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 22

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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 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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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. **malaria.**

2. **concerns about a sexually transmitted infection.**

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. **PAUL LAMBERT**, age 56, 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 posed?

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 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. **PAUL LAMBERT**, age 56. You have just returned from doing volunteer work in Tanzania and have been having some fever and chills. On your last night in Tanzania you had a sexual encounter with a local woman. You are married and worried that you may have caught a disease you could transmit to your wife.

You did not wish to visit your own family physician (FP), **Dr. SIMONE JACKSON**, as she is also the FP for the rest of your family and you are a little worried about the sensitive nature of your problem.

HISTORY OF THE PROBLEM

Possible Malaria

You are an engineer. Annually for the past six years you have travelled to the interior of Tanzania, to the village of Uvinza. It is outside Kigoma on the shores of Lake Tanganyika. For two months you stay with other Western volunteers in a purpose-built compound near a water treatment plant. The compound has sleeping areas, a cafeteria, and a media room. While you are there, you help build water and sewerage pipelines from the village to the lake, via the appropriate treatment plants. The distance to the lake is approximately 50 km.

Your visits to Tanzania are usually in August and September, when the weather is not too hot in the interior. This is not during the rainy season, which occurs from December to April. The malaria risk is greatest during those months; however, the risk is always present, especially as the compound is near a lake and rivers.

You are aware of the risk of malaria and always undergo prophylaxis before and during your time in Tanzania. Specifically, you take mefloquine, 250 mg once a week. You also sleep in an air-conditioned room, have a mosquito net around your bed, and wear clothes that cover most of your body. Each day, you liberally spray mosquito repellent over your clothes and body.

You don’t like taking mefloquine because it makes you a little depressed and gives you very vivid dreams. Occasionally you forget to take your scheduled tablet, and may take one a day or so late. After a hot, busy day you sometimes fall asleep without pulling the net around your bed, or leave the window open to the outside air. On rare occasions, you forget to cover yourself in DEET before you go to work in the

early morning. You would describe yourself as 80% to 90% reliable in protecting yourself against malaria.

About a week before returning from Africa two weeks ago, you started having sweats and chills, although these don't occur daily. You haven't really thought about your symptoms, but the fever occurs perhaps every second day, and mainly at night. Initially the symptoms weren't too bad, but they have continued and worsened slightly since you returned to Canada. You have woken up with the bed sheets soaked and a fever above 38.5 degrees Celsius. You feel fatigued and your muscles ache. Acetaminophen (Tylenol) seems to have no effect. However, the fever appears to disappear within 12 hours and then you feel better again.

You have no cough, sore throat, or earache. You also have no rashes, urethral discharge, photophobia, or neck stiffness, although you have had a low-grade, "grumbling" headache (3 out of 10 on a 10-point pain scale) since your return from Tanzania. This headache seems to be present at all times, is bilateral, and does not affect your vision. Tylenol has no effect on it.

You have no pain on urination and no change in bowel habit, although you do seem to be having some abdominal cramping and a dull pain centrally. There is no blood in your stools or urine.

Your weight may be down a few pounds, but you always lose a little weight during your two months in Tanzania. You have attributed your five- to six-pound weight loss to your lifestyle and your current slight nausea, which is associated with your abdominal pain. This may have led you to cut down on your food intake a bit. You have not vomited.

You own a small construction company and are thus your own boss, so asking for time off work would not really be a problem. You haven't taken any time off yet, but would gladly consider doing so. You feel worn out and exhausted. You have difficulty concentrating on complex tasks, and twice your secretary has mentioned that you look pale and should see a doctor. She was the one who arranged this appointment for you.

The possibility that you may have malaria has crossed your mind. The area in which you volunteer is considered a high-risk one, and you have not been 100% vigilant in protecting yourself. However, the thought that another disease is causing your symptoms has crossed your mind, and you would also like to talk to the FP about this.

