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. thyroiditis

2. post-concussion syndrome

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. **CHARLES POTVIN**, age 30, who is new to your practice.

CASE DESCRIPTION

Introduction

You are Mr. **CHARLES POTVIN**, a 30-year-old gym teacher. You have booked this appointment today because you have been feeling generally unwell and you are concerned that something is wrong.

You have never gotten around to finding a family physician (FP), but a friend recommended this practice. Your wife and daughter's FP is not taking new patients at this time.

History of the problems

THYROIDITIS

About a month ago, you had an upper respiratory infection (URI) that lasted about one week. It was like a regular cold with a stuffy nose, mild fever, and no sore throat. You thought nothing of it. You began to feel unwell only about two weeks ago. You were coaching a basketball game at the high school where you work, when you noticed you just couldn't keep up. You felt that your heart was beating quickly and that you were overheated. You had to get someone to fill in for you while you sat down and drank some cold water. Eventually you felt fine again, but you began to worry that something was wrong with you. Since then, you have become aware that your heart seems to beat fast all the time. You have a machine at the gym that reads blood pressure and pulse rate, and your resting heart rate is about 100 bpm. Before this, it would have been 50 to 60 bpm. Even when you are lying in bed you are aware that your heart is beating fast. It is not episodic; the pulse is always fast. You have not had chest pain. Your heartbeat does not seem irregular.

The only other factor that you have definitely noticed is a sore neck. The pain is not excruciating (3 out of 10) but moving your neck causes soreness and pressing on your anterior neck, around the Adam's apple, also leads to a slight soreness.

Your neck feels as if it is "stretched" or "bruised," but you can recall no trauma that could have caused this. No one has commented on any swelling in your neck, but it does feel fuller to you.

These are the only two symptoms you can describe clearly, but you know you feel generally unwell. You have discussed the problem with your wife, **DANIELLE POTVIN**, who strongly encouraged you to make an appointment with an FP. She is concerned that something may be wrong with your heart. She has told you that, until you have been "checked out," you should reduce your exercise and "stay quiet." This is not something you can do easily, given your job and your interests.

You do have other symptoms, but they are more subtle and you mention them only if the candidate asks specifically. Your exercise tolerance is definitely reduced.

You feel tired much sooner when you run. You are hungry all the time, but you have lost a couple of kilograms in the past month. You do not have diarrhea, but you are going to the toilet for bowel movements more often ("three times a day"). Your skin feels hot and dry to the touch. You have experienced no change in your hair in the past two weeks. You do not have a fever, and yet your wife finds you hot – and not in a good way. In fact, you have not felt like having sex in the past week or so, and this is not your regular pattern. In short, something is wrong.

You have never suffered from depression or anxiety, and your mood is good. You have not had any swelling of your legs or any pain or swelling around your eyes. You have not noticed any protrusion of your eyes. You have had no chest pain, no wheezing, and no shortness of breath at night or at rest. You have no cough.

POST-CONCUSSION SYNDROME

You would like to discuss another problem with the FP today. You have been experiencing headaches off and on for the past five months. You know exactly When the headaches began. You are in an amateur hockey team, which some friends and you started when all of you were physical education students at university. You are a defenceman on the team, and you play a very physical game. On one occasion five months ago, you were knocked into the boards, your helmet came off, and you cracked your head on the ice. You can't remember the blow, and you can't clearly remember being taken to the hospital and examined. You were told that you were unconscious for a couple of minutes. The memories didn't become clear until later that evening, when you were told that your computed tomography scan was normal, and you could go home. Your wife picked you up and scolded you all the way home about your failure to be careful during the game.

You experienced no vomiting immediately after the accident or in the days following, but since then, you have had frequent dull headaches. They are not completely disabling. The pain is 5 out of 10. You can still carry on with your daily routine.

