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

RATIONALE FOR SIMULATED OFFICE ORAL EXAMINATION #

[*] Stewart M, Brown JB, Weston W, McWhinney I, McWilliam C, Freeman T, eds. *Patient-Centered Medicine: Transforming the Clinical Method*. 3rd ed. London: Radcliffe Publishing; 2014.

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

1. caregiver burnout

2. headaches

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. Helen Pereira, who is new to your practice.

CASE DESCRIPTION

Introduction

You are **Ms. HELEN PEREIRA**, age 60. Yesterday, your mother's continuing care case manager phoned to tell you that your mother will soon be ready for discharge from the rehab unit. She has been a patient there for the past three weeks.

You felt overwhelmed by this news and argued that there was no way your mother was ready and safe to come home. The case manager said, "This is the way it is", and told you that you had to be prepared to look after your mother. She had not been willing to listen to you. This problem started a throbbing headache that will not go away.

This morning, you phoned your family physician (FP), **DR. JONES**, for advice about what to do to ensure your mother is not sent home. However, he is away for the next few months, and so you have this appointment with a new physician at the clinic.

History of the problems

CAREGIVER BURNOUT

Your mother, LENA ALLEN, is 93 and lives in her own home, in the same community as you. Despite her age, she is healthy. She takes no medications other than "herbal" ones and has never had a day's illness in her life.

Your mother has been a widow for 15 years. Your father died of heart failure; he was quite disabled near the end of his life and had become noticeably demented.

You were there for them both at that time and helped your mother care for him.

His death was not unexpected and initially your mother seemed to cope well. However, as her friends became disabled and died, she began to expect more and more of you: help with housework, help with shopping, etc.

For the past year or so she has been phoning at least three times a day, and if you do not physically check up on her she becomes quite rude to you. However, only in the past few months have you begun to realize how demanding your mother is and how her demands are interfering with your life. Your husband's or your daughter's visits to her are not enough of a break for you. She also is reluctant to accept their help these days.

Six years ago, your mother had a right hip-joint replacement. She sailed through that. During the past year, the pain in her left hip had become very severe and virtually constant, and she was much incapacitated. She had severe osteoarthritis on the x-rays just like her right hip had been. You went with her when she visited her FP about her hip. She told him bluntly that she wanted an operation. She said that the pain was too much to bear. If she died during or after the procedure, well, that was God's will, but she was sure that her God did not intend her to suffer quite this amount of pain. Because she is a Jehovah's Witness (JW), she was referred to the university hospital, which has blood-salvaging techniques that made the operation less risky. She received iron and erythropoietin preoperatively. Although her memory is still good, she is increasingly uncertain about decisions and needed constant reassurance and support before the operation.

The arthroplasty was completed a month ago. It went well. A week later she was transferred to receive rehabilitative care in a rehab/sub acute care wing in the same hospital, which is some distance away. It takes you 45 minutes to get there to visit.

You visited your mother in the hospital most days and really were surprised when the continuing care case manager phoned yesterday. You had expected that your mother would need at least a further month in the hospital. The physiotherapist had told you that your mother had spent so much of the past year sitting that she was quite deconditioned and would need at least a couple of months or so of rehab! Your mother had told you that while she was walking with a walker during physiotherapy, she still needed someone to be there; she went to the toilet only with supervision and needed help dressing and getting her shoes and socks on. She also told you that she was scared to get out of bed on her own. She felt quite light-headed and dizzy when she stood up from her chair or her bed. Although she complained to you, you suspected that she had not told her caregivers about this. You had, however, seen her get up from a chair and walk to the toilet and then rise from the toilet and walk back to her chair using her walker. You felt she pushed herself to impress you and prove that she was ready to go home.

Probably she was also putting pressure on her caregivers to let her go home. You think she told them that you will be there to take care of her and that you will stay with her if need be.

When you spoke to the case manager yesterday, you argued that there was no way she was ready to come home, that she was not safe to be on her own and would fall and be back in hospital. You did not broach your own issue of feeling overwhelmed with the care of your mother, or her expectation of your being there at any time, day or night, just for her.

