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

RATIONALE FOR SIMULATED OFFICE ORAL EXAMINATION #

[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.

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

1. a need for help with smoking cessation

2. memory loss

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. **LILLIANNE LAWRENCE**, age 50, who is new to your practice.

CASE DESCRIPTION

Introduction

You are Ms. **LILLIANNE LAWRENCE**, a 50-year-old interior decorator. You wish to stop smoking. You also are becoming increasingly concerned about lapses in memory.

Your family physician (FP), **Dr. SMITH**, has retired.

History of the problems

SMOKING

You started smoking at age 16 when your older brother and his friends dared you to try a cigarette. Very quickly you found that you liked the feeling nicotine gave you. You thought you looked quite sophisticated and grown up, especially as you were a pretty skinny teen with no womanly curves to speak of.

Your first and second husbands were smokers, and neither ever gave you any real encouragement to quit. You did cut down when you were pregnant with your son and your daughter, but resumed smoking your usual one and a half packs a day after both deliveries.

After you and your second husband divorced when you were 39, you went on a bit of a health kick and thought about quitting. It just seemed to make sense to stop smoking, and so you did—cold turkey. Unfortunately, you developed fairly severe withdrawal symptoms and lasted only six days without smoking.

About a year and a half ago, you met **ALEX** and started dating. Alex is a fitness nut (there is no other way to describe him), and he strongly encouraged you to embrace a whole new way of living. You learned about eating a sensible well-balanced diet as a vegetarian and took up jogging. You've really enjoyed the benefits of this healthier lifestyle. The only thing left is to quit the cigarettes. Alex is quite the anti-smoker. He has been encouraging you to quit and is willing to help you do this.

Now that the relationship with Alex is becoming progressively serious, he is talking about moving in together. However, you would have to quit smoking first. You have managed to cut down to about half a pack of cigarettes a day. This was hard work and meant giving up several of your favourite cigarette breaks of the day. You have found that the first morning cigarette (your favourite) and cigarettes during your coffee breaks are impossible to give up. You really enjoy a cigarette when you are driving between appointments with clients, and if you have a cup of coffee. You like a few cigarettes as you wind down in the evening. You do not wake up to smoke and you don't have to leave the table in a restaurant for a cigarette break anymore.

You wonder if there is a painless way of quitting. You really don't want to go through the same withdrawal you did before because it was absolutely miserable, and it would doom you to fail. You have gone to a local pharmacy, but the number of smoking aids only confused you. Which is better, the patch or pills? You want the doctor to give you advice about which aid to select.

You have chosen Alex's birthday (in one month) as your target quit day.

MEMORY LOSS

You have always had an excellent memory. You've prided yourself on the fact that you could always store in your head umpteen facts about a variety of clients and did not have to resort to computer files. However, over the past year you have noticed that your memory isn't as sharp as it used to be.

You are very embarrassed that your direct supervisor has pointed out several mistakes you have made in the past month. Lately you've taken to jotting down notes and leaving them all over your apartment as reminders to yourself. You have left notes at work, but a couple of your co-workers commented on them, and you are beginning to worry that you've lost your edge. Your business is very competitive, and you know that a few younger people in the office would be pleased to exploit any perceived weakness for their own advantage.

The memory problem started about a year ago. At first it involved simple things, like misplacing your keys or your reading glasses. You figured that the house cleaner who dusted your apartment three times a week must be moving things around. You became rather short-tempered with her, and she quit four months ago. However, the disappearance of personal items (keys, glasses, clothes, Palm pilot, etc.) has increased, and you've conceded that perhaps she wasn't to blame.

You also have had trouble remembering your newer clients' names. You find that a bit strange because you ran into a former friend from junior high school just a few weeks ago at a business dinner, and you remembered her instantly.

Recently the office changed to a new software system. You attended the classes with the others in the office, but you just can't seem to learn how to use the system. You have left multiple sticky notes with instructions like "password for entry is X763R," but each day you sit down at your desk, the entire computer data entry seems like a new task you've never tried before. You can easily use your sewing machine and the temperamental serger (fancy sewing machine) that many others can't seem to get the hang of, so you don't think the problem is one of manual dexterity.