They last for hours at a time but disappear overnight. You have been sleeping poorly since the accident, but you don't blame your poor sleep on the headaches. You just seem to sleep fitfully. The headaches are not associated with limb weakness, numbness, or visual disturbances. You have had a few episodes of what you would describe as "dizziness." The room does not spin around you, and you do not feel as if you are going to faint. Rather, you have a vague sensation, as if your head is moving without you. You have no associated nausea or vomiting. You have noticed no change in balance. The headaches occurred every day at first, but you think the problem is improving slowly. Now you experience a dull headache toward the end of the afternoon, two or three times a week. You have not mentioned the headaches to your wife or anyone else, because you suspect Danielle would worry or (worse) keep you from playing the rest of the season.

Since the accident, you have definitely noticed more difficulty concentrating. You will read the same paragraph twice to try to figure out its meaning. Your wife is constantly on your case about things you are forgetting, like grocery lists and appointments. You had to withdraw from an online course on educational communication because you couldn't retain the information. You also found that prolonged use of the computer was making your headaches worse.

You do not want to say so out loud, but you have been thinking about the long-term effects of frequent blows to the head. You have read about repetitive head injuries, and the possibility of long-term damage. It frightens you a bit. What if you get early dementia? In addition, in your university classes, your instructors stressed the importance of protecting students' heads during games, so you are quite aware that banging your head repeatedly is not a good idea. You know (intellectually) that you should be more careful. You also know that you should not have gone rushing back to play hockey the week following the concussion. After all, this is not the first time you have been knocked out. Hockey was always your passion, and you can remember several bumps to the head when you were in high school.

On one other occasion, when you were in university, you were knocked unconscious and taken to the hospital. You believe you have been knocked out completely three times, and on two occasions the blow to your head was severe enough to send you to the hospital. On some other occasions you have received a blow serious enough to make you “see stars” for a few minutes. This, however, is the first time you have experienced ongoing headaches.

You have tried not to modify your activities because of the headaches, except for decreasing your computer time. You are continuing to do your work at school, including teaching all the gym classes and coaching the hockey and basketball teams. If you were honest with yourself, you would admit that you might have to stop playing hockey. You remember enough from your university classes to know that repeated blows to the head take longer and longer to heal. The school also has a strict policy about students returning to physical education after head injuries. You would never allow one of your students to play after a head injury unless he or she had been fully cleared by a physician. You are not following your own rules, but being unable to play hockey would take away one of your greatest pleasures in life. It would also wreak havoc with your social life and might even damage your career.

You do not feel comfortable discussing this with your wife. You know she will keep you from playing any contact sports again.

You do not see any relationship between the head injury and this recent illness that is making your heart race.

Medical history: You have been very healthy all your life.

Surgical history: None.

Medications : Currently you are taking no medications. You tried some Tylenol and some ASA (Aspirin) for your headaches. These medications helped a bit, but the headaches returned and so now you don’t bother to take anything.

Pertinent laboratory results: None

Allergies: None known.

Immunizations: Up to date.

Lifestyle issues

- Tobacco: You have never smoked.

- Alcohol: Once a week, you have two beers with your teammates after a hockey game. Danielle and you have an occasional glass of wine at home with meals. You probably have an average of eight drinks a week.

- Caffeine: You drink two cups of coffee a day. You drink no cola.

- Cannabis: None

- Recreational and/or other substances: You have never used illicit drugs.

- Diet: You eat "everything." Your wife is quite health conscious and tries to get you to follow a balanced diet. Recently, you have been quite hungry, and you believe you are eating even more than usual.

- Exercise and recreation habits: You exercise regularly as part of your job and because you love sports.

Family history

Your parents are healthy. Your paternal grandfather died of a heart attack at age 80. Your other grandparents are still alive. You do not believe you have a family history of any health concerns. Specifically, you know of no thyroid disease, psychiatric illness, or neurological disorders.

Personal history

- Family of Origin

You are the second of three sons. You were born and raised in this town. Your father works as a civic planner for the city. He has a stable job and a decent income. Your mother works as a teacher. She stopped working when you and your brothers were young but returned when your younger brother reached school age.

Your older brother, PHIL POTVIN, is 32. He studied architecture at university in another town. He now lives there with his boyfriend of four years. You see the two of them every few months when they visit your parents. Your younger brother,

SAM POTVIN, is 28. He studied restaurant management, and he is now employed at a local hotel restaurant. He hopes to open his own restaurant one day. He married last year, and you see him and his wife at least once a month.

