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. hypertension

2. plantar fasciitis

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. **GARY MCNICHOLL**, age 50, who is new to your practice**.**

CASE DESCRIPTION

Introduction

You are Mr. **GARY MCNICHOLL**, age 50, who is concerned about pain in your foot because it is limiting your activity and affecting a new relationship. In addition, you have been concerned about your blood pressure (BP). The last few times you went to your local after-hours clinic with other minor concerns, you were told that it was elevated, and you needed to follow up on it. Today in the office it was 160/105 mm Hg. You hope that this new physician will be able to help you.

You also hope that he or she will understand that you are hearing impaired and need to see his or her face to read lips.

History of the problems

HYPERTENSION

Over the past three months, your BP has been elevated on three occasions at your local after-hours clinic. The readings were 160/100, 155/100, and 160/100 mm Hg. The doctors at the clinic suggested that you see a physician to follow your elevated values.

You have been using the walk-in clinic (WIC) because of a recent series of chest colds. You have not taken over-the-counter cold remedies; in particular, you have not taken pseudoephedrine.

You have been reluctant to make an appointment with a physician because you really hate being sick. The only family physician (FP) you have ever really trusted looked after your family when your ex-wife was pregnant. You are reluctant to return to see her as your ex-wife is still her patient. (Who would have thought that custody of the FP was something that the two of you should have worked out?) As far as you can recall, this is the first time that you have had high BP.

You have no symptoms that you would consider cardiac, although you have been paying attention because you know that high BP causes heart attacks. You father had a heart attack when he was three years older than you are now. Your older brother had a heart attack two years ago.

You have had no chest pain and no shortness of breath. You have been physically active at work but do not really exercise much outside of work.

You are a non-smoker and have a relatively healthy diet, especially since you met **DONNA BENNING**, your new girlfriend. Donna enjoys outdoor activities like hiking and camping. She has been encouraging you to be more active. She has even suggested that the two of you should extend your stay in the country after her friend's upcoming wedding, as this would give you the chance to do some day hikes.

Donna has been putting some pressure on you to get your BP problem taken care of. You like the fact that she cares about you and feel that this gentle push is what you have needed to get to a doctor.

You may have had your "lipids and sugars done" in the past, but your last check-up was at least 10 years ago, and you are quite fuzzy about the details.

PLANTAR FASCIITIS

You have had a painful left foot for the past two months. The pain has come on gradually, but you are starting to find it more and more bothersome. You have wondered if a splinter or a pebble is embedded in your heel. You have checked your foot and know that nothing is there, but that's what it feels like. You are on your feet most of the day at work, which is not helpful. You have not yet modified your work to accommodate this; you are a bit of a stoic. In fact, you are somewhat disdainful of your colleagues who have taken "disability leave" for things like this— as if they know the meaning of the word "disability". Now that Donna has suggested a weekend away and hiking, as well, you worry that you will not be able to hide your discomfort. You really would prefer that Donna not see you as an "old man". You have never been hiking/camping in the past, and while you are not unwilling to try, with your foot…

The pain is worse when you start walking. It starts the moment you get up in the morning. You have tried some acetaminophen (Tylenol) without any real relief. You have not changed your shoes or added insoles. You have never injured this foot or leg.

The pain is localized to the heel. It is not only worse when you start walking but is really bad when you move (dorsiflex) your foot. You have never been told that you have flat feet. You are not athletic and never have been, and so the pain is not related to excessive training. You have no other joint pains to suggest a rheumatologic disease. You have never had a foot X-ray examination. In fact, this is the first time you have discussed the problem with a physician.

The pain does not get worse at night. If the candidate asks, you say that you go barefoot around the house and first thing in the morning. You may preface your answer with "That's an odd question, but.…"

You are a dedicated WIC consumer, and really would like this doctor to fix the problem quickly. However, you respond well to a candidate who offers you a stepped approach to care.

Medical history

You had meningitis at age three.

You have long-term profound hearing loss. You lip read perfectly and do not wear hearing aids as you have very little residual hearing.

Surgical history

None.

Medications

None.

Pertinent laboratory results

None.

Allergies

None.

Immunizations

Up to date.

Lifestyle issues

- Tobacco: You are a non-smoker.
- Alcohol: You occasionally you drink beer during the week; at most you have one to two drinks after work. On Fridays a group of you from work go out for drinks. Most Fridays you are sensible, but lately you have been a little less prudent with your drinking. You have drunk enough that you have had to take a taxi home and pick up your car in the morning. Still, even on these occasions you have rarely had more than three drinks in an evening.
- Caffeine: Coffee in the morning
- Cannabis: None
- Recreational and/or other substances:
- Diet: Regular North American dies
- Exercise and recreation habits: You play baseball in the summer. Recently you took up curling as a winter sport.

Family history

Your father, **George MCNICHOLL**, age 80, has had a heart attack. He has elevated lipids but no diabetes.

Your mother, **Mary MCNICHOLL**, age 80, is in excellent health.

