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. grief secondary to her husband’s death

2. diabetes

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**. JANE WEBBER**, age 62, who is new to your practice.

CASE DESCRIPTION

Introduction

You are Ms. JANE WEBBER, age 62. Your husband, a retired farmer, died five months ago and your four children insisted you see a physician because they are worried about you. They think you are depressed and aren't coping with your husband's death. You do not really think there is anything wrong.

You have also noticed that controlling your diabetes has been a lot more difficult over the past few months. Your last check was about eight months ago. Over the past several months your blood sugar measurements have fluctuated a lot. They range from the low 4s to over 12, and occasionally you have a reading as high as 15 or 16.

You have not been back to see your family physician (FP) since your husband died. You both had been his patient for many years and you haven't felt you could go to see him. You are not upset with him; you just feel that his office is one more place that reminds you of your husband.

History of the problem

HUSBAND'S DEATH

Your husband, **WILLIAM**, died five months ago. He was 70. He had had diabetes and heart problems for many years. He had a by-pass operation six years ago. Unfortunately, it helped for only a brief period before he began having problems again. The physician said that a second surgery would not improve his heart function and that his problems would have to be managed with medication. Three weeks before he died, he was admitted to hospital for emergency surgery for his bowel. He apparently perforated a diverticulum. The surgery went fine, but after being in hospital for about 10 days, he had a small heart attack and then got pneumonia. Subsequently he had to be admitted to the intensive care unit and put on a ventilator. After three days there the physician thought his condition was unlikely to improve. You and your children decided to stop treatment and he died the next day.

Your husband's death seems very sudden to you. While he had had a heart problem and been slowing down over the past few years, the last three weeks of his life seemed to happen overnight and completely out of the blue.

You know you made the right decision about his care. The two of you had talked about what you would want if something serious ever happened, and he said he wouldn't want to be kept alive by a machine. You know that the people at the hospital did everything they could for your husband, and you felt that the staff was very supportive when you decided to stop life support.

You are still sad about your husband's death and think about him all the time; everywhere you look there are reminders of him. Since his death you feel there is a gaping hole in your life. The two of you had been married for 42 years. You had four children together and were very happy. You miss him terribly. You often think about how you have to tell him something, and then remember that he isn't here anymore.

At the same time, you are trying to move forward. You are not angry about your husband's death. You are planning your garden and perhaps some landscaping. You have always enjoyed doing this and it does give you something else to think about.

You find that the evenings are the most difficult time. The two of you would have supper and then talk about your day and enjoy each other's company. This is now the time your children usually call to see how you are doing. This is the most difficult thing you have to do. You feel so sad that they have lost their father and that your grandchildren will not have the chance to know him. This knowledge often brings you to tears, even if you have been having a good day. You know this upsets your children and you try very hard not to cry, but your efforts don't seem to do much good. It is because of this they wanted you to see a physician. They think that you are depressed and need to "do something to get better".

For the most part, you sleep relatively well. Sometimes if you wake up at night you take a while to fall asleep again, but generally you feel rested when you get up. You are not having nightmares or flashbacks about your husband or his death. You still enjoy working in your yard and planning your garden, but things do seem empty without William. He was the one with whom you discussed the spring each year. You feel sad when you think about the loss you and your family have had, but still enjoy others' company. However, your relationship with some friends seems to have changed since your husband's death. You and William were active in service clubs (Kiwanis, 4-H) in town and regularly got together with other couples. This was generally at William's instigation. He was the outgoing one; you went with him and enjoyed yourself, but would have been just as content to stay at home. You have been out to see friends a few times, but this feels uncomfortable as he really held your social life together. You had always been part of a couple and your friends seem uncomfortable with having just you along. One couple you know, **EVA** and **GEORGE**, came to visit and brought another man along so "George would have someone to talk to". You had always thought you and George had good conversations.

You would describe your appetite as fair. You do not feel guilty about trying to move forward. You know your husband would want you to keep living your life. Your concentration is fine. You have no previous history of depression or mania. You have no thoughts of self-harm or suicide.

You have not seen a counselor. You have been coping well as the executrix of your husband's will.

You expect the candidate to agree that all your feelings are quite normal for a woman who has just lost her husband.

