A STANDARDIZED PATIENT'S MEDICAL JOURNEY:

WHEN ART IMITATES LIFE

BY

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Acting sick for twelve years has been educational and rewarding. I am a standardized patient (SP), also known as a medical actor. I feign illnesses as part of a training program for medical students. My stage is the Clinical Skills and Patient Simulation Center in the UNC – Chapel Hill School of Medicine. Recently, I was faced with a very real personal health issue and quickly realized, because of my SP experience, that I am now a more informed "real" patient and a better advocate for my own health. More about this later.

My audiences range from a single student in a one-to-one encounter to groups of students with their instructors who are practicing doctors. My performances are based on real patient histories. The scripts—written by doctors—are as varied as a dying patient discussing end-of-life advanced directives (e.g. living wills, health care power of attorneys, etc.) or a sunburned farmer concerned about a suspicious lesion on his arm. Over the years, I've played patients with urinary tract problems; I've faked chest pains following Transurethral Resection of the Prostrate (TURP) surgery. I've peppered med students with questions about prostate cancer screening, and I've been a life-long smoker who feels no need to quit in spite of the student's kind encouragement. I've been bi-polar and obsessive compulsive personalities in sessions with psychiatry students. I've portrayed a gent with advanced dementia; and saddest of all, I've been a grandfather whose grandson is dying. In that case—one of the most difficult—the student must deliver the bad news. And, at times, I've stepped out of the patient role and acted as a surgeon in an anesthesiology simulation activity or a pharmacy customer learning how to take a new medication.

As a SP, I attend a training orientation and then commit the script/scenario to memory. In the encounter, the student interviews me; my answers are based on the case with minimal improvisation. The student then performs an exam and completes a summary of possible diagnoses and treatments.

My role as a patient then is to evaluate the student according to a technical and qualitative checklist, which the instructors review and grade. This measures the student's skill, not only for the ability to do a particular exam but also to obtain my medical history. I evaluate how well the student communicates—the ability to make me feel comfortable, to use good eye contact, to express empathy, etc.

I take this role very seriously and do my very best to judge correctly and fairly. If I'm uncertain, I write an accompanying note to the checklist. All this interaction— between me as a medical actor and the medical student—is recorded for review and training.

From an educational standpoint, I've learned about various ailments, their symptoms and causes. I've interacted with medical faculty possessing wide-ranging specialties: internists, pediatricians, neurologists, Emergency Department (ED) physicians, anesthesiologists, hospitalists, cardiologists, and gerontologists. From them, I've gained a great deal of general medical information, and I've observed trends in medical education.

My SP experience has been rewarding in many aspects, especially when students show vast improvement in their medical history-taking and their relationship and communication skills. Often SPs are asked to provide verbal feedback and the students are extremely receptive and appreciative. Helping them grow into confident doctors gives me, and I believe I speak for

my fellow SPs, a great sense of accomplishment. We believe we are making a positive difference in their educational experience.

Another reward includes learning from the students. I'm more knowledgeable and more able to discuss my own health issues with my primary care physician (PCP) and specialists I see. The students' health history-taking and review of systems prompts questions for my "real" doctors. Now I always go to real medical appointments armed with a list of questions.

MY MEDICAL JOURNEY

Recently I undertook a medical journey that was prompted by a medical student's discovery while examining me. This series of events will show how my standardized patient work intersected and influenced my real patient experience.

CPX EXAM

In mid-April 2017, I worked a Clinical Skills Practice Exam (CPX). This high-stakes event for third-year students prepares them for a real-world exam—an important milestone for graduating from medical school. I portrayed two different patients—one complaining about frequent urination and another experiencing chest pains following TURP surgery.

In the frequent-urination case, the student explained this could be caused by an enlarged prostate (BPH). Even though I am in the age demographic of the standardized patient I portrayed, I gave little thought to BPH because I had no similar symptoms. And, in a "by-the-way" moment while auscultating my heart, he asked if I knew I had a heart murmur. I didn't think so, but made a mental note to ask my doctor about it.

In the second case, I was a hospital patient awaiting discharge after a transurethral resection of the prostate (TURP) surgery. The scenario called for the SP to experience sudden chest pain requiring the students to assess for heart attack and other causes.

(On a personal note, I never seriously investigated TURP—just the thought made my urethra, prostate, and bladder twinge. Regarding chest pains, I was sensitive to the student's questions since the SP scenario had medical conditions similar to my real-life health history—hypertension, high cholesterol, former smoker, and family history of heart disease.)

SP ULTRASOUND SCANS

The next day, I acted another case involving fourth-year students practicing ultrasound scans of the heart. The student and his supervising doctor confirmed I indeed had a heart murmur. Lucky, because had I not learned this, I may not have mentioned it to my primary care physician.

PRIMARY CARE PHYSICIAN (PCP) VISIT

Later, I saw my primary care physician for my annual checkup. After I mentioned the possible heart murmur, he performed an ultrasound scan and confirmed it. Then palpation of my bladder area indicated another problem. He did an ultrasound scan and informed me I had a distended bladder and possible obstruction.

This needed immediate attention; so, he directed me to the Emergency Department (ED) at UNC Hospital. He also ordered a series of tests (CT Heart scan, echocardiogram, renal and bladder scans, and blood work) to determine what issues existed with heart, kidneys, bladder, and prostate.

