Assessing Interviewing Skills: The Simulated Office Oral Examination

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The College of Family Physicians of Canada uses a simulated office oral examination to test candidates for certification in family medicine. This examination has been highly successful. An analysis of this instrument provides a description of skills required for a certificant of the college. Its basic outline can be used to assess residents' interviewing skills during training and to help prepare them for practice.

Experience as a simulated office oral examination chairman for the College of Family Physicians of Canada gives an in-depth experience in the creation of the simulated patient oral examination and in the assessment of family medicine interviewing skills at a postgraduate certificant level. Further experience as a trainer of the actors for their roles enhances an understanding of this instrument. The purpose of this article is to explain the examination itself and to clarify the skills required of a certificant in the college.*

THE SIMULATED OFFICE EXAMINATION

The simulated office oral examination is a 15-minute encounter with an actor, actress, or physician simulating a patient presenting to the office. The encounter is strictly timed. A signal is given at 12 minutes (a knock on the one-way mirror or a timer in the room, if there is a physician-actor), and the interview is terminated at 15 minutes. The actor, actress, or physician remains in role throughout the experience. The candidate is marked by an observing examiner behind a one-way mirror or by the physician who is acting. Since 1984 physicians have been used exclusively as both actors and evaluators. The cases are chosen from actual cases, and the scripts and marking schemes are developed and refined over eight months by two committees, one regional and the other national. Videotapes are made. An excellent candidate and borderline candidate tape are scored by both committees, and a consensus is reached at the national level as to the scores given to the candidates. A description of the scoring and reasons for the score are also written. These tapes and their descriptions are used to train the actors and examiners for the examination. They are also used as standards for acting performance and scoring of candidates.

TRAINING PERSONNEL

Actors and actresses are trained before the examination by having them learn detailed information about the person and situation they are portraying. These scripts are developed by a local and national committee over a five-month period. Videotapes are also produced during this time by having an actor or actress role playing the case at various stages of its development. This step also helps iron out problems in the case. The videotapes are then selected to help train actors and actresses in various locations across the country. Five cases are produced each year. One day before the oral certification examinations, training sessions are conducted at examining sites across the country. Examiners learn the case from the written material developed by the examination committee before the training day. During this training day, two tapes are shown to examiners, one that involves an excellent candidate, and one that involves a borderline candidate. Examiners score the taped performance of the candidates and compare their scores with the scores

Submitted, revised, September 30, 1986.

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given by the national committee. Standards are thus learned and discussed. Serious disputes about standards are settled on the training day evening by a cross-country telephone discussion between examination centers.

Also, during the training day residents not yet eligible to write their certification examination are used in a trial run to polish the training of actors and examiners and to help standardize scoring.

In 1983 physicians acted and evaluated simultaneously in two of the examinations. This venture was successful, and in 1984 all four examinations involved physicians who both acted and evaluated simultaneously. In 1986 five examinations were used. When professional actors were used, examiners observed the encounter behind a two-way mirror.

Cases selected have a medical or physical presenting problem with underlying emotional or psychosocial components. Candidates have traditionally been scored in three categories: the cognitive area, the affective area, and the coordination of professional skills. In 1984 the learning objectives of the College of Family Physicians of Canada were used to replace these three areas to evaluate each candidate. Candidates are evaluated on their definition of the health problem, affective skills, management, the family, practice organization, professional responsibility, health maintenance, and research and evaluation. The following areas of the interview are scored.

EVALUATION OF SPECIFIC INTERVIEWING SKILLS

Cognitive (Knowledge) Skills

Problem Definition. This skill involves the clarification and statement of each problem. The physician may use a number of affective interviewing skills to obtain his or her clarified view of the problem list. Background (in practice) knowledge will lead the physician to begin forming hypotheses and to check them out by further questioning.

Problem Management. Having defined and clarified a problem list based on data given by the patient, the physician then interprets the data into hypotheses upon which further investigation and management rests. In the examination situation, students are judged in this area by the actual data that are obtained from the interview and the manner in which they are translated into appropriate management. The interpretation of the data into management may be explicitly stated where appropriate or must be inferred from the investigative and management plan. In the office oral examination the situation is designed so that no physical examination is required. If investigation results are required to solve the case, they are provided in the statement of the case, which the candidate reads before the encounter, or are given by the simulated patient when appropriate questions are asked.

The definition and management of family problems require knowledge of family dynamics.[1] This knowledge allows the physician to conceptualize at a family level even though he or she predominantly may see individuals. Certificant family physicians relate to individuals and their families at the level of dealing with feelings and providing support.[2] Ideally, they are also able to assess a family systematically.[3] These goals, however, are not always met.[4] The college at present does not test skills in interviewing families, but requires that certificants recognize problems at the family level and are, at a minimum, able to define these problems, make appropriate suggestions, and make proper referrals for family assessment or counseling. The definition of problems at this level, nonetheless, requires a knowledge of family development and function (ie, dynamics). Skills required to assess and counsel families are described elsewhere.[5]

Affective Skills

Attitudes. The physician educates the patient, where necessary, at a level the patient understands. Although the physician has a personal value system, he does not impose these values on the patient under ordinary circumstances (child abuse would be an example in which the state imposes value judgments or standards on both the patient and the physician). The physician accepts his responsibility as a member of the society with whom people may entrust their physical, mental, and social problems. He does not, however, encourage inappropriate dependency in his patients; rather, he encourages autonomy and independence wherever possible.

