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 8

THE COLLEGE OF FAMILY PHYSICIANS OF CANADA

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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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CERTIFICATION EXAMINATION IN FAMILY MEDICINE

SIMULATED OFFICE ORAL EXAMINATION

RATIONALE

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

1. **anogenital warts (condylomata acuminate);**

2. **been a victim of sexual assault.**

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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SIMULATED OFFICE ORAL EXAMINATION

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. **FLORENCE BRUNEAU**, age 40, who is new to your practice.

SPECIAL NOTE

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

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CASE DESCRIPTION

INTRODUCTORY REMARKS

You are Ms. **FLORENCE BRUNEAU**, a 40-year-old secretary. You are coming to see the family physician (FP) today because a doctor in the emergency department (ED) told you that you have genital warts. The ED doctor recommended that you consult with an FP for treatment and follow-up. You did not mention at the time that you believe you were sexually assaulted two months before the warts appeared.

HISTORY OF THE PROBLEM

Anogenital warts

About three weeks ago you were trying to relax before bedtime by taking a long bath. You had been having trouble sleeping during the previous month, and you thought a bath would help you drift off. When you were washing your "privates", you noticed some small bumps on the skin around the vagina. There were maybe five of them. They seemed to be darker than the skin around them, and were soft and raised. They did not hurt at all, and at first you wondered if they had always been there. Over the next two weeks you checked every day. The bumps were growing in size and number, and you were sure that they were new.

You have never been one to go to the doctor, so you did not have a regular physician. You moved to this community only a year ago, and you had not yet bothered to find one. You were really frightened by what was happening to you, and you were afraid that it might be a sign of a serious disease. ("What if this is AIDS?") You worried about it more and more, to the point where you were almost unable to sleep because the fears were constantly in your mind. It was difficult to get time off work, and you didn't know where to go, so you presented at the local ED one evening a week ago. You had to wait five hours, but it didn't matter because you wouldn't have been able to sleep anyway.

You were finally brought into an examination room and asked to undress and to put on a gown. When the doctor came in, she was clearly in a hurry. She looked at the spots you pointed out to her and told you that you had genital warts. She apologized for not having more time, but explained that she was very busy that evening and that, in any case, this was not serious and is not usually treated in the ED. She suggested you make an appointment at the hospital gynecology clinic, or find an FP to treat the problem. She asked a few other questions to make sure "nothing else was wrong down there" and then she suggested that you go home and not worry about the problem for the moment. "Just get an appointment with a doctor in the next few weeks" she said.

Of course you continued to worry. You know that warts are transmitted through intercourse. You are afraid that you might have caught other things, as well. You know that when you see the FP there will be more awkward questions, and that you might not be able to avoid answering them as well as you did in the ED. You pray to God that you will be able to get through this nightmare with no permanent damage. You are not one to spend time on the internet – you do not own a computer – but you have seen advertisements warning women that warts can lead to cervical cancer.

Fortunately, you were able to answer truthfully all the questions the ED doctor asked you. Your last period was three weeks ago. It was normal. You have had no pelvic pain, vaginal discharge, odour, or itchiness. You have had no fever, no abdominal pain, and no pain with urination. You have no other skin changes.

In addition, when she asked you when your last intercourse was, you were able to look away and say, "I broke up with my former husband two years ago. I think that was the last time." Thank heavens she didn't say, "What do you mean, you *think* that was the last time?" You got away without talking about it. You are afraid that if this issue comes up, you will start crying again. What would the doctor think of you? How could you have been so stupid?

Sexual assault

How would you explain that you were feeling lonely and a bit homesick three months ago? Your co-worker at the shipping company where you work, **MARIE**, suggested that you go out for a drink on Friday night. She had been teasing you for weeks about the boring life you were leading since you came to town, and had been trying to get you to taste the nightlife. You had to admit that you were feeling quite isolated here. You had come to this city in order to start a new life after your marriage broke up. The plan was to leave the small town where everyone knew you so that you could become someone else, and perhaps even meet someone new. Instead of that, you were going to work every day and then going home every night to watch television. Marie was right. It was time to take the plunge.

