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

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[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.

RATIONALE FOR SIMULATED OFFICE ORAL EXAMINATION #

The goal of this simulated office oral examination is to test the candidate's ability to deal with a patient who has:

1. manage chronic disease as it presents in diabetes

2. recognize and manage post-traumatic stress disorder (PTSD) in a culturally sensitive manner

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. **JEFFREY HOPE**, age 54, who is new to your practice.

CASE DESCRIPTION

Introduction

You are Mr. **JEFFREY HOPE**, age 54, and are visiting this physician for the first time. Your previous physician is no longer in practice locally. You have been on edge for some time, and your boss and girlfriend, **JEAN REDHEAD**, told you that you needed some help. She noticed that you have become increasingly distracted and "edgy" since you returned from your brother **TOMMY HOPE**'s funeral eight months ago. She recommended that you see a physician, as she felt that maybe you needed time off work.

You are diabetic, and until your brother's death had taken excellent care of yourself. You wanted to ensure that you would not lose a leg as your mother, **AGNES HOPE**, did. You had maintained good haemoglobin A1c (HbA1C) levels and a healthy weight and had meticulously avoided sugar.

You need a refill for your diabetic medication. You also want to talk about your insomnia, and your feelings of apprehension and anxiety.

You are of First Nations descent.

History of the problems

DIABETES

You have not seen a physician in a while. Your former physician gave you a refillable prescription last year; she has left the area since then. You need a refill of your metformin (Glucophage), glyburide (Diaβeta), and ramipril (Altace).

Your symptoms started about six or so years ago. First came fatigue, and then an irritation at the corners of your mouth that the doctor said was a yeast infection. Finally, you became very thirsty and had to visit the toilet much more, particularly at night, when you had to urinate three or more times. You made the diagnosis yourself and saw a physician who confirmed it.

Your diabetes has been treated for the past five years. Initially you tried dieting and getting rid of the sugary drinks that you had indulged in since you quit drinking alcohol, but that was not enough. Metformin on its own reduced your blood sugar levels well, but your physician at the time wanted them even lower. She added glyburide, and a small dose worked well; a larger dose caused low blood sugar levels.

You attended diabetic education classes at the time of diagnosis, and until the past year, you diligently had your blood work done every three months and monitored your glucose regularly. For the past several months you have taken your pills but have measured your blood sugar level only sporadically.

After the initial year of juggling medications and losing 20+ pounds, your diabetes was really well controlled. You were well motivated because diabetes is a family problem and you saw your mother lose a leg to the disease. Your recent emotional troubles have undermined this motivation.

For the few years before today's visit, your HbA1c level was measured every three months. It varied between 6.6% and 7.5%.

About two years ago, your doctor added ramipril; she told you that your blood pressure (BP) was very slightly high. She said she wanted your BP to be 135/75 mm Hg or less.

Once a year she checked your urine for protein, and results were always good. She was always amazed at how low your cholesterol was, and never discussed with you cholesterol treatment. Your eyes were checked every two years, and the eye doctor whom you last saw about two years ago said you had no sign of any diabetic changes but did have very early cataracts.

You have always been careful about your feet and have neither tingling nor numbness in your feet or hands. You have no visual symptoms. You have no chest pain or respiratory problems. You get up only once at night to empty your bladder. Cuts and sores heal well and in a timely fashion.

You have kept your weight down well. You check your BP at a drugstore. It is 130/70 mm Hg.

You take a baby acetylsalicylic acid (ASA) tablet every day.

INSOMNIA AND POST-TRAUMATIC STRESS DISORDER

Your boss, Jean suggested you make today's appointment with the candidate because you are not doing well at work. You put this problem down to difficulty sleeping. Your mind is so busy with thoughts and at night you cannot get to sleep! You compare your thoughts with "airplanes circling an airport, but the air traffic controller has lost control and they fly every which way and never come in to land". When you do get to sleep your dreams are very disturbing and wake you up; rarely can you get back to sleep. You are irritable at work and frequently distracted. You feel anxious and are "jumpy". You talked to Jean about what was going on, and she suggested that maybe you needed some time off to deal with things, or even needed sleeping pills.

