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[*] 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

[*] 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. anogenital warts (condylomata acuminate)

2. been a victim of sexual assault

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. **FLORENCE BRUNEAU**, age 40, who is new to your practice**.**

CASE DESCRIPTION

Introduction

You are Ms. **FLORENCE BRUNEAU**, a 40-year-old secretary. You are coming to see the family physician (FP) today because a doctor in the emergency department (ED) told you that you have genital warts. The ED doctor recommended that you consult with an FP for treatment and follow-up. You did not mention at the time that you believe you were sexually assaulted two months before the warts appeared.

History of the problems

ANOGENITAL WARTS

About three weeks ago you were trying to relax before bedtime by taking a long bath. You had been having trouble sleeping during the previous month, and you thought a bath would help you drift off. When you were washing your "privates", you noticed some small bumps on the skin around the vagina. There were maybe five of them. They seemed to be darker than the skin around them and were soft and raised. They did not hurt at all, and at first you wondered if they had always been there. Over the next two weeks you checked every day. The bumps were growing in size and number, and you were sure that they were new.

You have never been one to go to the doctor, so you did not have a regular physician. You moved to this community only a year ago, and you had not yet bothered to find one. You were really frightened by what was happening to you, and you were afraid that it might be a sign of a serious disease. ("What if this is AIDS?") You worried about it more and more, to the point where you were almost unable to sleep because the fears were constantly in your mind. It was difficult to get time off work, and you didn't know where to go, so you presented at the local ED one evening a week ago. You had to wait five hours, but it didn't matter because you wouldn't have been able to sleep anyway.

You were finally brought into an examination room and asked to undress and to put on a gown. When the doctor came in, she was clearly in a hurry. She looked at the spots you pointed out to her and told you that you had genital warts.

She apologized for not having more time, but explained that she was very busy that evening and that, in any case, this was not serious and is not usually treated in the ED. She suggested you make an appointment at the hospital gynecology clinic, or find an FP to treat the problem. She asked a few other questions to make sure "nothing else was wrong down there" and then she suggested that you go home and not worry about the problem for the moment. "Just get an appointment with a doctor in the next few weeks" she said.

Of course, you continued to worry. You know that warts are transmitted through intercourse. You are afraid that you might have caught other things, as well.

You know that when you see the FP there will be more awkward questions, and that you might not be able to avoid answering them as well as you did in

the ED. You pray to God that you will be able to get through this nightmare with no permanent damage. You are not one to spend time on the internet – you do not own a computer – but you have seen advertisements warning women that warts can lead to cervical cancer.

Fortunately, you were able to answer truthfully all the questions the ED doctor asked you. Your last period was three weeks ago. It was normal. You have had no pelvic pain, vaginal discharge, odour, or itchiness. You have had no fever, no abdominal pain, and no pain with urination. You have no other skin changes.

In addition, when she asked you when your last intercourse was, you were able to look away and say, "I broke up with my former husband two years ago. I think that was the last time." Thank heavens she didn't say, "What do you mean, you think that was the last time?" You got away without talking about it. You are afraid that if this issue comes up, you will start crying again. What would the doctor think of you? How could you have been so stupid?

SEXUAL ASSAULT

How would you explain that you were feeling lonely and a bit homesick three months ago? Your co-worker at the shipping company where you work, **MARIE**, suggested that you go out for a drink on Friday night. She had been teasing you for weeks about the boring life you were leading since you came to town and had been trying to get you to taste the nightlife. You had to admit that you were feeling quite isolated here. You had come to this city in order to start a new life after your marriage broke up. The plan was to leave the small town where everyone knew you so that you could become someone else, and perhaps even meet someone new.

Instead of that, you were going to work every day and then going home every night to watch television. Marie was right. It was time to take the plunge.

You agreed to meet Marie at a downtown bar the next Friday. In preparation you had your hair styled and got a new outfit. You felt (and looked) 10 years younger. When you thought about it, you realized that you were actually nervous about going out again. You hadn't been out on your own since before you were dating **ROBERT FORTIN**, your former husband. That was more than 10 years ago.

Fortunately, Marie would be there. You had not socialized with your co-worker before, but you knew from her stories that she was a "party girl". She is in her late 30s and was divorced a few years ago. In her case she wasted no time in getting back into action. She is out at the clubs quite often, and you know she has no trouble picking up new men. The relationships don't seem to last, but you suspect that Marie prefers things that way.

