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. rectal bleeding of unknown etiology

2. headaches following a concussion.

The patient's feelings, ideas, and expectations, as well as an acceptable approach to management, are detailed in the case description and the marking scheme.

The candidate will view the following statement:

THE PATIENT

You are about to meet Ms. **SHEENA MURDOCH**, age 27, who is new to your practice.

CASE DESCRIPTION

Introduction

You are Ms. **SHEENA MURDOCH**, age 27. You are a respiratory therapist working on the resuscitation team of a local hospital. You have come to the doctor today because you think you need endoscopy. You have rectal bleeding, which has gradually been getting worse. While you are at the physician's office, you also want to ask about the headaches you have been experiencing over the past five days.

History of the problems

RECTAL BLEEDING

In the past two weeks you have been having rectal bleeding. At first you were having just a bit of bleeding, mostly when you wiped, but it has been getting heavier. In the past two days you have even seen some small clots. The blood is bright red.

There has been no change in the colour of your bowel movements, but the consistency has changed in the last while. You think your stools have been looser and that maybe some mucus has been present. Your bowel movements have been like this for the past three weeks or so. There has even been blood mixed in with the stool.

You have been having crampy pain in your stomach. It is hard to localize, and you wouldn't say any one spot is worse than another. You also have noticed a real sense of urgency when you have to have a bowel movement, and you do not always feel empty when you are done. You have difficulty saying exactly when these other symptoms started, but you are certain it was before the blood appeared and after the diarrhea appeared.

Your bowel movements have become quite variable in the past six months. Normally you have one or two bowel movements each day, with soft stools. Currently you are sometimes fine, but at other times you have a bowel movement up to seven or eight times a day.

You have definitely noticed the number varies depending on your stress level and you find when the problem is acting up, you have to stop playing hockey (your hobby) to have a bowel movement. You sometimes experience bloating and crampy pain in your stomach at these times.

Neither the pain nor your bowel movements have ever awakened you at night. You do not feel overtly fatigued or short of breath. You never feel light-headed or dizzy. You get the nurses to check your blood pressure and pulse every once in a while, and they haven't changed. You have not had any mouth sores or vision problems, and you have never had a problem with joint pain. Much to your disappointment, you have not travelled recently. You have not been camping or hiking. You do not know of anyone else with similar bowel problems.

You have not taken antibiotics for several years. You have no pain in your epigastric region and have never had symptoms of heartburn. You are not able to relate your symptoms to any particular food or to when you eat. You haven't lost any weight. You have not noticed a fever or chills. You have no "funny" rashes. You have no stiffness or fatigue. As far as you know, you have never had a rectal fissure. No one in your family has ever had any bowel problems of which you are aware. Specifically, there is no history

of inflammatory bowel disease (IBD). You have not had anal sex. There is no gastroenteritis outbreak at work right now.

You do not feel there was anything particularly unusual about your bowel movements in the past.

The loose stools and urgency have been pretty inconvenient at work. You wonder if you could have cancer.

HEADACHES/CONCUSSION

You have been having headaches off and on for the past five days, ever since you fell at work. You were running to a cardiac arrest when you slipped on a wet patch on the floor. You fell backward and hit your head. You saw stars for a bit and felt a little "out of it" for a while after, maybe an hour or so. You did not lose consciousness and had no weakness or unsteadiness. You were not dizzy or light-headed before the fall. None of your co-workers commented on a change in your behaviour following the accident.

Since the accident, you have had a bit of a headache all the time; you have noticed that the pain is worse when you do any physical activity, whether it is training for hockey or running around the hospital. You have not noticed that the headache impairs your ability to do your job or think clearly. You have been taking acetaminophen, about 1,000 mg four times a day (two extra-strength Tylenol four times a day). It hasn't really helped much.

Your headache does get better when you stop doing the activity that makes it worse. You have not had any weakness or numbness anywhere, and you have not noticed changes in your vision or sleep. You do not have a bump anywhere on your head. The headache is generalized, not focused on any one spot on your head. The pain is a low-grade nuisance for the most part. It is always there, but never awakens you at night. You have had no nausea or vomiting. You do not find that light or sound worsens your headache. You have no ringing in your ears. You have no discharge from your eyes or nose.

