



McGill

Family Medicine

Exam

Orientation Manual

2014-2015

ANNOUNCEMENT

*** Effective January 1, 2016, the College of Family Physicians of Canada (CFPC) and the Medical Council of Canada (MCC) will modify the examination process for family medicine candidates. Upon review, the CFPC has determined that the Certification Examination in Family Medicine, featuring content from both organizations, has not resulted in the anticipated benefits for the Certification decision. For this reason, starting in 2016, the exams will be run as two separate examinations, as they were before 2013. The MCC respects this decision and will work with CFPC to create a transition that is as seamless as possible for candidates.

For the joint announcement, please visit: <http://mcc.ca/about/news/press-releases/sept-9-2014/>

McGill Family Medicine Exam Orientation Manual 2014-2015

Table of Contents

Introductory Letter to Residents.....	4
Reminder of Important Exam Preparation Dates.....	6
Components of the New Certification Examination	7
Short Answer Management Problems (SAMPs).....	8
SAMPs INSTRUCTIONS for the on line demonstration as per the CFPC website	9
Introduction to the SOOs.....	19
Preparation for the Simulated Office Orals (SOOs).....	21
Anatomy of a SOO	25
Sample SOO (Case 33 & Marking Scheme)	29
Objective Structured Clinical Examination (OSCE)/ Medical Council of Canada component of harmonized CFPC exam:	49
Reference List for Home Study	56
ALDO – General Information	58
Working Knowledge of French Language	60

Introductory Letter to Residents

Dear Residents,

This orientation manual has been prepared by the members of the McGill University Family Medicine Exam Committee to help you understand the Family Medicine Exams.

The Harmonized Certification Examination in Family Medicine was launched in the spring 2013. Currently the exam is offered each year in the spring and fall, and takes place over 3 days. However, effective January 1, 2016, the College of Family Physicians and the Medical Council of Canada will modify the examination process for family medicine candidates. The exam will run as two separate examinations as they were before 2013. Currently, the exam includes the following components:

1. A full day of computer-based short answer management problems (SAMPs), based on the College of Family Physicians of Canada's (CFPC's) Evaluation Objectives.
2. A clinical skills assessment consisting of:
 - a.) 4 simulated office orals (SOOs), based on the CFPC's Evaluation Objectives.
 - b.) 8 objective structured clinical examination (OSCE) stations, based on the Medical Council of Canada's Evaluation Objectives for the Qualifying Examination.

Candidates who meet all other requirements of both organizations and pass the new exam will be granted certification in Family Medicine from the College of Family Physicians of Canada (CCFP) and the Licentiate of the Medical Council of Canada (LMCC).

Exam candidates will be required to pass both written and oral components to be granted Certification in Family Medicine. If candidates fail both components they will be required to re-sit the full exam on a subsequent attempt. If candidates fail one of the two exam components they will be required to re-sit the failed component only.

Please refer to the CFPC and MCC websites for in- depth information on the new Certification exam: www.cfpc.ca and www.mcc.ca.

Residents who intend to practise in Quebec must have a working knowledge of the French language and must also fulfill requirements for the ALDO-Quebec educational activity. The ALDO is about the legal, ethical and organizational

aspects of medical practice in Quebec. For further information about these requirements please log on to the CMQ website: www.cmq.org.

In this manual you will find:

1. The dates of practice exams and scheduled exams for 2014-2015.
2. Descriptions of the different examination instruments that you will encounter, in order to help you to understand and to prepare for the certification and licensing exams.
3. Sample questions and cases of the CFPC exams.
4. References and web sites for your home study.

Please note that on the CFPC website (www.cfpc.ca) under Exam Information and under Certification Examination in Family Medicine there is valuable information about the CFPC examinations including an online demonstration version of the SAMPs, sample SAMPs, a video demonstration of a SOO, several SOO cases and a section on Evaluation Objectives in Family Medicine which includes a list of priority topics for family medicine competency with key features for each topic.

On the Medical Council of Canada website (www.mcc.ca) there are examples of 10 minute OSCE stations.

The dates of the 2014-2015 CFPC exams are:

October 23-26, 2014

April 30 -May-3, 2015

Please note that the application dates for the CFPC exams are listed on the CFPC website.

Wishing you every success in your residency and in your exams,

Susan Still, MD, CCFC, FCFP

Chair, McGill University Family Medicine Exam Committee

Reminder of Important Exam Preparation Dates

✚ **McGill Family Medicine Exam Orientation Session** for R2s on the OSCEs/MCCQE-II exam, SAMPS, and SOOs: Wednesday, October 8th, 2014 2:00 p.m. to 4:00 p.m. (CLSC CDN room 350-353)

✚ **Unit SOO Practices:**

1. For R2s: Wednesday October 15, 2014 (SMH, JGH, CDN)
2. For R2s: Wednesday, November 26, 2014 (JGH),
3. For R2s: Wednesday, December 10, 2014 (SMH), **TBD, (CDN)**
4. For R1s: Wednesday, February 18, 2015 (SMH, JGH, CDN.)

✚ **McGill Wide SOO Practices** for R2s:

1. Wednesday, January 21, 2015 (SMH, JGH, CDN)
2. Wednesday, March 18, 2015 (SMH, JGH, CDN)

✚ **Unit OSCE practices: ****

For R2s and R1s:

1. Wednesday, November 5, 2014 (SMH, JGH, CDN)
2. Wednesday, April 1, 2015 (SMH, CDN, JGH)

** For these exams we plan to ask R1s to act the roles of simulated patients for R2 candidates.

✚ **Unit SAMPS Exam Practice:** For R1s and R2s: February 4, 2015 (SMH, JGH, CDN)

Components of the New Certification Examination

1. THE WRITTEN EXAMINATION

The written examination is a computerized exam comprised of short answer management problems (SAMPs), which are designed to test a candidate's recall of factual knowledge and problem solving abilities in the area of definition of health problems, management of health problems, and critical appraisal. An online demonstration version of the SAMPs is available in the section on Short Answer Management Problems (SAMPs) under Certification Examination in Family Medicine on the CFPC website (www.cfpc.ca).

2. CLINICAL SKILLS COMPONENT consisting of

i) Four simulated office orals (SOOs) each 15 minutes in length. As described on the CFPC website, they are designed to duplicate, insofar as possible, the actual "setting" in which the family physician conducts a practice. Family physician examiners are trained to role-play patients presenting with specific complaints. The physician playing the role of the patient notes the management of the case by the candidate and he or she will score the candidate according to pre-defined criteria. This examination will assess both the definition and management of health problems. The scoring system has been devised to focus on the candidate's approach to dealing with patients -- including their ability to understand the patient's unique experience and to establish a positive doctor-patient relationship. Of course, getting the "right diagnosis" and managing the problem plays a role in the scoring. There are no hidden agendas.

A video demonstration of a SOO is available in the section on Simulated Office Orals (SOOs) under Certification Examination in Family Medicine on the CFPC website (www.cfpc.ca).

ii) Eight objective structured clinical examination (OSCE) stations, each 10 minutes in length. At each station candidates are expected to interact with a standardized patient in the same way that they interact with actual patients. The format of this exam is similar to the former MCCQE-II exam. The task(s) for each station may involve taking a history, conducting a physical examination, making initial management decisions and/or addressing issues raised by the patient or the examiner. A physician examiner observes the interaction and scores candidates' performances according to a standardized marking grid.

Short Answer Management Problems (SAMPs)

The Short Answer Management Problems (SAMPs), as described on the CFPC website, are intended to measure a candidate's problem solving skills and knowledge in the context of a clinical situation. Basic information regarding the presentation of the patient will be provided and a series of three or four questions will follow for each scenario. When answering questions in this examination please read the question carefully and provide only the information that is requested. For the most part, each question will require a single word, short phrase or short list as a response. The examination is six hours in length.

In an effort to give candidates more help preparing for the family medicine examination there is an online demonstration version of the SAMPs for review. It contains 12 SAMPs used on previous examinations. These demonstrate the format and content that you can expect at the time of the exam and demonstrate the correct way to answer the questions. They are not intended to be study aids.

The evaluation objectives, including priority topics and key features which guide the College's Committee on Examinations in the development of the test items for the Certification Examination in Family Medicine, are available on the CFPC website, www.cfpc.ca, in the section on Short Answer Management Problems (SAMPs) under Certification Examination in Family Medicine. These materials/documents ensure that the examination maintains acceptable validity and reliability. To do this the evaluation objectives have been designed to clearly describe the domain of competence to be tested within each topic area. The majority of cases will be based on these evaluation objectives.

NOTE: The following references were written to help candidates prepare for the SAMP examination:

- 1- Guide to the Canadian Family Medicine Examination by editors Megan Dash and Angela Arnold. The book is also known as the "Saskatchewan Notes"; It is a useful study guide, providing a skeleton of information that you should expand on and complete with further reading. It probably does not provide enough information to pass the examination.

The book is available to purchase from amazon.ca at the cost of 80 \$

- 2- Family Medicine Notes, Preparing for the CCFP EXAM – 2014, by Dr Danielle O'Toole. It is a more in depth collection of information on the 99 key features than the above reference. I would not recommend it as a study guide but rather as a book to help you review your factual knowledge a month prior to the exam. Previous residents found it very helpful.

The 2014 book is available from [http:// www.familymedicine.com](http://www.familymedicine.com) at the cost of 70 \$.

SAMPs INSTRUCTIONS for the on line demonstration as per the CFPC website

For each case, the setting in which you are practicing will be described i.e., hospital emergency department, family medicine clinic, physician's office.

- You can answer most questions in ten words or less.
- When ordering laboratory investigations be SPECIFIC. For example, CBC, or electrolytes are not acceptable, you must list the specific indices/test you would like for that question; i.e.

1. haemoglobin
2. white blood cell count
3. potassium

Note: urinalysis is an acceptable answer.