- Marriage/Partnerships

You met Danielle when you both were in university. She was studying business. You dated for two years and married when you both were 27. You are very happily married. The time you spend with your wife and daughter means a great deal to you.

- Children

Your first child, **MICHELLE POTVIN**, was born a year ago. Danielle had no problems with the pregnancy, labour, or delivery. Michelle is a healthy child, who attends daycare during the work week. Danielle and you hope to have another child in the next year or two.

Education and work history

You graduated from high school with fairly good marks, although you were uninterested in most academic subjects. Your passion was sports. You were the star player on the high school hockey team, and studying to become a physical education teacher seemed a natural progression from high school. You knew that you did not have the talent to become a professional athlete, and this was a way to stay involved with your interests. You did well in your university career. You were a member of the university hockey team, which won the provincial championship. After graduation, you were lucky to find a position immediately at a large public school in the city. The school has a large gym and an active physical education department. You are not the only physical education teacher in the school, and so you are able to work as a coach for the high school hockey team. You get along well with the kids and love your job.

In terms of health matters, you are not as well informed as you should be. You certainly learned a bit of exercise physiology in university, as well as the basics of nutrition, safety concerns, sports psychology, etc. However, you never really cared much for this aspect of your education. You are also aware that your job and your recreational interests depend on your continued physical health.

Finances

A few months ago, Danielle returned to her job as a manager for a retail chain. Your two salaries combined are more than enough to cover the mortgage on your home, your regular expenses, and your planned savings. You also both have good salary insurance in case one of you becomes ill.

Social supports

You are a popular guy. You have many friends at work, as well as your buddies on the hockey team. You are also close to your wife and your parents. However, you do not want to tell anyone that you are worried about your health. For some reason, that would be difficult.

You also do not want to worry your parents, and you fear your wife's reaction. She might say, "That's it! No more hockey!"

Your hockey teammates are not the sort to talk about their aches and pains. In other words, you have many friends, but no support for these particular problems. You know that if you became really sick or incapacitated, your wife, your family, and your friends would stand by you – but you don't want to face that possibility.

Religion: You are a non-practising Roman Catholic.

ACTING INSTRUCTIONS

You are casually dressed. You are university educated and able to express yourself well. Your speech is direct and friendly. You have difficulty showing that you are worried about your health. You could say, with a chuckle, “I just wonder what the heck is going on!” A skillful candidate will get you to admit that your FEELINGS include worry about both problems.

After the first prompt, the candidate will probably ask you what you mean when you say your heart is “racing.” Go on to describe the circumstances on the basketball court, and how you have checked your resting pulse rate and found that it is fast.

You should emphasize that your heart rate is always fast recently. It is not an intermittent problem. (We do not want candidates to be concerned about episodic palpitations.) Thereafter, you should be able simply to answer the candidate’s questions. Do not voluntarily reveal the URI symptoms from a month ago.

You have no clear **IDEA** about what could be making your heartbeat quickly. Could it be a heart problem? It seems unlikely to you, because of your age and family history. At the same time, one hears about athletes suddenly dropping dead.

In terms of the headaches, your **IDEA** is that they are related to the concussion: “I banged my head too many times.” After the second prompt, the candidate is likely to ask you what the headaches are like. Then you can go on to describe the dull headache you have had off and on for the past five months. Wait until the candidate asks about trauma, or until he or she explores your ideas, before bringing up the concussion. You are feeling a bit guilty about going back to playing hockey so soon after the injury and you fear a lecture from the FP.

Your **FUNCTION** is impaired by the hyperthyroidism. You had to sit out a basketball game you were coaching. The post-concussion headaches are keeping you from concentrating. You had to drop an online course.

You are really looking forward to talking to the FP today. Your **EXPECTATIONS** are that he or she will diagnose whatever is making your heartbeat more quickly, and that he or she will reassure you that your brain is not permanently damaged. You trust physicians and feel that you will get a clearer picture of what is going on.

A superior candidate will make statements like the following:

• “You are usually in good health. This must make you worried.”

