THE COLLEGE OF FAMILY PHYSICIANS OF CANADA

LE COLLÈGE DES MÉDECINS DE FAMILLE DU CANADA

Certification Examination in Family Medicine

Overview of Simulated Office Oral (SOO) Structure and Marking

Updated June 2023

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

Introduction

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

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

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

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

The following Appendices will be of interest to all examiners:

Appendix 1: Standardized Instructions to Candidates

Appendix :2 Ten CFPC Preparation Pointers for Examiners

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

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

RATIONALE FOR SIMULATED OFFICE ORAL EXAMINATION #

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

1. a concern about headaches in his son

2. a concern about possible post-traumatic stress disorder

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. Michael Sears, who is new to your practice.

CASE DESCRIPTION

Introduction

You are Mr. MICHAEL SEARS, age 32. You would like to see the doctor today to discuss concerns you have regarding your son's headaches. You are also having trouble sleeping and feel 'on edge'.

History of the problem

SON'S HEADACHES

You are concerned about your son **JAMES**, who is aged 7. He has been getting headaches for the past 5 months although they seem to have increased in frequency over the past 3 weeks. You have been overseas for the past 6 months and only got back home yourself 3 weeks ago. Last week, you received a call from the school saying that James hasn't felt well because of the headaches, and you had to collect him. Because of this incident, you decided to take him to the Emergency Department as you were unable to find a walk-in clinic that was open. That evening the emergency department was very busy dealing with the aftermath of a major car accident and you remember waiting quite a long time for him to be seen. When he finally was seen, it was obvious that the physician there was being rushed off his feet. It was felt that he probably had a 'tension headache', you were reassured, and he was discharged. No investigations were done at that time. However, with the craziness that seemed to be going on in the emergency department that evening, you aren't convinced that he received a proper assessment and in any case the explanation seemed very rushed and overall, you feel the consultation was not 100% satisfactory.

Your wife **JANE** had mentioned to you about 5 months ago by telephone that James was starting to complain of getting headaches. She didn't think too much of it as the headaches seemed to be mild, didn't last very long and they weren't really bothering him that much. However, when you heard about this over the phone, you became very concerned and strongly urged your wife to try and get him seen by a physician. Unfortunately, your own family doctor had retired last year leaving you and your family as 'orphans'. Jane finally took James to a walk-in clinic and after an assessment was told that there wasn't anything obviously wrong and he was sent home with reassurance and a diagnosis of 'tension headache'. On the advice of the doctor, Jane did take James to see an optometrist to have his eyes checked, and all was noted to be well. According to Jane, up until the time when you returned home from overseas, the headaches haven't really caused her any concern, and seemed to settle down. Jane wasn't keen to give James any medication for these and until you returned home, he hadn't tried any simple analgesia such as acetaminophen and ibuprofen.

When James describes the headaches to you, they are across the front of his forehead. They tend to last for 1-2 hours, often in the mid-morning and early afternoon. He finds it hard to describe them and just says 'they are sore.' Apart from this, he is not complaining of any other obvious symptoms. In particular, he has no vomiting, weakness of his limbs, blackouts, seizures. He doesn't complain of any abdominal pain. He has been otherwise generally healthy, and has not had any recent colds, sinus infections, runny nose or other upper respiratory tract symptoms. There has been no fever or rash. He seems to be thriving, growing and developing well, has met all of his developmental milestones, and all of his immunizations are up to date.

