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 10

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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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. **caregiver burnout;**

2. **headaches.**

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. **HELEN PEREIRA**, age 60, 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. **HELEN PEREIRA**, age 60. Yesterday, your mother's continuing care case manager phoned to tell you that your mother will soon be ready for discharge from the rehab unit. She has been a patient there for the past three weeks.

You felt overwhelmed by this news and argued that there was no way your mother was ready and safe to come home. The case manager said, "This is the way it is", and told you that you had to be prepared to look after your mother. She had not been willing to listen to you. This problem started a throbbing headache that will not go away.

This morning, you phoned your family physician (FP), **DR. JONES**, for advice about what to do to ensure your mother is not sent home. However, he is away for the next few months, and so you have this appointment with a new physician at the clinic.

HISTORY OF THE PROBLEM

Caregiver burnout

Your mother, **LENA ALLEN**, is 93 and lives in her own home, in the same community as you. Despite her age, she is healthy. She takes no medications other than "herbal" ones, and has never had a day's illness in her life.

Your mother has been a widow for 15 years. Your father died of heart failure; he was quite disabled near the end of his life and had become noticeably demented. You were there for them both at that time, and helped your mother care for him. His death was not unexpected and initially your mother seemed to cope well. However, as her friends became disabled and died, she began to expect more and more of you: help with housework, help with shopping, etc.

For the past year or so she has been phoning at least three times a day, and if you do not physically check up on her she becomes quite rude to you. However, only in the past few months have you begun to realize how demanding your mother is and how her demands are interfering with your life. Your husband's or your daughter's visits to her are not enough of a break for you. She also is reluctant to accept their help these days.

Six years ago your mother had a right hip-joint replacement. She sailed through that. During the past year, the pain in her left hip had become very severe and virtually constant, and she was much incapacitated. She had severe osteoarthritis on the x-rays just like her right hip had been. You went with her when she visited her FP about her hip. She told him bluntly that she wanted an operation. She said that the pain was too much to bear. If she died during or after the procedure, well, that was God's will, but she was sure that her God did not intend her to suffer quite this amount of pain. Because she is a Jehovah's Witness (JW), she was referred to the university hospital, which has blood-salvaging techniques that made the operation less risky. She received iron and erythropoietin preoperatively. Although her memory is still good, she is increasingly uncertain about decisions and needed constant reassurance and support before the operation.

The arthroplasty was completed a month ago. It went well. A week later she was transferred to receive rehabilitative care in a rehab/sub acute care wing in the same hospital, which is some distance away. It takes you 45 minutes to get there to visit.

You visited your mother in the hospital most days and really were surprised when the continuing care case manager phoned yesterday. You had expected that your mother would need at least a further month in the hospital. The physiotherapist had told you that your mother had spent so much of the past year sitting that she was quite deconditioned and would need at least a couple of months or so of rehab! Your mother had told you that while she was walking with a walker during physiotherapy, she still needed someone to be there; she went to the toilet only with supervision, and needed help dressing and getting her shoes and socks on. She also told you that she was scared to get out of bed on her own. She felt quite light-headed and dizzy when she stood up from her chair or her bed. Although she complained to you, you suspected that she had not told her caregivers about this. You had, however, seen her get up from a chair and walk to the toilet and then rise from the toilet and walk back to her chair using her walker. You felt she pushed herself to impress you and prove that she was ready to go home.

Probably she was also putting pressure on her caregivers to let her go home. You think she told them that you will be there to take care of her and that you will stay with her if need be.

When you spoke to the case manager yesterday, you argued that there was no way she was ready to come home, that she was not safe to be on her own and would fall and be back in hospital. You did not broach your own issue of feeling overwhelmed with the care of your mother, or her expectation of your being there at any time, day or night, just for her.

In the past, home support workers did not work out. Your mother could not see why they were necessary when you were there to help. They never did things the way she wanted. She was too proud to allow an attendant to help her bathe. You fear that, even if "supports" are in place, your mother will soon fire them and expect you to "do" for her.