POORLY CONTROLLED DIABETES

You were diagnosed with diabetes seven years ago. You had been in for a check-up and your FP tested your blood sugar. This diagnosis was very worrying for you as all your older brothers, **ETHAN**, age 72, **ALEXANDER**, age 70, and **PETER**, age 66, have diabetes, high blood pressure (BP), and heart disease.

You went to a diabetes education programme, and for the first two years you managed to control your blood sugar levels with diet and exercise. Eventually you found that this wasn't working as well as your physician thought it should.

You started taking metformin about four years ago. The dose was gradually increased and then the physician added glyburide. These two medications seemed to work well together, and your glycosylated hemoglobin (HbA1c) has generally stayed under 7.0.

At the same time as your high blood sugar was identified, your cholesterol level was also discovered to be high. It didn't come down with changes in diet and exercise. The physician started simvastatin and this brought your level down to the target range.

You had had high BP for about eight years when you were diagnosed with diabetes. You have been taking hydrochlorothiazide (HCTZ) for it since the diagnosis was made. About six years ago, your BP was slowly increasing so the physician prescribed enalapril.

Your last review for your medical problems was eight months ago. It was not long after your last check-up that your husband became ill. At that visit the physician said that your HbA1c was 6.8 and your BP was 130/85. He also said that your cholesterol was staying at target.

You think your last eye exam was about three years ago, but your eyesight seems fine. You can't remember when you last had a urine test, and you are not sure if your physician has ever talked to you about your kidney function. You have no tingling or numbness in your feet. You regularly have pedicures (your one indulgence!) and have never had any problems with your feet. You have never had chest pain or shortness of breath. You are not having increased thirst or increased urination. You have not had any episodes that seem to indicate hypoglycemia.

Normally you are faithful about keeping your blood sugar levels under control. You have been checking your blood sugar levels regularly for many years, although while your husband was in the hospital and initially after the funeral you stopped checking. You just had too many other things on your mind. Generally, your levels have been between about 5 and 7, but in the past four months they have been higher. You must admit that you really have not been paying attention to your blood sugar over the past two months.

Currently your results usually range from 4 to 12. You have had occasional readings of 15 or 16. The "4" readings are usually first thing in the morning, and the higher values usually are in the later part of the day. You did not bring your book in

with you today. You do not feel any different when your blood sugar readings are especially high.

You have been taking all your medications regularly.

You think the biggest recent change is in your meal preparation. You had a hard time adjusting from cooking for a large family, and now you are cooking for just yourself. You have difficulty cooking a whole meal just for you, and the time of day you eat isn't consistent. None of the portion sizes at the grocery store seem to be for one person. You know it is not good for your blood sugar levels, but it seems so much simpler just to have cereal or toast than to try to make a proper supper. You don't like pre-packaged foods and worry about their salt content. You know this is not good for your BP.

Probably you also are not as active as usual. You used to try to go for a walk each day, and you haven't since your husband was in the hospital.

You expect the physician to help you get your diabetes control back on track.

Medical history

Diabetes diagnosed seven years ago. High BP for 15 years.

Four normal vaginal deliveries.

Mammograms every year; the last was seven months ago.

Surgical history

Hysterectomy 20 years ago because of fibroids.

Medications

Metformin, 850 mg tid.

Glyburide, 7.5 mg bid.

Simvastatin, 40 mg HS.

HCTZ, 25 mg OD.

Enalapril, 20 mg OD.

Pertinent laboratory results

Your last lab work was eight months ago. At that time your HbA1c level was 6.8, and your physician said your lipid levels were at target.

Your last BP measurement in the physician's office was 130/85. You go to a community centre where a nurse checks your BP. The last reading six months ago was 125/72.

Allergies: None.

Immunizations: Up to date.

Lifestyle issues

- Tobacco: You have never smoked.
- Alcohol: You do not drink alcohol.
- Caffeine: You have two cups of tea with breakfast.

- Cannabis: None
- Recreational and/or other substances: You do not use recreational drugs.
- Diet: You had been faithful in following a low-fat, balanced diet. You knew this was important for both you and your husband. You have not been consistent with this in the past five months.
- Exercise and recreation habits: Most of your exercise is related to working in the home and your yard. You have a large house to clean and a big garden that you put in every year. You used to try to go for a 30-minute walk every evening.

Family history

Your father died of a heart attack 10 years ago. Your mother died of breast cancer five years ago.