The story starts during your childhood. You grew up in a Native community in British Columbia. You were the second of seven children. You had no idea who your father was. You suspect he was not Native, given your looks. Your mother drank back then, and her first three children had different fathers. Your elder brother knew his father and you were and are envious of that; you and your next brother did not know who fathered you. All the others were born after your mother married **JOSEPH HOPE**, the man you knew as your father. Joseph was a good man: he was a little lazy and not the best provider, but he accepted all the children as his own. Your grandparents also accepted you all, and they were very important to you as you grew up. As you became older you discovered that this pattern was followed by many in your community. The community raised children and looked out for them, and many women had children with different men before marrying. Your white friends had difficulty understanding this.

When you were 10, you were sent to the residential school 50 km away. It was run by the Church. There you received an education, for which you were grateful. However, although you were never abused, you saw other boys being taken out of their beds by caregivers at night and coming back crying. You later learned that they had been sexually abused. Your elder brother was one of them. He never talked to you about it. You also never spoke of your experiences at school until the past few years, when stories of the atrocities started to come out in newspapers and on television. You mentioned these experiences in passing when you were in treatment for alcohol problems and discussed them more substantially with Jean.

At school, you were a rebel and tough. You and Tommy ran home many times, only for your mother to send the two of you back! Eventually you left school, and at 16 you started to work in the woods with your uncles. Everybody who had a job outside the reserve worked in the logging industry.

At 18 you left home to see the world. You ended up in Vancouver, where you discovered that prejudice was rampant, and discrimination not even hidden. On impulse you went into a recruiting office and joined the Royal Canadian Air

Force (RCAF). Some of your uncles had fought in the Second World War and told stories of Europe and of a decent life in the armed forces. For you, enlisting turned out to be a good thing. You liked military life and eventually became a warrant officer. The institutional structure and order of the RCAF suited you. After 25 years you retired with a pension.

You left the RCAF bilingual; you had ended up in the communications field and underwent training in French. You found that you had a knack for picking up languages when you were abroad. You are passably fluent in German, too; you learned the language when you were stationed in Lahr, Germany.

Alcohol problems: You moved back to your home community when you retired from the RCAF, but found you no longer fit in. You could not find a job, so you moved from place to place. You had difficulty dealing with the freedom of civilian life. You drifted from relationship to relationship and started to drink more and more. Eight years ago, it hit you that you were a drunk and were drinking your life away. You entered a treatment centre and have never had a drink since then.

During that time, you first started to talk of your childhood. Since then, you have worked in drug and alcohol centres for the First Nations community; you have worked in drop-in centres and currently are working as a youth liaison worker in a Native friendship centre in this community.

Eight months ago, Tommy died in a motor vehicle accident (MVA). He was a passenger in a truck that went off the road.

You went home for the funeral. It was an odd experience, a blending of traditional with church rites. As soon as the priest (pastor) started his “mumbo-jumbo”, you had a flashback to your brother and yourself at residential school. Since that day you have been consumed with anger toward clergy and the church.

Most days you have flashbacks to the events of your childhood. Occasionally in your work you must deal with church youth groups, but now you make a point of avoiding such contact. At times the anxiety gets so bad that you find yourself checking rooms you are in for clergymen’s collars. A recurring image just as you fall asleep is of a priest coming into your room.

You are quite surprised by all this. You have told yourself repeatedly that you should grow up and get on with things. After all, for 40 years you have been able to cope with your childhood!

You are not suicidal.

Despite your edginess you enjoy life, look forward to working with teenagers, and are optimistic about their future. You see many opportunities opening up for First Nations’ youth and encourage as many as you can to take available opportunities and better themselves. You are not sad or, if asked, depressed.

