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

RATIONALE FOR SIMULATED OFFICE ORAL EXAMINATION #

[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.

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

1. wants to bank his sperm because of an abnormal prostate-specific antigen test result

2. has parents who have dementia and whose health is deteriorating

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. **BRUCE CROTHERS**, age 56, who is new to your practice.

CASE DESCRIPTION

Introduction

You are Mr. **BRUCE CROTHERS**, age 56, a self-employed and highly successful financial services consultant. You are used to planning and being in control,

but recent events are causing havoc in your well-ordered life. You have recently found out that your prostate-specific antigen (PSA) level is high, which raises the possibility of prostate cancer and impaired fertility.

You would normally see your own family physician (FP), but inconveniently, **DR. WILLIAM KIDD** had a major heart attack last week, shortly after you last saw him. You would have talked to him about sperm donation and sperm banks, but now that's impossible. That's why you've come to see the candidate.

To make a bad situation worse, a few minutes ago your parents' housekeeper informed you of a crisis at their home. This is all too much!

History of the problems

ELEVATED PROSTATE-SPECIFIC ANTIGEN LEVEL

Two weeks ago, you went to your FP for a physical examination. You were feeling perfectly healthy, but you hadn't seen a physician for three years and thought it was about time. Dr. Kidd did a complete physical exam, including a digital rectal examination (DRE), which he said was normal. He also ordered some blood tests and sent you home with a fecal occult blood test. You wondered why you had to pay for some of the blood tests, but the cost was trifling; Dr. Kidd has always been pretty thorough.

Your blood pressure (BP) and cholesterol, blood sugar, and fecal occult blood results were normal. However, your PSA level was elevated (6.8).

You have mixed feelings about the PSA screening. You hadn't had a PSA measurement before, but now you know that screening for prostate cancer is controversial, and that you didn't have an opportunity to give consent. You realize that the laboratory charge was for the PSA test. You're not sure that you would have consented to PSA screening and are angry that Dr. Kidd didn't give you that choice. Now he has had this heart attack, and you can't talk to him.

You've done your research and you're pretty sure you wouldn't do anything except periodically repeat the PSA measurement if you weren't contemplating starting a family with your new girlfriend, **ABIGAIL CHAPMAN**. Now you feel forced to investigate the problem further: "I know it may not be cancer, but if it is, I want to have all my ducks in a row and be properly prepared."

You feel that if you do have prostate cancer, you will decide to go ahead with treatment. You've reviewed reliable information on the internet and are fully informed about possible side effects. If given the choice between radiation and surgery, and assuming both would be equally effective, you would probably choose surgery because you are worried about inducing a chronic painful condition (prostatitis) with radiation. Dr. Kidd was going to refer you to a urologist, but the day after you received the results, he had his massive heart attack and nothing at all has been done. You know that the new physician can set up the urology appointment: that's a pretty routine thing to do.

You've never had any prostate symptoms, such as frequency, urgency, hesitancy, poor stream, nocturia, or hematuria. You've had no fevers, weight loss, or bone pain.

You have normal erections and ejaculations, and a healthy sex drive. You've never had any symptoms or a diagnosis of a sexually transmitted disease.

You know that treatment for prostate cancer will most likely cause infertility, and perhaps impotence. Because you are contemplating a future family, you want to make arrangements to bank your sperm, should you need treatment.

Unfortunately, you had one of your assistants do some research, and discovered some disquieting information about sperm banks. It appears that some centres do not adhere to federal standards, and that some of the "straws" can't be linked to the donors. You find this appalling and most unprofessional; you're now very worried that if you were to bank your sperm, you'd have no guarantee that future children would be genetically related to you. The Crothers name and the high-quality genes that go with it are too important to risk because of sloppy paperwork!

CRISIS WITH YOUR PARENTS

EMILDA, your parents' housekeeper for the past five years, reached you on your cell phone a few minutes ago, just as you were coming into the candidate's office. This morning, your father told her that for the past two nights he's been patrolling the house with his loaded Second World War rifle, "just to make sure those damned neighbours don't sneak over and look in our windows". He believes they do this only at night, so he's unloaded the rifle and put the ammunition back in storage now that Emilda is there. You know that this is a crisis, and a safety issue for the neighbours, your mother, and the housekeeper. Something has to be done – but what, and by whom? There has to be a solution, but you're too busy to deal with the situation, and have enough problems of your own.

