

CERTIFICATION EXAMINATION IN FAMILY MEDICINE

**SIMULATED OFFICE
ORAL EXAMINATION**

SAMPLE 16



THE COLLEGE OF FAMILY PHYSICIANS OF CANADA
CERTIFICATION EXAMINATION IN FAMILY MEDICINE
SIMULATED OFFICE ORAL EXAMINATION

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 deal with a patient who has:

- 1. a need for help with smoking cessation;**
- 2. memory loss.**

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 Ms. **LILLIANNE LAWRENCE**, age 50, 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 Ms. **LILLIANNE LAWRENCE**, a 50-year-old interior decorator. You wish to stop smoking. You also are becoming increasingly concerned about lapses in memory.

Your family physician (FP), **Dr. SMITH**, has retired.

HISTORY OF THE PROBLEM

Smoking

You started smoking at age 16 when your older brother and his friends dared you to try a cigarette. Very quickly you found that you liked the feeling nicotine gave you. You thought you looked quite sophisticated and grown up, especially as you were a pretty skinny teen with no womanly curves to speak of.

Your first and second husbands were smokers, and neither ever gave you any real encouragement to quit. You did cut down when you were pregnant with your son and your daughter, but resumed smoking your usual one and a half packs a day after both deliveries.

After you and your second husband divorced when you were 39, you went on a bit of a health kick and thought about quitting. It just seemed to make sense to stop smoking, and so you did—cold turkey. Unfortunately, you developed fairly severe withdrawal symptoms and lasted only six days without smoking.

About a year and a half ago, you met **ALEX** and started dating. Alex is a fitness nut (there is no other way to describe him), and he strongly encouraged you to embrace a whole new way of living. You learned about eating a sensible well-balanced diet as a vegetarian and took up jogging. You've really enjoyed the benefits of this healthier lifestyle. The only thing left is to quit the cigarettes. Alex is quite the anti-smoker. He has been encouraging you to quit and is willing to help you do this.

Now that the relationship with Alex is becoming progressively serious, he is talking about moving in together. However, you would have to quit smoking first. You have managed to cut down to about half a pack of cigarettes a day. This was hard work and meant giving up several of your favourite cigarette breaks of the day. You have found that the first morning cigarette (your favourite) and cigarettes during your coffee breaks are impossible to give up. You really enjoy a cigarette when you are driving between appointments with clients, and if you have a cup of coffee. You like a few cigarettes as you wind down in the evening. You do not wake up to smoke and you don't have to leave the table in a restaurant for a cigarette break anymore.

You wonder if there is a painless way of quitting. You really don't want to go through the same withdrawal you did before because it was absolutely miserable, and it would doom you to fail. You have gone to a local pharmacy, but the number of smoking aids only confused you. Which is better, the patch or pills? You want the doctor to give you advice about which aid to select.

You have chosen Alex's birthday (in one month) as your target quit day.

Memory loss

You have always had an excellent memory. You've prided yourself on the fact that you could always store in your head umpteen facts about a variety of clients, and did not have to resort to computer files. However, over the past year you have noticed that your memory isn't as sharp as it used to be.

You are very embarrassed that your direct supervisor has pointed out several mistakes you have made in the past month. Lately you've taken to jotting down notes and leaving them all over your apartment as reminders to yourself. You have left notes at work, but a couple of your co-workers commented on them, and you are beginning to worry that you've lost your edge. Your business is very competitive and you know that a few younger people in the office would be pleased to exploit any perceived weakness for their own advantage.

The memory problem started about a year ago. At first it involved simple things, like misplacing your keys or your reading glasses. You figured that the house cleaner who dusted your apartment three times a week must be moving things around. You became rather short-tempered with her, and she quit four months ago. However, the disappearance of personal items (keys, glasses, clothes, Palm pilot, etc.) has increased, and you've conceded that perhaps she wasn't to blame.

