THE COLLEGE OF FAMILY PHYSICIANS OF CANADA

LE COLLÈGE DES MÉDECINS DE FAMILLE DU CANADA

Certification Examination in Family Medicine

Overview of Simulated Office Oral (SOO) Structure and Marking

Updated June 2023

The College of Family Physicians of Canada
Certification Examination in Family Medicine

Introduction

The two components of the Certification Examination in Family Medicine are, together, designed to evaluate a representative sampling of the diverse knowledge, attitudes, and skills required by practising family physicians as set out in the Assessment Objectives for Certification in Family Medicine.

The short-answer management problem (SAMP) component assesses candidates' medical knowledge, problem-solving skills, and clinical reasoning. The simulated office oral (SOO) component assesses how a candidate establishes and uses the patient-centred method to care for patients in an office setting.

The College believes a patient centred approach using the patient centred clinical method[1] to providing clinical care helps patients more effectively. The SOOs marking scheme is based on the patient-centred clinical method (PCCM)developed by the Centre for Studies in Family Medicine at the Western University. The essential principle of the PCCM is integrating a traditional condition-oriented approach (e.g., understanding a patient's condition through effective history-taking, understanding pathophysiology, recognizing clinical presentation patterns, making a diagnosis, and knowing how to manage the identified condition) with an appreciation of the illness the health-issue creates (e.g., what does the disease's clinical aspects mean to the patient, what is the patient's emotional response to their illness, what is the patient's understanding of the health issue they are concerned about, and how is the health issue is affecting their life). Integrating the disease/condition with an understanding of the person living with the illness—through the act of interviewing, communicating, problem solving, and negotiating disease management-—is fundamental to the patient-centred approach.

While important, the emphasis of the SOO is **not** just on a candidate's ability to appropriately diagnose and manage a clinical scenario, but to explore patients' feelings, ideas, and expectations about the situation the health-issue is causing or contributing to and to determine the effect on their functional abilities. Candidates are scored on how they conduct the interview to both forge a connection with the patient and actively involve the patient in deciding a mutually acceptable management plan. The SOO cases reflect a variety of clinical situations, but all require PCCM communication skills to understand patients as individuals with unique illness experiences and to work with them to find the best next steps to effectively deal with the health issues presented.

The following Appendices will be of interest to all examiners:

Appendix 1: Standardized Instructions to Candidates

Appendix :2 Ten CFPC Preparation Pointers for Examiners

Appendix 3: Distinguishing a certificate-level from a superior-level performance: Exploration of the illness experience

RATIONALE FOR SIMULATED OFFICE ORAL EXAMINATION #

[1] Stewart M, Brown JB, Weston W, McWhinney I, McWilliam C, Freeman T, eds. *Patient-Centered Medicine: Transforming the Clinical Method*. 3rd ed. London: Radcliffe Publishing; 2014.

The goal of this simulated office oral examination is to test the candidate's ability to deal with a patient who has:

1. gastroesophageal reflux disease

2. a gambling addiction

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.

The candidate will view the following statement:

THE PATIENT

You are about to meet Mr. **BILL SNOOK**, age 42, who is new to your practice.

CASE DESCRIPTION

Introduction

You are Mr. **BILL SNOOK**, a 42-year-old brewery worker. You are new to this practice. Your last family physician (FP), **DR. IVANY**, dismissed you from his practice. You have been having problems with a burning pain behind the front of your chest and would like the candidate to see if he or she can help with this.

You are also aware that you may have a problem with excessive gambling. You are a little unsure about whether this FP can help you with this problem.

History of the problems

GASTROESOPHAGEAL REFLUX DISEASE

For the past 12 months you have been experiencing a sensation of "burning" behind the bone in the front of your chest. The sensation is not always there, and sometimes you feel as if the pain has gone for good. However, it returns after a day or so, and seems to originate in your upper stomach. It is worse shortly after eating, and because of your lifestyle, your mealtimes are quite erratic. Fatty meals seem to be worse than others. You have also noticed that the pain is worse when you lie down; on two or three occasions you have been awoken at night by a burning sensation in your chest, and a sour, acid taste in your mouth. Your morning cup of black coffee, which you sometimes have with a chocolate bar, also seems to worsen the symptoms.

The pain comes on suddenly and is sharp and burning. It lasts for several hours. It does not radiate to your back or your arm, but sometimes it feels as if it is going into the back of your throat.

You have had no weight loss. You have not vomited blood. Your stools have not changed colour, and your bowel habits are unchanged. You do not get short of breath with the pain although you often wake up with a dry, hacking cough.

You have also noticed that your voice has become a little hoarse in the past four months. Occasionally you feel nauseated, but you have not vomited.

You have never had any palpitations, crushing pains in your chest, or sweating. The pain is not worse by walking or exercise. You have never had any swelling or pain in your legs, and you have not coughed up any blood. You have no fevers or chills. You have had no alteration in your usual diet or any recent foreign travel. You have no difficulty swallowing.

You have no known medical problems. You have never had any surgery. As far as you know, you have no food sensitivity. There is no known family history of bowel complaints or heart disease. Your weight is stable. You have never had any trauma to your abdomen or chest.