- When ordering other investigations, be SPECIFIC. For example, ultrasound is not acceptable, you must specify abdominal ultrasound.
- Be SPECIFIC on treatment. For example, give route of administration of medications and fluids.
- When listing medications, the use of generic names or trade names will be accepted.
- When providing values on measures only system international (SI) units will be accepted.
- Avoid abbreviations which are not commonly used and which may not be clear to examiner.
- Give details about procedures **ONLY IF DIRECTED TO DO SO**
- You will be scored only on the number of answers required – 1 point per answer (e.g., if you are asked to provide three responses and put down five, only the first three will be scored).
- Record only one answer per box, subsequent answers in the same box will not be considered.
- If your answer to a question is “none”, please type “none”. Do not leave the box empty.

It is possible to switch from English to French and vice versa when reading the questions. If you are not sure of a meaning or nuance, it might be wise to read the question a second time in the other language to see if it is clearer.

Sample SAMPS

The following 3 SAMP cases have been printed in the manual for your review.

<u>SAMPLE CASES</u>	SAMPLE TOPICS
Sample case #2	Gestational Diabetes
Sample case #4	Red Eye
Sample case #11	Child Asthma

SAMPLE CASE #2

Elizabeth is a 24-year-old member of a First Nations People, and lives on a reservation. She is eight weeks pregnant with her second child. You are seeing her for the first time, for her first prenatal visit. She is 150 cm tall and weighs 90 kg.

1. What are Elizabeth's risk factors for developing gestational diabetes? List **TWO**.

1.

2.

2. What other items of her history would you like to know? List **TWO** items and explain their significance.

1.

2.

3. At what point in her pregnancy would you screen Elizabeth for gestational diabetes, given that her current fasting plasma glucose level is normal?

4. What screening test would you order?

5. A. What result of the screening test in question 4 would lead you to diagnose gestational diabetes?

B. What result of the screening test in question 4 would lead you to do further investigations?

C. Should further investigations be necessary, what test would you order next?

6. What are the **MOST** common risks for the infant of a woman with untreated gestational diabetes? List **TWO**.

1.

2.

Elizabeth is diagnosed as having gestational diabetes mellitus.

7. Postpartum, what advice would you give Elizabeth to prevent the development of type II diabetes mellitus later in life? List **ONE** goal and the way in which Elizabeth could achieve it.

1. Goal:

2. Way to achieve it:

8. How often would you screen Elizabeth for diabetes mellitus?

9. What screening test would you order?

10. What result of the screening test in question 9 would lead you to diagnose diabetes mellitus?

SAMPLE CASE # 4

Mrs. Nguyen, a 23-year-old day-care worker, presents at your office complaining of redness and irritation of her right eye over the past 24 hours. She denies any pain. The nurse assesses her visual acuity as OS 20/20, OD 20/20.

1. What other ocular symptoms are important to inquire about? List **FOUR**.

1.

2.

3.

4.

2. Other than viral, bacterial, allergic, or irritated conjunctivitis, what common conditions may cause a red eye? List **FOUR**.

1.

2.

3.

4.

Mrs. Nguyen admits that she has started using her mother's corticosteroid-based ophthalmic drops.

3. If the patient's condition were caused by certain broad groups of pathogens, corticosteroid drops could worsen the condition. List **TWO** broad groups of pathogens.

1.

2.

4. What are the potentially serious ocular side effects of prolonged use of topical corticosteroid drops in the eye? List **TWO** side effects.

1.

2.

5. If this patient were elderly, were complaining of acute pain in the eye, and had visual acuity of 20/200, what ophthalmic diagnosis would you be **MOST** concerned about?

6. What technique is recognized as the "gold standard" for diagnosing the condition in question 5?

7. What is the **DEFINITIVE** treatment for the condition in questions 5 and 6?

SAMPLE CASE # 11

Jamie is a seven-year-old boy who is brought to your office by his mother. He has a one-month history of dry cough, which is worse at night, and wheezing. The wheezing seems to be getting worse. His mother states that “colds seem to go to his chest”. The chest is clear on auscultation and percussion. An X-ray film of the chest was reported as normal.

1. Excluding family history, what additional information would be important in this child’s history? List **SIX**.

1.

2.

3.

4.

5.

6.

2. If you were quite certain that Jamie has asthma, what would be your initial treatment/management steps? List **FOUR**.

1.

2.

3.

4.

Despite adequate initial treatment, Jamie’s condition deteriorates and he presents at the emergency department one week later. You determine from the history and examination that he is in status asthmaticus.

3. In point form, give the stepwise management of status asthmaticus in this child. Arterial blood gases and peak expiratory flow measurements have been done. The patient's condition is being continuously monitored and reassessed. Assume his condition continues to deteriorate throughout treatment. List **EIGHT** steps.

1.

2.

3.

4.

5.

6.

7.

8.

SAMPLE CASE # 2

QUESTION 1

1. Aboriginal race
2. Obesity

QUESTION 2

1. Size of first baby: If this newborn weighed ≥ 4 kg, gestational diabetes mellitus (GDM) may have been present in the first pregnancy.
2. Family history of diabetes mellitus (DM)

QUESTION 3

At 24 to 28 weeks of gestation

QUESTION 4

1. Plasma glucose level measurement one hour after a 50-g oral glucose load

QUESTION 5

- A. Plasma Glucose level ≥ 10.3
- B. A plasma glucose level ≥ 7.8
- C. A 2hr 75 gm glucose tolerance test

QUESTION 6

1. Macrosomia (large size can lead to birth trauma)
2. Neonatal hypoglycemia

QUESTION 7

1. Goal: Weight control
2. Way to achieve it: Through diet and exercise

QUESTION 8

6 weeks – 6 month post partum

QUESTION 9

75 gram OGTT

QUESTION 10

2 hr – 75 gram GTT ≥ 11.1 mmol/L

SAMPLE CASE # 4

QUESTION 1 (Any 4)

1. Blurred vision
2. Photophobia
3. Exudation/Discharge
4. Itching
5. Colored halos in the visual field
6. Sensation of a foreign body
7. Double vision/Diplopia

QUESTION 2 (Any 4)

1. Iritis
2. Keratitis
3. Acute angle-closure glaucoma
4. Presence of a foreign body
5. Blepharitis
6. Subconjunctival hemorrhage
7. Pterygium
8. Abrasions
9. Chalazion/Hordeolum/Stye
10. Contact lens overuse
11. Dry eye syndrome
12. Episcleritis
13. Hyphema
14. Hypopyon

QUESTION 3

1. Viral pathogens
2. Fungal pathogens

QUESTION 4 (Any 2)

1. Cataracts
2. Elevated intraocular pressure
3. Optic nerve damage

QUESTION 5

Acute angle-closure glaucoma

QUESTION 6

Measurement of intraocular pressure/Tonometry

QUESTION 7

Surgical peripheral iridectomy/ Laser peripheral iridectomy

SAMPLE CASE # 11 ANSWERS

QUESTION 1

1. Child's history of atopy
2. Child's history of asthma
3. Child's history of allergies
4. Use of medications
5. Recent infection
6. History suggestive of foreign body aspiration

QUESTION 2

1. Patient education
2. Removing precipitating factors
3. Inhaled beta-agonist
4. Peak-flow meter

QUESTION 3

1. Supplemental oxygen (O₂)
2. Nebulized salbutamol (Ventolin)
3. Nebulized Atrovent
4. Subcutaneous epinephrine
5. Intravenous (IV) steroids
6. Intravenous (IV) Salbutamol
7. IV Magnesium
8. Intubation and monitoring
9. Admission to the intensive care unit (ICU)

Introduction to the SOOs

Each candidate will do four separate simulated office orals. Each of these oral examinations is 15 minutes in length and involves an interview with a simulated patient. In the simulated office orals the patient will be role-played by a family physician. This individual will also be responsible for scoring the candidate.

In all of these interviews the simulated patients/examiners have been programmed to play the part of a patient. The candidate will not perform a physical examination, but will be required to discuss the problem with the patient and bring the visit to a satisfactory conclusion within the defined time frame. The candidate is expected to define and manage the problems presented by the patient. In scoring, an emphasis is placed on understanding the patient's perspective of her or his problems and on arriving at a plan of management that is satisfactory to both parties. This is to be done in the context of the entire encounter through the use of appropriate interview techniques. The best advice is to try to behave as you would if you were seeing a patient in your own office. The patient/examiner will not be trying to mislead you.

The preparation for this examination takes place daily in your private office or family practice unit.

Before each SOO, you will be shown a "briefing sheet". You should read these instructions carefully and repeatedly. They contain a varying amount of information about the patient, including at least his/her name and age. A coordinator may ask if you have any questions. Be sure to ask the coordinator about any matter that causes you concern or uncertainty.

During the examination be aware of your own timing. The examiner is also timing you and will give you a warning when there are three minutes left. You are, however, responsible for managing your own time during the course of the interview. You may bring your watch. The timer in the room belongs to the examiner and you may not touch it. 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. In the event that you finish your interview before the 15 minutes have elapsed, you may conclude with the "patient" and leave the room.

You may make notes during the interview and use these notes to assist you during your summation. This will prevent you from forgetting to deal with any problems that you have identified in the course of the interview.

Please be aware that your Simulated Office Oral examination may be viewed by means of video equipment and/or mirrors; the purpose of this is to validate the examiner's performance, not the candidate's. Your examination will not be

recorded.

During the intervals between the oral examinations it is not permitted to discuss the content of the oral examinations with other candidates. Experience has shown that prior knowledge of the clinical content of oral examinations has resulted in poorer performance than might otherwise have been expected.

Most importantly, do not be discouraged if you feel you have done poorly in any one or more of the orals. Always keep in mind that the overall certification examination process comprises many different instruments. It is quite possible to be successful on the examination in spite of a poor performance on one or more of the oral examinations.