You also have had trouble remembering your newer clients' names. You find that a bit strange because you ran into a former friend from junior high school just a few weeks ago at a business dinner, and you remembered her instantly.

Recently the office changed to a new software system. You attended the classes with the others in the office, but you just can't seem to learn how to use the system. You have left multiple sticky notes with instructions like "password for entry is X763R," but each day you sit down at your desk, the entire computer data entry seems like a new task you've never tried before. You can easily use your sewing machine and the temperamental serger (fancy sewing machine) that many others can't seem to get the hang of, so you don't think the problem is one of manual dexterity.

Alex has noticed that something is wrong, too. He has spoken to you on several occasions. He states that more than just your memory seems to have changed. You don't really believe him, but he complains that your personality has changed slightly over the past six months. He says that you are more short-tempered than usual. He points out that you don't have a lot of expression on your face; you wear a blank look a lot and this bothers him because he thinks he's somehow boring you.

The final straw was losing a client's binder, which outlined the entire project for a newly built house that had been your exclusive project. You can't remember where the binder is, and it represents hours and hours of work. Worse still, you have little recollection of what the client had decided upon. Now, when you require your famous recall, it fails you.

You do not have any signs or symptoms of hypothyroidism, and you are not depressed. You have had no neurological changes such as headache, gait changes, or incontinence. You do not have insomnia. You are not menopausal. You have experienced no new stressors in your life to account for problems with concentration; in fact, life in the past couple of years has been the best it's ever been. You are not an unsafe driver and are not a danger to yourself (e.g., no lit cigarettes are left lying around).

You are secretly terrified that you may be developing a dementia similar to that of your aunt and your grandmother. You are horrified at the prospect.

MEDICAL HISTORY

You are generally pretty healthy, although you have a mild, chronic, dry smoker's cough and are prone to bronchitis; usually you get bronchitis twice a year, although you don't become seriously ill with it.

You had your appendix out when you were 18. You had a Caesarean section delivery with your second child.

You last saw an FP a year ago. At that time you were given a clean bill of health and told that all your screening test results were negative (no hypercholesterolemia, no diabetes, no hypertension, etc.).

MEDICATIONS

You take a daily multivitamin with iron, as well as calcium, 400 mg, and vitamin D, 1,000 IU.

Occasionally you take a laxative as you are very prone to constipation.

LABORATORY RESULTS

None.

ALLERGIES

Dog and cat dander.

IMMUNIZATIONS

Up to date.

LIFESTYLE ISSUES

Tobacco:

You have smoked for 34 years. Until recently, you smoked about a pack and a half of cigarettes a day. Now you smoke about half a pack a day.

Alcohol:

You drink alcohol daily, usually one or two glasses of wine with dinner if you are with clients or Alex. You have never had a problem with alcohol.

Illicit drugs:

Occasionally you smoke marijuana if you are at a party, but generally you can't be bothered to at home.

Diet:

You have become a vegetarian since you have been with Alex.

Exercise and Recreation:

You have taken up jogging since you have been with Alex. You experience mild breathlessness when you run.

FAMILY HISTORY

Both your parents are still alive and in reasonably good health. Your father has cataracts but is otherwise in good shape. Your mother has type 2 diabetes.

Your maternal aunt and grandmother died in their early 60s from progressive dementia. Your mother looked after her mother until near the end, and although this was many years ago, you remember the horror of watching your beloved grandmother wither away into a drooling husk of the woman she once was.

Your aunt died in a city several hundreds of miles away. You have no memories of her when she had advanced dementia, although you do know the toll her illness had on your mother.

PERSONAL HISTORY

Childhood, adolescence, and young adulthood

You were the second of four children. You had a pretty undistinguished childhood. You can't remember anything very significant happening to you as a child or teen.

You went to college for a year but didn't do very well and ended up dropping out before the end of the second semester. You always liked to dabble in decorating as a teen, and you often sewed cushions and drapes for your family and friends. When you realized that school was not for you, a friend of your mother's suggested that you work in her fabric store. You quickly adapted and flourished in that environment. Within a year you were teaching impromptu classes on making household decorations.