James has been doing reasonably well at school as far as you know. He just started Grade 2 at a new school two months ago. He has made a couple of good friends there. As far as you are aware, there have been no obvious bullying problems. There is no known history of other physical, emotional or sexual abuse from other adults and you are not concerned about this. However, when you went to fetch him home from school last week because he wasn't feeling very well, the teacher mentioned to you that James seems to be more distracted than usual and doesn't seem to be as focused on his work for the past 2-3 weeks, which is a change from normal. This was the first time that James has had to come home from school because of the headaches. This prompted you to try and take him to see a doctor, but because you couldn't find a walk-in clinic that was open, hence you ended up taking him to the emergency department that night. You are feeling very frustrated because of the difficulty trying to access a doctor for him and felt that the encounter in the emergency department was not that satisfactory. When James gets these headaches, all he wants to do is lie down and rest. He doesn't fall asleep and as mentioned above, seems to have no other symptoms. His headache seems to go away spontaneously. You think that since you got back home, he has about 5 of these episodes over the last 3 weeks.

This morning you had been hoping to bring James in to see the doctor with you as you had finally managed to get an appointment at this clinic, where you are on a waiting list to be accepted. The appointment offered was at very short notice due to a last-minute cancellation by another patient. However, this appointment conflicted with a school field trip to a museum in the provincial capital that James had been looking forward to for many weeks. You really wanted James to be seen today but your wife felt just as strongly that as James felt well, he should go on the field trip as he would otherwise be extremely disappointed. You ended up having a fairly intense argument over this but finally you deferred to your wife-James heard the two of you arguing and said he was feeling perfectly fine and didn't want to go and see the doctor. You decided to keep the appointment anyway so that you could at least establish a relationship with the new doctor and discuss the problem-the next appointment offered was unfortunately not for another 3 weeks, which is the day before you are about to leave overseas again.

When you discuss this issue with your wife, it seems that she doesn't think that these headaches are anything too serious. She was reasonably happy with the explanation given to her by the walk-in clinic doctor and the subsequent check up at the optometrist. Besides, she is really busy right now looking after James' baby sister **ANNIE**, who is 18 months old, who is basically 'into everything'. Your feeling is that the headaches seem to be more frequent since you arrived home, but your wife isn't convinced of this. Since you got home, the two of you have been arguing more openly about what to do about James' headaches-her view is that she has been the one who has been home with him on her own for the past 6 months and that she has a good handle on the situation. She is upset with the insinuation that she has not been looking after James properly and ignoring his symptoms. Your viewpoint is that he seems to be complaining more about his headaches since you arrived home and that he needs to have more tests or investigations done. Jane suffered from migraines as a teenager and feels she has a good sense of how serious these headaches are.

The other thing that you find worrying with James is a sense that he doesn't seem as connected to you as you remember before you left. It is a bit hard to put your finger on it as it is not consistent, but on a few occasions, he doesn't seem as interested in playing ball hockey with you, reading a story with you or playing games, things the two of you had enjoyed doing in the past. You had really been looking forward in particular to being with him when you arrived home and find this frustrating and disappointing. Sometimes when you hope to play with him, he will make the excuse that he is tired, and that he has a headache. He also seems, in your mind, to be clinging to his mother more.

PTSD AND SLEEP DISTURBANCE

You have been working in a conflict zone overseas for the last 6 months. Since you returned home 3 weeks ago, you have been feeling 'on edge' and a bit anxious. You notice that you startle easily to any sudden or loud noises and are not sleeping well. During the night, you find you lie awake and have difficulty falling asleep. Sometimes when you look at the curtains in your darkened room, you think that you see someone in the room moving around. When you eventually fall asleep, you are able to sleep for several hours, and you do not have any early morning wakening. However, you are also getting recurrent nightmares, where you see yourself and your son trapped in a house with the sound of bombs going off outside. When you are awake, you keep flashing back to images of dead children in the street. You do not have a depressed mood, but you find that sometimes you are irritable with your wife and snap at her when she asks you how you are feeling. Intellectually you know that she is genuinely concerned about you, but you still find her questions irritating. Due to security and secrecy, you cannot really divulge any specific details about what you saw except in very general terms.

These symptoms started after you arrived home 3 weeks ago. You don't recall this being a major problem when you were working there. However, you know you were very immersed and focused in your work whilst you were there and this is really the first time you have had downtime in the last 6 months.

