THE COLLEGE OF FAMILY PHYSICIANS OF CANADA

LE COLLÈGE DES MÉDECINS DE FAMILLE DU CANADA

CERTIFICATION EXAMINATION IN FAMILY MEDICINE

SIMULATED OFFICE ORAL EXAMINATION

SAMPLE 15

THE COLLEGE OF FAMILY PHYSICIANS OF CANADA

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INTRODUCTION

The Certification Examination of The College of Family Physicians of Canada is designed to evaluate the diverse knowledge, attitudes, and skills required by practising family physicians (FPs). The evaluation is guided by the four principles of family medicine. The Short-Answer Management Problems (SAMPs), the written component, are designed to test medical knowledge and problem-solving skills. The Simulated Office Orals (SOOs), the oral component, evaluate candidates' abilities to establish effective relationships with their patients by using active communication skills. The emphasis is not on testing the ability to make a medical diagnosis and then treat it. Together, the two instruments evaluate a balanced sample of the clinical content of family medicine.

The College believes that FPs who use a patient-centred approach meet patients' needs more effectively. The SOOs marking scheme reflects this belief. The marking scheme is based on the patient-centred clinical method, developed by the Centre for Studies in Family Medicine at the University of Western Ontario. The essential principle of the patient-centred clinical method is the integration of the traditional disease-oriented approach (whereby an understanding of the patient's condition is gained through pathophysiology, clinical presentation, history-taking, diagnosis, and treatment) with an appreciation of the illness, or what the disease means to the patients in terms of emotional response, their understanding of the disease, and how it affects their lives. Integrating an understanding of the disease and the illness in interviewing, problem-solving, and management is fundamental to the patient-centred approach. This approach is most effective when both the physician and the patient understand and acknowledge the disease and the illness.

In the SOOs, candidates are expected to explore patients' feelings, ideas, and expectations about their situation, and to identify the effect of these on function. Further, candidates are scored on their willingness and ability to involve the patient in the development of a management plan.

The five SOOs are selected to represent a variety of clinical situations in which communication skills are particularly important in understanding patients and assisting them with their problems.

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SIMULATED OFFICE ORAL EXAMINATION

RATIONALE

The goal of this simulated office oral examination is to test the candidate's ability to:

1. **manage chronic disease as it presents in diabetes;**

2. **recognize and manage post-traumatic stress disorder (PTSD) in a culturally sensitive manner.**

The patient's feelings, ideas, and expectations, as well as an acceptable approach to management, are detailed in the case description and the marking scheme.

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INSTRUCTIONS TO THE CANDIDATE

1. FORMAT

This is a simulated office situation, in which a physician will play the part of the patient. There will be one or more presenting problems, and you are expected to progress from there. You should not do a physical examination at this visit.

2. SCORING

You will be scored by the patient/examiner, according to specific criteria established for this case. We advise you not to try to elicit from the examiner information about your marks or performance, and not to speak to him or her "out of role".

3. TIMING

A total of 15 minutes is allowed for the examination. The role-playing physician is responsible for timing the examination. At 12 minutes, the examiner will inform you that you have three minutes remaining. During the final three minutes, you are expected to conclude your discussion with the patient/examiner.

At 15 minutes, the examiner will signal the end of the examination. You are expected to stop immediately, and to leave any notes with the examiner.

4. THE PATIENT

You are about to meet Mr. **JEFFREY HOPE**, age 54, who is new to your practice.

SPECIAL NOTE

Because the process of problem identification and problem management plays an important part in the score, it is in the best interest of all candidates that they not discuss the case among themselves.

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CASE DESCRIPTION

INTRODUCTORY REMARKS

You are Mr. **JEFFREY HOPE**, age 54, and are visiting this physician for the first time. Your previous physician is no longer in practice locally. You have been on edge for some time, and your boss and girlfriend, **JEAN REDHEAD**, told you that you needed some help. She noticed that you have become increasingly distracted and "edgy" since you returned from your brother **TOMMY HOPE**'s funeral eight months ago. She recommended that you see a physician, as she felt that maybe you needed time off work.