Alex has noticed that something is wrong, too. He has spoken to you on several occasions. He states that more than just your memory seems to have changed. You don't really believe him, but he complains that your personality has changed slightly over the past six months. He says that you are more short-tempered than usual. He points out that you don't have a lot of expression on your face; you wear a blank look a lot and this bothers him because he thinks he's somehow boring you.

The final straw was losing a client's binder, which outlined the entire project for a newly built house that had been your exclusive project. You can't remember where the binder is, and it represents hours and hours of work. Worse still, you have little recollection of what the client had decided upon. Now, when you require your famous recall, it fails you.

You do not have any signs or symptoms of hypothyroidism, and you are not depressed. You have had no neurological changes such as headache, gait changes, or incontinence. You do not have insomnia. You are not menopausal. You have experienced no new stressors in your life to account for problems with concentration; in fact, life in the past couple of years has been the best it's ever been. You are not an unsafe driver and are not a danger to yourself (e.g., no lit cigarettes are left lying around).

You are secretly terrified that you may be developing a dementia similar to that of your aunt and your grandmother. You are horrified at the prospect.

Medical history

You are generally pretty healthy, although you have a mild, chronic, dry smoker's cough and are prone to bronchitis; usually you get bronchitis twice a year, although you don't become seriously ill with it.

You last saw an FP a year ago. At that time, you were given a clean bill of health and told that all your screening test results were negative (no hypercholesterolemia, no diabetes, no hypertension, etc.).

Surgical history

You had your appendix out when you were 18.

You had a Caesarean section delivery with your second child.

Medications

You take a daily multivitamin with iron, as well as calcium, 400 mg, and vitamin D, 1,000 IU.

Occasionally you take a laxative as you are very prone to constipation.

Pertinent laboratory results

None.

Allergies

Dog and cat dander.

Immunizations

Up to date.

Lifestyle issues

- Tobacco: You have smoked for 34 years. Until recently, you smoked about a pack and a half of cigarettes a day. Now you smoke about half a pack a day.
- Alcohol: You drink alcohol daily, usually one or two glasses of wine with dinner if you are with clients or Alex. You have never had a problem with alcohol.
- Caffeine: You drink two cups of coffee a day. You drink no cola.

- Cannabis: Occasionally you smoke marijuana if you are at a party, but generally you can't be bothered to at home.

- Recreational and/or other substances: None

- Diet: You have become a vegetarian since you have been with Alex.

- Exercise and recreation habits: You have taken up jogging since you have been with Alex. You experience mild breathlessness when you run.

Family history

Both your parents are still alive and in reasonably good health. Your father has cataracts but is otherwise in good shape. Your mother has type 2 diabetes.

Your maternal aunt and grandmother died in their early 60s from progressive dementia. Your mother looked after her mother until near the end, and although this was many years ago, you remember the horror of watching your beloved grandmother wither away into a drooling husk of the woman she once was.

Your aunt died in a city several hundreds of miles away. You have no memories of her when she had advanced dementia, although you do know the toll her illness had on your mother.

Personal history

- Family of Origin

You were the second of four children. You had a pretty undistinguished childhood. You can't remember anything very significant happening to you as a child or teen.

You went to college for a year but didn't do very well and ended up dropping out before the end of the second semester. You always liked to dabble in decorating as a teen, and you often sewed cushions and drapes for your family and friends.

When you realized that school was not for you, a friend of your mother's suggested that you work in her fabric store. You quickly adapted and flourished in that environment. Within a year you were teaching impromptu classes on making household decorations.