You have three older brothers, all of whom have diabetes and high BP. Each has had a heart attack.

Personal history

- Family of Origin

You were born and raised in the town in which you live. Your parents were farmers, and ultimately your brothers took over the family farm.

- Marriage/Partnerships

Your husband was from the same community. He was eight years older than you, a friend of one of your brothers. You had known him "forever" and started dating him when you were in college. He asked you to marry him when you graduated, and you said yes.

He had been farming on his own for five years and the two of you built a house on the farm when you were married. You had good and bad years, but for the most part made a reasonable living.

You still live in the home you and William made on the farm. With your husband gone and your children living away, it seems like a very big place. You have no livestock, and therefore you were able to stay in your home. This works well as you were reluctant to leave the house.

- Children

You had four children: two daughters, **MARY**, age 40, and **ANNE**, age 33, and two sons, **MARK**, age 38, and **WADE**, age 30. All of them went to university and are now working. All are married. Mary has a five-year-old child, and Wade has a two-year-old. While you adore both of your grandchildren, you are careful to give your children space to establish their own families. Only Wade lives nearby, about 30 minutes away. Your husband retired from farming four years ago, and Wade bought the farm. He works in addition to running and working on the farm every day.

Education and work history

You were an average student. After completing high school, you took a bookkeeping course at a community college. Your mother's job on the farm was looking after the books and the house, and this was the role you wanted for yourself. You never worked outside the home but were actively involved with running the farm and looking after the house and children.

Finances

You are financially secure. You own your own home. While you wouldn't consider yourself rich, your husband's estate has left you without concerns about money. You were always involved with decisions about your family finances and are not worried about your ability to manage them in the future.

Social supports

Your husband was your best friend and confidant.

You have many people whom you consider good friends, although with several your relationship seems awkward since your husband's death. You have not been involved with any of your service clubs since he died.

You are close to your brothers. However, their health is not as good as yours and they are busy with their families. You have spoken to one of your brothers about some of your feelings since the loss of your husband. You don't really feel comfortable talking to any of your friends about something like this.

Religion

The church has always been an important part of your life. You and William attended church regularly. You were actively involved in the congregation and the church has been a source of support. You have been back only a few times since your husband's death. Everyone was very welcoming, and you are glad you attended, but sometimes the thought of going there by yourself is overwhelming.

ACTING INSTRUCTIONS

You are comfortably and casually dressed. You answer questions freely.

You have thought of yourself as an active participant in managing your diabetes. You are concerned that your blood sugar levels are so out of control. You do not want to be faced with the same health concerns as your brothers, especially now that you are on your own.

You are still sad about your husband's death. You are able to answer questions about his death and how life has been without him without becoming overly distressed. The fact that this physician did not know your husband somehow makes talking easier. You are not angry or upset that your children have insisted that you come in to talk about how you have been coping. You know they are just worried about you.

If the candidate tells you that lab work/blood tests will be ordered, you ask: "What tests, exactly?"

Cast of Characters

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

JANE WEBBER:	The patient, age 62, who was recently widowed and has poorly controlled diabetes.
WILLIAM WEBBER:	Jane's husband, who died five months ago at age 70.
MARY:	Jane and William's daughter, age 40, who has one child, age five years.
MARK:	Jane and William's son, age 38.
ANNE:	Jane and William's daughter, age 33.
WADE:	Jane and William's son, age 30, who took over the family farm and has one child, age two years.
ETHAN:	Jane's brother, age 72.
ALEXANDER:	Jane's brother, age 70.
PETER:	Jane's brother, age 66.
EVA:	Jane and William's friend.
GEORGE:	Jane and William's friend, and Eva's husband.

Timeline

Today:	Appointment with the candidate.
2 months ago:	Stopped paying as much attention to blood sugar levels.
4 months ago:	Blood sugar levels became higher.
5 months ago:	Husband died.
6 months ago:	Last BP measurement at the community centre.
7 months ago:	Most recent mammogram.
8 months ago:	Last HbA_{1c} measurement and lipid test.
3 years ago, age 59:	Last eye examination.
4 years ago, age 58:	Began taking medication for diabetes.
5 years ago, age 57:	Diabetes not well managed with diet and exercise.
6 years ago, age 56:	BP rising; enalapril added to HCTZ.
7 years ago, age 55:	Diabetes and hyperlipidemia diagnosed.
15 years ago, age 47:	High BP diagnosed; HCTZ started.
20 years ago, age 42:	Hysterectomy.
30 years ago, age 32:	Wade born.
33 years ago, age 29:	Anne born.
38 years ago, age 24:	Mark born.
40 years ago, age 22:	Mary born.
42 years ago, age 20:	Married William.
62 years ago:	Born.