You got to the club a bit early, and you didn't see Marie anywhere. You grabbed a chair at the bar to wait for her and ordered a drink to relax you a bit. You are not a big drinker, but you were in a club, after all. There was a dance floor with a lot of activity, but you were alone. After a while, a nice guy came up and asked you to dance. His name was BEN, if you remember correctly. You distinctly remember dancing with him. Marie finally showed up about an hour (and a couple of drinks) later. By then you were well acquainted with your new friend, and Marie winked and started off on her own.

After that, your memory of events is unreliable. When you confessed to Marie the next week that you didn't remember much about the evening, she told you that you were still dancing when she left the club much later. Did you keep drinking?

That wouldn't be like you. You have never been one to get drunk, and you usually stop at two or three. You remember dancing. You don't remember getting home. The next thing you remember is waking up in the morning feeling very drowsy.

You were in your bed. Some of your clothes were on and some were off. Your underwear was beside you in the bed, and your blouse was on the floor.

Some buttons were missing. When you got up to go to the bathroom, you were unsteady on your feet and almost blacked out. You had to lie down again for a few minutes. When you did get up, you were aware of some vaginal discomfort.

It suddenly occurred to you that you may have had intercourse. Was it with Ben? Had he come home with you? You would never have agreed to sex on a first date. Were you drunk? Had you been drugged? The last possibility frightened you,

but seemed very possible. How else could you explain the memory loss? You spent the rest of the day in a daze. You felt frightened. This person knows where you live. What if he came back? Should you try to find him? Should you go to the police?

How could this happen to you? You are 40 years old. Doesn't this sort of thing happen only to younger women?

Since then, your thoughts have returned continually to what might have happened. You decided to tell no one about the event. You are too ashamed of yourself for having put yourself at risk. You are angry when you think of the man who took advantage of you, but you also blame yourself. Marie has asked you to go out with her again, but you have come up with excuses. In the three months since the event, you find your mind racing back to the scene in the club. You are frustrated by your lack of memory of the events. You have had nightmares and insomnia, but the nightmares make no sense. Despite having the lock changed on your apartment door, you do not feel completely safe. When you go outside you look around constantly to make sure you are not being followed. You have prayed for life to return to normal so that you can forget this and move on. You have not tried to relax by resorting to the use of alcohol or illicit drugs.

Then the warts appeared. Not only were you sure that you had been "taken advantage of" but you were having medical consequences. You could no longer try to forget the whole thing. You had to see a doctor.

Medical history

You consider yourself to be generally very healthy. You have had no major health problems in the past.

You are G0P0.

Last Pap test was "at least three years ago."

You do not think that your FP would have done a sexually transmitted infection (STI) screen.

You experienced menarche at age 13. Your periods are regular (five days/28-day cycle), and you have no dysmenorrhea. Your last menstrual period (LMP) was three weeks ago.

Bone density testing a few months ago; your physician said that your spine was equivalent to a 45-year-old's and your hip to a 55-year-old's.

Surgical history: You have never had surgery.

Medications: None.

Pertinent laboratory results: None.

Allergies: None known.

Immunizations: You have had no immunizations since adolescence. Specifically, you have not been immunized with the hepatitis B vaccine or the human papillomavirus (HPV) vaccine (Gardasil).

Lifestyle issues

- Tobacco: You smoke 10 to 15 cigarettes a day. You began smoking at age 18.
- Alcohol: You will drink two to three beers at a party.
- Caffeine: Coffee in the morning
- Cannabis: None
- Recreational and/or other substances: You have never used illegal drugs.
- Diet: Regular North American diet
- Exercise and recreation habits: You do not exercise regularly. You would say that you have no hobbies.

Family history

Your father, **BERNARD**, is 68. He smokes and has been told he has a "bit of emphysema".

Your mother, **CLAIRE**, is 65. She also smokes but has no health problems of which you are aware.

Your brother, **DAVID**, is 38. He, his wife, and their two children are well. Your maternal grandmother is 85. Your other grandparents died in their 80s.

You are not aware of any diseases that run in your family.

Personal history

- **Family of Origin**

You were born and raised in a small town about 100 km from this city. You are the elder of two children. You would describe your childhood as a happy one. (You would be surprised or shocked if the candidate asked you about childhood sexual abuse or incest.) You grew up within a large extended family, as well.

