ASPE Scholars Certificate

- ASPE Scholar Certificate **criteria**: https://www.aspeducators.org/scholars-certificate-program
- To **document your attendance** at G&R Courses toward the Scholars Certificate:

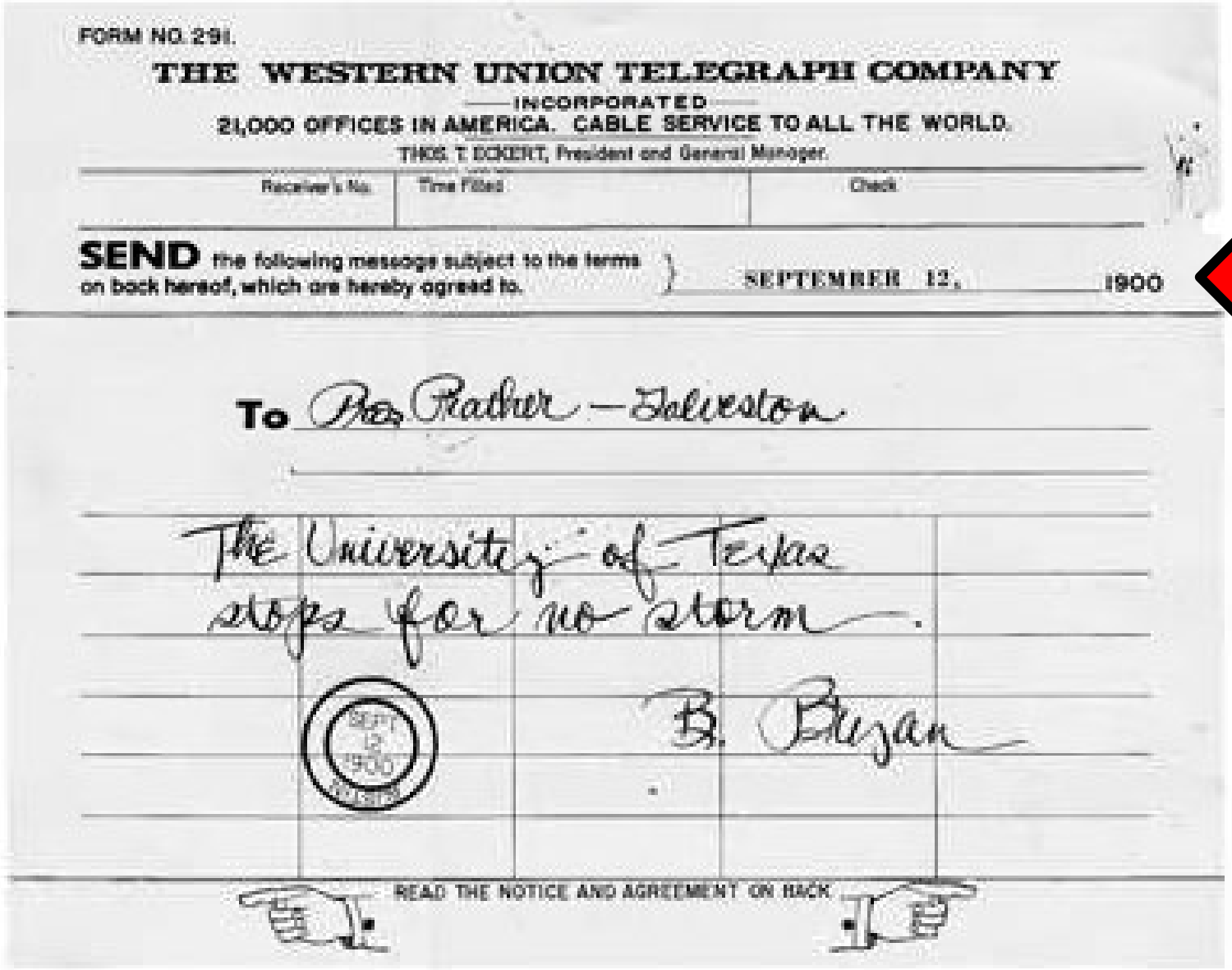
https://docs.google.com/forms/d/e/1FAIpQLSe9crwdDJXjVPxntU_h43d_p0bWysJMWTJVT9dQQje_JCUziA/viewform?usp=sf_link

If you have any difficulty accessing the form, G&R Chair, Jane Lindsay Miller, can send a direct invitation:

jane-l-miller@uiowa.edu (jane L miller)

Review of the Literature 2020

"WE STOP FOR NO STORM"



FORM NO. 291.

THE WESTERN UNION TELEGRAPH COMPANY

INCORPORATED

21,000 OFFICES IN AMERICA. CABLE SERVICE TO ALL THE WORLD.

THOS. T. ECKERT, President and General Manager.

Receiver's No.	Time Filed	Check

SEND the following message subject to the terms on back hereof, which are hereby agreed to. SEPTEMBER 12, 1900

To Bro. Rather — Galveston

The University of Texas stops for no storm.

B. Bryan

SEPT 12 1900 GALVESTON

READ THE NOTICE AND AGREEMENT ON BACK

Sept 12, 1900

Story Hour

Bibliography of papers that address SP methodology

Launched this in 2011 with a review of 2010.

Has morphed into an annual session with the goal of providing an overview of the year's publications.

Search OVID Medline for simulated patients, standardized patients, OSCE

Include all accessible journals, but limited to English language literature

Published within the calendar year 2020

Bibliography is now housed by ASPE. Will be updated after the conference

We Did Great Stuff and Wrote a Lot!

Adding to the Bibliography:

~ 430 new citations

over 200 unique journals

General Reviews

Methods, methodological challenges and lesson learned from phenomenological study about **OSCE experience**: Overview of paradigm-driven qualitative approach in medical education

Performance assessment: Consensus statement and recommendations from the 2020 Ottawa Conference

Interprofessional **Musculoskeletal Education**: A Review of National Initiatives from the Department of Veterans Affairs

Simulated patient scenario development: A methodological review of validity and reliability reporting

The Design and Validation of **Three Interprofessional Simulations**: A Feasibility Study

Scenes, symbols and social roles: raising the curtain on OSCE performances

An overview of and approach to selecting appropriate **patient representations in teaching and summative assessment** in medical education

The Modern Physical Exam - A Transatlantic Perspective from the Resident Level

Turning **Objective Structured Clinical Examinations** into Reality

Skill acquisition of **safe medication administration** through realistic simulation: an integrative review

Systematic Reviews

Cultural competency training for **psychiatry** residents and mental health professionals: A systematic review

Remediation of learners struggling with communication skills: a systematic review

Systematic review of **student anxiety and performance** during objective structured clinical examinations

Use of Simulated Patients in **Disaster Medicine Training**: A Systematic Review

A systematic review of the use of simulated patient methodology in **pharmacy practice research** from 2006 to 2016

Simulation-Based Learning Experiences in **Dietetics Programs**: A Systematic Review

Students as patients: A systematic review of **peer simulation** in health care professional education

Peer Role-Play for Training Communication Skills in Medical Students: A Systematic Review

Educational programs to teach **shared decision making** to medical trainees: A systematic review

Simulation in **psychiatry** for medical doctors: A systematic review and meta-analysis

The effectiveness of training interventions on **nurses' communication skills**: A systematic review

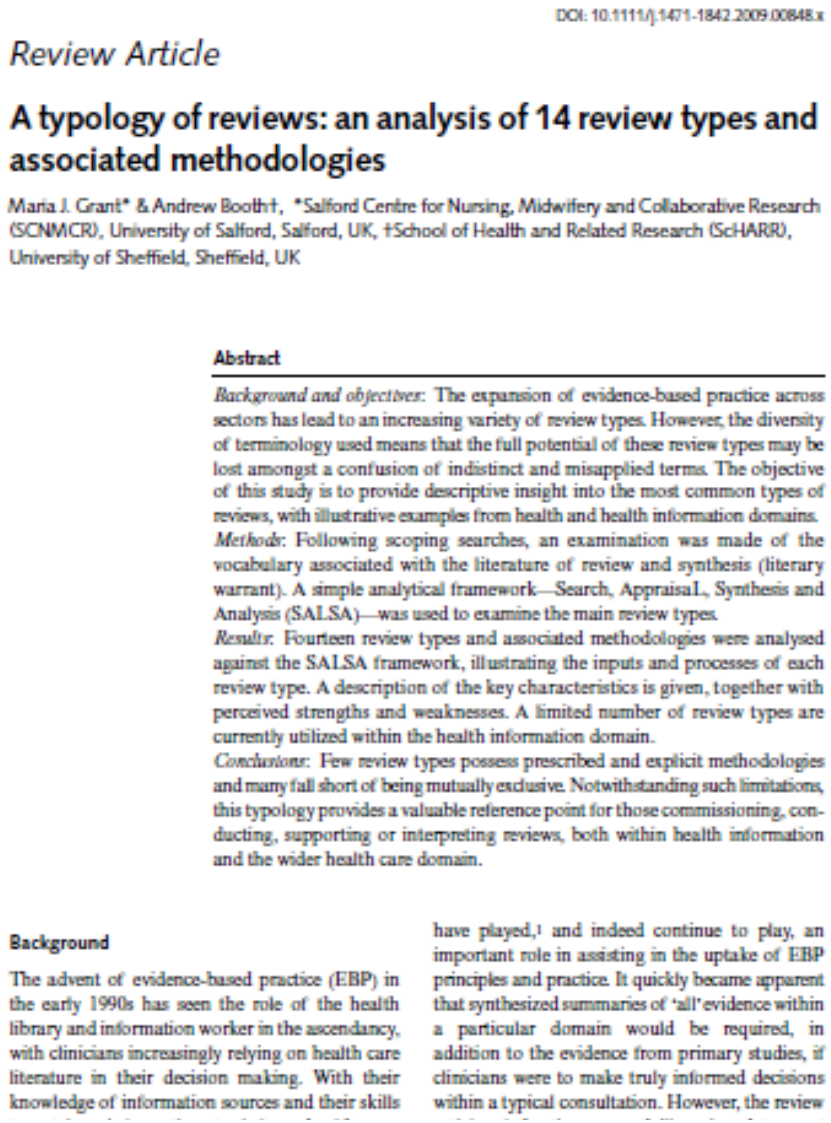
Scoping Reviews

Diversity in approach to teaching and assessing **ethics education** for medical undergraduates: A scoping review

