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 6

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. **thyroiditis;**

2. **post-concussion syndrome.**

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. **CHARLES POTVIN**, age 30, 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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10 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. **CHARLES POTVIN**, a 30-year-old gym teacher. You have booked this appointment today because you have been feeling generally unwell and you are concerned that something is wrong.

You have never gotten around to finding a family physician (FP), but a friend recommended this practice. Your wife and daughter's FP is not taking new patients at this time.

HISTORY OF THE PROBLEM

Thyroiditis

About a month ago, you had an upper respiratory infection (URI) that lasted about one week. It was like a regular cold with a stuffy nose, mild fever, and no sore throat. You thought nothing of it. You began to feel unwell only about two weeks ago. You were coaching a basketball game at the high school where you work, when you noticed you just couldn't keep up. You felt that your heart was beating quickly and that you were overheated. You had to get someone to fill in for you while you sat down and drank some cold water. Eventually you felt fine again, but you began to worry that something was wrong with you. Since then, you have become aware that your heart seems to beat fast all the time. You have a machine at the gym that reads blood pressure and pulse rate, and your resting heart rate is about 100 bpm. Before this, it would have been 50 to 60 bpm. Even when you are lying in bed you are aware that your heart is beating fast. It is not episodic; the pulse is always fast. You have not had chest pain. Your heartbeat does not seem irregular.

The only other factor that you have definitely noticed is a sore neck. The pain is not excruciating (3 out of 10), but moving your neck causes soreness and pressing on your anterior neck, around the Adam's apple, also leads to a slight soreness. Your neck feels as if it is "stretched" or "bruised," but you can recall no trauma that could have caused this. No one has commented on any swelling in your neck, but it does feel fuller to you.

These are the only two symptoms you can describe clearly, but you know you feel generally unwell. You have discussed the problem with your wife, **DANIELLE POTVIN**, who strongly encouraged you to make an appointment with an FP. She is concerned that something may be wrong with your heart. She has told you that, until you have been "checked out," you should reduce your exercise and "stay quiet." This is not something you can do easily, given your job and your interests.

You do have other symptoms, but they are more subtle and you mention them only if the candidate asks specifically. Your exercise tolerance is definitely reduced. You feel tired much sooner when you run. You are hungry all the time, but you have lost a couple of kilograms in the past month. You do not have diarrhea, but you are going to the toilet for bowel movements more often ("three times a day"). Your skin feels hot and dry to the touch. You have experienced no change in your hair in the past two weeks. You do not have a fever, and yet your wife finds you hot – and not in a good way. In fact, you have not felt like having sex in the past week or so, and this is not your regular pattern. In short, something is wrong.

You have never suffered from depression or anxiety, and your mood is good. You have not had any swelling of your legs or any pain or swelling around your eyes. You have not noticed any protrusion of your eyes. You have had no chest pain, no wheezing, and no shortness of breath at night or at rest. You have no cough.

Post-Concussion Syndrome

You would like to discuss another problem with the FP today. You have been experiencing headaches off and on for the past five months. You know exactly When the headaches began. You are in an amateur hockey team, which some friends and you started when all of you were physical education students at university. You are a defenceman on the team, and you play a very physical game. On one occasion five months ago, you were knocked into the boards, your helmet came off, and you cracked your head on the ice. You can't remember the blow, and you can't clearly remember being taken to the hospital and examined. You were told that you were unconscious for a couple of minutes. The memories didn't become clear until later that evening, when you were told that your computed tomography scan was normal and you could go home. Your wife picked you up and scolded you all the way home about your failure to be careful during the game.

You experienced no vomiting immediately after the accident or in the days following, but since then, you have had frequent dull headaches. They are not completely disabling. The pain is 5 out of 10. You can still carry on with your daily routine. They last for hours at a time, but disappear overnight. You have been sleeping poorly since the accident, but you don't blame your poor sleep on the headaches. You just seem to sleep fitfully. The headaches are not associated with limb weakness, numbness, or visual disturbances. You have had a few episodes of what you would describe as "dizziness." The room does not spin around you, and you do not feel as if you are going to faint. Rather, you have a vague sensation, as if your head is moving without you. You have no associated nausea or vomiting. You have noticed no change in balance. The headaches occurred every day at first, but you

think the problem is improving slowly. Now you experience a dull headache toward the end of the afternoon, two or three times a week. You have not mentioned the headaches to your wife or anyone else, because you suspect Danielle would worry or (worse) keep you from playing the rest of the season.