You are diabetic, and until your brother's death had taken excellent care of yourself. You wanted to ensure that you would not lose a leg as your mother, **AGNES HOPE**, did. You had maintained good haemoglobin A_{1c} (HbA_{1C}) levels and a healthy weight, and had meticulously avoided sugar.

You need a refill for your diabetic medication. You also want to talk about your insomnia, and your feelings of apprehension and anxiety.

You are of First Nations descent.

HISTORY OF THE PROBLEM

Diabetes

You have not seen a physician in a while. Your former physician gave you a refillable prescription last year; she has left the area since then. You need a refill of your metformin (Glucophage), glyburide (Diaβeta), and ramipril (Altace).

Your symptoms started about six or so years ago. First came fatigue, and then an irritation at the corners of your mouth that the doctor said was a yeast infection. Finally you became very thirsty and had to visit the toilet much more, particularly at night, when you had to urinate three or more times. You made the diagnosis yourself and saw a physician who confirmed it.

Your diabetes has been treated for the past five years. Initially you tried dieting and getting rid of the sugary drinks that you had indulged in since you quit drinking alcohol, but that was not enough. Metformin on its own reduced your blood sugar

levels well, but your physician at the time wanted them even lower. She added glyburide, and a small dose worked well; a larger dose caused low blood sugar levels.

You attended diabetic education classes at the time of diagnosis, and until the past year, you diligently had your blood work done every three months and monitored your glucose regularly. For the past several months you have taken your pills, but have measured your blood sugar level only sporadically.

After the initial year of juggling medications and losing 20+ pounds, your diabetes was really well controlled. You were well motivated because diabetes is a family problem and you saw your mother lose a leg to the disease. Your recent emotional troubles have undermined this motivation.

For the few years before today's visit, your HbA_{1c} level was measured every three months. It varied between 6.6% and 7.5%.

About two years ago, your doctor added ramipril; she told you that your blood pressure (BP) was very slightly high. She said she wanted your BP to be 135/75 mm Hg or less.

Once a year she checked your urine for protein, and results were always good. She was always amazed at how low your cholesterol was, and never discussed with you cholesterol treatment. Your eyes were checked every two years, and the eye doctor whom you last saw about two years ago said you had no sign of any diabetic changes, but did have very early cataracts.

You have always been careful about your feet, and have neither tingling nor numbness in your feet or hands. You have no visual symptoms. You have no chest pain or respiratory problems. You get up only once at night to empty your bladder. Cuts and sores heal well and in a timely fashion.

You have kept your weight down well. You check your BP at a drugstore. It is 130/70 mm Hg.

You take a baby acetylsalicylic acid (ASA) tablet every day.

Insomnia and post-traumatic stress disorder

Problems at work: Your boss, Jean suggested you make today's appointment with the candidate because you are not doing well at work. You put this problem down to difficulty sleeping. Your mind is so busy with thoughts and at night you cannot get to sleep! You compare your thoughts with "airplanes circling an airport, but the air traffic controller has lost control and they fly every which way and never come in to land". When you do get to sleep your dreams are very disturbing and wake you up; rarely can you get back to sleep. You are irritable at work and frequently distracted. You feel anxious and are "jumpy". You talked to Jean about what was going on, and she suggested that maybe you needed some time off to deal with things, or even needed sleeping pills.

Childhood trauma: The story starts during your childhood. You grew up in a Native community in British Columbia. You were the second of seven children. You had no idea who your father was. You suspect he was not Native, given your looks. Your mother drank back then, and her first three children had different fathers. Your elder brother knew his father and you were and are envious of that; you and your next brother did not know who fathered you. All the others were born after your mother married **JOSEPH HOPE**, the man you knew as your father. Joseph was a good man: he was a little lazy and not the best provider, but he accepted all the children as his own. Your grandparents also accepted you all, and they were very important to you as you grew up. As you became older you discovered that this pattern was followed by many in your community. The community raised children and looked out for them, and many women had children with different men before marrying. Your white friends had difficulty understanding this.