You have recently bought some calcium carbonate tablets (Tums) from the local pharmacy, and these seem to give you temporary relief. Likewise, an occasional glass of milk in the mornings before you go to work seems to aid the problem. However, the symptoms return about 30 minutes later.

A union representative at work noticed that you were eating a lot of Tums during the day, and he said that you had “heartburn”. He also said that his father had suffered from “heartburn” for many years, before the doctors realized he actually had angina. He suggested that you see a doctor about this, which prompted the original consultation with Dr. Ivany. The term “heartburn” wasn’t particularly frightening, but now, after these comments from your rep, you have become a little worried about your heart. After all, everyone has heard stories about people having stomach aches and chest pains, and the next thing you know, they’re having open heart surgery or they’re dead because the doctors took too long to find the right diagnosis.

You rarely see a doctor, but you went to see your FP about this problem about nine months ago. He asked you to go for some blood tests and a special type of X-ray, whereby you would be given a sort of dye to drink and the outline of your stomach would be seen. He was due to see you again after this was done, to discuss results and possible treatment options. You never went for the blood tests or the X-ray, and although you made three further appointments to see Dr. Ivany, you never kept any of these or called to cancel. You felt that the doctor didn’t really sound interested in your heart, and “other things” (i.e., visits to the local casino) seemed to take priority over the tests and follow-up appointments. Unfortunately for you, the clinic had a policy of removing patients who were “no shows” multiple times and you received a letter one month ago asking you to seek a new FP.

As far as you know, nobody in your family has ever had heart trouble, and you’re not particularly overweight. However, you DO smoke and rarely get any exercise except for walking home at night.

Apart from requiring you to take a lot of Tums at work, this condition hasn’t really affected your work. It awakens you intermittently at night, which is an inconvenience, and makes you drink more black coffee the following day.

Overall, the term “angina” has made you a little anxious and worried about your future health. You would like to be told that you heart is okay, and maybe get something for the pain. You would not be averse to some hints about changing your lifestyle, as you are beginning to suspect that changes are long overdue. You’d like to find a doctor who will reassure you about your heart, and perhaps provide the “nudge” you need to change your lifestyle. If your heart is in trouble, perhaps you should build bridges with your family before it’s too late. You haven’t seen them for many years, and you call your mother only very rarely.

GAMBLING ADDICTION

Your daughter, **GEORGINA CRANT**, wrote to you two months ago, asking you to attend her high school graduation in six weeks’ time. You have never met your daughter, although she is friends with your parents, and this letter has made you wonder if you should start to build bridges with her and the rest of your family.

However, you have a significant problem with finances.

Each half day off, every night, and most weekend days, you go to a casino that has “slot machine” games for public use. You can spend hours at a time at these machines, and when you are “in the zone” you seem to lose all idea of time.

Years ago, before the laws changed, you smoked heavily at the machine for most of the night; now you take a “smoke break” outside every hour or so, and therefore you have cut down from smoking 10 to

five cigarettes a night. Some nights, when you are really “in the zone”, you do not smoke at all. You rarely eat or drink.

You sometimes drink a bottle of beer simply to quench your thirst in the hot environment, but you never had more than one a night. A bottle of beer is useful for “saving” the machine that you are playing when you go outside to smoke.

It also stops the waitresses from continually bothering you. Sometimes you barely touch the drink. You do NOT have a drinking problem. On your way home, late at night, you frequently pick up a hot dog (preferably covered in onions and chilli sauce) from an all-night convenience store and eat it as you walk. You live about two kilometres from the casino, and so the walk isn’t too arduous.

If you are out particularly late, perhaps until 2 am, you get only four hours of sleep, as work starts at 8 am and your alarm goes off at 6:30 am. Breakfast is therefore a rushed affair, usually comprising of strong black coffee and a chocolate bar, gulped down before you catch the bus to work. If you have two late nights in a row (which is almost the norm now), you get quite tired at work and tend to drink more black coffee in an effort to keep yourself awake. You take an ibuprofen tablet intermittently, once or twice a month, to ease muscle aches and pains.

The urge to play on the gambling machines started about five years ago, when you first moved to this city. On paydays (Thursdays), your colleagues got on a local city bus and went out to the nearby casino. There were slot machines in abundance, and so you would sit at one of them and play it for about an hour or so before everybody left. You had no family to go home to, only a small apartment, and so you would stay behind a little longer and have a few more cigarettes and a few more plays before leaving. Your first apartment in this city was in quite a nice area, and money was no issue then; the taxi ride was a pleasant end to the evening.

You started to enjoy the Thursday evenings out and after a year had gone by, you found yourself going most weekends, as well.

Some machines you got to know very well, and certainly you had your favourites. Some of them paid out more money at certain times of the evening. You had a careful system for playing these favourites, which rarely changed from day to day.

In the early days, your cigarettes were always on your right, your deposited $10 (and no less) at one time and used “nudges” and “holds” only twice (each) every 30 minutes. When you were playing, you hated to have your concentration disturbed by anybody talking to you, especially when you were “in the game” and close to winning. Gradually you became more fixated upon the machines and their flashing lights and less upon your colleagues. If disturbed when a big payout was “just about to come along”, you often “snapped” at that person and were quite rude; then you usually left that area because of the “bad vibe” and lost concentration. Your work colleagues slowly learned to keep their distance and would often try to avoid you.

