THE COLLEGE OF
FAMILY PHYSICIANS
OF CANADA

LE COLLÈGE DES
MÉDECINS DE FAMILLE
DU CANADA

Certification Examination in Family Medicine

Overview of Simulated Office Oral (SOO) Structure and Marking

Updated June 2023

The College of Family Physicians of Canada
Certification Examination in Family Medicine

Introduction

The two components of the Certification Examination in Family Medicine are, together, designed to evaluate a representative sampling of the diverse knowledge, attitudes, and skills required by practising family physicians as set out in the Assessment Objectives for Certification in Family Medicine.

The short-answer management problem (SAMP) component assesses candidates' medical knowledge, problem-solving skills, and clinical reasoning. The simulated office oral (SOO) component assesses how a candidate establishes and uses the patient-centred method to care for patients in an office setting.

The College believes a patient centred approach using the patient centred clinical method[1] to providing clinical care helps patients more effectively. The SOOs marking scheme is based on the patient-centred clinical method (PCCM)developed by the Centre for Studies in Family Medicine at the Western University. The essential principle of the PCCM is integrating a traditional condition-oriented approach (e.g., understanding a patient's condition through effective history-taking, understanding pathophysiology, recognizing clinical presentation patterns, making a diagnosis, and knowing how to manage the identified condition) with an appreciation of the illness the health-issue creates (e.g., what does the disease's clinical aspects mean to the patient, what is the patient's emotional response to their illness, what is the patient's understanding of the health issue they are concerned about, and how is the health issue is affecting their life). Integrating the disease/condition with an understanding of the person living with the illness—through the act of interviewing, communicating, problem solving, and negotiating disease management-—is fundamental to the patient-centred approach.

While important, the emphasis of the SOO is **not** just on a candidate's ability to appropriately diagnose and manage a clinical scenario, but to explore patients' feelings, ideas, and expectations about the situation the health-issue is causing or contributing to and to determine the effect on their functional abilities. Candidates are scored on how they conduct the interview to both forge a connection with the patient and actively involve the patient in deciding a mutually acceptable management plan. The SOO cases reflect a variety of clinical situations, but all require PCCM communication skills to understand patients as individuals with unique illness experiences and to work with them to find the best next steps to effectively deal with the health issues presented.

The following Appendices will be of interest to all examiners:

Appendix 1: Standardized Instructions to Candidates

Appendix :2 Ten CFPC Preparation Pointers for Examiners

Appendix 3: Distinguishing a certificate-level from a superior-level performance: Exploration of the illness experience

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

RATIONALE FOR SIMULATED OFFICE ORAL EXAMINATION #

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

1. a new diagnosis of hepatitis infection

2. an anal fissure

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. **JEFFREY DALMAZIAN**, age 42, who is new to your practice.

CASE DESCRIPTION

Introduction

You are Mr. **JEFFREY DALMAZIAN**, a 42-year-old engineer. You recently received a letter from Canadian Blood Services, which stated that you have hepatitis infection. You are very worried about what this means for you. You also have symptoms of an anal fissure.

You are visiting the candidate today because you don't have your own family physician (FP).

History of the problem

HEPATITIS INFECTION

A month ago, your company sponsored a drive to increase blood donations by staging a competition among the various divisions. You and several of the people who work in your section decided to donate blood. You have never donated before. You went with the others, filled in the forms, and gave blood. It was a simple procedure, and you pretty much forgot about it until six days ago, when the letter arrived from the local blood services agency. This letter was about your recent blood donation, and shocked and worried you. It stated that you had a hepatitis infection and recommended that you follow up with a physician.

You don't know what this diagnosis means.

You discussed the letter with your wife, **ANNABELLA O'MALLEY**. She insisted that you make an appointment with this clinic right away. She has heard about hepatitis and thinks that this problem could be really serious.

You don't know much about hepatitis, except that it is a liver problem and that people turn yellow with it. You don't think you could have this because you feel well and haven't turned yellow.

You are generally a pretty healthy fellow. Except for feeling a bit tired lately, which you put down to working overtime, you consider yourself well. You have no malaise, nausea, or fever. You have no tattoos.

