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. ulcerative colitis

2. anxiety attacks

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. **RICHARD GRANDON**, age 47, who is new to your practice.

CASE DESCRIPTION

Introduction

You are Mr. **RICHARD GRANDON**, age 47, an investment advisor who has an appointment with the candidate because your ulcerative colitis is flaring up. You also want to mention episodes of pounding in your chest during the past month.

You are visiting this family physician (FP) because your own, **Dr. EVANS**, is long retired. You haven't seen your last gastroenterologist, **Dr. SHEPPARD**, in 15 years.

History of the problems

ULCERATIVE COLITIS

In the past four months you have had episodes when you have had to run to the bathroom more often—often up to once every hour. Sometimes you have overt diarrhea, but frequently there is nothing much in the way of a bowel movement. You have about five loose bowel movements a day. You are also suffering from crampy, colicky abdominal pains every day. You have intermittent rectal pain, embarrassing flatulence, and nausea. This does not wake you from sleep. You are not incontinent of feces.

This constellation of symptoms has occurred three times previously, and you have been diagnosed with "ulcerative colitis" in the past. More specifically, you were told you have "ulcerative proctitis." From experience, you know that rectal bleeding will soon follow unless treatment is started.

You had hoped that, by watching your diet carefully, the symptoms would go away and you wouldn't need to see a doctor. However, this hasn't been the case. In fact, gradually the problem has become more severe—and the flare-up could not have occurred at a worse time. You have many clients who expect personal service from their investment advisor, and this means a lot of golf is coming up. Long board meetings will follow with your fellow partners in the firm.

You wonder if the stress you have been experiencing since around Christmas may have caused the flare-up (see "Anxiety Attacks"). The abdominal pains started around that time, and your wife and colleagues have told you that you're much more tense and agitated. In addition, past attacks seemed to occur when you were under extreme stress.

Your appetite is unchanged, and you have not lost any weight. You have no food allergies, and you have not been abroad in the past year. You have never had joint pains or problems with your eyes. You have never had jaundice.

When you were 13, you started suffering with colicky abdominal pains and diarrhea. Initially, your father dismissed these symptoms as "nerves" and "growing pains," and he was quite unsympathetic. After several months, you began to bleed rectally and lose weight, and this prompted your mother (who had seen the same symptoms in her brother) to take you to a doctor. Eventually you went to a pediatrician and had sigmoidoscopy and colonoscopy. Biopsies showed that you had ulcerative colitis. Treatment was started with enemas, steroids, and a sulpha drug. You developed a rash and proved allergic to the

sulpha drug. This was stopped and you continued using only the oral and rectal steroids. Several months of treatment were required to bring the symptoms under control.

When you went away to university in New Orleans, the symptoms diminished when you began smoking cigarettes and disappeared when you began using marijuana. You drank alcohol only moderately, as it seemed to exacerbate your symptoms. You weaned yourself off the enemas and steroids within two months of starting university.

For a couple of years, you were fine, but you had another flare-up of the abdominal pains and subsequent rectal bleeding shortly after leaving the New Orleans university at age 21, and again just before your marriage at age 32. Each time your FP sent you to a specialist, and each time a colonoscopy proved that the colitis was flaring up. You would have a short course of oral and rectal treatment, and the disease would seem to go away.

You were never good at continuing maintenance therapy or follow-up care with your doctors, and as soon as the symptoms went, you weaned yourself off the drugs. You learned from books and specialists that certain diets could help the condition, and that spicy foods would worsen it. You became adept at following a simple, bland diet, and avoiding all triggers.

ANXIETY ATTACKS

About a month ago, you were about to attend a board meeting at work when you had the sudden, unexpected sense of "pounding" in your chest. You had no pain, but you felt as if you were being choked, and you couldn't breathe. Your hands were trembling, you started to sweat, and you felt light-headed. Although you did not collapse or lose consciousness, you were gasping for breath. Your hands and lips "tingled" after this. Colleagues said that you went "pale and clammy." This had never happened to you before.

An ambulance was called, and you were rushed to a nearby emergency department (ED). The pounding in your chest improved, spontaneously, after about 30 minutes. Your lips and hands went back to normal after the same time. You were given a "relaxing pill" under your tongue, and your heart was checked. You were led to believe that everything was fine, and you were allowed to go home later that day.