When you were 10, you were sent to the residential school 50 km away. It was run by the Church. There you received an education, for which you were grateful. However, although you were never abused, you saw other boys being taken out of their beds by caregivers at night and coming back crying. You later learned that they had been sexually abused. Your elder brother was one of them. He never talked to you about it. You also never spoke of your experiences at school until the past few years, when stories of the atrocities started to come out in newspapers and on television. You mentioned these experiences in passing when you were in treatment for alcohol problems, and discussed them more substantially with Jean.

At school, you were a rebel and tough. You and Tommy ran home many times, only for your mother to send the two of you back! Eventually you left school, and at 16 you started to work in the woods with your uncles. Everybody who had a job outside the reserve worked in the logging industry.

At 18 you left home to see the world. You ended up in Vancouver, where you discovered that prejudice was rampant and discrimination not even hidden. On impulse you went into a recruiting office and joined the Royal Canadian Air Force (RCAF). Some of your uncles had fought in the Second World War and told stories of Europe and of a decent life in the armed forces. For you, enlisting turned out to be a good thing. You liked military life and eventually became a warrant officer. The institutional structure and order of the RCAF suited you. After 25 years you retired with a pension.

You left the RCAF bilingual; you had ended up in the communications field and underwent training in French. You found that you had a knack for picking up languages when you were abroad. You are passably fluent in German, too; you learned the language when you were stationed in Lahr, Germany.

Alcohol problems: You moved back to your home community when you retired from the RCAF, but found you no longer fit in. You could not find a job, so you moved from place to place. You had difficulty dealing with the freedom of civilian life. You drifted from relationship to relationship and started to drink more and more. Eight years ago it hit you that you were a drunk and were drinking your life away. You entered a treatment centre and have never had a drink since then. During that time, you first started to talk of your childhood. Since then you have worked in drug and alcohol centres for the First Nations community; you have worked in drop-in centres and currently are working as a youth liaison worker in a Native friendship centre in this community.

Brother's death: Eight months ago Tommy died in a motor vehicle accident (MVA). He was a passenger in a truck that went off the road.

You went home for the funeral. It was an odd experience, a blending of traditional with church rites. As soon as the priest (pastor) started his "mumbo-jumbo", you had a flashback to your brother and yourself at residential school. Since that day you have been consumed with anger toward clergy and the church.

Most days you have flashbacks to the events of your childhood. Occasionally in your work you must deal with church youth groups, but now you make a point of avoiding such contact. At times the anxiety gets so bad that you find yourself checking rooms you are in for clergymen's collars. A recurring image just as you fall asleep is of a priest coming into your room.

You are quite surprised by all this. You have told yourself repeatedly that you should grow up and get on with things. After all, for 40 years you have been able to cope with your childhood!

You are not suicidal.

Despite your edginess you enjoy life, look forward to working with teenagers, and are optimistic about their future. You see many opportunities opening up for First Nations' youth and encourage as many as you can to take available opportunities and better themselves. You are not sad or, if asked, depressed. What you describe as anxiety is probably better described as being overly vigilant or overly aware of what is happening around you. You feel as though you are always ready for something to happen. You just want to be able to sleep well again.

MEDICAL HISTORY

You had an appendectomy at age 15.

Type 2 diabetes was diagnosed five years ago.

"Mild" hypertension was diagnosed two years ago.

Your Mantoux test is always positive. Chest X-ray films have always been clear. The last was three years ago.

You took isoniazid (INH) while you were in the RCAF. You could not tolerate INH, and therefore, did not take it for the full year that was advised.

MEDICATIONS

Metforming, 1 g twice a day.
Glyburide, 2.5 mg twice a day.
Ramipril, 10 mg daily.
ASA, 81 mg daily.
No over-the-counter medications.
No herbal medications.

LABORATORY RESULTS

Results of self-monitored fasting glucose tests have been between 5 and 8.

HbA_{1C} testing was last done a year ago, and the result was 6.7%.

Your cholesterol level was very good last time it was measured.

You have never had a positive micro albuminuria test.

ALLERGIES

None known.

IMMUNIZATIONS

All childhood immunizations were done, including BCG. All were kept up to date in the armed forces.

Since becoming diabetic, you have had a flu shot every year. You had Pneumovax vaccine five years ago.

