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. a flare-up of rheumatoid arthritis

2. hypertension

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. Ann Brown, who is new to your practice.

CASE DESCRIPTION

Introduction

You are Ms. **ANN BROWN**, age 56, a dog breeder and groomer who is suffering from a flare-up of rheumatoid arthritis (RA). Your mother, MARY BROWN, is concerned about you. She suggested you visit the candidate because your own family physician (FP), Dr. MARCUS, retired a year ago.

You also need to speak to the candidate about your hypertension.

History of the problems

RHEUMATOID ARTHRITIS FLARE-UP

The recent RA flare-up—your third—began six months ago and has been even worse over the past two months. You have severe pain and stiffness in your hands, wrists, and shoulders. Proximal joints in your fingers are mostly involved, today they are only minimally swollen. Getting out of bed in the morning is difficult, as is opening jars and cans.

Even worse, you are unable to work or even to walk your pet collie, SOLEIL. You enjoy your work grooming dogs and breeding rough collies, but you cannot hold the brushes, combs, and other tools. You are also increasingly fatigued. Your elderly mother has held the business together by taking over the grooming and kennelling, but she has had to cut back the hours of work.

Initially you tried to avoid asking for medical help by taking acetaminophen (Tylenol) and Tylenol with codeine for one month, with no relief—and the codeine caused constipation. Then you started ibuprofen (Advil), two tablets, three times a day. You have taken the Advil fairly regularly over the past five months, but it really is not helping at all.

You are feeling unwell and weak. You have less appetite. This is further compounded by the pain and stiffness in your joints, which is making preparing meals difficult. You have therefore lost about 2 kg (5 lb.) over the past two months.

You are not depressed, but you are upset that you are unable to look after yourself. You have not been enjoying any aspects of life in the past two months. You have no extra-articular signs such as eye signs, rash, nodules and fever. You have no deformed joints. You have never seen a physiotherapist or an occupational therapist or worn splints.

Your RA was diagnosed 10 years ago. Your FP provided treatment with Tylenol and anti-inflammatories, and the RA went into remission. You were taking no disease-modifying medications.

Unfortunately, five years ago you had a flare-up and it did not settle as it did the first time. Dr. Marcus had to send you to Dr. JONES, a rheumatologist. Dr. Jones prescribed oral methotrexate. Initially it worked, but you ended up in your small-town hospital for two weeks because of lung issues. You were told that the methotrexate caused your persistent dry, non-productive cough and severe shortness of breath. A chest X-ray examination showed some inflammation in the lungs (“methotrexate lung”). You were lucky to have only a mild case, and you recovered when you stopped taking the methotrexate. Eventually your arthritis went into remission again.

HYPERTENSION

The other medical condition you want the candidate to address is your high blood pressure (BP), which Dr. Marcus diagnosed five years ago when you saw him for RA management. Your BP has not been checked regularly since Dr. Marcus retired. In addition, your one-year prescription for hydrochlorothiazide and triamterene (Dyazide) is about to run out. You take it every day, and you want the prescription renewed.

You are also concerned that your high BP could cause health problems. Both your parents have hypertension. Your dad has had a heart attack, and your mother was diagnosed with kidney failure three months ago. She was told she may need dialysis, depending on what the kidney specialist says. This was a wake-up call and you began to check your BP with her new monitor and at the local pharmacy. The readings have averaged 155/95 mm Hg. You know this is too high. (If the candidate suggests that your high readings coincide with your increased Advil intake, you agree.) You are worried that your kidneys will fail like your mom's, or that your hypertension will lead to heart problems like your dad's.

Like most people with hypertension, you are asymptomatic. You know of no current complications of your high BP. You have no headaches or other symptoms that can be related to hypertension. You have seen an eye doctor in the past year and have no evidence of hypertensive changes.

Your last investigations including blood tests or urine tests were one year ago (all normal).

Medical history

RA was diagnosed 10 years ago.

Hypertension diagnosed five years ago.