Two weeks later, the same thing happened after you dropped your daughter off at school. Your heart raced, you became sweaty and light-headed, and your hands began to shake. You started to drive to the ED, but the feeling wore off after about 20 minutes. You therefore drove to work.

A few days ago, you had another episode when you were at a restaurant with your wife, **PENELOPE**. She insisted that you go to the ED, and you were checked again for a heart complaint. The palpitations lasted about 20 to 30 minutes. This time you were admitted to the hospital for two days, and **Dr. WONG**, a cardiologist, did a "full work-up" on you, including a heart tracing, blood tests, and a "stress echo" test. You also wore a heart monitor for 24 hours. Dr. Wong told you that the heart rhythm and structure, as well as the blood supply to your heart, were "100% perfect." He said something about your symptoms being caused by "palpitations," which were probably "stress related." He suggested a follow-up appointment with an FP. You were also told that all blood test results, including those for your thyroid, were "normal."

Your wife, other family members, and colleagues are worried about you. You also are worried that these attacks will occur again. Initially you had no idea what triggered them, as the occasions on which they occurred seemed unrelated. However, you have been pondering Dr. Wong's comment about stress. Specifically, you have been thinking about recent stressful events and their relationship to your palpitations.

About a month ago, the global chief executive officer (CEO) of your company retired, which prompted the board meeting at which you first had palpitations. You had survived the economic downturn by hard work, clever investments, and firing a lot of the junior staff. Board members noticed your ruthlessness, and you are now rumoured to be the next CEO. Barring a scandal, you should easily be voted in by the end of the month.

You fear that such a scandal is possible, and this is causing considerable anxiety. Years ago, you needed money and were in some pornographic films with **JUSTINE**, a girlfriend from your university days in New Orleans. You went by the pseudonym "**ROCK GRAND**" (see "Personal History" for more details). About four months ago, you read a newspaper article about Justine. She is a member of the Democratic Party and ran for local office in New Orleans during the last mayoral election. The Republican Party found some seedy pornographic movies she had made as a student and released them to the press. Website addresses were provided so that anybody who wished to could see her naked with an "unknown guy named Rock Grand." The newspaper article went on to state that the old 8-mm footage is now a "most-viewed video" on the web, and blog sites had been set up in an attempt to identify this "unknown American stud." Fortunately, nobody has contacted you— yet. The New Orleans election is long over, and Justine was easily defeated, but you are terrified that your past will somehow resurface. Your life was going so well until that awful newspaper article. This could ruin your chance for promotion and send your happy, upper middle-class life into turmoil.

You have always been a good sleeper, but in the past month, you have noticed that you wake up earlier. You also tend to wake up if there is a slight noise in the bedroom, and then you have trouble getting to sleep again. When you get up in the morning, you feel tense and apprehensive. That dreadful newspaper article undoubtedly caused your stress, which is magnified by fears about your promotion.

You have not had a cough, and you have not brought up any phlegm or blood. You have no calf pains. You are not depressed, and your appetite is unchanged.

Medical history

Except for your colitis flare-ups, you have been healthy.

Surgical history

You have never had surgery.

Medications

None currently.

Pertinent laboratory results

Recent tests in the ED included blood tests, electrocardiography, and stress echocardiography of your heart. Results were normal. Specifically, your complete blood count, electrolytes, lipids, and thyroid function were normal.

Allergies

Sulpha drugs give you a rash.

Immunizations

Up to date.

Lifestyle issues

- Tobacco: You do not smoke.
- Alcohol: You drink minimal amounts of alcohol, perhaps one glass of wine a day with dinner. Alcohol in larger quantities causes your colitis to flare up, and so you never drink more than this.
- Caffeine: You do not drink any caffeinated beverages (e.g., tea, coffee, cola, Red Bull).
- Cannabis: None
- Recreational and/or other substances: You use no illicit drugs.
- Diet: You have a healthy diet.
- Exercise and recreation habits: You are a member of a golf club and a squash club. You are fit and active, and you are not overweight. Your office building has an exercise club, and you go there daily. You are the sort of person who checks his pulse before and after exercise, and then announces loudly how fit he feels after a hard workout.

  When you have time, you enjoy playing the grand piano in your home.