About seven months ago, you had a nasty fall during a hockey game. (Perhaps you had some help in "falling" from the opposition.) You were checked into the boards during the playoffs and hit your head on the ice when you fell. You felt "out of it" for a few minutes, but then got better and kept playing. You were aware of what was happening and had no obvious problem continuing to play once you got back in the game. You were playing recreational league hockey and there was no trainer around. You did not see a physician about the fall afterward. You did not have problems with headaches after this episode.

You find the headache annoying more than anything else. The increased intensity and throbbing when you run make work a little more difficult, but you persevered. You are not too happy that you may still have the problem during your game in a few days. You thought you would ask the candidate about the headaches because you were here today anyway. You wonder if massage would help.

You are aware of concussions, but do not really know what the symptoms feel like. Besides, a concussion happens only in car accidents and contact sports – not from falling in a hall.

You have not filled out any forms, but your supervisor **SUSAN EDWARDS**, does know you fell. You have not mentioned the headaches to her.

Medical history

You have been an essentially healthy person. Other than for the occasional childhood sore throat or ear infection, you have seen a physician only for annual check-ups. Your last check-up was in May, when you had your Pap test and your oral contraceptive (OC) prescription renewed.

Surgical history

None.

Medications

Oral contraceptive pills.

Acetaminophen, 1,000mg QID

Pertinent laboratory results

None.

Allergies

Oranges.

Immunizations

Up to date.

You have had a hepatitis B series.

Lifestyle issues

- Tobacco: You are a non-smoker.
- Alcohol: You may have one or two beers when you are out with friends after a hockey game.
- Caffeine: You drink four cups of coffee a day.
- Cannabis: None
- Recreational and/or other substances: You use no recreational drugs.
- Diet: You try to eat a healthy, well-balanced diet.

- Exercise and recreation habits: Currently, you play recreational hockey. The season has started, and you practise once a week and also participate in scheduled games. You generally alternate between going to the gym and running most days of the week.

Family history

Your parents live in your hometown. They are both teachers, however, your father retired four years ago. Your mother, **DORA DELPHINE**, is 56, your father, **HAROLD MURDOCH**, is 57. Both are healthy.

You have two older sisters. **YVONNE**, age 35, teaches English in Prague. You don't have much contact with her. **ELISE**, age 31, lives here in town. She is married and has two daughters and a son. Both your sisters are well.

Your paternal grandfather had prostate cancer, and your maternal grandmother developed breast cancer in her late 70s. You are not aware of any other cancers in your family. You know of no family member with inflammatory bowel disease.

Personal history

- Marriage/Partnerships

You have never been in what you would consider a serious relationship. You have dated several men, but never found anyone to whom you would want to make a commitment. At present, you are quite happy with your life. You think it might be nice to have children, but on the other hand you enjoy your independence and the surrogate parenting of your nieces and nephew.

- Children

You have no children.

Education and work history

You graduated from high school without any problems. After graduation you worked for one year in retail jobs, and then travelled for six months. When you returned home you went to community college and trained to be an emergency medical technician (EMT). You worked in this field for about a year and enjoyed the intermittent intensity of the job, but decided you wanted to try something different. A couple of people on your former recreational hockey team were respiratory therapists, and you thought that work would be interesting. You felt you would enjoy being employed in a hospital for a while and liked the idea of being able to work for a private business in the future.

Upon completing the three-year respiratory therapy training program, you went to work in your local hospital. You were there for about two years when your current job in this community became available. That was approximately six months ago. The pay was better, and your sister lived here, so you decided to move. You are currently working in a tertiary care hospital. You are on the resuscitation

team, which means you spend a considerable portion of your day running from place to place in the hospital.

Finances

You are financially secure. Your salary covers your monthly living costs, and you have a small amount in savings. A considerable portion of your savings was consumed by the move to this community six months ago. Your rent an apartment and live alone.

