THE COLLEGE OF FAMILY PHYSICIANS OF CANADA

LE COLLÈGE DES MÉDECINS DE FAMILLE DU CANADA

Certification Examination in Family Medicine

Overview of Simulated Office Oral (SOO) Structure and Marking

Updated June 2023

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

Introduction

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

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

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

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

The following Appendices will be of interest to all examiners:

Appendix 1: Standardized Instructions to Candidates

Appendix :2 Ten CFPC Preparation Pointers for Examiners

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

[*] 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. experiencing hypertension secondary to a stressful work environment

2. suffering from symptoms of chronic prostatitis

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. MARK LEEVES,** who is new to your practice.

CASE DESCRIPTION

Introduction

You are Mr. **MARK LEEVES**, a 44-year-old clinical engineer. You have come to see this family physician (FP) because you think something needs to be done about your blood pressure (BP). Restructuring of the hospital system within which you work has created a very stressful environment. You have been checking your BP at work and are worried about the values you are getting.

You are also concerned because the other night your wife said she saw blood in your semen. You have been hearing lots in the news about prostate cancer and prostate-specific antigen (PSA) testing. You wonder if your symptoms could be due to cancer, and whether you should have the PSA test.

You have not had an FP for several years and have not talked to any other physicians about your concerns.

History of the problems

ELEVATED BP AND WORK STRESS

Over the past several years, all the cutbacks in the health system have led to considerable changes at work. You find these changes incredibly frustrating. The situation has gradually worsened over many years.

You became concerned about three months ago. You developed headaches shortly after arriving at the hospital dialysis unit where you maintain and repair equipment. Your head pounded and you felt flushed. These symptoms lasted most of the day, and seemed to improve only when you left work. You never felt bad in the evenings or on weekends. You told one of the unit nurses about your symptoms, and she suggested you check your BP. You couldn't believe it: your BP measurement was 180/105 mm Hg and your pulse rate (PR) was about 120 bpm!

Over the past three months you have been checking your BP fairly regularly. You use the automatic BP machines at work. Some days your readings are better, but your diastolic BP seems to be over 90 most times you check it. The systolic values are pretty variable but tend to be somewhere between 140 and 160. Your PR is always up around 100 bpm.

There is also a BP machine at your gym, and you have been keeping an eye on your levels there and at the drugstore. Your BP is generally much better at these locations and is always under 140/86 mm Hg. Your resting heart rate at the gym is about 70 bpm.

If you were to stop and think, you would say your sleep has been disrupted for several months. You toss and turn at night and often have strange dreams, although not usually on the weekend. You don't generally have trouble falling asleep: you often "just crash" as soon as your head hits the pillow. You also don't awaken particularly early, but always before your alarm goes off.

You are not depressed, and your appetite is fine. You have no trouble staying on task at work. You have no defined episodes of panic, but you do generally feel "on edge" at work. You would agree that this feeling is anxiety, although you just call it being "stressed".

Currently you are not experiencing headaches, flushing, sweating, nausea, weakness, or tremor. You have no chest pain or shortness of breath.

You have never had your cholesterol level tested.

PROSTATITIS

The other night your wife, **ALICE STEWART**, told you that she found blood in your ejaculate after the two of you made love. Although you didn't say anything to her, ejaculation was painful. You are not sure what the significance of this is, but you know it can't be good. After seeing information in the news about prostate cancer and PSA testing, you wonder if you should have your PSA level checked. You know from working at the hospital that prostate cancer at your age is serious.

For the most part you feel fine, but you have noticed that sometimes you have discomfort when you urinate. The discomfort is a general burning feeling. You think it has been present for about three months now. At times you also get an aching pain in your lower abdomen and an intermittent feeling of heaviness in your scrotum.

One time, maybe eight months ago, your wife thought you might have a bladder infection. You had the burning and also felt as if you had to urinate all the time. You went to a walk-in clinic and were given antibiotics for three days. You don't remember what kind of pills you got or any tests. Your symptoms improved and so you didn't think much of the episode.