Since the accident, you have definitely noticed more difficulty concentrating. You will read the same paragraph twice to try to figure out its meaning. Your wife is constantly on your case about things you are forgetting, like grocery lists and appointments. You had to withdraw from an online course on educational communication because you couldn't retain the information. You also found that prolonged use of the computer was making your headaches worse.

You do not want to say so out loud, but you have been thinking about the long-term effects of frequent blows to the head. You have read about repetitive head injuries, and the possibility of long-term damage. It frightens you a bit. What if you get early dementia? In addition, in your university classes, your instructors stressed the importance of protecting students' heads during games, so you are quite aware that banging your head repeatedly is not a good idea. You know (intellectually) that you should be more careful. You also know that you should not have gone rushing back to play hockey the week following the concussion. After all, this is not the first time you have been knocked out. Hockey was always your passion, and you can remember several bumps to the head when you were in high school. On one other occasion, when you were in university, you were knocked unconscious and taken to the hospital. You believe you have been knocked out completely three times, and on two occasions the blow to your head was severe enough to send you to the hospital. On some other occasions you have received a blow serious enough to make you "see stars" for a few minutes. This, however, is the first time you have experienced ongoing headaches.

You have tried not to modify your activities because of the headaches, except for decreasing your computer time. You are continuing to do your work at school, including teaching all the gym classes and coaching the hockey and basketball teams. If you were honest with yourself, you would admit that you might have to stop playing hockey. You remember enough from your university classes to know that repeated blows to the head take longer and longer to heal. The school also has a strict policy about students returning to physical education after head injuries. You would never allow one of your students to play after a head injury unless he or she had been fully cleared by a physician. You are not following your own rules, but being unable to play hockey would take away one of your greatest pleasure in life. It would also wreak havoc with your social life and might even damage your career.

You do not feel comfortable discussing this with your wife. You know she will keep you from playing any contact sports again.

You do not see any relationship between the head injury and this recent illness that is making your heart race.

MEDICAL HISTORY

You have been very healthy all your life.

SURGERY

None.

MEDICATIONS

Currently you are taking no medications. You tried some Tylenol and some ASA (Aspirin) for your headaches. These medications helped a bit, but the headaches returned and so now you don't bother to take anything.

ALLERGIES

None known.

IMMUNIZATIONS

Up to date.

LIFESTYLE ISSUES

Tobacco:	You have never smoked.
Alcohol:	Once a week, you have two beers with your teammates after a hockey match. Danielle and you have an occasional glass of wine at home with meals. You probably have an average of eight drinks a week.
Caffeine:	You drink two cups of coffee a day. You drink no cola.
Illicit Drugs:	You have never used illicit drugs.
Diet:	You eat "everything." Your wife is quite health conscious, and tries to get you to follow a balanced diet. Recently, you have been quite hungry and you believe you are eating even more than usual.

Exercise and Recreation: You exercise regularly as part of your job and because you love sports.

FAMILY HISTORY

Your parents are healthy. Your paternal grandfather died of a heart attack at age 80. Your other grandparents are still alive. You do not believe you have a family history of any health concerns. Specifically, you know of no thyroid disease, psychiatric illness, or neurological disorders.

PERSONAL HISTORY

Family of Origin

You are the second of three sons. You were born and raised in this town. Your father works as a civic planner for the city. He has a stable job and a decent income. Your mother works as a teacher. She stopped working when you and your brothers were young, but returned when your younger brother reached school age.

Your older brother, **PHIL POTVIN**, is 32. He studied architecture at university in another town. He now lives there with his boyfriend of four years. You see the two of them every few months when they visit your parents. Your younger brother, **SAM POTVIN**, is 28. He studied restaurant management, and he is now employed at a local hotel restaurant. He hopes to open his own restaurant one day. He married last year and you see him and his wife at least once a month.

Marriage

You met Danielle when you both were in university. She was studying business. You dated for two years and married when you both were 27. You are very happily married. The time you spend with your wife and daughter means a great deal to you.