You agreed to meet Marie at a downtown bar the next Friday. In preparation you had your hair styled and got a new outfit. You felt (and looked) 10 years younger. When you thought about it, you realized that you were actually nervous about going out again. You hadn't been out on your own since before you were dating **ROBERT FORTIN**, your former husband. That was more than 10 years ago. Fortunately, Marie would be there. You had not socialized with your co-worker before, but you knew from her stories that she was a "party girl". She is in her late 30s and was divorced a few years ago. In her case she wasted no time in getting back into action. She is out at the clubs quite often, and you know she has no trouble picking up new men. The relationships don't seem to last, but you suspect that Marie prefers things that way.

You got to the club a bit early, and you didn't see Marie anywhere. You grabbed a chair at the bar to wait for her, and ordered a drink to relax you a bit. You are not a big drinker, but you were in a club, after all. There was a dance floor with a lot of activity, but you were alone. After a while, a nice guy came up and asked you to dance. His name was **BEN**, if you remember correctly. You distinctly remember dancing with him. Marie finally showed up about an hour (and a couple of drinks) later. By then you were well acquainted with your new friend, and Marie winked and started off on her own.

After that, your memory of events is unreliable. When you confessed to Marie the next week that you didn't remember much about the evening, she told you that you were still dancing when she left the club much later. Did you keep drinking? That wouldn't be like you. You have never been one to get drunk, and you usually stop at two or three. You remember dancing. You don't remember getting home. The next thing you remember is waking up in the morning feeling very drowsy. You were in your bed. Some of your clothes were on and some were off. Your underwear was beside you in the bed, and your blouse was on the floor. Some buttons were missing. When you got up to go to the bathroom, you were unsteady on your feet and almost blacked out. You had to lie down again for a few minutes. When you did get up, you were aware of some vaginal discomfort. It suddenly occurred to you that you may have had intercourse. Was it with Ben? Had he come home with you? You would never have agreed to sex on a first date. Were you drunk? Had you been drugged? The last possibility frightened you, but seemed very possible. How else could you explain the memory loss? You spent the rest of the day in a daze. You felt frightened. This person knows where you live. What if he came back? Should you try to find him? Should you go to the police? How could this happen to you? You are 40 years old. Doesn't this sort of thing happen only to younger women?

Since then your thoughts have returned continually to what might have happened. You decided to tell no one about the event. You are too ashamed of yourself for having put yourself at risk. You are angry when you think of the man who took advantage of you, but you also blame yourself. Marie has asked you to go out with her again, but you have come up with excuses. In the three months since the

event, you find your mind racing back to the scene in the club. You are frustrated by your lack of memory of the events. You have had nightmares and insomnia, but the nightmares make no sense. Despite having the lock changed on your apartment door, you do not feel completely safe. When you go outside you look around constantly to make sure you are not being followed. You have prayed for life to return to normal so that you can forget this and move on. You have not tried to relax by resorting to the use of alcohol or illicit drugs.

Then the warts appeared. Not only were you sure that you had been "taken advantage of" but you were having medical consequences. You could no longer try to forget the whole thing. You had to see a doctor.

MEDICAL HISTORY

You consider yourself to be generally very healthy. You have had no major health problems in the past.

Obstetrical history: You are G0P0.

Menstrual history: You experienced menarche at age 13. Your periods are regular (five days/28-day cycle), and you have no dysmenorrhea. Your last menstrual period (LMP) was three weeks ago.

Wellness checks: Your last exam and Pap test were in your former town, "at least three years ago". You do not think that your FP would have done a sexually transmitted infection (STI) screen.

Other relevant factors: You have never had a blood transfusion. You have no tattoos or piercings.

SURGERY

You have never had surgery.

MEDICATIONS

None.

ALLERGIES

None known.

IMMUNIZATIONS

You have had no immunizations since adolescence.

Specifically, you have not been immunized with the hepatitis B vaccine or the human papillomavirus (HPV) vaccine (Gardasil).

LIFESTYLE ISSUES

Tobacco: You smoke 10 to 15 cigarettes a day. You began smoking at age 18.

Alcohol: You will drink two to three beers at a party.

Illicit drugs: You have never used illegal drugs.

Exercise and Recreation: You do not exercise regularly. You would say that you have no hobbies.

FAMILY HISTORY

Your father, **BERNARD**, is 68. He smokes and has been told he has a "bit of emphysema".

Your mother, **CLAIRE**, is 65. She also smokes but has no health problems of which you are aware.

Your brother, **DAVID**, is 38. He, his wife, and their two children are well.