This rifle incident is the latest in a string of problems. Both your parents seem to be suffering from dementia. Your mother has had progressive dementia (Alzheimer's disease) for 11 years, and recently your father has been showing signs of dementia, too. He's not quietly confused like your mother. Two months ago, he yelled at a gas company employee reading the meter, and recently he said he put out poisoned bait for the neighbour's dog. This doesn't make any sense as their yard is completely fenced, and the dog is a toy poodle that can barely jump onto a couch. He bears a grudge against the neighbours, and still remembers a dispute from 30 years ago.

Medical history

You have always been healthy. You've had no hospitalizations or emergency department visits. Recurrent tennis elbow is the worst ailment you've had. You had to attend physiotherapy for three weeks with one occurrence.

You have had no genitourinary (GU) symptoms or diagnoses except for the one high PSA test result recently.

Surgical history: None

Medications

You are not using any prescription drugs. You take the odd ibuprofen (Advil) for strains and sprains.

Pertinent laboratory results

PSA 6.8.

Normal fasting blood sugar measurement, lipid profile, and kidney and liver function.

Allergies: None.

Immunizations: Up to date.

Lifestyle issues

- Tobacco: You do not smoke
- Alcohol: You drink socially. Never more than two drinks.
- Caffeine: Two cups of tea in the morning.
- Cannabis: None
- Recreational and/or other substances: You've never dabbled in any street drugs. "My body is my temple."
- Diet: You really enjoy fine food. You've "inherited good genes", so your cholesterol and sugar levels have never been high, and you've been able to indulge in gourmet foods.
- Exercise and recreation habits: You belong to an executive health club in the downtown building where your office is located. You play squash twice a week and do a little stretching and weight training three days a week. Your aerobic capacity and flexibility are top-notch. You are a consistent winner at squash, and you're very comfortable on even the most demanding ski slopes.

Family history

There's no family history of prostate cancer.

Your grandparents were healthy and died of old age. (Your mother's parents lived into their 80s.)

Personal history

- Family of Origin

Your mother, **LOUISE CROTHERS**, was born in 1920 in London, England. She was an only child. She met your father during the Second World War; she was swept off her feet by the dashing Canadian flyer.

She had attended a secretarial school, and started working at age 17. She had a wonderful native intelligence and ended up as the executive secretary to a vice-president of a major book retailer. She retired in 1985, and lived a healthy, fulfilling retirement until her progressive dementia reared its head in 1993. She was always very healthy, swimming and playing tennis until her mind was overcome by her disease. She'd never taken any pills, but now she's taking donepezil (Aricept), which doesn't seem to have halted the progression of the Alzheimer's disease very successfully.

You've always gotten along with your mother; she was a sound, sensible Englishwoman, who gave you good advice. Seeing her slow decline has been so sad. At times she doesn't recognize you; sometimes she thinks you're her husband. She always looked ahead, so even before the Alzheimer's disease set in she gave you full control (a mandate) of all areas of her life. This mandate was to be used if necessary. She thought you were a better choice than her husband, as she believed it unwise to give legal powers to someone who was older than she was. This was a bone of contention between you and your father.

Your father, **GEORGE CROTHERS**, was born in 1914 in Winnipeg. He was trained as an accountant but signed up in the Royal Canadian Air Force in 1939, mainly for the adventure. He flew Hurricanes early on, and then switched to Typhoons (tank busters). He was a natural fighter pilot and was given a medal and a promotion for his exploits on D-Day. (He's been a consultant for major motion pictures about the war.)

He returned to Canada a hero and rose to become a senior manager in the aerospace industry. He retired in 1984. Like your mother, he's been very healthy. They both have the same FP, Dr. SUSAN MELDRUM, but your father prides himself on never going to see her.

Your relationship with your father has always been difficult. If you got a grade of 95% at school, your father would always ask about the other five percentage points. He never understood your wish to go away to university in the USA, and still doesn't understand quite what you do, although he does acknowledge that you have a knack for making money. He was a team player, in both the air force and sports. He wanted you to play soccer and football, sports with which you were never comfortable. He thought squash and skiing weren't really sports at all.