Your mother lives in a duplex, which is all on the ground-floor level. Three steps lead up to her front door. Her toilet is in the "ensuite" with her bedroom, and has a raised seat and grab bars. There are also other grab bars in her bathroom. Her kitchen is well laid out. She has good seating that was bought after her first arthroplasty, on the advice of an occupational therapist.

Caring for your mother has made you irritable of late. You feel like "a bone that dogs fight over", being dragged this way and that, with no control over your life. You feel that your mother now controls you and your family completely. For the past year, you have had no time to yourself, and have not been able to go off for a weekend with your husband or just have a day for yourself. You have not had a holiday for five years. For years before that time, you had a winter and a summer holiday.

You have been thinking about this loss of control over your own life a lot recently. During yesterday's phone call, you needed a lot of willpower not to break down in tears and tell this case manager just to leave you alone because you had had enough. You love your mother dearly and feel guilty, but not too guilty, about the way you think. You believe that you have been more than attentive to your mother and that she is manipulating you now. You do not know why or how this happened; you just became caught up in it all. You have never confronted your mother or discussed your feelings seriously with her. She is not the easiest person to talk to; she becomes defensive and angry when confronted.

You still sleep well. You are not sad or depressed, just pulled and pushed too far. You are not suicidal and have never thought of suicide or of harming your mother.

Headaches

After yesterday's phone call, you developed a headache. You knew it was coming as soon as you put the phone down. You had this vague sensation of your head being full and of being very light-headed, which led to blurred vision and then distorted vision followed by pounding pain behind your right eye. This pain radiated over the whole right side of your head. You took one dimenhydrinate (Gravol) tablet and two acetaminophen (Tylenol) with codeine, and went to bed with an ice pack. You slept, and when you woke up you still had the headache but it was tolerable. You felt completely "washed out".

For the past year you have been having these headaches again. You have at least one a month, and they are becoming more frequent. You had thought you were rid of them!

You have suffered with "migraine" since your late teens. The attacks are typical, with an aura, scintillations, and a throbbing headache. For years you suffered two or three episodes of a headache a year. Typically you had blurred vision, and then a sensation of flashing lights, often in both eyes, followed by a terrible, painful headache that defies description. You vomited with the headache. You used to take Gravol and a couple of Tylenol with codeine and try to sleep.

The headache would last for up to three days, coming and going and then leaving you exhausted and drained. Your physician at the time offered you drugs to try to prevent them, but you never thought they came often enough to justify daily medication. Twice you went to the emergency department (ED) because the headaches were so bad. There you received intravenous medication that was effective.

Then, about 12 years ago, your headaches changed; they started as always, but the pain was different and the vomiting was incessant. You did "the Tylenol #3 and Gravol thing", but it had no effect. You went to your FP, who tried stronger narcotics; in the ED, the usual cocktail did not work. Eventually your headache and vomiting were so bad that you were kept in the ED; when your family physician met you the next day, he discovered that you were delirious. You have no recollection of that, but your family tells you that you had a computed tomography (CT) scan within the hour and were on your way to a neurosurgeon just as quickly. You had had a spontaneous subdural haemorrhage. No cause was ever found. It was drained and you made a complete recovery. For the next several years you were headache free, although for a few of those years you lived in dread of another subdural haemorrhage. Eventually you persuaded yourself that "lightning does not strike in the same place twice and relaxed about things".

A year ago, the old migraine headaches returned, with the same blurring of vision, the same flashes, and the same throbbing headache. You had little nausea, and usually they incapacitated you for only a morning or an afternoon. When the headaches returned you were sent for a CT scan on the advice of the neurosurgeon. The result was normal.

You now recognize stress and disturbed sleep as triggers for your headaches. If you become tense because there are not enough hours in the day or because a situation develops and you lose control of it, you can be sure of a headache. If you have a disturbed night, you worry that a headache will follow.

MEDICAL HISTORY

Craniotomy for subdural haematoma 12 years ago.

Migraine history.

