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 11

THE COLLEGE OF FAMILY PHYSICIANS OF CANADA

CERTIFICATION EXAMINATION IN FAMILY MEDICINE

SIMULATED OFFICE ORAL EXAMINATION

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.

THE COLLEGE OF FAMILY PHYSICIANS OF CANADA

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. **cluster headaches;**

2. **undiagnosed paranoid schizophrenia.**

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

THE COLLEGE OF FAMILY PHYSICIANS OF CANADA

CERTIFICATION EXAMINATION IN FAMILY MEDICINE

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 Mr. **HENRY BROOKS**, age 29, 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 Mr. **HENRY BROOKS**, a 29-year-old engineer working as an electronic chip designer. You are consulting the candidate because you want a referral to have an electronic chip removed from your head. You believe this chip is causing headaches.

You think this chip was inserted when you had a car accident two years ago.

You are certain that your former boss, **WILLIAM FORCER,** ordered the chip placed in your head, so he could control you at work.

HISTORY OF THE PROBLEM

Cluster headaches

You have been having headaches for the past two years. They started following an accident while you were driving to work one day. A driver ran a red light and the car smashed into yours on the driver's side. You suffered no loss of consciousness. You were brought to a hospital emergency department (ED). A doctor examined you and asked for "a bunch of tests, X-rays, and computed tomography (CT) scans", results of which were supposedly normal. You had a scalp laceration on the left side, which was repaired. You are sure that is where the chip was inserted.

On that day your life began to be controlled by these "crummy headaches" which you've been getting ever since. The pain starts on the left side and feels as if a knife is being inserted, or maybe as if someone is driving a stake through your head. The pain tends to worsen as it progresses. The first hour is pure agony. Along with the headache you experience a stuffy nose and tearing on the same side of your face. Often you become nauseated. There is no warning. All these symptoms last a couple of hours, and you become non-functional because of the pain. You have to leave work to get some rest. Then the pain seems to go away until it starts again the next day. This cycle can continue for eight weeks before the headaches stop completely. The episodes occur about twice a year.
You have missed a lot of workdays because of this nightmare. In fact, your boss, **JIM MCDONALD**, is on your case about your absences. Unfortunately, something similar happened at your previous job.

Paranoid schizophrenia

Bosses always seem to want to screw you. In your previous job, you lost a promotion to the boss's son-in-law, supposedly because you weren't management material. You were really pissed off, and told your boss. He explained that you were an excellent engineer but didn't have management skills. He added that you were preoccupied with what you thought people were saying behind your back. He even encouraged you to consult the employee assistance program to see if therapy would help. You quit although your boss tried to persuade you to stay. In fact, he practically pleaded because you are so good in your field.

You had no difficulty finding a new job. The first week at your new job you had your car accident. You, therefore, are convinced that your former boss told the emergency physician to insert the chip in your head because he wanted to force you to come back to his company against your will.

Then "these bloody headaches" started, and once again you found yourself "falling into a nest of vipers". You're sure the two bosses have talked about you. You are certain of your beliefs, and as time goes by the proof is coming out. For example, last week your current boss asked you how you were doing on a project in progress. You explained the glitches and told him you were progressing anyway. He said, with a wry smile, "Don't get headaches over it". His attitude makes you sick. However, this time you will stay and fight. You intend to start by getting this lousy chip out of your head. You will then show them what a hell of a good engineer you are, and that you're not someone to be pushed around.

Maybe then the voices will stop, too. You have never discussed these with anyone before, but since the chip was inserted, you sometimes hear voices coming from inside your head. You are getting more and more anxious about them, which perturbs you because you've never been an anxious fellow. You have never heard voices coming from walls or radios or anywhere else. The voices scare you because they seem to be emanating from deep within your head, kind of like an echo of your thoughts. They don't tell you to do things or obey commands, but usually confirm what you already know about your former boss's agenda. You have never had any visual hallucinations. You have absolutely no homicidal or suicidal ideas. Simply having the chip removed will liberate you from your former boss's influence. Then you will regain your peace of mind.

MEDICAL HISTORY

Appendectomy at age seven.

MEDICATIONS

You take acetaminophen, 500 mg every four hours, when you have headaches. A doctor at a walk-in clinic gave you a prescription for some narcotic, which didn't help. You never went to see him again.

LABORATORY RESULTS

None.

ALLERGIES

None known.

IMMUNIZATIONS

Up to date.

LIFESTYLE ISSUES

Tobacco: You've smoked one pack of cigarettes a day for eight years.

Alcohol: You drink a couple of beers a month.

Caffeine: Other than 12 ounces of coffee when you wake up, you don't drink caffeinated beverages.

Illicit drugs: You tried pot when you were in university but didn't like it because it made you feel strange; your senses were dulled and you were afraid that your classmates would steal your notes. These were excellent because you "really tripped" on your courses and were a very good student who completed your degree with honours.

Exercise and Recreation:

You don't exercise anymore because physical activity seems to bring on the headaches.

You don't have many leisure activities.