Family history

Your Father, **PETER GRANDON**, is an only child. He was born in New Orleans. Your mother, **MARY GRANDON**, is from Montreal. She was a fine arts major and met your father when they attended university in New Orleans in the late 1950s. They moved to a small town 300 km outside Montreal when your father accepted a posting as an Anglican minister.

Both your parents are now in their early 70s and well. However, your mother has always had "bad nerves," which your father blames on her artistic temperament. She drinks gin and wine; your father is a non-drinker. Your father tends to have "fire and brimstone" beliefs, and during your childhood he sometimes became irate about religious or social issues. At these times your mother's gin consumption increased a little, perhaps because she was trying to "calm her nerves."

Your brother, **DAVID**, is 45. He was the rebel in the family. He took after your mother, while you were more like your father. He works as an artist on an island off the coast of British Columbia. You believe he is single. The two of you don't have much in common, and you have little contact with him.

Your mother's brother suffered from colitis all his life. He ended up having an operation and a bag attached to his side.

Colitis seems to be the only family illness. There is no history of bowel cancer, heart trouble, hypertension, stroke, thyroid disease, or depression. Family members tend to live into their 80s, at least.

Personal history

- Family of Origin

You were born and grew up in another city. During early adolescence, you became more introverted and shy because of your colitis. Sports, sleepovers, and camping weekends ended. You had to be near a bathroom at all times, and you lost contact with most of your friends. Your bowel movements also had a dreadful smell, and you were teased a lot about your disease.

You spent most weekdays studying. On Sundays you helped your father in the church, and you loved serving at the altar and singing in the choir. Your mother noticed your musical talent and encouraged you to take singing lessons and learn the piano. As a teenager, you played the church organ every Sunday.

When you graduated from high school with honours, you decided to attend your father's old university in New Orleans. You chose mathematics and economics as your major.

Initially you did well in your studies. However, because of your love of music, you gravitated to the blues and jazz bars in the older parts of the city. The long nights in the bars and clubs affected your studies and your financial situation, as did your "dope" smoking.

You also started a passionate affair with Justine, a fellow student in sociology and political science. You made an attractive, striking couple, and you both were aware that people stared at you on the street and in bars. In your second semester, a man named **PHILIPPE** approached you. He said he was a professional photographer and asked to take some pictures of you and Justine. He offered you a few dollars and you accepted gladly. A few more photos were taken "to advertise the city," and then a few more. As the months went by, the photos with Justine became more and more risqué, and the money became better. You began appearing in movies. Philippe said these would be shown only in private clubs, and so nobody would find out. To protect your anonymity, you used the pseudonym "Rock Grand." You earned about $500 a semester, which paid most bills and your rent.

At the end of your second year, your father and brother paid a surprise visit. They walked into an apartment filled with cigarette and marijuana smoke, your friends' empty rye bottles, and a naked girl in your bed. Your father was furious. He took you back to Canada to continue your degree program here.

You felt shame and humiliation; you believed your father when he said a colitis flare-up was a result of "the evil inside you." You visited a gastroenterologist and underwent colonoscopy, and the flare-up resolved after medical therapy. You quit cigarette and marijuana smoking, although doing so was difficult.

- Marriage/Partnerships

You moved to this city about 24 years ago, and you met Penelope at a golf club social event 17 years ago. You married two years later.

Penelope is the only daughter of a wealthy family in this city, which made its money by building golf courses in exotic locations around the globe. You both have become even richer because of your job, which has allowed you to indulge your expensive tastes.

You and Penelope have never discussed your past in New Orleans.

- Children

Your son, **DANIEL**, is 14 and a keen football player. Your daughter, **SIMONE**, is 12 and passionate about horses. Both attend private schools, where they excel.

Education and work history

You graduated from high school at the top of your class. After returning to Canada following two years at university in New Orleans, you earned a first-class honours degree in mathematics and economics at a Montreal university.

After graduating, you had interviews for top jobs at investment consulting firms. You took your first job in this city in the late 1980s, when economic times were good. You have stayed with your firm, Cray Bros. Inc., your entire career. You have a pension and shares in the company and are now a senior partner who is likely to become the next global CEO.

Finances

You have a very good income. Although you've suffered a personal loss of about $500,000 in the stock market over the past two years, you are still extremely rich. However, you have a mortgage on a house and acreage worth nearly two million dollars, payments on your Lexus and Porsche, and the monthly fees for two private schools. Time off work is not an option.

