strategies. Following are some strategies for "rolling with resistance" (for a complete treatment of these strategies see Miller and Rollnick, *Motivational Interviewing*, pp. 102-110):

- Reflective listening: Communicating your understanding of what the patient is trying to tell you (e.g. *You are concerned that you will never be able to stop smoking)*
- Amplified reflection: Exaggerating what the patient is telling you as an invitation to have the patient disagree with your exaggeration (e.g. *So, there is no possible way that you could stop smoking as long as you continue to live with your present husband*)
- Double sided reflection: Feeding back on both sides of the patient's ambivalence (*e.g. On the one hand you would love to quit smoking because you think you would feel better and be healthier, on the other hand, you feel that smoking is a part of who you are. That's a tough dilemma)*
- Shifting focus: Taking a detour around the barrier to change presented by the patient (*e.g. So, smoking may not be the cause of your breathing problem.. You seem quite convinced that it is not. Tell me a bit about other explanations that you have been thinking about)*
- Agreement with a twist: Agree with a portion of the patient's premise, but use the agreement as a jumping off place to explore a new direction (*e.g. I am getting the picture that you are painting. In your house it is impossible for you to give up smoking because everyone else is smoking and so it has become a family issue. Let's talk about how you can deal with this family issue)*
- Emphasizing personal choice and control: Respond to the patient's concern that changing a behavior represents loss of control with an affirmation of his/her control *(e.g. This choice is ultimately up to you. No pushing or shoving from your wife or children can take that away from you. You will be the person who makes the decision about what you do about your smoking)*
- Reframing: Use the information that the patient has provided you in a new way that opens up possibilities rather than closes them down (*e.g. I understand that you are worried that you will never be able to stop smoking because you have tried in the past and, as you see it, you didn't stop. Actually, I think it is a good sign because it demonstrates your long-term commitment to stop. To me, the difficulty appears to be a failure of strategies, not of your will. It's clear you are motivated to stop, we just have to find the right approach)*
- Paradox: Create a situation for the patient in which resistance to the clinician brings about movement in the desired direction (*e.g. It seems like the prospect of quitting smoking would cause you to change the way you think about yourself more than you could handle. If I understand you, smoking is not something you do, it is who you are and you can't imagine changing that part of yourself. So, it makes sense to me to continue to smoke as a way of protecting your sense of yourself)*

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Miller W; Rollnick S: Motivational Interviewing: Preparing People to Change Addictive Behavior: The Guilford Press, New York: 1991

Choices and Change: Clinician Influence and Patient Action: The Bayer Institute for Healthcare Communication: 1996

For more information on the Bayer Institute:

Institute for Healthcare Communication, Inc.
555 Long Wharf Drive
13th Floor
New Haven, CT 06511-5901

TUTOR MATERIALS

TUTOR MATERIALS

Tutor Materials

These materials should be given to the tutors/facilitators if the case is being used for small group teaching/tutorial

This section contains:
Tutor Notes
Patient Education and Counseling Handout (same as given to students)
Guidelines for Session Implementation

Tutor Notes

General Background

This case focuses on heart disease risk assessment and counseling for an African American female patient. It is designed to emphasize

- Heart disease risk in women
- Patient education and counseling skills
- Cultural awareness and influence
- The National Heart, Lung, and Blood Institute's *The Heart Truth* patient education materials

Why focus on heart disease in women?
Heart disease is the #1 killer of women in the United States. It also can lead to disability and a significantly decreased quality of life. Women often fail to make the connection between risk factors, such as high blood pressure and high cholesterol, and their own risk of developing heart disease.

Why teach patient education and counseling skills?
One need only to consider the leading causes of death in the Unite States (heart disease, cancer, stroke) and their relationship to life style choices and behaviors (smoking, diet, exercise, medication adherence) to appreciate the importance of patient education and counseling skills to the health of our patients. Studies have shown that physicians overestimate the amount of time that they spend counseling and negotiating treatment plans and options with patients, and that patients want more attention paid to this area. This has been validated by focus group studies performed as part of *The Heart Truth* project where the number one concern of the female patients of all cultural and ethnic backgrounds who participated was the way doctors shared information and provided discussion around health behaviors.

