THE COLLEGE OF FAMILY PHYSICIANS OF CANADA

LE COLLÈGE DES MÉDECINS DE FAMILLE DU CANADA

Certification Examination in Family Medicine

Overview of Simulated Office Oral (SOO) Structure and Marking

Updated June 2023

The College of Family Physicians of Canada
Certification Examination in Family Medicine

Introduction

The two components of the Certification Examination in Family Medicine are, together, designed to evaluate a representative sampling of the diverse knowledge, attitudes, and skills required by practising family physicians as set out in the Assessment Objectives for Certification in Family Medicine.

The short-answer management problem (SAMP) component assesses candidates' medical knowledge, problem-solving skills, and clinical reasoning. The simulated office oral (SOO) component assesses how a candidate establishes and uses the patient-centred method to care for patients in an office setting.

The College believes a patient centred approach using the patient centred clinical method[*] to providing clinical care helps patients more effectively. The SOOs marking scheme is based on the patient-centred clinical method (PCCM)developed by the Centre for Studies in Family Medicine at the Western University. The essential principle of the PCCM is integrating a traditional condition-oriented approach (e.g., understanding a patient's condition through effective history-taking, understanding pathophysiology, recognizing clinical presentation patterns, making a diagnosis, and knowing how to manage the identified condition) with an appreciation of the illness the health-issue creates (e.g., what does the disease's clinical aspects mean to the patient, what is the patient's emotional response to their illness, what is the patient's understanding of the health issue they are concerned about, and how is the health issue is affecting their life). Integrating the disease/condition with an understanding of the person living with the illness—through the act of interviewing, communicating, problem solving, and negotiating disease management-—is fundamental to the patient-centred approach.

While important, the emphasis of the SOO is **not** just on a candidate's ability to appropriately diagnose and manage a clinical scenario, but to explore patients' feelings, ideas, and expectations about the situation the health-issue is causing or contributing to and to determine the effect on their functional abilities. Candidates are scored on how they conduct the interview to both forge a connection with the patient and actively involve the patient in deciding a mutually acceptable management plan. The SOO cases reflect a variety of clinical situations, but all require PCCM communication skills to understand patients as individuals with unique illness experiences and to work with them to find the best next steps to effectively deal with the health issues presented.

The following Appendices will be of interest to all examiners:

Appendix 1: Standardized Instructions to Candidates

Appendix :2 Ten CFPC Preparation Pointers for Examiners

Appendix 3: Distinguishing a certificate-level from a superior-level performance: Exploration of the illness experience

RATIONALE FOR SIMULATED OFFICE ORAL EXAMINATION #

[*] Stewart M, Brown JB, Weston W, McWhinney I, McWilliam C, Freeman T, eds. *Patient-Centered Medicine: Transforming the Clinical Method*. 3rd ed. London: Radcliffe Publishing; 2014.

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 candidate will view the following statement:

THE PATIENT

You are about to meet **Mr. HENRY BROOKS**, age 29, who is new to your practice.

CASE DESCRIPTION

Introduction

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 problems

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.

Surgical 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.

Pertinent laboratory results

None.

Allergies

None known.

Immunizations

Up to date.

Lifestyle issues

- Tobacco: You smoke one pack of cigarettes a day for the last eight years.
- Alcohol: You drink a couple of beers a month.
- Caffeine: Other than the 12 ounces of coffee when you wake up, you don’t drink caffeinated beverages.
- Cannabis: None currently

- Recreational and/or other substances: 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.

- Diet: Regular North American diet

- Exercise and recreation habits: 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

- **Family of Origin**

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.

- **Marriage/Partnerships**

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.

- **Children**

You have no children.

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.

Finances

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".

Religion: Anglican, but you rarely attend.

ACTING INSTRUCTIONS

You are dressed simply in 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. You may make them up if needed.

HENRY BROOKS: The patient, age 29, who is an engineer and believes an electronic chip, has been implanted in his head.

HARRY BROOKS: Henry's father, age 65.

MARY WIGGINS BROOKS: Henry's mother, age 60.

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.

Examiner Interview Flow Sheet - Prompts

Initial statement	**"I'm having terrible headaches."**
10 minutes remaining* Optional, use only if you feel it's needed	If the candidate has not brought up the issue of the schizophrenia, the following prompt is to be used: **"I'm sure it's that lousy chip in my head that's the problem."**
7 minutes remaining* Optional, use only if you feel it's needed	If the candidate seems to have forgotten about the headachest, the following prompt is to be used: **"These headaches are really messing up my life."** (This prompt is often not necessary.)
0 minutes remaining	**"Your time is up."**

* To avoid interfering with the flow of the interview, remember that the seven- and 10-minutes remaining prompts are optional. To avoid interrupting the candidate in mid-sentence or disrupting their reasoning process, delaying the delivery of these prompts is acceptable.