- Marriage/Partnerships

You met your first husband, **ANDY**, in a college class and were smitten with him pretty quickly. While you were working in the fabric store you became pregnant with your first child. As having a child out of wedlock was frowned upon, you quickly tied the knot with Andy. When your son, **ADAM**, was 14 months old you gave birth to your daughter, **AMY**. Having two young children and little money placed a strain on your marriage. You realize now that you and Andy were probably too immature to have married. You divorced when Adam was six. You have had very little contact with Andy over the years, mostly because he moved to the United States a couple of years after the divorce.

You were single for about three years when you met **JEFF**, a general contractor. He shared your interest in creating beautiful homes, and for a while you worked with him. He was divorced himself and had custody of his three children.

After dating for a year, you were married and created a blended family of five children. Jeff was an ample provider, but he really wanted a stay-at-home wife to mother his children, not a woman with a business to run. You argued a lot and the eight years you were together were fairly tempestuous. However, after your divorce you became better friends than when you were married; in fact, you still often decorate the homes that he builds.

You see your former stepchildren at holidays. You consider that you are as close to them as you are to your biological children.

After divorcing Jeff, you were content not to date for several years. Men were just too much trouble, and you were pretty busy with your work. As your career grew, you often travelled to trade shows and to find new ideas. This travel afforded you the opportunity to meet many men and to have frequent brief liaisons, which appealed to your sense of independence. (The thought of being tied to only one man was stifling to you.) Although you were frequently sexually active, you always insisted on using condoms. You are regularly tested for sexually transmitted diseases and have never had an infection.

Your relationship with Alex has become serious in the past six months, although you have been sexually active with him for 16 months. You consider the relationship to be the most stable you have ever had, and the only bone of contention between the two of you is your smoking. Alex is very health conscious, and he says he worries about how much you smoke. The two of you rarely spend the night at your apartment because he finds the smell of cigarettes annoying.

You usually leave his house after an amorous interlude because you need to smoke, and he won't permit it in his house.

You are very interested in moving in with Alex, but you know that you need to quit smoking first.

- Children

Your have two children, Adam, age 29 and Amy, age 28.

Education and work history

You completed high school and attended college for a short time. Although you did not complete college, you are intelligent and speak well. You are relatively well-read and keep abreast of current events diligently.

You are a self-taught decorator, although you have taken many night school courses on design and decorating. You have a flair for design and an eye for colours.

You have worked for several design firms over the past 27 years. Your work is highly sought by a high-end clientele, and you know that you have an excellent reputation in your field. You are known for your unique sense of colour and textures. You are proud of what your hard work and skill have wrought.

Five years ago, you were wooed to your current company by its owner, **PHILIPPE CONSTANCE**, a well-known decorator. He urged you to join him as a senior decorator, and the prestige and pay increase were enough to tempt you into leaving your previous company, where you were a partner. You haven't been sorry that you went to work for Philippe; he has an exclusive and interesting clientele and, generally, the projects on which you work have few financial restraints.

You have disability insurance through your work, and an excellent health care plan.

Finances

You have saved a lot of money and live reasonably well. You own your own condominium.

Social supports

You have few interests other than your work.

Your children are grown and independent. They live in other cities but see you at holidays and call fairly frequently. They have partners but no children yet.

Your former stepchildren are not parents yet, either.

Religion

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

ACTING INSTRUCTIONS

You are dressed somewhat flamboyantly (as befits an artistic person), perhaps in clothing with bold patterns or colours.

You are pleasant and cordial. Your affect is perhaps a bit blunted, but only very slightly. You are used to dealing with all sorts of clients, and this gives you a degree of confidence in meeting new people. However, you are a bit nervous meeting this doctor. Initially you avoid eye contact as you are upset and concerned that you will forget things in the interview. You warm up to the candidate if he or she is non-judgemental and seems concerned about you.

You are well spoken.

You hesitate slightly when you talk about recent events; small details have escaped you. You are very clear about things that have happened in the past.

You have several pieces of paper in your hands; these are your "reminder notes". Alternatively, you might bring a notepad with lots of scribbles in it if you prefer that to loose papers.

