THE COLLEGE OF FAMILY PHYSICIANS OF CANADA

LE COLLÈGE DES MÉDECINS DE FAMILLE DU CANADA

CERTIFICATION EXAMINATION IN FAMILY MEDICINE

SIMULATED OFFICE ORAL EXAMINATION

SAMPLE 13

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INTRODUCTION

The Certification Examination of The College of Family Physicians of Canada is designed to evaluate the diverse knowledge, attitudes, and skills required by practising family physicians (FPs). The evaluation is guided by the four principles of family medicine. The Short-Answer Management Problems (SAMPs), the written component, are designed to test medical knowledge and problem-solving skills. The Simulated Office Orals (SOOs), the oral component, evaluate candidates' abilities to establish effective relationships with their patients by using active communication skills. The emphasis is not on testing the ability to make a medical diagnosis and then treat it. Together, the two instruments evaluate a balanced sample of the clinical content of family medicine.

The College believes that FPs who use a patient-centred approach meet patients' needs more effectively. The SOOs marking scheme reflects this belief. The marking scheme is based on the patient-centred clinical method, developed by the Centre for Studies in Family Medicine at the University of Western Ontario. The essential principle of the patient-centred clinical method is the integration of the traditional disease-oriented approach (whereby an understanding of the patient's condition is gained through pathophysiology, clinical presentation, history-taking, diagnosis, and treatment) with an appreciation of the illness, or what the disease means to the patients in terms of emotional response, their understanding of the disease, and how it affects their lives. Integrating an understanding of the disease and the illness in interviewing, problem-solving, and management is fundamental to the patient-centred approach. This approach is most effective when both the physician and the patient understand and acknowledge the disease and the illness.

In the SOOs, candidates are expected to explore patients' feelings, ideas, and expectations about their situation, and to identify the effect of these on function. Further, candidates are scored on their willingness and ability to involve the patient in the development of a management plan.

The five SOOs are selected to represent a variety of clinical situations in which communication skills are particularly important in understanding patients and assisting them with their problems.

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SIMULATED OFFICE ORAL EXAMINATION

RATIONALE

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

1. **grief secondary to her husband's death;**

2. **diabetes.**

The patient's feelings, ideas, and expectations, as well as an acceptable approach to management, are detailed in the case description and the marking scheme.

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INSTRUCTIONS TO THE CANDIDATE

1. FORMAT

This is a simulated office situation, in which a physician will play the part of the patient. There will be one or more presenting problems, and you are expected to progress from there. You should not do a physical examination at this visit.

2. SCORING

You will be scored by the patient/examiner, according to specific criteria established for this case. We advise you not to try to elicit from the examiner information about your marks or performance, and not to speak to him or her "out of role".

3. TIMING

A total of 15 minutes is allowed for the examination. The role-playing physician is responsible for timing the examination. At 12 minutes, the examiner will inform you that you have three minutes remaining. During the final three minutes, you are expected to conclude your discussion with the patient/examiner.

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

4. THE PATIENT

You are about to meet Ms. **JANE WEBBER**, age 62, who is new to your practice.

SPECIAL NOTE

Because the process of problem identification and problem management plays an important part in the score, it is in the best interest of all candidates that they not discuss the case among themselves.

THE COLLEGE OF FAMILY PHYSICIANS OF CANADA

CERTIFICATION EXAMINATION IN FAMILY MEDICINE

SIMULATED OFFICE ORAL EXAMINATION

CASE DESCRIPTION

INTRODUCTORY REMARKS

You are Ms. **JANE WEBBER**, age 62. Your husband, a retired farmer, died five months ago and your four children insisted you see a physician because they are worried about you. They think you are depressed and aren't coping with your husband's death. You do not really think there is anything wrong.

You have also noticed that controlling your diabetes has been a lot more difficult over the past few months. Your last check was about eight months ago.
Over the past several months your blood sugar measurements have fluctuated a lot. They range from the low 4s to over 12, and occasionally you have a reading as high as 15 or 16.

You have not been back to see your family physician (FP) since your husband died. You both had been his patient for many years and you haven't felt you could go to see him. You are not upset with him; you just feel that his office is one more place that reminds you of your husband.