Your maternal grandmother is 85. Your other grandparents died in their 80s.

You are not aware of any diseases that run in your family.

PERSONAL HISTORY

Childhood and adolescence

You were born and raised in a small town about 100 km from this city. You are the elder of two children. You would describe your childhood as a happy one. (You would be surprised or shocked if the candidate asked you about childhood sexual abuse or incest.) You grew up within a large extended family, as well. Most of your uncles, aunts, and cousins lived in or around the same town.

Your family was not wealthy. Until his retirement two years, your father worked in the shipping and receiving department of a local farm supply store. Your mother still works as a cashier at the local grocery store. They both know everyone in town. You and your younger brother attended the local school.

You dated a couple of boys in high school, but not seriously. You became sexually active with one boy when you were 16, but you had to hide this from your parents. The relationship lasted for only a few months. You went to parties and dances with your peers, but for some reason the boys seemed to settle on other girls when it came to serious dating.

Early adulthood

At about this time, you got a job in the farm supply store where your father worked. Your secretarial skills were good, and you were hired as a clerk. You soon learned to look after the shipping invoices and the orders—a skill that you were able to transfer to your new job in the city. The work kept you busy and the years seemed to go by. Almost all your friends got married. Even your little brother married and started to have children. Meanwhile, you were still living with your parents.

Marriage and divorce

When you were 28 and getting desperate, you met Robert. He was only 21, and the son of a local farmer. He came to the store fairly often on business, and he always flirted with you quite openly. When he finally asked you out on a date, you accepted immediately. It was your first and only serious relationship.

During the time you and Robert were dating, David warned you that Robert had a bit of a reputation for womanizing. You didn't feel inclined to be too judgmental, as he was the only game in town. You ignored David's warning, and in retrospect you realize that you also turned a blind eye to some indications that you were not the only woman in Robert's life.

You and Robert married when you turned 29 and he was 22. You moved to the farm and did your best to be a good farm wife. You helped out in any way you could. Your mother-in-law was very supportive.

After two years of marriage, you and Robert had not managed to conceive. You dragged Robert to see the local FP, who did some tests and confirmed that Robert had a low sperm count. He was not interested in considering any infertility treatments, and you got the impression that he was just as happy not to have children. You, on the other hand, were disappointed not to have kids. You settled into your life on the farm with a quiet resignation, and continued this way for the next seven years of your marriage.

Robert often found reasons to go into town for one thing or another, and sometimes he came back fairly late. Your suspicions grew that he was "straying". You once overheard your mother-in-law arguing with him about his behaviour. The situation came to a head two years ago, when your brother drove to the farm, sat you down, and told you that everyone in town knew that Robert was seeing another woman. David said that he had caught them out together in a bar in the next town. Your brother told Robert that he would "beat the shit out of him" if he ever saw him out with another woman again.

You confronted Robert, who told you that he had had "a few" girlfriends. He also said that he had never really loved you and that he had married you only to please his parents. They were genuinely fond of you and were worried that their son showed no signs of settling down. At that point you knew the marriage was over. You said that you wanted a divorce, and you went back to your parents' house.

The next few months were very difficult. If there were a soul in town who did not know about Robert's infidelities, he or she soon found out. You felt humiliated, as if the situation were all your fault. You should have admitted earlier that you knew there were problems. You soon decided that it was time to get out of town and to start over without the "sympathy" of an entire village. Your family was supportive—especially your brother and his wife—but you felt you could never be happy there again.

You have not spoken to Robert since the divorce was finalized. You hope that you never see him again. You realize that your brother is right: Robert always was a big jerk. You do miss his parents, but you feel that there is no way you could see them again, either.

EDUCATION AND WORK HISTORY

You graduated from the local high school. You took some secretarial courses while you were there.

From age 18 to 29 you worked in a farm supply store. Then you worked on Robert's family farm from age 29 to 38. You have worked for a local shipping company for the past year.

FINANCES

You support yourself on your salary. You received some money from Robert at the time of your divorce, but you receive no ongoing support.

You have a good benefits plan at work, but you are not well paid. You "have enough to get by".

SOCIAL SUPPORTS

You would say that your best support is your family—especially your brother, David. Your co-worker, Marie, is a friend but not a confidante. You are actually quite isolated in the city, and sometimes you wonder if you made the right choice in leaving your home community.