Concerns About Sexually Transmitted Infection Risk

You attended a farewell party on your last night in Tanzania. You are a popular guy, and your co-workers laid on a fancy meal and some drinks for you. You weren't feeling too well that night because of sweating and chills. You also were eager to get home and see your wife, and were quite happy to be leaving. Maybe it was the effect of the mefloquine, but during this trip you felt more down and lonely than ever before. Nevertheless, you felt you should attend your party as everyone had put a

lot of effort into preparing it. The party was as close to "formal" as one can get out in that area. You don't normally drink, but you drank a few (four) bottles of beer that night.

With four beers inside you, you retired at about 10 pm. You expected another night of vivid dreams and nightmares, but you were glad this was your last night and you would be home soon.

Sometime in the night your door opened and a young local woman, **HANIFA**, entered your room. She had been serving you during the party and you have known her for several years. She is one of the friendlier local workers, and you guess she is about 20 years old. She said her family had sent her to you "to say thank you for all your hard work" for the village. She got into your bed and it was obvious that she was offering you some free sex.

You are not sure if your willpower was low because of the beer or whether you thought that this was just another vivid dream, but you put up little resistance and spent the next few minutes, or maybe hours, having sex with Hanifa. It was all a bit of a blur. You did not wear a condom as far as you recall.

The next morning Hanifa was gone and you were a little confused as to whether or not this episode had really happened. The bed was a mess, but then it frequently was if you had been having a bad nightmare.

However, when you said goodbye to the kitchen staff before leaving, Hanifa turned to you and gave you more than the normal kiss on the cheek. Then she said, "Thank you for last night!" You were mortified! The deed really **did** happen!

You returned home two weeks ago and have been consumed with guilt ever since. You have never been unfaithful to your wife before this event and have always had an open and honest relationship with her. You are regular churchgoers and this is one of the reasons that you volunteer in Africa; you would feel very ashamed if any of this got out to your church community.

In addition, you worry you may have caught a disease from the young woman. You didn't wear a condom, and thus you may have "contracted something." You have no urethral discharge or pain on urination. There are no lumps in your groin to suggest lymphadenopathy. You have no sores or rashes around your genitalia, or any pain in your groin or anywhere in your pelvis. The only unusual symptoms are the fever, chills, and mild abdominal pains and headaches, and these started a week before your sexual encounter.

You are an honest man and you decided, on your flight home, that you had to tell your wife, **CHRISTINE HOUGHTON**, what had happened. No doubt she would want to make love on your return, and she would find it a little odd if you refused or wore a condom for the first time in your relationship. You thought you could try telling her that you were tired and jetlagged and not feeling very well at the moment, but this ploy would work only so long before the truth came out. Hence you concluded that honesty was the best policy, and you told Christine what had happened.

Naturally she was shocked initially and shed tears, but you love each other deeply and have decided to put this behind you and try to move on. The atmosphere in the house is tense, and you are sleeping apart for the time being, but you are being sociable and neither of you is talking about splitting up.

You have told no one else about what happened. Dr. Jackson goes to your church, as does her secretary, **ANTONIA**, and you simply couldn't tell her your story for fear of embarrassment.

You would like this FP to lend a sympathetic ear and to rule out any serious diseases. Human immunodeficiency virus (HIV) infection is very common in the area of Tanzania where you worked, and you would certainly like this to be ruled out first and foremost.

You haven't considered that the young woman might be pregnant. However, you have wondered how this turn of events might affect your future trips to Tanzania. The water pipes are almost complete now, so you have probably done more than most people in ensuring their health and safety. In addition, you are pretty sure that Christine would not be pleased if you returned, so maybe this has been your last trip. Now might be a good time to concentrate on rebuilding bridges with your wife.

MEDICAL HISTORY

You had acne as a young adult.

SURGERY

- You had an appendectomy at age 14 years.
- You had a laparoscopic cholecystectomy 10 years ago.

MEDICATIONS

You have taken mefloquine, 250 mg once a week, for malaria prevention.

LABORATORY RESULTS

You have had no blood tests in the past year. Your last "complete physical" revealed no particular abnormalities, as far as you recall. Specifically, you seem to remember that your blood count, glucose, and thyroid results were normal.

ALLERGIES

You are allergic to tetracycline. It gives you a rash. This was used to treat your acne but the acne became a lot worse and you ended up with both the acne and an allergic reaction.