HISTORY OF THE PROBLEM

Husband's death

Your husband, **WILLIAM**, died five months ago. He was 70. He had had diabetes and heart problems for many years. He had a by-pass operation six years ago. Unfortunately, it helped for only a brief period before he began having problems again. The physician said that a second surgery would not improve his heart function and that his problems would have to be managed with medication.
Three weeks before he died, he was admitted to hospital for emergency surgery for his bowel. He apparently perforated a diverticulum. The surgery went fine, but after being in hospital for about 10 days, he had a small heart attack and then got pneumonia. Subsequently he had to be admitted to the intensive care unit and put on a ventilator. After three days there the physician thought his condition was unlikely to improve. You and your children decided to stop treatment and he died the next day.

Your husband's death seems very sudden to you. While he had had a heart problem and been slowing down over the past few years, the last three weeks of his life seemed to happen overnight and completely out of the blue.

You know you made the right decision about his care. The two of you had talked about what you would want if something serious ever happened, and he said he wouldn't want to be kept alive by a machine. You know that the people at the hospital did everything they could for your husband, and you felt that the staff was very supportive when you decided to stop life support.

You are still sad about your husband's death and think about him all the time; everywhere you look there are reminders of him. Since his death you feel there is a gaping hole in your life. The two of you had been married for 42 years. You had four children together and were very happy. You miss him terribly. You often think about how you have to tell him something, and then remember that he isn't here anymore.

At the same time you are trying to move forward. You are not angry about your husband's death. It is spring and you are determined to get your garden in and the rest of the yard in shape. You have always enjoyed doing this and it does give you something else to think about.

You find that the evenings are the most difficult time. The two of you would have supper and then talk about your day and enjoy each other's company. This is now the time your children usually call to see how you are doing. This is the most difficult thing you have to do. You feel so sad that they have lost their father and that your grandchildren will not have the chance to know him. This knowledge often brings you to tears, even if you have been having a good day. You know this upsets your children and you try very hard not to cry, but your efforts don't seem to do much good. It is because of this they wanted you to see a physician. They think that you are depressed and need to "do something to get better".

For the most part, you sleep relatively well. Sometimes if you wake up at night you take a while to fall asleep again, but generally you feel rested when you get up. You are not having nightmares or flashbacks about your husband or his death. You still enjoy working in your yard and planning your garden, but things do seem empty without William. He was the one with whom you discussed the spring each year. You feel sad when you think about the loss you and your family have had, but still enjoy others' company. However, your relationship with some friends seems to have changed since your husband's death. You and William were active in service clubs (Kiwanis, 4-H) in town and regularly got together with other couples. This was generally at William's instigation. He was the outgoing one; you went with him and enjoyed yourself, but would have been just as content to stay at home. You have been out to see friends a few times, but this feels uncomfortable as he really held your social life together. You had always been

part of a couple and your friends seem uncomfortable with having just you along. One couple you know, **EVA** and **GEORGE**, came to visit and brought another man along so "George would have someone to talk to". You had always thought you and George had good conversations.

You would describe your appetite as fair. You do not feel guilty about trying to move forward. You know your husband would want you to keep living your life. Your concentration is fine. You have no previous history of depression or mania. You have no thoughts of self-harm or suicide.

You have not seen a counselor. You have been coping well as the executrix of your husband's will.

You expect the candidate to agree that all your feelings are quite normal for a woman who has just lost her husband.

Poorly controlled diabetes

You were diagnosed with diabetes seven years ago. You had been in for a check-up and your FP tested your blood sugar. This diagnosis was very worrying for you as all your older brothers, **ETHAN**, age 72, **ALEXANDER**, age 70, and **PETER**, age 66, have diabetes, high blood pressure (BP), and heart disease.

You went to a diabetes education programme, and for the first two years you managed to control your blood sugar levels with diet and exercise. Eventually you found that this wasn't working as well as your physician thought it should. You started taking metformin about four years ago. The dose was gradually increased and then the physician added glyburide. These two medications seemed to work well together and your glycosylated hemoglobin (HbA_{1c}) has generally stayed under 7.0.

At the same time as your high blood sugar was identified, your cholesterol level was also discovered to be high. It didn't come down with changes in diet and exercise. The physician started simvastatin and this brought your level down to the target range.

You had had high BP for about eight years when you were diagnosed with diabetes. You have been taking hydrochlorothiazide (HCTZ) for it since the diagnosis was made. About six years ago, your BP was slowly increasing so the physician prescribed enalapril.

Your last review for your medical problems was eight months ago. It was not long after your last check-up that your husband became ill. At that visit the physician said that your HbA_{1c} was 6.8 and your BP was 130/85. He also said that your cholesterol was staying at target.