"Who Am I and Why Am I Here?" A Scoping Review Exploring the **Templates and Protocols** That Direct Actors in Their Roles as Simulated (Standardized) Patients

Training **Surgical Residents** to **Communicate** with Their Patients: A Scoping Review of the Literature

Simulation to educate healthcare providers working within **residential age care settings**: A scoping review



DOI: 10.1111/j.1471-1842.2009.00848.x

Review Article

A typology of reviews: an analysis of 14 review types and associated methodologies

Maria J. Grant* & Andrew Booth†, *Salford Centre for Nursing, Midwifery and Collaborative Research (SCNMCR), University of Salford, Salford, UK, †School of Health and Related Research (ScHARR), University of Sheffield, Sheffield, UK

Abstract

Background and objectives: The expansion of evidence-based practice across sectors has lead to an increasing variety of review types. However, the diversity of terminology used means that the full potential of these review types may be lost amongst a confusion of indistinct and misapplied terms. The objective of this study is to provide descriptive insight into the most common types of reviews, with illustrative examples from health and health information domains.
Methods: Following scoping searches, an examination was made of the vocabulary associated with the literature of review and synthesis (literary warrant). A simple analytical framework—Search, AppraisaL, Synthesis and Analysis (SALSA)—was used to examine the main review types.
Results: Fourteen review types and associated methodologies were analysed against the SALSA framework, illustrating the inputs and processes of each review type. A description of the key characteristics is given, together with perceived strengths and weaknesses. A limited number of review types are currently utilized within the health information domain.
Conclusions: Few review types possess prescribed and explicit methodologies and many fall short of being mutually exclusive. Notwithstanding such limitations, this typology provides a valuable reference point for those commissioning, conducting, supporting or interpreting reviews, both within health information and the wider health care domain.

Background

The advent of evidence-based practice (EBP) in the early 1990s has seen the role of the health library and information worker in the ascendancy, with clinicians increasingly relying on health care literature in their decision making. With their knowledge of information sources and their skills have played,[1] and indeed continue to play, an important role in assisting in the uptake of EBP principles and practice. It quickly became apparent that synthesized summaries of 'all' evidence within a particular domain would be required, in addition to the evidence from primary studies, if clinicians were to make truly informed decisions within a typical consultation. However, the review

Twelve Tips (Medical Teacher and MedEdPublish)

... for introducing simulation-based assessment in the objective structured clinical examination

... for running an effective session with standardized patient

... for conducting a virtual OSCE

... for OSCE-style Tele-assessment

... for teaching empathy using simulated patients - A student's perspective

MedEdPORTAL

Professionalism and Ethics: A Standardized Patient Observed Standardized Clinical Examination to Assess ACGME Pediatric Professionalism Milestones

Evaluating Shared Decision Making in Trial of Labor After Cesarean Counseling Using Objective Structured Clinical Examinations

Shared Decision Making for the Emergency Provider: Engaging Patients When Seconds Count

Standardized Patient Simulation Using SBIRT (Screening, Brief Intervention, and Referral for Treatment) as a Tool for Interprofessional Learning

Thyrotoxicosis in a Postpartum Adolescent: A Simulation Case for Emergency Medicine Providers

The Mental Status Exam: An Online Teaching Exercise Using Video-Based Depictions by Simulated Patients

Stat Pearls Publishing

Roles and Responsibilities of the Standardized Patient Director in Medical Simulation

Standardization of Standardized Patient Training in Medical Simulation

Set Up and Execution of an Effective Standardized Patient Program in Medical Simulation

Validating Assessment Tools in Simulation

The How When Why of High Fidelity Simulation

Mastery Learning in Medical Simulation

Past Present and Future of Simulation in Pediatrics

Simulation Training and Skill Assessment in Obstetrics and Gynecology

The Current Role of Medical Simulation in Otolaryngology

Simulation Training and Skill Assessment in EMS

Current Topics in Healthcare Education

Diversity, Equity, and Inclusion

Underrepresentation of Racial Diversity in Simulation: An International Study

Learning environment must be welcoming for all students to work at their best capacity

Prior work suggested that simulation equipment was dominantly white

This study expands on that work to assess:

- Racial diversity in simulation centers globally
- Opinions of the community related to diversity component in the international simulation standards

Survey distributed through INACSL Linked in, NLN Sim Educators Google Group, SSIH SimConnect

Underrepresentation of Racial Diversity in Simulation: An International Study

Respondents: n=161

USA (89.5%), Australia (2.5%); Canada (2.5%), England (1.9%), Scotland (1.2%) Brazil, New Zealand, Poland, Germany (0.6%)

Presence of manikins, body parts/ task trainers, SPs, Simulation Facilitators – majority of respondents said "yes" ***but***

Percent of these in the total pool of equipment – not representative of the local population

Qualitative aspect of the study – already okay, working to improve, challenges with resources

Addressing microaggressions in racially charged patient-provider interactions: a pilot randomized trial

Focus on microaggressions / workshop to assist in training of response options in charged situations.

Black SPs presented with specific concerns about response to racially directed mistreatment

Workshop focus: Improved responsiveness and emotional rapport building behaviors

Excellent examples of language use that addressed patient concerns

Clinical Reasoning

Assessing clinical reasoning in undergraduate medical students during history taking with an empirically derived scale for clinical reasoning indicators

Clinical reasoning is complex – very much a hot topic in medical education

Unpacked the steps in clinical reasoning during a patient encounter

Authors developed and piloted a scale for the assessment of clinical reasoning

Video encounters of learners with SPs

Assessing clinical reasoning in undergraduate medical students during history taking with an empirically derived scale for clinical reasoning indicators

Clinical Reasoning Indicators - History Taking (CRI-HT)

Clinical reasoning indicators	1	2	3	4	5
1. Taking the lead in the conversation The student takes control of the interview in order to get the required information.	0	0	0	0	0
2. Recognizing and responding to relevant information The student shows that s/he recognizes relevant information by e.g. responding with obvious interest to them.	0	0	0	0	0
3. Specifying symptoms The student makes targeted inquiries to capture the symptoms in more detail which s/he considers to be important.	0	0	0	0	0
4. Asking specific questions that point to pathophysiological thinking The student's questions indicate that s/he is considering specific causes for certain symptoms.	0	0	0	0	0
5. Putting questions in a logical order The student asks the questions in a logical order and not according to a list.	0	0	0	0	0
6. Checking with the patient The student assures her-/himself by checking with the patient that her/his clinical thinking is based on correct information.	0	0	0	0	0
7. Summarizing The student summarizes her/his collected information aloud as soon as they have reached a meaningful level.	0	0	0	0	0
8. Collected data and effectiveness of the conversation The student collects sufficient, high quality data at reasonable speed.	0	0	0	0	0

(1)	(2)	(3)	(4)	(5)
does not meet the criterion	**does rather not meet the criterion**	**partly meets the criterion**	**rather meets the criterion**	**fully meets the criterion**

Evaluation of the effect of a new clinical reasoning curriculum in a pre-clerkship clinical skills course

Many transition points in training

Pre-clerkship clinical reasoning curriculum introduced : study to look at outcome of curricular reform

Case presentation and discussion (interview SP in pairs, nonspecific presentation, debrief)

Clinical case discussion (defend the data points that you request)

OSCE prior to beginning clinical rotations

OSCE: note – identified key history items. DDX is high priority

Evaluation of the effect of a new clinical reasoning curriculum in a pre-clerkship clinical skills course

Table 1 Relevant symptom query elements (based on clinician responses)

Relevant symptom query[a]	Study cohort ($n=101$)	Comparison cohort ($n=97$)	p-value
Shortness of breath/ dyspnea	65 (64.36%)	88 (82.24%)	0.0035
Chest pain	57 (56.44%)	69 (64.49%)	0.2351
Syncope/presyncope	32 (31.68%)	28 (26.17%)	0.3802
Orthopnea/PND	34 (33.66%)	33 (30.84%)	0.6633
Lower extremity Swelling/ edema	41 (40.59%)	45 (42.06%)	0.8305
Diaphoresis/heat intolerance	53 (52.48%)	27 (25.23%)	<0.0001
Weakness or numbness	20 (19.80%)	14 (13.08%)	0.1904
Weight changes	51 (50.50%)	32 (29.91%)	0.0023
Fever	25 (24.75%)	21 (19.63%)	0.3733
Average number of relevant symptoms queried	*3.74*	*3.34*	*$p>0.05$*

Table 2 High priority differential diagnosis (based on clinician responses)

High priority differential diagnosis[a]	Study cohort ($n=100$)	Comparison cohort ($n=97$)	p-value
Atrial fibrillation	42 (42.00%)	40 (41.24%)	0.9135
Hyperthyroidism	52 (52.00%)	21 (21.65%)	<0.0001
Acute congestive heart failure	25 (25.00%)	31 (31.96%)	0.2790
Anxiety attack	51 (51.00%)	36 (37.11%)	0.04970
Acute pulmonary embolism	30 (30.00%)	47 (48.45%)	0.0008
Average score on high priority differential diagnosis Maximum: 3 points	*1.98 (0.79)*	*1.64 (0.92)*	*$p<0.001$*

