Student version

What is an illness script?	An illness script is data packaged in such a way to make storage in memory easier. They are built over time with repeated exposure to patients. This packet includes relevant signs and symptoms, predisposing conditions, pathologies, and syndromes

Outcomes – there are two

1. Develop an illness script that identifies the distinguishing features for the specific pathology of your PBL case that will provide an approach to that symptom should you encounter it again.
2. A descriptive problem representation for that symptom to facilitate cognitive storage.

Why are illness scripts useful?

Experts store cases in memory so that when the symptom is encountered again, any part of that memory can be recalled to aid in diagnosis. Purposely developing a prototype following a PBL case will lay the groundwork for you to build your cognitive database of cases organized in a meaningful way- the way the data will be retrieved.

What are the components of an illness script?

1. Chief complaint

Is written in broad terms from the PBL case

2. Working HO

A list of plausible working hypotheses focused on the "horses" initially, but can be expanded to include those "zebras". This is similar to step 1 of the PBL process but will focus on the most likely differential diagnoses. After reviewing the Casebook you can pare this list down to 3 or 4 working hypotheses for the illness script.

3.Predisposing Conditions

Think about what may make the individual more susceptible to this pathology – consider pertinent FH (genetics), elements of the SH, immobility, previous trauma, etc. This may come for the PBL case or a resource.

4. Pathophysiological Insult

Briefly describe the unique pathophysiology focusing on distinguishing features of each working hypothesis.

5. Discriminating Features (expected findings)

These are attributes of the symptom (OLDCARTS) or salient features that help describe the particular working hypothesis. These are based on what you would expect to find from a pathophysiology perspective and the natural progression of disease, not necessarily on what was found on your particular case. To develop this list, you may want to initially include all expected

pertinent positives from the history, exam and diagnostic tests, from the case and/or other resources. Then shorten the list by identifying the features that help distinguish the specific working hypothesis.

6. Defining Features

These features help define the diagnosis by refining the discriminating features. To do this you will take the list of discriminating features for each working hypothesis and delete terms that are not the priority symptoms and those that do not help distinguish the diagnosis. You will need to pare the list down to the key salient features, which will result in a concise way to define the diagnosis using the minimum number of important words.

7. Problem representation

Using the words chosen as "defining features" above, write a brief phrase that could be used to describe the specifics of the case to your preceptor. The information in this phrase will be stored in memory. When you encounter a patient with similar signs and symptoms you will retrieve the illness script from your memory.

8. Name the illness script

Develop a brief descriptive title for the illness script that summarizes common features of all potential working hypotheses.

See example of illness script below

References

Charlin, B., Tardif, J., & Boshuizen, H.P.A. (2000). Scripts and medical diagnostic knowledge: Theory and applications for clinical reasoning instruction and research. *Academic Medicine*, 76, 182-190.

Bowen, J.L. (2006). Educational strategies to promote clinical diagnostic reasoning. *New England Journal of Medicine, 355(*21), 2217-2225.