What is the role of culture and gender?
While the racial and ethnic disparities in health care in the United States have been well documented[2], the etiologies behind them are complex and multifactoral.[3] Communication style is one important variable that has only recently been subject to study.[4],[5] Previous research has shown that female primary care physicians engage in more patient centered communication behavior into their male colleagues do.[6],[7] The link between adherence and health outcomes and patient and physician cultural backgrounds is only beginning to be explored.[8],[9] While there are many models for teaching "cultural competency", this case emphasizes general concepts and principles drawn from multiple sources.

What is the NHLBI Heart Truth Campaign?
In September 2002, the National Heart, Lung, and Blood Institute (NHLBI) launched a consumer awareness campaign called *The Heart Truth*. The Red Dress Project, which debuted in February 2003, is the centerpiece of *The Heart Truth* campaign. More information on this campaign can be found at http://hearttruth.gov

The target audience for the campaign is women 40-60 years of age. The goal of *The Heart Truth* campaign is to increase awareness among women that heart disease is the #1 killer of women and that having risk factors can lead to heart disease, disability and death; and to encourage women to talk to their doctors and to take action to control these risk factors. Although professionals now realize that heart disease is the most common cause of morbidity and mortality in both men and women, physician bias has been documented as affecting assessment of an individual woman patient's risk, depending on the patient's presentation style[10] and race.[11] Women, especially younger women, may present with different symptoms than men and tend to arrive for emergency care one hour later than men,[12] because they attend to others before proceeding to the hospital.[13]

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[5] Kagawa-Singer M, Kassim-Lakha S. A Strategy to Reduce Cross-Cultural Miscommunication and Increase the Likelihood of Improving Health Outcomes. Acad Med. 2003; 78: 577-587
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Therefore, there is a need to educate both consumers and health care professionals on the most recent recommendations on the prevention of heart disease in women.

Why use standardized patients?
Standardized patient methodology, where laypersons are explicitly trained to portray a medical case with accuracy and reproducibility, has been used as a key component of medical education since 1964. The methodology has achieved such wide spread accuracy and acceptance that it will be incorporated in the United States Medical Licensing Examination, in the fall of 2004. All medical students will be required to pass the USMLE Step 2 CS examination, or clinical skills examination, using standardized patients as part of the single pathway to medical licensure in the United States. The ECFMG (Education Commission on Foreign Medical Graduates) has required all candidates from non-US medical schools seeking education or licensure in the United States to pass a clinical skills examination using standardized patients since 1984. Standardized patients are uniquely suited to teaching and assessment of core clinical skills such as communication and interpersonal skills and physical examination technique.

The SP methodology allows the teaching and practice of skills in a safe and controlled environment. When used for assessment, it tests and measures the ability to put into clinical practice the knowledge and skills learned through participation in other educational settings.

Standardized patient methodology has the additional advantage of enabling the distribution of curricular content in a consistent and reproducible way across large populations of learners, thereby conserving faculty expertise and time.

Case Background

This case is based on the Procheska and Diclemente transtheoratical model (stages of change) and on the Keller and White “confidence/conviction” model of assessing and counseling for behavior change. The key to this case is learning/demonstrating correct use of this model and the associated techniques for the patient’s specific stage of change in relationship to each one of her health behaviors. Studies have shown that EMPATHY, RESPECT, UNCOVERING PERSONAL VALUES AND HEALTH BELIEFS, LINKING CHANGE RECOMMENDATIONS TO LIFE STYLE/VALUES/SUPPORT SYSTEMS, NEGOTIATING FOR DOABLE CHANGE, and ALLOWING THE PATIENT TO TAKE THE LEAD are critical to effective practice and outcomes.

This case is designed to highlight major concepts and to serve as one example, and is in NO WAY intended to stereotype any group. All medical care is delivered in the context of the individual. Everyone is influenced by factors such as culture, family, and past experience with the healthcare system during medical encounters. This case serves a way for students to explore the effect of these influences on patient beliefs and outcomes.

