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 24

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 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 (SOO) examination is to test the candidate's ability to deal with a patient who has

1. **a child with atypical behaviours.**

2. **polyarthritis secondary to ulcerative colitis.**

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. **ROBERT MARTIN**, age 38, 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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Ten CFPC Preparation Pointers for SOO Examiners

1. The first rule for successful acting is to put yourself into the mindset of the person you are impersonating. You have been around patients long enough to have a fairly good idea of how patients speak, behave, and dress.

Think of the following:

- The defensiveness and reticence of a patient with alcoholism.
- The embarrassment of someone with a sexual problem.
- The anxiety of a person with a terminal illness.
- The shyness of a young teenager asking for birth-control pills.

Once you receive your SOO script, think about the following:

- How is this type of patient going to react to a new physician initially? Will he or she be open, shy, defensive, "snarky," supercilious, etc.?
- How articulate will a person of his or her education level and social class be? What jargon, expressions, and body language will he or she use?
- What will his or her reactions be to questions a new physician asks? Will the patient be angry when alcohol abuse is brought up? Will he or she display reticence when questions about family relationships are asked?

2. Do not give away too much information! This is a common error. Allow the candidate to conduct a patient-centred interview to obtain the information he or she needs to zero in on the problem. The SOO is set up for you to give two or three specific cues to focus the candidate on the real issue(s), whether it (they) be alcohol abuse, sexual fears, worry about AIDS, etc.

You have all sweated through this exam yourself. It is normal to feel sorry for the poor, nervous, sweating candidate sitting in front of you. This exam is the result of years of experience on the part of the College, and the cues you are given are enough for the average candidate to realize what the real issues are. If the candidate still has not caught on after the two or three cues you have given as instructed in the case script, that is his or her problem, not yours. Do not give away too much after that.

3. Many candidates are not native English-speaking and may have language difficulties. They may not comprehend subtle verbal cues and jargon (e.g., "I only have a couple of beers a day, Doc"). The College is proud that so many physicians, many of whom are older than traditional candidates and have come from foreign countries, apply for certification. Transcultural medicine is a field unto itself, and these physicians can perform a valuable service in providing care to Canada's large immigrant population. These physicians will have to attend to Canadian-born patients, as well, and in the interest of fairness, do not act or speak differently during the examinations of these candidates. However, do feel free to write "possibility of language difficulties" on the score sheet if you feel this is the case.

4. Occasionally a candidate will get off on a tangent, or onto a completely unproductive line of questioning. During this exam you must walk the fine line of not giving away too much, but also of not leading the candidate down a completely inappropriate path of inquiry. His or her time is limited. If a candidate begins a completely unproductive line of questioning, answer "No!" (or appropriately negatively) firmly and decisively, with proper body language. This will, in a subtle way, prevent him or her from wasting several valuable minutes on such questioning.

5. Do not overact. Bizarre, hysterical gestures, arm flapping, inappropriate clothes (e.g., a retired carpenter probably will not show up in a $500 suit), etc., have no place in this exam. Always try to think how this person would act with a physician he or she had never met.

6. As the examinations proceed, you will (we hope) truly begin to **be** the patient. You will notice there will be some "doctors" with whom you feel comfortable, some with whom you feel less comfortable, some who conduct the interview the way you would have, and some who conduct the interview in a different way. We ask you to mark each candidate as objectively as possible, using the criteria we supply.

7. Remember to give the prompts! We all slip up once in a while and forget to give a prompt. If you suddenly remember, give the prompt as soon as you can. Sometimes you might be unsure about whether you need to give a prompt: you may be uncertain if the candidate has already covered the material on which the prompt is supposed to help him or her focus. When in doubt, **err on the side of giving the cue!**

8. Please pay attention to the clothing and acting instructions we give you. We find that even a change that seems minor to you, such as wearing a long-sleeved shirt instead of the specified "short sleeves," has a way of changing the whole atmosphere of the encounter for candidates.