LIFESTYLE ISSUES

Alcohol: You stopped drinking eight years ago. Before that you had become a heavy binge drinker in the armed forces. After leaving the RCAF, you drank increasingly heavily: beer, wine, and, by preference, rye.

You have never been charged with drunk driving.

Tobacco: You have never smoked cigarettes.

Illicit drugs: In the past you have used marijuana, very rarely. You last used it at your brother's funeral.

Diet: You try to eat as you should, and avoid sugar obsessively.

Exercise and Recreation: You have no formal exercise program, but you do walk to and from work, which is about 1 km each way.

You enjoy fishing.

FAMILY HISTORY

Your father is unknown.

Your mother died of a heart attack at age 65. Two years before that her right leg was amputated because of diabetes.

Originally you had six siblings. Tommy died eight months ago in an MVA. He was 55. Your five surviving siblings are **JIMMY HOPE**, age 53; **JEANNIE HOPE**, age 50; **JOANNIE HOPE**, age 47; **MELANIE HOPE**, age 44; and **RODDY HOPE**, age 38. As far as you know, they all are healthy, but you are not close and live well away from them.

Both your grandparents died in their 60s. They were diabetic and had had tuberculosis when they were young.

PERSONAL HISTORY

You have had three failed marriages and countless brief relationships. The first marriage was to **MARY GRACE**, for four years. The second was to **IRENE**, for three years, and the third was to **JOAN**, for six years. You do not know how to nurture a relationship. Two of your wives thought that they had the key to your happiness, but after a couple of years you had hurt them so badly emotionally that they left. Probably your heavy binge drinking in the non-commissioned officers' mess had something to do with that. You tried relationships with white women, Native women, and black women, but none worked.

As far as you know, you have no children. This is not an issue for you as you never wanted any. During your time in the treatment centre you came to realize that this was probably a reaction to your childhood. No child should have to endure what you saw.

Irene, (your second wife) insisted you undergo fertility testing, and when you were found to be infertile; her doctor said this must have resulted from mumps or something like that. Again, this was no big deal to you. Unfortunately, you did not understand at the time that it was a big deal to your wife.

You would not call what you currently have with Jean a relationship, but it works well for both of you. She is 10 years younger than you and has gone through the marriage and alcohol thing, too. She seems to understand you. You give each other space, but meet at least once a week for a meal at your or her apartment. You can talk to each other, but just as easily you can simply be together in silence, respecting each other. Sometimes you have sex; more often than not you don't. In other ways you do not get involved in each other's non-working life.

EDUCATION AND WORK HISTORY

From age 18 to 43 you were in the RCAF, and reached the rank of warrant officer. From age 43 to 46 you had the odd job, but mostly you drank.

Currently you are a youth liaison worker in a Native friendship centre. Before this you worked for a variety of agencies as a Native counselor on drug and alcohol abuse.

FINANCES

You have a pension from the RCAF.

You earn only $15 an hour in your current job, but do have a good benefits package that includes counselling with a psychologist.

Being a First Nations member, you receive your medications free.

You rent an apartment.

SOCIAL SUPPORTS

You have many acquaintances but few close friends. You do have a fishing buddy you met in Alcoholics Anonymous (AA), but Jean is probably the only person to whom you can open up.

You are not close to your family.

You spend a lot of your spare time at the friendship centre, probably just to be available if someone needs you. From time to time the youth you meet tell you to "get a life!"

The AA organization was and is very important to you. The meetings brought back the structure you enjoyed in the RCAF. You attend at least two meetings a week.

RELIGION

You are not religious. In fact, you have nothing good to say about organized religion.

When you were growing up, Native spirituality had not recovered from its suppression and the Church was the dominant force in the community. There was a revival of Native ways in your home community, and you listened to some of the ardent proselytizers talk of returning to the old ways. You had little time for their way of thinking, but when you went to powwows you enjoyed the rhythmic dancing, and the drumming and chanting of Native songs sent a chill up your spine.

EXPECTATIONS

You expect that you will be given a prescription for your drugs.

You expect that the physician will want to do blood tests.

You expect the physician to remind you to look after yourself and tell you to be responsible for your health.