Most of your uncles, aunts, and cousins lived in or around the same town.

Your family was not wealthy. Until his retirement two years, your father worked in the shipping and receiving department of a local farm supply store. Your mother still works as a cashier at the local grocery store. They both know everyone in town. You and your younger brother attended the local school.

You dated a couple of boys in high school, but not seriously. You became sexually active with one boy when you were 16, but you had to hide this from your parents. The relationship lasted for only a few months. You went to parties and dances with your peers, but for some reason the boys seemed to settle on other girls when it came to serious dating.

At about this time, you got a job in the farm supply store where your father worked. Your secretarial skills were good, and you were hired as a clerk. You soon learned to look after the shipping invoices and the orders—a skill that you were able to transfer to your new job in the city. The work kept you busy, and the years seemed to go by. Almost all your friends got married. Even your little brother married and started to have children. Meanwhile, you were still living with your parents.

- **Marriage/Partnerships**

When you were 28 and getting desperate, you met Robert. He was only 21, and the son of a local farmer. He came to the store fairly often on business, and he always flirted with you quite openly. When he finally asked you out on a date, you accepted immediately. It was your first and only serious relationship.

During the time you and Robert were dating, David warned you that Robert had a bit of a reputation for womanizing. You didn't feel inclined to be too judgmental, as he was the only game in town. You ignored David's warning, and in retrospect you realize that you also turned a blind eye to some indications that you were not the only woman in Robert's life.

You and Robert married when you turned 29 and he was 22. You moved to the farm and did your best to be a good farm wife. You helped out in any way you could. Your mother-in-law was very supportive.

After two years of marriage, you and Robert had not managed to conceive. You dragged Robert to see the local FP, who did some tests and confirmed that Robert had a low sperm count. He was not interested in considering any infertility treatments, and you got the impression that he was just as happy not to have children. You, on the other hand, were disappointed not to have kids. You settled into your life on the farm with a quiet resignation and continued this way for the next seven years of your marriage.

Robert often found reasons to go into town for one thing or another, and sometimes he came back fairly late. Your suspicions grew that he was "straying". You once overheard your mother-in-law arguing with him about his behaviour.

The situation came to a head two years ago, when your brother drove to the farm, sat you down, and told you that everyone in town knew that Robert was seeing another woman. David said that he had caught them out together in a bar in the next town. Your brother told Robert that he would "beat the shit out of him" if he ever saw him out with another woman again.

You confronted Robert, who told you that he had had "a few" girlfriends. He also said that he had never really loved you and that he had married you only to please his parents. They were genuinely fond of you and were worried that their son showed no signs of settling down. At that point you knew the marriage was over. You said that you wanted a divorce, and you went back to your parents' house.

The next few months were very difficult. If there were a soul in town who did not know about Robert's infidelities, he or she soon found out. You felt humiliated, as if the situation were all your fault. You should have admitted earlier that you knew there were problems. You soon decided that it was time to get out of town and to start over without the "sympathy" of an entire village. Your family was supportive—especially your brother and his wife—but you felt you could never be happy there again.

You have not spoken to Robert since the divorce was finalized. You hope that you never see him again. You realize that your brother is right: Robert always was a big jerk. You do miss his parents, but you feel that there is no way you could see them again, either.

- **Children**

You have no children.

Education and work history

You graduated from the local high school. You took some secretarial courses while you were there.

From age 18 to 29 you worked in a farm supply store. Then you worked on Robert's family farm from age 29 to 38. You have worked for a local shipping company for the past year.

Finances

You support yourself on your salary. You received some money from Robert at the time of your divorce, but you receive no ongoing support.

You have a good benefits plan at work, but you are not well paid. You "have enough to get by".

Social supports

You would say that your best support is your family—especially your brother, David. Your co-worker, Marie, is a friend but not a confidante. You are actually quite isolated in the city, and sometimes you wonder if you made the right choice in leaving your home community.

You do not want to tell anyone about the warts or the sexual assault.

Religion

You are Roman Catholic, but you rarely go to church.

ACTING INSTRUCTIONS

You are casually dressed. You may appear nervous and shy.

FEELINGS: You are anxious about seeing the new doctor. You blame yourself for the sexual assault because you "put yourself at risk", and so you are embarrassed and ashamed of having to see a physician to deal with the consequences. If the candidate asks if you are planning to contact the police, you admit that you don't know what to do. You are afraid of what might happen if you go to the police.