Even though you are officially on leave, you do have some reports you need to finish before you return there in 3 weeks time. Normally you would have been able to finish these within a few days, but you are finding it more difficult to concentrate and have had trouble completing this task.

You also find that you are more anxious about leaving James alone and have been checking in on him every couple hours or so during the night, since you are finding that you can't sleep yourself and often lie awake.

- **Working Overseas**

You are a foreign service officer, posted to [any foreign place of current deployment]. At the present time you are on 6 weeks of leave, back home in Canada, before you return ovrersease, to finish off your posting. You work at the Canadian High Commission there as a consular officer supporting the Ambassador and senior diplomatic staff. Although you are used to traveling and living overseas, this was the first time that you had to leave your family back home, for security reasons. This was considered a 'hardship' posting because of the security situation in the country, and will only last a year, so now you are about halfway through the posting. Your movements were limited due to the relative lack of security in the country, and for the most part you were living in a diplomatic compound which was under heavy military protection. Whilst there you also act as a civilian liaison officer with the Canadian military forces and on a number of occasions had to travel to and from the Canadian Forces base in Kandahar. You were sent there on behalf of the government in order to lay the groundwork and gather information for visiting Ministers and other Members of Parliament so that they could be briefed as to the current situation there. These trips were usually conducted at very short notice due to the need for military security and secrecy. As a result of being in this position, it afforded you the privilege of traveling with the military into the countryside. You were able to witness firsthand some of the poverty and devastation as a result of the war, as well as get a good sense of the pressures that the military were under on a daily basis.

On one such visit, you had to travel with the military to a site where a recent bombing had taken place. There had been a skirmish with the Taliban forces, and air support had been called in. In the confusion of

the battle, there were a number of civilian casualties, including children. It is not clear exactly what happened and the official military authorities were quite tight-lipped about the details and who was to blame. You did not have any access to privileged information regarding the military operation itself but one of your tasks was to inspect and report on the aftermath of this incident to the Deputy Minister of Foreign Affairs who was about to arrive in the country for a briefing. When you visited the site, it was obvious that there had been a lot of damage and that a number of innocent civilians, including children had died as a result of the battle. Although you consider yourself well-travelled and experienced in the Foreign Service, this particular experience is more traumatic and it has left you feeling a bit shaken. This was the first time that you had really seen the reality of the war up front, and seeing the bodies of the dead had a profound effect upon you. You started thinking about your own family, in particular your 7-year-old son-many of the children killed looked to be of a similar age to James. This was also around the same time that you started to receive word from your wife that your son was getting headaches and you started to feel very anxious about this. You insisted that James see a doctor as soon as possible and called your wife 2-3 times a day to urge her to get him to a doctor for an assessment.

You have so far been fortunate enough not to be personally involved in any violence but the situation there remains tense, with regular news of bombings, gun battles and violence against the civilian population.

This work is very demanding involving a lot of responsibility, time pressure, deadlines to meet, multi-tasking, discretion, diplomacy and more than a little controversy at times. Overriding all of this is the general instability and the always tense security situation. For security and confidentiality reasons, you aren't really allowed to discuss any specific details of what you are doing there, except in a very general way. Also, being a civil servant and diplomat, you are more or less prohibited in making any overt political statements either in favour or against the current conflict, at least in public, as your role is to be more or less neutral and support the ambassador.

Medical history

Normally very healthy, last check up nine months ago.

Has never suffered from depression, anxiety or other psychiatric illnesses.

Surgical history

None.

Medications

Not taking any medications.

Pertinent laboratory results

None.

Allergies

None.

Immunizations

Up to date.

Lifestyle issues

- Tobacco: You do not smoke.
- Alcohol: You might have a glass of wine with dinner, no more than three to four units spread throughout the week. You do not binge drink.
- Caffeine: You drink coffee occasionally, but not daily.
- Cannabis: None
- Recreational and/or other substances: You do not use any recreational drugs.
- Diet: Adapts to local diet.
- Exercise and recreation habits: You do some exercise, but not on a regular basis, usually going to the gym once a week to use the elliptical machine.