Uneventful menopause 10 years ago.

Pap test results always normal; last test was a year ago.

Mammography results always normal; last mammogram was a year ago.

Bone density testing a few months ago; your physician said that your spine was equivalent to a 45-year-old's and your hip to a 55-year-old's.

MEDICATIONS

Tylenol with codeine (Tylenol #3), two tablets for headaches; never more than four a day.

Gravol, one 50-mg tablet with the Tylenol with codeine; never more than two tablets a day.

Vitamin D 800 IU with 1,200 mg of calcium a day.

LABORATORY RESULTS

None.

ALLERGIES

Although you are not allergic to them, you have always avoided nonsteroidal anti-inflammatory drugs (NSAIDs). This is because you do not want any bleeding problems.

IMMUNIZATIONS

Up to date.

LIFESTYLE ISSUES

Alcohol: You do not drink alcohol.

Tobacco: You do not smoke and never have.

Exercise and Recreation: You used to go to a Tai Chi group twice a week. You do not seem to have time for it now.

FAMILY HISTORY

Your father, **WILLIAM ALLEN**, had congestive heart failure secondary to ischaemic cardiomyopathy. He became demented in the last year of his life, and died at age 82. You are not aware of any other family medical history.

Your mother is healthy for her age. Your mother told her family physician that if she cannot make decisions about her health, you will. However, no formal document exists to confirm this.

Your brother, **ROBERT ALLEN**, age 65, is married and lives 100 km away.

PERSONAL HISTORY

You have always lived in this community. You graduated from high school and worked as a secretary in a local law office.

Husband

You met **JOSE PEREIRA**, age 67, at a JW convention. He was "an exotic-looking man", whose Spanish parents had immigrated when he was a boy. After a short romance you were married. You have never regretted the marriage.

Jose has his own business. He installs and refurbishes hardwood floors. He works at the upper end of that market and gets much of his work by word-of-mouth referrals among "the wealthy crowd". He has always worked 12-hour days.

Daughter and son-in-Law

You conceived only once, and gave birth to your daughter, **ELIZABETH**, who is now 25. You had no explanation for the absence of another pregnancy, and you long ago accepted that you would have only one child.

Your 30-year-old son-in-law, **JOHN**, has been a welcome addition to the family. Elizabeth married him three years ago. He is a nice young man and a hard worker. However, although he had a college education in business studies, he did not seem to get ahead. After his marriage to Elizabeth, he was laid off. During this time he worked with your husband in the flooring business and found that he liked it. Jose trained him to take over. The takeover should have been happening now, but a year after John and Elizabeth's marriage, John had to visit the same neurosurgeon who had cared for you. He had had headaches and also weakness of his arm.

John was found to have a brain tumour. The tumour was removed and he underwent radiation. So far, the tumour has not returned. The oncologists have been cautiously optimistic. That was "a year from hell", during which you supported your daughter and son-in-law, both financially and emotionally. (His family lives two provinces away.) Your daughter had been planning a pregnancy when the tumour was discovered.

Brother

Your elder brother is not religious. He has very little to do with caring for your mother. When you are not angry at him for failing to pull his weight, you realize that his detachment from the family was your parents' doing. When he married, he decided that the JW life was not for him and left the fellowship. Your parents had little to do with him for some years. As he had children they relented, and now your mother sees him as "a good man, but not one of us".

EDUCATION AND WORK HISTORY

After graduating from high school, you worked initially as a legal secretary. You have also kept the books and organized the bookings for your husband's business. You have done this for years and continue to be involved in the business.

FINANCES

Your home is in a nice part of town and has been mortgage free for some time. You are well prepared for retirement; in fact, you and Jose had planned that he would be retired by now, and that your son-in-law would have taken over the business.

Money is not an issue for your mother. She has more than enough to pay for help or even private nursing home care if necessary. (You were surprised to learn that in addition to her house, she has well over $300,000 in investments and at least another $250,000 in guaranteed investment certificates [GICs].) However, she likes to save and not spend her money. Leaving an inheritance for both of her children is important to her, although neither you nor your brother needs her money.