9. Remember to give a clear three-minute prompt! When candidates ask that their performance be reviewed after a poor score, a common complaint is that this prompt was not given. To prevent any misunderstanding, give both verbal and visual cues: say something like **"You have three minutes left"** and flash a three-finger sign.

After you have given the three-minute warning, you should not volunteer any new information. Limit your responses to direct answers or clarification. If the candidate finishes before the alarm, simply sit in silence until it goes off. Do not offer any more information or inform him or her that he or she has time left.

10. Remember to follow the script and assist the College by clearly and adequately documenting important details of the interview on the reverse side of the score sheet, particularly with "problem" candidates.

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CASE DESCRIPTION

INTRODUCTORY REMARKS

You are Mr. **ROBERT MARTIN**, age 38, an accountant who recently moved to this city with your wife and two children. You are here today because recently your elder son, **MARC MARTIN**, age 10 years, has been exhibiting bizarre behaviour. In addition, you have had a recent flare-up of ulcerative colitis, with associated joint pain.

HISTORY OF THE PROBLEM

Son's Behaviour

Marc has always been in good health and has done well in school. He has had no developmental problems. Before your move to this city two months ago, he had close friends at his old school. In the past two weeks, however, you and your wife, **RACHEL MARTIN**, have been worried about his behaviour. He will suddenly clap his hands and shout loudly. The outbursts last only a few seconds. Marc seems embarrassed when the outbursts occur.

The first time this happened, you were at home on a Saturday morning, and he and his brother, **WILLIAM MARTIN**, age seven years, were quietly watching some cartoons on television. Marc's sudden outburst startled you all. William started to laugh because he thought Marc had made a joke. Marc, on the other hand, seemed confused. You told him to be quiet, and he replied that he did not know why he did it. "It just happened," he said.

An identical outburst occurred the next day, during a church service. Marc suddenly clapped his hands repeatedly and shouted "Ow!" You and Rachel reprimanded him, but something about the outburst worried both of you. In particular, you and Rachel also were concerned because Marc was obviously embarrassed by the occurrence.

When you arrived home and questioned him, he told you again that "it just happened," and he was in tears.

The situation came to a head last week. Marc's Grade 5 teacher called Rachel to tell her that Marc had disrupted the class twice that day by clapping and shouting. The teacher wanted to know if he had any psychiatric or behaviour problems of which she should be aware. Your wife told her that this was an entirely new behaviour, and that you were also worried about it. The teacher suggested that you all try to ignore it for the time being, in case it was due to the stress of arriving in a new school.

You and Rachel went along with the suggestion last week, but the episodes became more frequent. They outbursts occurred two to three times each evening, and a few times during the day at school. Marc was clearly bothered by them, and told you he could not make them stop. He also told you that the kids at school were making fun of him. You and your wife gave him general advice about how to deal with teasing and bullying; but at that point you and Rachel decided that he needed medical attention. Nevertheless, you are still trying to follow the teacher's advice by not "making a big thing out of it." You therefore made today's appointment for yourself so you could discuss Marc's behaviour with a physician before bringing Marc in. Rachel is not able to get away from work today.

Marc is a rambunctious boy. At one point you wondered if he was "a bit ADD," but he has never shouted or acted out like this before. You and Rachel do not think that he has been exceptionally stressed about the new school. He misses his old friends, but he was not dreading going to a new school. You do not think that he has been bullied, although you are worried that these outbursts will keep him from integrating and making friends. His sleep and appetite have been normal. He has not cried out or clapped his hands during the night.

The outbursts typically last less than a minute. Marc does not seem confused or "lost" afterward. He is not incontinent during the episodes. He does not complain of headaches and he seems to run, play, and act normally between outbursts.

His immunizations are up to date. Up until now he has received medical care from your former family physician (FP), **Dr. SIMON**, who assisted in the delivery of both your children and cared for all four members of your family.