You have no idea how you might have contracted this problem. Your wife said that people can get this from intravenous (IV) drug use or sexual contact, and she is understandably upset.

You have just landed a pretty lucrative position within your company. It will require a great deal of travel to Asia, including several underdeveloped areas. You are concerned that liver problems may place you at increased risk during your travels. Can you take the same medications as your colleagues to prevent these problems? What if you become ill when you travel? Could you pass anything on to Annabella?

ANAL FISSURE

About two months ago, you got on a bit of a health kick and decided to take up running. You haven't done this kind of thing since you were in your early 20s, but you thought that if you took it slow, you wouldn't have any problems. You bought expensive shoes and a jogging suit and headed out.

A few weeks into running (about a month ago), you decided to join the guys at the office for a very long run. You thought you were prepared for it. Unfortunately, you were wrong; after several kilometres you twisted your right knee and were unable to finish the run. The guys had to bring the car and get you. You iced the knee and took a few ibuprofen tablets, but the pain was really bad. You went to the local emergency department and were checked out. There was nothing seriously wrong with the knee, and you were told to ice it, rest it, and think about an easier exercise programme. The emergency physician gave you some acetaminophen (Tylenol) with codeine (30 mg) tablets, which you found were very good for the pain. You took two tablets four times a day for six days, until the pain subsided. It was really too bad that no one told you to take something for your bowels, too.

You got very constipated. It was eight days before you moved your bowels, and by that point you were in agony. Your wife bought some over-the-counter (OTC) laxatives (Senokot) and you tried them. You had to take several doses of several pills before anything happened, and then, WOW! That first bowel movement was horrifically painful; you thought you had been ripped apart.

You had several bowel movements, which eventually became quite loose, but each time you went to the toilet it hurt. A lot. The pain is sharp and worse when you pass stools, but you can also have pain just sitting or lying down. Your wife suggested that maybe you have a haemorrhoid (you won't let her look), and she bought some cream at the pharmacy. You tried using it, but it just stung like crazy.

You have noticed a bit of bright red blood in the toilet after you move your bowels (you don't check regularly because it's too disgusting), and sometimes on the toilet paper. You don't know how long this has been going on.

You've tried to avoid going to the bathroom in the past day or so, because it hurts so much, but of course this isn't a viable option. By the time you were totally desperate to move your bowels, the stool was very hard, and it hurt like crazy. The stools are brown, not black. When the stool comes out it is in small balls like pellets.

You have taken a couple of the codeine tablets again for the pain, but they constipate you and that makes everything worse.

You are pretty worried about this. The pain seems to be getting worse. You swing between constipation and loose bowel movements with the laxatives, and you are starting to think there may be something really wrong with you. Does cancer start this way? Could you have damaged your internal organs by straining? Could you bleed to death?

You've always been rather private about your body. (You hated to change in the gym, didn't shower with the other boys in high school gym class, etc.) You've never been abused nor had any other particular reason for this attitude. All your family members avoid showing or discussing their bodies. As a consequence, you are extremely embarrassed to talk about this subject and only the severe pain has driven you to see a doctor. You are rather horrified that anyone will have to "check you out" (give you a physical examination). This is why it has taken you so long to come in to see a doctor about the problem. In the past, you have generally avoided seeing a doctor unless you have injured something (like your

knee). You've never had an FP. You also feel very uncomfortable seeing a doctor; you don't know why this is.

Before this episode you had regular bowel movements. When you looked at the stools, they were brown and formed.

You have never used IV drugs. You have not had casual sex since you met Annabella. You can't remember the number of sexual partners you have had; you admit that when you were in university you did drink to excess on several occasions and had unprotected sex with several partners. You didn't use condoms back in those days. You've never had sex with another man. You have no idea how you may have gotten this problem and wonder if the lab has made a mistake.

Medical history

You travelled extensively when you were a child and lived in several different countries. You had your childhood vaccinations in Africa.

You have never been immunized against hepatitis. You have travelled to resorts in Mexico and didn't take precautions with ice cubes and salads, etc. You never really seemed to get sick when you travelled.