You have no hesitancy when you void. There has been no change in your stream and no dribbling. You have not noticed blood when you void. However, you need to urinate frequently, and this has been interfering with your work.

You do not recall ever having any type of penile discharge. There is no pain when you have a bowel movement. You have not had any constipation, diarrhea, fever, or chills.

You have had no sexual partners other than your wife, and you are confident that she has had no other partners. You do no long-distance or stationary cycling and have experienced no trauma.

Medical history

You have been healthy up to this point. You have had the odd cold now and then, but nothing particularly serious.

Surgical history

You have never had surgery.

Medications

You had antibiotics several months ago for the bladder infection.

You are taking no prescribed medications. You take no over-the-counter medications or anything from the health food store or the gym. Specifically, you have not been using anabolic steroids or decongestants.

Pertinent laboratory results

None available.

Allergies

None.

Immunizations

Up to date.

Lifestyle issues

- Tobacco: None.
- Alcohol: You have two to three beers socially, perhaps once or twice a month.
- Caffeine: You have about four cups of coffee a day.
- Cannabis: None
- Recreational and/or other substances:
- Diet: You generally try to follow a healthy diet, but you do like your burgers and fish and chips.
- Exercise and recreation habits: You work out every day after work. You usually run for about 30 minutes and lift free weights for 40 to 60 minutes.

Family history

Your father, **FRANK LEEVES**, is a 74-year-old retired grain farmer. He is a long-time smoker and suffers from chronic obstructive pulmonary disease (COPD).

Your mother, **ELIZABETH LEEVES**, is 68. She suffers from osteoarthritis.

Your sister, **SUSAN JOHNSTON**, is 48 and healthy. She and her 50-year-old husband, **TOM JOHNSTON**, work on the farm. They have two children.

Your paternal uncle was diagnosed with type II diabetes in his 60s. Your maternal grandfather died of a stroke in his 70s. No other family history suggests heart disease. As far as you know, no one in your family has had prostate cancer.

Personal history

- **Family of Origin**

You were born in a small town in southern Saskatchewan (e.g. Gravelbourg) and grew up there on your parents' farm. You worked on the farm when you were not attending school. You had a fairly happy childhood, and over the years your family's finances were about as stable as could be expected.

You keep in contact with your family and see them on holidays. You are not as close as you would like because of the geographic distance between you.

- **Marriage/Partnerships**

At university you met your first wife, **MARIE WINSTON**, who was a nursing student. The two of you married at age 22, while attending university. Looking at her nursing textbooks was what got you interested in clinical engineering.

You and Marie divorced when you were 33. Things never really were all that great during your marriage and you think you both just gave up trying to fix problems. You did not have children. Your divorce was not particularly pleasant, but you got through it and were glad the marriage was finally over. After the divorce was final, you moved to this community to take a new job. That was 11 years ago. You are not making any ongoing support payments and have lost touch with Marie. You don't know where she is now.

You met **ALICE**, age 41, at the hospital where you are now employed. She came to work as a secretary in an outpatient clinic. You met at a hospital social function and dated for about two years before marrying three years ago. You know you can talk to her about anything.

Alice was married previously and has two daughters. **LISA STEWART** is 15 and **KAREN STEWART** is 12. Their father lives out of town and generally they see him only on holidays. He does provide child support.

Initially Lisa and Karen seemed to adjust to your involvement in their lives fairly well. Then puberty hit. From your perspective Lisa has become obnoxious. She is rude to her mother, and you might as well not exist. Karen is not as bad, but at times she emulates her older sister. Your parents never would have put up with this kind of behavior from you or your sister, and you think Alice shouldn't either. Alice says this is just a phase and puts up with Lisa's behavior. She thinks if she responds to it, it will just get worse. You disagree but realize that Lisa and Karen are Alice's children and that she's known them a lot longer. You and Alice work hard to prevent their behavior from affecting your relationship negatively. Besides, compared with work, your home life is an oasis.

- **Children**

You have two stepchildren, Lisa who is 15 and Karen who is 12. You do not have biological children of your own.