Note:

During the last three minutes of the interview, you may only provide information 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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Session

Simulated Office Oral

Marking Scheme

NOTE: To cover a particular area, the candidate must address at least 50 per cent of the bullet points listed under each numbered point in the left-hand box on the marking scheme.

1. Identification: Cluster Headaches

Issue #1	Illness Experience
Areas to be covered include: 1. history of 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).	**Description of the patient's illness experience**. You are fed up with the headaches and believe that the chip is what is causing them. You are missing work because of the headaches, and you are hoping that the doctor will be able to remove the chip.

		Determining the patient's illness experience is **not** a checklist assessment where a candidate asks about the patient's feelings, ideas, functioning, and expectations and should two or three of these four be asked aloud, a pass is then awarded. A certificate level illness experience performance is where the candidate gathers the patient's illness experience conversationally and integrates the knowledge gained in a way that communicates to the patient that this candidate is

		working to see the patient as a unique person with an illness, more than just a textbook disease process to be appropriately managed.
Superior Level	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.
Certificate Level	Covers points 1, 2, and 3.	Learns about the illness experience arriving at a **satisfactory** understanding of it. This is achieved by asking appropriate questions and using non-verbal skills.
Non-Certificate Level	Does **not** cover points 1, 2, and 3.	Demonstrates minimal interest in the illness experience, focusing mainly on the disease process, and so gains **little** understanding of the illness experience. There is little acknowledgement of the patient's verbal or non-verbal cues, or the candidate often cuts the patient off.

2. Identification: Paranoid Schizophrenia

Issue #2	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 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 if psychiatric disease. • No systemic symptoms. 4. no risk that he will try to remove the chip himself.	**Description of the patient's illness experience.** You are anxious and somewhat angry because you believe the chip is causing the voices. Although you know it sounds crazy, you think you are under the influence of your former boss, and this is impacting your ability to work. Consequently, you are becoming progressively isolated socially, and you are not getting any pleasure out of your hobbies. Since doctors have been harmful to you in the past, you don't know how much you can expect from this visit with the FP.

		Determining the patient's illness experience is **not** a checklist assessment where a candidate asks about the patient's feelings, ideas, functioning, and expectations and should two or three of these four be asked aloud, a pass is then awarded. A certificate level illness experience performance is where the candidate gathers the patient's illness experience conversationally and integrates the knowledge gained in a way that communicates to the patient that this candidate is working to see the patient as a unique person with an illness, more than just a textbook disease process to be appropriately managed.

Superior Level	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.
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Non-Certificate Level	Does **not** cover points 1, 2, and 3.	Demonstrates minimal interest in the illness experience, focusing mainly on the disease process, and so gains **little** understanding of the illness experience. There is little acknowledgement of the patient's verbal or non-verbal cues, or the candidate often 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. social factors/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 empathic 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 an example of a statement a superior level candidate may make: "Everything that seems to have happened in your life and at work 4 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 Level	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.
Certificate Level	Covers points 1, 2, and 3.	Demonstrates recognition of the impact of the contextual factors on the illness experience.
Non-Certificate Level	Does **not** cover points 1, 2, and 3.	Demonstrates minimal interest in the impact of the contextual factors on the illness experience or often cuts the patient off.

4. Management: Cluster Headaches

Plan for Issue #1	Finding Common Ground
Areas to be covered include: 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 crisis).	Behaviours indicating efforts to find common ground go beyond the candidate asking "Any questions?" after a management plan is presented. Finding common ground is demonstrated by the candidate encouraging patient discussion, providing the patient with opportunities to ask questions at multiple points, encouraging the patient to express their thoughts, seeking clarification, checking for consensus, and recognizing then addressing patient hesitation or disagreement if it arises. Examiners need to determine the candidate's ability to find common ground based on behaviours they demonstrate during the interview.

Superior Level	Covers points 1, 2, 3, and 4.	Actively asks about the patient's ideas and wishes for management. Purposefully involves the patient in the development of a plan and seeks his or her feedback about it. Encourages the patient's full participation in decision-making.
Certificate Level	Covers points 1, 2, and 3.	Involves the patient in the development of a plan. Demonstrates flexibility.
Non-Certificate Level	Does **not** cover points 1, 2, and 3.	Does **not** involve the patient in the development of a plan. Only asks the patient "any questions" after a management plan is presented without doing more to involve the patient.

5. Management: Paranoia

Plan for issue #2	Finding Common Ground
Areas to be covered include: 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 overtime 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 indicating efforts to find common ground go beyond the candidate asking "Any questions?" after a management plan is presented. Finding common ground is demonstrated by the candidate encouraging patient discussion, providing the patient with opportunities to ask questions at multiple points, encouraging the patient to express their thoughts, seeking clarification, checking for consensus, and recognizing then addressing patient hesitation or disagreement if it arises. Examiners need to determine the candidate's ability to find common ground based on behaviours they demonstrate during the interview.