You do not want to tell anyone about the warts or the sexual assault.

RELIGION

You are Roman Catholic, but you rarely go to church.

ACTING INSTRUCTIONS

You are casually dressed. You may appear nervous and shy.

FEELINGS: You are anxious about seeing the new doctor. You blame yourself for the sexual assault because you "put yourself at risk", and so you are embarrassed and ashamed of having to see a physician to deal with the consequences. If the candidate asks if you are planning to contact the police, you admit that you don't know what to do. You are afraid of what might happen if you go to the police. There are points for the candidate who explores this with you. You should explain that you just can't imagine talking to the police about this right now. A candidate who persists in trying to send you to the police despite your reticence should be marked down in "finding common ground". You never want to see Ben again. You do not want to have to talk about what happened.

IDEAS: You feel that the warts are probably proof that you had intercourse three weeks ago, but you are not sure. Could you have caught these warts two years ago from your ex-husband? Might you have contracted other diseases as well: AIDS? Syphilis? You have heard of these diseases but know nothing about them. Will the warts give you cervical cancer? Were you drugged, and are there consequences associated with that? Ben knows where you live. Will he return?

EFFECT ON FUNCTION: Since the assault, you have been wary of your surroundings. You do not like to go out at night. You have changed your locks. Your sleep is disrupted by nightmares. You just don't feel safe. You are still functional at work, although easily distracted. If you are going home from work after dark, you take a taxi instead of walking. If the candidate (appropriately) explores possible post-traumatic stress disorder, you do not meet all the criteria. (You have no flashbacks or reliving of the event, no feelings of detachment, and no exaggerated startle response.)

EXPECTATIONS: You expect the FP to confirm that you probably have warts and to suggest treatment. You hope that he or she will reassure you about other possible diseases with appropriate testing. You expect that you will have to mention the intercourse three months ago, because you imagine that the FP is going to ask you the details. You dread this.

It may be a challenge to introduce the problem of sexual assault. You do not want to be too forthcoming, and yet you ***do*** want the candidate to find out about the second problem! If it has not come up by the 10-minute mark, you give this prompt: "There is something I just have not been able to talk about." Then you mention that you told the ED doctor you had not had intercourse in two years. You add, "But that may not have been true. There is one night that I don't remember very well." Then you can provide the details when the candidate asks about them. Before the 10-minute prompt, you volunteer this information ***only*** if the candidate asks open-ended questions and if he or she has gained your trust.

Before the 10-minute prompt, if the candidate asks about your last sexual encounter, you might say something like, "Well, the last time *I am sure of* was two years ago." This should be a big enough clue to draw out further questioning.

Please note that the marking for Identification of the Problem of Sexual Assault gives a mark for "has told anyone". This is not the same as the mark given in Context for "has no one she feels she can confide in". These answers are in response to different questions from the candidate: "Have you told anyone?" and "Is there anyone you feel you can talk to about this?"

If the candidate outlines several treatment options for your genital warts and then asks you to choose, you answer, "Whichever you think is best, Doctor."

Remember that a large part of your embarrassment is your sense that ***you*** are the one who did something wrong.

CAST OF CHARACTERS

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

FLORENCE BRUNEAU:	The patient, age 40, who has anogenital warts and was sexually assaulted three months ago.
BERNARD BRUNEAU:	Florence's father, age 68.
CLAIRE BRUNEAU:	Florence's mother, age 65.
DAVID BRUNEAU:	Florence's brother, age 38, who is very supportive.
ROBERT FORTIN:	Florence's ex-husband, age 33.
MARIE:	Florence's co-worker.
BEN:	The man Florence met at a bar three months ago.

TIMELINE

Today:	Appointment with the candidate.
1 week ago:	Went to the ED because of the anogenital warts.
3 weeks ago:	Noticed anogenital warts; LMP.
3 months ago:	Possible sexual assault.
1 year ago, age 39:	Moved to this city.
2 years ago, age 38:	Marriage ended.
11 years ago, age 29:	Married Robert.
12 years ago, age 28:	Met Robert.
22 years ago, age 18:	Graduated from high school.
40 years ago:	Born.