You are not sure what the physician might do to help you with your anxiety, but you think you will probably receive medications. You are not sure if these are what you need or want. You expect that the physician might be able to tell you what is wrong with you.

ACTING INSTRUCTIONS

You are clean and casually but smartly dressed in jeans and an open-necked shirt.

You are quiet and initially do not offer much in the way of information except in response to questions. You are restless and vigilant throughout the interview. You are knowledgeable about your diabetes, and if tests are mentioned, you want to know which ones.

When asked why you sleep poorly, you reply, **"I have these very disturbing dreams"** or **"Sometimes it is easier to stay awake than suffer those nightmares"**. If asked if you have bad memories or flashbacks, you say, **"It's just as though I was back in the dormitory at school again"** or **"I thought I had left those memories behind years ago"** or "**They make me so angry I do not know what to do with myself"**.

If the candidate mentions hypnotics or selective serotonin-reuptake inhibitors, you are not sure you want drugs—particularly drugs you could become addicted to. If the candidate pushes pharmacotherapy, you want to know all the pros and cons and to have time to think before committing to it. You do not rule it out, but need to consider it carefully first. You will not agree to take any addictive drug.

If the candidate mentions PTSD, you recognize the syndrome (you were in the military). You acknowledge that you have felt your past has started to haunt you, but have not thought you might be experiencing PTSD. However, if the candidate discusses criteria for diagnosis, you quickly accept the diagnosis and want to know your treatment options. If the candidate does not discuss PTSD or any other diagnosis, you should ask what the doctor thinks you are suffering from.
If generalized anxiety disorder or depression is the diagnosis suggested, you accept it but quizzically and hesitantly. Give the cue **"I don't feel depressed"** or **"I enjoy life. I am not sad; I am angry and on edge"**. Give this cue once.

You are a member of a First Nations band and carry a status card. Having status allows you coverage for your medications and medical care. It allows you access to free education. It identifies you legitimately as a Canadian of Native descent.

If the candidate displays "exam-manship" by asking early in the interview if something more than the diabetes is an issue, say, **"I want to deal with my diabetes"**, or use other words that will direct him or her back to your presenting problem.

CAST OF CHARACTERS

The candidate is unlikely to ask for other characters' names. If he or she does, make them up.

JEFFREY HOPE:	The patient, age 54, who is suffering from diabetes and PTSD.
AGNES HOPE:	Jeffrey's mother, who died seven years ago at age 65.
JOSEPH HOPE:	Jeffrey's stepfather, age 70.
TOMMY HOPE:	Jeffrey's brother, who died in an MVA eight months ago at age 55.
JIMMY HOPE:	Jeffrey's brother, age 53.
JEANNIE HOPE:	Jeffrey's sister, age 50.
JOANNIE HOPE:	Jeffrey's sister, age 47.
MELANIE HOPE:	Jeffrey's sister, age 44.
RODDY HOPE:	Jeffrey's brother, age 38.
JEAN REDHEAD:	Jeffrey's boss and girlfriend, age 44.
MARY GRACE:	Jeffrey's first wife.
IRENE:	Jeffrey's second wife.
JOAN:	Jeffrey's third wife.

TIMELINE

Today:	The appointment with the candidate.
Eight months ago:	Brother Tommy died in an MVA.
Five years ago:	Diabetes diagnosed.
Six years ago:	First symptoms of diabetes.
Seven years ago:	Mother died at age 65.
Eight years ago:	Stopped drinking.
11 years ago:	Left armed forces.
21 years ago:	Marriage to Joan.
27 years ago:	Marriage to Irene.
34 years ago:	Marriage to Mary Grace.
36 years ago:	Joined armed forces.
38 years ago:	Left school.
44 years ago:	Sent to residential school.
54 years ago:	Born.