SAMPLE SOO

You may watch a demonstration video of a SOO at the CFPC website, and see an example of how it is graded. In the future there may be more video demonstrations available on the website. There are also 9 SOO scripts available for your review on the website. In this manual at the end of this section there is also a full sample SOO. Grading is based on objective criteria and has been standardized. In each case, the candidate is assessed on the content of the criteria as well as the doctor-patient communication skills as applicable to the content. These are based on the Patient-Centred Clinical Method described by the Centre for Studies in Family Medicine, the University of Western Ontario.

REFERENCES

1. Weston WW, Brown JB, Stewart MA. Patient-centred interviewing part I: Understanding patients' experiences. *Can Fam Physician* 1989;35:147-51.
2. Brown JB, Weston WW, Stewart MA. Patient-centred interviewing part II: Finding common ground. *Can Fam Physician* 1989;35:153-7.
3. Stewart MA, Brown JB, Weston WW. Patient-centred interviewing part III: Five provocative questions. *Can Fam Physician* 1989;35:159-61.

Preparation for the Simulated Office Orals (SOOs)

Dr. D. Dalton

Revised August 2014

First of all, let's compare the two aspects of the CFPC Exam. The SAMPs and OSCE's exist to test your clinical knowledge. The College wants the candidates to demonstrate an adequate level of understanding of the diagnosis and management of the conditions that appear in the SAMPs problems. The questions are varied enough to test some aspect of your knowledge in most areas of Family Medicine. The College has identified certain indicators of each condition ("key features") that distinguish the knowledgeable physician from the not so knowledgeable. You must look at the Key Features on the College website (<http://www.cfpc.ca>). You will see that they are not lists of everything you need to know about a disease, but more about which aspects of the disease or condition can be tested to demonstrate competence.

The SOOs also test your ability to diagnose and manage problems. But the added goal is to test your ability to use the patient-centered model. You must be able to talk to a patient, to find out who a patient is, to put the illness experience of the patient in the context of his or her life. (The standard text book on the patient-centered model is Patient-Centered Medicine, Transforming the Clinical Method, by Moira Stewart, Judith Belle Brown, et al.) This is what you have been practicing in your family medicine clinics throughout your residency.

The best way to prepare for the SOOs is to do practice exams, in which you get appropriate feedback on your style and errors. In addition, it is a good idea to look at all your patient encounters as if they were SOOs. (It is surprising how much more information you get from your patients if you actually consciously try these interview techniques!)

There are four SOOS in the CFPC/MCC harmonized exam, each lasting 15 minutes. This may not sound like a lot of time, and, indeed, it isn't. It is rare to get out all the possible information in this length of time, so you will often leave a SOO with the feeling that you have missed something. Don't worry about it. You will miss some aspect of the case, and your colleague may miss another aspect, and yet you will both pass. Forget each SOO as you leave it, and move on to the next one.

During the College exams, the "patient" is actually the examiner who is marking you. They have spent time standardizing their acting to present a credible case, and to make sure that the marks they give are consistent across all test centers. A second examiner behind a mirror or via camera will watch some of your SOOS. This is to insure that the patient / examiner acts and marks consistently. I mention all this just to emphasize the point that the patient / examiner will not step out of role. You may not ask him or her anything about

the exam process. He or she will just look at you strangely. They are in the role of the patient and they remain in that role. There is a pad and pencil in the room for you to scribble notes, if that is your style, but remember to leave the paper in the room when you finish, and to focus on the patient and not on your pad.

Before you enter each SOO, you will be shown a briefing sheet where there are instructions. These are often posted on the door of the room in which you will be interviewing “the patient”. Read them carefully. The instructions always end with the name and the age of the patient you are about to meet. For example, “You are about to meet Mr. John Smith, a 54 year-old man who is new to your practice.” You should knock on the door when you are ready, open the door and give the examiner / patient your exam label. When the label business has been dealt with, introduce yourself. “Hello, Mr. Smith. My name is Dr. [Insert your name here, if you can remember your name.] What can I do for you today?” Please begin with an open-ended question like this. Some candidates mistakenly begin by telling the patient that they “just want to ask a few questions first” and launch into Previous Medical History, Drugs, Allergies, etc, before getting around to asking why the patient is there. This reduces the time that the patient has to discuss his or her problem. The first line that the patient uses is known in SOO Language as “the first prompt”. Listen to this chief complaint and follow up on it. It is your clue to the First Problem. Ask about PMH, Meds, Allergies, etc. later in the interview.

Understanding how a SOO is marked will help you to understand how to conduct your interview. There are always two problems. Both problems could be medical (this is the case more-and-more often), or one could be medical and one social. In fact, the second problem could refer to the social repercussions of the first problem. You are marked on proper identification of each problem. This means asking the relevant questions to make a diagnosis and to exclude other possibilities. For example, if the problem is angina, you will be marked on a full history of CVS disease, risk factors, precipitating factors, etc. You would do this same thing in your office with any patient you see. You are identifying the problem by asking questions sufficient to arrive at a tentative diagnosis. This is equally true of social and medical problems. This is Problem Identification, and it is usually the easiest part of the exam. The first thing the patient tells you will be a prompt for the first problem. After about 5 minutes there will be a second prompt to introduce the second problem (if it has not already been identified).

When you are identifying each problem, you are also exploring how the patient experiences the problem. This is where the famous FIFE comes in: FEELINGS, IDEAS, FUNCTION, and EXPECTATIONS. It does no good to ask the patient these questions by rote. There is nothing that sounds more contrived than a candidate who says, “What are your ideas about this illness, Mr. Smith?” The excellent candidate will (and I quote) “Actively explore 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.” When you are beginning to get a

feeling for how the patient is experiencing his illness, try questions like, “Most people would find this situation frustrating, Mr. Smith. How is it affecting you?” or, “You seem a bit angry (sad / frustrated / guilty / worried) about this.” If you are commenting on the patient’s feelings or reflecting it back, the examiner will give you full marks. For IDEAS, try questions like, “Are you thinking that your blood pressure is up because of your recent stresses?” For FUNCTION you can be more direct: “How has this illness affected your ability to work and to cope at home.” (Even better if you can pick up on functional problems related to the illness and reflect them back: “So you really can’t work at full capacity any more, can you?”) For EXPECTATIONS, you should pick up on the patient’s requests of you. “So, if I understand correctly, you are hoping that I can help you with this problem by giving you better medicines.” (There could be unexpressed expectations. For example, the patient may be expecting that the physician will be accepting and non-judgmental. This does not have to be expressed. It will show in your manner.)

The next section is the hardest for many candidates, and yet it should be fairly simple. It is the CONTEXT INTEGRATION. This means demonstrating that you understand who this patient is, and how he or she is being affected by these illnesses. You will have identified the person’s family members, supports, as well as any financial or other concerns. At some point further along in the interview, you should say a few things that show that you have understood the situation. For example: “So, you have had to deal with this new illness, Mr. Smith, without much support from your family. It seems as if it is affecting your work, and even the way you are looking at yourself; and now you tell me that you are afraid that your problems with alcohol may have contributed to your daughter’s delinquency. Is that right?” My advice for remembering this is to say, out loud, **why you think this illness is a problem for this patient at this time. “I can see that this is a problem for you right now because ...”**

Then comes the obvious: treating the problems. A treatment plan is expected for each of the problems you have identified. This means appropriate investigations, and a suggestion of available therapies. It is not enough to say that you want to do some tests. You have to outline, as you would to a lay person, what you are looking for and what tests you want to do. If the problem is fairly acute, and you wish to start treatment today, explain briefly what the medicine is and what the side effects are. ALWAYS SAY THAT YOU WANT TO HAVE THE PATIENT BACK FOR A COMPLETE EXAM, AND SAY WHEN YOU WANT THEM BACK. MENTION WHAT YOU WANT TO EXAMINE SPECIFICALLY. For example, “Mr. Smith I would like to have you back for a complete physician exam in a few days. I especially would like to do a thorough neurological exam.” ALWAYS ASK FOR OLD RECORDS, IF APPLICABLE. In treating the problems, you will be marked on your treatment plan, and also on your ability to “find common ground”. Make sure that the patient is agreeing to your treatment plan. “I think we should Does that sound like a good plan?”

“Do you think it would help if?” Avoid, “I want you to take these pills and see me in a week. Then we will do this and that.” Test to see if the patient is

agreeable with your plan. And, yes, it is a good idea to involve other family members and support people in your plan. Offer to see other key people along with the patient, if you feel it would be helpful.

Lastly, you will be marked on your interview process and organization. You will do fine if you have an organized flow and if you do not cut off the patient or ignore clues. Remember to listen for prompts. The opening line is a prompt. There are sometimes one or two other prompts if new subjects have to be introduced, so if your patient suddenly says something that seems unrelated to the current discussion – pick up on it immediately and follow the lead you have been given. The last prompt is the Three Minute Warning. This is the only time the patient / examiner will step out of role, and it is to let you know that you have three minutes left to finish your questioning, summarize, present a logical treatment plan, and conclude your interview. Nothing you say will be credited after the bell rings for the end of the exam. It is always best if you tie things up just before the bell rings, but after the three-minute warning. If you happen to finish before the bell rings, you should conclude your interview and leave the room. You go back to the central waiting area for the next SOO. If you think you have finished in less than 12 minutes, I guarantee you that you have not! Fall back to the basics and ask more questions. Did you ask about the family history? Do you know who this patient is? Do you know marital status? Children? Employment?

In summary, here is an idea of the marking grid:

- 1) Problem 1 (a) identification / (b) illness experience (FIFE)
- 2) Problem 2 (a) identification / (b) illness experience (FIFE)
- 3) Social and Developmental Context (a) Identification / (b) Integration
- 4) Problem 1 (a) Management / (b) Finding Common Ground
- 5) Problem 2 (a) Management / (b) Finding Common Ground
- 6) Interview Process and Organization.