You are covered under the hospital's disability program. Extended medical benefits are part of your employment contract.

Social supports

You grew up close to your sisters, so it has been nice living in the same community as Elise again. You spend quite a bit of time visiting her and her family.

You have a good relationship with your parents. You are looking forward to Christmas, as they are planning to come here, and you all are hoping Yvonne will get home from Prague.

You have made many friends at the hospital. Because you work takes you all over the hospital, you meet all kinds of people. You have joined the hospital's recreational hockey league and enjoy going out with the team after games.

In your hometown, you have two very good friends with whom you keep in close contact. You could tell them anything.

You are not in a steady relationship. You are not averse to developing one, but at present are quite content to see what comes your way casually. During sexual encounters, you always use condoms in addition to your birth control pills.

Religion: You have no religious affiliation.

ACTING INSTRUCTIONS

You are dressed stylishly but simply. You don't wear a lot of makeup or jewellery. You are a straightforward person who likes straight answers to her questions.

You express your **FEELINGS** and opinions clearly and **EXPECT** other people to do the same.

You are quite worried about the rectal bleeding You haven't told anyone about it. You don't want to worry anyone prematurely. You wonder if you could have cancer. You know you are not really at the right age for it, but don't have any other explanation for the bleeding.

The headaches are a nuisance more than anything else. You would like them to go, but don't have a clear idea of the possible underlying problem. You think that muscle tensions may be the cause, and that massage might help. You are not particularly interested in changing your activities to respond to this problem. You would rather "play through" the pain. If the candidate clearly explains the nature of the problem and the importance of modifying activity, you will agree to try.

You do not volunteer information about the previous fall as you do not see that it has any relevance to this visit. However, you provide details freely if the candidate asks about any prior falls or head injuries.

Cast of Characters

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

SHEENA MURDOCH:	The 27-year-old patient, who is a respiratory therapist experiencing headaches and rectal bleeding.
HAROLD MURDOCH:	Sheena's 57-year-old father, who is a retired teacher.
DORA DELPHINE:	Sheena's 56-year-old mother, who is a teacher.
YVONNE MURDOCH:	Sheena's 35-year-old sister, who teaches English in Prague.
ELISE MURDOCH:	Sheena's 31-year-old sister, who lives in the same city; she is married with three children.

SUSAN EDWARDS:	Sheena's supervisor at the hospital.

Timeline

Today:	Appointment with the candidate.
Five days ago:	Fell at work.
Six months ago:	New job in tertiary care hospital.
Seven months ago:	Head injury in hockey game.

Examiner Interview Flow Sheet - Prompts

Initial statement	**"I have been having blood in my bowel movements, and I think I need to get it checked out."**
10 minutes remaining* Optional, use only if you feel it's needed	If the candidate has not brought up the issue of the concussion, the following prompt is to be used: **"While I am here, I want to ask you about these headaches I have been having."**
7 minutes remaining* Optional, use only if you feel it's needed	If the candidate seems to have forgotten about the rectal bleeding, the following prompt is to be used: **"So what about this bleeding?"** (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: Rectal Bleeding

Issue #1	Illness Experience
Areas to be covered include: 1. history of the current symptoms: • Bleeding began two weeks ago. • No melena. • Loose bowel movements. • Sensation of incomplete emptying. • Crampy abdominal pain 2. history of bowel problems: • Change in bowel habits six months ago. • Episodic diarrhea. • Symptoms exacerbated by stress and physical activity. • Bowel pattern normal in the past. 3. systemic symptoms: • No fatigue. • No weight loss. • No joint pain. • No rashes. • No epigastric pain or heartburn. 4. ruling out alternative causes: • No recent antibiotic use. • No exposure to contaminated water (e.g., while camping) • No recent travel. • No gastroenteritis outbreak at work.	**Description of the patient's illness experience**. You are worried that the bleeding could be due to cancer. The frequent trips to the toilet interfere with your work and your hockey games. You expect that the doctor will investigate further.