Interpersonal Skills. The physician joins[8] with the patient, if he has not already done so in previous visits, by the warmth of his greeting and his nonverbal behavior, which is one of openness and appropriate concern. The physician is congruent with the patient by the accuracy and appropriateness of his response as shown by facial expression, tone of voice, and body position. He may initially "mirror" the patient by adopting his body position and language style. Voice itself will be modulated to express concern, empathy, or authority, where appropriate.

Active Listening. Active listening indicates an openness, receptivity, and initial undecidedness of the senses and requires careful attention to words and nonverbal messages. To be free to listen actively in emotionally charged situations, the physician must be free from or aware of and in control of internal messages and conflicts from his own past that might interfere with his listening. He must be flexible with his own agenda, so that the patient is free to bring up sensitive areas if he wishes to. Active listening allows

a physician to find out the patient's concerns. The patient's own understanding of the situation and value system are thus allowed expression.

Comfort in Dealing with Affect. Family physicians are called upon to deal with highly charged emotions such as anger or sadness. These emotions are the expression of some hurt in the patient's present or past life. For the patient to feel free to share these issues, the physician needs to join with the patient, have adequate internal comfort and self-knowledge to be able to listen to the patient without becoming overly angry or sad (and thus lose empathy and become ineffective), and give the patient permission to talk about the underlying issues. It is thus essential that the physician come to some knowledge of his own family of origin as it is present in his internal system.[9] Such knowledge is gained from discussions with his own family, assessment of families, and reflection on these experiences. Emotions expressed by a patient should never be ignored. They should be pointed out sensitively. By asking what a patient was thinking while showing an emotion (ie, crying), the underlying issues may be unraveled. Aggression or anger is a distancing mechanism that reflects a defense of some underlying hurt. By discerning where the hurt may be and labeling or pointing it out as a hurt, the physician may join with the patient and allow ventilation of feeling rather than becoming defensive and disengaging.

Control of Interview. Control of the interview is established by beginning with openness (ie, open questions) initially and then staying on each topic long enough to define the problems. When emotions come to the surface, they must be allowed some ventilation. How much ventilation should occur is determined by a sense of timing. Emotions may flood out and then begin to dissipate in a matter of minutes. Patients can be asked to come back for an assessment or counseling session another time if there is not enough time during that visit for adequate ventilation and exploration of feelings. Some ventilation of sadness must occur, however, if the patient is willing to share these feelings.

Confrontation. Confrontation speeds up the action of the interview. Confrontation is a placing in front of the person some part of his reality that he may not be aware of or see clearly. It may be a constructive bringing together of misunderstandings or discrepancies. It may involve pointing out the patient's emotional expression, or clarifying issues by focusing the conversation until problems are clearly defined.[10] In a busy family practice, time is precious. Thus a physician must clarify the problems quickly, collect any data necessary to heighten or confirm the hypothesis, form a list of priorities for that visit, and manage whichever problems seem appropriate. An appropriate degree of control during interviews is thus necessary.

With verbose patients or those who are very unclear and rambling, control is established by keeping the patient on the topic long enough to define issues, asking the patient to state all the problems they were concerned about at the outset, and then selecting which will be dealt with during the session. Limiting the interview to particular issues and outlining a clear plan as to whether other issues will be dealt with are also important.

All problems should be listed and a management plan stated, even if the plan is to explore the area at a later date. Stating that one is unsure of some medical fact is acceptable. A willingness to be fallible is good modeling of the physician's limitations. The patient should be assured that the physician will try to find out the answers before the next visit by consultation with colleagues or by the use of the literature.

Termination. The termination is an extremely important part of the interview, and often the last skill to be mastered by the student. During these last few minutes, the physician summarizes briefly the problem list. He establishes the priorities as he understands them. He then lists the management for each problem, stating clearly when the next visit should be. He asks the patient whether he understands and is in agreement with the summary. All of these steps should be taken at the end of the session, even if they have been covered during various parts of the interview.

Coordination of Professional Skills

An interview that is well done will leave the patient feeling that he has been listened to and understood, and that the physician appears competent and has a plan for dealing with his problems. Thus the interview will have been logical with a clarification of data preceding discussion of management plans. It will have been pulled together at the end by a clear summation and listing of the management plan for each problem. The physical, emotional, and social dimensions will have been integrated. The patient will have a better understanding of his problems and the direction in which he will proceed. The physician will also have made appropriate inquiries about the impact of the situation. He also will have included the family as a support system and agent of change where appropriate. He may have challenged the patient to growth rather than have encouraged dependence on himself as the expert who solves the patient's problem for him. Through a series of such encounters, the patient will be supported and yet encouraged to be a freer, more independent, healthier human being. With the use of these skills, a physician may deal efficiently with complex issues and problems and help the patient toward growth and the solution of his problems.