You spend most of your spare time listening to classical music and Gregorian jazz. Music alleviated the headaches a bit. It also helps calm the anxiety that develops at work, and decreases the voices.

You collect comic books, and have been looking after an iguana for the past two years.

FAMILY HISTORY

Your mother, **MARY WIGGINS BROOKS**, is 60 and in good health. When you were very young, she was hospitalized "for something psychiatric". You never knew what the diagnosis was because talking about it was taboo. Until you left home for university, your mother was present and caring but somewhat distant. She had a family physician and sometimes saw a "shrink". Perhaps she still does, but you don't know because your family contacts are now limited to Christmas visits and an occasional phone call.

Your father, **HARRY BROOKS,** is 65 and suffered from headaches when he was younger.

You have no siblings or children.

PERSONAL HISTORY

Childhood and adolescence

You were born in England. You immigrated to Canada with your parents when you were one year old.

You attended a couple of elementary and high schools because of your father's work. He was a salesman who worked his way up to an executive position. This required the family to move around. Nonetheless, your parents were always present in your childhood and adolescence, and you figure you turned out okay.

You were a loner in elementary and high school. Your hobby was collecting comic books. You weren't into sports much.

Relationships

You live alone in an apartment and manage well. You had a few girlfriends in the past. You met **SUSAN HAWKS**, your supposed soul mate, in university about six years ago. You dated for three years. After a while she began accusing you of being too jealous because you believed she was "flirting around". She even mentioned that you were becoming paranoid. Eventually she insisted that you consult a doctor or else she would leave. Even though you did not believe you were sick, about three and a half years ago, you agreed to see a psychiatrist, **DR. EDWARD LUDWIG**. He told you that you were delusional and prescribed a medication called olanzapine. You took it for a while for Susan's sake but noticed it interfered with your concentration. You, therefore, stopped taking it. With time you became distant and secluded. Finally Susan left you.

Since Susan and you split up, you haven't been seriously involved with anyone, and don't intend to be. You go out occasionally with **JANE WILSON**, a friend from work. She is a secretary and shares certain opinions about the workplace. That is to say, she agrees that the bosses are up to no good.

You go out to dinner and sometimes a movie. You enjoy her company because she reinforces your ideas about your boss. In the past, you both had a serious relationship that ended in disaster because you believed your partners were screwing around with others; you both "got shafted". You and Jane have had sex but you both realized your friendship is more important than sex, and decided to keep the relationship platonic.

You haven't had sex in the past year, partly because of your headaches, which have been triggered during intercourse. You also don't trust people to be honest about any sexually transmitted disease they may have picked up.

EDUCATION AND WORK HISTORY

You studied electrical engineering at university. You completed your degree with excellent marks, which allowed you to complete a master's degree in computer engineering. After graduating you found your first job at a firm specializing in computer systems. You thought you had "made it" until a promotion for which you were hoping was given to someone else. You've been in your current position for two years. You have no management role and no contact with clients. You are financially secure.

SOCIAL SUPPORTS

Jane is your only friend. You have had no other real friends since you finished school and went to university. You believed other engineering students just wanted your notes, and decided to be no one's friend. That continues to be your motto.

You attended company parties until this year, when you realized they are "just a scam" to make employees work harder and to "keep them from bitching".

ACTING INSTRUCTIONS

You are dressed simply in a rumpled shirt and slacks. You have one or two days' growth of beard and your hair is messy as though you forgot to comb it.

Your activity is sluggish, but you seem to be preoccupied with the doctor. You look anxious: after all, a doctor inserted the electronic chip in the first place, under your boss's influence. You look around the room as though searching for hidden microphones.

You answer questions about the chip clearly and bluntly. You seem to be sizing up the candidate's genuine interest in your problems. If the candidate seems to be nonjudgmental about the chip's existence, you will blab about your former boss's whole plan and explain the intricacies. If the candidate openly says that you are nuts, you clam up about your boss's hidden agenda, but continue to discuss the chip in a matter-of-fact manner. In this circumstance you will not become angry and also will not shut up about the headaches and their cause.

You discuss the voices and seem to become anxious as you elaborate on their existence. If the candidate puts you at ease, your anxiety level drops and you answer questions. If the candidate says you have cluster headaches, you acknowledge this fact but maintain that you have a chip in your head. You avoid eye contact. If the candidate suggests an X-ray examination you will be happy, although your suspect a cloaking device will hide the chip from view. You have never attempted to remove the chip yourself, and don't intend to do so.

CAST OF CHARACTERS

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

HENRY BROOKS:	The 29-year-old patient, who is an engineer and believes an electronic chip, has been implanted in his head.
HARRY BROOKS:	Henry's 65-year-old father.
MARY WIGGINS BROOKS:	Henry's 60-year-old mother.
SUSAN HAWKS:	Henry's former girlfriend and soul mate, who left him three years ago.
JANE WILSON:	Henry's co-worker and friend.
JIM MCDONALD:	Henry's current boss.
WILLIAM FORCER:	Henry's former boss.
DR. EDWARD LUDWIG:	Henry's psychiatrist about three and a half years ago.