You were hospitalized five years ago because of RA and methotrexate lung. Your only other hospitalizations have been for the births of your two daughters.

Went through menopause at 51 years of age.

Last screening mammography was 18 months ago.

Medications

Dyazide, once a day, regularly.

Ibuprofen (Advil), 400 mg, three times a day.

No other over-the-counter medications, herbal medications, or homeopathic remedies.

Pertinent laboratory results

None recently.

Allergies

None known.

Immunizations

Up to date.

Lifestyle issues

- Tobacco: You quit smoking 10 years ago, after smoking two packs a day for 35 years.
- Alcohol: You drink two to three glasses of red wine in a week.
- Caffeine: You drink one cup of coffee in the morning.
- Cannabis: None
- Recreational and/or other substances: You do not use recreational drugs.
- Diet: You have not followed a specific diet, such as the Dietary Approaches to Stop Hypertension (DASH) diet, since your hypertension was diagnosed. You use less salt sometimes, but your diet has been worse than usual lately, your arthritis has made eating difficult and your appetite has decreased.
- Exercise and recreation habits: You are unable to exercise because of your fatigue.

Family history

Your mother is 76 and had hypertension for years before her renal failure was diagnosed three months ago.

Your father, **LUKE BROWN**, is a semi-retired, 76-year-old music teacher and farmer. He has hypothyroidism as well as hypertension. His heart attack occurred two years ago.

You have no siblings.

Your two adult daughters are well. You have no family history of RA. There also is no family history of stroke, diabetes, elevated cholesterol, or other significant medical conditions.

Personal history

- **Family of Origin**

You were born, raised, and still live in a small town outside this city. You have always had a good relationship with your parents. You live in a house on the farm where your parents also have a home. Your kennel is adjacent to your house.

- **Marriage/Partnerships**

You met your first husband, **JOHN BLACK**, when you were 20 and he worked in town. You became pregnant and got married because "that was what you did in those days". Your first daughter, **JANE BLACK**, was born shortly after. You had your second daughter, **SUE BLACK**, when you were 22. Around that time, John became distant and you discovered he had alcoholism. You threw him out, as he would not seek help. He was never a mean drunk and you were never abused. You do not know his whereabouts now.

You met **MARK GREEN** shortly after your first marriage ended. He was a firefighter in town, "a real looker" and about the same age as you. You married when you were 24 and did not have any children with him.

You looked after Mark's every need because he seemed very nice and a better choice than your first husband. When you developed RA, however, he had trouble dealing with it. He has always been healthy, as were you up until that point. Just before your most recent RA flare-up worsened two months ago, he left you for a younger woman. You are actually relieved it is all over. He moved into town and left you the house.

You are comfortable living on your own. You are not interested in any new relationships.

- **Children**

Your first daughter, **JANE BLACK**, was born shortly after your first marriage. You had your second daughter, **SUE BLACK**, when you were 22.

Education and work history

You completed grade 12 at the small school in town. You helped out on your parents' farm and did various part-time jobs in town. Your two loves were writing and dogs, and you enjoyed writing for the town newspaper for 10 years, until the paper ceased publishing 10 years ago. You continued to help out on the farm.

Four years ago, you started grooming and kennelling dogs and breeding rough collies. You became busier as your "hobby" grew, and it became your livelihood when your husband left two months ago.

Finances

Currently you have no financial concerns, but you are awaiting the finalization of your separation agreement. Your grooming and kennelling business is your only source of income. Your financial independence is contingent upon your ability to get back to work.

Your parents are willing to help out, but they do not have a large financial reserve.

You are too proud to ask for social assistance.

Currently you have medical coverage, and your medication costs are covered by Mark's plan.

Social supports

Your main supports are your parents. Your mother is a strong woman, despite her medical conditions. You feel bad because you think you should be helping your parents, rather than relying on them for help.

Your daughters are supportive but are busy with their own lives. They cannot help you physically or financially. You also would prefer not to be a burden to them.

You have a few friends in the community, but no one on whom you want to depend or with whom you wish to share intimate details of your life.