Education and work history

You finished high school and realized that you did not want to be a farmer. You liked working with machinery on the farm and decided you wanted to be an engineer. Your father would have liked you to study agriculture and come back to run the farm, but he accepted your decision. (He was relieved when your older sister married someone who was willing to take over the farm when he retired.)

You started university with the intention of becoming a mechanical engineer. You completed this program but discovered biomedical engineering in your final year. Following graduation, you did a two-year program in clinical engineering. You have always been a hard worker. Growing up on the farm, you always had chores after school and worked throughout the summer. Later you continued to work on the farm

when you were not at university. You had an arrangement with your father: in exchange for summer labor, he helped pay for your education.

After completing your degree and the subsequent specialization in clinical engineering, you obtained an entry-level position in the clinical engineering department of a Saskatoon hospital. This was in 1982. Marie also obtained a position at the hospital and did well. Everything was great initially. You spent the next nine years at the hospital. You enjoyed your work and had lots of opportunities for further training.

As your marriage to Marie was ending in 1990 to 1991, you received an offer to work at a hospital in this community. It seemed like a good offer. You would be a relatively senior technician and be able to make a new start after your divorce. This is the job you still have today.

Initially your new job was quite satisfying. You worked with a good group of people and all the staff had a good relationship with management. You all worked independently and shared the work to be sure everything got done in a timely manner.

In the mid-1990s, hospital cutbacks resulted in reduced staff in your department. There were early retirements for some of the senior staff and no one was replaced. These changes led to an increased workload, but initially things seemed to go fairly well. There was still a good group of skilled people in the department, and for the most part you all were able to keep up with demands.

About two years ago, further cutbacks caused the hospital to change the management structure in your department. A new supervisor, **JIM PETRUCIC**, was brought in, and things seemed to go from bad to worse. You didn't like your new boss's management style and disagreed with some of his decisions. Your department went from one where people had responsibility for independent actions to one where the supervisor made almost all decisions. On occasions you have been told to sign off on reports and projects when you felt it was inappropriate to do so. You know this has happened to other people, and that no one is particularly happy about the changes. However, you are the only one who has ever made your feelings public. For the most part, when people have had enough, they either go on "stress leave" for several months or get a new job elsewhere. Fortunately, there is a demand for skilled people in your field— but unfortunately this demand has made finding highly qualified replacements more difficult for your department. This has caused an increased workload and hours for remaining senior staff members.

You dread going to work these days. You have tried keeping your head down and your mouth shut. You were ignored or called a troublemaker when you tried to make suggestions. You don't know how much longer you can stand your job. You would like to quit and take a position elsewhere. You have had several offers for positions in other cities; some of these are with employers for whom your former colleagues enjoy working. Unfortunately, Alice is not prepared to move. She likes her full-time job and does not want to disrupt her daughters' lives with a move.

You don't know what to do or what you want to do but are open to suggestions. You agree that time off might help in the short term but are not sure that this is the best solution. It just leaves everyone else at work with more to do, and eventually you would have to go back. You doubt anything would have changed during your absence. You do have lots of sick time saved up and there is a short- and long-term disability program, so you know you could take time if it were appropriate to do so. You are not prepared to move for a new job without your wife. You are willing to see a counselor to discuss how to cope with the situation and are sure the hospital has an employee assistance program that would cover the cost. You are also willing to talk to your union representative or to the hospital's human resources department to see if anything else can be done about the situation.

Social supports

You have a good relationship with your colleagues and see them socially as well as at work. The people at the gym are really just acquaintances.

Religion: None

ACTING INSTRUCTIONS

You are dressed in a casual shirt and pants. You have come to the FP's office from work and had planned to return there after this visit.

You are open and forthright in discussing your concerns about your BP. The high readings have been an increasing worry. Working in the dialysis unit gives you a clear understanding of the consequences of not treating high BP appropriately. You realize that work is probably influencing the values because they are fine when you aren't there.

You are resistant to the idea of taking time off work. You have seen the impact of others' leaves and there are not many around who can do the specialized work for which you are trained.