After three years or so in the city, you had no friends left. This was no problem, as you were now free to go to the casino EVERY NIGHT! The bus from work took you there, but money for your taxi home was suddenly becoming hard to find.

Savings helped a bit, but they were running short. You moved out of your rather “high-end” apartment, and began to rent in a more rundown, cheaper area of the city. It was conveniently only about two

kilometres from the casino, a fact that certainly influenced your choice. A few months after your move to the new area, you were going to the casino every night, every half day, and every weekend.

Most of the times you lose, and frequently (about once a week), you forget to save enough money to get some food on the way home, and thus spend the whole evening without eating. When you win you feel exhilarated, euphoric, and excited, and this is a marvellous sensation to have. You describe it as being like a “rush”.

These rushes are what keep you coming back to the casino. Straight after a win, you notice that you have the urge to increase the rush by playing some more; in the past you always walked away after a win. Now, even when you lose and get ready to leave the casino, part of you wants to go back inside to try just one more time! The wins and rushes occur only about once a week, and the following day you love to tell all of your colleagues about your success. If you lose money, which is the norm, you don’t share the information. Because of your rudeness to your colleagues when you are playing the machines in the casino, you don’t, in fact, have many friends at work, so the thrill of telling anybody is not as great as it used to be.

In the first few months of going to the casino, your expenditure each Thursday night was only $10 to $20. One evening can now cost you $50 to $100. The cost is about double that for each weekend day. In the past few months, there have been one or two nights when you have lost up to $150. Once a week you will be “up” once a week you will be left with no money whatsoever, and the rest of the time you will be down about $50 by the time you leave the casino. As you leave on these nights, you get the urge to return, just one more time…

For the past 18 months you have been at the slot machines nightly, and you have barely enough money to pay rent or eat proper meals. A month’s expenditure can be around $2,000. You earn just under $6,000 a month, before tax. Banks have stopped giving you short-term loans as you have defaulted on two of these in the past ($500 each). Likewise, your credit card was cancelled 10 months ago for a similar reason. You are slowly paying off the bank and the Visa Company with the minimum monthly payments, and have not, as yet, had to declare bankruptcy. You have never borrowed from colleagues or taken up offers of cheap cash advances from dubious sources. You are too embarrassed to ask your mother for money. You have never sold street drugs to get money, but you have sold your TV, DVD player, and computer to get a quick cash injection. You no longer have a phone line and make calls through pay phones. So far, you have done nothing illegal apart from defaulting on your loans and being late with you rent on occasion. You are not currently in debt to anybody except for the bank and the Visa Company.

If, for some reason, your trip to the casino is delayed by work, you feel restless, agitated, and unhappy. To prevent this feeling, you now go straight to the casino when work ends.

Every week you buy a Lotto 6/49 ticket. In your apartment are numerous slips of old gambling tickets. They are in every room, in every drawer, and even in boxes hidden away under your bed. You always play the same numbers, and one day, these numbers WILL come up. You firmly believe that one day you will get a HUGE win, and this will allow you to pay off all your debts.

You are NOT depressed.

The letter from your last doctor, the cancellation of your credit card, comments by your landlord and union representative, and letters from the bank have made you realize that you could have a problem.

Your daughter' letter has given you a "goal" to work toward, as you would dearly love to go to meet her. You have no friends to talk to, and thus a doctor's visit may be a good opportunity to get some facts about how to alter your lifestyle. Managers at work don't seem to like you, and your colleagues don't want to talk to you. You are willing to make a change, but you have no idea how to do it and don't know if the doctor can help in any way.

Medical history: There is nothing of note in your medical history. You rarely visit a doctor.

Surgical history: None.

Medications: You take ibuprofen (about one to two tablets a month) for intermittent aches and pains. Recently you have been taking some Tums.

Pertinent laboratory results: None.

Allergies: None.

Immunizations: Up to date.

Lifestyle issues

Tobacco: You have smoked since age 16. Originally you smoked about 25 cigarettes a day; you now smoke about five.

Alcohol: You drink one bottle of light (4% alcohol) beer a day.

Caffeine: You drink several cups of strong coffee each morning.

Cannabis: None

Recreational and/or other substances: You do not use any illicit drugs.

Diet: Frequent "convenience foods".

Exercise and recreation habits: You get almost no exercise. Walking home from work or the casino is the only exercise you get.

Family history

You know of no illnesses that run in the family. Your father and brother were chain-smoking, hard-drinking men, both with violent tempers. Your father's brother, **TIM**, was always the "life and soul" of any party, was full of "get rich quick" schemes, and had a seemingly endless supply of pretty women by his side. You believe that, before you left home, he was told he was "manic-depressive".

There is no history of heart disease.

Nobody in your family has had a gambling problem. And aside from alcohol and nicotine addictions, there is not drug addiction.

Personal history

- Family of Origin

You were the younger of two boys born to a working class family. Your father, **GARY**, was a steelworker who had a violent temper when he was drunk, and he frequently beat his children and wife. Much to your disgust, your mother, to whom you were very close, was forever supporting your father – even when she was sporting obvious bruises on her face.