You think your last eye exam was about three years ago, but your eyesight seems fine. You can't remember when you last had a urine test and you are not sure if your physician has ever talked to you about your kidney function. You have no tingling or numbness in your feet. You regularly have pedicures (your one indulgence!) and have never had any problems with your feet. You have never had chest pain or shortness of breath. You are not having increased thirst or increased urination. You have not had any episodes that seem to indicate hypoglycemia.

Normally you are faithful about keeping your blood sugar levels under control. You have been checking your blood sugar levels regularly for many years, although while your husband was in the hospital and initially after the funeral you stopped checking. You just had too many other things on your mind. Generally your levels have been between about 5 and 7, but in the past four months they have been higher. You must admit that you really have not been paying attention to your blood sugar over the past two months.

Currently your results usually range from 4 to 12. You have had occasional readings of 15 or 16. The "4" readings are usually first thing in the morning, and the higher values usually are in the later part of the day. You did not bring your book in with you today. You do not feel any different when your blood sugar readings are especially high.

You have been taking all your medications regularly.

You think the biggest recent change is in your meal preparation. You had a hard time adjusting from cooking for a large family, and now you are cooking for just yourself. You have difficulty cooking a whole meal just for you, and the time of day you eat isn't consistent. None of the portion sizes at the grocery store seem to be for one person. You know it is not good for your blood sugar levels, but it seems so much simpler just to have cereal or toast than to try to make a proper supper. You don't like pre-packaged foods and worry about their salt content. You know this is not good for your BP.

Probably you also are not as active as usual. You used to try to go for a walk each day, and you haven't since your husband was in the hospital.

You expect the physician to help you get your diabetes control back on track.

MEDICAL HISTORY

Diabetes diagnosed seven years ago.
High BP for 15 years.
Four normal vaginal deliveries; hysterectomy 20 years ago because of fibroids.
Mammograms every year; the last was seven months ago.

MEDICATIONS

Metformin, 850 mg tid.
Glyburide, 7.5 mg bid.
Simvastatin, 40 mg HS.
HCTZ, 25 mg OD.
Enalapril, 20 mg OD.
Acetylsalicylic acid (ASA), 81 mg OD.

LABORATORY RESULTS

Your last lab work was eight months ago. At that time your HbA_{1c} level was 6.8, and your physician said your lipid levels were at target.

Your last BP measurement in the physician's office was 130/85. You go to a community centre where a nurse checks your BP. The last reading six months ago was 125/72.

ALLERGIES

None.

IMMUNIZATIONS

Up to date.

LIFESTYLE ISSUES

Tobacco:	You have never smoked.
Alcohol:	You do not drink alcohol.
Caffeine:	You have two cups of tea with breakfast.
Illicit drugs:	You do not use recreational drugs.
Diet:	You had been faithful in following a low-fat, balanced diet. You knew this was important for both you and your husband. You have not been consistent with this in the past five months.

Exercise and Recreation: Most of your exercise is related to working in the home and your yard. You have a large house to clean and a big garden that you put in every year. You used to try to go for a 30-minute walk every evening.

FAMILY HISTORY

Your father died of a heart attack 10 years ago. Your mother died of breast cancer five years ago.

You have three older brothers, all of whom have diabetes and high BP. Each has had a heart attack.

PERSONAL HISTORY

You were born and raised in the town in which you live. Your parents were farmers, and ultimately your brothers took over the family farm.

Your husband was from the same community. He was eight years older than you, a friend of one of your brothers. You had known him "forever" and started dating him when you were in college. He asked you to marry him when you graduated, and you said yes.

He had been farming on his own for five years and the two of you built a house on the farm when you were married. You had good and bad years, but for the most part made a reasonable living. You had four children: two daughters, **MARY**, age 40, and **ANNE**, age 33, and two sons, **MARK**, age 38, and **WADE**, age 30. All of them went to university and are now working. All are married. Mary has a five-year-old child, and Wade has a two-year-old. While you adore both of your grandchildren, you are careful to give your children space to establish their own families. Only Wade lives nearby, about 30 minutes away. Your husband retired from farming four years ago, and Wade bought the farm. He works in addition to running and working on the farm every day.

You still live in the home you and William made on the farm. With your husband gone and your children living away, it seems like a very big place. You have no livestock, and therefore you were able to stay in your home. This works well as you were reluctant to leave the house.