IMMUNIZATIONS

You have had all the normal immunizations. Specifically, you have had measles, mumps, and rubella and diphtheria, pertussis, and tetanus immunizations. You have also had hepatitis A and B vaccines (Twinrix), as well as typhoid, polio, yellow fever, and even rabies vaccines. A travel clinic in this city recommended all these six years ago, before you went to Tanzania for the first time.

LIFESTYLE ISSUES

Tobacco:	You are a non-smoker.
Alcohol:	You drink very rarely. You have a beer about once a month.
Caffeine:	You do not drink caffeinated beverages.
Illicit Drugs:	You use no illicit drugs.
Diet:	You have no special dietary needs.
Exercise and Recreation:	You go to a gym once a week and play squash once a week with **GRANT HOLT**, a friend from your church. However, since you returned home two weeks ago, you haven't had the energy to play any sports.

FAMILY HISTORY

There is no significant family history of any illnesses, as far as you know. Both your parents seem very healthy.

Specifically, there are no strokes, heart attacks, or diabetes in the family. No hematological conditions (e.g., sickle cell anemia) run in the family.

You are an only child.

PERSONAL HISTORY

Family of Origin

Your parents emigrated from France to Canada in the early 1950s. They settled in this province and have never moved away. You see them at church every Sunday.

Marriage

You met Christine while the two of you were attending university in a different province. You met through mutual friends when you both were 20. You and Christine were hard-working and held similar religious and moral beliefs. You married after three years. You moved back here to your home city two years later when you were offered a job at a local engineering company.

Christine is an only child. Her father died many years ago in a motor vehicle accident. Both he and Christine's mother were schoolteachers. They lived in the province where you and Christine attended university.

Four years ago, Christine's mother, **ALEX**, had a stroke that affected her balance. She now uses a wheelchair. She wanted to be closer to family, and hence she moved to this city shortly after the stroke. You and Christine visit her in her assisted living condominium every week after church.

Children

You and Christine had your first son, **WESLEY**, shortly after you moved to this province. Your son **ROBERT** was born two years later. Wesley is now 30 and Robert is 28. You are a very close-knit family and keep in regular contact. Both sons share your religious beliefs.

When your church first formed ties with the Kigoma region in the west of Tanzania, many members of the congregation went there for extended periods to help build a school, a library, and a new church. Wesley was among the first to volunteer when he was only 20. You were very proud of him.

During his first summer there, violence erupted in the neighbouring provinces and spread into west Tanzania. Wesley's right leg was badly wounded when he was shot while defending some schoolchildren in the church. The villagers kept him alive and hidden from the armed rebels for several days, and without their intervention and care, undoubtedly he would have died. Months later, he returned to Canada in a wheelchair, and you took a few weeks off work to support him. With the help of the doctors, your church, and your family, Wesley recovered well.

He did need several operations to enable him to walk again. He still needs a cane. Once he was able to, he earned a teaching degree in this city and now teaches in a primary school about 5 km from you. He is married to **GEORGINA**, and they are expecting their first baby within the next few months.

Wesley never returned to Tanzania, but thanks to him, your family name is held in very high esteem in the villages around Uvinza. Likewise, your family owe a huge debt to the local villagers for keeping your son alive. The violence in the area has never arisen again, and seems to have retreated across the border into the Democratic Republic of Congo and Rwanda.

Robert is attending university in a different province and is studying theology. He hopes to enter the church as a minister. He is unmarried.

EDUCATION AND WORK HISTORY

Like your father, you always had an interest in engineering. You graduated from high school with good grades and went on to earn an engineering degree in a different province. Christine earned a sociology degree at the same university.

You have worked at Carrow Engineering for 31 years. The company's main activity is laying underground pipelines or cables.

The company boomed when the Internet surfaced because cables were needed everywhere, and your work ethic saw you gradually rise to the top of the company. You are now chairman and CEO.

You employ about 50 workers and think of the company as being ethically and ecologically driven. You know all your employees by first name, and your company is listed as one of the top 10 to work for in this city. You have a good support team at work and they seem very capable of running the company without you for a month or two.

