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

[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. is pregnant.

2. has post-traumatic stress disorder.

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. **WENDY FRONTENAC**, age 32, who is new to your practice.

CASE DESCRIPTION

Introduction

You are Ms. **WENDY FRONTENAC**, age 32. You have just discovered that you are pregnant, and by your calculation you are 10 weeks along. The surprise of the pregnancy could not have come at a more challenging time, as you recently started to relive the sexual abuse of your childhood.

You have never had a regular family physician (FP). The small town in which you grew up has relied on locum doctors for decades. You selected this physician from the list available when you called the hospital.

History of the problems

PREGNANCY

You did a pregnancy test last week and discovered that you are pregnant. Your last menstrual period (LMP) was 12 weeks ago.

This is not your first pregnancy. From age 17 to 22, you lived on the street, supporting yourself through petty theft and working in the sex trade. You were pregnant three times and decided to terminate those pregnancies -all well before you were 12 weeks. At that time, you were not certain you could identify the fathers, and at age 22, you were using cocaine and prescription opiates daily.

This pregnancy was not planned, and you and your partner of three years, **TIM**, age 27, have not really discussed a family. Because of the terminations and an episode of pelvic inflammatory disease (PID), you wondered whether you could even become pregnant. You have not used contraception of any kind since you moved in with Tim. After a year with no pregnancy, you figured you were “probably safe.” Tim seemed fine with not having children, but now that you are pregnant, he is very happy.

You believe that this pregnancy will go well. You have been pretty healthy. You have had no nausea or vomiting, although you have had some fatigue and breast tenderness. You have had no bleeding.

Your past medical history is uncomplicated. You did contract hepatitis C infection when you were injecting drugs but completed treatment for it five years ago. Your infectious disease specialist and, more important, your hepatitis nurse have always reassured you that you should have no problems with a pregnancy.

As far as you know, you don’t need to worry about any genetic issues. However, you have not decided whether to have genetic testing—you are not certain you would ever go through with another termination.

Currently you don’t use any drugs. Ten years ago, you entered a drug treatment program. After multiple residential and outpatient treatments, you started using methadone and kept using it for five years. You are no longer using it, but you continue to be part of a program and still attend a meeting once a week—more often if you are feeling fragile. You have a great relationship with your sponsor, **LORRAINE**, age 45.

You have one remaining bad habit: you still smoke a half pack of cigarettes a day and would be interested in stopping.

You have two cats, and one roams outside. You look after the cats, which includes cleaning the litter box.

You are fine with the pregnancy but are starting to wonder what giving birth will be like.

POST-TRAUMATIC STRESS DISORDER

The past month has been one of the most difficult you have ever experienced. Five weeks ago, you received a phone call from **TANYA**, age 42, who is one of your cousins. She was in town to support her daughter, **CANDICE**, age 18, who was testifying in court.

Candice was sexually abused by **PHIL**, a family friend, when she was 11 and 12 years old. She was not the only one who was abused, and she is one of several young women who testified. Tanya called because she thought you might want to go to court; she suspected Phil might have assaulted you.

She was right. As an 11-year-old you were pretty confused. Life at home was chaotic, and looking back as an adult, you realize that your parents had drug and alcohol issues. Your father drank heavily on weekends and your mother drank daily and used lots of pills. You were flattered by Phil's attention. He would visit the house and, because your parents were not there to care for you, gave you your first real drinks. He introduced you to marijuana at the same time. You cannot believe your parents did not know about Phil. Your behaviour and clothes changed in ways that, as an adult, you see as obvious warning signs. You used alcohol and drugs to bury the pain of the abuse, which lasted until you were 14.

In your more charitable moments, you forgive your parents for failing to notice, and you suspect your mother may have been abused. Most of the time, however, you are angry that no one protected you. At 17, you left home after repeated arguments with your parents, who did not seem to notice the pain you were experiencing.

Sex became a way to survive and get what you needed. You mostly lived by couch surfing and traded sex for drugs and rent. Occasionally you had a paying customer, but mostly you were able to avoid the seedier side of sex work.

You changed your life when you were 22 because you were tired of the lifestyle. In addition, a friend's body had been found in a ditch and that scared you. You are pretty certain she crossed one of the gangs in town.

After Tanya's call, you decided to testify against Phil. You went to court alone because Tim was working out of town.

When you arrived in court you "felt solid," but as soon as you saw Phil, memories of the abuse started to return. You had the sensation of choking and could not catch your breath. You felt trapped and unable to move. Your eyes filled with tears, but you could do nothing. A court officer saw your distress and helped you out of the courtroom. Her kind words about how hard these events can be felt like a warm blanket, and you managed to return home.