What you describe as anxiety is probably better described as being overly vigilant or overly aware of what is happening around you. You feel as though you are always ready for something to happen. You just want to be able to sleep well again.

Medical history.

Type 2 diabetes was diagnosed five years ago.

“Mild” hypertension was diagnosed two years ago.

Your Mantoux test is always positive. Chest X-ray films have always been clear. The last was three years ago.

You took isoniazid (INH) while you were in the RCAF. You could not tolerate INH, and therefore, did not take it for the full year that was advised.

Surgical history

You had an appendectomy at age 15.

Medications

Metformin, 1 g twice a day.

Glyburide, 2.5 mg twice a day.

Ramipril, 10 mg daily.

ASA, 81 mg daily.

No over-the-counter medications.

No herbal medications.

Pertinent laboratory results

Results of self-monitored fasting glucose tests have been between 5 and 8. HbA 1C testing was last done a year ago, and the result was 6.7%.

Your cholesterol level was very good last time it was measured. You have never had a positive micro albuminuria test.

Allergies

None known.

Immunizations

All childhood immunizations were done, including BCG. All were kept up to date in the armed forces.

Since becoming diabetic, you have had a flu shot every year. You had Pneumovax vaccine five years ago.

Lifestyle issues

- Tobacco: You have never smoked cigarettes.
- Alcohol: You stopped drinking eight years ago. Before that you had become a heavy binge drinker in the armed forces. After leaving the RCAF, you drank increasingly heavily: beer, wine, and, by preference, rye. You have never been charged with drunk driving.
- Caffeine: You drink two cups of coffee a day. You drink no cola.
- Cannabis: In the past you have used marijuana, very rarely. You last used it at your brother's funeral.
- Recreational and/or other substances: None
- Diet: You try to eat as you should and avoid sugar obsessively.
- Exercise and recreation habits: You have no formal exercise program, but you do walk to and from work, which is about 1 km each way. You enjoy fishing.

Family history

Your father is unknown.

Your mother died of a heart attack at age 65. Two years before that her right leg was amputated because of diabetes.

Originally you had six siblings. Tommy died eight months ago in an MVA. He was 55. Your five surviving siblings are **JIMMY HOPE**, age 53; **JEANNIE HOPE**, age 50; **JOANNIE HOPE**, age 47; **MELANIE HOPE**, age 44; and **RODDY HOPE**, age 38. As far as you know, they all are healthy, but you are not close and live well away from them.

Both your grandparents died in their 60s. They were diabetic and had tuberculosis when they were young.

Personal history

- Marriage/Partnerships

You have had three failed marriages and countless brief relationships. The first marriage was to **MARY GRACE**, for four years. The second was to IRENE, for three years, and the third was to **JOAN**, for six years. You do not know how to nurture a relationship. Two of your wives thought that they had the key to your happiness, but after a couple of years you had hurt them so badly emotionally that they left.

Probably your heavy binge drinking in the non-commissioned officers' mess had something to do with that. You tried relationships with white women, Native women, and black women, but none worked.

As far as you know, you have no children. This is not an issue for you as you never wanted any. During your time in the treatment centre, you came to realize that this was probably a reaction to your childhood. No child should have to endure what you saw.

Irene, (your second wife) insisted you undergo fertility testing, and when you were found to be infertile; her doctor said this must have resulted from mumps or something like that. Again, this was no big deal to you. Unfortunately, you did not understand at the time that it was a big deal to your wife.

You would not call what you currently have with Jean a relationship, but it works well for both of you. She is 10 years younger than you and has gone through the marriage and alcohol thing, too. She seems to understand you. You give each other space but meet at least once a week for a meal at your or her apartment. You can talk to each other, but just as easily you can simply be together in silence, respecting each other. Sometimes you have sex; more often than not you don't.

In other ways you do not get involved in each other's non-working life.

- Children

No children.

Education and work history

From age 18 to 43 you were in the RCAF and reached the rank of warrant officer. From age 43 to 46 you had the odd job, but mostly you drank.