A summary of these skills is contained in the Appendix. It may be used as a device for giving feedback to students.

CURRENT FORMULATION OF SKILLS AREAS

The College of Family Physicians of Canada has been administering an annual certification since 1969. This examination includes a variety of examination techniques in addition to the simulated office oral examination. Multiple-choice questions, pictoral multiple-choice questions, patient management problems, and formal oral examinations (until 1985) are also used. In 1984 skill areas related to the learning objectives of the college were introduced, as mentioned above. Thus candidates are now scored on each of eight learning objectives (problem definition, etc) rather than on their overall performance on three skill areas (ie, cognitive, affective, and coordination of professional skills) as scored in all the examinations collectively. A study based upon the analysis of four simulated office oral examinations and the formal oral examination in 1984[11] demonstrated that there was little variation in the performance of the candidate group (493 candidates) from one examination to another (ie, among the different oral examinations). The results supported the emergence of content-specific factors, however, rather than general skill factors, which might have been demonstrated throughout the various individual examinations. This finding might suggest that the objectives of the college are not completely in agreement with the observed skills of certificant level physicians as articulated, or that the articulation of the skills might be further modified to reflect those objectives. Experience has shown, however, that demonstration of the skills does differentiate between competent certificant standards and noncertificant performances. Scores on each examination instrument are compared with scores from all the other instruments to help ensure internal consistency and validity in the examination as a whole. The entire examination of unsuccessful candidates is carefully reviewed by the Board of Examiners. Comments of the oral examiners written on the examination scoring sheets are often helpful in discerning problematic areas.

The college proposes that further research will be necessary to resolve the issue of general skill vs content-specific factors. The experience with the simulated office oral examination has nonetheless facilitated the development of a list of skills that aid in both the teaching of interviewing skills and in the assessment of certification attainment.

References

1. Sawa RJ: Family Dynamics for Physicians: Guidelines to Assessment and Treatment. Lewiston and Queenston, Edwin Mellen, 1985
2. Doherty WJ, Baird MA: Developmental levels in family-centered medical care. Fam Med 1986; 18:153-156
3. Sawa RJ, Henderson EA, Pablo RY, Falk WA: Family practice impact of a teaching curriculum in family dynamics. Fam Syst Med 1985; 3:50-59
4. Sawa RJ, Pablo RY: Teaching family theory and family counseling in Canadian medical schools. Can Fam Physician 1981; 27:1833-1836
5. Sawa RJ: Family counseling skills. In Family Dynamics for Physicians: Guidelines to Assessment and Treatment. Lewiston and Queenston, Edwin Mellen, 1985, pp 65-94
6. Wilson D: Communication and the family system. Can Fam Physician 1980; 26:1710-1716
7. Educational Objectives for Certification in Family Medicine. Toronto. The College of Family Physicians of Canada, 1982
8. Tomm K, Wright L: Training in family therapy: Perceptual, conceptual, and executive skills. Fam Process 1979; 18:227-250
9. Sawa RJ: Connectedness. In Family Dynamics for Physicians: Guidelines to Assessment and Treatment. Lewiston and Queenston, Edwin Mellen, 1985, pp 95-124
10. Cleghorn JM, Levin S: Training family therapists by setting learning objectives. Am J Orthopsychiatry 1973; 43:xxx-xxx
11. Rainsberry P, Grava-Gubins I, Kahn SB: A Factor Analytic Investigation of the Simulated Office Orals and the Formal Oral Examination. Toronto, The College of Family Physicians of Canada, April 1985

APPENDIX: INTERVIEW EVALUATION

General Comments:

Date _____
Resident _____
Supervisor _____

E = Excellent
S = Satisfactory
U = Unsatisfactory
NA = Not Applicable

Discussed with residents:
Yes ___ No ___

Patient's Name _____

Comments:

I. History Contents
Problem Definition:

Management: ___ appropriate, ___ thorough
Investigation: ___ appropriate, ___ thorough
Records: ___ legible, ___ relevant

II. Evaluation of Interviewing Skills
Attitudes
___ Educates where necessary at a level patient understands
___ Nonjudgmental
___ Accepts responsibility
___ Does not encourage inappropriate dependence

Interpersonal skills
___ Initiation—engagement
___ Empathy
___ Listening ability
___ Warmth

Comfort in dealing with affect
___ Allows expression of feelings appropriately

Control of interview
___ Uses open questions initially
___ Stays on topic long enough to define problem
___ Allows ventilation when appropriate
___ Confronts where necessary
___ Keeps appropriate tempo (shifts topic as necessary)

Termination
___ Summarizes problem list
___ Establishes priority list
___ Lists management for each problem
___ Delineates follow-up
___ Checks out whether patient understands

III. Coordination of Professional Skills
___ Logical
___ Efficient
___ Integrated (emotional, physical, and social)
___ Awareness of epidemiology, risk factors
___ Uses consultants, community resources, support staff appropriately
___ Awareness of family context