If the candidate asks you to perform a Folstein Mini-mental State Examination, you pass the test with no difficulty. However, going through each question is considered an "examination", and the candidate should be discouraged from wasting time in this area.

You **FEEL** motivated to quit smoking on Alex's birthday. You **EXPECT** that the doctor will give you something to help you quit. You realize that you are dependent on the cigarettes and that you can't quit on your own.

You are **FEARFUL** and **ANXIOUS** about your memory problem. What if it means you have your grandmother's dementing condition?

You have had to write notes to yourself in order to remember when to do things. You WORRY that you are losing your edge. You expect that the doctor will sort this problem out for you.

If asked about your diet, emphasize that you are a vegetarian.

Cast of Characters

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

LILLIANNE LAWRENCE:	The patient, age 50, an interior decorator with memory loss and a desire to stop smoking.
ALEX:	Lillianne's boyfriend, a "health nut", age 53.
ADAM:	Lillianne and Andy's son, age 29.
AMY:	Lillianne and Andy's daughter, age 28.
ANDY:	Lillianne's first husband.
JEFF:	Lillianne's second husband.
PHILIPPE CONSTANCE:	Lillianne's boss.
DR. SMITH:	Lillianne's FP for the past 10 years; retired

Timeline

Today:	Appointment with the candidate.
1 month ago:	Supervisor began pointing out mistakes at work.
6 months ago:	Relationship with Alex became serious.
At age 49:	Memory problems began; last visit to an FP.
At age 48:	Met Alex; became a vegetarian and started jogging.
At age 45:	Began working at your current job.
At age 39:	Divorced Jeff; first attempt to quit smoking.
At age 31:	Married Jeff.
At age 30:	Met Jeff.
At age 27:	Divorced Andy.
At age 23:	Began working as an interior decorator.
At age 22:	Daughter, Amy, born.
At age 21:	Son, Adam, born.
At age 20:	Married Andy.
At age 19:	Dropped out of college and began working at a fabric store.
At age 18:	Started college and met Andy.
At age 16:	Started smoking.

Examiner Interview Flow Sheet - Prompts

Initial statement	**"I want to quit smoking."**
10 minutes remaining* Optional, use only if you feel it's needed	If the candidate has not brought up the issue of memory loss, the following prompt is to be used: **"I think I'm having trouble remembering things."**
7 minutes remaining* Optional, use only if you feel it's needed	If the candidate seems to have forgotten about the smoking the following prompt is to be used: **"Could I have something to quit smoking?"** (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: Smoking

Issue #1	Illness Experience
Areas to be covered include: 1. history of smoking: • Has smoked since age 16. • Smokes one and a half packs a day. • Cut down during both pregnancies. 2. assessment of addiction: • Signs of withdrawal. • Times she always smokes (after dinner, etc.). • The first cigarette in the morning is the most satisfying. 3. attempts at quitting: • Has cut down to half a pack a day. • Hasn't tried a patch. • Hasn't bought nicotine gum. • Previous cold turkey attempt was a failure. 4. the fact that she has set a "quit date".	**Description of the patient's illness experience**. You are motivated to quit smoking. However, you are dependent on cigarettes and cannot do this on your own. You have a smoker's cough, and you get mildly breathless when running. You are hoping that the FP will give you something to help you quit.

		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: Memory Loss

Issue #2	Illness Experience
Areas to be covered include: 1. current symptoms: • Forgetfulness (e.g., forgets clients' names, appointments, car keys). • Long-term memory maintained. • Trouble learning new skills. 2. potentially reversible causes: • No symptoms of hypothyroidism. • Alcohol intake. • No signs of depression. • Vegetarian diet. 3. clean bill of health from previous family physician. 4. neurological symptoms: • No gait changes. • No headaches. • No incontinence. • No neurological deficits.	**Description of the patient's illness experience.** You are anxious and afraid that you might have the same dementia as your grandmother and your aunt. You have to write yourself reminder notes. You hope that the doctor will help you sort this out, as it really is becoming a problem for you.