Study cohort students with clinical reasoning in the curriculum; *comparison cohort* students not taught clinical reasoning

[a]Organized in the frequency of clinician preference

Medical education, simulation and uncertainty

Presentation of a patient scenario that highlights clinical uncertainty

Encourage students to think about not getting to the "right" answer because there is no one best single diagnosis

Model for thinking about how to deal with not knowing

Highlights the "diamond model" for debrief

Student reported that simulation encouraged expectations of textbook diseases, which did not reflect the complexities of authentic patient encounters

Co-constructive Patient Simulation: A Learner-Centered Method to Enhance Communication and Reflection Skills

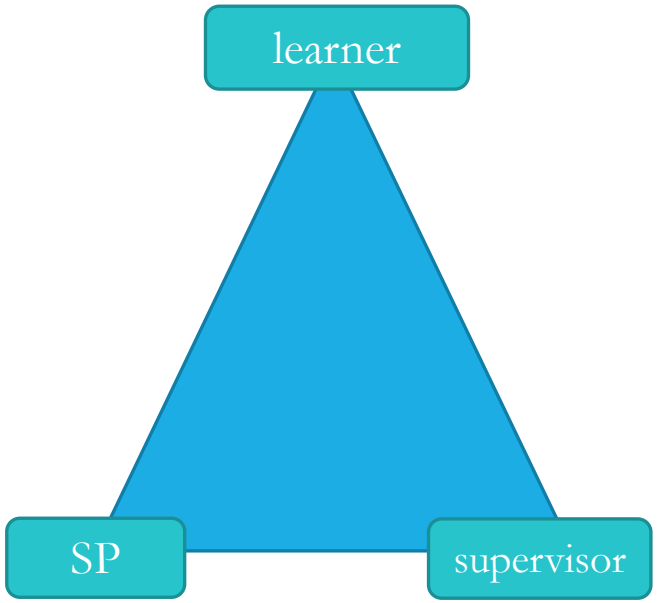
Co-constructive patient simulation

- Learner creates a scenario based on a personal experience
- SP works with learner to adapt a portrayal
- Supervisor with learner and SP to edit, practice role play

Learning Goals are co-created

Fellow learner engages in the case as the physician

Outcomes described from multiple perspectives



Communication

"I Guess I Didn't Like That Word *Unfortunately*": Standardized Patients' Unscripted Techniques for Training Medical Students

Study based on Breaking Bad News activity used in the classroom setting

Two experienced SPs portray the patient, 3 students in each cohort (18 total) participate in the interview and class feedback ensues

Researchers did a conversation analysis of recordings of the encounters: define concept of "repair request" in discussions

"Echo utterance"

SPs are using improv to guide the conversations. Research looked at how the SPs were using student language in the conversation

Types of student speech that trigger repair requests:

- Speculative language
- Inappropriate utterances
- Awkward timing
- Medical Jargon

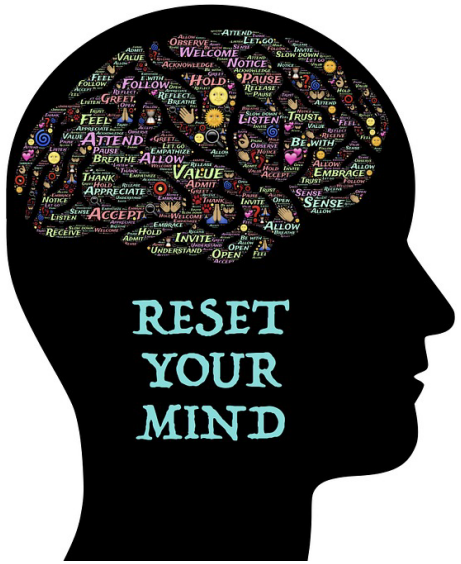
"I Guess I Didn't Like That Word *Unfortunately*": Standardized Patients' Unscripted Techniques for Training Medical Students

Potential application for other types of encounter

Discuss in training as a technique useful in guiding student reflection

“repeat and repair”

Mindfulness Improves Otolaryngology Residents' Performance in a Simulated Bad-News Consultation: A Pilot Study



ENT residents in simulation / education sessions.

Completed: State-Trait Anxiety Inventory State form , Mindful Attention Awareness Scale, Fear of Negative Evaluation Scale

- Pulled out of other training for BBN session
- Evaluation of stress, self confidence

Mindfulness Session VS other reading by same voice

- 8-min SP encounter (laryngeal cancer) - SPs recorded perceived empathy

Post sim – evaluation of stress, self confidence , sense of empathy for the patient

Rating of residents who did mindfulness session was higher by evaluators

Teaching Death Disclosure: A Mixed-Method Comparison of Resident Self-Assessment and Standardized Patient Assessment

Focus on death of a child

Didactic with explanation of personal experience

Review of video with key concepts in death disclosure

SP scenarios [performed global rating and written feedback]

Small group debriefing

Panel of parents who experienced loss of a child

Autopsy lecture

Panel discussion on spirituality and physician self care

Resident self-evaluation

Teaching Death Disclosure: A Mixed-Method Comparison of Resident Self-Assessment and Standardized Patient Assessment

SP feedback to residents provided

Great examples of language and attention for care

What are patients and carers looking for in the OSCE?

Simple / short paper that captures the patient voice from the OSCE

Patient/carer focused. “Be flexible. Don’t stick to your own agenda or you’ll miss important information from the patient or carer. Students need to remember we have the information they need.” Julie Whittaker

Treat me as an individual. “Don’t make assumptions—other patients with my condition are not the same as me.” Joannie Tate

Establish the patient or carer’s knowledge of the problem. ‘“So what do you think could be happening?’ or ‘what are your thoughts?’ are good phrases to use—I’ve had a lot longer to think about my problem than you so ask me what I think.” Margaret Forth

Ask open questions and listen. “We know when you’re not listening, it shows on your face.” Margaret Forth

Provider-Patient Interaction: Exploring Elderspeak in Simulated Preclinical Chiropractic Student Encounters

Boomers are moving to retirement – and the millennials are taking over the workforce

Elderspeak: register of speech used with older adults

Specific characteristics defining elderspeak include the following:

- slow speech rate
- elevated pitch
- simplified vocabulary
- reduced grammatical complexity
- exaggerated intonation
- elevated volume
- repetition
- use of diminutives such as “hon and sweetie”

Provider-Patient Interaction: Exploring Elderspeak in Simulated Preclinical Chiropractic Student Encounters

Chiropractic students during encounters with SP

Extensive training of coders to recognize specific speech patterns:

Diminutives: modification of word or name to make small/short; childlike terms of endearment (e.g., hon, sweetie, granny).

Collective pronoun substitutions: using collective pronoun when singular pronoun is appropriate (e.g., "Should we eat our dinner now, Miss Lucy?" instead of "Can you eat your dinner today, Miss Lucy?").

Tag questions: posing a question in a way that shows a preferred response (e.g., "You're ready for a shower now, aren't you?").

Reflective: encouraging act to satisfy provider not the patient (e.g., "Take the Tylenol for me").

Provider-Patient Interaction: Exploring Elderspeak in Simulated Preclinical Chiropractic Student Encounters

Table 1. Elderspeak Occurrences in Simulated Preclinical Chiropractic Student Encounters ($n = 60$).

Category	Minimum	Maximum	No. of occurrences	Average occurrences per encounter
Diminutives	0	2	3	0.05
Collective pronoun usage	0	9	183 (137)[a]	3.05
Tag questions	0	6	60**	1.00
Reflective	0	6	85	1.42

[a]Forty six occurrences of collective pronoun usage might be attributed to students being trained to use the phrase "we" at the end of an encounter to emphasis how the patient and doctor will work together to find a solution.
**$p = .002$.

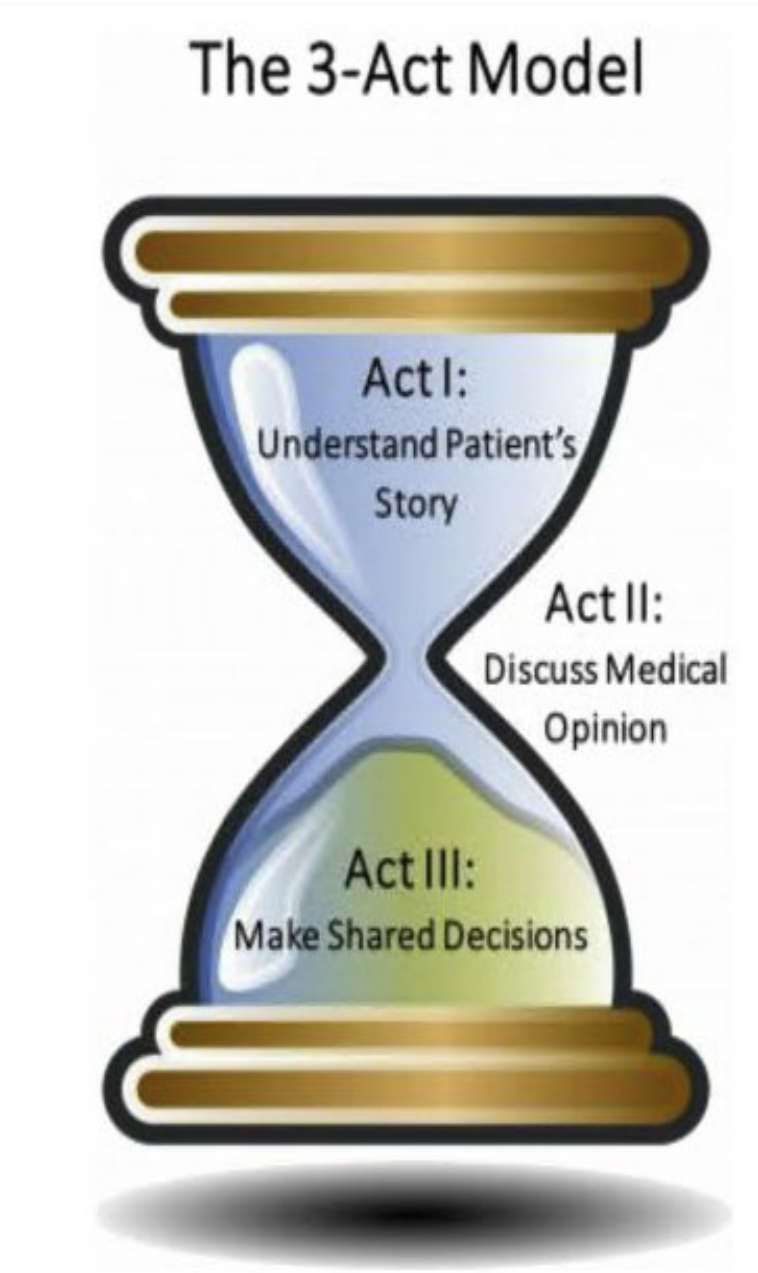
Annoying and potentially offensive to patients