Children

Your first child. **MICHELLE POTVIN**, was born a year ago. Danielle had no problems with the pregnancy, labour, or delivery. Michelle is a healthy child, who attends daycare during the work week. Danielle and you hope to have another child in the next year or two.

EDUCATION AND WORK HISTORY

You graduated from high school with fairly good marks, although you were uninterested in most academic subjects. Your passion was sports. You were the star player on the high school hockey team, and studying to become a physical education teacher seemed a natural progression from high school. You knew that you did not have the talent to become a professional athlete, and this was a way to stay involved with your interests. You did well in your university career. You were a member of the university hockey team, which won the provincial championship. After graduation, you were lucky to find a position immediately at a large public school in the city. The school has a large gym and an active physical education department. You are not the only physical education teacher in the school, and so you are able to work as a coach for the high school hockey team. You get along well with the kids and love your job.

In terms of health matters, you are not as well informed as you should be. You certainly learned a bit of exercise physiology in university, as well as the basics of nutrition, safety concerns, sports psychology, etc. However, you never really cared much for this aspect of your education. You are also aware that your job and your recreational interests depend on your continued physical health.

FINANCES

A few months ago, Danielle returned to her job as a manager for a retail chain. Your two salaries combined are more than enough to cover the mortgage on your home, your regular expenses, and your planned savings. You also both have good salary insurance in case one of you becomes ill.

SOCIAL SUPPORTS

You are a popular guy. You have many friends at work, as well as your buddies on the hockey team. You are also close to your wife and your parents. However, you do not want to tell anyone that you are worried about your health. For some reason, that would be difficult.

You also do not want to worry your parents, and you fear your wife's reaction. She might say, "That's it! No more hockey!"

Your hockey teammates are not the sort to talk about their aches and pains. In other words, you have many friends, but no support for these particular problems. You know that if you became really sick or incapacitated, your wife, your family, and your friends would stand by you – but you don't want to face that possibility.

RELIGION

You are a non-practising Roman Catholic.

EXPECTATIONS

You hope the FP will determine what is causing your increased heart rate. You also want reassurance that the headaches don't indicate you have permanent brain damage.

ACTING INSTRUCTIONS

You are casually dressed. You are university educated and able to express yourself well. Your speech is direct and friendly. You have difficulty showing that you are worried about your health. You could say, with a chuckle, "I just wonder what the heck is going on!" A skillful candidate will get you to admit that your **FEELINGS** include worry about both problems.

After the first prompt, the candidate will probably ask you what you mean when you say your heart is "racing." Go on to describe the circumstances on the basketball court, and how you have checked your resting pulse rate and found that it is fast. You should emphasize that your heart rate is always fast recently. It is not an intermittent problem. (We do not want candidates to be concerned about episodic palpitations.) Thereafter, you should be able simply to answer the candidate's questions. Do not voluntarily reveal the URI symptoms from a month ago.

You have no clear **IDEA** about what could be making your heart beat quickly. Could it be a heart problem? It seems unlikely to you, because of your age and family history. At the same time, one hears about athletes suddenly dropping dead.

In terms of the headaches, your **IDEA** is that they are related to the concussion: "I banged my head too many times." After the second prompt, the candidate is likely to ask you what the headaches are like. Then you can go on to describe the dull headache you have had off and on for the past five months. Wait until the candidate asks about trauma, or until he or she explores your ideas, before bringing up the concussion. You are feeling a bit guilty about going back to playing hockey so soon after the injury and you fear a lecture from the FP.

Your **FUNCTION** is impaired by the hyperthyroidism. You had to sit out a basketball game you were coaching. The post-concussion headaches are keeping you from concentrating. You had to drop an online course.

You are really looking forward to talking to the FP today. Your **EXPECTATIONS** are that he or she will diagnose whatever is making your heart beat more quickly, and that he or she will reassure you that your brain is not permanently damaged. You trust physicians and feel that you will get a clearer picture of what is going on.

A superior candidate will make statements like the following:

- "You are usually in good health. This must make you worried."
- "What do you think might be going on?"
- "You really need to be able to be physically active in this job, and so having to sit out a game affects your work. Is it keeping you from doing other things?"
- "I suppose you would like me to do some tests to help figure this out."

With statements like these, a superior, patient-centred candidate will demonstrate a skillful exploration of FIFE.