Examiner Interview Flow Sheet - Prompts

Initial statement	"**My children thought I should see you about how I am feeling**."
10 minutes remaining* Optional, use only if you feel it's needed	If the candidate has not brought up the issue of the diabetes, the following prompt is to be used: "**My sugars have not been very good lately**."
7 minutes remaining* Optional, use only if you feel it's needed	If the candidate seems to have forgotten about the grief, the following prompt is to be used: "**What should I tell my family**?" (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: Grief

Issue #1	Illness Experience
Areas to be covered include: 1. husband's death: • Husband died five months ago. • Admitted to hospital and died three weeks later. • Had heart disease but had been doing fairly well. • Family had to make the decision to stop life support. • Married 42 years. 2. identification of normal grief reaction: • Misses her husband/wishes he were still alive. • Thinks about him every day. • Experiences episodes of significant sadness. • No feelings of guilt about his death. 3. ruling out other causes: • No thoughts of suicide/self-harm. • No use of alcohol or other drugs. • No significant sleep disturbance. • No sense of hopelessness. • Planning for the future/enjoying planning a garden. 4. stage of grief: • No anger or bitterness about the circumstances of her husband's death. • No flashbacks or nightmares. • Accepts her husband's death.	**Description of the patient's illness experience**. You are feeling sadness and loneliness after the death of your husband. You are still crying when you speak to your children. You think that the way you are feeling is normal for someone who has lost a spouse. You expect that the FP will concur that this is normal.

		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: Poorly Controlled Diabetes

Issue #2	Illness Experience
Areas to be covered include: 1. history and management: • Diagnosed with diabetes seven years ago. • Sugar levels 4 to 12, and sometimes 15 or 16. • Diet is erratic. • Reduced exercise. • Last assessment eight months ago. 2. current medications: • Diabetes: metformin, glyburide. • Hypertension: enalapril, HCTZ. • Hyperlipidemia: simvastatin, ASA. 3. end-organ assessment: • No tingling or numbness in feet. • No chest pain. • No change in eyesight. • Last eye exam was three years ago. 4. taking medication as prescribed.	**Description of the patient's illness experience.** You are concerned that your diabetes is not under control. Although there aren't any current impacts on your function, you are expecting that the FP will help you get back on track.

		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.

3. Social and developmental context

Context Identification	Context Integration
Areas to be covered include: 1. current context: • Living alone in the family home on the farm. • Four children. • Financially secure. 2. supports: • Her husband was her main support and confidant. • Only one child lives nearby. • Decreased social activities (e.g., church, service clubs like Kiwanis and 4-H). • Speaks with her brother about her grief. 3. the fact that her husband was the outgoing one and her link to the community.	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: "You must be finding it difficult to deal with the grief over the loss of your husband. It is not surprising that your children are worried. It is also likely that, given your grief, your sugars are less well controlled."

Superior Level	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.
Certificate Level	Covers points 1 and 2.	Demonstrates recognition of the impact of the contextual factors on the illness experience.
Non-Certificate Level	Does **not** cover points 1 and 2.	Demonstrates minimal interest in the impact of the contextual factors on the illness experience or often cuts the patient off.

4. Management: Grief

Plan for Issue #1	Finding Common Ground
Areas to be covered include: 1) Reassure the patient that what she is experiencing is an appropriate grief reaction. 2) Recommend review in a few weeks to re-evaluate coping. 3) Offer grief support (e.g., grief support groups, self for support, resources for grief, pet therapy). 4) Suggest how to reassure children/could offer to see family members.	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: Poorly Controlled Diabetes

Plan for issue #2	Finding Common Ground
Areas to be covered include: 1) Concur that her diabetes needs better control. 2) Follow-up for a physical examination must include a BP check. 3) Arrange for lab work, which must include HbA1c testing. 4) Discuss arranging an eye examination. 5) Arrange for her to see a nutritionist/attend a diabetic class (e.g., a class on cooking for one).	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 OR 5.	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 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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