Your mother, **GEORGINA**, was born in eastern Quebec, and thus you have dual Canadian and American citizenship, as does she. She met your father when she was on a camping holiday in the United States and moved there to be with him in the late 1950s.

Both you and your brother, **TERRY** were born in Pittsburgh. Terry was five years older than you. Your mother had a series of miscarriages before you were born.

Childhood memories are not that nice and consist mainly of your father coming home drunk after an afternoon shift at the steelworks and the family arguments that followed. You left high school as soon as possible and entered the then booming steel industry. Just as your father had done a generation earlier and your brother had done five years earlier. Terry, like your father, was a heavy drinker. He lived on the "wild side", working hard and playing even harder.

Because of the example, your father set, you were always wary of drink and its consequences, but (at that time) you did spend a few Friday nights out, after payday, with Terry and your fellow workers. The others at the steel plant admired him a lot because he had charm, charisma, a huge physique, and a seemingly endless capacity for drink! After one particularly heavy night out, he tried to drive home and suffered a horrific car crash. He appeared to be travelling at high speed when severely drunk, and lost control of his car. He crashed into a roadside pillar and was killed instantly, according to the coroner. This sudden death and the beatings that your mother was taking, led you to decide to leave home once and for all.

Terry died when he was 28 and you were 23. You both had been living with your parents at the time.

- Marriage/Partnerships

You were in an "on-again/off-again" relationship with **TRACY CRANT**. You decided to take Tracy and your mother to Canada to get away from bad memories and a drunken father. Initially, your mother agreed to leave, but after spending a few months with her parents on the east coast, she changed her mind and went back to your father. He promised to "reform and change his ways" if she came back. Your mother writes on your birthday and at Christmas. You fear that your father still blames you for your mother's leaving, and you are scared to return. Your mother's letters tell you that your father sought help from doctors for his drinking and anger and has been a reformed character (as he promised he would be) ever since her return. "We all want you home" your mother keeps writing in her letters. After each letter you call her, often from work, but simply tell her where you are living and say that you are "doing well".

- Children

Tracy left a few months after your mother, leaving you alone in Canada. She missed home and her parents and wanted to get back to Pittsburgh.

At that time, your relationship wasn't going well, and money was tight, and this move wasn't entirely unexpected. After getting back home, she contacted you and told you that she was pregnant. She later gave birth to a little girl, whom she named after your mother. You have not seen Tracy since her move back home, and you have never seen your daughter, although they write to you once a year. Tracy never married, and now she works as a nurse in a small hospital outside Pittsburgh. She never asked you for any money or support. Your daughter is a teenager and is doing well in high school, according to the last letter you got at Christmas. In their latest letter, Georgina asked if you could come down to see her when she graduates from high school later this year. Tracy and your daughter have remained in contact with your parents, and have a good, close relationship with them.

Current desire to see family

Now that you are worried about your heart and your way of life and have no strong ties to this city, you are tempted to make contact with your daughter and other family membres after all these years. You are forgetting the hard times of the past, and your father genuinely seems to have stopped drinking over the past 15 years. Tracy always seems keen to see you again, and the time may be right for a major life change and heading back to the United States. You probably cannot afford a major move back home, but maybe you could save up enough money by doing major overtime shifts and forgoing a few casino trips.

Education and work history

You left school at 16 and went into the steelworks, like your father and brother before you. In the early 1980s, Pittsburgh was a boom town and the auto industry was demanding more and more steel.

Your family situation led you to leave home. First you went to stay with your mother's parents, who still lived on the east coast of Canada, but this lasted for
only a month or two. Then you rented an apartment wherever the jobs and money took you, and, after your mother and Tracy returned to the United States,
you started work as a deckhand for the east coast cod fisheries. This worked out well for a few years before cod stocks disappeared, thus ushering in the era of the moratorium and the downsizing of the Atlantic fisheries. You were out of work by 1992 at the age of 25.

Luckily you found a job, within a year, in the local brewery. Shortly after, this was taken over by a big multinational company. You have worked in the brewery industry ever since, slowly, climbing up the promotional ladder. You are now
working on the factory floor, supervising the bottling for the company's most popular brew. You went wherever the company sent you and you arrived here about five years ago. At that time you were moderately well off, with savings of about $20,000, and thus initially you were able to rent a nice apartment.
Things have changed since then.

You now live in a rented apartment that is little more than a living room, bathroom, and bedroom. You have no TV or cable, as you simply cannot afford these items after gambling most of your income and savings away. Twice in the past year
you have had notices form your landlord about being late with your rent (and underpaying), and he would love to get you out of the apartment so he could clean it up and rent it for more money.

You are frequently late for work, and, when you are tired, you spend much of the day drinking black coffee. You take “smoke breaks” in an area outside the bottling plant. When you first arrived, this was a popular thing to do, but now you are the only employee who uses the area. Management would like to remove it altogether. The amount you smoke has decreased considerably, and you go through about five cigarettes each working day. Some days you don’t smoke at all. Even so, your late arrival for work and frequent absences from the floor of the bottling plant have led higher management to send you two “warning” letters in the past year. You feel that management would not be averse to removing you from the workforce either, although this is just a suspicion based upon the tone of the letters. Your union rep defended you in both cases, but also commented that you should seriously consider going to a doctor about your “heartburn”. He also suggested that you get a general checkup as you were becoming a “serious train wreck” of a person. These comments really alarmed you, and your worry has worsened since you received your former FP’s letter asking you to find a new doctor.

