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PERSPECTIVE

THE STANDARDIZED PATIENT WILL SEE YOU NOW

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"How were you hoping I would feel as your patient?"

This was the first question I asked a first-year medical student after her simulated patient encounter. As a standardized patient (SP), it was my job to act out a healthcare scenario and facilitate a conversation about it with the medical student afterwards. As we talked about the encounter, I was taking my own notes because now, two years later, I am the first-year medical student in "Mock Exam Room A."

SPs were first incorporated into medical education in the 1960s when Dr. Howard S. Barrows, a neurologist at the University of Southern California, sought a way to expose his students to a wide variety of patients.[1] Since then, it has become a broad tool that teaches clinical reasoning, and general communication skills.[2] SPs have become an integral part of medical education; it is even part the United States Medical Licensing Exam.[3] SPs, who are often working actors, perform simulated activities that allow trainees the opportunity to practice communication and clinical skills in a safe, lower stakes environment. My time as an SP gave me the unique chance to think purposefully about what I would do differently. My most valuable lessons, however, came from the experience of being the patient in these encounters.

As an SP, I had to portray different illnesses and patient personalities. That part of the job was no different than any acting experience. What was unique was keeping track of your feelings and why you were feeling them. If I reacted to something a student said, it was my job to make note of it and discuss it with them later. Each encounter was unique and I got the sense that the medical students were often uncomfortable with the unpredictability.

Talking with a stranger can be difficult, but we can learn to embrace it. Part of being an actor is meeting new people and being in unfamiliar situations. I learned through constant practice how to meet and quickly form a bond with others. In medicine, this communication has greater importance. Doctors need to be able to create trust *immediately*. The challenge is to take first-year medical students and make them comfortable talking with a stranger about personal issues.

In medical school, we are taught methods of communication from journal articles and given checklists for discussing difficult topics. Following these checklists provides a roadmap for a situation, but they can't account for the lived experience of an individual. A person may react unexpectedly to a simple question. What do you use as a guide when the methods and checklists fall apart?

There was one encounter I performed frequently as an SP. The premise was this: discuss smoking cessation with a married 28-year-old male with a 10 pack-year history. I portrayed the 28-year-old, who was being seen for an annual physical. The patient was currently healthy but the medical student was charged with discussing smoking cessation. After a few weeks, I knew how the encounter typically went and I had formulated what I felt was the correct way for the medical student to handle the situation. I imagined being a medical student and decided I would know the right questions to ask, I would be very good at dealing with this sensitive topic. Then a first-year student came in, she was bubbly and kind but very disorganized. She initially asked about smoking, but quickly backed off after I resisted a little. She then began to ask questions about my life. While she was making a connection, she was not hitting any of the key topics of the case and had not collected the pertinent information about my condition. She was using up a lot of her time asking questions about my fictitious wedding. I was concerned she was going to have issues with time management.

I just got married as well," she said.
"Congrats," I replied.
"Are you thinking about kids?"
"Maybe, but not right now."
"Your wife smokes as well, right?"

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"Yes." I said, taking a mental note that I should score her higher on the *Understood the impact of my condition on my life* section.
"She would probably have to quit smoking if you ever decided to have kids."
"I guess so," I said.
"Would you let her quit on her own?" She stared at me. "I think couples can really help each other. If you quit smoking, it might make it easier for her when it came time to start having kids."

Her approach was manipulative; but, combined with her personality, it was effective. I don't know how she scored on her documentation or what her physician-educators told her, but I scored her very highly. She made me feel like I was a friend. She sat down with me, a stranger, and had an honest conversation.

Checklists and interview tools provide a framework for discussion and can help new learners develop their communication skills.[4] Simultaneously, it is important to keep in mind how we want our patients to feel. It holds us accountable to them as humans, rather than just clients, and gives us a goal to aim for. While there is a desire to move medicine towards standardization and checklists,[5] we have to remember that our well-validated methods are most effective when they help us make a human connection. Checklists can build a strong foundation, but they are made stronger when we can use them, not just follow them.

How do I hope people will feel as my patient?

I want them to feel heard; I want them to feel ownership. I want to never stop learning how to better answer that question.

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