Family history

Your parents are both alive and well. You are the eldest of three children and have a younger brother and sister (twins), who are eight years younger and in good health. They are single, and you are the only child in the family who is married and has children.

Personal history

- **Family of Origin**

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

Your father was also a foreign service officer and you spent much of your childhood living in several foreign countries (the UK, India, Kenya, Jamaica), attending different international private schools every 2-3 years. When you were fifteen, your parents settled back in Canada, where you finished high school and went to university. Your mother stayed home to raise you and your younger brother and sister-who are twins-8 years younger than yourself. You remember your father as being somewhat aloof and dedicated to his career, and you felt closer to your mother who focused entirely on raising her children. You did very well at school, and your time overseas as a child piqued your interest in travel and learning about different cultures. You knew when you went to university that you would be following in your father's footsteps to try and enter the foreign service. Your father strongly encouraged and supported you in trying to achieve this goal and you felt that your relationship with him improved during this period.

You have a good relationship with your brother, **Daniel**, and your sister **Susan** although you only see them periodically now-they are both still single and working in different parts of the country, having finished their own degrees. In view of the fact that they were twins, their relationship with you is more distant than it is between themselves, given the 8-year age difference. Neither of them were particularly interested in joining the foreign service, Daniel is a computer scientist and Susan is now finishing law school.

- **Marriage/Partnerships**

You have been married to your wife Jane for 9 years. You met her whilst you were both at University. You were studying political science and international affairs and she was studying nursing. Both of you are from the same hometown although the two of you went to different high schools and didn't know each other socially until you met at university. You dated for about 2 years and then she fell pregnant with James, just before you both graduated. You decided to get married just after graduation, and Jane gave birth to James about 7 months later. Although the pregnancy was generally uneventful, the labour was very prolonged and not a very pleasant experience for her. Jane mentioned at the time that she would never ever get pregnant again, based upon that experience. You, on the other hand, were keen to have at least one more sibling for James and this also became a source of some tension between the two of you-never really overt but always simmering below the surface.

Jane originally trained as a nurse but she put her career on hold in order to stay at home with James. At first she seemed to enjoy the life of an expatriate living overseas but after about a year of looking after James, she started to express some unhappiness with this. You felt, probably based in part on your own childhood and your own mother's willingness to stay at home that Jane should stay home until at least James was able to go to school. Initially Jane agreed with this, but looking after a toddler was stressful, particularly in the circumstances where every two years you would be posted to a different country. Jane began telling you that she was feeling more isolated and unsettled, and the two of you were starting to argue more and more with her about your perceived lack of support in trying to develop her own career further and in helping her to look after James.

Although you were using condoms (Jane didn't want to use Mirena or Depoprovera), Jane somehow fell pregnant again, the timing of which could not have come at a worse time, as she had been hoping to kick-start her nursing career once James was able to go to school full-time. There was no question in either of your minds about terminating the pregnancy, however. Fortunately for Jane, the experience of childbirth was more positive than the first time and the delivery was relatively straightforward. However, what this meant was that at a time when Jane was considering a return to the workforce, she was now having to look after a new baby again.

After **ANNIE** was born Jane found it quite difficult adjusting to looking after an infant again. In retrospect, you wonder whether or not Jane may have had post-partum depression. At that time, you were based in Pretoria, South Africa, and the last few months of that posting were quite stressful as you and Jane started to argue more and more. She left for Canada with the children about 1 month before your posting officially ended so that she could get more family support (from her mother), and you were able to join her soon after that.