The brewery has recently seen a huge upturn in the demand for its beer, and workers are being asked to do overtime shifts so that the production line can operate 24 hours a day. Overtime is DOUBLE pay, but staying longer at work makes you anxious and agitated as you are wasting time that could be spent getting that “big payout” at the casino.

Finances

You earn $39 an hour and work 4 ½ days a week. Money is very tight right now, as your expenses at the casino are leaving you almost penniless. You have no savings, and you have sold many items of value. After taxes and gambling, you have barely enough to pay the rent ($500 a month in one of the more rundown suburbs).

The brewery company has been putting money into pension schemes for its employees for many years. So far you haven’t touched this money. You also receive good medical and dental benefits from the company.

Social supports

You have very few social supports. Your work colleagues barely talk to you as you are a bit of a loner. If they approach you at the casino after work, you are often ”in the game” if you are playing a machine, and hate to be disturbed. They all have wives and families, and this is hardly your scene. All your family members are back in Pittsburgh, including your ex-girlfriend and your daughter.

Before moving here, you had a few casual relationships with women, but nothing serious. In the past, you visited prostitutes (not in this city), with whom you always practised safe sex. Now that your evenings and weekends are spent in the casino, you have no time to make any lasting relationship.

Religion:

You have no religious affiliation.

ACTING INSTRUCTIONS

You are unshaven and unkempt. Your clothes are those you work in and are crumpled and unwashed. You have no jewellery and no rings. You are very shy and withdrawn and feel awkward in social settings. Thus, at the beginning of the visit you don't make much eye contact. A friendly candidate will rapidly gain your trust, and you will become progressively more sociable and talkative.

You know that your life is a mess. You readily accept ANY advice from the doctor, as this is your only real social contact, and a chance to tell your story. An empathic, non-judgemental candidate will get you to open up fully and tell the whole story.
Someone who thinks you are an addict and there is "no hope for you" will simply cause you to remain sullen, monosyllabic, and quiet.

As you aren't sure whether a doctor is somebody who can actually help with your gambling or your "train wreck" of a life, you definitely do NOT volunteer this information to any candidate who goes "fishing" for a second problem early in the interview (e.g., by asking whether there is any other problem you want to talk about). Indeed, the heartburn is the reason you're at the candidate's office, and you haven't really worked out how to bring up the subject of your lifestyle. A good candidate will ask why your last doctor removed you from his practice, and why you didn't go for any tests or follow-up appointments; this would be a good opportunity to bring up your gambling problem, especially if you like the candidate. Otherwise, unless the topic has already been mentioned, a 10-minute prompt of "I think my life is a mess" is about as much as you will give away.

A candidate definitely needs a patient-centred approach with this SOO. Empathy and the sharing of ideas will go a long way in gaining your trust and, therefore, the whole story. A candidate who asks direct, closed-ended questions and judges you harshly will simply receive one-word answers and thus fail to pick up key points.

If the candidate asks, you say that there was never any conflict between you and your former FP. You simply failed to show up for appointments.

Cast of Characters

The candidate is unlikely to ask for other characters' names. You may make them up if needed.

BILL SNOOK:	The patient, age 42, a brewery worker with GERD and a gambling addiction.
GARY SNOOK:	Bill's father, age 70.
GEORGINA SNOOK:	Bill's mother, age 67.
TERRY SNOOK:	Bill's brother, who was killed in an automobile accident 19 years ago, at age 28.
TIM SNOOK:	Bill's uncle.
TRACY CRANT:	Bill's ex-girlfriend, age 40.
GEORGINA CRANT:	Bill and Tracy's daughter, age 18. **DR.**
IVANY:	Bill's former FP.

Timeline

Today:	Appointment with the candidate.
1 month ago:	"Dropped" by Dr. Ivany.
2 months ago:	Received a letter from your daughter.
9 months ago:	First sought help about heartburn.
10 months ago:	Credit card cancelled.
11 months ago:	Late with the rent; received a letter from the landlord.
1 year ago, age 41:	First noticed heartburn.
18 months ago, age 40:	Started going to the casino more often.
5 years ago, age 37:	Moved here and started playing the slot machines.
16 years ago, age 26:	Started work in the brewery industry.
18 years ago, age 24:	Daughter born after your mother and girlfriend had returned to the United States; started work in the fisheries industry.
19 years ago, age 23:	Left home with your mother and girlfriend and came to Canada, following your brother's death.
26 years ago, age 16:	Left high school and began working in the steel industry.
42 years ago:	Born in Pittsburgh.