Currently you are a youth liaison worker in a Native friendship centre. Before this you worked for a variety of agencies as a Native counselor on drug and alcohol abuse.

Finances

You have a pension from the RCAF.

You earn only $15 an hour in your current job but do have a good benefits package that includes counselling with a psychologist.

Being a First Nations member, you receive your medications free. You rent an apartment.

Social supports

You have many acquaintances but few close friends. You do have a fishing buddy you met in Alcoholics Anonymous (AA), but Jean is probably the only person to whom you can open up.

You are not close to your family.

You spend a lot of your spare time at the friendship centre, probably just to be available if someone needs you. From time to time the youth you meet tell you to "get a life!"

The AA organization was and is very important to you. The meetings brought back the structure you enjoyed in the RCAF. You attend at least two meetings a week.

Religion

You are not religious. In fact, you have nothing good to say about organized religion.

When you were growing up, Native spirituality had not recovered from its suppression and the Church was the dominant force in the community. There was a revival of Native ways in your home community, and you listened to some of the ardent proselytizers talk of returning to the old ways. You had little time for their way of thinking, but when you went to powwows you enjoyed the rhythmic dancing, and the drumming and chanting of Native songs sent a chill up your spine.

ACTING INSTRUCTIONS

You are clean and casually but smartly dressed in jeans and an open-necked shirt.

You are quiet and initially do not offer much in the way of information except in response to questions. You are restless and vigilant throughout the interview.
You are knowledgeable about your diabetes, and if tests are mentioned, you want to know which ones.

When asked why you sleep poorly, you reply, “I have these very disturbing dreams” or “Sometimes it is easier to stay awake than suffer those nightmares”. If asked if you have bad memories or flashbacks, you say, “It’s just as though I was back in the dormitory at school again” or “I thought I had left those memories behind years ago” or “They make me so angry I do not know what to do with myself.”

If the candidate mentions hypnotics or selective serotonin-reuptake inhibitors,
you are not sure you want drugs—particularly drugs you could become addicted to. If the candidate pushes pharmacotherapy, you want to know all the pros and cons and to have time to think before committing to it. You do not rule it out but need to consider it carefully first. You will not agree to take any addictive drug.

If the candidate mentions PTSD, you recognize the syndrome (you were in the military). You acknowledge that you have felt your past has started to haunt you but have not thought you might be experiencing PTSD. However, if the candidate discusses criteria for diagnosis, you quickly accept the diagnosis and want to know your treatment options. If the candidate does not discuss PTSD or any other diagnosis, you should ask what the doctor thinks you are suffering from.
If generalized anxiety disorder or depression is the diagnosis suggested, you accept it but quizzically and hesitantly. Give the cue “I don’t feel depressed” or
“I enjoy life. I am not sad; I am angry and on edge”. Give this cue once.

You are a member of a First Nations band and carry a status card. Having status allows you coverage for your medications and medical care. It allows you access to free education. It identifies you legitimately as a Canadian of Native descent.

If the candidate displays “exam-manship” by asking early in the interview if something more than the diabetes is an issue, say, “I want to deal with my diabetes”, or use other words that will direct him or her back to your presenting problem.

Cast of Characters

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

JEFFREY HOPE:	The patient, age 54, who is suffering from diabetes and PTSD.
AGNES HOPE:	Jeffrey's mother, who died seven years ago at age 65.
JOSEPH HOPE:	Jeffrey's stepfather, age 70.
TOMMY HOPE:	Jeffrey's brother, who died in an MVA eight months ago at age 55.
JIMMY HOPE:	Jeffrey's brother, age 53.
JEANNIE HOPE:	Jeffrey's sister, age 50.
JOANNIE HOPE:	Jeffrey's sister, age 47.
MELANIE HOPE:	Jeffrey's sister, age 44.
RODDY HOPE:	Jeffrey's brother, age 38.
JEAN REDHEAD:	Jeffrey's boss and girlfriend, age 44.
MARY GRACE:	Jeffrey's first wife.
IRENE:	Jeffrey's second wife.
JOAN:	Jeffrey's third wife.