TIMELINE

Today:	Appointment with the candidate.
Age 27:	Car accident and alleged electronic chip insertion.
Age 26:	First psychotic episode.
Age 25:	First job.
Age 23:	Started dating Susan.

INTERVIEW FLOW SHEET

INITIAL STATEMENT:	**"I'm having terrible headaches."**
10 MINUTES REMAINING:*	If the candidate has not brought up the issue of the delusions, the following prompt must be said: **"I'm sure it's that lousy chip in my head that's the problem."**
7 MINUTES REMAINING:*	If the candidate has not brought up the issue of the cluster headaches, the following prompt must be said: **"These headaches are really messing up my life."** *(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) Defining competence in family medicine for the purposes of certification by The College of Family Physicians of Canada: the evaluation objectives in family medicine; 2011 – [cited 2011 Feb 7}. Available from: *http://www.cfpc.ca/uploadedFiles/Education/Definition%20of%20Competence%20Complete%20Document%20with%20skills%20and%20phases%20Jan%202011.pdf*

1. IDENTIFICATION: CLUSTER HEADACHES

Cluster headaches	Illness Experience
Areas to be covered include: **1. history of the headaches:** • They began following a car accident. • There are recurring bouts. • The cycle lasts eight weeks. • They occur about twice a year. • No history of headaches before the motor vehicle accident. **2. current symptoms:** • Symptoms started two days ago. • Unilateral pain. • Tearing and rhinorrhea. • Nausea. **3. aggravating and alleviating factors:** • Intercourse worsens symptoms. • Alcohol worsens symptoms. • Listening to music alleviates symptoms. • Little benefit from analgesics. **4. ruling out other causes:** • Family history of headaches. • Normal CT scan of the brain. • No loss of consciousness. • No focal neurological symptoms (e.g., blurred vision, slurred speech, weakness, and paresthesias).	**Feelings** • Fed up with headaches. **Ideas** • The chip is causing the headaches. **Effect/Impact on Function** • Missing work. **Expectations for this visit** • The doctor will arrange for a chip removal. **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: PARANOID SCHIZOPHRENIA

Paranoid schizophrenia	Illness Experience
Areas to be covered include: **1. current symptoms:** • Auditory hallucinations. • No visual hallucinations. • Not homicidal. • Not suicidal. **2. past history and management:** • First episode three and a half years ago. • Paranoid behaviour observed by his former girlfriend. • Prior psychiatric consultation. • Received treatment with olanzapine. • Side effects of olanzapine. **3. other pertinent areas:** • No current use of street drugs. • Family history of psychiatric disease. • No systemic symptoms. **4. no risk that he will try to remove the chip himself.**	**Feelings** • Anxiety. • Anger. **Ideas** • The chip might be causing the voices. • He knows it sounds crazy but he is under his former boss's influence. **Effect/Impact on Function** • Able to work. • Progressive social isolation. • Loss of pleasure in hobbies. **Expectations for this visit** • Doctors have been harmful to him in the past, so he doesn't know how much he can expect from the candidate. **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.

3. SOCIAL AND DEVELOPMENTAL CONTEXT

Context Identification	Context Integration
Areas to be covered include: **1. family:** • His parents are alive. • No siblings. • Little contact with his parents. **2. life cycle issues:** • Friendship with Jane. • No social support. • One serious relationship in the past. • No children. **3. work-related issues:** • Electronic chip designer. • His previous boss was concerned about his behaviour. • No contact with clients. • No management role. **4. social factors:** • He lives alone. • He collects comic books. • No financial concerns.	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: **"Everything that seems to have happened in your life and at work these past few years and then following your accident – the voices and headaches, along with the idea that they may be due to an implanted chip – could certainly be cause for concern, especially as you are 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.	Demonstrates recognition of the impact of the contextual factors on the illness experience. The following is the type of statement that a Certificant may make: **"You've had a lot of events in your life. These headaches coming out of the blue for no apparent reason must certainly be of concern."**
Non-certificant	Does not cover points 1, 2, and 3.	Demonstrates minimal interest in the impact of the contextual factors on the illness experience, or cuts the patient off.

4. MANAGEMENT: CLUSTER HEADACHES

Plan	Finding Common Ground
1. Identify the medical condition as cluster headaches. **2. Arrange a physical examination.** **3. Discuss medication options which may include abortive and prophylactic medications.** **4. Discuss non-pharmacological treatment of headaches (smoking cessation or oxygen therapy at an ED in a crisis).**	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: PARANOID SCHIZOPHRENIA

Plan	Finding Common Ground
1. Arrange a plan for follow-up care either by self or through a referral to a psychiatrist. **2. Lay the groundwork for a long-term relationship (i.e., working over time to address current and future problems).** **3. Rule out an organic cause (i.e., through a metabolic work-up which may include a complete blood count; thyroid stimulating hormone testing; liver function tests; and albumin, calcium, urea and random blood glucose measurements).** **4. Arrange to obtain the patient's medical records.**	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.