Examiner Interview Flow Sheet - Prompts

Initial statement	"**I've been having a pain in my chest**."
10 minutes remaining* Optional, use only if you feel it's needed	If the candidate has not brought up the issue of the gambling, the following prompt is to be used: "**I think my life is a mess**."
7 minutes remaining* Optional, use only if you feel it's needed	If the candidate seems to have forgotten about the GERD, the following prompt is to be used: "**Can you do something to help my chest pains**?" (This prompt is often not necessary.)
0 minutes remaining	"**Your time is up**."

* To avoid interfering with the flow of the interview, remember that the seven- and 10-minutes remaining prompts are optional. To avoid interrupting the candidate in mid-sentence or disrupting their reasoning process, delaying the delivery of these prompts is acceptable.

Note:

During the last three minutes of the interview, you may only provide information 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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The College of Family Physicians of Canada

Certification Examination in Family Medicine

Session

Simulated Office Oral

Marking Scheme

NOTE: To cover a particular area, the candidate must address at least 50 per cent of the bullet points listed under each numbered point in the left-hand box on the marking scheme.

1. Identification: Gastroesophageal Reflux Disease

Issue #1	Illness Experience
Areas to be covered include: 1. current symptoms: • Burning pain. • Intermittent. • Radiates to the throat. • Nocturnal awakening. • Sour taste in the mouth. 2. significant lifestyle factors: • Worse with coffee and/or with fatty or spicy foods. • Eased by milk and/or Tums. • Smoker. • Irregular eating pattern. • Rare use of nonsteroidal anti-inflammatory drugs. 3. excluding cardiac disease: • No relation to exercise. • No family history of heart troubles. • No diaphoresis. • No dyspnoea. • No palpitations. 4. ruling out red flags: • No weight loss. • No gastrointestinal (GI) bleeding. • No family history of GI malignancy.	**Description of the patient's illness experience**. You are worried that the problem might be your heart and while the symptoms aren't currently impacting your daily functions, you are hoping that the doctor will make sure that your heart is okay.

		Determining the patient's illness experience is **not** a checklist assessment where a candidate asks about the patient's feelings, ideas, functioning, and expectations and should two or three of these four be asked aloud, a pass is then awarded. A certificate level illness experience performance is where the candidate gathers the patient's illness experience

		conversationally and integrates the knowledge gained in a way that communicates to the patient that this candidate is working to see the patient as a unique person with an illness, more than just a textbook disease process to be appropriately managed.
Superior Level	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.
Certificate Level	Covers points 1, 2, and 3.	Learns about the illness experience arriving at a **satisfactory** understanding of it. This is achieved by asking appropriate questions and using non-verbal skills.
Non-Certificate Level	Does **not** cover points 1, 2, and 3.	Demonstrates minimal interest in the illness experience, focusing mainly on the disease process, and so gains **little** understanding of the illness experience. There is little acknowledgement of the patient's verbal or non-verbal cues, or the candidate often cuts the patient off.

2. Identification: Depression

Issue #2	Illness Experience
Areas to be covered include: 1. history of gambling: • Started five years ago. • Goes to the casino to play slot machines. • Does not bet on sports or card games. • Has no drug addictions. • Is not depressed. 2. current effect of gambling: • Goes every night. • Spends $2,000 a month. • Feels euphoric when he wins. • Gambles alone. 3. evidence that gambling is becoming a problem: • Visa card has been cancelled. • Has defaulted on bank loans. • Conflict with his landlord. • Gets agitated when he cannot get to the casino. • Has used up all his savings. 4. the fact that he has not yet resorted to illegal means of obtaining funds.	**Description of the patient's illness experience.** You are feeling desperate and now realize that your gambling has become a problem. You are also desperate financially because you don't have money to attend your daughter's graduation. You want to overcome your gambling addiction but are unsure how it can be done.

		Determining the patient's illness experience is **not** a checklist assessment where a candidate asks about the patient's feelings, ideas, functioning, and expectations and should two or three of these four be asked aloud, a pass is then awarded. A certificate level illness experience performance is where the candidate gathers the patient's illness experience conversationally and integrates the knowledge gained in a way that communicates to the patient that this candidate is working to see the patient as a unique person with an illness, more than just a textbook disease process to be appropriately managed.

Superior Level	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.
Certificate Level	Covers points 1, 2, and 3.	Learns about the illness experience arriving at a **satisfactory** understanding of it. This is achieved by asking appropriate questions and using non-verbal skills.
Non-Certificate Level	Does **not** cover points 1, 2, and 3.	Demonstrates minimal interest in the illness experience, focusing mainly on the disease process, and so gains **little** understanding of the illness experience. There is little acknowledgement of the patient's verbal or non-verbal cues, or the candidate often cuts the patient off.

3. Social and developmental context

Context Identification	Context Integration
Areas to be covered include: 1. work history: • Five years in this city. • Works at the bottling plant. • Good income. • Several conflicts with management. • Unionized 2. family history: • Family lives in the United States. • Rare contact with his mother. • Family history of alcohol abuse. • Uncle has bipolar disorder. 3. social factors: • Has never met his daughter. • No friends in this city. • Has been asked to attend his daughter's graduation. • No current partner. 4. his opportunity for overtime work.	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 an example of a statement a superior level candidate may make: "What you're going through at this moment, with no support from friends or family must be incredibly stressful. Let's see if we can explore ways to get things turned around so that you can get to your daughter's graduation."