Social supports

You have many friends at your golf and squash clubs. Most are quite well off and from the middle to upper classes. You also have friends at church.

Penelope's parents live in town, and you see them regularly. However, they are abroad for the colder parts of the year.

Religion

You, Penelope, and the children attend the local Anglican church every Sunday. You put considerable sums of money in the collection tray, and you enjoy singing hymns. You don't believe all the rubbish that is preached, but a good member of society should be seen to go to church.

ACTING INSTRUCTIONS

You are well-dressed in smart shoes, pants, and a shirt. A tie is optional. You are also wearing a wedding ring and a nice watch.

You don't care much for FPs and feel that you could easily do this job yourself. Although you desperately want treatment for your colitis and palpitations, you believe that all FPs do is refer patients to proper doctors who can actually prescribe something; initially, therefore, you are quite condescending.

Because of the awful story that has come out about your past, you appear stressed and tense. If the candidate asks why you are stressed, you do not hesitate to mention the possibility of your rise to the very top of your firm. However, you keep your sordid past more hidden.

A good candidate will make the link between stress and colitis and realize that something occurred around Christmas last year. If you are put at ease and gain confidence in the candidate, you explain more openly that you read something about yourself in the newspaper at Christmas. The seven-minute prompt is intended to give the candidate a huge hint that something awful happened in your life around this time. If the candidate does not follow up on the hint and inquire about it, you probably will not mention the event again.

You are **FEELING** embarrassed about your colitis, and your **IDEA** is that it is all caused by stress and the revelations about your past. It is affecting your **FUNCTION** because you cannot attend any lengthy meetings or play any golf. Your **EXPECTATION** is that you will receive treatment as soon as possible, either from the FP or a specialist.

You are **FEELING** worried about your palpitations, and your IDEA is that they are due to worsening stress. Is your sordid past catching up with you and affecting both your colitis and your palpitations? The attacks of palpitations are affecting your **FUNCTION** as you simply cannot cope with normal events during them. Your **EXPECTATION** is that you will have treatment as soon as possible to make them go away.

Cast of Characters

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

RICHARD GRANDON:	The patient, age 47, an investment advisor suffering from colitis and anxiety attacks.
"ROCK GRAND":	Richard's pseudonym when he acted in pornographic films.
PETER GRANDON:	Richard's father, an Anglican minister.
MARY GRANDON:	Richard's mother.
DAVID GRANDON:	Richard's brother, age 45.
PENELOPE GRANDON:	Richard's wife.
DANIEL GRANDON:	Richard and Penelope's son, age 14.
SIMONE GRANDON:	Richard and Penelope's daughter, age 12.
JUSTINE:	Richard's former lover and "co-star" in the pornographic films.
PHILIPPE:	The director of the pornographic films.
Dr. EVANS:	Richard's former FP, who has retired from practice.
Dr. SHEPPARD:	Richard's former gastroenterologist.
Dr. WONG:	The cardiologist whom Richard saw during his recent hospital stay.

Timeline

Today:	Appointment with the candidate.
5 days ago:	Palpitations and second ED visit; admission to hospital for a cardiac work-up.
2 weeks ago:	Anxiety attack in the car.
1 month ago:	Anxiety attack at work.
1 month ago:	Company CEO retired; rumours that you will be the next CEO began circulating.
4 months ago:	Read a revealing newspaper article; colitis flare-up began.
12 years ago, age 35:	Daughter born.
14 years ago, age 33:	Son born.
15 years ago, age 32:	Flare-up of colitis; last visit to a gastroenterologist; married Penelope.
17 years ago, age 30:	Met Penelope.