For each of these 11 sections you will be awarded an S (superior), C (Certificant), or N (non-certificant). The marks are well standardized and there is remarkably little inter-examiner variation. The examiner, even though he or she is doing the marking, does not know whether any candidate actually passes or fails, because the results are adjusted once the College receives them all.

Remember:

- Use a natural conversational tone and an organized approach to taking a history.
- Establish what the problems are by using a thorough history. (Do not be afraid to express a tentative diagnosis. They can't read your mind.) As you identify the problems, discuss with the patient how the problems are affecting him or her. If you explore the effect on the patient, as well as his expectations, you will be doing the FIFE without even knowing it.
- Listen for prompts and follow those leads.
- Identify the patient's social context (work, family members, supports) and

reflect back to the patient your impression of how the illnesses are impacting on his world.

- Negotiate a reasonable treatment plan.
- ALWAYS suggest that the patient come back for a complete physical exam. Try to get old reports if there are any.
- Try to conclude smoothly in the last three minutes.
- Move on to the next SOO and forget the one you are leaving behind.

In a strange sort of way, the exams can be fun. The cases may seem complicated, but they were all developed from actual patients who presented to a GP's office. Pretend you are in your office and all should go well.

Please read the following section, The Anatomy of a SOO, by Dr. Perle Feldman. It gives you some more strategies and breaks down the exam marking for you. Good luck!

Anatomy of a SOO

By Dr. Perle Feldman

Problem Identification (Boxes 1&2)

Look at the **SOO Marking Grid** on the college website. The first two sections Problem 1 & 2 are the two main issues to be dealt with in the SOO. This was designed this way in recognition that there is often more than one issue when a patient presents. The presence of two problems is a standardization to allow for consistent marking. These two problems can be any combination of medical and/or psychosocial problems. The script is written in such a way that the actor (who is always a family physician, by the way) is able to present both the biomedical facts of the case and the patient's illness experience.

So, by questioning, the candidate can arrive at a reasonable differential as well as an understanding of the patient's ideas & feelings about their illness and the impact on function. The physician can also determine what the patient expects the doctor to do in the interaction. Both components are necessary to achieve a satisfactory score on the first 2 sections of the SOO.

Experienced physicians such as yourself often do very well on the left-hand boxes (identifying the problem). They swiftly and efficiently arrive at a differential diagnosis. However they often do not explicitly explore the patient's illness experience. You must let the examiner know that you are checking what the patient is feeling. You must understand the patient's explanatory model of the disease and how it is affecting their life.

For example among francophone Quebecois a frequent explanatory model for how one catches a U.T.I. (to go back to that mundane example) is that one gets one's feet wet, for a woman, that she sat on something cold. When I first started my practice in St. Henri, I was completely puzzled by why women would start their stories; "I was sitting on a cold sidewalk last week and then I found that I was going to the bathroom all the time and it was burning me etc...."

It is important to understand what the patient's expectations of the physician are. If you do not know that the patient expects a certain treatment or investigation plan it is impossible to negotiate a plan that takes into account both your expectations and those of the patient's. "My friend had a CT scan when he had a headache, is that what I need?"

Useful phrases are: "How did you feel about that?", "What did you worry was happening?", "How have things changed for you since you became ill?", "What had you hoped that I would do for you today?"

Social And Developmental Context (Box 3 left)

The third section of the SOO is the social and developmental context. This is often neglected by candidates during the exam and is the most frequently failed section. Remember the name of the specialty, Family Medicine. It is important to know who the patient's significant contacts are. One has to know the impact of the family on the patient's illness and the impact of the illness on the patient's family. It is also important to place the patient in the context of their developmental "Ericsonian" stage, to determine the developmental tasks that the patient is performing and how things are going. One should also know what the patient's social situation is, their work and their finances in a basic way. What happens to a patient is often determined by who controls the finances and how. It takes just a few questions to determine this: Who lives with you? Who helps you with your illness, How has your illness impacted on the people important to you? Etc.

Context Integration (Box 3 right)

Now you have developed an understanding of the patient's illness, and also their disease differential and the context in which it has arisen and in which you must treat it. The next step is to integrate your understanding of the situation in a kind of global summing up. This integration then checks with the patient whether your understanding of the situation is congruent with theirs.

“While you’ve always had this sleep disorder, as a student you were able to cope. With your new responsibilities your old coping strategies no longer work.”

“The sore throat you are experiencing is very troubling to you, and because your mother died of throat cancer, you are afraid that it may not be the result of a simple virus.”

Practice this in your own setting and when you do it right patients will give you that look of wonderment - “Wow someone finally understands me”. When you haven’t got it right they will often clarify in a very meaningful way.

This is the most difficult area in the Exam and the hardest to define. But this is necessary for going on to the next step which is management.

Management (Boxes 4-5)

In the Management sections the candidate is required to propose and negotiate a reasonable management with the patient. There are several elements which are key to successful management of this part of the SOO. Firstly the SOO questions are constrained by the fact that you are not able to do a physical examination in order to proceed. One must propose a management plan even though in real life you would never do that without examining the patient first. That does not preclude however suggesting an appropriate physical examination and telling the examiners how your management would change depending on the findings of the physical.

“The story that you are telling me is suggestive of Irritable Bowel Disease, I would like to examine your abdomen today and reassure myself that there are no worrisome findings”

You should then give a detailed differential, again something that you might not do in real life, giving your reasoning as to why or why not you expect the diagnosis to be true.

After this is done and you have explained, your thinking on the 2 problems which you identified earlier in the context of what you know about the patient’s life you must then negotiate a management plan. You discuss with the patient what investigations and treatments you would like to do. You then check back with the patient on what you think is a reasonable plan and listen to what the patient thinks about it.

They may have ideas about tests or treatments they want to add, they may find your management to aggressive, or not aggressive enough. You must check if your plan is doable for them because of constraints of children other family members or money or whatever. The patient may have a plan that is complete nonsense to you – using alternative treatments for example.

Whatever the issues are you must elicit and address them until you both agree on a congruent agenda. Negotiation is the Key even if you cannot for whatever reason agree with the patient you must demonstrate that you have understood their position, clarified yours, addressed the differences openly and tried to come to a reasonable compromise.

Summing up

Once you have negotiated the plan, you should sum up: going over what you feel the 2 problems are your diagnosis, your analysis of the context and your negotiated plan. You should make sure that you and the patient are both aware what each of you are going to do before your next encounter, the date which you should set up. This is usually done once you have got the 3-minute warning. Remember that after the 3-minute bell, the patient will not volunteer any new information. The patient will only answer your questions and negotiate a plan with you.

You might be thinking; “how will I ever be able to do all this stuff in 15 minutes when in a real patient this would take several interviews probably over an hour and a half of time.” It does work, and you can do it because **these are not real patients**. They do not take time to open up, they are not suspicious, and they do not obscure or go off on tangents or lie. If you give them an open question and a sympathetic hearing they will give you the goods. Any medical information that they give you is likely to be true and helpful to the case. If you are completely on the wrong track they will give you hints to bring you back to the requirements of the case. However, if they are depressed or alcoholic or whatever, standard questionnaires will reveal the specifics. If they flat out say “I don’t have XYZ”, then they don’t have it. The examiners don’t lie and are trying to help you.

So this is my anatomy lesson. What I suggest is that once or twice a week you practice on your own patients using some of these techniques, making your negotiations quite explicit.

Sample SOO (Case 33 & Marking Scheme)

The College of Family Physicians of Canada

Le Collège des médecins de famille du Canada

CERTIFICATION EXAMINATION IN FAMILY MEDICINE

THE COLLEGE OF FAMILY PHYSICIANS OF CANADA

CERTIFICATION EXAMINATION IN FAMILY MEDICINE – SPRING 2001

INTRODUCTION TO SIMULATED OFFICE ORALS

The Certification Examination of The College of Family Physicians of Canada is designed to evaluate the diverse knowledge, attitudes and skills required by practicing family physicians. 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 family physicians who use a patient-centered approach meet patients' needs more effectively. The SOOs marking scheme reflects this belief. The marking scheme is based on the patient-centered clinical method, developed by the Centre for Studies in Family Medicine at the University of Western Ontario. The essential principle of the patient-centered 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-centered 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.

RATIONAL FOR SIMULATED OFFICE ORAL EXAMINATION #1

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

- 1) is pregnant
- 2) has associated nausea and vomiting

The goal is not to do a complete first prenatal visit, and no forms should be completed. Rather, the goal is to ensure the safety of the pregnancy until there is a formal first prenatal visit.

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.

CERTIFICATION EXAMINATION IN FAMILY MEDICINE – SPRING 2001

SIMULATED OFFICE ORAL EXAMINATIONS

INSTRUCTIONS TO THE CANDIDATE – CASE #1

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 3 minutes remaining. During the final 3 minutes, you are expected to conclude your discussions with the patient/examiner.

At 15 minutes, the examiner will signal the end of the examination. You are expected to stop immediately and to leave any notes with the examiner.

4. THE PATIENT

You are about to meet **Ms. Tanya Bracewell**, age 25, who is new to your practice. She has normal vital signs.

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.

**THE COLLEGE OF FAMILY PHYSICIANS OF CANADA
CERTIFICATION EXAMINATION IN FAMILY MEDICINE – SPRING 2001**

SIMULATED OFFICE ORAL EXAMINATION #1

CASE DESCRIPTION

INTRODUCTORY REMARKS

You are **Ms. Tanya Bracewell**, age 25. You are visiting this family physician (FP) for the first visit of your pregnancy. You are particularly bothered by the amount of nausea and vomiting.

HISTORY OF THE PROBLEMS

Nausea in Pregnancy

You married **Rick Menzies** six weeks ago, and became pregnant on your honeymoon. Currently you are eight weeks pregnant. (Use this information to calculate your last menstrual period.)