Superior Level	Covers points 1, 2, 3, and 4.	Actively asks about the patient's ideas and wishes for management. Purposefully involves the patient in the development of a plan and seeks his or her feedback about it. Encourages the patient's full participation in decision making.
Certificate Level	Covers points 1, 2, and 3.	Involves the patient in the development of a plan. Demonstrates flexibility.
Non-Certificate Level	Does **not** cover points 1, 2, and 3.	Does **not** involve the patient in the development of a plan.

6. Interview process and organization

The previous scoring components address specific components of the interview. However, assessing the candidate's interview technique as an integrated whole is also important. The entire encounter should resonate with a sense of structure and timing, and the candidate should always be employing a patient-centred approach.

The following are certificate-level techniques applicable to your experience of the entire interview:

- Good direction with a sense of order and structure
- A conversational rather than interrogative tone or presenting many questions to the patient in checklist-style.
- Flexibility and good integration of all components and stages of the interview; the interview should not be piecemeal or choppy.
- Appropriate prioritization, with an efficient and effective allotment of time for the various interview components.

Superior Level	Demonstrates advanced ability in conducting an integrated interview with clear evidence of a beginning, a 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.
Certificate Level	Demonstrates average ability in conducting an integrated interview. Has a good sense of order, conversation, and flexibility. Uses time efficiently.
Non-Certificate Level	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.

Appendix 1 Standardized Instructions to Candidates

1. **Format**
   Although the patient/examiner encounter occurs virtually, the SOO is designed to be a **simulated office situation** in which an examiner will play the part of the patient seeing you, the doctor, in your office. There will be an opening statement and you are expected to manage the interview from then on. You do **not** perform a physical examination as part of the encounter.

2. **Scoring**
   You will be scored by the examiner according to specific criteria established for each case. Do not ask the examiner for information about your marks or performance, and do not speak to them out of their role.

3. **Timing**
   Each SOO station lasts 28 minutes broken down to 1 minute of reading time, 15 minutes for your visit with the patient, and 12 minutes of waiting time which the examiner will use for marking. During the SOO examination, timing is shown by two countdown clocks. The station countdown clock in the blue bar at the top of the screen starts at 28 minutes and counts down time remaining for all the components of the station combined. The time in the segment countdown clock in the yellow bar changes depending on which of the three sections of the station you are in.

   Before the examination starts, you will be placed in a setting where the examination will occur, but the clocks will not be active. During this pre-examination waiting time, your identification will be checked, and the proctor will ensure your microphone and camera works.

   The first SOO station starts when the segment countdown clock in the yellow bar appears saying **READING TIME**. You have **one minute** to review the provided patient information. At the second and subsequent stations, the READING TIME in the yellow bar starts automatically when you are transferred to the next SOO station.

   Following READING TIME, **ASSESSMENT TIME** starts in the segment countdown clock in yellow bar, and you will have 15 minutes to manage the interview. No verbal or visual warnings of time remaining are given (e.g., at the three-minute mark). It is a misconception that discussion with the patient to find common ground on a management approach must only occur in the last three minutes of the encounter. The encounter stops at the 15-minute mark, even if you are in mid-sentence.

   The yellow bar then changes to **MARKING TIME** but there isn't a countdown clock for this segment. Marking time is a rest period for you. If, for example, you start a SOO station five minutes late, the station clock in the blue bar will show that seven minutes are left once you get to the marking time segment.

Appendix 2 CFPC Preparation Pointers for Examiners

1. The first rule for successful acting is to put yourself into the mindset of the person you are role-playing. You have been around patients long enough to have a fairly good idea of how they speak, behave, and dress.

Think of the following:

- The defensiveness and reticence of a patient living with alcohol use disorder
- The potential embarrassment of someone living with a very difficult partner
- The anxiety of a person living with a terminal illness
- The shyness of a young teenager with a sexual-related concern

Once you receive your SOO script, think about the following:

- Initially, how is this type of patient going to react to a new physician?
    - Will the patient be open, shy, defensive, etc.?
- How articulate will a person of their education level and background be?
    - What jargon, expressions, and body language will the patient use?
- What will the patient's reactions be to questions a new physician asks?
    - Will the patient be angry when alcohol use is brought up?
    - Will the patient display reticence when questions about family relationships are asked?

2. Allow the candidate to conduct an interview to determine what's going on. The SOO is set up for you to share one or more specific cues to help focus the candidate. Find the right balance between initially oversharing information and being too restrictive. You can predict the first few questions you will be asked so you plan your responses.

    You have all been through this exam yourselves. It is normal to feel for the nervous candidate sitting in front of you. But this exam is the result of years of experience on the part of the College, and the cues you are given are enough for the average candidate to realize what the issues in the case are. If the candidate still has not caught on after the cues you have given as instructed in the case script, that is the candidate's issue, not yours. Do not give away too much after that.