Coders picked up on incidences of assumptions with patients

Area ripe for additional study

Impacting Practice


Expert
Performance in practice
Direct observation, workplace-based assessments
DOES
Demonstration
Simulations, OSCEs
SHOWS
Interpretation and application
Case presentations, essays
KNOWS HOW
Fact recall
MCQ assessments
KNOWS
Knowledge | Skills | Attitudes
Novice



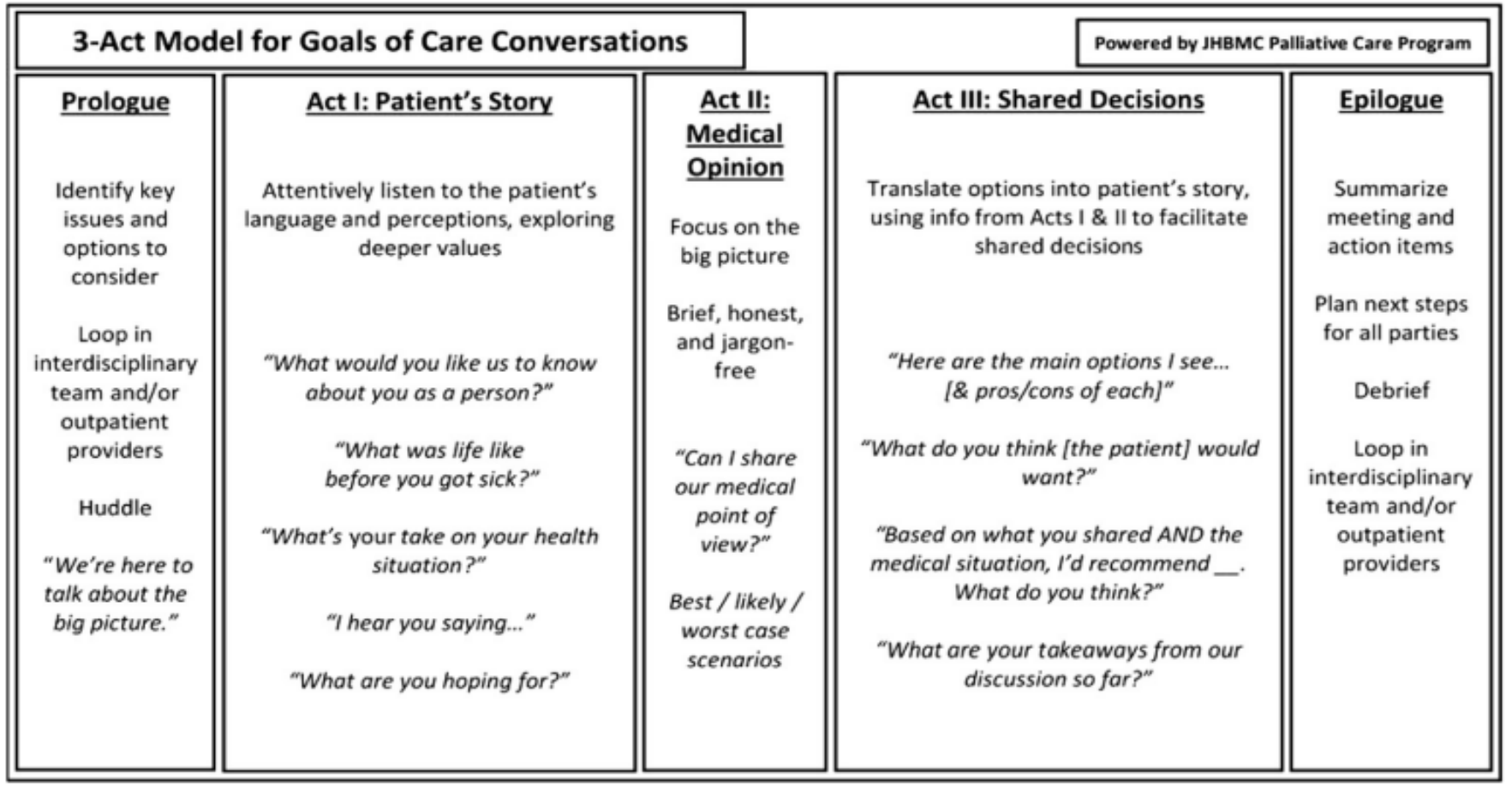
Narrative Approach to Goals of Care Discussions: Assessing the Use of the 3-Act Model in the Clinical Setting

Important discussion on goals of care

Not SPs per se, but structured role play in training

Monitor implementation by interns over time

Narrative Approach to Goals of Care Discussions: Assessing the Use of the 3-Act Model in the Clinical Setting



3-Act Model for Goals of Care Conversations

Powered by JHBMC Palliative Care Program

Prologue	Act I: Patient's Story	Act II: Medical Opinion	Act III: Shared Decisions	Epilogue
Identify key issues and options to consider Loop in interdisciplinary team and/or outpatient providers Huddle *"We're here to talk about the big picture."*	Attentively listen to the patient's language and perceptions, exploring deeper values *"What would you like us to know about you as a person?"* *"What was life like before you got sick?"* *"What's your take on your health situation?"* *"I hear you saying..."* *"What are you hoping for?"*	Focus on the big picture Brief, honest, and jargon-free *"Can I share our medical point of view?"* *Best / likely / worst case scenarios*	Translate options into patient's story, using info from Acts I & II to facilitate shared decisions *"Here are the main options I see... [& pros/cons of each]"* *"What do you think [the patient] would want?"* *"Based on what you shared AND the medical situation, I'd recommend __. What do you think?"* *"What are your takeaways from our discussion so far?"*	Summarize meeting and action items Plan next steps for all parties Debrief Loop in interdisciplinary team and/or outpatient providers

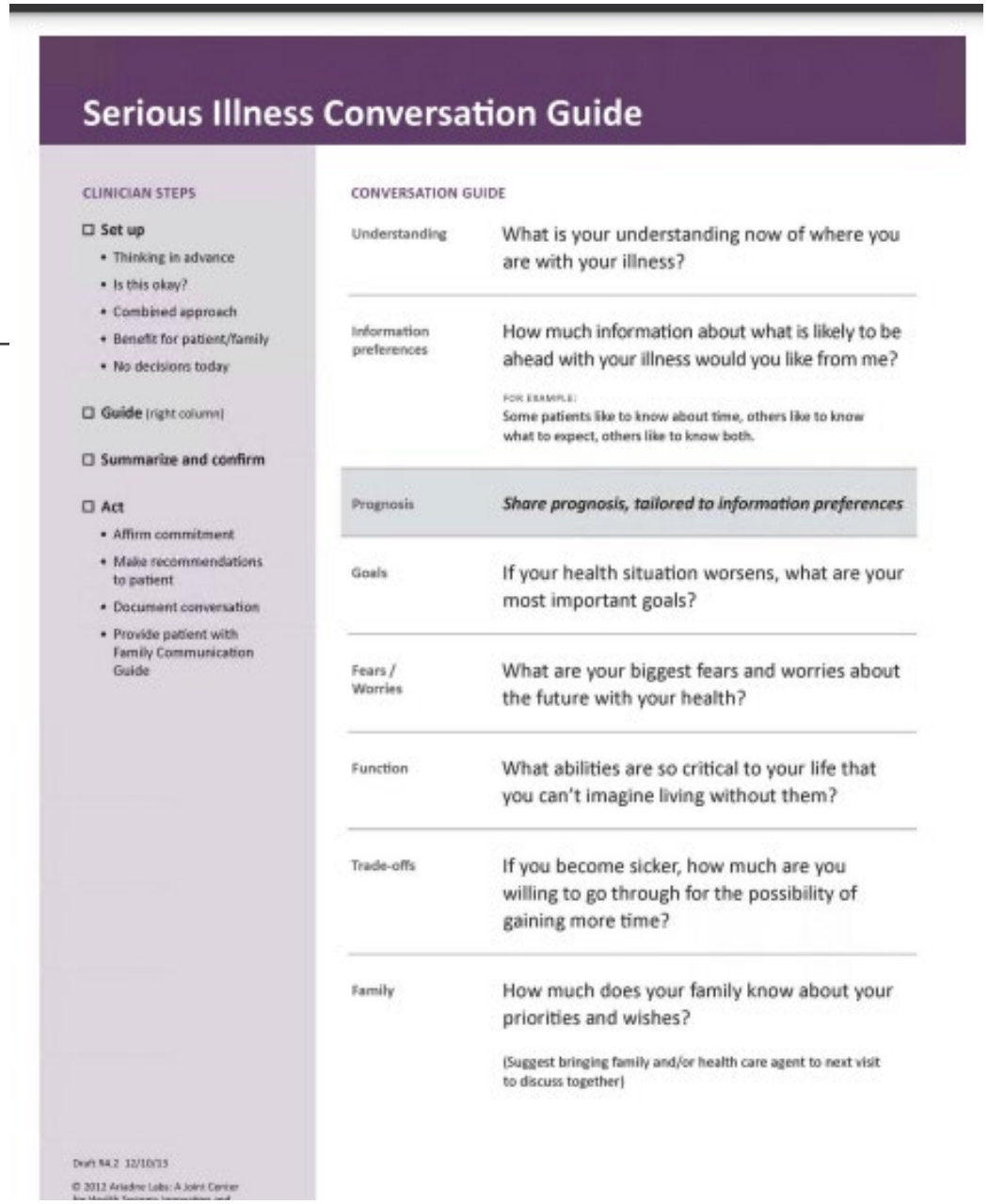
Implementation and Impact of a Serious Illness Communication Training for Hematology-Oncology Fellows