You see your previous marriage as a failure and would not leave your job to find other work without your wife's full support. You came today to get medication to treat your BP while you are at work. However, you accept advice that there may be a better way to deal with this problem than with pills you may not need. You agree to a temporary leave if the candidate says this may be necessary to sort out your BP and to help you find better ways to cope with work.

When you talk about work you become obviously irritated and frustrated. You punctuate your **FEELINGS** with hand gestures. You say that "**the place drives me nuts!!!**" You describe your boss, Jim, as the "**bane of my existence**". You could talk for hours about the inappropriate hiring of under-trained staff, how he treats you all as if you were children or else thieves, how he gets upset if you do other people's work when they get behind, and how he makes the senior staff train new staff but gets angry when your work falls behind because you are teaching. **FEEL** free to rant a bit.

The blood in your semen scares you. There has never been any cancer in your family, and you are not even sure if that is the problem. You worry that your kidneys may be affected, especially as it hurts when you pee. This kind of problem is not something you would normally share with anyone, so you have some difficulty talking about it. You are worried enough, however, to want to discover what is going on. You will do whatever the doctor thinks will make the problem better, but you would also like a clear answer about what the problem is. If the doctor offers you antibiotics without clearly specifying duration of use, ask for clarification about how long you will be taking them.
If the candidate becomes focused on the interaction between you and your stepdaughters minimize the impact it is having on your marriage. You don't think the situation is bad enough that you need help to deal with it.

Cast of Characters

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

MARK LEEVES:	The patient, age 44, who is a clinical engineer.
ALICE STEWART:	Mark's current wife, age 41, who is a secretary in a hospital outpatient unit.
LISA STEWART:	Alice's daughter, age 15.
KAREN STEWART:	Alice's daughter, age 12.
FRANK LEEVES:	Mark's father, age 74, who is a retired grain farmer.
ELIZABETH LEEVES:	Mark's mother, age 68.
SUSAN JOHNSTON:	Mark's sister, age 48.
TOM JOHNSTON:	Susan's husband, age 50.
MARIE WINSTON:	Mark's ex-wife, age 44.
JIM PETRUCIC:	Mark's supervisor at work.

Examiner Interview Flow Sheet - Prompts

Initial statement	**"Doc, I'm worried about my blood pressure."**
10 minutes remaining* Optional, use only if you feel it's needed	If the candidate has not brought up the issue of the prostatic symptoms, the following prompt is to be used: **"I'm wondering if I need my PSA checked."**
7 minutes remaining* Optional, use only if you feel it's needed	If the candidate seems to have forgotten about your blood pressure, the following prompt is to be used: **"Do you think work could be affecting my blood pressure?"** (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: Elevated BP and Work Stress

Issue #1	Illness Experience
Areas to be covered include: 1. elevated BP: • First noted three months ago. • BP consistently >140/90 mm Hg at work. • BP always <140/86 mm Hg away from work. • Heart rate always elevated at work. 2. work factors: • Has worked in the same department for 11 years. • Problems began with supervisor. • Increased responsibility. • Poorly trained junior staff. • Longer hours. 3. lifestyle issues: • No excessive alcohol intake. • Non-smoker. • Exercises regularly. • No illicit drug use. • Four cups of coffee a day. 4. ruling out secondary hypertension: • No tremor. • No anabolic steroids. • No sweating. • No weakness.	**Description of the patient's illness experience**. You are concerned about the elevation of your blood pressure. You are also experiencing frustration and anxiety due to on-going work-related stress.

		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: Prostatic Symptoms

Issue #2	Illness Experience
Areas to be covered include: 1. current symptoms: • Dysuria. • Suprapubic pain. • Hematospermia. • Painful ejaculation. 2. history of symptoms: • Symptoms began three months ago. • Similar symptoms treated as a urinary tract infection. • No history of problems before eight months ago. 3. pertinent negative factors: • No penile discharge. • No trauma. • No pain with defecation. • No fever or chills. 4. sexual issues: • Monogamous relationship. • No history of sexually transmitted infections.	**Description of the patient's illness experience.** You are afraid that you might have cancer or that something is wrong with your kidneys. Your frequent urination is also affecting the completion of work tasks. You want to know what is wrong.