Your nausea has been overwhelming. You vomit two or three times each morning and once or twice during the rest of the day. In the morning, you vomit one-half to one cup of bilious green liquid. Later in the day, the vomit usually consists of particles of what you have eaten earlier; the amount is the same as in the morning. You never vomit any blood.

You work in a retail store specializing in fragrances, soaps and cosmetics. For the past two weeks you have been unable to work because the strong odours worsen your vomiting. You would vomit within minutes of arriving each morning, and remain nauseated all day long. As long as you remained at the store, you vomited every hour or so. Your frequent vomiting made the store manager, **Cheryl**, suspect that you are pregnant. She was concerned and encouraged you to see a doctor to “do something about the vomiting.”

You are able to eat small amounts of food throughout the day, but are unable to cook without vomiting. You have started to eat softer foods because they hurt less when they come up. You enjoy salty and creamy foods, and have a craving for Kraft dinner and popcorn.

You are very sleepy and the vomiting becomes worse when you are fatigued. The bathroom scale shows that you have not lost any weight and your clothes still fit.

You urinate frequently. You have no pain on urination, no abdominal cramps, no diarrhoea, no vaginal spotting and no fever.

You have not tried any over-the-counter remedies such as Gravol or ginger because you are concerned about their possible impact on your baby. You are also concerned that the vomiting may be harming the baby. You want the FP to reassure you that you are healthy enough to have this baby. You also want to know if he or she will take care of you, and if so, what his or her care plan is.

Rick does not understand why you feel so bad. He did not expect you to be this sick. He resents having to cook for you when he gets home from work, and he cannot understand why housework is not done when you have been at home all day. His mother had six children and never had any problems managing home and family.

Pregnancy-Related Issues

A home pregnancy test two weeks ago was positive. An internet site helped you calculate the number of weeks of pregnancy (8 weeks) and your due date (December 15).

Your breasts are very sore. You are not taking folic acid or any other vitamin supplements.

You have a family history of mental illness: your mother has bipolar disorder and your father is schizophrenic. You have heard that genetic testing is available and are interested in learning more about testing for mental illness. However, you would not make a decision about testing without talking to Rick first. You value him as an equal partner and you believe you both should be involved in decisions concerning your baby. You know that there is a chance the baby will inherit your parents' problems but feel that because you "turned out okay," there is a good chance the "bad genes" skipped you.

There is no history of any other type of illness or medical condition in either your family or Rick's.

MEDICAL HISTORY

You have always described yourself as a "disgustingly healthy" person. You have never been hospitalized or had surgery. You have no medical conditions, such as blood disorders or renal problems; no personal history of psychiatric

disorders; and no neurologic problems.

You have never had a sexually transmitted disease. Your last gynaecologic exam was last year. Before becoming pregnant, you and Rick used condoms for contraception. You decided to stop using them after your wedding.

You have had no therapeutic abortions or miscarriages.

MEDICATIONS

None, not even vitamin supplements.

LABORATORY RESULTS

Positive urine home pregnancy test two weeks ago.

ALLERGIES

None

IMMUNIZATIONS

Up-to-date

LIFESTYLE ISSUES

Tobacco: Half a pack of cigarettes a day for ten years; you quit when you met Rick.

Alcohol: None since you discovered you are pregnant (i.e., none for the past two weeks). Before your pregnancy, you would have a glass of wine when you went out for dinner or on special occasions at home.

Illicit Drugs: None

FAMILY MEDICAL HISTORY

You have no family history of congenital cardiac abnormalities, genetic diseases, diabetes, or hypertension.

Your mother, **Lizzi Wilson**, has bipolar disorder, which was diagnosed when you were ten years old. She has never been hospitalized. Her erratic behaviour secondary to her disease probably predated your birth. You are very grateful to the doctor who started her on lithium treatment. Your mother's condition is relatively stable, but her behaviour is rather odd and inappropriate. She goes on occasional shopping sprees, buying you gifts you know she cannot afford.

You are no longer surprised when she returns these gifts to the store a few days later after you have received them. You have learned to live with her verbosity and flamboyant hot-pink outfits.

Your father, **Thomas Bracewell**, has paranoid schizophrenia. His condition was diagnosed as “schizophrenia” before you were born. Before their divorce, your mother always said that she was the only one capable of keeping your father under control; she believed that if she had had the right resources, she could have cured his problem.

Your father’s condition has been poorly controlled with medication. Recently his medication was changed and he has a new psychiatrist. For the first time in years, he seems to be a little better.

Because he lives in the same apartment building as you, often you are the only one to call an ambulance when he requires hospitalization. Frequently you accompany him to medical and psychiatric appointments.

PERSONAL HISTORY

Childhood

You are an only child. (Your father says that he was rendered infertile by a government experiment.)

You had a rather chaotic childhood. Your parents were not like other kids’ parents. They were very disorganized and had a lot of trouble getting you to school. You moved very frequently and they were unable to budget. You depended on monthly welfare checks, but they rarely lasted more than three weeks. You usually ended up going to food banks during the last week of the month.

Your mother sometimes gave you wonderful presents, but they often disappeared. Now that you are an adult, you understand she could not pay for these and probably returned them to the store. Currently she lives in the same city as you.

Your father was very sweet most of the time, but sometimes he was subject to irrational rages. He would rant against the government and their plots, and was particularly upset at the dental profession. He accused dentists of inserting thought-control devices in his dental fillings.

Oddly enough, social workers and Children’s Aid were absent from your childhood. Your mother managed to hold things together with the on-again, off-again help of her mother, **Edna Wilson**. Sometimes your grandmother gave you a square meal. She always bought your school clothes. Three years ago

she died peacefully of a heart attack.

Your parents lived together until you finished high school. When you moved out of the apartment, they were no longer able to tolerate each other; they separated and later divorced.

There was never any physical, sexual, or alcohol abuse in your family.

You have not yet told your parents that you are pregnant. You hope to create the “normal” family that you never had, but are terrified that you are going to mess up or that your parents are going to ruin everything. They have often made your life difficult and you don’t know how to handle this anymore.

Marriage

Rick is 25 and manages a fast-food restaurant. You met him two years ago in a coffee shop where you and your long-time friend, **Emma**, hung out after work. Rick had been dating another friend of Emma’s, who had dropped him because he was “too nice.” You hit it off with Rick immediately and dated for a year before moving in with him. About ten months later, you married because you both wanted to start a family. You had a small ceremony at the courthouse, which was attended by a few close friends and family. This was followed by a wonderful dinner catered by some of Rick’s restaurant friends.

Neither your parents nor Rick’s approved of your marriage, but they attended the wedding. In general, your parents are resistant to change. Rick’s parents were a little concerned because of the type of family into which their son was marrying.

Rick is one of the most accepting people you have ever met. You see him as the key to a new life for you. He grew up in a warm and loving family. He is close to his parents and his siblings. He is wonderfully sociable, but despite having a great group of guys to hang around with, he always has time for you.

Rick has always enjoyed working with food. Cooking is a survival skill when you have five siblings, he says. He completed some community college/technical college courses in cooking and restaurant management. You know his dream is to own a restaurant and to complete further culinary studies. However, you love the fact that a family is very important to him, too.

Rick is working long hours to support you and to earn extra money for the new baby. Fortunately, he does not work shifts as the restaurant serves only breakfast and lunch. You are happy that Rick’s schedule allows you to spend time together as a couple. You share a love of movies and outdoor activities like hiking and cycling. Rick is solid and dependable, and thinks that you are wonderful.

Up until now, he has taken everything in stride. However, he is really thrown by “this puking thing.” He hates coming home and cooking supper after he has spent the entire day cooking at work.

In-Laws

Your in-laws, **Jim Menzies** and **Carolyn Jones-Menzies**, have accepted you coolly. They will have nothing to do with your parents, of whom they are terrified. You sense that your in-laws are a little concerned that you may inherit your parents’ illnesses. Your in-laws also wish you had waited to start a family, but you imagine they will accept this grandchild lovingly, as they have accepted their other four. Rick supports you when his parents are critical, and deep down you feel that ultimately they will accept you.

You have joked with Rick that his family seems to be as physically healthy as yours.

EDUCATION AND WORK HISTORY

You have worked from the time you were old enough. During high school, you worked at least 20 hours a week in a chain clothing store.

You were an average student in high school. You would have liked to continue your education, but doing so would have been difficult. Your need to earn a living and become independent of your parents was greater than your desire to attend college or university. You don’t regret your decision not to pursue further education.

You have been working in retail full time since high school graduation and at the fragrance store for the past two years. The store is part of a national chain that has good benefits, including an excellent insurance policy. Up until now you have really enjoyed this job. You refuse to consider receiving welfare payments ever again.

ACTING INSTRUCTIONS

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

You are well dressed, well groomed, and wearing no fragrance. You have a tissue or a hanky clutched in your hand “just in case” breakfast come back up. You are very friendly and cooperative.

You are excited that you are pregnant, but at the same time you are concerned. You worry that this amount of vomiting cannot be normal and that it may be harming your baby. You are very much in love with your husband and think that he is the best thing that ever happened to you. However, you feel that he is not as supportive of you at this time as you had expected him to be.

You want to know everything that you should be doing to have a healthy baby. If the physician suggests that you should be taking folic acid, you ask what amount.

You expect that the physician will be straight with you about the impact of the vomiting and you hope that he or she will suggest some way to stop it. You really cannot go in to work and need a note to allow you time off. If you have a doctor’s letter, your company insurance will pay for your work absence.

You are a true survivor. Despite your parents, you have grown up to be a basically normal person. You are strong emotionally and “in control,” and these traits probably helped you survive your childhood. What frightens you now is that for the first time in your adult life, you are not in control.