You would characterize your marriage as being under some tension over the past few years, and this relationship has been particularly tested in the last 6 months due to your absence from home. The time that you were home from South Africa until the time you had to leave again was only 3 months. When

you were initially offered the current posting, Jane was very reluctant for you to take it, because of the relatively unstable situation in the country, the enforced separation and the concerns she was having with the stability of your relationship. You, on the other hand, felt that this was good for your career in the long-term and pressed her hard to allow you to go. She did acquiesce, albeit reluctantly, with the proviso that you would try to press for a posting in Canada after that. Although you told Jane you would do this, you know that if you want to move upwards in the ranks of the Foreign Service you are likely going to need more international experience in the future, which means another overseas posting.

Jane was very happy to see you back home initially, but within days you could sense a tension building up again, as it was 6 months previously leading to your departure last spring. You have had sex once since you got home (on the first night back) but since then things have cooled down. Jane has hinted to you that she doesn't know how much longer she is prepared to stay in the marriage unless there is more of an opportunity for her to develop her career. She also has told you that she wants more stability and is not very keen to continue with the constant moving around that your job entails. You are frustrated about this as you feel that once this posting is over your career may actually take off and your ambition is one day to be offered an ambassadorship. At the same time, returning overseas is now filling you with some ambivalence given what you have seen there. For the first time you are actually having second thoughts about your chosen career.

- **Children**

You have two children. James, age 7 and Annie, 18 months.

Education and work history

After you graduated from university, you immediately applied to join the Foreign Service, which entailed sitting a number of perquisite examinations. This had been an ambition of yours since you started university. You really applied yourself and successfully completed all of the requirements, with the result that at the relatively young age of 24, you became a foreign service officer. At first you worked primarily in the visa section and consular section of the various High Commissions to which you were posted in subsequent years. You have now lived and worked in South Africa, Argentina, Italy and Indonesia for the Canadian Government as a consular officer. These postings usually lasted 24-36 months at a time, and between the postings you would return to Canada for 2-3 months before heading overseas again. The quality of your work was high and you were noticed by your superiors as having a good potential to move up through the ranks. About 9 months ago, you were offered the current posting, which was described as a promotion. The difference with this job was that you would be working more in the diplomatic section with the ambassador as one of the primary government liaison officers with members of the Canadian government who would be visiting the country. Although you knew that working in this conflict zone would be stressful, you were initially very excited because you knew this was a chance to move up the career ladder. In fact, you still feel that the current position you currently hold is crucial to your future job prospects and career in the Foreign Service.

Finances

Social supports

Your father retired about 3 years ago, on a very healthy pension, and since then your parents have spent most of their time travelling overseas. They have property in the south of France where they spent a lot of time, and you don't see them very often now, perhaps once a year for Christmas.

Jane's parents are divorced, but her mother still lives nearby, and she has been able to help out with the kids while you have been away. You know that Jane is quite close to her mother and gives her support. Your own relationship with your mother-in-law is a bit cool, as she shares Jane's view that the travelling and your career has had a negative impact on your family life. However, you do appreciate the fact that your mother-in-law has been available to support Jane while you have been away.

EAP is available but he hasn't availed himself of it yet.

Despite the problems in your marriage, you have not sought out any relationships with anyone else and have remained monogamous. You have many acquaintances in the Foreign Service, but no close friends that you feel you could confide in to discuss the state of your marriage. Your parents and siblings don't really have any idea how bad things have been.

You know that there in an Employee Assistance Program available through work to deal with counselling, stress and mental health issues but you haven't availed yourself of this service as of yet. You know very worried about any news leaking out to your superiors about any health issues as you don't want to do anything that may in some way jeopardize your career prospects.

Religion: United Church – you attend with the family occasionally

ACTING INSTRUCTIONS

You are dressed casually, in a golf shirt and jeans, in keeping with your current status as being on leave from work. You are quite confident and forthcoming with what you would like from the doctor. You are used to dealing with important people in the government, but as you are also in the diplomatic service, you are generally tactful and thoughtful.