You have an enduring power of attorney for your mother's finances. Like you, she has a will.

SOCIAL SUPPORTS

You have close friends at the Kingdom Hall and can turn to most of them for help and support. They also visit your mother and will bring her food when she comes out of the hospital, but they are not involved in her care.

Your daughter, son-in-law, and husband all try to help and understand your mother. Occasionally your husband can be irritated by her demands. He tries to be protective of you and probably picks up on your irritability much sooner than you become conscious of it.

For the past two winters, Jose has gone on a skiing vacation on his own. That upset him. He, too, has been pressuring you to look after yourself and not give so much of yourself to your mother. He is disappointed that you have not been firmer with her, but you notice that he is just as easily manipulated by her.

RELIGION

Like your mother, you are a Jehovah's Witness. You are active and practising, as are your husband, daughter, and son-in-law.

EXPECTATIONS

You expect that this physician will tell you how to manipulate the system to buy yourself more time before your mother comes home. You expect that he or she will agree with you that it is too soon for your mother to come home, and make a phone call on your behalf.

You do not expect that you will become the focus of the interaction.

ACTING INSTRUCTIONS

You are casually dressed in clothes appropriate for a middle-aged woman. You are obviously distressed by the prospect of your mother being discharged from the hospital so abruptly.

You agreed to see this physician as you feel the imminent discharge is a crisis. You had not expected your mother to recover as well as she has. You had expected to have a chance to rest, and you have not. You are angry that you have been told she is coming home. You focus on her dizziness and incapacity as the reasons for her need to be in care longer. You may say things such as **"She cannot possibly be left alone yet"**, **"She cannot even put her shoes on by herself"**, or **"She will fall because she is so dizzy"**.

At the beginning of the interview you try to dominate and press the physician to see your point of view: **"I know you have not met my mother, but can you just phone them and tell them to keep her?"** At least initially, you do not realize that the issue may be as much about you as about your mother, and that you are "burned out" by caregiving and your relationship with her. If a candidate becomes empathic or understanding about your predicament, you become less assertive and more realistic. You may say, **"They need to give me more time"** or **"They sprang this on me, and I am not emotionally ready for her yet"**.

You are willing to discuss both prophylactic and abortive therapy for your headache. You are quite happy if you are referred to another physician, but you would like something to help you while you wait for the referral.

If the candidate offers NSAIDs, you say that you will not take them because you are a Jehovah's Witness.

If the candidate suggests that you are depressed, you emphatically state that you are not. You agree that you are emotionally exhausted or "burned out". You quickly agree and latch on to any suggestion that will buy time before your mother is discharged.

You are happy to return to the candidate, with or without your mother, to discuss care issues once she has been discharged.

CAST OF CHARACTERS

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

HELEN PEREIRA:	The patient, age 60, who is suffering from caregiver burnout and migraines.
JOSE PEREIRA:	Helen's husband, age 67.
ELIZABETH:	Helen's daughter, age 25.
LENA ALLEN:	Helen's mother, age 93.
ROBERT ALLEN:	Helen's brother, age 65.
JOHN:	Elizabeth's husband, age 30.
WILLIAM ALLEN:	Helen's father, who died at age 82.
DR. JONES:	Helen's FP, who is away for the next few months.

TIMELINE

Today:	Appointment with the candidate.
One month ago:	Mother's second arthroplasty.
Two years ago:	Son-in-law diagnosed with a brain tumour.
Three years ago:	Daughter and son-in-law married.
Five years ago:	The last year in which you had a vacation.
Six years ago:	Mother's first hip arthroplasty.
12 years ago:	Craniotomy for subdural haemorrhage.
15 years ago:	Father died.
25 years ago:	Daughter born.