Do not volunteer the information that you are pregnant unless the candidate asks you either directly or indirectly in such a way that a response is appropriate. Otherwise, wait for the ten-minute prompt. (You may actually believe that the doctor already knows that you are pregnant because you are certain you said so when you called to make the appointment.)

CAST OF CHARACTERS

Tanya Bracewell:	The 25-year-old, recently married patient who is eight weeks pregnant
Rick Menzies:	Tanya's 25-year-old husband
Lizzie Wilson:	Tanya's mother who has bipolar disorder
Thomas Bracewell:	Tanya's father who has paranoid schizophrenia.
Jim Menzies:	Rick's father
Carolyn Jones-Menzies:	Rick's mother
Emma:	Tanya's friend
Cheryl:	Tanya's boss
Edna Wilson:	Tanya's maternal grandmother who died of a heart attack three years ago

INTERVIEW FLOW SHEET

INITIAL STATEMENT:

I need some help with this vomiting.”

10 MINUTES REMAINING:

If the candidate has not addressed vomiting in pregnancy, say, **“I’m scared that this much vomiting can’t be good for the baby.”**

6 MINUTES REMAINING:

If the candidate has not addressed pregnancy-related issues, including the patient’s personal and family medical history, ask, **“What needs to be done in general to take care of my pregnancy?”**

If the candidate has not addressed vomiting in pregnancy, ask, **“What can I do to stop vomiting?”**

3 MINUTES REMAINING:

“You have three minutes left.”

0 MINUTES REMAINING:

“Your time is up.”

Note: If you have followed the prompts indicated on the interview flow sheet, there will 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 agreeing or disagreeing. You should allow the candidate to conclude the interview during this time.

THE COLLEGE OF FAMILY PHYSICIANS OF CANADA

CERTIFICATION EXAMINATION IN FAMILY MEDICINE – SPRING 2001

SIMULATED OFFICE ORAL EXAMINATION # 1

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.

1. IDENTIFICATION: VOMITING IN PREGNANCY

Vomiting in Pregnancy	Illness Experience
<p>Areas to be covered include:</p> <p>1. History of the current problem:</p> <ul style="list-style-type: none"> Onset 2 weeks ago Vomiting 2 – 3 times per morning Vomiting some afternoons Ability to tolerate some food <p>2. Patient's current management of vomiting:</p> <ul style="list-style-type: none"> Eats small meals Eats salty, creamy foods Uses no over-the-counter remedies (e.g., Gravol, ginger) <p>3. Potential contributing factors:</p> <ul style="list-style-type: none"> Associated with fragrances Inability to tolerate cooking smells Worse when she is fatigued <p>4. Ruling out systemic illness:</p> <ul style="list-style-type: none"> No weight loss No hematemesis No diarrhea No epigastric pain No hyperthyroidism 	<p><u>Feelings:</u></p> <ul style="list-style-type: none"> Sense of being out of control for the first time in her adult life Worried Scared Anxious about Rick's response <p><u>Ideas:</u></p> <ul style="list-style-type: none"> Vomiting is a result of the pregnancy Vomiting may harm the baby <p><u>Effect/Impact on Function:</u></p> <ul style="list-style-type: none"> Inability to work Marital relationship is strained; Rick does not understand <p><u>Expectation for this Visit:</u> She wants treatment for the vomiting!</p>

Superior Certificant	Covers points 1, 2, 3, & 4	Actively explores the illness experience to arrive at an <u>in-depth</u> understanding of it. This is achieved through the purposeful use of verbal and non-verbal techniques, including both effective questioning and active listening.
Certificant	Covers points 1, 2, and 3	Inquires about the illness experience to arrive at a <u>satisfactory</u> understanding of it. This is achieved by asking appropriate questions and using non-verbal skills.
Non-certificant	Does <u>not</u> cover points 1, 2, and 3	Demonstrates only minimal interest in the illness experience and so gains <u>little</u> understanding of it. There is little acknowledgement of the patient's verbal or non-verbal cues, or the candidate cuts the patient off.

2. IDENTIFICATION: PREGNANCY-RELATED ISSUES

Pregnancy-Related Issues	Illness Experience
<p><u>Areas to be covered include</u></p> <p>1. Diagnosis of pregnancy:</p> <ul style="list-style-type: none"> • Last menstrual period 8 weeks ago • Positive urine pregnancy test • Planned pregnancy • G1P0 (i.e. no previous pregnancies) <p>2. Other relevant symptoms:</p> <ul style="list-style-type: none"> • No vaginal bleeding • No fever • No pelvic pain • No major illnesses in past medical history <p>3. Lack of folic-acid supplement</p> <p>4. Exposure to toxins:</p> <ul style="list-style-type: none"> • No drug use • No smoking • No alcohol use • No exposure to infection <p>5. No history of genetic diseases that can be diagnosed early in pregnancy (e.g., trisomy 21, neural tube defects, etc.)</p>	<p><u>Feelings</u></p> <ul style="list-style-type: none"> • Excited • Happy <p><u>Ideas:</u></p> <ul style="list-style-type: none"> • Wants to do everything possible to have a healthy baby • Want to have a “normal” family <p><u>Effects/Impact on Function:</u></p> <ul style="list-style-type: none"> • Fatigue <p><u>Expectations for this Visit:</u> She want the doctor to give her a plan so That her baby will be healthy.</p>

Superior Certificat	Covers points 1, 2, 3, 4 & 5	Actively explores the illness experience to arrive at an <u>in-depth</u> understanding of it. This is achieved through the purposeful use of verbal and non-verbal techniques, including both effective questioning and active listening.
Certificat	Covers points 1, 2, 3, and 4	Inquires about the illness experience to arrive at a <u>satisfactory</u> understanding of it. This is achieved by asking appropriate questions and using non-verbal skills.
Non-certificat	Does <u>not</u> cover points 1, 2, 3 and 4	Demonstrates only minimal interest in the illness experience and so gains <u>little</u> understanding of it. There is little acknowledgement of the patient’s verbal or non-verbal cues, or the candidate cuts the patient off.

3. SOCIAL AND DEVELOPMENTAL CONTEXT

Context Identification	Context Integration
<p><u>Areas to be identified include</u></p> <p>1. Husband:</p> <ul style="list-style-type: none"> • The patient is married • Recent marriage (6 weeks ago) • Rick is supportive and caring <p>2. Family:</p> <ul style="list-style-type: none"> • The patient’s mother, Lizzie Wilson, has bipolar disorder • The patient’s father, Thomas Bracewell, has paranoid schizophrenia • Both parents are unaware of her pregnancy • She has no siblings • Her parents are divorced <p>3. Work:</p> <ul style="list-style-type: none"> • She works in a fragrance store • Her boss is supportive • The store has a good insurance plan <p>4. Support Systems:</p> <ul style="list-style-type: none"> • Rick’s parents are ambivalent about the pregnancy • Emma is the patient’s long-time friend • The patient usually manages without the extensive social support 	<p>Context integration measures the candidate’s ability to:</p> <ul style="list-style-type: none"> • Integrate issues pertaining to the patient’s family, social structure, and personal development with the illness experience. • Reflect observations and insights back to the patient in a clear and empathic way. <p>This step is crucial to the next phase of finding common ground with the patient to achieve an effective management plan.</p> <p>The following is the type of statement that indicates good context integration: “You are excited that this new pregnancy is going to bring you the normal family you always wanted. You are afraid that the vomiting might jeopardize your dreams.”</p>

Superior Certificant	Covers points 1, 2, 3, & 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 factor on the illness experience. The following is the type of statement that a certificant may make: “Sounds like you’ve never received much support from your family.”
Non-certificant	Does <u>not</u> cover points 1, 2, and 3	Demonstrates minimal interest in the impact of the contextual factors on the illness experience, or cuts the patient off.

4. MANAGEMENT: VOMITING IN PREGNANCY

Plan	Finding Common Ground
<p>1. Reassure the patient that this amount of vomiting is not abnormal.</p> <p>2. Suggest non-pharmacological management, such as:</p> <ul style="list-style-type: none"> • Eating small amount of food more often • Eating crackers and other carbohydrate foods • Eating before getting out of bed • Separating solids and liquids • not cooking <p>3. Discuss the use of doxylamine succinate/pyridoxine hydrochloride (Diclectin).</p> <p>4. Discuss follow-up for the vomiting within the next two weeks, either by an office visit or a phone call.</p> <p>5. Discuss arranging time off work for the patient.</p>	<p>Behaviours that indicate efforts to involve the patient include:</p> <ol style="list-style-type: none"> 1. encouraging discussion 2. providing the patient with opportunities to ask questions 3. encouraging feedback 4. seeking clarification and consensus 5. addressing disagreements <p>This list is meant to provide guidelines, not a check list. The points listed should provide a sense of the kind of behaviours for which the examiner should look.</p>

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

5. MANAGEMENT: PREGNANCY-RELATED ISSUES

Plan	Finding Common Ground
<p>1. Arrange a follow-up appointment for a physical examination and laboratory tests.</p> <p>2. Suggest the use of folic acid supplements in a dosage of at least 0.4 mg/day.</p> <p>3. Discuss her husband's attendance at prenatal visits.</p> <p>4. Provide and /or set the patient up with some prenatal supports, such as a new parents group, prenatal classes, reading materials, etc.</p>	<p>Behaviours that indicate efforts to involve the patient include:</p> <ol style="list-style-type: none"> 1. encouraging discussion 2. providing the patient with opportunities to ask questions 3. encouraging feedback 4. seeking clarification and consensus 5. addressing disagreements <p>This list is meant to provide guidelines, not a check list. The points listed should provide a sense of the kind of behaviours for which the examiner should look.</p>

Superior Certificant	Covers points 1, 2, 3, 4, & 5	Actively inquires about the patient's ideas and wishes for management. Purposefully involves the patient in the development of a plan and seeks her feedback about it. Encourages the patient's full participation in decision-making.
Certificant	Covers points 1, 2, 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-centered approach.