Training of heme-onc fellows on the use of the Serious Illness Conversation Guide

Application of skills with SP encounters (at month 1 and month 4)

Monitoring of actual clinical performance over the next 12 months

dotphrase use in EMR monitored



Serious Illness Conversation Guide

CLINICIAN STEPS

- ☐ **Set up**
  - Thinking in advance
  - Is this okay?
  - Combined approach
  - Benefit for patient/family
  - No decisions today
- ☐ **Guide** (right column)
- ☐ **Summarize and confirm**
- ☐ **Act**
  - Affirm commitment
  - Make recommendations to patient
  - Document conversation
  - Provide patient with Family Communication Guide

CONVERSATION GUIDE

Understanding	What is your understanding now of where you are with your illness?
Information preferences	How much information about what is likely to be ahead with your illness would you like from me? FOR EXAMPLE: Some patients like to know about time, others like to know what to expect, others like to know both.
Prognosis	***Share prognosis, tailored to information preferences***
Goals	If your health situation worsens, what are your most important goals?
Fears / Worries	What are your biggest fears and worries about the future with your health?
Function	What abilities are so critical to your life that you can't imagine living without them?
Trade-offs	If you become sicker, how much are you willing to go through for the possibility of gaining more time?
Family	How much does your family know about your priorities and wishes? (Suggest bringing family and/or health care agent to next visit to discuss together)

Draft 9A.2 12/10/13

Implementation and Impact of a Serious Illness Communication Training for Hematology-Oncology Fellows

Training was well received and improved confidence

Skills were learned (SP encounters)

BUT

Most conversations were happening without faculty present and were not documented

Template for documentation not known

Coaching of fellows was not optimal

How accurate is the medical record? A comparison of the physician's note with a concealed audio recording in unannounced standardized patient encounters

Documentation issues are not new

Prior studies show both over-documentation and under-documentation of important medical information

Unannounced SPs in private practice settings. Presentations as "moderately complex" (level 4)

-Asthma

-Pre-operative eval for hip replacement

-Diabetes and near syncope

-Weight loss

Why do we document?

- Maintain healthcare information longitudinally
- Share information with other providers
- Billing

How accurate is the medical record? A comparison of the physician's note with a concealed audio recording in unannounced standardized patient encounters

Selected data gathered from prior study

USPatient seen – audio-recorded visit – transcribed – compared to note

All new patients, so "copy paste" not an option ; no pre-visit patient template

Results represent 36 MDs, 105 encounters

10% - no documentation errors

636 documentation errors:

- 71% omission
- 28.5% commission

83% of errors were clinically significant

Verify transcript
Look for corresponding transcript information in note

- Medical error of omission
- Medical error of commission
- Inaccuracy

Consequential errors
related to chief complaint
related to other information without clinical significance

Impact of Unannounced Standardized Patient Audit and Feedback on Care, Documentation, and Costs: an Experiment and Claims Analysis

Also an unannounced SP study

Looked at

- ✓ Quality of care
- ✓ Fidelity of documentation
- ✓ Impact of reimbursement claims

Demonstrated that feedback to MDs can correct deficits in quality and documentation with subsequent impact on cost of care

Adapting to the Pandemic

Understanding crisis-response measures

Fuller R, et al Could COVID-19 be our "there is no alternative" (TINA) opportunity to enhance assessment Medical Teacher 2020

So Many Papers to Help Us in our Work!

Addressing the Rapidly Increasing Need for Telemedicine Education for Future Physicians Martinez L. PRIMER

Baccalaureate nursing students' experiences with multi-patient, standardized patient simulations using telehealth to collaborate Powers K Journal of Professional Nursing

Development and implementation of an e-visit objective structured clinical examination to evaluate student ability to provide care by telehealth Quinlin L Journal of the American Association of Nurse Practitioners

Building Telemedicine Capacity for Trainees During the Novel Coronavirus Outbreak: a Case Study and Lessons Learned Lawrence K. J Gen Intern Med

Death notification: a digital communication platform for simulated patient-based training with medical students. Hughes M. BMJ Simulation and Technology Enhanced Learning

Expanding Telehealth Competencies in Primary Care: A Longitudinal Interdisciplinary Simulation to Train Internal Medicine Residents in Complex Patient Care Wong R. Journal of Graduate Medical Education

Nurse Practitioner Student Perceptions of Face-to-Face and Telehealth Standardized Patient Simulations. Posey L Journal of Nursing Regulation.

Telehealth etiquette training: a guideline for preparing interprofessional teams for successful encounters. Gustin T. Nurse educator.

Evaluation of a telemedicine-based training for final-year medical students including simulated patient consultations, documentation, and case presentation Harendza S GMS Journal for Medical Education

A Novel Method of Assessing Clinical Preparedness for COVID-19 and Other Disasters

February 2020

Unannounced Standardized Patient – presents to the clinic feeling "unwell"

25 year old woman , fever, roommate just returned from Bejing

Assessment of care from the clinical system

- Isolation
- Masking / PPE
- Where told to wait
- Signage

Using Simulation to Teach Methods for Improving Patient Literacy about Medicines

Pharmacy students

Management of medications

Focus: counsel someone about use of medications

Previously assessment on site – now make a video " at home"

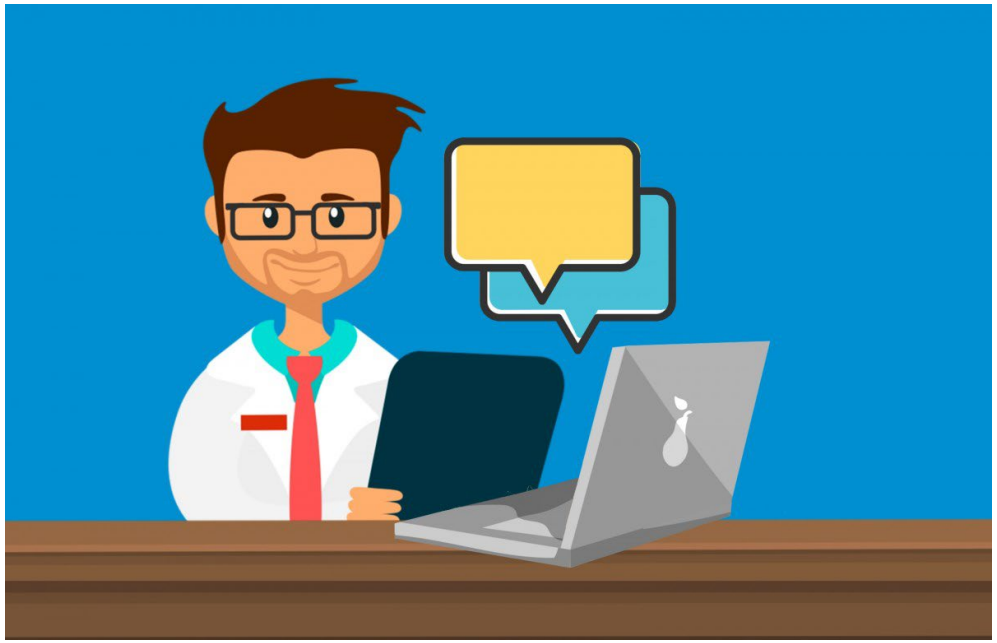
- Paper has a very good example of clear instructions/ expectations to learners

For a grade – but since this was a communication effectiveness (not content checklist) "cheating" or "redo" not an issue (give it your best!!)