INTERVIEW FLOW SHEET

INITIAL STATEMENT:	**"I need your help with my mother."**
10 MINUTES REMAINING:*	If the candidate has not brought up the issue of the headaches, the following prompt must be said: **"Since she phoned yesterday, I have had another headache."**
7 MINUTES REMAINING:*	If the candidate has not brought up the issue of the caregiver burnout, the following prompt must be said: **"You know, I don't know that I can cope with my mother any longer."** *(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: CAREGIVER BURNOUT

Caregiver burnout	Illness Experience
Areas to be covered include: **1. mother's current care issues:** • Recent arthroplasty. • Rehabilitation for three weeks. • Being discharged with a sudden change in care plan. • Not independent in activities of daily living (ADLs); needs help bathing, dressing, etc. **2. mother's care issues before hospitalization:** • Lived alone. • No evidence of dementia. • Other family members not acceptable as caregivers. **3. caregiving burden:** • Mother accepts help only from the patient. (The patient's husband and daughter are no longer acceptable to the mother.) • The patient's brother is not helpful. • Home care services are not acceptable to her mother. **4. boundary setting:** • Has never discussed this issue with her mother.	**Feelings** • Anger at the hospital. • Overwhelmed. • Guilt about how she feels. **Ideas** • She is no longer able to look after her mother alone. Her mother is being discharged inappropriately and without a plan in place. **Effect/Impact on Function** • She has no time for herself (no holidays, gave up exercise class). **Expectations for this visit** • The physician will intervene and keep her mother in the hospital until she is ready to look after her. **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: HEADACHES

Headaches	Illness Experience
Areas to be covered include: **1. current headache:** • Aware when it is coming (aura). • Usual migraine headache. • Scintillations. • Hemi cranial. **2. past history:** • Migraine since youth. • Craniotomy for subdural haemorrhage 12 years ago. • Migraine restarted a year ago. • Normal CT a year ago. • Increased frequency. **3. treatment:** • Gravol. • Acetaminophen with codeine. • Has never used prophylactic medications. **4. refusal of NSAIDs because she is a Jehovah's Witness.**	**Feelings** • Fed up with headaches, and this one is the last straw. **Ideas** • The case manager's phone call triggered a headache. • This was her usual migraine. **Effect/Impact on Function** • Incapacitated for up to three days less recently. **Expectations for this visit** • She will be able to vent. • The physician will be empathic. **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. support for the patient:** • Supportive husband. • Supportive daughter. • Daughter has increased responsibilities (because of her husband's brain tumour). • Congregation of the patient's church is very supportive. **2. social factors/life cycle issues:** • Works for her husband as a bookkeeper. • Had planned retirement. • Son-in-law is unable to take over the business. • Financially independent. **3. mother's affairs:** • Financially well off. • Patient has power of attorney. • Will in place. • No formal alternative health care decision maker.	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: **"Being a good daughter and caring for your mother have become overwhelming for you, despite the support of your family and your church. It seems your mother is demanding more than you can give, and this is manifest in increasing migraines and your irritability."**

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 **OR** 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 seem burned out. Your headaches are bad and it seems you are not fit to look after your mother yet."**
Non-certificant	Does <u>not</u> cover points 1, and 2 **OR** 3	Demonstrates minimal interest in the impact of the contextual factors on the illness experience, or cuts the patient off. The following is the type of statement that a Non Certificant may make: **"Be a daughter and suck it up."**

4. MANAGEMENT: CAREGIVER BURNOUT

Plan	Finding Common Ground
1. Validate the patient's concerns, identifying the problem as caregiver burnout/stress. **2. Support the patient in creating a plan to deal with the immediate situation/advocate for the patient.** **3. Offer supportive counselling/ follow-up for her stress.** **4. Discuss or offer to discuss long-term strategies for the mother's care.**	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 not cover points 1, 2, and 3.	Does not involve the patient in the development of a plan.

5. MANAGEMENT: HEADACHES

Plan	Finding Common Ground
1. Identify that these are migraine headaches. **2. Offer/discuss an alternative migraine therapy.** **3. Discuss prophylactic medications.** **4. Discuss the need or the lack of a need to investigate the headaches further.**	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.