There are specific concerns this patient has as an African American woman that reflect both gender differences and cultural values and practices. Specifically,

- Although chest pain is the most common heart attack symptom in both men and women, women are more likely to present with symptoms other than chest pain. Women are more likely to report fatigue and generalized weakness in addition to or in lieu of chest pain.
- Risk factors are weighted differently in women than in men.
- Family role and dynamics are key to women's lives.
- Body image and weight are viewed differently in different cultures.
- Food has a very significant social role in all cultures though specific foods/events may differ among cultures.
- Access to power differs between cultures and within different families.
- The perceived meaning of illness and symptoms varies between cultures and within different families.

The patient is somewhat leery about physicians. She has had previous unpleasant experiences; feeling that doctors were not listening to her, and not feeling respected, understood or valued. She has felt rushed and "talked down to". She will be very receptive to respectful listening, inquiries about her as person, interest in her life and family, willingness to explain risks and procedures, asking for her ideas about change, not using medical jargon.

The patient is in the following stages of change with respect to each risk factor for CVD and related issues:

- Smoking: CONTEMPLATION. She knows she needs to quit and she has the desire to do so. Successful counseling/negotiation strategies include:
  - Asking about how long/where/why she smokes: She did not start smoking until she was 28. African American women in this age group generally initiated smoking in their late teens or 20s; African Americans have been less likely than other ethnic groups to begin smoking as younger teenagers (although this may be changing). She mostly smokes in the evenings and on weekends.
  - Asking about triggers for smoking: She identifies stress and boredom
  - Asking about support systems for quitting (family, coworkers): Her husband, coworkers, children, friends ALL want her to quit and have encouraged her to stop smoking. She has one other friend who smokes (the one who recently started walking with her).
  - Asking about previous quit attempts: She has quit once before for several years. She started again 4 years ago when her daughter got pregnant the second time.
  - Negotiating about what the patient thinks might help her quit: She does not want to try nicotine replacement, bupropion, and varenicline (though learner should mention and offer these options). She thinks she can do it on her own as she did before. The learner may mention that a person who

quits smoking is “strong” (which appeals to patient’s self image as a strong woman who can handle anything).
  - Strategizing about the patient’s support system for quitting: She and her friend both want to quit. Can they do it together and support each other?
  - Discussing alternatives to smoking: Exercise is a good alternative to smoking; she and her friend have recently started to walk, and both want to quit smoking.

- Weight: CONTEMPLATION. She is not happy about gaining back 5 pounds since menopause. She is confident she can lose it, which is why she started walking with her friend. Successful counseling/negotiation strategies include:
  - Asking what the patient thinks FIRST (before dispensing advice)
  - Finding out what she thinks her ideal body weight would be. African Americans and Latinos often describe women who are “heavy” as normal and attractive. As a result, many African Americans and Latinos would identify a woman who is medically overweight as being at a healthy weight, even though her weight puts her at risk for CVD and other complications. The patient identifies BMI 25 kg/m^2 as her ideal weight (SPs should be told the weight this approximates based on their height in order to give this weight if asked by the learner). In the patient’s family, all the women are “big”
  - Inquiring about what changes the patient thinks she can make

- Diet: ACTION. She has been trying to avoid snack foods and is carefully following her husband’s diabetic diet (for both of them). Successful counseling/negotiation strategies include:
  - Asking about her usual diet
  - Supporting her with positive reinforcement for the changes she has made
  - Inquiring about triggers for snacking/relapse

- Exercise: ACTION. She and her friend have started walking in the mornings before work. Successful counseling/negotiation strategies include:
  - Asking about her current efforts
  - Supporting her with positive reinforcement for the changes she has started
  - Inquiring about obstacles and discussing how best to overcome them