INTERVIEW FLOW SHEET

INITIAL STATEMENT:	**"I need a refill of my prescription."**
10 MINUTES REMAINING:*	If the candidate has not brought up the issue of the PTSD, the following prompt must be said: **"Since my brother's funeral, I have not been sleeping well."**
7 MINUTES REMAINING:*	If the candidate has not brought up the issue of the diabetes, the following prompt must be said: **"Will I need blood tests done again?"** *(It is unlikely that this prompt will be necessary.)*
3 MINUTES REMAINING:	**"You have THREE minutes left."** *(This verbal prompt **AND** a visual prompt **MUST** be given to the candidate.)*
0 MINUTES REMAINING:	**"Your time is up."**

*To avoid interfering with the flow of the interview, remember that the 10- and seven-minute prompts are optional. They should be offered only if necessary to provide clues to the second problem or to help the candidate with management. In addition, to avoid interrupting the candidate in mid-sentence or disrupting his or her reasoning process, delaying the delivery of these prompts momentarily is perfectly acceptable.

NOTE: If you have followed the prompts indicated on the interview flow sheet, there should be no need to prompt the candidate further during the last three minutes of the interview. During this portion of the interview, you may only clarify points by answering direct questions, and you should not volunteer new information. You should allow the candidate to conclude the interview during this time.

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MARKING SCHEME

NOTE: To cover a particular area, the candidate must address **AT LEAST 50%** of the bullet points listed under each numbered point in the **LEFT-HAND** box on the marking scheme.

Distinguishing a "Certificant" from a "Superior Certificant": Exploration of the Illness Experience

While it is critical that a certificant gather information about the illness experience to gain a better understanding of the patient and his or her problem, superior performance is not simply a matter of whether a candidate has obtained all of the information. A superior candidate **actively explores** the illness experience to arrive at an-in-depth understanding of it. This is achieved through the purposeful use of communication skills; verbal and non-verbal techniques, including both effective questioning and active listening. The material below is adapted from the CFPC's document describing evaluation objectives for certification (1) and is intended to act as a further guide to assist evaluators in determining whether a candidate's communication skills reflect superior, certificant, or non-certificant performance .

Listening Skills

- Uses both general and active listening skills to facilitate communication

Sample Behaviours

- Allows the time for appropriate silences
- Feeds back to the patient what he or she thinks he or she has understood from the patient
- Responds to cues (doesn't carry on questioning without acknowledging when the patient reveals major life or situation changes, such as "I just lost my mother")
- Clarifies jargon used by the patient

Language Skills

Verbal

- Adequate to be understood by the patient
- Able to converse at an appropriate level for the patient's age and educational level
- Appropriate tone for the situation - to ensure good communication and patient comfort

Sample Behaviours

- Asks open- and closed-ended questions appropriately
- Checks back with the patient to ensure understanding (e.g., "Am I understanding you correctly?")
- Facilitates the patients' story (e.g., "Can you clarify that for me?")
- Provides clear and organized information in a way the patient understands (e.g., test results, pathophysiology, side effects)
- Clarifies how the patient would like to be addressed

Non-verbal Skills

Expressive

- Conscious of the impact of body language on communication and adjusts appropriately

Sample Behaviours

- Eye contact is appropriate for the culture and comfort of the patient
- Is focused on the conversation
- Adjusts demeanour to be appropriate to the patient's context
- Physical contact is appropriate to the patient's comfort

Receptive

- Aware of and responsive to body language, particularly feelings not well expressed in a verbal manner (e.g., dissatisfaction/anger/guilt)

Sample Behaviours

- Responds appropriately to the patient's discomfort (shows appropriate empathy for the patient)
- Verbally checks the significance of body language/actions/behaviour. (e.g., "You seem nervous/upset/uncertain/in pain.")

Cultural and Age Appropriateness

- Adapts communication to the individual patient for reasons such as culture, age and disability

Sample Behaviours

- Adapts the communication style to the patient's disability (e.g., writes for deaf patients)
- Speaks at a volume appropriate for the patient's hearing
- Identifies and adapts his or her manner to the patient according to his or her culture
- Uses appropriate words for children and teens (e.g., "pee" versus " void")

Prepared by:
K. J. Lawrence, L. Graves, S. MacDonald, D. Dalton, R. Tatham, G. Blais, A. Torsein, V. Robichaud for the Committee on Examinations in Family Medicine, College of Family Physicians of Canada, February 26, 2010.

Allen T, Bethune C, Brailovsky C, Crichton T, Donoff M, Laughlin T, Lawrence K, Wetmore S.