Examiner Interview Flow Sheet - Prompts

Initial statement	**"My colitis is flaring up again."**
10 minutes remaining* Optional, use only if you feel it's needed	If the candidate has not brought up the issue of the anxiety, the following prompt is to be used: **"I'd like to talk to you about these episodes I've been having."**
7 minutes remaining* Optional, use only if you feel it's needed	If the candidate seems to have forgotten about the colitis, this prompt may be used: **"Life has thrown me a real curveball in the past few months."** (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: Ulcerative Colitis

Issue #1	Illness Experience
Areas to be covered include: 1. current symptoms of colitis: • Abdominal pain. • Tenesmus. • Five loose bowel movements a day. • Flatulence. • Nausea. 2. history of colitis: • Started in his early teens. • Has had three previous attacks. • Treated previously with oral and rectal steroids. • Diagnosis confirmed by biopsy testing. • Uncle had colitis. 3. pertinent negative factors: • No blood in stools. • No weight loss. • No foreign travel. • No food sensitivity.. • No family history of bowel cancer. 4. excluding involvement of other systems: • No iritis. • No arthritis. • No rash.	**Description of the patient's illness experience**. You are feeling embarrassed that you cannot attend lengthy board meetings or play a full round of golf due to the symptoms. You believe that recent stress has caused the exacerbation. You hope to receive treatment for the attacks, either by the doctor (candidate) or a specialist. You would like to have treatment sooner than later.

		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: Anxiety Attacks

Issue #2	Illness Experience
Areas to be covered include: 1. history of the attacks: • Occurred three times in the past month. • This has never happened before. • Attacks lasted 20 to 30 minutes. • Two visits to the ED. • Attacks subsided spontaneously. 2. symptoms: • Palpitations. • Sweating. • Tremor. • Paleness. • Hands and fingers tingled. 3. lifestyle factors: • Non-smoker. • No coffee. • Exercises daily. • No current substance abuse. • One glass of wine a day. 4. pertinent negative factors: • No chest pain. • Not depressed. • No hemoptysis. • Full cardiac work-up negative. • No family history of heart complaints.	**Description of the patient's illness experience.** You are worried that this all due to stress and that your past is coming back to haunt you. During the attacks, you are unable to function. You want the doctor to make the feelings go away, sooner rather than later (as with the colitis).

		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. work history: • Senior investment advisor. • Potential for promotion. • Survived the economic downturn. • Has downsized the firm workforce. 2. family history: • Married. • Two children, ages 12 and 14. • Parents alive. • Minimal contact with his brother. 3. "sordid" past: • Previous pornographic movie career. • Previous illegal drug use. • Old videos on the Internet. 4. the lack of a confidant/nobody to talk to.	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: "There is obviously a lot happening for you at work right now. You also have stress regarding parts of your past life and all these factors may be connected to your Colitis flare up. This must be especially difficult for you as you have nobody to talk to."

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: Ulcerative Colitis

Plan for Issue #1	Finding Common Ground
Areas to be covered include: 1) Arrange a physical examination. 2) Obtain old records. 3) Discuss pharmacological treatment options. 4) Discuss referral to a gastroenterologist. / referral for colonoscopy 5) Discuss the link with bowel cancer.	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, 4 and 5.	Actively asks about the patient's ideas and wishes for management. Purposefully involves the patient in the development of a plan and seeks his or her feedback about it. Encourages the patient's full participation in decision-making.
Certificate Level	Covers points 1, 2, 3, and 4.	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: Anxiety Attacks

Plan for issue #2	Finding Common Ground
Areas to be covered include: 1) Suggest that the diagnosis is anxiety/panic attacks. 2) Discuss referral for therapy or counselling. 3) Discuss pharmacological treatment (e.g., beta-blockers, selective serotonin-reuptake inhibitors, short-term anxiolytics). 4) Discuss his coping strategies if his past becomes common knowledge.	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 Uses both general and active listening skills to facilitate communication. Sample behaviours • Allows time for appropriate silences • Feeds back to the patient what the candidate thinks has been understood from the patient • Responds to cues (doesn't carry on questioning on unrelated topics without acknowledging the patient if a major life or situation change is revealed) • Clarifies jargon the patient uses	**Cultural and Age Appropriateness** Adapts communication to the individual patient for reasons such as culture, age, and disability. Sample behaviours • Adapts their communication style to the patient's disability (e.g., writes for patients with hearing challenges) • Speaks at a volume appropriate for the patient's hearing • Identifies and adapts their manner to the patient according to the patient's culture • Chooses appropriate medical terminology for each patient (e.g., "pee" rather than "void" for children)
Non-Verbal Skills Expressive • Is conscious of the impact of body language on communication and adjusts it appropriately Sample behaviours • Ensures eye contact is appropriate for the patient's culture and comfort • 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 • Asks open- and closed-ended question appropriately

• 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")	• 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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