BONUS OUTCOME:

Role players had opportunity to be trained on accurate medication use

The TeleHealth OSCE: Preparing Trainees to Use Telemedicine as a Tool for Transitions of Care



Work done in 2019

Internal Medicine Residents – simulation of a visit with patient who had recently been discharged

No formal training in telemedicine - Formative assessment

The TeleHealth OSCE: Preparing Trainees to Use Telemedicine as a Tool for Transition of Care

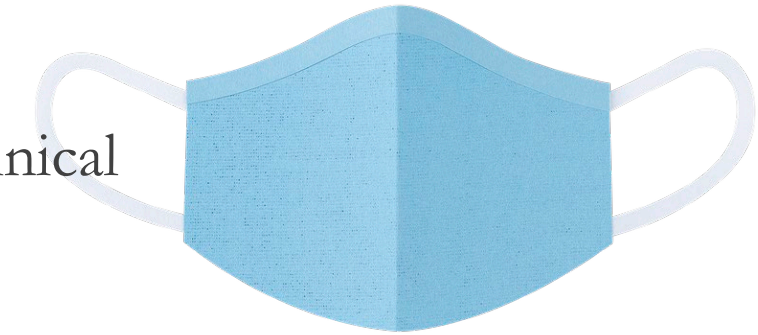
Telemedicine skills	Confirmed patient identifiers	9 (7)	86 (67)	5 (4)	46 (45)	Asked patient to confirm name/ date of birth, callback number, and location
	Used nonverbal communication to enrich communication on camera	0 (0)	6 (5)	94 (73)		Maintained eye contact with webcam throughout encounter, sat squarely in front of camera, and at appropriate distance
	Actively optimized technical aspects of the virtual encounter	76 (59)	20 (16)	4 (3)		Assessed sound quality, video quality, and backup plan if audio/video failed
	Exhibited comfort and confidence using video interface	0 (0)	10 (8)	90 (70)		Confident on camera, acknowledged and moved forward from technical glitches, and did not let video interface detract from natural conversation
	Utilized live video to augment information gathering	13 (10)	70 (55)	17 (13)		Attempted to do 2 or more: visually reconcile meds, witness reproducible symptoms, talk with onsite collateral, assess the home
	Partnered with patient to perform physical examination	82 (64)	6 (5)	12 (9)		Asked patient to perform maneuvers or access peripheral monitoring device (home blood pressure cuff, FitBit/apple watch, glucometer), followed by verbal confirmation of findings
	Maintained appropriate computer etiquette during encounter	1 (1)	0 (0)	99 (77)		Paused video or provided clear explanation while documenting, searching another website, or having another screen open for the purpose of patient care

Conducting a high-stakes OSCE in a COVID-19 environment

Paper is a thorough and practical description of how the final year OSCE was administered early in the pandemic

Students / examiners / SPs placed into cohorts – no mingling with people of other groups.

Strict hygiene protocols.



No change to the OSCE blueprint - both SP encounters and clinical skills / tasks

Were able to examine the full cohort of students

Delivering a geriatric OSCE station in times of Covid-19 using makeup artistry

Authors recognized the special risk to persons > 65 years old

OSCE (live) with social distancing and face cover.

No available older SPs

Make-up and wigs used to “age” 4 SPs in their 50s

Feedback from OSCE participants – no specific comments on realism

Feedback from the SPs – adoption of role, importance of wigs, nice to go back to “young” without makeup.

"BS" wearing no makeup (including personal makeup). Photo: BS

"BS" wearing a wig, forehead wrinkles, stippled crow's feet and with age spots added. Photo: AUM

"GA" during make-up removal. The partly peeled off Probondo transfer reveals significantly younger skin. Photo: AUM

SP safety is so important!!

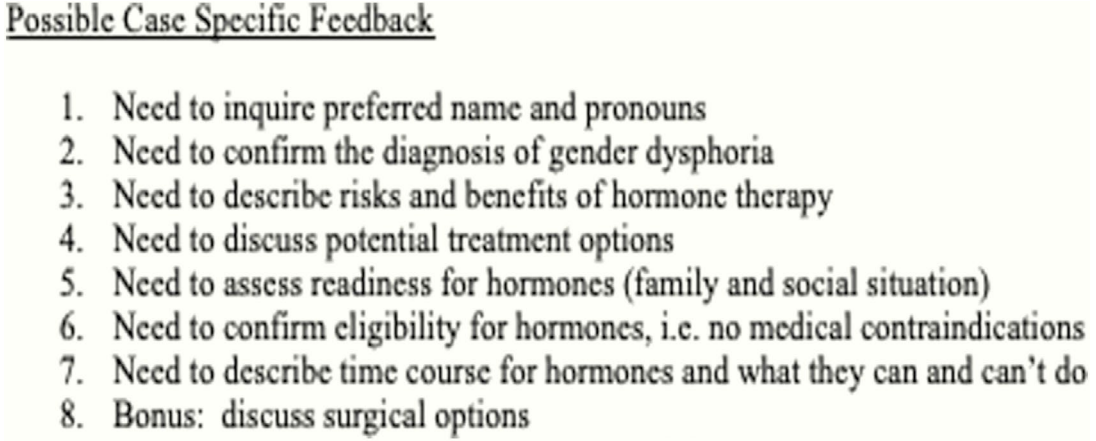
Special Populations

Use of Standardized Patients in Endocrinology Fellowship Programs to Teach Competent Transgender Care

Application of SP methodology to teach and assess skills in the care of transgender individuals by endocrinology fellows

Core ACGME skills assessed:

- Medical Knowledge
- Patient Care
- Professionalism
- Interpersonal and Communication Skills



Possible Case Specific Feedback

1. Need to inquire preferred name and pronouns
2. Need to confirm the diagnosis of gender dysphoria
3. Need to describe risks and benefits of hormone therapy
4. Need to discuss potential treatment options
5. Need to assess readiness for hormones (family and social situation)
6. Need to confirm eligibility for hormones, i.e. no medical contraindications
7. Need to describe time course for hormones and what they can and can't do
8. Bonus: discuss surgical options

Use of Standardized Patients in Endocrinology Fellowship Programs to Teach Competent Transgender Care

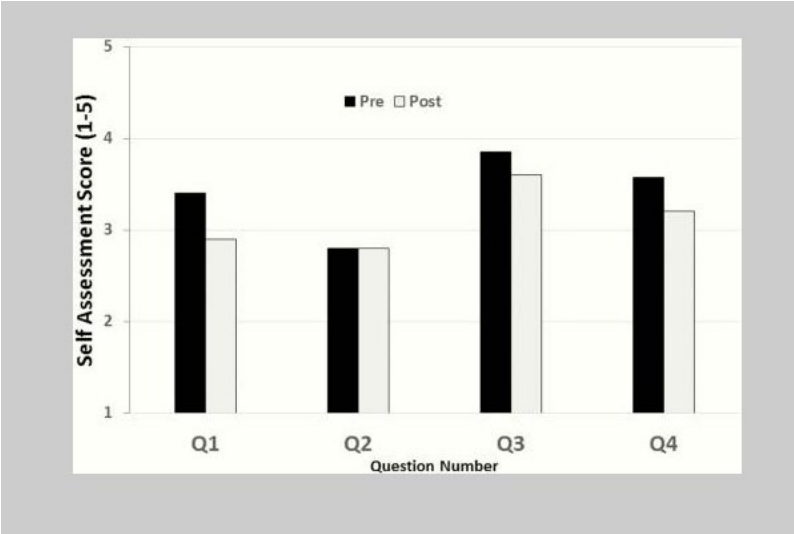
Small study

A great feature of this paper is the outline of the patient story

Grouping skills for feedback by ACGME competencies

Interesting outcome:
Pre-post self assessments by the fellows declined

Suggests that fellows were unaware of limitations in their skills



Fellows were asked to rate their comfort level on a Likert scale (1–5) (1 = poor, 5 = outstanding)
Q1: Ability to provide compassionate, appropriate, and effective treatment and management of transgender patients;
Q2: Medical knowledge regarding the endocrine treatment of transgender patients
Q3: Communication skills with transgender patients in a medical/clinical situation
Q4: Understanding and sensitivity to the needs of transgender patients.

The influence of the oncology-focused transgender-simulated patient simulation on nursing students' cultural competence development

Presentation of patient oncological emergency : transwoman SP

Breast cancer / hypercalcemia

Goal for the student:

- evaluation of patient recognize signs and symptoms of emergency
- familiarize students with hypercalcemia management
- recognize cultural background, concerns, anxiety and emotional status

Specific training on cultural awareness / humility / congruence in health care

Using an OSCE to assess the potential for assistive technology to enhance communication between student pharmacists and simulated patients who are deaf/hard of hearing

Interaction by pharmacy student with SP portraying patient who is deaf/hard of hearing

Use of a free APP to enhance communication

Opportunity to increase skills with the APP and increase skill and confidence in interacting with hearing impaired patient

Limitation: SPs were theatre students with no hearing impairment

Unique Approaches

A New Paradigm for Testing Clinical Competence in Chaplaincy Certification

Description of a new Spiritual Care Association certification system

criteria for evaluating clinical competence:

(a) The process should test an evidence-based set of competencies.

(b) The process should have demonstrable validity and reliability.

(c) The process should be capable of directly observing chaplains in clinical practice.

(d) The process should be reliably scorable based on behavioral criteria.

(e) The process should minimize cost and be as efficient as possible.

Video encounter with an SP followed by charting. Encounter reviewed by 2 raters

A New Paradigm for Testing Clinical Competence in Chaplaincy Certification

Setting the bar for the examiners:

Does the chaplain exhibit an evident sense of deep caring for the patient or caregiver's human predicament?

Is this attitude clearly therapeutic in the sense of effecting a relationship where the person feels accepted and understood by the chaplain?

Does the engagement contribute to the person(s) having a greater sense of comfort, acceptance—even for the unacceptable; connected to self and others, and even a sense of wellness, wisdom and peace?

Finally, does the chaplain use his/her clinical acuity in a caring way to move some or all these goals forward?