You've never been able to stand up to him. He has a ferocious command of logic, and you could never win an argument with him.

All in all, you really don't like him. Generally, you've been distant, but now you've been dragged back into his life as the situation has worsened.

Since your mother became sick, your father has been her sole caregiver; he used to handle their finances, and shop for groceries. Fortunately, he did give up driving several years ago. This was likely a financial decision: all the services he needs are within easy walking distance of the house. Even Dr. Meldrum's office is just around the corner.

He was never able to master cooking and cleaning, so five years ago he agreed to hire Emilda. She works from 9 am to 8 pm, Monday through Friday. She's been buying the groceries for the past couple of years. A year ago, you persuaded him to hire **SWEE-SIM**, who performs Emilda's tasks on the weekend.

Your father has been increasingly forgetful, missing garbage and blue box collections. If your parents hadn't previously made arrangements for lawn mowing, window cleaning, and eaves trough clearing, those tasks would probably remain undone.

Because your father recognizes your financial skills, he has allowed you to guide their investment strategy, but in the past year his memory has slipped: he missed paying some bills and you've assumed de facto control of all the finances.

You actually have no legal authority to do so. You see these events as evidence of your father following in your mother's footsteps.

You would love to find a quick solution to your parents' care. Money is not a problem, as both you and your parents are very well off, but your father has been resistant to any change. For example, you've suggested they'd be better off in a retirement home, but your father will have none of that foolish talk. He has refused even to consider placement on a waiting list.

- Marriage/Partnerships

You married at age 38 but divorced after five years. Your wife, **CATHY HOFFMAN**, was a real bitch—a ball-buster: "She seemed so sweet at first, but all she really wanted was her own career as a lawyer." She'd been the Canadian champion in the 100-meter hurdles and was a great squash player. You met playing squash.

You and Cathy had no children, and you have no children from any other relationship. Before and after your disastrous marriage, you had short-term relationships with women you met on vacation; the sex was always good.

You usually used condoms.

Over the past six months you have been dating Abigail, a student in the undergraduate course for which you guest lectured two classes last year. She's 23, and a real sweetie: gentle and kind. She wasn't one of the best students, but with the extra tutoring she requested, she passed the course. You enjoyed the celebratory dinner that ensued. She grew up in a small town, and was quite sheltered, so it's been fun showing her the sophisticated life in the city. You've taken her out to dinner a couple of times, and to the opera once.

She'd never been to an opera before, and got a bit confused by the plot turns in Mozart's Le Nozze di Figaro—"That's The Marriage of Figaro, of course"—but she seemed to enjoy it.

This relationship is moving ahead more slowly than usual. Abigail is inexperienced sexually, so you've kissed her only once. That was a goodnight kiss after the opera. Certainly nothing sexual has happened so far (although you do desire her), but you think that she could be the one with whom you will have a family.

She's eager to graduate and get out into the real world, but with her grades she's not likely to find a job that's very interesting. She'll probably realize she's not cut out for the rough-and-tumble of the business world and settle for a part-time job; you think she'd be a great front desk person. You could provide her with a good life, and she'd be a wonderful mother, wife, and companion. You'd never think of just living with her: this is your future wife!

You have not discussed your thoughts about the future with Abigail; she has exams coming up, and really needs to concentrate on studying. Knowing that she was going to be married, wealthy, and living in the city would put her in such a tizzy that she might not do well.

You haven't met Abigail's parents.

- Children: You have no children.

Education and work history

Your parents sent you to all the best schools. Your birthday is toward the end of the year, so you were younger than most of your classmates. You did fine academically, but you had no real social life.

You attended Cal Tech, where you earned a degree in the new field of computer engineering. You realized that if you obtained an MBA, you could be in the forefront of a major new business paradigm, so you did and you were. You could have stayed in the USA, but that would have meant entering the lottery for the draft; you returned to Canada.

You are now a well-known consultant in the financial services sector. You entered the field early and have been on the leading edge ever since. For the past 15 years you've been on your own. Your company is small, but you get big contracts because of the quality of your work. You are often on the national networks as a commentator on business issues. However, you may say to the candidate, "I know doctors don't seem to keep up with financial matters, so you may not have seen me".