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1. IDENTIFICATION: DIABETES

Diabetes	Illness Experience
Areas to be covered include: **1. current management:** • Taking metformin and glyburide. • Taking ramipril. • Walks daily. • Follows a diabetic diet. • Six-year history. • Examines feet regularly. **2. diabetic control:** • Erratic self-monitoring. • Normally excellent control. • Cholesterol is normal. • Excellent BP control. **3. end-organ damage:** • Eye exam one year ago. • No paraesthesias. • Normal urine testing one year ago. **4. motivation for good control:** • Mother lost a leg to diabetes.	**Feelings** • Sheepish/embarrassed that he has neglected himself. **Ideas** • He has to get his diabetes control back on track. **Effect/Impact on Function** • None. **Expectations for this visit** • The physician will renew his pills. • The physician will do a diabetic check-up. **A satisfactory understanding of all components (Feelings, Ideas, and Expectations) is important in assessing the illness experience of this patient.**

Superior Certificant	Covers points 1, 2, 3, and 4.	Actively explores the illness experience to arrive at an in-depth understanding of it. This is achieved through the purposeful use of verbal and non-verbal techniques, including both effective questioning and active listening.
Certificant	Covers points 1, 2, and 3.	Inquires about the illness experience to arrive at a satisfactory understanding of it. This is achieved by asking appropriate questions and using non-verbal skills.
Non-certificant	Does not cover points 1, 2, and 3.	Demonstrates only minimal interest in the illness experience, and so gains little understanding of it. There is little acknowledgement of the patient's verbal or non-verbal cues, or the candidate cuts the patient off.

2. IDENTIFICATION: POST-TRAUMATIC STRESS DISORDER

Post-traumatic stress disorder	Illness Experience
Areas to be covered include: **1. current symptoms:** • Flashbacks. • Nightmares. • Hyper vigilance. • Eight-month duration. **2. precipitant:** • Brother's funeral. • Residential school experience. • Witnessed abuse of others. • Contact with church groups, which he now avoids. **3. ruling out other diagnoses:** • Not suicidal/homicidal. • Not depressed. • No panic disorder. • No psychotic symptoms. **4. no personal history of childhood abuse.**	**Feelings** • Anger. • Anxiety. **Ideas** • His past experiences have come back to haunt him. **Effect/Impact on Function** • Distracted at work. **Expectations for this visit** • The physician will help him make sense of all this. **A satisfactory understanding of all components (Feelings, Ideas, Effect/Impact on Function, and Expectations) is important in assessing the illness experience of this patient.**

Superior Certificant	Covers points 1, 2, 3, and 4.	Actively explores the illness experience to arrive at an in-depth understanding of it. This is achieved through the purposeful use of verbal and non-verbal techniques, including both effective questioning and active listening.
Certificant	Covers points 1, 2, and 3 **OR** 4.	Inquires about the illness experience to arrive at a satisfactory understanding of it. This is achieved by asking appropriate questions and using non-verbal skills.
Non-certificant	Does not cover points 1, 2, and 3 **OR** 4 (i.e., covers this area in a superficial way).	Demonstrates only minimal interest in the illness experience, and so gains little understanding of it. There is little acknowledgement of the patient's verbal or non-verbal cues, or the candidate cuts the patient off.

3. SOCIAL AND DEVELOPMENTAL CONTEXT

Context Identification	Context Integration
Areas to be covered include: **1. life cycle issues:** • Retired from the armed forces. • No children. • Many failed relationships. • Recovering alcoholic. **2. social support:** • His boss, Jean, is his main social support. • AA is very important to him. • Not close to his family. **3. social factors:** • Not interested in First Nations spirituality. • Actively involved in the Native community. **4. First Nations status.**	Context integration measures the candidate's ability to: • integrate issues pertaining to the patient's family, social structure, and personal development with the illness experience; • reflect observations and insights back to the patient in a clear and empathetic way. **This step is crucial to the next phase of finding common ground with the patient to achieve an effective management plan.** The following is the type of statement that a Superior Certificant may make: **"As I understand what is happening, you are an indigenous Canadian with diabetes. You were strongly motivated to control your diabetes, but attending your brother's funeral has rekindled memories of your childhood in a residential school. You have become distressed by these memories, and you are neglecting control of your diabetes."**