INTERVIEW FLOW SHEET

INITIAL STATEMENT:	**"I need to see you because I have genital warts."**
10 MINUTES REMAINING:*	If the candidate has not brought up the issue of the sexual assault, the following prompt must be said: **"There is something I just have not been able to talk about."**
7 MINUTES REMAINING:*	If the candidate has not brought up the issue of the warts, the following prompt must be said: **"So, what do I do about the warts?"** *(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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SIMULATED OFFICE ORAL EXAMINATION

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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Allen T, Bethune C, Brailovsky C, Crichton T, Donoff M, Laughlin T, Lawrence K, Wetmore S.

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1. IDENTIFICATION: ANOGENITAL WARTS

Anogenital warts	Illness Experience
Areas to be covered include: **1. history of condylomata:** • Diagnosed by a physician in the emergency department. • Non-painful. • Appeared three weeks ago. • No previous history of warts. • Not aware of a partner with warts. **2. symptoms of other genitourinary pathology:** • No discharge. • No pelvic pain. • No vaginal odour. • LMP three weeks ago. **3. sexual risk factors:** • No Pap test in the past three years. • Ex-husband had other partners. • He was her only sexual partner during her marriage. • No current sexual partner. • Previous Pap tests were normal. **4. other factors for infections transmitted by blood or sexual contact:** • No transfusions. • No piercings. • No tattoos. • No intravenous drug use. • Never tested for STIs.	**Feelings** • Worry. **Ideas** • This could lead to cancer. • This could mean that other diseases are present. **Effect/Impact on Function** • Difficulty in sleeping. **Expectations for this visit** • She will be checked for all diseases and the warts will be treated. **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: SEXUAL ASSAULT

Sexual assault	Illness Experience
Areas to be covered include: **1. the event:** • An unknown male perpetrator. • Alcohol involved. • Assault occurred in her apartment. • Amnesia for the event. • Unsteady the next morning/almost passed out. **2. subsequent behaviour:** • Changed the locks. • Wary (e.g., checking behind her, taking cabs at night) • Experiencing nightmares. **3. negative factors:** • Not suicidal. • No flashbacks. • No subsequent alcohol use. • No feelings of detachment. **4. the fact that she has not told anyone.**	**Feelings** • Shame and isolation. • Fear that he might return. **Ideas** • She put herself at risk. **Effect/Impact on Function** • Not leaving home at night. • Withdrawing from socializing. **Expectations for this visit** • She has no real expectations. She hopes that the FP will not be too judgmental if he or she finds out about the assault. **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 **OR** 4.	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 **OR** 4.	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 status:** • No children. • Moved to this city one year ago. • Currently employed. **2. supports:** • Has no one she feels she can confide in. **3. her past marriage:** • Had to be told (did not find out herself) that her husband had multiple affairs. • Community was aware of the circumstance of her divorce/she felt a need to move because of embarrassment. • No contact with her ex-husband. **4. the fact that she was ready to go out socially again.**	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: **"Ms. Bruneau, what has happened to you would leave anyone feeling frightened. That this happened just at the time when you were starting to think about dating again must leave you feeling that you will never be able to find someone. The appearance of the genital warts would also make you worried about your health and your future. Unfortunately, you don't really have anyone to talk about this, which must make you feel even more alone."**

Superior Certificant	Covers points 1, 2, 3, and 4.	Demonstrates initial synthesis of contextual factors, and an understanding of their impact on the illness experience. Empathically reflects observations and insights back to the patient.
Certificant	Covers points 1, 2, and 3 **OR** 4.	Demonstrates recognition of the impact of the contextual factors on the illness experience.
Non-certificant	Does not cover points 1, 2, and 3 **OR** 4.	Demonstrates minimal interest in the impact of the contextual factors on the illness experience, or cuts the patient off.

4. MANAGEMENT: ANOGENITAL WARTS

Plan	Finding Common Ground
1. Discuss treatment options for anogenital warts (e.g., cryotherapy, imiquimod, podophyllin). **2. Arrange for a Pap test.** **3. Offer testing for STIs.** **4. Discuss the natural history of HPV infection (e.g., the likelihood of spontaneous remission, the low risk of progression to cancer).**	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: SEXUAL ASSAULT

Plan	Finding Common Ground
1. Identify to the patient that this event was a sexual assault (non-consensual sexual activity). **2. Explain that the assault was not her fault.** **3. Arrange follow-up counselling with self or a specialized service.** **4. Explore her willingness to report the assault to the police.**	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.

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.