Timeline

Today:	The appointment with the candidate.
Eight months ago:	Brother Tommy died in an MVA.
Five years ago:	Diabetes diagnosed.
Six years ago:	First symptoms of diabetes.
Seven years ago:	Mother died at age 65.
Eight years ago:	Stopped drinking.
11 years ago:	Left armed forces.
21 years ago:	Marriage to Joan.
27 years ago:	Marriage to Irene.
34 years ago:	Marriage to Mary Grace.
36 years ago:	Joined armed forces.
38 years ago:	Left school.
44 years ago:	Sent to residential school.
54 years ago:	Born.

Examiner Interview Flow Sheet - Prompts

Initial statement	**"I need a refill of my prescription**."
10 minutes remaining* Optional, use only if you feel it's needed	If the candidate has not brought up the issue of the insomnia, the following prompt is to be used: "**Since my brother's funeral, I have not been sleeping well**."
7 minutes remaining* Optional, use only if you feel it's needed	If the candidate seems to have forgotten about the diabetes, the following prompt is to be used: "**Will I need blood tests done again?**" (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: Diabetes

Issue #1	Illness Experience
Areas to be covered include: 1. current management: • Taking metformin and glyburide. • Taking ramipril. • Walks daily. • Follows a diabetic diet. • Six-year history. • Examines feet regularly. 2. diabetic control: • Erratic self-monitoring. • Normally excellent control. • Cholesterol is normal. • Excellent BP control. 3. end-organ damage: • Eye exam one year ago. • No paraesthesias. • Normal urine testing one year ago. 4. motivation for good control: • Mother lost a leg to diabetes.	**Description of the patient's illness experience**. You are embarrassed to admit that you have been neglecting yourself. You want to get your diabetes under control in order to get back on track. You are expecting that the FP will renew your prescription and do a diabetic check-up.

		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: Post-Traumatic Stress Disorder

Issue #2	Illness Experience
Areas to be covered include: 1. current symptoms: • Flashbacks. • Nightmares. • Hyper vigilance. • Eight-month duration. 2. precipitant: • Brother's funeral. • Residential school experience. • Witnessed abuse of others. • Contact with church groups, which he now avoids. 3. ruling out other diagnoses: • Not suicidal/homicidal. • Not depressed. • No panic disorder. • No psychotic symptoms. 4. no personal history of childhood abuse.	**Description of the patient's illness experience.** Your past traumatic experiences are coming back to haunt you, and this is making you both angry and anxious. This is impacting your concentration at work. You are hoping that the FP will help you make sense of all of this.

		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. life cycle issues: • Retired from the armed forces. • No children. • Many failed relationships. • Recovering alcoholic. 2. social support: • His boss, Jean, is his main social support. • AA is very important to him. • Not close to his family. 3. social factors: • Not interested in First Nations spirituality. • Actively involved in the Native community. 4. First Nations status.	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: "As I understand what is happening, you are an indigenous Canadian with diabetes. You were strongly motivated to control your diabetes, but attending your brother's funeral has rekindled memories of your childhood in a residential school. You have become distressed by these memories, and you are neglecting control of your diabetes."

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: Diabetes

Plan for Issue #1	Finding Common Ground
Areas to be covered include: 1) Provide a prescription for medications 2) Order diabetes monitoring tests 3) Arrange for a physical examination. 4) Reinforce self-care (e.g., glucose monitoring, exercise, diet).	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: Post-Traumatic Stress Disorder

Plan for issue #2	Finding Common Ground
Areas to be covered include: 1) Identify PTSD or allude to current symptoms related to previous life traumas. 2) Arrange or offer self for counselling. 3) Discuss pharmacologic therapy. 4) Discuss the appropriateness of time off work.	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	**Language 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	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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