		Determining the patient's illness experience is **not** a checklist assessment where a candidate asks about the patient's feelings, ideas, functioning, and expectations and should two or three of these four be asked aloud, a pass is then awarded. A certificate level illness experience performance is where the candidate gathers the patient's illness experience conversationally and integrates the knowledge gained in a way that communicates to the patient that this candidate is working to see the patient as a unique person with an illness, more than just a textbook disease process to be appropriately managed.
Superior Level	Covers points 1, 2, 3, and 4.	Actively explores the illness experience to arrive at an **in-depth** understanding of it. This is achieved through the purposeful use

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

3. Social and developmental context

Context Identification	Context Integration
Areas to be covered include: 1. the relationship with Alex: • Alex is a non-smoker. • They have been together for 16 months. • They are planning to move in together. 2. life cycle issues: • Two divorces. • Two grown children who have left home. • No grandchildren. 3. work: • Interior decorator. • Sought after. • Financially secure. • Few outside interests.	Context integration measures the candidate's ability to: • Integrate issues pertaining to the patient's family, social structure, and personal development with the illness experience. • Reflect observations and insights back to the patient in a clear and empathic way. This step is crucial to the next phase of finding common ground with the patient to achieve an effective management plan. The following is an example of a statement a superior level candidate may make: "You have made a significant effort to adopt a healthy lifestyle, but you are concerned about the effort required to quit smoking. In addition, you are seriously worried that your memory may be failing and that might signal a serious condition that could affect your work and your relationship."

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: Smoking

Plan for Issue #1	Finding Common Ground
Areas to be covered include: 1) Support smoking cessation. 2) Discuss non-pharmacological strategies (e. g., behaviour modification). 3) Develop a plan of ongoing support (e. g., a smoking cessation program, regular follow-up with the FP, engaging a friend for support). 4) Discuss pharmacotherapeutic options in relation to current memory problems.	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: Memory Loss

Plan for issue #2	Finding Common Ground
Areas to be covered include: 1) Acknowledge that memory loss is a problem. 2) Arrange for a physical examination. 3) Arrange for memory testing. 4) Arrange to rule out reversible causes (this must include thyroid-stimulating hormone and vitamin B12 testing). 5) Offer support/aids to coping with memory loss (e.g., keeping adequate sleep, decreasing alcohol intake).	Behaviours indicating efforts to find common ground go beyond the candidate asking "Any questions?" after a management plan is presented. Finding common ground is demonstrated by the candidate encouraging patient discussion, providing the patient with opportunities to ask questions at multiple points, encouraging the patient to express their thoughts, seeking clarification, checking for consensus, and recognizing then addressing patient hesitation or disagreement if it arises. Examiners need to determine the candidate's ability to find common ground based on behaviours they demonstrate during the interview.

Superior Level	Covers points 1, 2, 3, and 4 OR 5.	Actively asks about the patient's ideas and wishes for management. Purposefully involves the patient in the development of a plan and seeks his or her feedback about it. Encourages the patient's full participation in decision making.
Certificate Level	Covers points 1, 2, and 3.	Involves the patient in the development of a plan. Demonstrates flexibility.
Non-Certificate Level	Does **not** cover points 1, 2, and 3.	Does **not** involve the patient in the development of a plan.

6. Interview process and organization

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

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

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

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

Appendix 1 Standardized Instructions to Candidates

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

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

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

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

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

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

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

Appendix 2 CFPC Preparation Pointers for Examiners

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

Think of the following:

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

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

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

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

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

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

4. Occasionally a candidate will get off on a tangent or onto a completely unproductive line of questioning. During this exam you must walk the fine line of not giving away too much, but also of not leading the candidate down a completely inappropriate path of inquiry. Time is limited. If

a candidate begins a completely unproductive line of questioning, answer “No” (or find another appropriate way). This should help prevent the candidate from wasting several valuable minutes on tangents not in the script.

5. Do not overact.

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

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

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

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

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

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

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

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

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

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

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

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

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