First marriage

You met your first husband, **ANDY**, in a college class and were smitten with him pretty quickly. While you were working in the fabric store you became pregnant with your first child. As having a child out of wedlock was frowned upon, you quickly tied the knot with Andy. When your son, **ADAM**, was 14 months old you gave birth to your daughter, **AMY**. Having two young children and little money placed a strain on your marriage. You realize now that you and Andy were probably too immature to have married. You divorced when Adam was six. You have had very little contact with Andy over the years, mostly because he moved to the United States a couple of years after the divorce.

Second marriage

You were single for about three years when you met **JEFF**, a general contractor. He shared your interest in creating beautiful homes, and for a while you worked with him. He was divorced himself and had custody of his three children. After dating for a year, you were married and created a blended family of five children. Jeff was an ample provider, but he really wanted a stay-at-home wife to mother his children, not a woman with a business to run. You argued a lot and the eight years you were together were fairly tempestuous. However, after your divorce you became better friends than when you were married; in fact, you still often decorate the homes that he builds.

You see your former stepchildren at holidays. You consider that you are as close to them as you are to your biological children.

Other sexual partners

After divorcing Jeff, you were content not to date for several years. Men were just too much trouble, and you were pretty busy with your work. As your career grew, you often travelled to trade shows and to find new ideas. This travel afforded you the opportunity to meet many men and to have frequent brief liaisons, which appealed to your sense of independence. (The thought of being tied to only one man was stifling to you.) Although you were frequently sexually active, you always insisted on using condoms. You are regularly tested for sexually transmitted diseases and have never had an infection.

Current relationship

Your relationship with Alex has become serious in the past six months, although you have been sexually active with him for 16 months. You consider the relationship to be the most stable you have ever had, and the only bone of contention between the two of you is your smoking. Alex is very health conscious and he says he worries about how much you smoke. The two of you rarely spend the night at your apartment because he finds the smell of cigarettes annoying. You usually leave his house after an amorous interlude because you need to smoke and he won't permit it in his house.

You are very interested in moving in with Alex, but you know that you need to quit smoking first.

EDUCATION AND WORK HISTORY

You completed high school and attended college for a short time. Although you did not complete college, you are intelligent and speak well. You are relatively well-read and keep abreast of current events diligently.

You are a self-taught decorator, although you have taken many night school courses on design and decorating. You have a flair for design and an eye for colours.

You have worked for several design firms over the past 27 years. Your work is highly sought by a high-end clientele, and you know that you have an excellent reputation in your field. You are known for your unique sense of colour and textures. You are proud of what your hard work and skill have wrought.

Five years ago you were wooed to your current company by its owner, **PHILIPPE CONSTANCE**, a well-known decorator. He urged you to join him as a senior decorator, and the prestige and pay increase were enough to tempt you into leaving your previous company, where you were a partner. You haven't been sorry that you went to work for Philippe; he has an exclusive and interesting clientele and, generally, the projects on which you work have few financial restraints.

You have disability insurance through your work, and an excellent health care plan.

FINANCES

You have saved a lot of money and live reasonably well. You own your own condominium.

SOCIAL SUPPORTS

You have few interests other than your work.

Your children are grown and independent. They live in other cities but see you at holidays and call fairly frequently. They have partners but no children yet. Your former stepchildren are not parents yet, either.

RELIGION

You were raised as a Protestant, but you do not attend church regularly.

EXPECTATIONS

You expect the doctor to support your desire to quit smoking and to provide assistance with this task.

You expect the doctor to confirm your suspicions that you are suffering from memory loss.

ACTING INSTRUCTIONS

You are dressed somewhat flamboyantly (as befits an artistic person), perhaps in clothing with bold patterns or colours.