Your brother, **STEVE MCNICHOLL**, age 53, had a heart attack two years ago. He had bypass surgery and is doing really well. You think that he has mild hypertension, but this is not the kind of thing that the two of you discuss.

All your grandparents are dead, but they lived well into their 80s.

Personal history

- **Family of Origin**

You are the younger of two sons. When you were three years old, you nearly died of meningitis. Because of this, your parents were even more delighted to have you.

Your significant hearing loss became apparent soon after this illness. Your mother was a stay-at-home mom, and she devoted herself to making certain that you were "normal". You learned to lip-read early, and with some assistance managed to go to the local school. Your father accepted the challenges you faced head-on, and the fact that he was the local high school principal certainly helped ease your way educationally. Your brother was probably your best asset. His ability to treat you normally compensated for the times that your mother coddled you. Steve figured that, as the big brother, his prerogative was "to rail on" you before anyone else did.

- **Marriage/Partnerships**

You married **GENNY JONES**, now 40, when you were 38. You had had a number of previous relationships before you decided that she was the one. You met at the large firm where the two of you worked; she worked as a human resources agent and you as a software support technician.

Your son, **TYLER JONES-MCNICHOLL**, was born two years into your marriage. Your son is your pride and joy. He is 10 years old and a great student and a superb athlete. He lives with his mother, but you have shared custody and liberal access.

You and Genny separated as a couple when Tyler was five years old. The two of you had grown apart. She was promoted to director of human resources and was clearly being groomed for upper management. At the same time, you tired of the stress of the tech support job. You probably could have used your hearing loss as an excuse, but you recognize that you just prefer a slower pace. You had thought that Genny shared your lack of ambition, but eventually it became clear that she did not.

The arguments started and then you left. Now that you live apart, there is a truce. The two of you are able to co-parent successfully.

Six months ago, you met Donna, age 45. She is your first serious girlfriend since your divorce five years ago. She is wonderful. She "gets" you. The "hearing impaired thing" is not an issue for her. You love the way that she is so relaxed about things. She has three adolescent children at home and so she has really been laid back about moving your relationship to a new level. However, her best friend is getting married four weeks from now in a small town that is a two-hour drive from here. Donna's children are not going to the wedding. Donna has asked you to go as her date. She has suggested that the two of you drive down on Friday night and spend the weekend at a local inn. That way you will have no need to drive back on Saturday after the ceremony. She has suggested that the two of you could do some day hiking in the area.

Tyler likes Donna, and even Genny has remarked that she seems nice. (This is high praise from Genny.)

- **Children**

You have one son, Tyler, age 10 years.

Education and work history

You were educated in both sign language and lip-reading. You quickly dispensed with sign language and exclusively lip-read.

You graduated from high school and completed a college degree in technical support. Following college, you worked at the company where you met Genny. You moved from tech support to your current job about the time you and Genny separated. You have been at your current job at a local factory for five years.

You make enough to support yourself and keep your financial commitments to your son.

Your factory job involves basic assembly line work. You never take work home with you, and there is no pressure to be anything other than what you are.

Finances

While you are not wealthy, you are able to maintain your car and your apartment, as well as to provide support payments for Tyler.

Social supports

You have a good relationship with your parents and your brother, all of whom live in the same city.

You go out for Friday night beers with the guys from work. Occasionally, you get together to watch sports with the gang on some day other than Friday.

You play on a baseball team in the summer. Recently, at Donna's urging, you took up curling as a winter sport.

Religion

None.

ACTING INSTRUCTIONS

You are well, but casually, dressed. You tend to speak a little louder than normal as a result of your hearing loss. If a candidate wants to use sign language, you indicate that you prefer to lip-read.

You are forthright with a candidate who is non-judgemental. You will advise the candidate that you need her or him to face you when speaking so you can “hear”. If the candidate turns away, you remind her or him that you need to see her or his face. You are less forthcoming if you must repeatedly ask the candidate to face you. You are not surprised if the candidate deals well with your hypertension.

You keep your shoes on during the SOO but can use your foot as a prompt to show where the pain is occurring. You clearly indicate that the pain is coming from the heel area. Obviously this is not possible if the SOO is happening in a virtual platform!

If the candidate mentions past blood tests, you are a bit fuzzy about the details as you had these tests 10 years ago.

Cast of Characters

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

GARY MCNICHOLL:	The patient, age 50, who has hypertension and plantar fasciitis.
DONNA BENNING:	Gary's new girlfriend, age 45.
GENNY JONES:	Gary's former wife, age 40.
TYLER MCNICHOLL-JONES:	Gary and Genny's 10-year-old son.
GEORGE MCNICHOLL:	Gary's father, age 80
MARY MCNICHOLL	Gary's mother, age 80
STEVE MCNICHOLL:	Gary's brother, age 53.