The following are important techniques or qualities applicable to the entire interview:

1. Good direction with a sense of order and structure.
2. A conversational rather than interrogative tone.
3. Flexibility and good integration of all interview components; the interview should not be piecemeal or choppy.
4. Appropriate prioritization, with an efficient and effective allotment of time for the various interview components.

Superior Certificant	Demonstrates advanced ability in conducting an integrated interview with clear evidence of a beginning, middle, and an end. Promotes conversation and discussion by remaining flexible and by keeping the interview flowing and balanced. Very efficient use of time, with effective prioritization.
Certificant	Demonstrates average ability in conducting an integrated interview. Has a good sense of order, conversation, and flexibility. Uses time efficiently.
Non- certificant	Demonstrates limited or insufficient ability to conduct an integrated interview. Interview frequently lacks direction or structure. May be inflexible and/or overly rigid, with an overly interrogative tone. Uses time ineffectively.

CLINICAL SKILLS COMPONENT:

Objective structured clinical examination stations (OSCEs)

Please visit the Medical Council of Canada (MCC) website for full details (www.mcc.ca: under examinations click on Certification Examination in Family Medicine)

You will undergo 8 stations of 10 minute OSCEs and have 2 rest stations. You have 2 minutes to read each case.

The 10 minute OSCE stations assess your ability to appropriately obtain a history and/or conduct a physical examination, as well as to demonstrate interviewing/communication skills and/or management skills.

At each station, a brief written statement introduces a clinical problem and directs you to appropriately examine a standardized patient and respond to his or her concerns.

A physician examiner is present at each station to observe the patient encounter and uses standardized scoring instruments (<http://mcc.ca/wp-content/uploads/Exams-interaction-rating-scale-items.pdf>) to assess your performance. In some cases the clinical encounter ends at 9 minutes and is followed by a one minute oral examination. During the oral examination the physician examiner will ask one to three prespecified questions related to the patient problem.

On the MCC website there is a very useful slide show entitled “**Orientation to the OSCE Format of the Clinical Skills Component**” which orients candidates to this exam.

<http://mcc.ca/examinations/certification-in-family-medicine/exam-preparation-resources/>

OSCE Station Examples on the MCC website

<http://mcc.ca/examinations/certification-in-family-medicine/clinical-skills-station-descriptions/>

- **A history taking and physical examination station with a video of a candidate in the station, candidate instructions and examiner checklist.**
- **A management station with candidate instructions, nurse’s instructions and examiner’s checklist**
- **A history taking station with candidate’s instructions and examiner’s checklist**

Common mistakes made on OSCEs (as per the MCC website)

Not reading the instructions carefully

Read the task as well as the patient problem. The verbs in the instructions matter, as do the limits stated in the questions. For example:

If the task is to conduct a focused history, then that is what you will get credit for; that is, taking a history in a clinically appropriate manner. You will not get credit for educating the patient or advising them when the assigned task is to take a history.

If the task is “assess and advise” OR “discuss” OR “counsel”, then you will get credit for tasks like eliciting key information about the patient’s problem, understanding how the patient perceives the problem, AND for actions like advising the patient, providing them with information, and recommending follow-up, depending on the nature of the presenting problem.

If the task is to “assess and manage” then you will get credit for assessing the patient (e.g., relevant history and/or physical exam) AND for managing the problem, which may include ordering investigations and making immediate treatment decisions.

If a question asks, “List 3 factors that will determine this patient’s prognosis” or something similar, key words are “3” and “THIS PATIENT”. Your answer must be based on the information you gathered from the patient. Generic answers relevant to the diagnosis but not relevant to THIS PATIENT will not get credit; nor will extra answers.

In each station, you must decide what information and actions are the most clinically relevant, given the patient information provided in the instructions AND the time allowed. Having priorities matter!

Asking too many questions (referred to as the shotgun approach)

Asking as many questions as you can, especially if done in a rapid-fire, disorganized fashion, in hopes of asking enough of the right questions, is not a good strategy. The relatively short amount of time allowed for each task requires that you organize your approach, preferably around a differential diagnosis or around generating a differential diagnosis.

Misinterpreting the instructions

Sometimes candidates approach a station by trying to figure out “what is on the test”, rather than basing their actions on a clinically appropriate approach to the patient problem. For example, the patient information describes a belly pain problem and you are asked to conduct a focused physical examination. You enter the station and do a complete basic abdominal exam; for example, inspection, auscultation and palpation of the four quadrants. But, that is all you

do. This is generally not sufficient to pass and you may have conducted some manoeuvres that were irrelevant to identifying the most likely diagnosis. The focus of a focused physical examination should be determined by the need to make a diagnosis and to rule out differential diagnoses. In the preceding example, an abdominal examination is obviously important but based on the patient information given to you and whatever findings (or lack of findings) you discover, there are other manoeuvres and/or systems you will need to assess in order to rule your differential diagnoses in or out.

Using too many directive questions

While the patients will not tell you “everything” if you ask a broad open question like “Tell me why you are here”, they will tell you something. Using some open questions is helpful in this exam, just as it is in clinical practice. Questions like “Can you describe the pain for me?” or “Have you noticed any other changes?” are helpful. You will likely have to follow up with more direct questions to get the full picture from the patient but it is easier to start with their initial comments than to run through endless “yes / no” questions that limit the patients to saying yes or no.

Remember that, as in real life, patients cannot report what they do not have and may not report changes that they do not relate to the presenting problem. However, your score is based on eliciting critical information, not just on eliciting specific pertinent positives. If a patient says they have no other symptoms but you need to know whether there has been any weight loss or specific neurological changes to determine the diagnosis, then you should ask specifically about these points.

Not listening to the patients

Patients often report that candidates do not listen to them and therefore miss crucial information. If a patient’s answer is not clear AND the issue is important, then explore the point at least a little bit. For instance, you ask the patient if they have ever had this problem before and they respond with “not like this”. You may want to know what they mean by this statement.

If you appear indifferent to their concerns, the patients are expected to react accordingly – you will get less information from them. They are not required to give everyone their whole story. You are expected to elicit their story. And as in clinical practice, patients will be reluctant to confide their underlying fears or embarrassing information if they feel you are indifferent, judgmental, or hostile to them.

Missing scores on physical examination and management stations

Please note that you cannot receive credit for genital, rectal or vaginal examinations unless you indicate to the examiner that you would do such an exam. In most cases, the examiner is given findings to report to you, but they

can only do so after you state which examination you would do.

Saying what you are doing when examining a patient will aid the examiner in scoring you. You do not need to justify what you are doing – just state it. For example:

If you inspect the abdomen before auscultation but say nothing, the examiner is left guessing whether you did inspect the abdomen or if you were frozen momentarily.

Indicate when you are doing light palpation or deep palpation so the examiner can better judge your technique. If you only do light palpation and don't specify, the examiner will not be sure what you intended.

Report positive findings – pain, loss of range of motion, difficulty with gait, shortness of breath, etc., so that the examiner knows that you observed the finding. Similarly, stating that there is a lack of findings or that what you found was normal can be helpful. For instance, informing the examiner that bowel sounds are normal.

In management stations where there is a nurse present, remember that they are there to help you. However, you must provide clear directions. If the nurse asks for more direction, answer as best you can, as clarifying what you want will likely improve your performance.

Missing the urgency of a patient problem

With urgent patient problems where an acute problem or trauma must be managed, set clinical priorities. Do the most important things first, then go back and get more information, if you need it, or make further orders. Beware of ordering investigations or treatments by rote, before you understand a particular patient's situation. This can be dangerous in practice and will be flagged as such on your examination sheet.

Talking too much

Sometimes candidates talk so much while with the patient that they lose valuable time and miss information. Efficiency does not exclude the professional courtesies of introducing yourself or explaining briefly why you need to ask a difficult question or conduct a painful manoeuvre but do not get carried away. You are expected to speak to the patient in language that they will understand, not to quote textbooks to the examiner. Your manner tells both the patient and the examiner a lot about your attitude to the patient; you do not need to do it all with words. Avoid lecturing and avoid showing off.

Giving generic information

In some stations you are expected to provide the patient with information or advice relevant to their problem. Some candidates seem to miss the purpose of these stations and only offer very quality of information that reflects your

abilities as a physician, assists in informed decision-making by the patient and goes beyond what is available at the newsstand general statements like “There are risks associated with X and you should really do Y.” If you are expected to advise a patient then you are expected to provide them with the quality of information that reflects your abilities as a physician, assists in informed decision-making by the patient and goes beyond what is available at the newsstand.

Frequently Asked Questions – OSCE (as per MCC website)

1. What if the time allowed is too short – can I get extra time?
2. Should I worry if I finish a station early?
3. What are some effective strategies for studying for this examination?
4. Are there any books about the Objective Structured Clinical Examination (OSCE)?
5. What exam-taking strategies might help?
6. Should candidates take a preparatory course to prepare for the Objective Structured Clinical Examination (OSCE) format?

1. What if the time allowed is too short – can I get extra time?

You should have ample time to complete the task(s) at each station as the stations were designed to fit the allotted time. The tasks have been reviewed by many physicians and were deemed appropriate for the time limit. Even if the time limit is particularly challenging for a specific station, all candidates face the same challenge and the pass mark will reflect the difficulty/complexity of the station. However, most candidates finish most stations well within the time limit. If you are running out of time at each station, then you may be too slow, for any one of several reasons. Your physical examinations may be too generic and thorough relative to the patient problem or you may be asking far more questions than is necessary. Remember that your approach should be based on the clinical problem and its possible causes. Re-assess your style. For example, if you are using too many “yes – no” questions, or if you are making the patient move around unnecessarily, or if you are explaining too much, or if you are missing cues from the patient (either verbal or body language), then you may not complete enough of the critical actions to perform well.