Several years after Wesley volunteered to go to Tanzania, your church again asked for volunteers to help lay some water piping in the area. You felt that the time was right to go to Tanzania. Christine was very supportive, and the job would last for only two months every year. You both felt that you owed the villagers a huge debt for saving your son, and also felt moral and religious obligations.

You have now flown out to Tanzania every year for the past six years. The church has paid your way. Gradually the pipeline has been built and it is now near completion. Within weeks Uvinza should have clean running water, as well as a modern sewage treatment plant.

For the first two years, Christine accompanied you on the trips. Then, after her mother had a stroke four years ago, Christine felt she couldn't leave her alone in her condo for several months at a time. Therefore you have been alone during your last four visits.

FINANCES

You are comfortably off. You have paid off your house mortgage and have money set aside for your retirement. Every year, you and Christine vacation in Hawaii, where you have a time-share apartment.

Christine works part time (three days a week) in the hospital social work department. She has published several articles on the link between lack of inner city funding by local government and the rise in the abuse of women and children. Once a week she volunteers at a centre for abused women.

SOCIAL SUPPORTS

Your family and your church are very important to you.

You see Wesley, Georgina, and your parents most Sundays when you go to church. You send an e-mail or a Facebook message to Robert every Sunday.

You also made many of your friends through the church. You met Grant at church and try to play squash with him weekly. You aren't into partying or drinking too much, but you may have a bottle of beer with him, after a game, perhaps once a month.

You have an elderly black Labrador dog named DaliWali. He was supposed to be named after the Dalai Lama, but his name has sort of changed over time.

RELIGION

Both of your parents are from the Rhone Valley in the south of France and are very spiritual. When they came to Canada they attended the church nearest their home, which was a non-denominational one. This is the church you have always attended in this city, and through which most of your contacts have been made. Your regular FP attends services there each Sunday, as does her secretary.

In your office you have many religious pictures and ornaments demonstrating your faith.

EXPECTATIONS

You expect the FP to test you for malaria and to rule out the possibility of STIs, especially HIV infection.

ACTING INSTRUCTIONS

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

You are casually dressed. You wear no jewellery other than your wedding ring.

You are polite and thoughtful. You make good eye contact. You are not having any fevers, sweats or chills today, but you did yesterday.

You readily volunteer the information that the woman involved in the sexual encounter was 20 years old, so that there is no concern about sex with a minor.

You would be quite forthcoming that you suspect that this is Malaria.

You are **FEELING** worried and your **IDEA** is that you may have malaria. The effect on **FUNCTION** is difficulty working effectively. Your **EXPECTATION** is that the FP will do a test for malaria.

You have told your wife about your sexual encounter, and although you are **FEELING** ashamed of what you did, you have no problem talking about it with the candidate. Your **IDEA** is that you may have an STI. There is no effect on **FUNCTION** yet. Your **EXPECTATION** is that the FP will rule out the possibility of STIs.

Your answers are precise, as one would expect from an engineer.

CAST OF CHARACTERS

PAUL LAMBERT:	The patient, age 56, an engineer with malaria and concerns about STIs.
CHRISTINE HOUGHTON:	Paul's wife, age 56.
HANIFA:	A Tanzanian woman, about age 20, with whom Paul had sex.
WESLEY LAMBERT:	Paul and Christine's son, age 30.
ROBERT LAMBERT:	Paul and Christine's son, age 28.
ALEX:	Christine's mother.
GEORGINA:	Wesley's wife.
GRANT HOLT:	Paul's friend from church.
Dr. SIMONE JACKSON:	Paul's regular FP.
ANTONIA:	Dr. Jackson's secretary.

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:	Returned from Tanzania after a sexual encounter the night before leaving.
3 weeks ago:	Feeling of malaise started.
2 months ago:	Left for Tanzania.
6 years ago:	First trip to Tanzania.
10 years ago:	Wesley injured in Tanzania; had your gallbladder removed.
28 years ago:	Robert born.
30 years ago:	Wesley born.
31 years ago:	Moved back to this province.
33 years ago:	Married Christine.
36 years ago:	Met Christine at university in a different province.
42 years ago:	Appendix removed.
56 years ago:	Born.