Superior Level	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.
Certificate Level	Covers points 1, 2, and 3.	Demonstrates recognition of the impact of the contextual factors on the illness experience.
Non-Certificate Level	Does **not** cover points 1, 2, and 3.	Demonstrates minimal interest in the impact of the contextual factors on the illness experience or often cuts the patient off.

4. Management: Gastroesophageal Reflux Disease

Plan for Issue #1	Finding Common Ground
Areas to be covered include: 1) Advise the patient that the diagnosis is likely GERD. 2) Reassure the patient that it is unlikely to be heart trouble. 3) Suggest lifestyle modifications (e. g., decreasing coffee intake, reducing smoking, elevating the head of his bed, avoiding spicy foods.) 4) Consider pharmacological treatments.	Behaviours indicating efforts to find common ground go beyond the candidate asking "Any questions?" after a management plan is presented. Finding common ground is demonstrated by the candidate encouraging patient discussion, providing the patient with opportunities to ask questions at multiple points, encouraging the patient to express their thoughts, seeking clarification, checking for consensus, and recognizing then addressing patient hesitation or disagreement if it arises. Examiners need to determine the candidate's ability to find common ground based on behaviours they demonstrate during the interview.

Superior Level	Covers points 1, 2, 3, and 4.	Actively asks 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.
Certificate Level	Covers points 1, 2, and 3.	Involves the patient in the development of a plan. Demonstrates flexibility.
Non-Certificate Level	Does **not** cover points 1, 2, and 3.	Does **not** involve the patient in the development of a plan. Only asks the patient "any questions" after a management plan is presented without doing more to involve the patient.

5. Management: Gambling Addiction

Plan for issue #2	Finding Common Ground
Areas to be covered include: 1) Suggest that he has a problem with gambling. 2) Offer information about support groups (e.g., addictions counselling, Gamblers Anonymous). 3) Offer follow-up to review progress. 4) Discuss the patient's own strategies to address his addiction such as keeping diaries, doing overtime, taking up a hobby, etc. (The patient needs to admit that he has a problem, and to be an active partner in suggesting solutions.)	Behaviours indicating efforts to find common ground go beyond the candidate asking "Any questions?" after a management plan is presented. Finding common ground is demonstrated by the candidate encouraging patient discussion, providing the patient with opportunities to ask questions at multiple points, encouraging the patient to express their thoughts, seeking clarification, checking for consensus, and recognizing then addressing patient hesitation or disagreement if it arises. Examiners need to determine the candidate's ability to find common ground based on behaviours they demonstrate during the interview.

Superior Level	Covers points 1, 2, 3, and 4.	Actively asks 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.
Certificate Level	Covers points 1, 2, and 3.	Involves the patient in the development of a plan. Demonstrates flexibility.
Non-Certificate Level	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 previous scoring components address specific components of the interview. However, assessing the candidate's interview technique as an integrated whole is also important. The entire encounter should resonate with a sense of structure and timing, and the candidate should always be employing a patient-centred approach.

The following are certificate-level techniques applicable to your experience of the entire interview:

- Good direction with a sense of order and structure
- A conversational rather than interrogative tone or presenting many questions to the patient in checklist-style.
- Flexibility and good integration of all components and stages of the interview; the interview should not be piecemeal or choppy.
- Appropriate prioritization, with an efficient and effective allotment of time for the various interview components.

Superior Level	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.
Certificate Level	Demonstrates average ability in conducting an integrated interview. Has a good sense of order, conversation, and flexibility. Uses time efficiently.
Non-Certificate Level	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.

Appendix 1 Standardized Instructions to Candidates

1. **Format**
   Although the patient/examiner encounter occurs virtually, the SOO is designed to be a **simulated office situation** in which an examiner will play the part of the patient seeing you, the doctor, in your office. There will be an opening statement and you are expected to manage the interview from then on. You do **not** perform a physical examination as part of the encounter.

2. **Scoring**
   You will be scored by the examiner according to specific criteria established for each case. Do not ask the examiner for information about your marks or performance, and do not speak to them out of their role.

3. **Timing**
   Each SOO station lasts 28 minutes broken down to 1 minute of reading time, 15 minutes for your visit with the patient, and 12 minutes of waiting time which the examiner will use for marking. During the SOO examination, timing is shown by two countdown clocks. The station countdown clock in the blue bar at the top of the screen starts at 28 minutes and counts down time remaining for all the components of the station combined. The time in the segment countdown clock in the yellow bar changes depending on which of the three sections of the station you are in.

   Before the examination starts, you will be placed in a setting where the examination will occur, but the clocks will not be active. During this pre-examination waiting time, your identification will be checked, and the proctor will ensure your microphone and camera works.

   The first SOO station starts when the segment countdown clock in the yellow bar appears saying **READING TIME**. You have **one minute** to review the provided patient information. At the second and subsequent stations, the READING TIME in the yellow bar starts automatically when you are transferred to the next SOO station.

   Following READING TIME, **ASSESSMENT TIME** starts in the segment countdown clock in yellow bar, and you will have 15 minutes to manage the interview. No verbal or visual warnings of time remaining are given (e.g., at the three-minute mark). It is a misconception that discussion with the patient to find common ground on a management approach must only occur in the last three minutes of the encounter. The encounter stops at the 15-minute mark, even if you are in mid-sentence.