In the past seven years you have been a guest lecturer in the undergraduate program at the local university. You enjoy teaching. You are really pleased that the students, especially the women, seem to like you. You've written a number of reference letters for students; you're a bit disappointed they haven't kept in touch once they've graduated.

Finances:

You are rich. You have an extensive investment portfolio, and own property in several cities. Your home is here, and you have a condo in Snowmass, Colorado, to which you escape when you need a break.

You do, of course, take other vacations: you attend shows in London, enjoy the Venice Carnival, and take ski and golf trips.

Social supports:

You have a few squash and golf buddies. They are good for having a beer with, but you have no contact outside the club, or off the course.

Your employees are just your employees. You don't believe in mixing work and pleasure.

You've been spending some time with Abigail recently.

Religion:

You suppose that you're Anglican. You really like the sound of a choir in a fine Gothic chapel.

ACTING INSTRUCTIONS

You are immaculately dressed. You are wearing a jacket with or without a tie.

You treat the candidate as an equal and will put him or her down if he or she "doesn't seem up to snuff".

After the opening statement, begin the history by mentioning the new relationship. For example, you might say, "Well, I've begun seeing this wonderful girl, but now I don't know if we'll be able to have kids."

You are self-centred, and have the following opinions:

- Dr. Kidd has let you down by having a myocardial infarction (MI).
- Why don't the feds have better control over things they license (e.g., sperm banks)?
- Why is my father making things difficult right now?
- Who's going to look after these things? I'm too preoccupied with my PSA and Abby.

You have great expertise with internet searching; you've learned a lot about prostate cancer (probably more than the average FP), and are completely familiar with all the terms, acronyms, staging systems, etc. You expect anyone you talk with to be as familiar with the material as you are.

If asked about finances, clearly indicate that no expense (a nighttime caregiver for your parents, etc.) will cause any hardship.

If the candidate suggests waiting to see the results of further prostate investigations before considering sperm donation, insist that you wish to know the facts about sperm banks, and to be put in touch with a good one now.

If the candidate asks you to return for a physical exam (and does not mention DRE specifically), ask: "What needs to be done, as I had a physical two weeks ago?"

Cast of Characters

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

BRUCE CROTHERS:	The patient, a 56-year-old financial services consultant, with an elevated PSA level.
ABIGAIL CHAPMAN:	Bruce's new love interest, a 23-year-old student.
GEORGE CROTHERS:	Bruce's father, age 90.
LOUISE CROTHERS:	Bruce's mother, age 84.
CATHY HOFFMAN:	Bruce's former wife.
EMILDA:	George and Louise's housekeeper, who works Monday through Friday.
SWEE-SIM:	George and Louise's weekend housekeeper.
DR. WILLIAM KIDD:	Bruce's FP, who had an MI last week.
DR. SUSAN MELDRUM:	George and Louise's FP.

Timeline

Today:	Appointment with the candidate.
Two days ago:	Learned his father was patrolling with a gun
6 months ago:	Began “dating” Abigail
11 years ago:	Mother diagnosed with Alzheimer’s Disease
13 years ago:	Divorced Cathy Hoffman
18 years ago:	Married Cathy Hoffman

Examiner Interview Flow Sheet - Prompts

Initial statement	"**I've been doing some research about prostate cancer and fertility, and I need to talk to you about it**."
10 minutes remaining* Optional, use only if you feel it's needed	If the candidate has not brought up the issue of the parents' dementia, the following prompt is to be used: "**And now my father's acting up**."
7 minutes remaining* Optional, use only if you feel it's needed	If the candidate seems to have forgotten about the prostate issue, the following prompt is to be used: "**So what about my future kids**?" (This prompt is often not necessary.)
0 minutes remaining	"Your time is up."

* To avoid interfering with the flow of the interview, remember that the seven- and 10-minutes remaining prompts are optional. To avoid interrupting the candidate in mid-sentence or disrupting their reasoning process, delaying the delivery of these prompts is acceptable.

Note:

During the last three minutes of the interview, you may only provide information by answering direct questions, and you should not **volunteer** new information. You should allow the candidate to conclude the interview during this time.

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Session

Simulated Office Oral

Marking Scheme

NOTE: To cover a particular area, the candidate must address at least 50 per cent of the bullet points listed under each numbered point in the left-hand box on the marking scheme.