		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: Headaches/Concussion

Issue #2	Illness Experience
Areas to be covered include: 1. current headaches: • Dull, throbbing headache. • Exacerbated by activity. • Present for five days. • Acetaminophen not helping. 2. pertinent negative factors: • No photophobia and/or phonophobia. • No nausea or vomiting. • No other neurologic symptoms. • No mental slowness since the fall. 3. history of the fall: • Fell and hit her head at work. • No loss of consciousness. • Felt "out of it" for approximately one hour aftwerward. 4. previous head trauma: • Similar episode seven months earlier at a hockey game. • No headaches after this prior fall.	**Description of the patient's illness experience.** You are annoyed by the headaches, and you believe they might be related to your fall. You haven't changed any of your activities with the appearance of the headaches. You hope that the physician will help make the headaches go away and perhaps give you a referral for massage therapy.

		Determining the patient's illness experience is **not** a checklist assessment where a candidate asks about the patient's feelings, ideas, functioning, and expectations and should two or three of these four be asked aloud, a pass is then awarded. A certificate level illness experience performance is where the candidate gathers the patient's illness experience conversationally and integrates the knowledge gained in a way that communicates to the patient that this candidate is working to see the patient as a unique person with an illness, more than just a textbook disease process to be appropriately managed.

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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: • Her parents live out of town. • She is close to her sister who lives in town. • She has little contact with her sister in Prague. 2. life cycle issues: • She recently moved to a new community. • She has no long-term relationship. • She has no children. • She often cares for her sister's children. 3. social support: • She has made friends at work. • She has two very good friends in her hometown. • The hockey team is an important source of social and physical activities. 4. social factors: • She works as a respiratory therapist. • She is required to do physical activity in her current position. • She has a secure job. • She is trained as an EMT as well as a respiratory therapist.	Context integration measures the candidate's ability to: • Integrate issues pertaining to the patient's family, social structure, and personal development with the illness experience. • Reflect observations and insights back to the patient in a clear and empathic way. This step is crucial to the next phase of finding common ground with the patient to achieve an effective management plan. The following is an example of a statement a superior level candidate may make: "You are an active person, both at work and during your leisure time. You are now faced with two problems that are limiting your ability to be involved in the activities that are an integral component of your life."

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: Rectal Bleeding

Plan for Issue #1	Finding Common Ground
Areas to be covered include: 1) Arrange for a complete physical exam. 2) Arrange for a complete blood count. (Other blood work, such as erythrocyte sedimentation rate or coagulation studies, may also be included.) 3) Arrange for endoscopy within the next few weeks. (A gastroenterology or surgery referral is sufficient.) 4) Investigate for possible infectious causes.	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: Polyarthritis / Ulcerative Colitis

Plan for issue #2	Finding Common Ground
Areas to be covered include: 1) Inform the patient that she has a concussion. 2) Advise her to stop all physical activity (any activity that produces pain) at work and during her leisure time. 3) Arrange a follow-up appointment to re-evaluate the headaches in one week. 4) Discuss pain management. Massage may help with soft tissue pain but won't take away the pain due to the concussion; she must be pain-free without medication before she returns to sports or other activities.	Behaviours indicating efforts to find common ground go beyond the candidate asking "Any questions?" after a management plan is presented. Finding common ground is demonstrated by the candidate encouraging patient discussion, providing the patient with opportunities to ask questions at multiple points, encouraging the patient to express their thoughts, seeking clarification, checking for consensus, and recognizing then addressing patient hesitation or disagreement if it arises. Examiners need to determine the candidate's ability to find common ground based on behaviours they demonstrate during the interview.

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

6. Interview process and organization

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

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

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

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

Appendix 1 Standardized Instructions to Candidates

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

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

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

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

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

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

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

Appendix 2 CFPC Preparation Pointers for Examiners

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

Think of the following:

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

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

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

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

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

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

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

on tangents not in the script.

5. Do not overact.

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

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

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

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

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

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

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

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

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

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

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

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

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