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[1] 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 #

[1] 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. suffering from chronic obstructive pulmonary disease, COPD

2. being financially abused by her daughter

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 Ms. **IRENE BOUCHARD**, age 55, who is new to your practice.

CASE DESCRIPTION

Introduction

You are Ms. IRENE BOUCHARD, a 55-year-old woman, who has been working as a housekeeper for your entire adult life. You are visiting the physician today because you are getting shorter of breath when you work and when you climb stairs. This is your first visit to a family physician in many years.

History of the problems

SHORTNESS OF BREATH (COPD)

You currently work as a housekeeper in other people's homes. Every week you visit five or six different residences, where you do the cleaning and the laundry. Your work is physical. It involves scrubbing, vacuuming, carrying laundry baskets, and ironing. Most of the houses you visit have stairs. Gradually, over the past two years, you have found that you get short of breath when you climb stairs or when you exert yourself. It seems to be getting worse. Two weeks ago, Ms. Lalonde, one of your employers, noticed that you had to stop halfway up the staircase to catch your breath. She asked you if you had seen a doctor recently. When you said you had not, she offered to make this appointment for you. Ms. Lalonde has been one of your regular employers for the past 10 years. She has "always been kind".

It is the first time you have seen a family physician by appointment in over five years. You really haven't had time to look after yourself. Most days are spent running from one house to another. If you take a day off, it means no income that day, and you really do need to work regularly to make ends meet. The last time you went to a walk-in clinic was for a "bad cold" with a fever. This was about eight months ago ("e.g., last fall"). The doctor gave you antibiotics and suggested that you stop smoking. The cold got better, and you did try to cut down on your smoking. You were smoking 1 1/2 packs per day at that time, and you now smoke about 10 to 15 per day. It is a rare employer who lets you smoke in the house these days. This has contributed to your decrease in smoking.

You would say that you used to get the same number of colds as other people, "maybe four or five a year". In the past year or two they seem to be getting worse.

You bring up more phlegm and the cough lingers on longer. The one you had eight months ago was particularly bad because you had a fever, and you were bringing up a lot of yellow phlegm.

The shortness of breath has been creeping up on you. At first you felt that it was normal to be a bit winded as you get older, but now you recognize that you are more winded than most people your age. On the other hand, you only cough when you first wake up, and this pattern has not changed. You usually cough up a bit of yellow phlegm in the morning, but it is not a large quantity. You have no blood in your sputum, no fever, and no weight loss. You sleep well at night with one pillow and without waking up short of breath. You are not short of breath when walking on flat surfaces, unless you try to run or walk quickly (running for a bus).

You have never had asthma as a child or as an adult, and you do not hear yourself wheezing. You have no chest pain at rest or with effort. You do not feel your heart race or beat irregularly. You had a

symptom-free menopause five years ago and have had no vaginal bleeding since then. You have noticed no blood in your stool or urine, and you have not been told that you are pale.

You do worry that there may be something wrong with your lungs. All kinds of ideas go through your head. “I have always been a hard worker. Maybe I am just getting tired out.” “Maybe the smoking is catching up with me.” “Could this be cancer?” The decline has been gradual, though. You have noticed that you have slowly been getting shorter of breath.

You expect the physician to tell you to stop smoking. You are not sure that you can, especially “right now when you are so stressed”. (This could be a clue to the second problem.)

ABUSE BY DAUGHTER

When you were 18 years old, you had a boyfriend named Jimmy. To make a long story short, you got pregnant, and Jimmy disappeared. Your parents were not at all pleased, but they let you stay at home until your daughter, **ISABELLE**, was born. You then left home and found a small apartment where you raised Isabelle on your own, with some help from your parents. At first you were on welfare, but when Isabelle was old enough to go to school, you started to go out to people’s homes to do some cleaning and to get some extra money. For a while this was done “under the table”, but after a few years you were earning enough money that you were able to get off welfare. This has been your employment on a steady basis since you were 28 and Isabelle was 10.

Isabelle was always a strong-willed child. She tested the limits at every possibility. You disciplined her as best you could, but you had no experience with child raising.