Polyarthritis Secondary to Ulcerative Colitis

During the past three months, you have been experiencing morning stiffness in your lower back when you get out of bed. This stiffness is somewhat painful, but the pain

is not disabling, and there is no radiation of the pain. It seems to be only in the lower back.

You can “work the pain out” by walking around, but it seems odd to you that you feel this way. You have never been bothered by back pain, and you can’t remember straining your back. You are only 38 and don’t think this should be happening.

About a month and a half ago, you had a swollen and painful left wrist. You assumed this was due to unpacking boxes after your recent move, but you could not really remember straining your wrist. You had to turn the unpacking over to your wife, because your wrist really was quite painful. The pain lasted about a week and gradually went away after you took some ibuprofen.

Three weeks ago, you had a swollen and painful right knee for five days. There was no trauma and you could not figure out why the knee was so painful and swollen. It was not red and you don’t think it was hot. You took some ibuprofen again and that seemed to help the problem resolve. The ibuprofen also seemed to help your back a bit. You have no joint swelling today.

You have no history of arthritis in your family. You have never had similar symptoms in the past. You have had no recent infections or illnesses. You have taken no antibiotics for any reason in the recent past. You have not travelled to any foreign destination recently.

In the past you have received follow-up management for ulcerative colitis. Your colitis has been “quiet” for the past three years, but you were told to expect recurrences at any time.

Your stools have been mostly normal for the past three years. You have a bowel movement about once a day, with no pain or bleeding. On a few occasions you have had more frequent stools for a few days at a time. When this occurs, the bowel movements may occur two to three times a day and be associated with some rectal pain and the passing of mucus. So far, these episodes have lasted for less than a week, and have not been associated with the passing of blood. Your ulcerative colitis “acted up” like this two weeks ago, but your bowel movements have been normal for the past week. You have not noticed a relationship between your bowel symptoms and stress.

Your gastroenterologist also suggested that you have a sigmoidoscopy every five to 10 years, and your last exam was about three years ago.

MEDICAL HISTORY

You were very healthy all your life until your first episode of colitis at age 30. It began with the gradual onset of frequent mucus-like stools and some pain with defecation. After about three weeks, you went to see your FP. Dr. Simon conducted a number of tests, including stool cultures and blood tests, and then referred you to a local gastroenterologist who performed a colonoscopy. The results of the exam and the biopsy confirmed what the gastroenterologist described as "mild" ulcerative colitis. The physicians were pleased that the pain was not severe and that there was very little blood in the stool. At that time, you told yourself you would hate to know what the "severe" pain was like! They also informed you that the disease was limited to the rectum at that time.

The gastroenterologist reported to Dr. Simon that your disease could be managed with mesalamine (Asacol) at a dose of 800 mg three times a day for six weeks. The dosage was dropped to twice a day after your symptoms resolved. You continued with this dosage for several months, but then discussed with your physician the possibility of discontinuing it. You experienced mild nausea with the drug and, although you were willing to continue taking it if necessary, you would rather take it only as needed. You discussed the pros and cons of maintenance therapy, and you opted to stop the medication. Since that time, you have had only one flare-up of the colitis. This was about three years ago, and you required another few months of mesalamine. You do have occasional mild exacerbations with a few days of mucus-like stools and more frequent bowel movements, but you do not worry about it unless it goes on for more than a week or if there is blood in your stool. You understand that you would have to restart your medication if this happened.

At the time of your initial episode, the gastroenterologist also explained that you were at increased risk of bowel cancer and other complications. This is why he recommended that you have a sigmoidoscopy every five years or so. Your last one was three years ago. You don't really remember much else about that conversation. After the gastroenterologist mentioned cancer, you "missed the rest." You don't recall any discussion of arthritis related to the disease, but he may have mentioned it. You are not one to look up diseases on the Internet.

Dr. Simon has all your records and has offered to transfer them as soon as you find a physician in your new city. You and Rachel really wish that you could continue seeing Dr. Simon. You had a good relationship with him, and you can only hope that your relationship with the new FP will be as good.