		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. family: • Previous failed marriage. • Married to current wife for three years. • Two adolescent stepdaughters. • No children of his own. 2. supports: • His wife is his main support. • Good relationship with colleagues at work. • Acquaintances at the gym. 3. financial factors: • His wife's former husband pays child support. • Short-term disability coverage available at work. • His wife works full time. • He is making no support payments to his first wife.	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: "After your last marriage, you want this new one to succeed and are prepared to stay in a negative work environment if that is what it would take. At the same time, you are faced with concerns about significant health problems."

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: Elevated BP and Work Stress

Plan for issue #1	Finding Common Ground
Areas to be covered include: 1) Recommend ongoing BP assessment. 2) Discuss strategies for coping with a stressful work environment. 3) Suggest lifestyle modifications (e.g., decrease caffeine intake, follow a low-salt diet). 4) Discuss the possible need to take leave from work in future to deal with health concerns.	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: Prostatic Symptoms

Plan for issue #2	Finding Common Ground
Areas to be covered include: 1) Reassure the patient that he likely has prostatitis, not cancer. 2) Discuss the treatment for prostatitis, which may involve providing antibiotics today. 3) Arrange for urinalysis and urine culture-and-sensitivity testing. 4) Review indications for and limitations of PSA testing, whether the candidate chooses such testing or not.	Behaviours indicating efforts to find common ground go beyond the candidate asking "Any questions?" after a management plan is presented. Finding common ground is demonstrated by the candidate encouraging patient discussion, providing the patient with opportunities to ask questions at multiple points, encouraging the patient to express their thoughts, seeking clarification, checking for consensus, and recognizing then addressing patient hesitation or disagreement if it arises. Examiners need to determine the candidate's ability to find common ground based on behaviours they demonstrate during the interview.

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

6. Interview process and organization

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

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

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

Superior Level	Demonstrates advanced ability in conducting an integrated interview with clear evidence of a beginning, a middle, and an end. Promotes conversation and discussion by remaining flexible and by keeping the interview flowing and balanced. Very efficient use of time, with effective prioritization.
Certificate Level	Demonstrates average ability in conducting an integrated interview. Has a good sense of order, conversation, and flexibility. Uses time efficiently.
Non-Certificate Level	Demonstrates limited or insufficient ability to conduct an integrated interview. Interview frequently lacks direction or structure. May be inflexible and/or overly rigid, with an overly interrogative tone. Uses time ineffectively.

Appendix 1 Standardized Instructions to Candidates

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

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

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

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

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

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

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

Appendix 2 CFPC Preparation Pointers for Examiners

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

Think of the following:

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

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

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

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

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

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

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

on tangents not in the script.

5. Do not overact.

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

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

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

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

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

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

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

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

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

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

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

• Ensures physical contact is appropriate for the patient's comfort Receptive • Is aware of and responsive to body language, particularly feelings not well expressed in a verbal manner (e.g., dissatisfaction, anger, guilt) Sample behaviours • Responds appropriately to the patient's discomfort (e.g., shows appropriate empathy for the patient) • Verbally checks the significance of body language/actions/behaviour (e.g., "You seem nervous/upset/uncertain/in pain")	• Asks open- and closed-ended question appropriately • Checks with the patient to ensure understanding (e.g., "Am I understanding you correctly?") • Facilitates the patient's story (e.g., "Can you clarify that for me?") • Provides clear and organized information in a way the patient understands (e.g., test results, pathophysiology, side effects) • Clarifies how the patient would like to be addressed

Prepared by: K. J. Lawrence, L. Graves, S. MacDonald, D. Dalton, R. Tatham, G. Blais, A. Torsein, and V. Robichaud for the Committee on Examinations in Family Medicine, College of Family Physicians of Canada, February 26, 2010.