You had no steady boyfriend or partner. Your parents were really not too interested in you, or Isabelle and you ended up having less and less contact with them. You were living in a part of town that was a bit rough, and Isabelle’s school was a breeding ground for drugs and gang activities. She attached herself to the “wrong crowd”, and you didn’t know what to do about it other than to lecture her every night. When she was 16, she was failing in school and (you were fairly sure) taking drugs. You had never taken drugs yourself, and you had no idea what to expect or how to deal with it. Soon after her 17th birthday, she left a note on the table saying that she was tired of listening to you and that she was leaving town with her boyfriend. You contacted the school and the police, but they did not track her down and she disappeared from your life completely.

This was devastating for you. You loved your daughter and you felt that you should have done a better job of protecting her. The truth was that she was drifting away from you throughout her adolescent years, and you were powerless to stop it. You had a few friends in the neighbourhood whom you could talk to. None of them seemed surprised that she had taken off, and some even told you that you were better off without her. They told you that you were only 35 and that you could start over. “It would be easier to find a man if you didn’t have a daughter in the house.” The truth was, though, that you really had no interest in starting a relationship. You were distrustful of men and happier living on your own. You maintained your friendships and your cleaning jobs, but you did not look for anyone with whom to share your life.

Six months ago, the 37-year-old Isabelle suddenly reappeared at your door. She said that she needed a place to stay and some money. You took her in immediately. She looked like she had been through some

hard times. She was thin, nervous, and seemed both tired and frightened. She gradually told you about her life. She had been heavily involved in drugs – especially heroin – and had been working as a prostitute in another town in order to get money for drugs. She had come back to try to get clean. She told you that she had been off drugs for several months, and just needed to get a fresh start. On the one hand, you were pleased to see Isabelle again and relieved to see that she was still alive. She told you that she had never had a lasting relationship and had never had a child. (You are not a grandmother.) On the other hand, you were a little frightened by the way she looked and by the stories she was telling you. Nevertheless, you took her in and started looking after her. She said that she had absolutely no money, and that she would need some cash to get clothes and to try to find a job. You gave her $500 from your savings.

Your jobs kept you out of the house most of the day. Isabelle told you that she was out looking for work. For a month things were fairly good. You had occasional arguments about little things. Isabelle seemed to "fly off the handle" easily. During the second month you were more suspicious about her efforts to find work. She was asleep when you left the apartment and was still in bed on a few occasions when you came home at the end of the day. She was going out in the evenings and coming back after you were asleep. She kept "borrowing" money. You told her that you did not have a lot of savings, and that you needed your money to make ends meet, but she promised to return it and yelled at you for being selfish. She was becoming more and more verbally abusive. Last week she said, "You should give me your money, you bitch! You did nothing for me when I was a kid." She said you were "worthless". "A maid for rich people." You kept giving her what money you had after these arguments. Frankly, you are getting frightened. You want her to leave. You suspect that she is taking drugs again. You suspect she is prostituting herself. You have noticed that money had been taken from your purse. Yesterday you told her that you didn't have any money to spare. "You should get a job soon, Isabelle, and find a place of your own." Isabelle screamed at you. She called you a worthless bitch and threw a chair against the wall before storming out. She was back home, asleep, when you left to go to the doctor's appointment today.

So far, your neighbours have not been involved. You have had no fights in the doorway. You have been able to keep the problem "within the family." Your friends in the neighbourhood were as surprised as you were that Isabelle showed up again "out of the blue", but they assume that you are happy to have her back with you. Isabelle has not brought strangers home with her. You have not found any drugs or needles in your apartment.

You are frightened and feel guilty. You feel that you should help your daughter, but at the same time you do not have a lot of money and you are not sure what she is doing with it. Her outbursts are violent, and although you have not been physically harmed, you are worried.

Medical history: No regular medical care as an adult. Occasional visit to walk-in clinics with minor problems. No PAP tests since post-partum period.
G1P1A0. Spontaneous vaginal delivery.

Surgical history: None.

Medications: None.

Pertinent laboratory results: None

Allergies: None known.

Immunizations: You had "your shots" in school.