SURGERY

You have never had any surgical procedures.

MEDICATIONS

- You take no medications regularly.
- You take no supplements.
- You recently took some ibuprofen purchased without prescription for joint pain.
- In the past, you have taken mesalamine for treatment and suppression of ulcerative colitis.

LABORATORY RESULTS

- None are available.
- You do not know what blood tests were performed at the time of your ulcerative colitis diagnosis.

ALLERGIES

You have no known allergies.

IMMUNIZATIONS

All your immunizations are up to date.

LIFESTYLE ISSUES

Tobacco: You have never smoked.

Alcohol: You have three to four alcoholic beverages a week. Usually, your alcohol intake consists of a glass of wine with Rachel in the evening or with a client at a business lunch.

Caffeine: You drink four cups of coffee a day.

Illicit Drugs: You do not use any illicit drugs.

Diet: You have a "regular" North American diet, which is generally well-balanced. Rachel is concerned about your general health, and tries to encourage you to eat well.

Exercise and Recreation: You haven't settled into a routine in this new town yet; in your former town, you went to the gym three times a week. You and Rachel play tennis in the summer. You enjoy cycling.

FAMILY HISTORY

Your parents are in their early 60s and have no health problems of which you are aware. One paternal grandmother is still alive and well. Your other grandparents died "of old age." You are not aware of any history of cancer, bowel disease, or rheumatic diseases, other than older relatives' aches and pains. There is no history of psychiatric illnesses, degenerative neurological diseases, or seizure disorders in the family.

PERSONAL HISTORY

Family of Origin

You grew up in a happy home with one older brother and one younger sister. Your father was employed as an office manager, and your mother stayed at home to care for the children.

Your brother joined the military in his early 20s, and is still with the armed forces. He is married with two children who are a bit older than yours. The cousins do not see each other often, as your brother's family travels a great deal with the military.

Your younger sister works as a real estate agent. She is an unmarried lesbian. She enjoys caring for her cats.

Marriage

You met Rachel when both of you were attending university. You were studying management, while she was studying social work. You attended the same church at the time. Rachel sang in the choir. After dating for a couple of years, you decided to marry. You had graduated and had just started working as a junior accountant at that time. Both of you were 26.

EDUCATION AND WORK HISTORY

You graduated with good grades in high school (and in CEGEP, if the exam is taking place in Québec). Then you went to university and graduated with a management degree. Subsequently, you passed exams to practise as a chartered accountant. You began working for a large bank. Your transfer to this town is a result of a promotion within the bank.

FINANCES

You are quite comfortable financially. You have a good salary with the bank and good insurance. Your plan would cover any additional health-related expenses. (You mention this if the candidate asks if you could afford private treatments or therapy.)

Rachel has found a job with the local social service department, which involves residential planning for the elderly with loss of autonomy. This is the type of work she had in your former community. She started her job this week, and is excited about it.

SOCIAL SUPPORTS

The move to this new town has left you without your usual supports. You have yet to make friends here. You have been attending church on Sunday, but do not yet know members of the community.

Your family and Rachel's live in your old community. Both of you are close to your parents, and you have been in contact with them about Marc and his strange behaviour. Both sets of grandparents are worried, although your parents were willing to accept the explanation that this might be a temporary behaviour problem due to stress.

Rachel was an only child, and her parents dote on their grandchildren. It was very difficult for them when you left your former community. Now that Marc might have a problem, they are almost frantic. They have been calling every day to find out "if it has happened again." They were very relieved when you said you were going to consult a doctor. At this point, they are more "anxiety-enhancing" than supportive. On the other hand, you know that all the extended family on both sides would help in any way possible if one of your children became sick or disabled.