EDUCATION AND WORK HISTORY

You were an average student. After completing high school, you took a bookkeeping course at a community college. Your mother's job on the farm was looking after the books and the house, and this was the role you wanted for yourself. You never worked outside the home, but were actively involved with running the farm and looking after the house and children.

FINANCES

You are financially secure. You own your own home. While you wouldn't consider yourself rich, your husband's estate has left you without concerns about money. You were always involved with decisions about your family finances and are not worried about your ability to manage them in the future.

SOCIAL SUPPORTS

Your husband was your best friend and confidant.

You have many people whom you consider good friends, although with several your relationship seems awkward since your husband's death. You have not been involved with any of your service clubs since he died.

You are close to your brothers. However, their health is not as good as yours and they are busy with their families. You have spoken to one of your brothers about some of your feelings since the loss of your husband. You don't really feel comfortable talking to any of your friends about something like this.

RELIGION

The church has always been an important part of your life. You and William attended church regularly. You were actively involved in the congregation and the church has been a source of support. You have been back only a few times since your husband's death. Everyone was very welcoming, and you are glad you attended, but sometimes the thought of going there by yourself is overwhelming.

ACTING INSTRUCTIONS

You are comfortably and casually dressed. You answer questions freely.

You have thought of yourself as an active participant in managing your diabetes. You are concerned that your blood sugar levels are so out of control. You do not want to be faced with the same health concerns as your brothers, especially now that you are on your own.

You are still sad about your husband's death. You are able to answer questions about his death and how life has been without him without becoming overly distressed. The fact that this physician did not know your husband somehow makes talking easier. You are not angry or upset that your children have insisted that you come in to talk about how you have been coping. You know they are just worried about you.

If the candidate tells you that lab work/blood tests will be ordered, you ask:
"What tests, exactly?"

CAST OF CHARACTERS

The candidate is unlikely to ask for other characters' names. If he or she does, make them up.

JANE WEBBER:	The patient, age 62, who was recently widowed and has poorly controlled diabetes.
WILLIAM WEBBER:	Jane's husband, who died five months ago at age 70.
MARY:	Jane and William's daughter, age 40, who has one child, age five years.
MARK:	Jane and William's son, age 38.
ANNE:	Jane and William's daughter, age 33.
WADE:	Jane and William's son, age 30, who took over the family farm and has one child, age two years.
ETHAN:	Jane's brother, age 72.
ALEXANDER:	Jane's brother, age 70.
PETER:	Jane's brother, age 66.
EVA:	Jane and William's friend.
GEORGE:	Jane and William's friend, and Eva's husband.

TIMELINE

Today:	Appointment with the candidate.
2 months ago:	Stopped paying as much attention to blood sugar levels.
4 months ago:	Blood sugar levels became higher.
5 months ago:	Husband died.
6 months ago:	Last BP measurement at the community centre.
7 months ago:	Most recent mammogram.
8 months ago:	Last HbA_{1c} measurement and lipid test.
3 years ago, age 59:	Last eye examination.
4 years ago, age 58:	Began taking medication for diabetes.
5 years ago, age 57:	Diabetes not well managed with diet and exercise.
6 years ago, age 56:	BP rising; enalapril added to HCTZ.
7 years ago, age 55:	Diabetes and hyperlipidemia diagnosed.
15 years ago, age 47:	High BP diagnosed; HCTZ started.
20 years ago, age 42:	Hysterectomy.
30 years ago, age 32:	Wade born.
33 years ago, age 29:	Anne born.
38 years ago, age 24:	Mark born.
40 years ago, age 22:	Mary born.
42 years ago, age 20:	Married William.
62 years ago:	Born.

INTERVIEW FLOW SHEET

INITIAL STATEMENT:	**"My family said I had to come to talk to someone."**
10 MINUTES REMAINING:*	If the candidate has not brought up the issue of the diabetes, the following prompt must be said: **"My sugars have not been very good lately."**
7 MINUTES REMAINING:*	If the candidate has not brought up the issue of the grief following her husband's death, the following prompt must be said: **"What should I tell my family?"** *(It is unlikely that this prompt will be necessary.)*
3 MINUTES REMAINING:	**"You have THREE minutes left."** *(This verbal prompt **AND** a visual prompt **MUST** be given to the candidate.)*
0 MINUTES REMAINING:	**"Your time is up."**

*To avoid interfering with the flow of the interview, remember that the 10- and seven-minute prompts are optional. They should be offered only if necessary to provide clues to the second problem or to help the candidate with management. In addition, to avoid interrupting the candidate in mid-sentence or disrupting his or her reasoning process, delaying the delivery of these prompts momentarily is perfectly acceptable.