- Blood Pressure: PRECONTEMPLATION. She knows many people with high blood pressure and it runs in her family. She is very reluctant to take medication. She is scared about this because she knows some people from church whose family members are on dialysis from “high blood”. She is willing to continue to work on diet and exercise and will need careful discussion of the risk this poses to her heart and brain. Successful counseling/negotiation strategies include:
  - Finding out what she knows about high blood pressure (“high blood”)
  - Finding out what her experiences are (family, friends)
  - Inquiring about her thoughts about medication

- Uncovering her fear of the consequences of high blood pressure
- Linking her blood pressure to a SPECIFIC risk for heart attack/stroke (use Framingham/JNC 7 criteria)
- Supporting her continued efforts with diet and exercise
- Negotiating agreement to continue to monitor and discuss at next visit

- Lipids: PRECONTEMPLATION. She has heard something about "fat in the blood" but doesn't know much about it. Successful counseling/negotiation strategies include:
  - Asking her what she knows
  - Asking her if she would like to know more
  - Linking "high fat in the blood" to a SPECIFIC risk for heart disease (Framingham risk assessment)
  - Explaining "good and bad" cholesterol
  - Explaining why he/she is ordering the test, how and why to fast before the test, and when to expect results

- Risk for Diabetes: ACTION. Her husband has diabetes, her mother had it, many friends, and coworkers have it. She wants to get her blood sugar checked and want to avoid getting diabetes if she can. Successful counseling/negotiation strategies include:
  - Asking her what she knows
  - Exploring her fears about diabetes and its complications
  - Linking diabetes to a SPECIFIC risk for heart disease (single greatest risk factor for women)
  - Getting agreement to be tested
  - Explaining the test, how and why to fast, and when to expect results
  - Supporting her diet, exercise and weight loss efforts as ways to prevent diabetes

- Impact of Family History on CVD Risk: CONTEMPLATION. She is afraid to end up like her mother. She does NOT know that her mother's early heart attack poses a risk to her own health. Successful counseling and negotiation strategies include:
  - Asking her what she knows
  - Exploring her fears about ending up like her mother
  - Linking her family history to a SPECIFIC risk for heart disease
  - Supporting her lifestyle efforts as ways of preventing heart disease

- Stress: CONTEMPLATION. She recognizes she is "stressed" but accepts it as part of her life. Her boss and her daughter are constantly "working on my nerves". She has no symptoms of depression (sleeping well, good appetite, overall positive mood, interest in usual activities). Successful counseling and negotiation strategies include:
  - Exploring the patient's current life situation, e.g., "*How things are going in your life?"*

- Listening to her concerns with respect
- Acknowledging her concerns with empathetic response, e.g. "*That sounds tough, how are you coping?*
- NOT jumping in to provide solutions
- Exploring symptoms of depression (sleep, mood, appetite, pleasure/interest, thoughts of suicide)

- Menopause: CONTEMPLATION. She went through menopause 2 years ago. She did not have many symptoms, and currently feels well. She and her husband are satisfied with their sex lives, though he sometimes has difficulty with erections (a common problem for diabetics). She has heard about hormones and wonders if she should be taking hormone therapy. Successful counseling and negotiation strategies include:
  - Exploring her symptoms/experiences with menopause
  - Inquiring about her current sex life (satisfaction, etc)
  - Providing information that "hormones" are not indicated for her (explaining recommendation for limited use for severe menopausal symptoms only)

Guidelines for Session Implementation

Each facilitator will be assigned to a group of 4 to 5 students. Begin by reviewing the handout "Patient Education and Counseling for Behavior Change" that includes the stages of change and the confidence/conviction model. Make sure that you understand both models, and have an idea of appropriate intervention techniques for each quadrant on the confidence/conviction grid. You will have a chance to see the techniques in action as you work through the standardized patient case.

Each student will take turns interviewing/counseling the patient. The student interviewing or the facilitator are the only ones who can call a time out. The SP will "freeze" whenever not actively engaged in being interviewed.

Opening the Session

1. Begin the session by having one student start the interview. The focus is on gathering information from the patient using open-ended questions, reflective listening, and appropriate summary skills. The student should concentrate on issues related to risk assessment and behavioral change and not biomedical details.

