

Station #1: Instructions for the Standardized Patient

The students will be asked to evaluate an 80 year-old married woman who presents to the emergency department (ED) presenting with dizziness.

Claire Peters receives primary care at another hospital across town so she is not known to the ED staff.

Mrs. Peters was tending to her garden around 11:30 a.m., moving pots about when she suddenly felt faint. She describes this as lightheadedness, with a feeling that she was about to pass out. She recalls no other accompanying sensations (no chest pain, palpitations, numbness, tingling, focal weakness, shortness of breath, nausea, etc.). She does not recall any spinning sensation (vertigo). She was sweaty but she thinks this is because of the heat. She has never had something like this happen to her before. She does not recall passing out but the next thing she remembers is being sprawled on the ground being awoken by her husband, a broken pot next to her head. She had breakfast of bagel at 8 a.m. but admits to limiting her fluid intake to half a glass of orange juice because of fear of losing control of her bladder and ‘having an accident’. She doesn’t think she was out for more than a couple of minutes. Her husband called 911 and an ambulance took her to the ED.

Her past medical history is significant for hypertension, hardness of hearing, urinary incontinence, lower extremity edema, and constipation. Her medications include: Atenolol 100 mg daily; Imipramine 50 mg daily, Aspirin 81 mg daily, Calcium (‘Tums’) 650 mg twice daily, Vitamin D 1,000 units daily, Senna 2 tablets at night, and Hydrochlorothiazide (HCTZ) 50 mg added last week for ankle edema. She has normal weight, went through menopause at age 50 and was never on estrogen replacement therapy. She is a retired nurse, married for 45 years and has one child. Family history is significant for a father who had a stroke at 72 and died from heart attack at age 80 and a mother who died at age 82 of the complications of Type II diabetes. She plays tennis with her husband 3 times a week and baby-sits for her granddaughter two days a week. She has never smoked and drinks about one glass of wine with dinner.

In the ED, the patient appears slightly anxious but comfortable. She periodically fingers the bloodstained bandage covering the laceration on her forehead. She emphasizes that she has been healthy and wants to know why she passed out. If the student asks what the patient thinks is the cause of the problem, the patient should respond that she is worried that she might have had a stroke or a heart attack.

The student will have 15 minutes to interview you and there will be 5 minutes at the end of the session for discussion and feedback.

Station #2: Instructions for the Standardized Patient

The students will be asked to evaluate an 80 year-old widow who presents to the emergency department (ED) presenting with dizziness.

Rebecca Spiegel is a resident of a local nursing home so she is not known to the ED staff.

Mrs. Spiegel just finished washing herself and was ambulating to the dining room at around 11:30 am to have lunch when she suddenly felt faint (does not remember if she used her walker or not). She describes this as lightheadedness, with a feeling that she was about to pass out. She recalls no other accompanying sensations (no chest pain, palpitations, cold sweats, numbness, tingling, focal weakness, shortness of breath, nausea, etc.) [For ROS questions, repeatedly answers *'I don't think so'* or *'I don't remember'*]. She does not recall any spinning sensation (vertigo). She does not remember anything like this happen to her before. She does not recall passing out but the next thing she remembers is being wheeled to the ambulance. She had a bowl of oatmeal and a glass of orange juice at 7:30 a.m..

Her past medical history is significant for hypertension, mild congestive heart failure, hyperlipidemia, osteoarthritis, COPD, chronic renal insufficiency, and gout (patient denies any medical problems when asked *'I'm healthy as a bull!'*). Her medications include: Amlodipine 5 mg daily, Atenolol 50 mg (added last month for hypertension), Furosemide 60 mg daily in the morning, Aspirin 81 mg daily, senna 2 tablets at night, Simvastatin 20 mg daily, Lisinopril 5 mg daily (added last week for HTN), Acetaminophen as needed for joint pains. Family history is significant for a father who died of an acute myocardial infarction at age 45 and a mother who died of 'old age' at age 93 (became forgetful and had to be confined to nursing home five years prior to death) [*patient has excellent recollection of family history and other things that occurred in the distant past*]. Social history: retired bookkeeper; widow (*'My husband died ages ago'*); 3 children. She uses a walker *'whenever I remember it'*. She used to smoke half a pack of cigarette a day (*'I never inhaled'*) for over 30 years but quit over 20 years ago; used to have a couple of 'hard balls' a day but does not drink alcohol anymore (*'I could use a drink right now!'*).

In the ED, the patient appears thin/frail and inappropriately jocular (*'How old are you kids? You look younger than my grandchildren!'*). She periodically tries to get up and take off the bloodstained bandage covering the laceration on her forehead. She repeatedly claims to be healthy and not to be taking any medications. She neither remembers the name of her nursing home (*'Jewish rehab something'*) nor how long she has lived there. She is not concerned about the cause of her problems. If the student asks about her memory, she responds *'My memory is perfect!'* If the student asks what the patient thinks is the cause of the problem, the patient should respond: *'I probably slipped on a banana peel or something!'* If student tries to perform mental status exam, patient responds: *'My memory is perfect. I'm not in the mood to do that kind of tests right now'*.

The student will have 15 minutes to interview you and there will be 5 minutes at the end of the session for discussion and feedback.