In the past, home support workers did not work out. Your mother could not see why they were necessary when you were there to help. They never did things the way she wanted. She was too proud to allow an attendant to help her bathe.

You fear that, even if “supports” are in place, your mother will soon fire them and expect you to “do” for her.

Your mother lives in a duplex, which is all on the ground-floor level. Three steps lead up to her front door. Her toilet is in the “ensuite” with her bedroom and has a raised seat and grab bars. There are also other grab bars in her bathroom. Her kitchen is well laid out. She has good seating that was bought after her first arthroplasty, on the advice of an occupational therapist.

Caring for your mother has made you irritable of late. You feel like “a bone that dogs fight over”, being dragged this way and that, with no control over your life. You feel that your mother now controls you and your family completely. For the past year, you have had no time to yourself, and have not been able to go off for a weekend with your husband or just have a day for yourself. You have not had a holiday for five years. For years before that time, you had a winter and a summer holiday.

You have been thinking about this loss of control over your own life a lot recently. During yesterday’s phone call, you needed a lot of willpower not to break down in tears and tell this case manager just to leave you alone because you had had enough. You love your mother dearly and feel guilty, but not too guilty, about the way you think. You believe that you have been more than attentive to your mother and that she is manipulating you now. You do not know why or how this happened; you just became caught

up in it all. You have never confronted your mother or discussed your feelings seriously with her. She is not the easiest person to talk to; she becomes defensive and angry when confronted.

You still sleep well. You are not sad or depressed, just pulled and pushed too far.

You are not suicidal and have never thought of suicide or of harming your mother.

HEADACHES

After yesterday's phone call, you developed a headache. You knew it was coming as soon as you put the phone down. You had this vague sensation of your head being full and of being very light-headed, which led to blurred vision and then distorted vision followed by pounding pain behind your right eye. This pain radiated over the whole right side of your head. You took one dimenhydrinate (Gravol) tablet and two acetaminophen (Tylenol) with codeine, and went to bed with an ice pack. You slept, and when you woke up you still had the headache, but it was tolerable. You felt completely "washed out".

For the past year you have been having these headaches again. You have at least one a month, and they are becoming more frequent. You had thought you were rid of them!

You have suffered with "migraine" since your late teens. The attacks are typical, with an aura, scintillations, and a throbbing headache. For years you suffered two or three episodes of a headache a year. Typically, you had blurred vision, and then a sensation of flashing lights, often in both eyes, followed by a terrible, painful headache that defies description. You vomited with the headache. You used to take dimenhydrinate and a couple of acetaminophens with codeine and try to sleep.

The headache would last for up to three days, coming and going and then leaving you exhausted and drained. Your physician at the time offered you drugs to try to prevent them, but you never thought they came often enough to justify daily medication. Twice you went to the emergency department (ED) because the headaches were so bad. There you received intravenous medication that was effective.

Then, about 12 years ago, your headaches changed; they started as always, but the pain was different, and the vomiting was incessant. You did "the Tylenol #3 and Gravol thing", but it had no effect. You went to your FP, who tried stronger narcotics; in the ED, the usual cocktail did not work. Eventually your headache and vomiting were so bad that you were kept in the ED; when your family physician met you the next day, he discovered that you were delirious. You have no recollection of that, but your family tells you that you had a computed tomography (CT) scan within the hour and were on your way to a neurosurgeon just as quickly.

You had had a spontaneous subdural haemorrhage. No cause was ever found. It was drained and you made a complete recovery. For the next several years you were headache free, although for a few of those years you lived in dread of another subdural haemorrhage. Eventually you persuaded yourself that "lightning does not strike in the same place twice and relaxed about things".

A year ago, the old migraine headaches returned, with the same blurring of vision, the same flashes, and the same throbbing headache. You had little nausea, and usually they incapacitated you for only a morning or an afternoon. When the headaches returned you were sent for a CT scan on the advice of the neurosurgeon. The result was normal.

You now recognize stress and disturbed sleep as triggers for your headaches. If you become tense because there are not enough hours in the day or because a situation develops and you lose control of it, you can be sure of a headache. If you have a disturbed night, you worry that a headache will follow.