2. Stop the interview when the patient has given sufficient information to discuss. Ask the group observing the interaction "*Can you summarize for the group why this patient is here? What are the major issues the* ***patient*** *wants to discuss?"* Depending on how the initial interview went, this may be easily answered or may be a chance for a different student to interview the patient with the explicit goal of uncovering the patient's complete agenda. If the group needs coaching, you might say *"What could*

you say to the patient that might help us discover the real reason for the visit?" Ask the group *"Do you think we have discovered all of the patient's concerns?"*

Risk Assessment

3. This patient has several risk factors/health behaviors that need attention and discussion. For each risk factor, ask the group:

"What is known about this particular risk factor in women?" It may be the same or different than in men.

Emphasize the use of validated and published risk screening tools and guidelines. The patient does not have lipid levels or fasting glucose measurements available yet. Students should acknowledge the need to obtain them. Suggest some "what if" values to demonstrate the effect that these risk factors have on overall ten-year cardiovascular risk in women.

Counseling for Behavior Change

4. Have each student volunteer to address at least one factor/behavior. For each risk factor, discuss the following with the group:

Before each student begins, ask him/her what techniques they are thinking of using and why. Let the group have input and make suggestions briefly. Do not allow them engage in prolonged discussion of the theories themselves, rather, the focus should be on practical interventions focused on the patient at hand. Techniques should be related to the stage or quadrant. The student responsible for that risk factor/behavior should be allowed to try their ideas out with the patient.

Feedback:

5. After each role-playing segment, ask the group for feedback. Specifically ask about information giving, the congruence of the student's suggestions with the patient's goals and values, and about negotiation. Do not allow personal criticism of the student's performance. Model good feedback yourself for the group. Say, *"How did the patient react to the suggestion of using the patch?"* **NOT** *"Did you notice how the patient cringed and was disgusted when you mentioned nicotine gum?"*

After each student has had an opportunity to work with the patient, discuss the following:

A. What stage of change (transtheoratical model) or quadrant (confidence/conviction model) is this patient in for this behavior?
B. How could you address the patient regarding this behavior? Be sure to emphasize the following:
    1. Tailor the strategy to the stage of change

2. Express personal concern and interest throughout
3. Ask the patient for HER ideas before dispensing advice
4. Consider the effect of any intervention on her family and environment (suggest asking "*How would that affect others and other areas of your life?)*
5. Negotiate for realistic and doable changes
6. Change takes time. Getting a commitment to think about it counts as success, especially for those areas of precontemplation/contemplation.
7. People can only change a few things at a time. Choose the one the patient is most willing to address and that has the greatest health impact.
8. A physician's information/advice is a powerful motivator for change.

6. Have the students check for understanding. Encourage them to have the patient describe in his/her own words what he/she plans to do.

7. At the end, as a group, review the major teaching/learning issues that came up. Ask each student to summarize the major thing he/she learned.

8. Ask the standardized patient to give feedback to the group.

WORKING WITH SPs

VI WORKING WITH SPs

Working with Standardized Patients

This section contains:
Standardized Patient Recruiting Information
Standardized Patient Training Notes
Tips for standardized patients on giving feedback

Standardized Patient Recruiting Information

Case Name: TBA

Reason for Patient Seeing Doctor:
Patient is concerned about her own health following the recent sudden death of a friend from an acute myocardial infraction (heart attack)

What will happen during the encounter:
Medical history will be taken, waist circumference will be measured, patient education regarding risk factors and treatment plan options, including exploring cultural contexts, will occur.