1. Identification: Elevated PSA Level

Issue #1	Illness Experience
Areas to be covered include: 1. history of elevated PSA level: • PSA 6.8. • No previous PSA testing. • No current symptoms of benign prostatic hypertrophy. • No family history of prostate cancer. 2. concern regarding fertility: • Loss of fertility with treatment. • Wants to bank his sperm before treatment. • Has never had a child. 3. potency/fertility: • No erectile dysfunction. • Unchanged (normal) sexual desire. 4. no discussion of plans for pregnancy with Abigail.	**Description of the patient's illness experience**. You are feeling irritated regarding PSA testing. You are upset that the incompetent bureaucracy is messing up your plans. You think you might have prostate cancer or that your sperm samples might get mixed up. You are expecting that you will find a decent sperm bank with the help of the visit to the FP, and that the FP will arrange for a urology referral.

		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: Parents' Dementia

Issue #2	Illness Experience
Areas to be covered include: 1. current crisis: • Father is patrolling with a loaded rifle at night. • Rifle is unloaded at this moment. • Mother is demented. • No caregivers at home at night. 2. parents' current situation: • No financial barriers to care. • Father has refused to put their names on waiting lists. • Father is not driving. • Patient is managing their finances. • Patient has full legal responsibility (mandate) for mother. 3. father's gradual deterioration: • Requires daytime caregivers. • Increasingly paranoid ideation (meter reader, dog, neighbours). • Loss of short-term memory. 4. parents have their own FP.	**Description of the patient's illness experience.** You are feeling annoyed that you cannot manage your parents on your own ("I'm trying the best I can.") and you think your father is becoming demented. You don't have more time to spend on looking after your parents and you are hoping that the FP will help solve the crisis for you.

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

Superior Level	Covers points 1, 2, 3, and 4.	Actively explores the illness experience to arrive at an **in-depth** understanding of it. This is achieved through the purposeful use of verbal and non-verbal techniques, including both effective questioning and active listening.
Certificate Level	Covers points 1, 2, and 3.	Learns about the illness experience arriving at a **satisfactory** understanding of it. This is achieved by asking appropriate questions and using non-verbal skills.
Non-Certificate Level	Does **not** cover points 1, 2, and 3.	Demonstrates minimal interest in the illness experience, focusing mainly on the disease process, and so gains **little** understanding of the illness experience. There is little acknowledgement of the patient's verbal or non-verbal cues, or the candidate often cuts the patient off.

3. Social and developmental context

Context Identification	Context Integration
Areas to be covered include: 1. family: • Only child. • Strained relationship with father. • Close to mother. 2. employment: • Financial services consultant. • National commentator/expert in his field. • Guest lecturer. 3. relationship with Abby: • She's 23 years old. • He tutored her. • They've had only a few dates. • No sex.	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 seem caught in the increasingly common sandwich generation phenomenon: you feel the need to be looking after yourself and your future, and you feel the pressure of the needs of your aging parents."

Superior Level	Covers points 1, 2, and 3.	Demonstrates initial synthesis of contextual factors, and an understanding of their impact on the illness experience. Empathically reflects observations and insights back to the patient.
Certificate Level	Covers points 1 and 2.	Demonstrates recognition of the impact of the contextual factors on the illness experience.
Non-Certificate Level	Does **not** cover points 1and 2	Demonstrates minimal interest in the impact of the contextual factors on the illness experience or often cuts the patient off.

4. Management: Elevated PSA Level

Plan for Issue #1	Finding Common Ground
Areas to be covered include: 1) Arrange for Digital Rectal Exam 2) Discuss follow-up of high PSA measurement (e.g., refer to a urologist, repeat PSA testing, order trans rectal ultrasonography). 3) Discuss referral to a sperm bank. 4) Acknowledge the patient's perception of lack of informed consent for PSA testing.	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: Parents' Dementia

Plan for issue #2	Finding Common Ground
Areas to be covered include: 1) Insist the patient arrange removal of ammunition and/or the gun. 2) Discuss options for care arrangements (e.g., adding an overnight caregiver, removing the mother from the home). 3) Encourage the patient to arrange assessment of the father by Dr. Meldrum. 4) Offer to encourage the patient to provide an update to his parents' FP.	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.

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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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