You are pleasant and cordial. Your affect is perhaps a bit blunted, but only very slightly. You are used to dealing with all sorts of clients, and this gives you a degree of confidence in meeting new people. However, you are a bit nervous meeting this doctor. Initially you avoid eye contact as you are upset and concerned that you will forget things in the interview. You warm up to the candidate if he or she is non-judgemental and seems concerned about you.

You are well spoken.

You hesitate slightly when you talk about recent events; small details have escaped you. You are very clear about things that have happened in the past.

You have several pieces of paper in your hands; these are your "reminder notes". Alternatively, you might bring a notepad with lots of scribbles in it if you prefer that to loose papers.

If the candidate asks you to perform a Folstein Mini-mental State Examination, you pass the test with no difficulty. However, going through each question is considered an "examination", and the candidate should be discouraged from wasting time in this area.

You **FEEL** motivated to quit smoking on Alex's birthday. You **EXPECT** that the doctor will give you something to help you quit. You realize that you are dependent on the cigarettes and that you can't quit on your own.

You are **FEARFUL** and **ANXIOUS** about your memory problem. What if it means you have your grandmother's dementing condition?

You have had to write notes to yourself in order to remember when to do things. You **WORRY** that you are losing your edge. You expect that the doctor will sort this problem out for you.

If asked about your diet, emphasize that you are a vegetarian.

CAST OF CHARACTERS

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

LILLIANNE LAWRENCE:	The patient, age 50, an interior decorator with memory loss and a desire to stop smoking.
ALEX:	Lillianne's boyfriend, a "health nut", age 53.
ADAM:	Lillianne and Andy's son, age 29.
AMY:	Lillianne and Andy's daughter, age 28.
ANDY:	Lillianne's first husband.
JEFF:	Lillianne's second husband.
PHILIPPE CONSTANCE:	Lillianne's boss.
DR. SMITH:	Lillianne's FP for the past 10 years; retired

TIMELINE

Today:	Appointment with the candidate.
1 month ago:	Supervisor began pointing out mistakes at work.
6 months ago:	Relationship with Alex became serious.
At age 49:	Memory problems began; last visit to an FP.
At age 48:	Met Alex; became a vegetarian and started jogging.
At age 45:	Began working at your current job.
At age 39:	Divorced Jeff; first attempt to quit smoking.
At age 31:	Married Jeff.
At age 30:	Met Jeff.
At age 27:	Divorced Andy.
At age 23:	Began working as an interior decorator.
At age 22:	Daughter, Amy, born.
At age 21:	Son, Adam, born.
At age 20:	Married Andy.
At age 19:	Dropped out of college and began working at a fabric store.
At age 18:	Started college and met Andy.
At age 16:	Started smoking.

INTERVIEW FLOW SHEET

INITIAL STATEMENT:

“I want to quit smoking.”

10 MINUTES REMAINING:*

If the candidate has not brought up the issue of memory loss, the following prompt must be said: **“I think I’m having trouble remembering things.”**

7 MINUTES REMAINING:*

If the candidate has not brought up the issue of smoking cessation, the following prompt must be said:

“Could I have something to quit smoking?”

(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

<p>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 .</p>	
<p>Listening Skills</p> <ul style="list-style-type: none"> • Uses both general and active listening skills to facilitate communication <p>Sample Behaviours</p> <ul style="list-style-type: none"> • 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 	<p>Language Skills</p> <p>Verbal</p> <ul style="list-style-type: none"> • 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 <p>Sample Behaviours</p> <ul style="list-style-type: none"> • 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
<p>Non-verbal Skills</p> <p>Expressive</p> <ul style="list-style-type: none"> • Conscious of the impact of body language on communication and adjusts appropriately <p>Sample Behaviours</p> <ul style="list-style-type: none"> • 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 <p>Receptive</p> <ul style="list-style-type: none"> • Aware of and responsive to body language, particularly feelings not well expressed in a verbal manner (e.g., dissatisfaction/anger/guilt) <p>Sample Behaviours</p> <ul style="list-style-type: none"> • 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.”) 	<p>Cultural and Age Appropriateness</p> <ul style="list-style-type: none"> • Adapts communication to the individual patient for reasons such as culture, age and disability <p>Sample Behaviours</p> <ul style="list-style-type: none"> • 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”)
	<p>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.</p>