Medical history

Migraine history as above.
Uneventful menopause 10 years ago.
Pap test results always normal; last test was a year ago.
Mammography results always normal; last mammogram was a year 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: Craniotomy for subdural haematoma 12 years ago.

Medications : Acetaminophen with codeine (Tylenol #3), two tablets for headaches; never more than four a day.
Dimenhydrinate (Gravol), one 50-mg tablet with the acetaminophen with codeine; never more than two tablets a day.
Vitamin D 800 IU with 1,200 mg of calcium a day.

Pertinent laboratory results: None

Allergies: Although you are not allergic to them, you have always avoided nonsteroidal anti-inflammatory drugs (NSAIDs). This is because you do not want any bleeding problems.

Immunizations: Up to date.

Lifestyle issues

- Tobacco: You do not smoke and never have.
- Alcohol: You do not drink alcohol.
- Caffeine: One coffee in the morning
- Cannabis: None
- Recreational and/or other substances: None
- Diet: Standard North American diet

- Exercise and recreation habits: You used to go to a Tai Chi group twice a week. You do not seem to have time for it now.

Family history

Your father, **WILLIAM ALLEN**, had congestive heart failure secondary to ischaemic cardiomyopathy. He became demented in the last year of his life and died at age 82. You are not aware of any other family medical history.

Your mother is healthy for her age. Your mother told her family physician that if she cannot make decisions about her health, you will. However, no formal document exists to confirm this.

Your brother, **ROBERT ALLEN**, age 65, is married and lives 100 km away.

Personal history

You have always lived in this community. You graduated from high school and worked as a secretary in a local law office.

- Family of Origin

Your elder brother is not religious. He has very little to do with caring for your mother. When you are not angry at him for failing to pull his weight, you realize that his detachment from the family was your parents' doing. When he married, he decided that the JW life was not for him and left the fellowship. Your parents had little to do with him for some years. As he had children they relented, and now your mother sees him as "a good man, but not one of us".

- Marriage/Partnerships

You met **JOSE PEREIRA**, age 67, at a JW convention. He was "an exotic-looking man", whose Spanish parents had immigrated when he was a boy. After a short romance you were married. You have never regretted the marriage.

Jose has his own business. He installs and refurbishes hardwood floors. He works at the upper end of that market and gets much of his work by word-of-mouth referrals among "the wealthy crowd". He has always worked 12-hour days.

- Children

You conceived only once, and gave birth to your daughter, **ELIZABETH**, who is now 25. You had no explanation for the absence of another pregnancy, and you long ago accepted that you would have only one child.

Your 30-year-old son-in-law, **JOHN**, has been a welcome addition to the family.

Elizabeth married him three years ago. He is a nice young man and a hard worker. However, although he had a college education in business studies, he did not seem to get ahead. After his marriage to Elizabeth, he was laid off. During this time, he worked with your husband in the flooring business and found that he liked it. Jose trained him to take over. The takeover should have been happening now, but

a year after John and Elizabeth's marriage, John had to visit the same neurosurgeon who had cared for you. He had had headaches and also weakness of his arm.

John was found to have a brain tumour. The tumour was removed, and he underwent radiation. So far, the tumour has not returned. The oncologists have been cautiously optimistic. That was "a year from hell", during which you supported your daughter and son-in-law, both financially and emotionally. (His family lives two provinces away.) Your daughter had been planning a pregnancy when the tumour was discovered.

Education and work history

After graduating from high school, you worked initially as a legal secretary. You have also kept the books and organized the bookings for your husband's business. You have done this for years and continue to be involved in the business.

Finances

Your home is in a nice part of town and has been mortgage free for some time. You are well prepared for retirement; in fact, you and Jose had planned that he would be retired by now, and that your son-in-law would have taken over the business.

Money is not an issue for your mother. She has more than enough to pay for help or even private nursing home care if necessary. (You were surprised to learn that in addition to her house, she has well over $300,000 in investments and at least another $250,000 in guaranteed investment certificates [GICs].) However, she likes to save and not spend her money. Leaving an inheritance for both of her children is important to her, although neither you nor your brother needs her money.

You have an enduring power of attorney for your mother's finances. Like you, she has a will.