Superior Certificant	Covers points 1, 2, 3, and 4.	Demonstrates initial synthesis of contextual factors, and an understanding of their impact on the illness experience. Empathically reflects observations and insights back to the patient.
Certificant	Covers points 1, 2, 3, **OR** 4.	Demonstrates recognition of the impact of the contextual factors on the illness experience.
Non-certificant	Does not cover points 1, 2, and 3 **OR** 4.	Demonstrates minimal interest in the impact of the contextual factors on the illness experience, or cuts the patient off.

4. MANAGEMENT: DIABETES

Plan	Finding Common Ground
1. Provide a prescription for medications. **2. Order diabetes monitoring tests.** **3. Arrange for a physical examination.** **4. Reinforce self-care (e.g., glucose monitoring, exercise, diet).**	Behaviours that indicate efforts to involve the patient include: 1. encouraging discussion. 2. providing the patient with opportunities to ask questions. 3. encouraging feedback. 4. seeking clarification and consensus. 5. addressing disagreements. **This list is meant to provide guidelines, not a checklist. The points listed should provide a sense of the kind of behaviours for which the examiner should look.**

Superior Certificant	Covers points 1, 2, 3, and 4.	Actively inquires about the patient's ideas and wishes for management. Purposefully involves the patient in the development of a plan and seeks his feedback about it. Encourages the patient's full participation in decision-making.
Certificant	Covers points 1, 2, and 3 **OR** 4.	Involves the patient in the development of a plan. Demonstrates flexibility.
Non-certificant	Does not cover points 1, 2, and 3 **OR** 4.	Does not involve the patient in the development of a plan.

5. MANAGEMENT: POST-TRAUMATIC STRESS DISORDER

Plan	Finding Common Ground
1. Identify PTSD or allude to current symptoms related to previous life traumas. **2. Arrange or offer self for counselling.** **3. Discuss pharmacologic therapy.** **4. Discuss the appropriateness of time off work.**	Behaviours that indicate efforts to involve the patient include: 1. encouraging discussion. 2. providing the patient with opportunities to ask questions. 3. encouraging feedback. 4. seeking clarification and consensus. 5. addressing disagreements. **This list is meant to provide guidelines, not a checklist. The points listed should provide a sense of the kind of behaviours for which the examiner should look.**

Superior Certificant	Covers points 1, 2, 3, and 4.	Actively inquires about the patient's ideas and wishes for management. Purposefully involves the patient in the development of a plan and seeks his feedback about it. Encourages the patient's full participation in decision-making.
Certificant	Covers points 1, 2, and 3 **OR** 4.	Involves the patient in the development of a plan. Demonstrates flexibility.
Non-certificant	Does <u>not</u> cover points 1**,** 2, and 3 **OR** 4.	Does <u>not</u> involve the patient in the development of a plan.

6. INTERVIEW PROCESS AND ORGANIZATION

The other scoring components address particular aspects of the interview. However, evaluating the interview as a whole is also important. The entire encounter should have a sense of structure and timing, and the candidate should always take a patient-centred approach.

The following are important techniques or qualities applicable to the entire interview:

1. Good direction, with a sense of order and structure.

2. A conversational rather than interrogative tone.

3. Flexibility and good integration of all interview components; the interview should not be piecemeal or choppy.

4. Appropriate prioritization, with an efficient and effective allotment of time for the various interview components.

Superior Certificant	Demonstrates advanced ability in conducting an integrated interview with clear evidence of a beginning, middle, and an end. Promotes conversation and discussion by remaining flexible and by keeping the interview flowing and balanced. Very efficient use of time, with effective prioritization.
Certificant	Demonstrates average ability in conducting an integrated interview. Has a good sense of order, conversation, and flexibility. Uses time efficiently.
Non-certificant	Demonstrates limited or insufficient ability to conduct an integrated interview. Interview frequently lacks direction or structure. May be inflexible and/or overly rigid with an overly interrogative tone. Uses time ineffectively.