2. Should I worry if I finish a station early?

Finishing early does not necessarily indicate a problem. Many stations can be completed in less than the time allotted. However, there are no negative marks. If you have done all the most important things, consider what else might help you understand or confirm the patient’s problem. If you forgot something, go ahead and do it, even if you have been sitting quietly for the past few moments.

3. What are some effective strategies for studying for this examination?

a) Form study groups

Forming a multidisciplinary study group may be very helpful. Identify which objectives are most important for each group member to review (e.g.

management of chest pain, assessment of vomiting in a child). Do not let the most competent members in a group spend all their time helping others. It is unfair and often hurts the performance of your most competent members. They also need to be challenged. Consider having each member generate common patient presentations that they understand well. Each person can then present their patient problems to the group and quiz individuals within the group about how they would assess and manage these problems. Be critical. Challenge each other. What other diagnoses should you think about? How would you differentiate between them? What investigations are essential? Why? What should you assess on your physical examination? What else should you assess?

b) Create a study plan

Identify the objectives that you most need to study and focus on common or critical patient presentations. Be honest in assessing your own knowledge and ability.

Create differential diagnoses, identify key features that will lead you to establish or confirm your differential diagnoses, create checklists, identify key orders for investigation and management plans for each one. If you realize there is a knowledge deficit in a particular area, then go back to learning the basics.

4. Are there any books about the Objective Structured Clinical Examination (OSCE)?

Yes, there are some, like the text “Mastering the OSCE / CSA” (1999) by J Retegui and B. Corne-Avendano (and published by McGraw Hill). The study approach in this book is appropriate for the OSCE part and it provides a review of key principles of doctor- patient communication that may be helpful.

However, the patient problems and checklists are examples of assessment tasks for entry into a training program. The OSCE assesses entry into independent practice. Furthermore, the examples in this book assume longer, more complete encounters than what you will find on the OSCE part of the exam.

5. What exam-taking strategies might help?

The following suggestions may help you cope with the Objective Structured Clinical Examination (OSCE) format:

Use the notebook provided at exam registration when reading the instructions. If you are stressed and likely to get confused, consider noting the task first (shown at the bottom of the instruction page) and then reading the patient information. Note what you want to know or do. The instructions are also available in the station if you want to check the patient information again.

Have back-up strategies in case you feel lost about a patient problem. Fall back on basic clinical interviewing and physical examination skills. Find out what you can, as best you can. Be willing to think a moment about what you want to do next.

Ignore the examiner's pencil. Some checklists are longer than others and some items (like the rating scales) can only be completed after you leave. How often the examiner's pencil is moving is not a reliable indicator as to how well you are doing. Concentrate on the patient.

6. Should candidates take a preparatory course to prepare for the Objective Structured Clinical Examination (OSCE) format?

There are no MCC-approved preparatory courses. Some medical faculties offer programs and these may be the most helpful. There may also be a commercial preparatory course available in your city.

Comments from candidates who have spoken to MCC staff about their experiences with a commercial course suggest that they vary widely in their helpfulness. In most cases, a preparatory course will give you an opportunity to become familiar with the OSCE format.

The emphasis of some preparatory courses appears to be on exam-taking skills, not on assessing your clinical knowledge, skills and judgment. If you have weaknesses in your clinical competence, such a preparatory course is unlikely to help you.

Reference List for Home Study

Recommended books & websites for your home study

1. Bope, E.T. (2007). Review of Family Medicine: Text with Online Testbook. 4th ed. Philadelphia, Pa.: Saunders Elsevier.
2. Bratton, Robert. L. (2010). Bratton's Family Medicine Board Review, 4th ed. Lippincott Williams & Wilkins.
3. Canadian Pharmacists Association. (2014). Compendium of Therapeutic Choices, 7th ed. Canadian Pharmacists Association.
4. CFPC web site: www.cfpc.ca: Guide to the Certification Examination in Family Medicine. Online demonstration version of the SAMPs with 12 sample SAMPs. Video demonstration of a simulated office oral (SOO) and sample SOO scripts. Evaluation objectives in family medicine i.e. topics, key features and procedural skills.
5. Dash, Megan and Angela Arnold, ed. (2013). Guide to the Canadian Family Medicine Examination. McGraw-Hill - Professional.
6. Evans, Michael. (2006), Mosby's Family Practice Sourcebook: An Evidence-Based Approach to Care. 4th ed. Toronto Elsevier: Mosby Canada, 2006.
7. Knutson, Doug. (2012). Family Medicine: Pretest Self-Assessment and Review. 3rd. ed. New York: McGraw-Hill Medical, 2012.
8. Lipsky, M.S. et al. (2007). Family Medicine Certification Review. 3rd. ed. Philadelphia: Lippincott Williams & Wilkins.
9. O'Toole, Danielle. (2014). Family Medicine Notes. Preparing for the CCFP Exam. <http://www.familymedicinenotes.com>
10. Perez, Mayra, Lindsay K. Botsford, and Winston Liaw. (2011). Deja Review: Family Medicine. 2nd ed. New York: McGraw-Hill Medical.
11. Practice Guidelines:
 - a. Canadian Medical Association Clinical Practice Guidelines
 - i. www.cma.ca/cpgs
 - b. Guidelines Advisory Committee Guidelines
 - i. www.gacguidelines.ca
 - c. U.S. National Guideline Clearinghouse
 - i. www.guideline.gov

Note: The CFPC website www.cfpc.ca provides a list of Canadian guideline developers with full text access to guidelines which cover a wide range of medical topics. Click on Library Services to find this information. The CFPC Library also provides a list of “New Books in Family Medicine”.

12. Rakel, Robert E. and David Rakel (2011). Textbook of Family Medicine, 8th Edition. Saunders.
13. Stewart, Moira, J. B. Brown, W. W. Weston, I.R. McWhinney, C. L. McWilliam, and T. R. Freeman. (2003). Patient-centred Medicine: Transforming the clinical method. 2nd ed. Abingdon, U.K. Radcliffe Medical Press.
14. Swanson, Richard W., Alfred F. Tallia, Joseph E. Scherger, and Nancy Dickey. (2013). 7th ed. Swanson's Family Medicine Review: A Problem-Oriented Approach. Saunders
15. Wilbur, Jason K and Mark A. Graber. (2013). Family Practice Examination and Board Review. 3rd ed. New York: McGraw-Hill Professional.

Suggested journals for review:

Canadian Family Physician

American Family Physician

British Journal of General Practice

Journal Watch

ACP Journal Club

Canadian Prescribers Letter (www.canadianprescribersletter.com)

The Medical Letter. On Drugs & Therapeutics

REVIEW PROGRAMS

Self Learning®

Self Learning® is a voluntary, Internet-based, CFPC educational program that allows physicians to evaluate themselves on how well they are able to keep in touch with current issues in the medical literature. Written by a group of family physicians from across Canada, the program is self-contained with all the information needed to understand new research results and therapeutic techniques. Residents in family medicine may register to have free online access to the Self Learning program. For more detailed information, check the CFPC website at www.cfpc.ca or contact the Self Learning staff at (905) 629-0900, Fax: (905) 629-0893, or slinfo@cfpc.ca. 66211.

ALDO – General Information

(www.cmq.org)

Attendance at the ALDO-Québec educational activity is mandatory for the issuance of a permit to practice. To register, residents must complete the [registration form](#) online using their resident number.

Document to read

[Legal, Organizational and Ethical Aspects of Medical Practice in Québec \(ALDO-Québec\)](#), Collège des médecins du Québec, April 2011(aldo@cmq.org).

Schedule

Confirmation of presence: 1:00 pm

Activity: 1:30 to 4:30 pm

Eligibility

Residents can take the ALDO-Québec educational activity whenever they choose during their postgraduate training. However, the activity is subject to availability based on the size of the rooms in which the training is offered. Registration priority will be given to residents who are in the process of completing their program so as not to delay issuance of their license to practice. Please note that a session may be cancelled if there is an insufficient number of participants.

ALDO Calendar 2014-2015

Date	City	University and Language
October 7	Montreal	McGill University (ANG)
October 21	Montreal	Université de Montréal (FRA)
November 4	Sherbrooke	Université de Sherbrooke (FRA)
November 19 9:30 to 12:30	Quebec	Université Laval (FRA)
November 25	Montreal	Université de Montréal (FRA)
December 9	Montreal	McGill University (ANG)

**** The 2015 calendar for the Aldo-Québec Educational Activity will be available on line during the month of October.**

Working Knowledge of French Language

(as per website www.cmq.org)

McGill University medical graduates:

As you are aware, applicants for licensure in the Province of Québec must have a working knowledge of the French language. When you apply for a permit to practice medicine, you will have to submit, according to the terms of article 35 of The Charter of the French Language, one of the following documents (original document or [certified true copy](#)):

A medical degree (M.D.) from a university whose language of instruction is French

OR

An official document proving that you have followed a full time course of instruction starting from the secondary level for at least three (3) years in a French language institution

OR

An official document (record of marks from the Ministère de l'Éducation du Québec) proving that you have succeeded the "Français, langue maternelle" examination in your fourth or fifth grade in the secondary level course

OR

An official document (record of marks from the Ministère de l'Éducation du Québec) proving that you have obtained a certificat d'études secondaires from Québec after the 1985-1986 school year.

If you cannot submit any of these documents, you will have to sit for the French test held at the Office Québécois de la langue française. In order to obtain the required application form to register for the test, you have to [contact the Collège des médecins du Québec](#). You have to complete the application form and send it back to the Collège des médecins du Québec. Then, to take an appointment for the test, you will have to contact the Office québécois de la langue française. If you are successful, an attestation will be sent to the Collège and kept in your file until you submit your application for a permit to practice in the Province of Québec.

ATTENTION: In accordance with the article 39 of The Charter of the French Language, since December 31st, 1980, no temporary permit can be issued to a candidate who has obtained a diploma of doctor of medicine from McGill University.