NOTE: If you have followed the prompts indicated on the interview flow sheet, there should be no need to prompt the candidate further during the last three minutes of the interview. During this portion of the interview, you may only clarify points by answering direct questions, and you should not volunteer new information. You should allow the candidate to conclude the interview during this time.

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MARKING SCHEME

NOTE: To cover a particular area, the candidate must address **AT LEAST 50%** of the bullet points listed under each numbered point in the **LEFT-HAND** box on the marking scheme.

Distinguishing a "Certificant" from a "Superior Certificant": Exploration of the Illness Experience

While it is critical that a certificant gather information about the illness experience to gain a better understanding of the patient and his or her problem, superior performance is not simply a matter of whether a candidate has obtained all of the information. A superior candidate **actively explores** the illness experience to arrive at an-in-depth understanding of it. This is achieved through the purposeful use of communication skills; verbal and non-verbal techniques, including both effective questioning and active listening. The material below is adapted from the CFPC's document describing evaluation objectives for certification (1) and is intended to act as a further guide to assist evaluators in determining whether a candidate's communication skills reflect superior, certificant, or non-certificant performance .

Listening Skills

- Uses both general and active listening skills to facilitate communication

Sample Behaviours

- Allows the time for appropriate silences
- Feeds back to the patient what he or she thinks he or she has understood from the patient
- Responds to cues (doesn't carry on questioning without acknowledging when the patient reveals major life or situation changes, such as "I just lost my mother")
- Clarifies jargon used by the patient

Language Skills

Verbal

- Adequate to be understood by the patient
- Able to converse at an appropriate level for the patient's age and educational level
- Appropriate tone for the situation - to ensure good communication and patient comfort

Sample Behaviours

- Asks open- and closed-ended questions appropriately
- Checks back with the patient to ensure understanding (e.g., "Am I understanding you correctly?")
- Facilitates the patients' story (e.g., "Can you clarify that for me?")
- Provides clear and organized information in a way the patient understands (e.g., test results, pathophysiology, side effects)
- Clarifies how the patient would like to be addressed

Non-Verbal Skills

Expressive

- Conscious of the impact of body language on communication and adjusts appropriately

Sample Behaviours

- Eye contact is appropriate for the culture and comfort of the patient
- Is focused on the conversation
- Adjusts demeanour to be appropriate to the patient's context
- Physical contact is appropriate to the patient's comfort

Receptive

- Aware of and responsive to body language, particularly feelings not well expressed in a verbal manner (e.g., dissatisfaction, anger, guilt)

Sample Behaviours

- Responds appropriately to the patient's discomfort (shows appropriate empathy for the patient)
- Verbally checks the significance of body language/actions/behaviour. (e.g., "You seem nervous/upset/uncertain/in pain.")

Cultural and Age Appropriateness

- Adapts communication to the individual patient for reasons such as culture, age, and disability

Sample Behaviours

- Adapts the communication style to the patient's disability (e.g., writes for deaf patients)
- Speaks at a volume appropriate for the patient's hearing
- Identifies and adapts his or her manner to the patient according to his or her culture
- Uses appropriate words for children and teens (e.g., "pee" versus " void")

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1. IDENTIFICATION: GRIEF

Grief	Illness Experience
Areas to be covered include: **1. husband's death:** • Husband died five months ago. • Admitted to hospital and died three weeks later. • Had heart disease, but had been doing fairly well. • Family had to make the decision to stop life support. • Married 42 years. **2. identification of normal grief reaction:** • Misses her husband/wishes he were still alive. • Thinks about him every day. • Experiences episodes of significant sadness. • No feelings of guilt about his death. **3. ruling out other causes:** • No thoughts of suicide/self-harm. • No use of alcohol or other drugs. • No significant sleep disturbance. • No sense of hopelessness. • Planning for the future/enjoying planning a garden. **4. stage of grief:** • No anger or bitterness about the circumstances of her husband's death. • No flashbacks or nightmares. • Accepts her husband's death.	**Feelings** • Sadness. • Loneliness. **Ideas** • The way she feels is normal for someone who has lost her husband. **Effect/Impact on Function** • Crying when speaking to her children. **Expectations for this visit** • The physician will agree that her feelings are normal. **A satisfactory understanding of all components (Feelings, Ideas, Effect/Impact on Function, and Expectations) is important in assessing the illness experience of this patient.**