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

- (1) Defining competence in family medicine for the purposes of certification by The College of Family Physicians of Canada: the evaluation objectives in family medicine; 2011 – [cited 2011 Feb 7]. Available from: <http://www.cfpc.ca/uploadedFiles/Education/Definition%20of%20Competence%20Complete%20Document%20with%20skills%20and%20phases%20Jan%202011.pdf>

1. IDENTIFICATION: SMOKING

Smoking	Illness Experience
<p><u>Areas to be covered include:</u></p> <p>1. history of smoking:</p> <ul style="list-style-type: none"> • Has smoked since age 16. • Smokes one and a half packs a day. • Cut down during both pregnancies. <p>2. assessment of addiction :</p> <ul style="list-style-type: none"> • Signs of withdrawal. • Times she always smokes (after dinner, etc.). • The first cigarette in the morning is the most satisfying. <p>3. attempts at quitting:</p> <ul style="list-style-type: none"> • Has cut down to half a pack a day. • Hasn't tried a patch. • Hasn't bought nicotine gum. • Previous cold turkey attempt was a failure. <p>4. the fact that she has set a "quit date".</p>	<p><u>Feelings</u></p> <ul style="list-style-type: none"> • Motivated to quit. <p><u>Ideas</u></p> <ul style="list-style-type: none"> • She's dependent on cigarettes. • She can't do this on her own. <p><u>Effect/Impact on Function</u></p> <ul style="list-style-type: none"> • Smoker's cough. • Mildly breathless when running. <p><u>Expectations for this visit</u></p> <ul style="list-style-type: none"> • The doctor will give her something to help her quit. <p>A satisfactory understanding of all components (Feelings, Ideas, Effect/Impact on Function, and Expectations) is important in assessing the illness experience of this patient.</p>

Superior Certificant	Covers points 1, 2, 3, and 4.	Actively explores the illness experience to arrive at an <u>in-depth</u> 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 <u>satisfactory</u> understanding of it. This is achieved by asking appropriate questions and using non-verbal skills.
Non- certificant	Does <u>not</u> cover points 1, 2, and 3.	Demonstrates only minimal interest in the illness experience, and so gains <u>little</u> 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: MEMORY LOSS

Memory loss	Illness Experience
<p><u>Areas to be covered include:</u></p> <p>1. current symptoms:</p> <ul style="list-style-type: none"> • Forgetfulness (e.g., forgets clients' names, appointments, car keys). • Long-term memory maintained. • Trouble learning new skills. <p>2. potentially reversible causes:</p> <ul style="list-style-type: none"> • No symptoms of hypothyroidism. • Alcohol intake. • No signs of depression. • Vegetarian diet. <p>3. clean bill of health from previous family physician.</p> <p>4. neurological symptoms:</p> <ul style="list-style-type: none"> • No gait changes. • No headaches. • No incontinence. • No neurological deficits. 	<p><u>Feelings</u></p> <ul style="list-style-type: none"> • Fear. • Anxiety. <p><u>Ideas</u></p> <ul style="list-style-type: none"> • She might have the same dementia as her grandmother and her aunt. <p><u>Effect/Impact on Function</u></p> <ul style="list-style-type: none"> • She has to write reminder notes. <p><u>Expectations for this visit</u></p> <ul style="list-style-type: none"> • The doctor will sort this out if it really is a problem. <p>A satisfactory understanding of all components (Feelings, Ideas, Effect/Impact on Function, and Expectations) is important in assessing the illness experience of this patient.</p>