Social supports

You have close friends at the Kingdom Hall and can turn to most of them for help and support. They also visit your mother and will bring her food when she comes out of the hospital, but they are not involved in her care.

Your daughter, son-in-law, and husband all try to help and understand your mother. Occasionally your husband can be irritated by her demands. He tries to be protective of you and probably picks up on your irritability much sooner than you become conscious of it.

For the past two winters, Jose has gone on a skiing vacation on his own. That upset him. He, too, has been pressuring you to look after yourself and not give so much of yourself to your mother. He is disappointed that you have not been firmer with her, but you notice that he is just as easily manipulated by her.

Religion

Like your mother, you are a Jehovah's Witness. You are active and practising, as are your husband, daughter, and son-in-law.

ACTING INSTRUCTIONS

You are casually dressed in clothes appropriate for a middle-aged woman. You are obviously distressed by the prospect of your mother being discharged from the hospital so abruptly.

You agreed to see this physician as you feel the imminent discharge is a crisis. You had not expected your mother to recover as well as she has. You had expected to have a chance to rest, and you have not. You are angry that you have been told she is coming home. You focus on her dizziness and incapacity as the reasons for her need to be in care longer. You may say things such as **"She cannot possibly be left alone yet"**, **"She cannot even put her shoes on by herself"**, or **"She will fall because she is so dizzy"**.

At the beginning of the interview you try to dominate and press the physician to see your point of view: **"I know you have not met my mother, but can you just phone them and** tell them **to keep her?"** At least initially, you do not realize that the issue may be as much about you as about your mother, and that you are "burned out" by caregiving and your relationship with her. If a candidate becomes empathic or understanding about your predicament, you become less assertive and more realistic. You may say, **"They need** to **give me more time"** or **"They sprang this on me, and I am not emotionally ready for her yet"**.

You are willing to discuss both prophylactic and abortive therapy for your headache. You are quite happy if you are referred to another physician, but you would like something to help you while you wait for the referral.

If the candidate offers NSAIDs, you say that you will not take them because you are a Jehovah's Witness.

If the candidate suggests that you are depressed, you emphatically state that you are not. You agree that you are emotionally exhausted or "burned out". You quickly agree and latch on to any suggestion that will buy time before your mother is discharged.

You are happy to return to the candidate, with or without your mother, to discuss care issues once she has been discharged.

Cast of Characters

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

HELEN PEREIRA:	The patient, age 60, who is suffering from caregiver burnout and migraines.
JOSE PEREIRA:	Helen's husband, age 67.
ELIZABETH:	Helen's daughter, age 25.
LENA ALLEN:	Helen's mother, age 93.
ROBERT ALLEN:	Helen's brother, age 65.
JOHN:	Elizabeth's husband, age 30.
WILLIAM ALLEN:	Helen's father, who died at age 82.
DR. JONES:	Helen's FP, who is away for the next few months.

Timeline

Today:	Appointment with the candidate.
One month ago:	Mother's second arthroplasty.
Two years ago:	Son-in-law diagnosed with a brain tumour.
Three years ago:	Daughter and son-in-law married.
Five years ago:	The last year in which you had a vacation.
Six years ago:	Mother's first hip arthroplasty.
12 years ago:	Craniotomy for subdural haemorrhage.
15 years ago:	Father died.
25 years ago:	Daughter born.

Examiner Interview Flow Sheet - Prompts

Initial statement	"**I need your help with my mother**."
10 minutes remaining* Optional, use only if you feel it's needed	If the candidate has not brought up the issue of the headaches, the following prompt is to be used: "**Since she phoned yesterday, I have had another headache**."
7 minutes remaining* Optional, use only if you feel it's needed	If the candidate has not brought up the issue of caregiver burnout, the following prompt is to be used: "**You know, I don't know that I can cope with my mother any longer**." (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: Caregiver Burnout