Surgical history: None.

Medications : Acetaminophen (Tylenol) with 30 mg codeine PRN, which you started taking six weeks ago and have now stopped using. Sennosides (Senokot) PRN.

Pertinent laboratory results: Six days ago, you received a positive test result for hepatitis infection. The type was unspecified.

Allergies: Hay fever.

Immunizations: Up to date.

Lifestyle issues

- Tobacco: You have smoked half a pack of cigarettes a day since you were 19. You would consider quitting if your wife became pregnant. She quit smoking when she stopped taking the birth control pill, and she reminds you frequently that you should stop, too.
- Alcohol: You drink three to four beers a week (or wine when you go out to dinner). You are not a problem drinker and CAGE results are negative.
- Caffeine: Coffee in the morning
- Cannabis: None

- Recreational and/or other substances: You do not use illegal drugs, although in university you “dabbled” with “a few pills and stuff”. You didn’t really like using drugs and preferred liquor.

- Diet: Normal North American diet

- Exercise and recreation habits: You have recently taken up jogging, but this is on hold until your knee is “perfect” again.

Family history

Your parents, **JAMES** and **SUSANNAH**, are healthy. They live in Hawaii. Neither has significant health problems, but your father’s brother died of a myocardial infarction when he was 47. Your mother has hypothyroidism, which is treated, and suffers no ill effects.

Your brother, **WILL**, is 44 and has a very healthy lifestyle in Vancouver. He is a strict Buddhist and exercises all the time. He has no health problems that you know of.

You have no family history of colon cancer, or of alcohol abuse or cirrhosis.

You had a younger sister, **LIZABETT**, who died at age three years, when you lived in Ghana. Your parents never talk about Lizabett, but your older brother can remember her being sick. (He was about seven when she died.) He says that she turned very yellow before she went to the hospital. You were five years old when she died. Now that you have remembered this story, you suspect that she had jaundice. You wonder if you were ill with hepatitis when you were a child, and just never knew it.

You called your mother after you got the letter from the blood services agency, but she didn’t really want to talk about your sister and became very upset and refused to discuss the cause of Lizabett’s death. Your father doesn’t know too much about it, either; he stayed home with you and your brother when Lizabett went to the hospital, and he wasn’t there when she died. There were no medical records to speak of, and you can’t contact the hospital, either.

You don’t remember ever being sick in Africa and were never admitted to hospital there. You have never had a blood transfusion, or an operation of any kind.

Personal history

- Family of Origin

You were born in Canada but travelled extensively when you were a child because of your father’s employment. He had an engineering consulting business, and you, your brother, and your mother moved with him until you left for university at 18.

You have lived in Africa (in what are now Ghana, South Africa, and Zimbabwe), Australia, the Philippines, and Norway.

Generally, your childhood was good. You didn’t really like changing schools so often, but you usually went to the international school and that was pretty good. You have friends all around the world.

You know that your mother and older brother, both of whom are introverts, found the travelling very difficult, and that at one point your mother threatened to leave the marriage unless your father stopped moving. A few years later he sold the business, and they retired early and moved to Hawaii. They now travel only to visit you or your brother.

- Marriage/Partnerships

You have been very happily married to Annabella for three years. She is a manager in the human resources branch of your company and is quite smart and successful. You met because she interviewed you when you applied for the job at your current company.

You dated for a year, and then moved in together. You wouldn't have bothered with marriage, but her family insisted because they are quite religious, although Annabella is not. They paid for the wedding and, looking back, marriage was a good idea. Annabella has changed your life, giving it stability and a depth, you never even knew were missing.

The two of you live in a condo. Financially you are doing very well; two good salaries provide you with a great lifestyle. You have health insurance at your job, but you don't have disability insurance. You are young and pretty healthy; why would you look at disability insurance now?

You and Annabella are actively trying for a baby. She is 38 and stopped taking the pill four months ago. You hope that sometime soon, she'll give you the good news that you'll be a dad. You are really looking forward to having kids, which is funny because several years ago you never would have thought you wanted to be a dad.