There are points for the candidate who explores this with you. You should explain that you just can't imagine talking to the police about this right now. A candidate who persists in trying to send you to the police despite your reticence should be marked down in "finding common ground". You never want to see Ben again.

You do not want to have to talk about what happened.

IDEAS: You feel that the warts are probably proof that you had intercourse three weeks ago, but you are not sure. Could you have caught these warts two years ago from your ex-husband? Might you have contracted other diseases as well: AIDS?

Syphilis? You have heard of these diseases but know nothing about them. Will the warts give you cervical cancer? Were you drugged, and are there consequences associated with that? Ben knows where you live. Will he return?

EFFECT ON FUNCTION: Since the assault, you have been wary of your surroundings. You do not like to go out at night. You have changed your locks. Your sleep is disrupted by nightmares. You just don't feel safe. You are still functional at work, although easily distracted. If you are going home from work after dark, you take a taxi instead of walking. If the candidate (appropriately) explores possible post-traumatic stress disorder, you do not meet all the criteria.

(You have no flashbacks or reliving of the event, no feelings of detachment, and no exaggerated startle response.)

EXPECTATIONS: You expect the FP to confirm that you probably have warts and to suggest treatment. You hope that he or she will reassure you about other possible diseases with appropriate testing. You expect that you will have to mention the intercourse three months ago, because you imagine that the FP is going to ask you the details. You dread this.

It may be a challenge to introduce the problem of sexual assault. You do not want to be too forthcoming, and yet you ***do*** want the candidate to find out about the second problem! If it has not come up by the 10-minute mark, you give this prompt: "There is something I just have not been able to talk about." Then you mention that you told the ED doctor you had not had intercourse in two years.

You add, "But that may not have been true. There is one night that I don't remember very well." Then you can provide the details when the candidate asks about them. Before the 10-minute prompt, you volunteer this information ***only*** if the candidate asks open-ended questions and if he or she has gained your trust.

Before the 10-minute prompt, if the candidate asks about your last sexual encounter, you might say something like, "Well, the last time I am sure of was two years ago." This should be a big enough clue to draw out further questioning.

Please note that the marking for Identification of the Problem of Sexual Assault gives a mark for “has told anyone”. This is not the same as the mark given in Context for “has no one she feels she can confide in”. These answers are in response to different questions from the candidate: “Have you told anyone?” and “Is there anyone you feel you can talk to about this?”

If the candidate outlines several treatment options for your genital warts and then asks you to choose, you answer, “Whichever you think is best, Doctor.”

Remember that a large part of your embarrassment is your sense that you are the one who did something wrong.

Cast of Characters

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

FLORENCE BRUNEAU: The patient, age 40, who has anogenital warts and was sexually assaulted three months ago.

BERNARD BRUNEAU: Florence's father, age 68.

CLAIRE BRUNEAU: Florence's mother, age 65.

DAVID BRUNEAU: Florence's brother, age 38, who is very supportive.

ROBERT FORTIN: Florence's ex-husband, age 33.

MARIE: Florence's co-worker.

BEN: The man Florence met at a bar three months ago.

Timeline

Today:	Appointment with the candidate.
1 week ago:	Went to the ED because of the anogenital warts.
3 weeks ago:	Noticed anogenital warts; LMP.
3 months ago:	Possible sexual assault.
1 year ago, age 39:	Moved to this city.
2 years ago, age 38:	Marriage ended.
11 years ago, age 29:	Married Robert.
12 years ago, age 28:	Met Robert.
22 years ago, age 18:	Graduated from high school.
40 years ago:	Born.

Examiner Interview Flow Sheet - Prompts

Initial statement	**"I need to see you because I have genital warts."**
10 minutes remaining* Optional, use only if you feel it's needed	If the candidate has not brought up the issue of the sexual assault, the following prompt is to be used: **"There is something I just have not been able to talk about."**
7 minutes remaining* Optional, use only if you feel it's needed	If the candidate seems to have forgotten about the genital warts, the following prompt is to be used: **"So, what do I do about the warts?"** (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: Anogenital Warts

