SP CASE WRITING WORKING GROUP MATERIALS

Agenda

Meeting	Case Development – [Chief Complaint]
Date	
Time	
Location	
Attendees	
Facilitator	

		Item
1.	1:30 pm	Introduction
2.	1:45 pm	Discussion of possible case scenarios
3.	2:30 pm	Finalize the case scenario
4.	3:00 pm	Break
5.	3:10 pm	Complete the SP case template with the SP Facilitator
6.	4:00 pm	Develop a checklist for the case
7.	4:40 pm	Write an exemplar note for the developed and finalized case
8.	4:55 pm	Wrap Up
9.	5:00 pm	End

Case Development Instructions: Chest Pain

1. Case Development

You will be developing a standardized patient case scenario for a fourth-year medical student exam. The presenting chief complaint is chest pain and the final diagnosis is a myocardial infarction. Please design a case where the initial presenting complaint would elicit a differential of:

1. Myocardial infarction
2. Pulmonary embolism
3. Aortic dissection

The differential does not need to remain active through the end of the case. The student will ask questions to discard potential diagnoses as they progress through the case. After the discussion, please finalize the case scenario and complete the standardized patient case template provided.

Chief Complaint	Differential	Final Diagnoses	Demographics
Chest Pain	Myocardial infarction Pulmonary embolism Aortic dissection	Myocardial infarction	55 to 60 year old female

Objectives:

Assess the student's ability:

1. To conduct a focused history and physical exam
2. To interpret the findings to reach a working differential diagnosis
3. Relate to the patient in a professional patient-centered manner during the encounter
4. Synthesize their findings in a chart note following the encounter

SP Case Scenario Development Worksheet

Please think about patients you have seen who have elicited this differential and briefly describe them here.

1. Chief Complaint: Chest Pain
2. Differential:
    a. Aortic Dissection
    b. **Myocardial infarction**
    c. Pulmonary embolism
3. History of Present Illness

4. Relevant Physical Exam Findings

5. Other Relevant Factors

6. Personality characteristics of the Patient

Final SP Case Scenario Summary

After the group discussion of past cases, please choose one and develop a final scenario for the case.

Final SP Case Scenario Summary

1. Chief Complaint: Chest Pain

2. History of Present Illness

3. Relevant Physical Findings

4. Other Relevant Factors

5. Personality characteristics of the Patient

Checklist Development Worksheet

Please develop a checklist of history and physical exam items that are specific to this patient case. **The case checklist may not exceed a sum total of 15 items**; it may include one or two relevant items related to closing the encounter and next steps. The SP will also be completing our standard communication and interpersonal rating scale (please see attached).

	Student Action	SP Response
Example	***"Where does it hurt?"***	***Points to LUQ***
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		
11		
12		
13		
14		
15		

Exemplar Note Template

Faculty: Please write a "gold standard" exemplar note to be used when grading the student's note. Please highlight the key positive and negative findings. Note – you must follow the template below, which is formatted per the USMLE Step 2 CS.

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1. ***History: "****Describe the history you just obtained from this patient. Include only pertinent positives and negatives relevant to this patient's problem. Include CC and HPI that incorporates any relevant aspects of patient's medical history."*

2. ***Physical Exam:*** *"Describe any pertinent positive or negative PE findings that you elicited relevant to this patient's problems. Include VS from the chart."*

3. ***Data Interpretation****: "Based on what you have learned from the history and PE, list up to 3 diagnoses that might explain this patient's complaints. Do not list diagnoses that you have already ruled out. List your diagnoses from most to least likely. For some cases, fewer than 3 diagnoses will be appropriate. Then, enter the positive and negative findings from the history and PE (if present) that <u>support</u> each diagnosis. Do not include what you would or should have done if you forgot to do it, nor include something you did not do. There is no need to list history and PE findings that help refute a diagnosis."*

Diagnosis 1: _____

Supporting History Findings of This Patient	Supporting PE Findings of This Patient

Diagnosis 2: _____

Supporting History Findings of This Patient	Supporting PE Findings of This Patient

Diagnosis 3: _____

Supporting History Findings of This Patient	Supporting PE Findings of This Patient

4. ***Diagnostic Studies****: "List initial diagnostic studies (if any) you would order for this patient. Max 5."*