Corporate leadership training: Value added for your simulation center

Corporate business mid-level managers

Scenarios on common workplace dilemmas

Incorporates communications tools from TeamSTEPPS

Two more very interesting papers

Effects of using standardized patients on nursing students' moral skills

Kucukkelepce GE
Nursing Ethics
Turkey

Predictors of medical students' ethical decision-making: A pilot study using the Theory of Interpersonal Behavior

Li H.
Patient Education and Counseling
China & USA

Scoring and Checklists

Entrustment with an objective structured clinical examination (OSCE) progress test: Bridging the gap towards competency-based medical education

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Competency based medical education (CBME) is a topic of current interest in medical education

Faculty development on the concept of entrustment is essential

Study explored use of an entrustability scale within the context of a formative exam

Rating Instruments:

Case specific checklists (done / not done)

6 point global scale

5 point training rating scale

Entrustment scale

Entrustment with an objective structured clinical examination (OSCE) progress test: Bridging the gap towards competency-based medical education

Global rating of candidate performance (rated at the level of a fourth year resident)

Unsatisfactory			Satisfactory		
Inferior	Poor	Borderline	Borderline	Good	Excellent

In your opinion, this resident is functioning at the level of a:

Medical Student	PGY-1	PGY-2	PGY-3	PGY-4

In your opinion, if faced with a similar case in the clinical setting, how would you rate this candidate's performance

I would need to do	I would need to talk them through	I would need to prompt from time to time	Would need to be there just in case	I would not need to be there
Would require complete hands on guidance	Would be able to perform tasks but would require constant direction	Would demonstrate some independence, but would require intermittent direction	Independent but unaware of risks and still requires supervision for safe practice	Complete independence understands risks and performs safely practice ready

Entrustment rating in a formative exam = "assessment for learning"

The role of training in student examiner rating performance in a student-led mock OSCE

Formative OSCE for Year 2 students

- Examiners:
  - Year 5 students paired with:
  - Year 3 students (with training) <or>
  - Year 3 students (without formal training)

After completing the checklist, Yr 5 and Yr 3 **give feedback** to Yr 2 together

Feasibility study – good correlation between Yr 5 and Yr 3

Describes the importance of training raters

Examiners' Perceptions in Surgical Education: The Blind Spot in the Assessment of OSCEs

Examiner scores impacted by:

- Examiner expertise
- Read information about exam
- Knowledge of the student
- Number of students examined
- Professional position of examiner
- Time of day
- Interpretation of scoring schema

Physical examination station (10 min)

Variable content

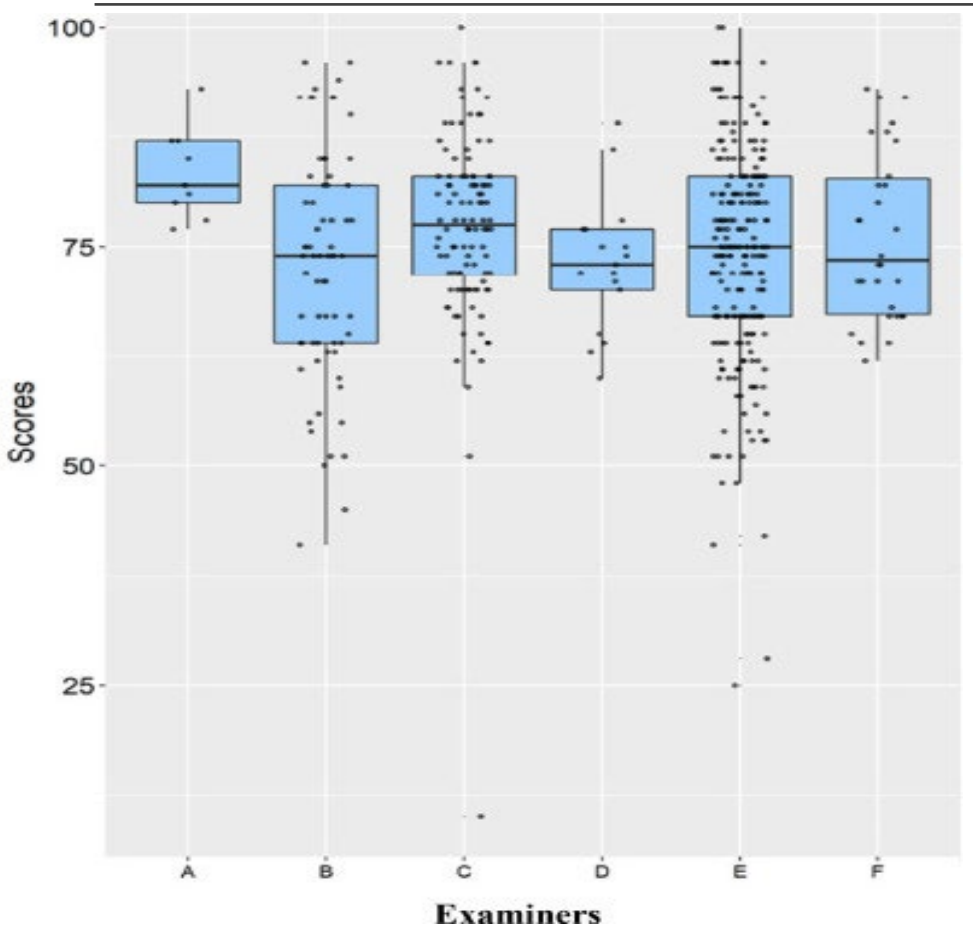
General checklist (communication skills)

Activity specific checklist (maneuvers done correctly)

Study looks at score distributions

Semi-structured interviews of the examiners

Examiners' Perceptions in Surgical Education: The Blind Spot in the Assessment of OSCEs



Variable	Result
Aim of OSCEs	To prepare students for surgery clerkship and to motivate them to read the course materials
Task of examiners	To provide suggestions and give advice to the students in order for them to learn. Differences were found regarding how examiners interpret the assessment form (rubric).
Content of OSCEs	Three of the six examiners mentioned that some content or tests when examining a patient are outdated, proven unreliable, or not useful.
	All examiners in this study mentioned that they enjoy their role as examiner and taking part in education. Although education is felt to be important by the participants, at the same time the participants perceive it as a 'compulsory' part of their job.

Assessing Advanced Communication Skills via Objective Structured Clinical Examination: A Comparison of Faculty Versus Self, Peer, and Standardized Patient Assessor

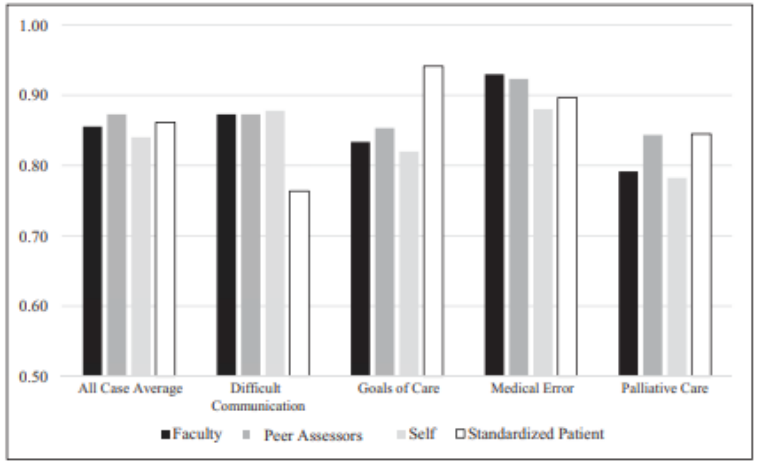
Comparison of scores on an advanced communication skills assessment

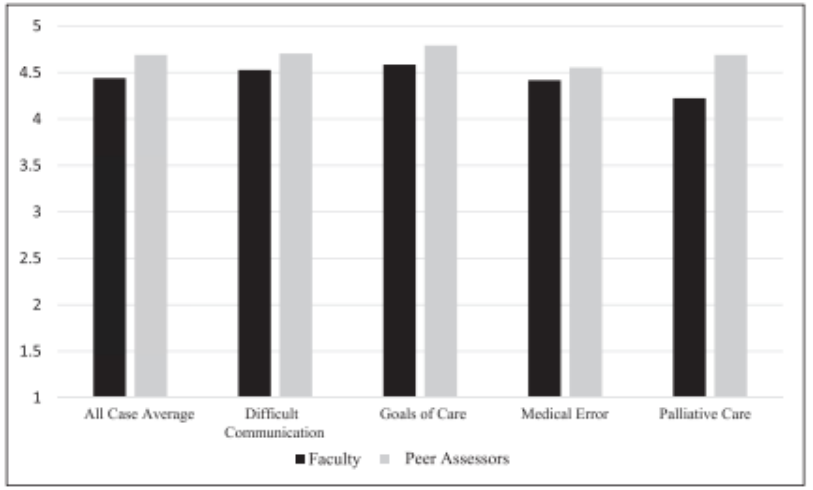
Part of transition to residency course

- Communication behavior checklist
- Modified Master Interview Rating Scale

Scored by:

- Student self assessment
- Peer assessment
- SP
- Faculty





Modified MIRS[a] mean scores (n = 45).