RELIGION

You and your family are churchgoers. (Choose any denomination or faith community.) You consider yourself to be a man of faith, and you and Rachel believe that raising your children within the church (or synagogue or mosque) is important. You were embarrassed by Marc's outburst during the sermon, especially as you and your wife and sons are new members of the congregation. You miss the support of your faith community in your former town.

EXPECTATIONS

You and Rachel are praying that Marc's problem will "just go away." It has come at a very bad time. You are settling in at your new management job at the bank, Rachel is starting her new job, you have barely unpacked, you all miss your family and your old friends, your joints are mysteriously swelling, and your child is acting strangely. Your primary worry is for Marc. You hope the FP will reassure you that this is just a normal "phase."

ACTING INSTRUCTIONS

Instructions are written according to ideas, feelings, expectations, and effect/impact on function.

You are in business attire, as if you have come directly from your job at the bank. You are nervous about meeting the new physician. You had a very good relationship with Dr. Simon, and you hope that you can have the same trust in this new physician.

When you discuss Marc, you are clearly worried and want to be reassured. You are hoping so hard that nothing is wrong, that you are almost apologetic about taking up the FP's time. You might make statements such as the following:

1. "I am sure it is nothing, but it worries us."
2. "The teacher told us that we shouldn't draw attention to it, but we are worried anyway."
3. "My wife is quite upset about it, even though we hope it is going to go away as the teacher told us."
4. "Should we be worried?"

If the candidate reassures you **inappropriately** (i.e., if he or she thinks Marc has a simple behaviour problem due to stress or acting out), express your concern a bit more forcefully. You might make comments such as the following:

1. "He is always such a good kid; we don't understand where this behaviour is coming from."
2. "It just doesn't seem normal."
3. "I have not seen other kids acting like this."

Your **FEELING** is worry. The candidate probably will not need to ask the question about your feelings, as you likely have already said you are worried. If he or she does ask, you could say, "Well, I guess we are worried. Do you think we should be?"

Your **IDEA** is that Marc could just be demonstrating a behaviour pattern because of the new school, but that this behaviour could also indicate a serious disorder. If pressed, you say something like "I hope it is nothing and that it will go away—but do kids who have mental problems start acting like this?" This comment will convey the fact that you and Rachel really have no idea what to expect. Could this be early mental illness? Epilepsy? A brain tumour?

The story clearly indicates that there has been no impact on **FUNCTION** at this point, and it would be an odd question for a candidate to ask. Your response might be "What do you mean?"

Your **EXPECTATION** is that the physician might give you some idea of what is going on. You expect that he or she will want to see Marc very soon if there is any possibility that he could have anything more serious than a transient behaviour problem due to stress. If the candidate says that he or she has to see Marc before suggesting what might be wrong, ask, "Well, what kind of things could cause this?"

You believe that your own physical problem is minor in comparison. You should begin by discussing the joint swelling and pain in an almost offhand way. The prompt should lead you to make some brief, apologetic comments about your joint pain. Stress the fact that you have had actual joint swelling. The candidate should discover the ulcerative colitis history, either by questioning you about possible causes of joint inflammation or by asking general questions about your past medical history. You might respond with the following types of comments:

1. "Yes, I do have ulcerative colitis, but it rarely causes me problems. I had a bit of a flare-up two weeks ago, but it is back to normal."

2. "I know that I will have to make an appointment with you about that some time. The family doctor who was treating us in our hometown told me that I should make an appointment with someone here to follow up on that."

Your **FEELING** is mostly annoyance that this is happening when so many other things are going on in your life.

Your **IDEA** is that you seem to have some early kind of arthritis. You might say, "I don't know. Do you think this could be arthritis? I am only 38! But it is odd the way the wrist and the knee swelled up for no reason." You do not know of any connection between ulcerative colitis and joint involvement.

There has been no major effect on your **FUNCTION**, except that you have had to leave some of the unpacking to your wife. You were limping quite a bit when your knee was swollen, but you still got around. The back pain means you take a bit longer to get going in the morning, but you do keep going.