For me, the PCP visit reinforced the logic underlying why students are trained to connect the dots between patients' complaints, symptoms, medical conditions, family and social histories. My PCP practiced in real time what I observed medical students currently being taught.

EMERGENCY DEPARTMENT (ED)

I'd never acted an SP role involving the ED. Now that I've experienced the reality of an ED visit, I'll share some general observations:

- The importance of having an advocate accompany you when experiencing serious health issues. Another set of eyes and ears improves the end result. My geriatric dementia and pediatric bad news cases taught me this valuable lesson. I'm grateful my wife accompanied me throughout this journey.
- The importance of medical professionals' relationship and communication skills. This is particularly relevant when a patient is introduced to new environment and unfamiliar procedures like catheterization. (Ouch!)
- The "small world" surprise of meeting a former medical student doing rotation in the ED. Not only did this renew my sense of accomplishment that we SPs share in the training of students, but in this instance, we rely on that skill and training for our very own health needs.

In short order, the visit to the ED confirmed my bladder obstruction, introduced me to the joys of catheterization and Flomax. Unfortunately, I was anxious to leave. In retrospect, I should have remained longer and asked more open-ended questions. My impatience necessitated an encore visit a few hours later to resolve complications.

UROLOGY

A week later, I saw the urologist. He was accompanied by a transcriptionist, a "medical scribe," who documented the doctor-patient exchange. The doctor focused his full attention on me and was not distracted with note taking. (He was very complimentary regarding the scribe's value. It turns out some of our SP colleagues also do this transcription work. Both SPs and medical scribes are excellent experiences prior to applying for medical school.)

The doctor confirmed the bladder obstruction and recommended self-catheterization to relieve pressure on the bladder pending a scheduled test to assess the extent of the problem. I asked whether this was really necessary. He convinced me with clear and concise reasoning. It impressed me how the doctor's relationship and communication skills mirror the techniques that medical school students are taught.

Later, because of a bleeding problem that developed, the doctor performed a cystoscopy. At this point, the video evidence indicated I needed surgery. An enlarged prostate (BPH) constricted the urethra and caused the bladder obstruction. The solution, you guessed it, was to have a TURP procedure. How ironic; I would now be a real TURP patient. Let's hope chest pains don't follow. (Fortunately, all the heart tests my PCP ordered confirmed my heart was in good shape—heart murmur and all.)

PRE-OPERATION, SURGERY AND RECOVERY

About 30 days transpired between the cystoscopy and the actual operation. During that period, I made frequent use of the electronic records system (My UNC Chart.org) to maintain communication with my PCP and the urology staff. As various test results arrived, it provided

the basis for posing open-ended questions to my doctors. If I had not been a SP, I would probably not be as proactive. Medical students are trained to close patient encounters with the standard open-ended comment, “What questions do you have?” Real patients should take advantage of this opportunity to clarify and get answers about their concerns.

Between the pre-operation care and the actual surgery/recovery, I (and my advocate wife) met with several doctors, nurses, technicians, and staff. When I’d mention that my wife and I were SPs, the doctors were especially complimentary of the important contribution SPs make to medical education.

Having been an SP, I found I had no trouble communicating with the medical professionals I encountered. And of course, I had my list of prepared open-ended questions for the anesthesiologist and surgeon. Their answers gave me a better understanding of what was involved and what to expect.

When a technician explained why anesthesiologists are interested in the chest X-ray results, it reminded me of anesthesiology simulations I had done. I realized I would soon experience the same procedures that I watched residents perform on the mannequins. The anesthesiology simulations gave me a deep appreciation for the critical role of the anesthesiologist.

When the nurse asked for a copy of advanced directives, my advocate wife had them at the ready. Having performed the end-of-life (EOL) case, I knew about these documents. In the end-of-life encounters, the students explain why the advanced directives are needed and so important.

In recovery, I experienced the leg bags around my calves. I was told this device helped prevent blood clots from forming and migrating to the lungs. Again, my SP TURP case entered

my mind, since pulmonary embolism caused by these clots could be a possible cause of chest pains.

Being a real patient will make me a better standardized patient for future cases. Now that I've had a heart murmur detected, BPH diagnosis, TURP procedure, cystoscopy, anesthesia, a plethora of tests, and two visits to the ED, I'll perform my acting roles with more confidence. I can offer more-informed suggestions to the SP Training specialist and doctors who author the cases. In fact, the SP community possesses a wealth of knowledge on medical issues they have personally encountered. Perhaps some of that knowledge can be incorporated into future case development. We have SPs who have experienced strokes, diabetes, COPD, serious falls and accidents, cancer, heart and lung problems, abdominal pain, drug interactions, etc. Mining this valuable knowledge could be beneficial to the overall training mission.

I've learned to keep a sense of humor as I traveled my medical path. After a while, it's easy to joke about wearing a catheter (although wearing one is not necessarily a laughing matter.) Humor at the appropriate time and place lightens the situation and enhances communication between patient and medical professionals.

On a final note: I wish to thank the Clinical Skills and Patient Simulation Center team at the School of Medicine. These dedicated professionals organize, schedule, train and support SPs to give their best performances possible. Also, I want to express my gratitude to the medical faculty who continually enhance the SP's learning experiences and performances.

I feel so fortunate to have a fine medical teaching hospital—UNC—available to me, and it is with great satisfaction that I feel very much a part of that community—both as a standardized patient and as an actual patient.