Issue #1	Illness Experience
Areas to be covered include: 1. mother's current care issues: • Recent arthroplasty. • Rehabilitation for three weeks. • Being discharged with a sudden change in care plan. • Not independent in activities of daily living (ADLs); needs help bathing, dressing, etc. 2. mother's care issues before hospitalization: • Lived alone. • No evidence of dementia. • Other family members not acceptable as caregivers. 3. caregiving burden: • Mother accepts help only from the patient. (The patient's husband and daughter are no longer acceptable to the mother.) • The patient's brother is not helpful. • Home care services are not acceptable to her mother. 4. boundary setting: • Has never discussed this issue with her mother.	**Description of the patient's illness experience**. You are angry that the hospital is discharging your mother inappropriately, without a plan in place. You feel overwhelmed, but at the same time guilty about how you are feeling. You are no longer able to look after your mother alone. You have not time for yourself. You can't take holidays and you even gave up you exercise class. You are hoping the physician will intervene and keep your mother in hospital until you are ready to look after her.

		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: Headaches

Issue #2	Illness Experience
Areas to be covered include: 1. current headache: • Aware when it is coming (aura) • Usual migraine headache • Scintillations • Hemi cranial 2. past history: • Migraine since youth. • Craniotomy for subdural haemorrhage 12 years ago. • Migraine restarted a year ago. • Normal CT a year ago. • Increased frequency. 3. treatment: • Dimenhydrinate. • Acetaminophen with codeine. • Has never used prophylactic medications. 4. refusal of NSAIDs because she is a Jehovah's Witness.	**Description of the patient's illness experience.** You are fed up with headaches, and this is one last straw. This was your usual migraine and the case manager's phone call triggered it. You are usually incapacitated for up to three days when you get a migraine, although it's a bit less recently. You expect that this visit will be an opportunity to vent, and that the physician will be emphatic.

		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

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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. support for the patient: • Supportive husband. • Supportive daughter. • Daughter has increased. • responsibilities (because of her husband's brain tumour). • Congregation of the patient's church is very supportive. 2. social factors/life cycle issues: • Works for her husband as a bookkeeper. • Had planned retirement. • Son-in-law is unable to take over the business. • Financially independent. 3. mother's affairs: • Financially well off. • Patient has power of attorney. • Will in place. • No formal alternative health care decision maker.	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, and 3.	Demonstrates initial synthesis of contextual factors, and an understanding of their impact on the illness experience. Empathically reflects observations and insights back to the patient.
Certificate Level	Covers points 1 and 2.	Demonstrates recognition of the impact of the contextual factors on the illness experience.
Non-Certificate Level	Does **not** cover points 1 and 2.	Demonstrates minimal interest in the impact of the contextual factors on the illness experience or often cuts the patient off.

4. Management: Caregiver Burnout

Plan for Issue #1	Finding Common Ground
Areas to be covered include: 1) Validate the patient's concerns, identifying the problem as caregiver burnout/stress. 2) Support the patient in creating a plan to deal with the immediate situation/advocate for the patient. 3) Offer supportive counselling/ follow-up for her stress. 4) Discuss or offer to discuss long-term strategies for the mother's care.	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: Headaches

Plan for issue #2	Finding Common Ground
Areas to be covered include: 1) Identify that these are migraine headaches. 2) Offer/discuss an alternative migraine therapy. 3) Discuss prophylactic medications. 4) Discuss the need or the lack of a need to investigate the headaches further.	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 Uses both general and active listening skills to facilitate communication. Sample behaviours • Allows time for appropriate silences • Feeds back to the patient what the candidate thinks has been understood from the patient • Responds to cues (doesn't carry on questioning on unrelated topics without acknowledging the patient if a major life or situation change is revealed) • Clarifies jargon the patient uses	**Cultural and Age Appropriateness** Adapts communication to the individual patient for reasons such as culture, age, and disability. Sample behaviours • Adapts their communication style to the patient's disability (e.g., writes for patients with hearing challenges) • Speaks at a volume appropriate for the patient's hearing • Identifies and adapts their manner to the patient according to the patient's culture • Chooses appropriate medical terminology for each patient (e.g., "pee" rather than "void" for children)
Non-Verbal Skills Expressive • Is conscious of the impact of body language on communication and adjusts it appropriately Sample behaviours • Ensures eye contact is appropriate for the patient's culture and comfort • Is focused on the conversation	**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

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

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