Lifestyle issues

- Tobacco: For the past eight months you smoked about 10 to 15 cigarettes per day. You smoked 1 ½ packs per day before that. You began smoking at age 16.
- Alcohol: Rare beer at a friend's home.
- Caffeine: A coffee in the morning
- Cannabis: None
- Recreational and/or other substances: None.
- Diet: Standard North American diet.
- Exercise and recreation habits: You enjoy watching television.

Family history

You have not been close to your parents although they lived in the same town. You mother died last year of a heart attack. She was 75 years old. Your father died three years ago of emphysema. He was 72 years old.

Personal history

- Family of Origin: Your childhood was uneventful. Your father worked in a factory in this town, and your mother was a grocery clerk. Your relationship with your family chilled when you got pregnant.
- Marriage/Partnerships: You have had a few boyfriends over the years, but never met anyone who wanted to stay with you. You pretty much gave up on dating by the time you were 40.
- Children: You have a daughter, Isabelle Bouchard, age 37.

Education and work history

You were never good in school. You dropped out when you were sixteen, without a high school diploma. You were living at home at that time and took a number of odd jobs to get spending money. You met Jimmy when you were 18 and dated him briefly.

Finances

Your income comes in cash payments from your house cleaning jobs. Finances are always tight, and you do not have a lot of money saved. If a candidate asks you for figures, you could say that you get $400 in a good week. You can pay rent, utilities, groceries, cigarettes, etc. but that there is not a lot left over at the end of the month. If the candidate begins to ask about finances before Isabelle is being discussed, this would serve as a means to bring up the second of your problems.

Social supports

You have a few close female friends in the neighbourhood. You will visit with them from time to time. Sometimes you will go to bingo with them. You would be embarrassed to talk about the situation with your daughter.

Religion: You do not practise any religion.

ACTING INSTRUCTIONS

You are dressed very simply in inexpensive clothing. You have no jewellery or make-up. You should remember that you dropped out of high school. Your level of education should be reflected in your speech: simple words, short phrases, and slang. Be prepared to appear confused by the candidate who uses elevated language or medical terms.

You are here to see a doctor for the first time in a long while. You are concerned about your increasing shortness of breath. Although you are not sure of exactly why it is happening, you expect that it is related to your smoking (**IDEAS**). You are worried about it (**FEELINGS**). It is beginning to affect your ability to work, which is a concern for the future. If you can't work, you would have to go back on welfare, and it would be very hard for you to pay your rent (**FUNCTION**). You would expect that the doctor will examine you, perhaps send you for a chest X-ray, and certainly tell you to stop smoking (**EXPECTATIONS**). You would listen politely to smoking advice, but you would not agree to stopping at this time. On the other hand, you are hoping that it is not too late to cure whatever is happening. If asked if you know about smoking cessation aids, you would say that you haven't paid too much attention to the TV commercials.

The situation at home is both the second problem and an important part of the context. Your daughter frightens you. Will she harm you physically? (FEELINGS) You suspect that she is taking drugs and that she is taking advantage of you (IDEAS), but you would be reluctant to say this out loud. She is your daughter, after all, and you are conflicted. Maybe you do owe her something. Maybe you were a bad mother. It is not yet affecting your FUNCTION, but you are concerned that you will be short of money at the end of the month. You have no expectations of the doctor at this visit. Your second prompt is about money being tight. The candidate should then ask you why. You should then volunteer that your daughter has been borrowing money. "Why?" "She doesn't have a job right now." Then your responses to subsequent questions should gradually reveal the rest of her history. The candidate has to get it from you with sensitive questioning. For example: "What was her job before?" "Well, we lost touch with each other, but I don't think she really had a job recently." "You lost touch?" "Yes, Isabelle left home when she was 17 and she just came back." Etc.

Although this patient is only 55 years old, the scenario should allow the candidate to demonstrate that he or she recognises the dynamics of elder abuse. They should see that you are an easy victim who feels trapped and powerless in a dangerous situation. It is important for marking the management of the abuse that you have a clear answer if the candidate asks you if you are willing to call the police or leave the apartment if you feel threatened. If they outline the plan without asking you clearly if you feel you could call the police or leave, you would just nod politely. If they really do explore whether you have the strength to do it, you would say that you can't imagine calling the police on your own daughter and you would be embarrassed to go to a neighbour.