General Criteria:

Age	43, (range 40 - 50) Post Menopausal
Gender	Female
Race	African American
Education	High School, completed course work to become a certified medical records coder
Cultural Backgrounds	African American women tend to view body image/weight differently. Words use to describe symptoms may be different , e.g. “sugar” instead of diabetes

Physical Characteristics:

General	Middle aged female
Height	Varies with each SP
Weight	Varies with each SP
Physical Findings	None except elevated BMI between 25 kg/m^2 and 30 kg/m^2 (not obese)

SP Responsibilities:

- Patient will be dressed in comfortable neat clothing
- Patient is somewhat reserved and skeptical in the beginning of the interview. She wants to heard and respected by the physician and will answer accordingly
- Patient must be comfortable with having waist measured

Standardized Patient Training Notes

Patients Demeanor/Affect:
She does not go to the doctor very often. She is somewhat reserved and a little bit skeptical in the beginning of the interview. If she feels respected and listened to by the doctor she will be receptive to recommendations.

Cultural Perspectives:
She shares the belief that black women should be strong and be there for others whose needs come before there own.

I can't afford to get sick, who's going to take care of my family?"

She has her own beliefs about the role that diet, exercise and medication have in causing and or treating high blood pressure, diabetes and heart attacks.

Diet (Action):
"I used to eat whatever I wanted until my husband got sugar diabetes. Now I follow his diabetes diet and I'm trying to cut down on snacking." She knows that this change "*makes me healthier*" and has no problem "*sticking*" with it. She believes:

Starchy foods and too many sweets causes diabetes
Too much salt, pork and spicy foods cause "high blood"

Beliefs about what causes heart attacks:
Old age, *"stressing out"*, drinking too much (alcohol), and being overweight (she is slightly overweight, elevated BMI between 25 kg/m^2 and 30 kg/m^2). She does not think that she needs to lose too much weight, *"I don't want to be skinny, all of the women in my family are big, bigger than me."*

Patient Education regarding risk factors and treatment plan:

Smoking:	Contemplation	Lipids:	Precontemplation
Weight:	Contemplation	Risk for Diabetes:	Action
Diet:	Action	Family History:	Contemplation
Exercise:	Action	Menopause:	Contemplation
Blood Pressure:	Precontemplation		

She is overwhelmed with having to make so many changes at once ("*Hey doctor, wait a minute, this is a lot of information"*). She needs to let the doctor know that she is not going walk away from this visit and make all of the changes he/she recommends, they must fit into her lifestyle. She is not resistant to change, just extremely overwhelmed.

If the doctor has not mentioned the heart health materials she should prompt. *"Do you have any written information that you can give me about all of the things we've talked about today?"*

Tips for Standardized Patients on Giving Feedback

"How feedback is delivered can make all the difference in learning."

Start by asking students what has been their experience in interviewing patients so far. This will put feedback exercise in context of the larger course.

"How has this experience compared to other patient interviews you've done?"

Make your feedback particular to each learner. This is easy here because it is a one-on-one experience. Resist comparing performance to other students.

Make feedback specific to particular things that happened in the interview. Resist making global assessments of the student's abilities - such as "but overall you did well". Comment only on skills observed, giving specific examples.

Balance positive and negative: Start and close with positive feedback, and in the middle identify one or two target areas to improve upon. Focus on areas that will bring the greatest growth in the student's skills.

Enlist the students in self-assessment. This will improve understanding and performance. Create a coaching environment by talking less and listening more. Have the students come up with their own ideas for areas of improvement, then you can reinforce. Open-ended questions help to do this:

"What do you think you did well on?" "What could you improve?"

"If you could do this interview over again, what would you change?" "How would you do this differently next time?"

Encourage continued effort: Do in a positive, encouraging, and upbeat way - we want them to leave with the feeling that they <u>can</u> do this. Remind them that they have many years to refine skills. However, be careful not to sugarcoat - we don't want them to leave feeling bad and defeated but with concrete ideas on how they might improve.

Consider word choices: Try using "strengths" and "target areas" rather than "good", "bad", "weaknesses".

If you have a resistant student - acknowledge their concerns and then work to steer the session back to giving feedback.

Give feedback in terms of how it made you feel as the patient. It is harder to argue with how someone felt rather than stating the feedback as a fact subject to debate.

"I felt_____ when you_____ because _____"

Incorporate these points but **do this in your own style** - we are confident in each of your abilities!