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

2. IDENTIFICATION: POORLY CONTROLLED DIABETES

Poorly controlled diabetes	Illness Experience
Areas to be covered include: **1. history and management:** • Diagnosed with diabetes seven years ago. • Sugar levels 4 to 12, and sometimes 15 or 16. • Diet is erratic. • Reduced exercise. • Last assessment eight months ago. **2. current medications:** • Diabetes: metformin, glyburide. • Hypertension: enalapril, HCTZ. • Hyperlipidemia: simvastatin, ASA. **3. end-organ assessment:** • No tingling or numbness in feet. • No chest pain. • No change in eyesight. • Last eye exam was three years ago. **4. taking medication as prescribed.**	**Feelings** • Concern. **Ideas** • Her diabetes is not under good control. **Effect/Impact on Function** • None. **Expectations for this visit** • The physician will help her get on track. **A satisfactory understanding of all components (Feelings, Ideas, and Expectations) is important in assessing the illness experience of this patient.**

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

3. SOCIAL AND DEVELOPMENTAL CONTEXT

Context Identification	Context Integration
Areas to be covered include: **1. current context:** • Living alone in the family home on the farm. • Four children. • Financially secure. **2. supports:** • Her husband was her main support and confidant. • Only one child lives nearby. • Decreased social activities (e.g., church, service clubs like Kiwanis and 4-H). • Speaks with her brother about her grief. **3. the fact that her husband was the outgoing one and her link to the community.**	Context integration measures the candidate's ability to: • integrate issues pertaining to the patient's family, social structure, and personal development with the illness experience; • reflect observations and insights back to the patient in a clear and empathetic way. **This step is crucial to the next phase of finding common ground with the patient to achieve an effective management plan.** The following is the type of statement that a Superior Certificant may make: **"You must be finding it difficult to deal with the grief over the loss of your husband. It is not surprising that your children are worried. It is also likely that, given your grief, your sugars are less well controlled."**

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

4. MANAGEMENT: GRIEF

Plan	Finding Common Ground
1. Reassure the patient that what she is experiencing is an appropriate grief reaction. **2. Recommend review in a few weeks to re-evaluate coping.** **3. Offer grief support (e.g., grief support groups, self for support, resources for grief, pet therapy).** **4. Suggest how to reassure children/could offer to see family members.**	Behaviours that indicate efforts to involve the patient include: 1. encouraging discussion. 2. providing the patient with opportunities to ask questions. 3. encouraging feedback. 4. seeking clarification and consensus. 5. addressing disagreements. **This list is meant to provide guidelines, not a checklist. The points listed should provide a sense of the kind of behaviours for which the examiner should look.**

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

5. MANAGEMENT: POORLY CONTROLLED DIABETES.

Plan	Finding Common Ground
1. Concur that her diabetes needs better control. **2. Follow-up for a physical examination must include a BP check.** **3. Arrange for lab work, which must include HbA_{1c} testing.** **4. Discuss arranging an eye examination.** **5. Arrange for her to see a nutritionist/attend a diabetic class (e.g., a class on cooking for one).**	Behaviours that indicate efforts to involve the patient include: 1. encouraging discussion. 2. providing the patient with opportunities to ask questions. 3. encouraging feedback. 4. seeking clarification and consensus. 5. addressing disagreements. **This list is meant to provide guidelines, not a checklist. The points listed should provide a sense of the kind of behaviours for which the examiner should look.**

Superior Certificant	Covers points 1, 2, 3, 4, and 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, and 4.	Involves the patient in the development of a plan. Demonstrates flexibility.
Non-certificant	Does not cover points 1, 2, 3, and 4.	Does not involve the patient in the development of a plan.

6. INTERVIEW PROCESS AND ORGANIZATION

The other scoring components address particular aspects of the interview. However, evaluating the interview as a whole is also important. The entire encounter should have a sense of structure and timing, and the candidate should always take a patient-centred approach.

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

1. Good direction, with a sense of order and structure.

2. A conversational rather than interrogative tone.

3. Flexibility and good integration of all interview components; the interview should not be piecemeal or choppy.

4. Appropriate prioritization, with an efficient and effective allotment of time for the various interview components.

Superior Certificant	Demonstrates advanced ability in conducting an integrated interview with clear evidence of a beginning, 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.