You have not used condoms with your wife as she was taking the pill when you met. Since you received the letter from the blood services agency, you have wondered if you might infect her, and you have suggested that the two of you abstain from sex until you get this hepatitis issue checked out.

Annabella is worried, too, but also annoyed; she is fertile right now and is upset because this is yet another month of not getting pregnant. Annabella has always wanted children and thinks she is getting too old to achieve a pregnancy. She is pretty concerned that at her age she might not get pregnant, and that any month you don't try for a baby is a setback for her. You think she'll be pretty angry and upset if you have to postpone attempts to conceive.

- Children

You have no children.

Sexual history

During your university days (especially during your first two-year stint) you were not careful and didn't think about the consequences of indiscriminate sexual behaviour. You did know a bit about the risk of contracting acquired immunodeficiency syndrome and other sexually transmitted diseases, but just never thought it would happen to you. You often didn't use condoms when you were in your late teens and early 20s.

After university, you had several long-term monogamous relationships before you met Annabella. You have been monogamous since you met her. You have never engaged in anal intercourse or used sex toys.

Education and work history

You went to university for two years right after high school but didn't like it very much. You also partied pretty hard and didn't get great grades. You decided to "take a break" for a while.

You worked in manual labour for a few years until you were 24, and then you went back to university with a completely different attitude. You got your civil engineering degree.

You took a position with a local company and worked for them for three years but found that the job wasn't as satisfying as you had hoped it would be. Five years ago, you had a job interview at a major international engineering firm. The job was everything you wanted, and you have been working for the firm ever since.

You were promoted a few weeks ago, and the new position is looking pretty exciting. There will be a lot of travel and you are strangely (considering your childhood) looking forward to the new challenges of projects in Malaysia.

Developing something modern in the places you'll be visiting is quite exciting. You have heard, though, that a couple of the guys who were previously on the team became sick in the jungle. The company has urged all employees to protect themselves while they are there.

Finances

You and Annabella make good money, and you are financially stable. You owe payments on a sports car and the condo. You have paid off your student loans.

Social supports

You have several friends, although you wouldn't say any of them are particularly close. Most of your social interactions come through your wife. You do hang out with three other couples (for dinner, dancing, theatre, etc.) because the women all went to school together.

Your brother lives in another city. You call him on holidays. You wouldn't say you are overly close to him.

Your parents are supportive but live far away. Your wife's parents are in the next city, and you see them pretty often. You would say they are supportive, but you don't feel particularly close to them.

Religion

You were raised as a Protestant, but you do not attend church regularly.

ACTING INSTRUCTIONS

You are casually dressed. You've come to see this FP on your day off.

You are **NERVOUS** (rubbing your hands together, jiggling your knees, etc.) about having to speak to the physician about the anal pain. You are embarrassed about discussing issues "down there", and struggle a bit to find the right words to discuss your symptoms. You don't use medical terms (i.e., "anus", "stool", etc.). Rather, you use more common terms.

You are **CONCERNED** about your wife and the possibility of giving her (or your yet-to-be-conceived child) an infection. You do stress how important it is for Annabella to get pregnant as soon as possible, and you don't want to wait. If the candidate suggests using a barrier method until testing is completed, you are a bit resistant unless he or she explains the importance of this request. You are compliant if a candidate fully explains the rationale behind any suggestions, but slightly resistant to a candidate who dictates what needs to be done.

You make certain the candidate understands that you are not a problem drinker.

Cast of Characters

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

JEFFREY DALMAZIAN:	The patient, age 42, an engineer with newly diagnosed hepatitis infection and an anal fissure.
ANNABELLA O'MALLEY:	Jeffrey's wife, age 38.
JAMES DALMAZIAN:	Jeffrey's father, a retired engineering consultant.
SUSANNAH DALMAZIAN:	Jeffrey's mother.
WILL DALMAZIAN:	Jeffrey's brother, age 44.
LIZABETT DALMAZIAN:	Jeffrey's sister, who died in Africa at three years of age.