Your **EXPECTATION** is that the FP will probably "want to do some X-rays or something." You would be pleased if investigations were started soon, although in your current state of mind you would not prioritize these.

Both these problems are potentially complex, with many possible differential diagnoses. The successful candidate will not necessarily diagnose the problem, but will recognize the potentially serious possibilities and will suggest reasonable diagnostic investigations. You should leave the office appropriately concerned about Marc and your own joint problems, but with the feeling that the problems "will be sorted out."

CAST OF CHARACTERS

ROBERT MARTIN:	The patient, age 38, an accountant with joint swelling and ulcerative colitis.
RACHEL MARTIN:	Robert's wife, age 38, a social worker whom he married 12 years ago.
MARC MARTIN:	Robert and Rachel's son, age 10 years, who is exhibiting uncontrollable, stereotypical behaviours.
WILLIAM MARTIN:	Robert and Rachel's son, age seven years.
Dr. SIMON:	Robert's former FP.

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

TIMELINE

Today:	Appointment with the candidate.
2 weeks ago:	Marc's first outburst.
3 weeks ago:	Right knee became swollen and painful.
6 weeks ago:	Left wrist became swollen and painful.
2 months ago:	Moved to this community.
3 months ago:	Stiffness in lower back began.
3 years ago:	Last flare-up of ulcerative colitis/last sigmoidoscopy.
7 years ago:	William born.
8 years ago:	Diagnosis of ulcerative colitis.
10 years ago:	Marc born.
12 years ago:	Married Rachel at age 26.
38 years ago:	Born.

INTERVIEW FLOW SHEET

INITIAL STATEMENT:	**"Thank you for seeing me, Doctor. We just moved to this town, and my son, Marc, is behaving strangely."**
10 MINUTES REMAINING:*	If the candidate has not brought up the issue of your arthritis symptoms, the following prompt must be said: **"It has been one thing after another since we moved. I started having pain in my joints."**
7 MINUTES REMAINING:*	If the candidate has not brought up the issue of son's behaviour, the following prompt must be said: **"I hope we can do something for Marc."** *(This prompt is unlikely to 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 a certificant **must** gather information about the illness experience to gain a better understanding of the patient and his or her problem, a superior performance is not simply a matter of whether a candidate has obtained all 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). It is intended to be 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 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 that the patient uses

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 the patient's culture
- Uses appropriate words for children and teens (e.g., "pee" rather than " void")

Non-Verbal Skills

Expressive

- Is conscious of the impact of body language on communication and adjusts it appropriately

Sample Behaviours

- Ensures eye contact is appropriate for the patient's culture and comfort
- Is focused on the conversation
- Adjusts demeanour to ensure it is appropriate to the patient's context
- Ensures physical contact is appropriate for the patient's comfort

Receptive

- Is 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.")

Language Skills

Verbal

- Has skills that are adequate for the patient to understand what is being said
- Is able to converse at a level appropriate for the patient's age and educational level
- Uses an appropriate tone for the situation, to ensure good communication and patient comfort

Sample Behaviours

- Asks open- and closed-ended question appropriately
- Checks with the patient to ensure understanding (e.g., "Am I understanding you correctly?")
- Facilitates the patient's 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

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.

(1) Allen T, Bethune C, Brailovsky C, Crichton T, Donoff M, Laughlin T, Lawrence K, Wetmore S. 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 February 7, 2011}. Available from: *http://www.cfpc.ca/uploadedFiles/Education/Defining%20Competence%20Complete%20Document%20bookmarked.pdf*