CAST OF CHARACTERS

CHARLES POTVIN:	The patient, age 30, a gym teacher with a rapid heartbeat and headaches.
DANIELLE POTVIN:	Charles's wife, age 30.
MICHELLE POTVIN:	Charles and Danielle's daughter, age one year.
PHIL POTVIN:	Charles's older brother, age 32.
SAM POTVIN:	Charles's younger brother, age 28.

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:	Felt heart racing and had to stop coaching a game.
4 weeks ago:	Had a mild viral illness.
5 months ago:	Had a concussion while playing hockey; have had headaches since then.
1 year ago:	Michelle born.
3 years ago:	Married Danielle.
5 years ago:	Met Danielle
30 years ago:	Born.

INTERVIEW FLOW SHEET

INITIAL STATEMENT:	**"My heart has been racing for the last two weeks."**
10 MINUTES REMAINING: *	If the candidate has not brought up the issue of headaches, the following prompt must be said: **"I also wonder if I could ask you about some headaches I have been having."**
7 MINUTES REMAINING: *	If the candidate has not brought up the issue of thyroiditis, the following prompt must be said: **"Do you think I should be worried about my heart?"** *(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, and 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: THYROIDITIS (HYPERTHYROIDISM)

THYROIDITIS (HYPERTHYROIDISM)	ILLNESS EXPERIENCE
Areas to be covered include: **1. current symptoms:** • Fast but regular heartbeat. • Neck pain. • Weight loss. • Decreased exercise tolerance. • Hot skin. **2. pertinent negative factors:** • No chest pain. • No fever. • No trauma to the neck. • No excessive caffeine use. **3. related questions:** • No ophthalmopathy. • No change in hair. • No family history of thyroid disease. • Increased frequency of stools. **4. viral upper respiratory track infection four weeks ago.**	**Feelings** • Worry. **Ideas** • Does not know what this could be. **Effect / Impact on Function** • Had to stop coaching a basketball game. **Expectations for This Visit** • The FP will tell him what is wrong with him. **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.

2. IDENTIFICATION: POST-CONCUSSION SYNDROME

POST-CONCUSSION SYNDROME	ILLNESS EXPERIENCE
Areas to be covered include: **1. history of the head injury:** • Hockey injury five months ago. • Loss of consciousness. • Normal CT. • Amnesia. **2. pertinent negative factors:** • No nausea or vomiting. • No loss of balance. • No visual scotoma. • No paresthesias. • Did not modify his activities. **3. history of headaches:** • Dull pain. • Daily initially, now two to three days a week. • Worse at the end of the day. • Experiencing some dizziness. • Decreased concentration/ forgetfulness. **4. the fact that when he was in university, he learned about long-term dangers from repeated concussions.**	**Feelings** • Worry. **Ideas** • There could have been permanent damage. **Effect / Impact on Function** • He had to withdraw from an online course. **Expectations for This Visit** • The FP will reassure him that this will eventually go away. **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:** • Works as a physical education teacher. • One young daughter. • Planning a second child. • Coaches hockey at school. **2. social factors:** • Good relationship with parents and brothers. • Would not talk to his friends about health issues. • Wife also works. • Financially secure. **3. hockey is very important in his life.** **4. the school has a post-concussion policy that he is required to enforce.**	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: **"Hockey is important to you, both in your career and in your personal life. I understand how these headaches would make you worry about continuing to play. After all, you haven't told your wife about these symptoms because you know she will tell you to stop playing. You suspect she might be right, don't you?"**

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 not 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: THYROIDITIS (HYPERTHYROIDISM)

PLAN	FINDING COMMON GROUND
1. Suggest this could be a thyroid problem. **2. Perform a physical exam.** **3. Arrange laboratory testing, which must include thyroid function tests.** **4. Discuss symptomatic pharmacological treatment, if it becomes necessary.**	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: POST-CONCUSSION SYNDROME

PLAN	FINDING COMMON GROUND
1. Confirm that this could be due To the head injury. **2. Inform him he should stop all physical activity until all symptoms have resolved.** **3. Discuss the need to avoid any head injuries in the future.** **4. Consider how he could re-orient his recreational and professional activities away from contact sports (e.g., he can coach hockey at school without playing, and he can take up other sports for recreation).**	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.