Superior Certificant	Covers points 1, 2, 3, and 4.	Actively explores the illness experience to arrive at an <u>in-depth</u> 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 <u>satisfactory</u> understanding of it. This is achieved by asking appropriate questions and using non-verbal skills.
Non- certificant	Does <u>not</u> cover points 1, 2, and 3.	Demonstrates only minimal interest in the illness experience, and so gains <u>little</u> 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
<p><u>Areas to be covered include:</u></p> <p>1. the relationship with Alex:</p> <ul style="list-style-type: none"> • Alex is a non-smoker. • They have been together for 16 months. • They are planning to move in together. <p>2. life cycle issues:</p> <ul style="list-style-type: none"> • Two divorces. • Two grown children who have left home. • No grandchildren. <p>3. work:</p> <ul style="list-style-type: none"> • Interior decorator. • Sought after. • Financially secure. • Few outside interests. 	<p>Context integration measures the candidate's ability to:</p> <ul style="list-style-type: none"> • 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. <p>This step is crucial to the next phase of finding common ground with the patient to achieve an effective management plan.</p> <p>The following is the type of statement that a Superior Certificant may make: "You have made a significant effort to adopt a healthy lifestyle, but you are concerned about the effort required to quit smoking. In addition, you are seriously worried that your memory may be failing and that might signal a serious condition that could affect your work and your relationship."</p>

Superior Certificant	Covers points 1, 2, and 3.	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 and 2.	Demonstrates recognition of the impact of the contextual factors on the illness experience. The following is the type of statement that a Certificant may make: "You need to quit smoking to keep your boyfriend, and you think that your memory is failing."
Non- certificant	Does <u>not</u> cover points 1 and 2.	Demonstrates minimal interest in the impact of the contextual factors on the illness experience, or cuts the patient off.

4. MANAGEMENT: SMOKING

Plan	Finding Common Ground
<p>1. Support smoking cessation.</p> <p>2. Discuss non-pharmacological strategies (e. g., behaviour modification).</p> <p>3. Develop a plan of ongoing support (e. g., a smoking cessation program, regular follow-up with the FP, engaging a friend for support).</p> <p>4. Discuss pharmacotherapeutic options in relation to current memory problems.</p>	<p>Behaviours that indicate efforts to involve the patient include:</p> <ol style="list-style-type: none"> 1. encouraging discussion. 2. providing the patient with opportunities to ask questions. 3. encouraging feedback. 4. seeking clarification and consensus. 5. addressing disagreements. <p>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.</p>

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 her feedback about it. Encourages the patient's full participation in decision-making.
Certificant	Covers points 1, 2, and 3.	Involves the patient in the development of a plan. Demonstrates flexibility.
Non-certificant	Does <u>not</u> cover points 1, 2 and 3.	Does <u>not</u> involve the patient in the development of a plan.

5. MANAGEMENT: MEMORY LOSS

Plan	Finding Common Ground
<p>1. Acknowledge that memory loss is a problem.</p> <p>2. Arrange for a physical examination.</p> <p>3. Arrange for memory testing.</p> <p>4. Arrange to rule out reversible causes (this must include thyroid-stimulating hormone and vitamin B₁₂ testing).</p> <p>5. Offer support/aids to coping with memory loss (e.g., keeping adequate sleep, decreasing alcohol intake).</p>	<p>Behaviours that indicate efforts to involve the patient include:</p> <ol style="list-style-type: none"> 1. encouraging discussion. 2. providing the patient with opportunities to ask questions. 3. encouraging feedback. 4. seeking clarification and consensus. 5. addressing disagreements. <p>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.</p>

Superior Certificant	Covers points 1, 2, 3, 4, and 5.	Actively inquires about the patient's ideas and wishes for management. Purposefully involves the patient in the development of a plan and seeks her feedback about it. Encourages the patient's full participation in decision-making.
Certificant	Covers points 1, 2, 3, and 4.	Involves the patient in the development of a plan. Demonstrates flexibility.
Non-certificant	Does <u>not</u> cover points 1, 2, 3, and 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.