1. IDENTIFICATION: SON'S BEHAVIOUR

SON'S BEHAVIOUR	ILLNESS EXPERIENCE
Areas to be covered include **1. history:** • Sudden onset. • Occurring more frequently. • Happened at school and church. • Child cannot control or explain the behaviour. **2. psychological factors:** • No history of disruptive behaviour in the past. • Did not seem stressed (e.g., was sleeping well). • No history of integration problems in school. • Children at school now making fun of him. **3. neurological factors:** • No confusion /cognitive changes following the outbursts. • No weakness before or after. • No incontinence. • No headache. • No history of repetitive behaviour (tic) **4. no family history of psychiatric and / or neurological disease.**	**Feelings** • Worry **Ideas** • This is because of stress, but could it be something more serious? **Effect / Impact on Function** • None **Expectations for This Visit** • The FP will explain what could be going on. **A satisfactory understanding of all components (Feelings, Ideas, Effect / Impact on Function, and Expectations) is important in assessing this patient's illness experience.**

Superior	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.
	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.
	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: POLYARTHRITIS/ULCERATIVE COLITIS

POLYARTHRITIS/ULCERATIVE COLITIS	ILLNESS EXPERIENCE
Areas to be covered include **1. history of joint involvement:** • Began with lower-back pain. • Morning stiffness in back. • Knee and wrist affected on separate occasions. • Swelling and pain. • Not temporally related to ulcerative colitis flare-ups in his case. **2. history of ulcerative colitis:** • Diagnosed eight years ago. • Described as "mild form of ulcerative colitis." • Treated with mesalamine. • Last severe flare-up three years ago (needing medication). **3. management to date/ current symptoms:** • Was told he should have sigmoidoscopy every five years. • Opted not to have maintenance therapy. • Aware of increased cancer risk. • Had one week of frequent stools with mucus two weeks ago. **4. no other extra-intestinal manifestations of ulcerative colitis (e.g., uveitis, erythema nodosum, hemolytic anemia).**	**Feelings** • Annoyed at the inconvenience **Ideas** • Is this arthritis? **Effect/Impact on Function** • Minor: made unpacking difficult, caused limping, led to slow movement in the morning **Expectations for This Visit** • The FP will probably want to do some tests. **A satisfactory understanding of all components (Feelings, Ideas, Effect/Impact on Function, and Expectations) is important in assessing this patient's illness experience.**

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.

3. SOCIAL AND DEVELOPMENTAL CONTEXT

CONTEXT IDENTIFICATION	CONTEXT INTEGRATION
Areas to be covered include **1. life-cycle issues:** • Married with two children. • New employment. • Moved to this new city. • Wife also working. **2. social/personal supports:** • Support through religious belief. • Not yet integrated into the religious community. • Emotionally close to parents and in-laws, but now separated by distance. **3. The family would have access to private therapy/treatments if these were needed.**	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 empathic 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: **"Everything does seem to be happening at once, doesn't it? We know that stress can make some things worse. Moving and starting a new job is stressful. Children often act out when they are stressed, and ulcerative colitis can get worse. But I think you realize that we would be wrong to blame all of this on stress. It would seem that these illnesses are adding to your stress rather than resulting from it, wouldn't you agree? We need to figure out what is going on. It is especially hard on you and your wife since you are missing the support of your family and your usual doctor."**

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 1and 2	Demonstrates recognition of the impact of the contextual factors on the illness experience.
Non-certificant	Does not 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: SON'S BEHAVIOUR

PLAN	FINDING COMMON GROUND
1. Recognize that this is not a normal behaviour. **2. Discuss differential diagnostic possibilities, which might include Tourette's syndrome, atypical epileptic behaviour, or compulsions.** **3. Outline possible investigations (e.g., electroencephalography, neurological referral).** **4. Consider supportive services for the child to help him cope with the problem at school (e.g. school resources to help with bullying).**	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 or 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: POLYARTHRITIS/ULCERATIVE COLITIS

PLAN	FINDING COMMON GROUND
1. Make the possible connection with ulcerative colitis. **2. Arrange to obtain old records.** **3. Discuss appropriate investigations (such as inflammatory markers in blood tests, radiographs of the lower back).** **4. Arrange referral for specialised arthritis treatment.**	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 or 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 not cover points 1, 2, and 3	Does not 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, a 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.