You have a number of friends who are fellow breeders, whom you see at shows. Most of them live in other cities, and your relationship is based on a shared interest.

Religion

You are a non-practising Protestant who believes in God. You do not think your illness is a punishment from God.

ACTING INSTRUCTIONS

You are dressed casually in loose clothing - whatever is easiest for you to get on during your RA flare-up. You appear tired and in pain. You may rub your wrists and hands.

Your first major problem is the RA. You feel a bit embarrassed that you did not seek help sooner, and you do not want the doctor to judge you. However, you do not ask for help easily. In addition, you **FEEL** upset that you are in so much pain and cannot work. Your **IDEA** is that the arthritis is preventing you from working and living "normally". It will have to improve in order for you to do so. In terms of **FUNCTION**, you are unable to look after yourself or work because of the arthritis. When asked about medications and effects, you readily mention effects and side effects. Life is not good. You **EXPECT** that the FP will manage your arthritis and pain. You also hope that he or she can help you get back to work grooming and kennelling dogs.

Your second problem is your hypertension. You know you have not taken your high BP seriously in the past. You began to take it more seriously when your mother's kidney failure was diagnosed three months ago. Your **FEELINGS** are concern and worry about your BP and its effect on your health. Your **IDEA** is that you could end up with kidney failure like your mother's if your hypertension is not managed properly. In addition, the hypertension could have other ill effects on your health. Currently it has had no negative effects or impact on your **FUNCTION**. You **EXPECT** the FP to help you manage your hypertension by setting out a plan and arranging regular follow-up care. You do not want the doctor to lecture you about neglecting your BP.

If the candidate focuses on the marriage breakdown you should direct the candidate away from it with the statement "While you are disappointed over the marriage breakdown, you are actually relieved it is over".

Cast of Characters

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

ANN BROWN:	The patient, age 56, who is suffering from RA flare-ups and hypertension.
LUKE BROWN:	Ann's father, age 76, a semi-retired music teacher and farmer with hypertension and heart problems.
MARY BROWN:	Ann's mother, age 76, a semi-retired dog groomer who has hypertension and renal failure.
JOHN BLACK:	Ann's first husband, who had alcoholism.
MARK GREEN:	Ann's second husband, who left her two months ago after 32 years of marriage.
JANE BLACK:	Ann and John's daughter, age 36, a married teacher who has a six-year-old daughter.
SUE BLACK:	Ann and John's daughter, age 34, who works in a local grocery store.
DR. MARCUS:	Ann's former FP, who retired a year ago.
DR. JONES:	Ann's rheumatologist five years ago.
SOLEIL:	Ann's pet collie.

Timeline

Today:	Appointment with the candidate.
Two months ago:	Unable to work because of the RA; mother took over the grooming and kennelling business; Mark left.
Three months ago:	Mother's kidney failure was diagnosed.
Five months ago:	Started taking Advil, 400 mg, three times a day.
Six months ago:	Arthritis flare-up started; tried Tylenol and Tylenol with codeine.
Two years ago, age 54:	Father had a heart attack.
4 years ago, age 52:	Started dog grooming and kennelling as a hobby.
5 years ago, age 51:	Hypertension diagnosed; admitted to hospital because of "methotrexate lung".
10 years ago, age 46:	RA diagnosed; newspaper for which you wrote ceased publication.
20 years ago, age 36:	Began writing for the local newspaper.
32 years ago, age 24:	Married Mark Green.
34 years ago, age 22:	Sue born; kicked John out because of his alcoholism.
36 years ago, age 20:	Married John Black; Jane born.
56 years ago:	Born.