Cast of Characters

The candidate is unlikely to ask for other characters' names. You may make them up if needed.

IRENE BOUCHARD:	The patient, age 55
ISABELLE BOUCHARD:	Your daughter, age 37

Timeline

Today:	Appointment with the candidate.
Yesterday:	Isabelle threw a chair against the wall.
4 months ago:	Isabelle became more verbally abusive.
6 months ago:	Isabelle reappeared.
8 months ago:	Took antibiotics for a "bad cold".
20 years ago:	Isabelle left home at age 17. You were 35.
37 years ago:	You got pregnant at age 18.
55 years ago:	You were born.

Examiner Interview Flow Sheet - Prompts

Initial statement	"**I am getting short of breath climbing the stairs**."
10 minutes remaining* Optional, use only if you feel it's needed	If the candidate has not brought up the issue of the problems with the daughter, the following prompt is to be used: "**I need to keep working. Money is tight**."
7 minutes remaining* Optional, use only if you feel it's needed	If the candidate seems to have forgotten about the shortness of breath, the following prompt is to be used: "**Do you think I will be able to keep working**?" (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: COPD

Issue #1	Illness Experience
Areas to be covered include: 1. history: • Began over the past two years. • Productive AM cough. • Gradual onset. • Yellow sputum. 2. smoking/lung history: • Began smoking in teens. • Smokes 10 to 15 a day. • Smoked more in the past. • One episode of a bad cold needing antibiotics about eight months ago. 3. ruling out other causes of dyspnoea: • No chest pain. • No shortness of breath at night. • No history of asthma. • No weight loss. • No haemoptysis. 4. not ready to stop smoking at this time (pre-contemplative).	**Description of the patient's illness experience**. You are worried that you might have cancer. You have had to slow down at work. You expect that the FP will request an X-ray.

		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: Abuse by Daughter

Issue #2	Illness Experience
Areas to be covered include: 1. daughter's past history: • Disappearance as a teenager. • Drug abuse. • Prostitution. • Daughter has no current partner. 2. financial abuse: • Demanding money. • Daughter disappearing at night. • Not obviously looking for work. • Money missing from purse. 3. escalating abuse: • Denigrating the patient. • Yelling at her. • Threw a chair. • No overt homicidal threats. 4. has not confided in friends or clients.	**Description of the patient's illness experience.** You are afraid because of your daughter's behaviour, yet you feel guilty for wanting her to leave. Thus far, the abuse hasn't had any impact on your function, but you might be short on money if this continues. You do not have any expectations about this issue during the 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.
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		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 situation: • Isabelle is the only child. • Single mother. • No current partner. • No grandchildren. 2. work history: • Works as a maid. • A number of employers. • Was on welfare when raising Isabelle. • Makes only enough money to pay rent and necessities. 3. supports: • A few friends. • Mrs. Lalonde (employer). • No family support (no living relatives). • No support from Isabelle's father. 4. would have no one to care for her if she were to become ill.	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: "This must be difficult for you because this indiscretion is affecting the most important things in your life: your family, your faith, your self-respect and your church."

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: COPD

Plan for Issue #1	Finding Common Ground
Areas to be covered include: 1) Identify the problem as possible damage to the lungs (COPD or chronic bronchitis, in understandable terms). 2) Arrange for a physical examination. 3) Arrange for testing, including both chest radiograph and spirometry. 4) Reviews options for smoking cessation for her future consideration.	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: Abuse by Daughter

Plan for issue #2	Finding Common Ground
Areas to be covered include: 1) State that you are concerned for her safety. 2) Offer community resources for her (social services, elder abuse services, etc.). 3) Outline a plan if patient is threatened (e.g., calling the police, leaving the apartment). 4) Assess her willingness to act on the plan (e.g., calling the police, leaving the apartment).	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.

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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 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	**Cultural and Age Appropriateness** 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	**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

• Is focused on the conversation • Adjusts demeanour to ensure it is appropriate to the patient's context • 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")	• Uses an appropriate tone for the situation, to ensure good communication and patient comfort Sample behaviours • 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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