Timeline

Today:	Appointment with the candidate.
2 months ago:	Pain began in left foot.
3 months ago:	First of three elevated BP readings at the after-hours clinic.
6 months ago:	Met Donna.
2 years ago, age 48:	Older brother had a heart attack.
5 years ago, age 45:	Divorce from Genny; began working at the factory.
10 years ago, age 40:	Son born; lipids and blood glucose testing.
12 years ago, age 38:	Married Genny.
47 years ago, age 3:	Meningitis and subsequent hearing loss.
50 years ago:	Born.

Examiner Interview Flow Sheet - Prompts

Initial statement	**"The other doctors thought I should see someone about my blood pressure."**
10 minutes remaining* Optional, use only if you feel it's needed	If the candidate has not brought up the issue of the plantar fasciitis, the following prompt is to be used: **"I am a little worried about what's going to happen over the weekend, especially if I go hiking."**
7 minutes remaining* Optional, use only if you feel it's needed	If the candidate seems to have forgotten about the hypertension, the following prompt is to be used: **"Now what about my blood pressure?"** (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: Hypertension

Issue #1	Illness Experience
Areas to be covered include: 1. history of the current problem: • Four readings of elevated BP. • Over a period of three months. • No previous history of elevated BP. • Asymptomatic. • Readings done in physicians' offices. 2. personal and family history: • Family history of myocardial infarction before age 60. • No family history of cerebrovascular accident. • No personal history of renal disease. 3. lifestyle: • Non-smoker. • Alcohol intake moderate/social (a maximum of three beers). • Healthy diet. 4. the fact that the patient had not used pseudoephedrine- containing medication/cold medication when he had his BP checked at the WIC.	**Description of the patient's illness experience**. You are ambivalent about treatment for your blood pressure. You don't like being labelled with an illness. You have no idea what is causing his high BP and you feel fine. It is not currently affecting any of your functions and you hope that the FP will be able to figure out the cause.

		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: Plantar Fasciitis

Issue #2	Illness Experience
Areas to be covered include: 1. current symptoms: • Painful left foot. • Pain present for the past two months. • Gradual onset. • Pain is worse when he starts walking. • Pain is worse when the foot is dorsiflexed. 2. past history: • No evidence of rheumatologic disease. • Has never had a foot X-ray examination/has not consulted a physician about this. • No history of trauma. 3. pertinent negative factors: • Pain does not get worse at night. • Pain is not training related/the patient is not athletic. • The patient does not have flat feet. 4. treatment to date: • Acetaminophen is not helping. • No change of shoes/insoles. • No change of work environment.	**Description of the patient's illness experience.** These current symptoms make you feel old, and you have no idea what is causing this. Thus far, there hasn't been any negative impact on your daily functions, but you are anticipating it will become a problem during your weekend getaway since activities, specifically hiking, will be involved. You are hoping that this visit with the doctor will fix the issue quickly so you can participate in the hike.

		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.
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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. new relationship: • Met Donna six months ago. • First serious relationship since his divorce. • She has three adolescent children. • She is younger than he is. 2. life cycle issues: • One son, Tyler. • Shares custody of his son. • Reasonable relationship with Tyler's mother. 3. employment: • Works in a factory. • Was in tech support. • Content with his work. 4. social factors: • Does not see himself as disabled.	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: "Being a good daughter and caring for your mother have become overwhelming for you, despite the support of your family and your church. It seems your mother is demanding more than you can give, and this is manifest in increasing migraines and your irritability."

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: Hypertension

Plan for Issue #1	Finding Common Ground
Areas to be covered include: 1) Acknowledge that the elevated BP needs to be addressed. 2) Arrange ongoing follow-up care for assessment of elevated BP. 3) Discuss non-pharmacologic options. 4) Order lab work (e.g., electrocardiography, electrolytes measurement, glucose testing, lipids testing). 5) Explain lab work as it relates to both secondary causes of hypertension and end-organ damage.	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, 4 AND 5.	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, 3, and 4.	Involves the patient in the development of a plan. Demonstrates flexibility.
Non-Certificate Level	Does **not** cover points 1, 2, 3, and 4.	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: Plantar Fasciitis

Plan for issue #2	Finding Common Ground
Areas to be covered include: 1) Identify that this is probably plantar fasciitis, or give an appropriate explanation (e.g., soft-tissue inflammation). 2) Identify that the condition is usually self-limiting. 3) Discuss conservative treatment (e.g., rest, ice, stretching exercises, avoiding walking barefoot). 4) Discuss conservative treatment (e.g., rest, ice, stretching exercises, avoiding walking barefoot).	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 Expressive • Is conscious of the impact of body language on communication and adjusts it appropriately Sample behaviours • Ensures eye contact is appropriate for the patient's culture and comfort • Is focused on the conversation • Adjusts demeanour to ensure it is appropriate to the patient's context	**Language Skills** Verbal • Has skills that are adequate for the patient to understand what is being said • Converses at a level appropriate for the patient's age and educational level • Uses an appropriate tone for the situation, to ensure good communication and patient comfort Sample behaviours

• 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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