How clinician examiners compare with simulated patients in assessing medical student empathy in a clinical exam setting

CARE form used in assessment of empathy

Students participate in encounter with SP

CARE completed by both SP and Faculty

Faculty also completed content checklist

How was the doctor at …	Poor	Fair	Good	Very Good	Excellent	Does Not Apply
1. Making you feel at ease…… *(being friendly and warm towards you, treating you with respect; not cold or abrupt)*	☐	☐	☐	☐	☐	☐
2. Letting you tell your " story"…… *(giving you time to fully describe your illness in your own words; not interrupting or diverting you)*	☐	☐	☐	☐	☐	☐
3. Really listening …… *(paying close attention to what you were sayings; not looking at the notes or computer as you were talking)*	☐	☐	☐	☐	☐	☐
4. Being interested in you as a whole person … *(asking/knowing relevant details about your life, your situation; not treating you as "just a number")*	☐	☐	☐	☐	☐	☐
5. Fully understanding your concerns…… *(communicating that he/she had accurately understood your concerns; not overlooking or dismissing anything)*	☐	☐	☐	☐	☐	☐
6. Showing care and compassion…. *(seeming genuinely concerned, connecting with you on a human level; not being indifferent or "detached")*	☐	☐	☐	☐	☐	☐
7 . Being Positive…… *(having a positive approach and a positive attitude; being honest but not negative about your problems)*	☐	☐	☐	☐	☐	☐
8. Explaining things clearly…….. *(fully answering your questions, explaining clearly, giving you adequate information; not being vague*	☐	☐	☐	☐	☐	☐
9. Helping you to take control…… *(exploring with you what you can do to improve your health yourself; encouraging rather than "lecturing" you)*	☐	☐	☐	☐	☐	☐
10. Making a plan of action with you … *(discussing the options, involving you in decisions as much as you want to be involved; not ignoring your views)*	☐	☐	☐	☐	☐	☐

How clinician examiners compare with simulated patients in assessing medical student empathy in a clinical exam setting

SPs higher than faculty

Moderate correlation btwn SP and Faculty CARE

- Female SP- gave highest ratings
- Female students – rated higher than male by faculty

1. Making you feel at ease
2. Letting you tell your "story"
3. Really listening
4. Being interested in you as a whole person
5. Fully understanding your concern
6. Showing care and compassion
7. Being positive
8. Explaining things clearly
9. Helping you to take control
10. Making a plan of action with you.

A Focus on SPs

Gender Minorities in Simulation: A Mixed Methods Study of Medical School Standardized Patient Programs in the United States and Canada

LGBTQ health content is not well represented in medical school curricula

Gender minorities have poorest health outcomes

Focus of the work: looking at how US and Canadian medical schools consider GM when developing / implementing patient simulations

- how are GM patients portrayed

- are GM persons employed as SPs

- general experiences with GM simulation

Gender Minorities in Simulation: A Mixed Methods Study of Medical School Standardized Patient Programs in the United States and Canada

Survey to 208 medical schools

- response 59 (28%)

Portrayals:

Neither GM or SM identities portrayed 10.2%

GM patients portrayed 52.5%

SM patients portrayed 89.8%

Casting:

GM roles: both GM and cisgender SPs 54.8%

SM roles: both SM and heterosexual SPs 90.6%

Follow up interviews with 24 programs

Themes:

- Catalyst for scenarios
  - Need for curriculum and representation
- Case development practices
  - Include GM community in case development
- Impact on learners, SPs, med schools, community
  - Predominantly positive
- Roadblocks
  - Curriculum time
  - Casting
  - Respect for persons
  - Bias

Perspectives of Transgender and Genderqueer Standardized Patients

Another "must read" to gain insight into the experiences of GM patients

Semi-structured focus groups with 10 GM SPs

- Experience and perception of portraying a patient seeking gender affirming care

- THEMES:
  - Personal Connection
  - Identifying gaps in care
  - Insights into medical education

Listening to young voices: The lived experiences of adolescent simulated patients in health professional education

Adolescents are a unique groups of people and have much to contribute as SPs

Semi-structured interviews with adolescent SPs

- Recruiting and maintaining adolescent's involvement
- Investing in preparation
- Finding the adolescent voice in the story
- Feeling adequately supported
- Experiencing the giving and receiving of feedback

A second article : Power and adolescent simulated patients: A qualitative exploration

Interpreting the value of feedback: Older adult voices in nursing education

Residential home for mature adults

Assisted living and higher levels of care

Has area for simulation

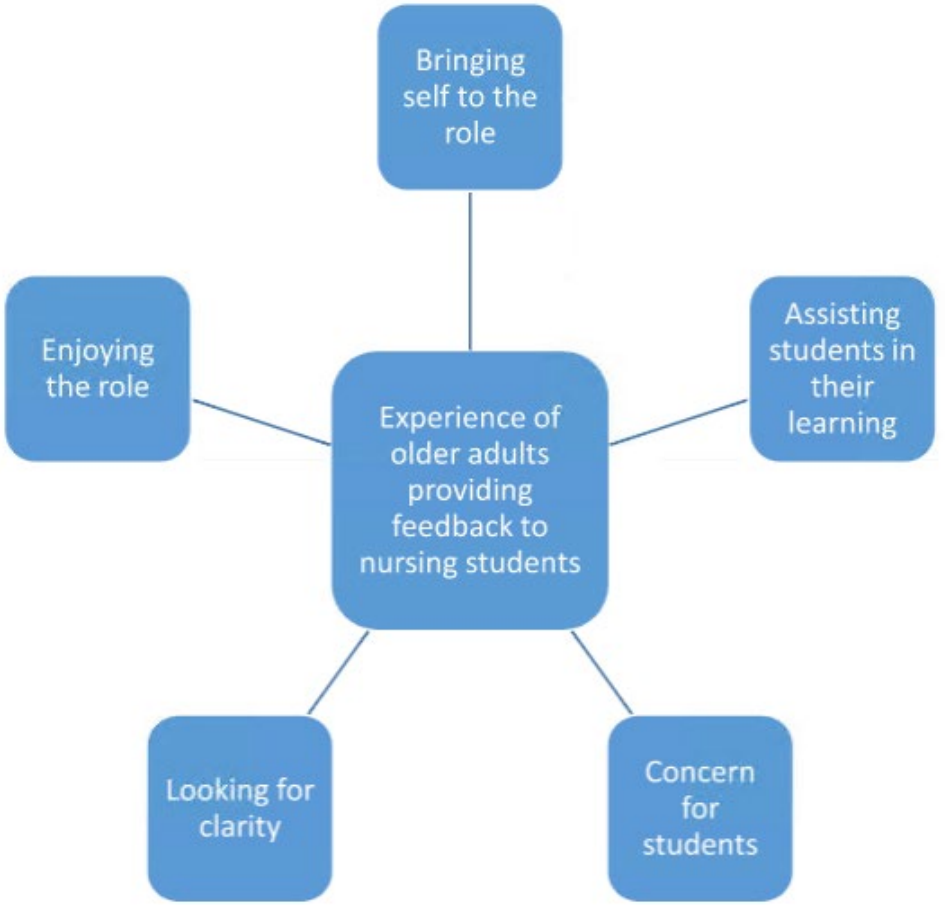
Learners: student nurses

Participants: 60-89 years old

direct observation of student -pt interactions

Audio recordings and transcriptions

One on one semi-structured interviews



How Do Standardized Patients Form Their Complex Identities? The Impact of Interactions With Medical Students

Qualitative study that looks at the identify formation of SPs

Semi structured interviews with SPs (n=18)

Themes:

- Identify transformation towards a new professional identity
- Self actualization toward their maximum potential
- Judgmental reactions to medical student behaviors
- Simulation –reality interactions between simulated and real selves

Theme—SPs Experienced:	Actions for SP Educators
***Identity transformation* toward a new professional identity**	• Reinforce the social good of the SP role to recruit, motivate and prevent burn-out • Provide new SPs with experienced SP narratives (face-to-face, video) that role model their developmental journey and expected future identity formation • Provide SPs with instruction on performance and boundaries in their roles as coach, supporter, and "parent"
***Self-actualization* toward their maximum potential**	• Provide experienced SPs opportunities to engage in peer teaching • Provide certificates of appreciation and awards for SPs • Provide SPs with opportunities to share their positive experiences (success stories) with peers; consider doing so using appreciative inquiry
***Judgmental reactions* —to medical student behaviors**	• Provide anti-bias workshops • Provide training sessions on dealing with negative emotions (using simulations with standardized students) • Provide opportunities for SPs to debrief on their experiences before leaving for the day (with emotional support) • Provide safe mechanisms for SPs to report negative student behavior

***Simulation-reality interaction* between their simulated and real selves**	• Screen SPs for role appropriateness to prevent case-SP mismatch: may strain SPs' ability to sustain their simulations, resulting in case portrayal contamination from the SP's real self • Provide enough case details for SPs to make informed decisions about accepting a case • Provide opportunities to discuss and debrief challenging cases where SPs find it difficult to separate their personal and simulated selves • Provide SP training to successfully implement programmatically useful channels for expression of the SP personal voice—eg, in giving feedback • Provide psycho/social/emotional support for SPs portraying challenging roles to help them manage their emotional distress, preventing it from intruding into the simulation • Provide program policies to prevent negative consequences from SP-student boundary crossings—eg, a "no learner-SP dating policy"

"It's Not an Acting Job Don't Underestimate What a Simulated Patient Does": A Qualitative Study Exploring the Perspectives of Simulated Patients in Health Professions Education

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Focus groups with SPs to explore experiences, perspectives and practices of SPs

Becoming and Being an SP

- Identity
- Attributes
- Impacts

Preparing for the SP role

- Developing the character
- Understanding the Learning Context
- Considering the health Issue

Performing an SP role

- Getting into character
- Navigating unpreparedness
- Navigating Challenges and Constraints
- Getting out or character

Discussion with Reflection on the ASPE Standards of Best Practice

Thank you for joining this session

ASPE Scholars Certificate

- ASPE Scholar Certificate **criteria**: https://www.aspeducators.org/scholars-certificate-program
- To **document your attendance** at G&R Courses toward the Scholars Certificate:

https://docs.google.com/forms/d/e/1FAIpQLSe9crwdDJXjVPxntU_h43d_p0bWysJMWTJVT9dQQje_JCUziA/viewform?usp=sf_link

If you have any difficulty accessing the form, G&R Chair, Jane Lindsay Miller, can send a direct invitation:

jane-l-miller@uiowa.edu (jane L miller)