3. If you feel a candidate is having language difficulties during the SOO, do not act or speak differently than you would with any other candidate. Be aware that this candidate may miss subtle verbal cues laid out in your SOO script. However, this candidate would be at high risk of missing these verbal cues in their own offices. All candidates need to be exposed a standardized which is portrayed similarly to all. Feel free to note any communication-related or language-difficulties you observe in the comments section of the score sheet.

4. Occasionally a candidate will get off on a tangent or onto a completely unproductive line of questioning. During this exam you must walk the fine line of not giving away too much, but also of not leading the candidate down a completely inappropriate path of inquiry. Time is limited. If a candidate begins a completely unproductive line of questioning, answer "No" (or find another appropriate way). This should help prevent the candidate from wasting several valuable minutes

on tangents not in the script.

5. Do not overact.

6. You will notice there will be some candidates with whom you feel comfortable, some with whom you feel less comfortable, some who conduct the interview the way you would have, and others who conduct the interview in a different way. We ask that you mark each candidate as objectively as possible, using the marking sheet anchor statements to guide your assessments.

7. The suggested prompts after the opening statement are optional. Give a prompt if you feel it is warranted (i.e., the information hasn't come up in discussion already). If you think of it later than suggested, but still feel it's needed, give the prompt then.

8. Pay attention to the clothing and acting instructions in the SOO script. A change that seems minor to you, such as wearing a long-sleeved shirt instead of the specified short sleeves, has a way of changing the whole atmosphere of the encounter for candidates.

9. In the last three minutes of the examination, you should not volunteer any new information. You can certainly provide it if asked directly but limit your responses to direct answers or clarifications.

10. If the candidate clearly finishes before the 15 minutes are up, do not offer any more information or inform the candidate there is time left, but answer if any additional questions are asked before the end of the Assessment time. Once the Marking time starts, cover up your camera and mute your microphone.

11. Remember to follow the script and assist the College by clearly and adequately documenting important details and comments in marking sheet.

Appendix 3 Distinguishing a Certificant-level from a Superior-level Performance: Exploration of the Illness Experience

A **certificate-level performance** must include gathering information about the illness experience to gain an acceptable understanding of the patient and their issues (acceptable to the patient/examiner).

A **superior-level performance** is not simply a matter of a candidate obtaining more or almost all the information. A superior candidate must actively explore the illness experience and demonstrate an in-depth understanding of it. A superior performance is achieved through the skillful use of communication skills notably the demonstration of: (1) excellent verbal and non-verbal techniques (2) use of effective questioning, and (3) impressive active listening that encourages patient-physician trust and the patient telling their full story.

The material below is adapted from the CFPC's Assessment Objectives for Certification in Family Medicine. The table below is intended to be a guide to assist evaluators in determining whether a candidate's communication skills reflect a certificate, superior, or non-certificate level performance. A certificate level candidate displays enough to gain an acceptable understanding, a superior candidate demonstrates all these aspects, while a non-certificate level demonstrates few or none of these aspects and fails to achieve an acceptable understanding of the patient and their issues.

Listening Skills	**Cultural and Age Appropriateness**
Uses both general and active listening skills to facilitate communication. Sample behaviours • Allows time for appropriate silences • Feeds back to the patient what the candidate thinks has been understood from the patient • Responds to cues (doesn't carry on questioning on unrelated topics without acknowledging the patient if a major life or situation change is revealed) • Clarifies jargon the patient uses	Adapts communication to the individual patient for reasons such as culture, age, and disability. Sample behaviours • Adapts their communication style to the patient's disability (e.g., writes for patients with hearing challenges) • Speaks at a volume appropriate for the patient's hearing • Identifies and adapts their manner to the patient according to the patient's culture • Chooses appropriate medical terminology for each patient (e.g., "pee" rather than "void" for children)
Non-Verbal Skills Expressive • Is conscious of the impact of body language on communication and adjusts it appropriately Sample behaviours • Ensures eye contact is appropriate for the patient's culture and comfort • Is focused on the conversation • Adjusts demeanour to ensure it is appropriate to the patient's context	**Language Skills** Verbal • Has skills that are adequate for the patient to understand what is being said • Converses at a level appropriate for the patient's age and educational level • Uses an appropriate tone for the situation, to ensure good communication and patient comfort Sample behaviours

• Ensures physical contact is appropriate for the patient's comfort Receptive • Is 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 (e.g., shows appropriate empathy for the patient) • Verbally checks the significance of body language/actions/behaviour (e.g., "You seem nervous/upset/uncertain/in pain")	• Asks open- and closed-ended question appropriately • Checks with the patient to ensure understanding (e.g., "Am I understanding you correctly?") • Facilitates the patient's 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

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