Since that time, you have been unable to get the events of your abuse out of your mind. You are having flashbacks and nightmares. Your heart starts pounding when you remember the events. You feel irritable and anxious. Once, when you were at the mall, you saw a man who looked like Phil and you

were overwhelmed with the same feelings. No one has noticed that your concentration has decreased, but lately people at the diner where you work as a waitress have noticed you are quite jumpy and are startled easily. You have spilled coffee at work.

In two weeks, you are supposed to travel by bus to a nearby town to attend the wedding of the only family member with whom you are still in contact, your sister, **KATHY**, age 47. Kathy and you reconnected when you were finally sober. Both of you have avoided a real heart-to-heart talk about what went on at home. Kathy has been in therapy for a long time, and you suspect she had some of the same issues as you did growing up. You see each other twice a year and chat perhaps once a month by phone. You both have great defences.

Tim is unable to go to the wedding. Your mother likely will be taking the same bus, and you know you won't be able to get on it if she is there. You would like the FP to validate your feelings and give you permission not to go, but you will respond favourably to a supportive plan, such as office visits before and after the wedding.

You have not discussed this as PTSD with anyone else except although you believe this is what it is most likely. You have not discussed this Lorraine your sponsor or at meetings.

Despite everything that has been happening you have not considered doing anything to change your sobriety by using again.

Medical history

You have received treatment for hepatitis C infection.

You have had previous PID.

You have had three therapeutic abortions-all before 12 weeks.

Surgical history

You have had no major surgery.

Medications

You take no medications.

You have not started taking prenatal vitamins.

Pertinent laboratory results

You have had no recent laboratory tests.

You had a Pap test three years ago and sexually transmitted infections testing when you started your relationship with Tim.

Allergies

You have no allergies, but you often tell people you have a narcotics allergy in order to avoid exposure to opiates.

Immunizations

Your immunizations, including hepatitis A and B immunizations, are up to date. Your rubella immune status is unknown.

Lifestyle issues

- Tobacco: You currently smoke half a pack of cigarettes a day. You are contemplating stopping smoking.
- Alcohol: You do not drink alcohol.
- Caffeine: You drink two cups of coffee a day.
- Cannabis: None currently
- Recreational and/or other substances: Currently you do not use any illicit drugs.
- Diet: You eat well generally, although you can easily slip back into the junk food habit of your early years. No one ever taught you how to cook.
- Exercise and recreation habits: You enjoy being outdoors with Tim. You never imagined that you would enjoy fishing and hunting, but you do.

Family history

Your parents abuse alcohol. You know of no family history of genetic diseases.

Personal history

- Family of Origin

You grew up in a small community. Your parents were employed in resource-based industries (mining, lumber for example) and there were times when money was abundant and others when it was not.

You laugh when you hear people discuss moving to the “country” to keep their children away from bad influences. The community was small enough for your family to be known for their alcohol use and chaotic home, but the school and community never took any action. You suspect that there were other families like yours in town, but no one really talked about this.

Your parents are still married. Ten years ago, they retired and moved to the same community in which you are now living. Their pensions are their sole source of income. You know that their drinking has continued and are relieved that this preoccupies them enough to avoid you. Basically, you are estranged from them, and deep down you wonder if they ever really cared about you.

Your only sibling is Kathy. She left home at age 18, when you were three years old. She put herself through college and eventually became a teacher. She has never had children and you have never asked why. Your relationship with her restarted only recently, and you would not say that the two of you are close. You understand Kathy's previous need to distance herself from your parents and from you. You realize she now understands you are leading a sober life. The invitation to her wedding is a real olive branch. You are perplexed that she has invited your mother to the wedding, but trust she has a good reason for doing so.

- Marriage/Partnerships

You and Tim met three years ago, when a friend from work set the two of you up. You have lived together for two years. You know Tim loves you: he has accepted your past and treats you well.

Tim has never had a problem with drugs, but both his parents suffered from alcoholism. His childhood was tough, and he is a survivor. He understands where you have been but is quite clear about his own need to live with a sober partner.

You have never been married and you and Tim have no plans to marry. A baby would not change this.

- Children

You have no children. Tim has a six-year-old daughter from a previous relationship. She lives with her mother in another city. Tim provides for her as required, and she has visited you for two weeks every summer.

Education and work history

You received your high school equivalency a few years ago. You work as a waitress in a breakfast and lunch diner. You like the regular hours, the early start, and meeting "morning people."

Finances

You and Tim make reasonable money. He works in construction. Your needs are simple and are met by your incomes.

Social supports

Tim is a major support, as is your sponsor, Lorraine. You have a good circle of friends, but, while you are quite sociable, they are not close friends. You have difficulty trusting people.

Religion

You do not attend any religious services.

ACTING INSTRUCTIONS

You are dressed in a tee-shirt and jeans. You do not wear makeup and you are modest in your appearance.

You respond well to a physician who is not judgmental about your past but will be more reticent if he or she does seem judgmental. You are very forthright and a bit rough around the edges in your speech ("Like, I got knocked up," and "He was a shit," etc.). You do work with the public and will apologize to the physician for any inappropriate language.