INTERVIEW FLOW SHEET

INITIAL STATEMENT:	**"I have been having some fevers and chills."**
10 MINUTES REMAINING:*	If the candidate has not brought up the issue of your fear of an STI, the following prompt must be said: **"I did something stupid on my last night in Tanzania."**
7 MINUTES REMAINING:*	If the candidate has not brought up the issue of the possibility of malaria, the following prompt must be said: **"Do you think I caught malaria when I was away?"** *(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: MALARIA

<table>
<tr><th>MALARIA</th><th>ILLNESS EXPERIENCE</th></tr>
<tr><td>

<u>Areas to be covered include</u>

1. symptoms suggestive of malaria:

High fever (above 38 degrees).
Intermittent.
Sweats.
Headache.
Abdominal pain.
Three weeks' duration.

2. pertinent negative factors:

No cough.
No sore throat.
No diarrhea or vomiting
Not relieved by Tylenol.

3. risk factors for malaria:

Recent travel to a high-risk area.
Occasionally forgot prophylaxis.
Occasionally exposed himself to mosquitos (eg slept with net open, didn't cover with DEET on a daily basis, left window open)

4. Feels depressed on Mefloquine

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<u>Feelings</u>

Worry

<u>Ideas</u>

This may be malaria.

<u>Effect/Impact on Function</u>

He is unable to work effectively.

<u>Expectations for This Visit</u>

The doctor will do a test for malaria.

A satisfactory understanding of all components (Feelings, Ideas, Effect/Impact on Function,
and Expectations) is important in assessing this patient's illness experience.

</td></tr>
</table>

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: CONCERN ABOUT AN STI

CONCERN ABOUT AN STI	ILLNESS EXPERIENCE
Areas to be covered include **1. sexual encounter:** • Two weeks ago. • Unprotected intercourse. • 20-year-old woman involved. • Has never been unfaithful to his wife previously. **2. pertinent negative factors:** • No dysuria. • No penile discharge. • No swelling in groin (lymphadenopathy). • No rash or sores **3. consequences:** • Has told his wife. • No intercourse with his wife. **4. the fact that Hanifa can be contacted, if necessary.**	**Feelings** • Guilt • Worry **Ideas** • Could he have an STI? **Effect/Impact on Function** • None **Expectations for This Visit** • He would like the doctor to rule out STIs, especially HIV infection. **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

<table>
<tr><th>CONTEXT IDENTIFICATION</th><th>CONTEXT INTEGRATION</th></tr>
<tr><td>

<u>Areas to be covered include</u>

1. family:
• Two children.
• Parents in town.
• CEO of an engineering company.
• Wife is a social worker.

2. church:
• Attends regularly
• Church-sponsored trip to Tanzania.
• Son intends to join the priesthood/ministry.
• Most friends are members of the church.

3. trips to Tanzania:
• Annual.
• Wife stays home to take care of her mother.
• Building a water pipeline.
• May not go back to Tanzania.

4. his intention to work out his marital difficulties.

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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:
"This must be difficult for you because this indiscretion is affecting the most important things in your life: your family , your faith, your self-respect and your church."

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</table>

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, and 3.	Demonstrates recognition of the impact of the contextual factors on the illness experience.
Non-certificant	Does <u>not</u> cover points 1, 2, and 3.	Demonstrates minimal interest in the impact of the contextual factors on the illness experience, or cuts the patient off.

4. MANAGEMENT: MALARIA

PLAN	FINDING COMMON GROUND
1. Agree that this could be malaria. **2. Arrange testing for malaria.** **3. Reassures patient that Malaria is treatable.** **4. Discuss the fact that this is a reportable disease.**	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.

5. MANAGEMENT: CONCERN ABOUT AN STI

PLAN	FINDING COMMON GROUND
1. Agree that the patient is at risk for an STI. **2. Arrange testing for STIs, which must include an HIV test.** **3. Offer support for the patient and his wife, in view of the current difficulties.** **4.Discuss repeat testing because of the window period for HIV infection and syphilis.**	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.

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.