   The yellow bar then changes to **MARKING TIME** but there isn't a countdown clock for this segment. Marking time is a rest period for you. If, for example, you start a SOO station five minutes late, the station clock in the blue bar will show that seven minutes are left once you get to the marking time segment.

Appendix 2 CFPC Preparation Pointers for Examiners

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

Think of the following:

- The defensiveness and reticence of a patient living with alcohol use disorder
- The potential embarrassment of someone living with a very difficult partner
- The anxiety of a person living with a terminal illness
- The shyness of a young teenager with a sexual-related concern

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

- Initially, how is this type of patient going to react to a new physician?
    - Will the patient be open, shy, defensive, etc.?
- How articulate will a person of their education level and background be?
    - What jargon, expressions, and body language will the patient use?
- What will the patient's reactions be to questions a new physician asks?
    - Will the patient be angry when alcohol use is brought up?
    - Will the patient display reticence when questions about family relationships are asked?

2. Allow the candidate to conduct an interview to determine what's going on. The SOO is set up for you to share one or more specific cues to help focus the candidate. Find the right balance between initially oversharing information and being too restrictive. You can predict the first few questions you will be asked so you plan your responses.

    You have all been through this exam yourselves. It is normal to feel for the nervous candidate sitting in front of you. But 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 issues in the case are. If the candidate still has not caught on after the cues you have given as instructed in the case script, that is the candidate's issue, not yours. Do not give away too much after that.

3. If you feel a candidate is having language difficulties during the SOO, do not act or speak differently than you would with any other candidate. Be aware that this candidate may miss subtle verbal cues laid out in your SOO script. However, this candidate would be at high risk of missing these verbal cues in their own offices. All candidates need to be exposed a standardized which is portrayed similarly to all. Feel free to note any communication-related or language-difficulties you observe in the comments section of the score sheet.

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. Time is limited. If a candidate begins a completely unproductive line of questioning, answer "No" (or find another

appropriate way). This should help prevent the candidate from wasting several valuable minutes on tangents not in the script.

5. Do not overact.

6. You will notice there will be some candidates with whom you feel comfortable, some with whom you feel less comfortable, some who conduct the interview the way you would have, and others who conduct the interview in a different way. We ask that you mark each candidate as objectively as possible, using the marking sheet anchor statements to guide your assessments.

7. The suggested prompts after the opening statement are optional. Give a prompt if you feel it is warranted (i.e., the information hasn't come up in discussion already). If you think of it later than suggested, but still feel it's needed, give the prompt then.

8. Pay attention to the clothing and acting instructions in the SOO script. 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. In the last three minutes of the examination, you should not volunteer any new information. You can certainly provide it if asked directly but limit your responses to direct answers or clarifications.

10. If the candidate clearly finishes before the 15 minutes are up, do not offer any more information or inform the candidate there is time left, but answer if any additional questions are asked before the end of the Assessment time. Once the Marking time starts, cover up your camera and mute your microphone.

11. Remember to follow the script and assist the College by clearly and adequately documenting important details and comments in marking sheet.

Appendix 3 Distinguishing a Certificant-level from a Superior-level Performance: Exploration of the Illness Experience

A **certificate-level performance** must include gathering information about the illness experience to gain an acceptable understanding of the patient and their issues (acceptable to the patient/examiner).

A **superior-level performance** is not simply a matter of a candidate obtaining more or almost all the information. A superior candidate must actively explore the illness experience and demonstrate an in-depth understanding of it. A superior performance is achieved through the skillful use of communication skills notably the demonstration of: (1) excellent verbal and non-verbal techniques (2) use of effective questioning, and (3) impressive active listening that encourages patient-physician trust and the patient telling their full story.

The material below is adapted from the CFPC's Assessment Objectives for Certification in Family Medicine. The table below is intended to be a guide to assist evaluators in determining whether a candidate's communication skills reflect a certificate, superior, or non-certificate level performance. A certificate level candidate displays enough to gain an acceptable understanding, a superior candidate demonstrates all these aspects, while a non-certificate level demonstrates few or none of these aspects and fails to achieve an acceptable understanding of the patient and their issues.

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 the candidate thinks has been understood from the patient • Responds to cues (doesn't carry on questioning on unrelated topics without acknowledging the patient if a major life or situation change is revealed) • Clarifies jargon the patient uses	**Cultural and Age Appropriateness** Adapts communication to the individual patient for reasons such as culture, age, and disability. Sample behaviours • Adapts their communication style to the patient's disability (e.g., writes for patients with hearing challenges) • Speaks at a volume appropriate for the patient's hearing • Identifies and adapts their manner to the patient according to the patient's culture • Chooses appropriate medical terminology for each patient (e.g., "pee" rather than "void" for children)
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	**Language Skills** Verbal • Has skills that are adequate for the patient to understand what is being said • Converses 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

• 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 (e.g., shows appropriate empathy for the patient) • Verbally checks the significance of body language/actions/behaviour (e.g., "You seem nervous/upset/uncertain/in pain")	• 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

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