Timeline

Today:	Appointment with the candidate.
1 month ago:	Anal bleeding and pain began.
2 months ago:	Started running.
3 years ago, age 39:	Married Annabella.
4 years ago, age 38:	Moved in with Annabella.
5 years ago, age 37:	Met Annabella; started working at current job.
37 years ago, age 5:	Sister died in Africa.
42 years ago:	Born.

Examiner Interview Flow Sheet - Prompts

Initial statement	"**I just got this disturbing letter**."
10 minutes remaining* Optional, use only if you feel it's needed	If the candidate has not brought up the issue of the anal fissure, the following prompt is to be used: "**I have pain when I go to the toilet**."
7 minutes remaining* Optional, use only if you feel it's needed	If the candidate seems to have forgotten about the hepatitis, the following prompt is to be used: "**Can I give this hepatitis to my wife?**" (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: Hepatitis

<table>
<tr><th>Issue #1</th><th>Illness Experience</th></tr>
<tr><td>

Areas to be covered include:

1. risk factors:
   - Lived in Africa as a child.
   - Several sexual partners in Canada/no condoms.
   - No sexual contact with males.
   - No IV drug use.
   - No blood transfusions.
   - No tattoos.

2. clinical evidence of disease:
   - No oedema/ascites.
   - No jaundice.
   - No itch.
   - No abdominal pain.
   - No upper gastrointestinal (GI) bleeding.

3. liver health:
   - No history of problem drinking.
   - No regular medications.

4. not immunized against hepatitis A and B.

</td><td>

Description of the patient's illness experience.

You are worried. You wonder if you got this during your childhood; especially when you thing about your sister dying after she turned yellow. Currently, you are refraining from sexual activity and you expect that the doctor will help you sort this all out.

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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.

</td></tr>
</table>

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: Anal Fissure

Issue #2	Illness Experience
Areas to be covered include: 1. current symptoms: • Pain on defecation. • Bright red blood on toilet paper or toilet bowl. • Change in stool (constipation). 2. relationship to recent codeine use. 3. pertinent negative factors: • No family history of inflammatory bowel disease. • No family history of cancer. • No weight loss. • No trauma. • No prior history of rectal bleeding. 4. personal history: • Smokes. • Normally has a high-fibre diet. 5. failure of OTC remedies (haemorrhoidal cream).	**Description of the patient's illness experience.** You are feeling extremely embarrassed that you worry that you might have done some real damage to yourself. You have been avoiding using the toilet due to the pain you've been having. You are expecting that the FP will help you fix this issue.

		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. relationship with Annabella: • Married. • She is trying to get pregnant. • She works for the same company. 2. family: • Brother distant. • Parents in Hawaii. 3. work: • Civil engineer. • Will be travelling with work. • Well paid; no financial worries. 4. his mother's inability to discuss his sister's death.	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 are worried that you may have developed a significant illness secondary to your time in Africa, and that it may negatively impact both your life and health, but also that of your wife and the possibility of creating the child you both want. In addition, you are concerned about the anal pain and bleeding you are experiencing, and fear that it may signify a serious problem."

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: Hepatitis

<table>
<tr><th>Plan for Issue #1</th><th>Finding Common Ground</th></tr>
<tr><td>Areas to be covered include:
1) Discuss hepatitis (e.g., types, transmission).
2) Offer further testing to clarify disease status.
3) Review precautions to prevent possible infection of sexual partner.
4) Discuss the possibility of a “false reactive” result.</td><td>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.</td></tr>
</table>

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: Anal Fissure

<table>
<tr><th>Plan for issue #2</th><th>Finding Common Ground</th></tr>
<tr><td>Areas to be covered include:
1) Arrange a physical examination and a rectal examination.
2) Suggest the diagnosis is likely an anal fissure.
3) Discuss various non-invasive methods of treating anal fissures (e.g., laxatives, stool softeners, sitz baths, increased fibre, improved hydration, etc.).
4) Discuss the natural history of anal fissures.
5) Discuss subsequent treatment, if necessary (e.g., surgery/colorectal surgery, a GI referral, use of vasodilatory creams).</td><td>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.</td></tr>
</table>

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.

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

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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.

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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

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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)

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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

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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

- Asks open- and closed-ended question appropriately

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• 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")	• 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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