• “What do you think might be going on?”

• “You really need to be able to be physically active in this job, and so having to sit out a game affects your work. Is it keeping you from doing other things?”

• “I suppose you would like me to do some tests to help figure this out.”

Cast of Characters

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

CHARLES POTVIN:	The patient, age 30, a gym teacher with a rapid heartbeat and headaches.
DANIELLE POTVIN:	Charles's wife, age 30.
MICHELLE POTVIN:	Charles and Danielle's daughter, age one year.
PHIL POTVIN:	Charles's older brother, age 32.
SAM POTVIN:	Charles's younger brother, age 28.

Timeline

Today:	Appointment with the candidate.
2 weeks ago:	Felt heart racing and had to stop coaching a game.
4 weeks ago:	Had a mild viral illness.
5 months ago:	Had a concussion while playing hockey; have had headaches since then.
1 year ago:	Michelle born.
3 years ago:	Married Danielle.
5 years ago:	Met Danielle
30 years ago:	Born.

Examiner Interview Flow Sheet - Prompts

Initial statement	"**My heart has been racing for the last two weeks**."
10 minutes remaining* Optional, use only if you feel it's needed	If the candidate has not brought up the issue of the headaches, the following prompt is to be used: "**I also wonder if I could ask you about some 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 thyroiditis, the following prompt is to be used: "**Do you think I should be worried about my heart?**" (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: Thyroiditis

Issue #1	Illness Experience
Areas to be covered include: 1. current symptoms: • Fast but regular heartbeat. • Neck pain. • Weight loss. • Decreased exercise tolerance. • Hot skin. 2. pertinent negative factors: • No chest pain. • No fever. • No trauma to the neck. • No excessive caffeine use. 3. related questions: • No ophthalmopathy. • No change in hair. • No family history of thyroid disease. • Increased frequency of stools. 4. viral upper respiratory tract infection four weeks ago.	**Description of the patient's illness experience**. You are worried about your symptoms as you don't know what they could be. You recently had to stop coaching a basketball game because of the symptoms. You are hoping the FP can tell you what is going wrong.

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

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

2. Identification: Post-Concussion Syndrome

Issue #2	Illness Experience
Areas to be covered include: 1. history of head injury: • Hockey injury five months ago. • Loss of consciousness. • Normal CT. • Amnesia. 2. pertinent negative factors: • No nausea or vomiting. • No loss of balance. • No visual scotoma. • No paresthesias. • Did not modify his activities. 3. history of headaches: • Dull pain. • Daily initially, now two to three days a week. • Worse at the end of the day. • Experiencing some dizziness. • Decreased concentration/ forgetfulness. 4. the fact that when he was in university, he learned about long-term dangers from repeated concussions.	**Description of the patient's illness experience.** You are worried that there is permanent damage. You have had to withdraw from an online course. You are hoping that during the visit with the FP that you will be reassured that what you are experiencing will eventually go away.

		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. life cycle issues: • Works as a physical education teacher. • One young daughter. • Planning a second child. • Coaches hockey at school. 2. social factors: • Good relationship with parents and brothers. • Would not talk to his friends about health issues. • Wife also works. • Financially secure. 3. hockey is very important in his life. 4. the school has a post- concussion policy that he is required to enforce.	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: "This must be difficult for you because this indiscretion is affecting the most important things in your life: your family, your faith, your self-respect and your church."

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: Thyroiditis

Plan for Issue #1	Finding Common Ground
Areas to be covered include: 1) Suggest this could be a thyroid problem. 2) Perform a physical exam. 3) Arrange laboratory testing, which must include thyroid function tests. 4) Discuss symptomatic pharmacological treatment if it becomes necessary.	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: Post-Concussion Syndrome

Plan for issue #2	Finding Common Ground
Areas to be covered include: 1) Confirm that this could be due to the head injury. 2) Inform him he should stop all physical activity until all symptoms have resolved. 3) Discuss the need to avoid any head injuries in the future. 4) Consider how he could re-orient his recreational and professional activities away from contact sports (e.g., he can coach hockey at school without playing, and he can take up other sports for recreation).	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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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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