Appendix A. Clinical Case Scenario Standardized Script

Case Information Provided to Resident (via electronic triage module of Emergency Department Electronic Health Record)

Chief Complaint: Headache

55 year old male with headache after hit in head with softball

Vitals: Heart Rate 77, Blood Pressure 134/78, Respiratory Rate 14

Patient History Script for Patient Role Player

Chief Complaint: My head hurts

Demographics: 55-year-old male

History of Present Illness: I was playing softball and got hit in the left side of the head with a fastball pitch. I was able to run to first base, but have since been feeling dizzy and have a headache. I vomited twice. No vision change. No motor or sensory symptoms. Walking normally. I was not wearing a helmet. I did not fall and have no pain in any other body part.

My head 'aches' on the left side where the pitch hit me. No radiation of pain. Severity 5/10. No medications tried. No neck pain.

Past Medical History: Hypertension
Atrial Fibrillation

Past Surgical History: none

Medications: Aspirin 81 mg by mouth daily

Hydrochlorothiazide 25 mg by mouth daily

Coumadin 5 mg by mouth nightly (last International Normalized Ratio checked last week was 2.4)

Allergies:	Morphine → hives	
Social History:	Family:	married with 2 kids
	Work:	Investment banker
	Hobbies:	Playing on work softball team
	No smoking; occasional alcohol use, no drugs	

Note: Participant questions that are not specifically addressed in this script, will be answered with "I don't know"

Physical Exam:

Vital signs: Temperature 98.7 F, Heart Rate 77, Blood Pressure 134/78, Respiratory Rate 14, Oxygen saturation 99% on room air

General:	alert, oriented, no distress, comfortable
Head:	patient wearing baseball cap – if removed, hematoma over left temporal scalp (no laceration)
	No battle signs
Eyes, Ears, Nose, Throat:	normal, pupils normal
Neck:	no midline tenderness to palpation, no step-offs
	Full range of motion
Chest:	no signs of external trauma

Irregularly, irregular; s1 and s2 heart sounds present, no murmurs, rubs or gallops

[*Note: If resident auscultates heart or checks pulses, informed heart is irregular*]

Lungs: clear to auscultation bilaterally

Abdomen: soft, non-tender

Extremity: full range of motion in all 4 extremities

No lower extremity edema

Neurological:

- Mental Status: awake, alert, and oriented to person, place and time
- Cranial Nerves: II-XII grossly intact
- Strength: 5/5 throughout
- Sensation: gross touch intact
- Cerebellar: finger to nose and rapid alternating movements normal
- Reflexes: normal
- Gait: normal

Laboratory and Imaging Results

1. Complete blood count and Coagulation factors → international normalized ratio (INR) 2.5
2. Type and Screen, Chemistry panel → within normal limits
3. Head Computed Tomography (CT) (headache, anticoagulant use, blunt trauma) → no bleed, mass, shift
4. No facial or cervical-spine CT needed -- clearance by National Emergency X-Radiography Utilization Study (NEXUS)[33] or Canadian cervical-spine rule[34]
5. Other tests ordered by resident will return within normal limits

[INTERRUPTION – When the participant *first begins typing text into the assessment and plan section of the provider documentation*, the participant will be asked by a nurse/technician to

review an electrocardiogram (ECG) for another patient (explaining that the nurse/technician could not find the attending physician to review the ECG). Participant given normal ECG to review]