Examiner Interview Flow Sheet - Prompts

Initial statement	**"I am afraid my arthritis is flaring up."**
10 minutes remaining* Optional, use only if you feel it's needed	If the candidate has not brought up the issue of the hypertension, the following prompt must be said: **"Doctor, my blood pressure has been high lately."**
7 minutes remaining* Optional, use only if you feel it's needed	If the candidate seems to have forgotten the issue of the rheumatoid arthritis, the following prompt must be said: **"What can be done for my arthritis?"** (It is unlikely that this prompt will be 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:

Rheumatoid Arthritis Flare-up	Illness Experience
Areas to be covered include: 1. current symptoms: • Pain in wrists, hands, and shoulders. • Morning stiffness. • Worsened two months ago. • Has lost 2kg (5lb.) in the past two months. • Fatigue 2. History of arthritis: • Started 10 years ago. • Has had three flare-ups. • No family history of RA. • Saw a rheumatologist five years ago. 3. past treatment: • Tylenol not effective. • Ibuprofen does not help much. • Codeine caused constipation. • Methotrexate caused lung issues. • No other medications tried. 4. no extra-articular signs or symptoms (i.e. eye signs, rash, nodules, and fever).	**Description of the patient's illness experience**. You are frustrated that the arthritis is preventing you from living your life fully and that it could get worse. You are unable to work as a groomer because you have difficulty holding the brushes and combs. In addition, you have trouble with daily living activities, such as opening jars.

		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:

Hypertension	Illness Experience
Areas to be covered include: 1. history of hypertension: • Diagnosed five years ago. • Takes Dyazide regularly. • Has checked her own BP. • Recent increase in BP. • Has not seen a physician in hypertension is not treated and almost a year. 2. family history: • Hypertension. • Myocardial infarction. • None of stroke. • Mother has chronic renal failure. 3. lifestyle factors: • Former smoker. • Drinks two to three glasses of red wine a week. • No use of illicit drugs. • Caffeinated beverages – one a day. 4. risk factors for end-organ damage: • No specific diet. • Unable to exercise. • No known diabetes. • No known elevated cholesterol.	**Description of the patient's illness experience.** You are worried that you might end up with kidney failure, like your mother, if your hypertension is not adequately managed.

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

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

3. Social and developmental context

Context Identification	Context Integration
Areas to be covered include: 1. Family/home situation: • Lives alone. • Separated. • Second marriage. • No siblings. 2. supports: • Mother has been running her business. • Two daughters in the same town. • Has a few close friends. • Financial support from husband not finalized yet. 3. career/life cycle issues: • Has lived in the same small town all her life. • Dog grooming is now her livelihood. • Ability to work is jeopardized by her RA. 4. no disability insurance due to self-employment.	Context integration measures the candidate's ability to: • Integrate issues pertaining to the patient's family, social structure, and personal development with the illness experience. • Reflect observations and insights back to the patient in a clear and empathic way This step is crucial to the next phase of finding common ground with the patient to achieve an effective management plan. The following is an example of a statement a superior level candidate may make: "You have been faced with some real challenge. Dog grooming is now your livelihood. Your arthritis is worsening and taking away your freedom, and your mother's illness has focused you on your own high blood pressure. As a self-employed person, you are facing serious financial challenges."

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: Rheumatoid Arthritis Flare-Up

Plan for Rheumatoid Arthritis Flare-Up	Finding Common Ground
Areas to be covered include: 1) Arrange an examination of the involved joints. 2) Arrange investigations to establish the severity of the disease (e.g., erythrocyte sedimentation rate and/ or C-reactive protein testing/ X-ray examination of the involved joints). 3) Discuss pharmacological treatment (e.g., an analgesic for pain and disease-modifying agents). 4) Discuss non-pharmacological treatments (e.g., exercise/physiotherapy, referral/occupational therapy). 5) Indicate other investigations to assess other RA-associated conditions (e.g., eye, skin, and lung examinations).	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 OR 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, 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:

Plan for Hypertension	Finding Common Ground
Areas to be covered include: 1) Agree to continue treatment for high BP. 2) Discuss possible links between nonsteroidal anti-inflammatory drug use and recent increasing BP. 3) Arrange a complete physical exam. 4) Discuss non-pharmacological treatment (e.g., dietary measures such as the DASH diet and no added salt, avoiding alcohol, exercising, and weight loss).	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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