Issue #1	Illness Experience
Areas to be covered include: 1. history of condylomata: • Diagnosed by a physician in the emergency department. • Non-painful. • Appeared three weeks ago. • No previous history of warts. • Not aware of a partner with warts. 2. symptoms of other genitourinary pathology: • No discharge. • No pelvic pain. • No vaginal odour. • LMP three weeks ago. 3. sexual risk factors: • No Pap test in the past three years. • Ex-husband had other partners. • He was her only sexual partner during her marriage. • No current sexual partner. • Previous Pap tests were normal. 4. other factors for infections transmitted by blood or sexual contact: • No transfusions. • No piercings. • No tattoos. • No intravenous drug use. • Never tested for STIs.	**Description of the patient's illness experience**. You are worried about the warts and think this could lead to cancer and could also mean there are other diseases present. Due to your worry about the warts, you have been having difficulty sleeping. In addition to having the warts treated, you hope that you will be checked for all diseases/STIs.

		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: Sexual Assault

Issue #2	Illness Experience
Areas to be covered include: 1. the event: • An unknown male perpetrator. • Alcohol involved. • Assault occurred in her apartment. • Amnesia for the event. • Unsteady the next morning/almost passed out. 2. subsequent behaviour: • Changed the locks. • Wary (e.g., checking behind her, taking cabs at night) • Experiencing nightmares. 3. negative factors: • Not suicidal. • No flashbacks. • No subsequent alcohol use. • No feelings of detachment. 4. the fact that she has not told anyone.	**Description of the patient's illness experience.** You are feeling shame and isolation, as well as a fear that the man who assaulted you will return. You believe that you put yourself at risk. You have stopped leaving home at night and you have withdrawn from socializing. You don't have any real expectations about the visit but hope that the FP won't be too judgemental when finding out about the assault.

		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. current status: • No children. • Moved to this city one year ago. • Currently employed. 2. supports: • Has no one she feels she can confide in. 3. her past marriage: • Had to be told (did not find out herself) that her husband had multiple affairs. • Community was aware of the circumstance of her divorce/she felt a need to move because of embarrassment. • No contact with her ex-husband. 4. the fact that she was ready to go out socially again.	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: "Ms. Bruneau, what has happened to you would leave anyone feeling frightened. That this happened just at the time when you were starting to think about dating again must leave you feeling that you will never be able to find someone. The appearance of the genital warts would also make you worried about your health and your future. Unfortunately, you don't really have anyone to talk about this, which must make you feel even more alone."

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: Anogenital Warts

Plan for Issue #1	Finding Common Ground
Areas to be covered include: 1) Discuss treatment options for anogenital warts (e.g., cryotherapy, imiquimod, podophyllin). 2) Arrange for a Pap test. 3) Offer testing for STIs. 4) Discuss the natural history of HPV infection (e.g., the likelihood of spontaneous remission, the low risk of progression to cancer).	Behaviours indicating efforts to find common ground go beyond the candidate asking "Any questions?" after a management plan is presented. Finding common ground is demonstrated by the candidate encouraging patient discussion, providing the patient with opportunities to ask questions at multiple points, encouraging the patient to express their thoughts, seeking clarification, checking for consensus, and recognizing then addressing patient hesitation or disagreement if it arises. Examiners need to determine the candidate's ability to find common ground based on behaviours they demonstrate during the interview.

Superior Level	Covers points 1, 2, 3, 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: Sexual Assault

Plan for issue #2	Finding Common Ground
Areas to be covered include: 1) Identify to the patient that this event was a sexual assault (non-consensual sexual activity). 2) Explain that the assault was not her fault. 3) Arrange follow-up counselling with self or a specialized service. 4) Explore her willingness to report the assault to the police.	Behaviours indicating efforts to find common ground go beyond the candidate asking "Any questions?" after a management plan is presented. Finding common ground is demonstrated by the candidate encouraging patient discussion, providing the patient with opportunities to ask questions at multiple points, encouraging the patient to express their thoughts, seeking clarification, checking for consensus, and recognizing then addressing patient hesitation or disagreement if it arises. Examiners need to determine the candidate's ability to find common ground based on behaviours they demonstrate during the interview.

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

6. Interview process and organization

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

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

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

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

Appendix 1 Standardized Instructions to Candidates

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

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

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

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

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

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

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

Appendix 2 CFPC Preparation Pointers for Examiners

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

Think of the following:

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

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

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

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

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

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

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

on tangents not in the script.

5. Do not overact.

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

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

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

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

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

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

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

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

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

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

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

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

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