Your **FEELING** is happiness about the pregnancy. You are pretty certain that it will go well, but you are worried about how your anxiety could affect the baby and the impact of your past on the baby. Your **IDEA** is that you may have anxiety, but you strongly suspect you have PTSD. Your **FUNCTION** has been affected because you are having difficulty sleeping and are jumpy at work. However, you have been able to keep working with the pregnancy. Your **EXPECTATION** is that the physician will help take care of your pregnancy needs and will support you in dealing with your new anxiety. You are concerned about taking any drugs and hope the physician will not prescribe any right away. You want to attend your sister's wedding, but you are really worried about seeing your mother and secretly hope the FP may give you an excuse not to attend.

Cast of Characters

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

WENDY FRONTENAC:	The patient, age 32, who works as a waitress and is pregnant and suffering from PTSD.
TIM:	Wendy's partner, age 27, who is the father of her baby.
KATHY:	Wendy's sister, age 47.
LORRAINE:	Wendy's sponsor, age 45.

Timeline

2 weeks from now:	Sister Kathy's wedding.
Today:	Appointment with the candidate.
1 month ago:	Saw your former abuser, Phil, at the courthouse.
12 weeks ago:	Last menstrual period.
2 years ago:	Moved in with Tim.
3 years ago:	Met Tim.
10 years ago:	Stopped drug use and changed lifestyle.
15 years ago:	Left parents' home to live on the street.

Examiner Interview Flow Sheet - Prompts

Initial statement	**"I think I am pregnant."**
10 minutes remaining* Optional, use only if you feel it's needed	If the candidate has not brought up the issue of the PTSD, the following prompt is to be used: **"Something weird happened at the courthouse a month ago."**
7 minutes remaining* Optional, use only if you feel it's needed	If the candidate seems to have forgotten about the pregnancy, the following prompt is to be used: **"What do I need to do for this pregnancy?"** (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: Pregnancy

Issue #1	Illness Experience
Areas to be covered include: 1. current pregnancy: • LMP 12 weeks ago. • No prenatal care to date. • No nausea/no vomiting. • No bleeding/no cramping. • No prenatal vitamins/no folic acid. 2. Past gynecological/obstetric history: • PID in the past. • Three therapeutic abortions. • Used no contraception before the pregnancy. 3. ruling out pregnancy red flags: • Is a smoker. • Has no genetic concerns. 4. substance use-related issues: • Hepatitis C virus infection treated. • Previously did well with methadone. • No drug use.	**Description of the patient's illness experience**. You are both hopeful and apprehensive about the pregnancy. You think that the doctor can help you plan for a health baby and that the doctor will also undertake your pregnancy care.

		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: PTSD

Issue #2	Illness Experience
Areas to be covered include: 1. current symptoms: • Started one month ago. • Trigger was seeing Phil. • Short of breath. • At times unable to move. • Recurrent episodes/nightmares. 2. past history: • Childhood sexual abuse. • Started at age 11. • Perpetrator was a family friend. • Other family members were abused. 3. treatment: • Never sought professional help/counselling about her abuse. • Tim accepts and understands her past. 4. has not been tempted to use substances in the past month.	**Description of the patient's illness experience.** You are worried that this is related to your past abuse. It is impacting your sleep and work, and you are concerned about attending your sister's wedding. You are hoping that the doctor will help you deal with the symptoms you have been experiencing.

		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: • Parents suffer from alcoholism. • Estranged from parents. • Sister Kathy. 2. Social factors: • No close friends. • Sponsor Lorraine. • Attends group (NA, Al- Anon). • Works as a waitress. 3. Teenage years: • Drug abuse. • Traded sex for drugs and rent. • Living on the street after the age of 17. 4. Tim: • Living together. • No abuse. • The father of her baby. • No history of substance use. • Happy about the baby.	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 have had real challenges in your life, from the family you came from to living on the streets and surviving childhood sexual abuse. You have done so well in remaining substance free and this pregnancy is positive for you I can understand your concern that this recent event will derail you."

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: Pregnancy

Plan for Issue #1	Finding Common Ground
Areas to be covered include: 1) Confirm she will be continuing with this pregnancy. 2) Arrange for prenatal care. 3) Advise the use of prenatal vitamins/folic acid. 4) Discuss smoking cessation.	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: PTSD

Plan for issue #2	Finding Common Ground
Areas to be covered include: 1) Agree with the patient that the symptoms are related to past abuse/suggest a diagnosis of PTSD. 2) Offer non-pharmacological support for treatment/counselling with self or others. 3) Validate/support her anxiety about her sister's wedding. 4) Discuss the importance of dealing with the past sexual abuse before giving birth.	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	**Language Skills** Verbal • Has skills that are adequate for the patient to understand what is being said • Converses at a level appropriate for the patient's age and educational level

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

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