You are very concerned about your son's headaches, and also feel that perhaps there has been a delay in getting a proper diagnosis because your wife hasn't been as aggressive in getting this sorted out as you would have liked when you were away. Jane's own attitude towards James' headaches that she doesn't feel there is anything serious-perplexes you. You don't have any specific ideas as to what is actually causing the headaches and they seem to be getting in the way of what should be quality time with your son. You are also frustrated with the difficulty in finding a family doctor to get a proper assessment and diagnosis. Initially, you don't have a lot of insight into the possible connection between your marital difficulties and James' headaches. However, if a candidate asks you if you have noticed whether or not your arguments with your wife in any way coincide with the timing of James' headaches, you would agree that this is possible but it is something you hadn't really thought of until now. You know your marriage is in trouble and this is something you are going to have to eventually deal with at some point, with major implications for your own future in the Foreign Service. Your expectations are that the doctor will organize some tests for your son or refer him to a specialist.

You are also worried about your lack of sleep, the nightmares and the general feeling of being 'on edge'. You would accept that PTSD may be an explanation for this if it is explained to you by the candidate. You are intelligent enough to realize that this is a possibility, having done a bit of research over the internet yourself. You have achieved your ambition of entering the foreign service but your recent experience has rattled you a bit and although you initially saw this posting as an excellent career move, you now are feeling some ambivalence for the first time. You would be amenable to a hypnotic for sleep only if you are reassured that it is not addictive and is temporary.

If the candidate offers marital counselling your reply should be along the lines of "well I have to go back in 3 weeks' time and I don't have time for marital counselling right now" or words to that effect. Because you are leaving in 3 weeks one of your main expectations is that you need to know what can be done for you in 3 weeks, before you head back overseas. This would be both with regards to marital counselling and/or counselling to help him deal with the PTSD.

Cast of Characters

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

MICHAEL SEARS: The patient, age 32, who is concerned about his son's headaches, and he (the patient) is suffering from PTSD and sleep disturbance.

JANE SEARS: Michael's wife, age 32.

JAMES SEARS: Michael's son, age 7.

ANNIE SEARS: Michael's daughter, age 18 months.

ROBERT SEARS: Michael's father, age 60.

MARY SEARS: Michael's mother, age 58.

DANIEL: Michael's brother, age 24.

SUSAN: Michael's sister, age 24.

KATHERINE SMITH: Jane's mother.

Timeline

Today: Appointment with the candidate.

Two days ago: James seen in ER with headache, sent home reassured nil serious.

One week ago: James sent home from school with a headache.

Three weeks ago: Michael returns from overseas for 6 weeks of leave.

Four months ago: Jane takes James to doctor regarding headache-reassured nil serious.

Five months ago: Jane mentions to Michael that James is getting headaches – Michael insists that Jane take him to a doctor.

18 months ago: Daughter Annie born while parents are living in South Africa.

Seven years ago: Son James born, Michael joins the Foreign Service.

Eight years ago: Michael and Jane graduate from university, get married.

32 years ago: Michael was born.

Examiner Interview Flow Sheet - Prompts

Initial statement	**"I'm very worried about my son."**
10 minutes remaining* Optional, use only if you feel it's needed	If the candidate has not brought up the issue of the PTSD, the following prompt is to be used: **"I haven't been sleeping well since I got home."**
7 minutes remaining* Optional, use only if you feel it's needed	If the candidate seems to have forgotten about the son, the following prompt is to be used: **"Do you think my son's headaches are serious."** (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.

THE COLLEGE OF FAMILY PHYSICIANS OF CANADA

LE COLLÈGE DES MÉDECINS DE FAMILLE DU CANADA

The College of Family Physicians of Canada

Certification Examination in Family Medicine

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: Son's headaches

Issue #1	Illness Experience
Areas to be covered include: 1. history of headaches: • James has had headaches for five months. • More frequent since you arrived home three weeks ago. • Headaches are intermittent. • No problem with headaches previously. • No other symptoms (James is otherwise well) 2. interaction with health care system so far: • Wife took him to a walk-in clinic four months ago. • Taken to ER by father three days ago. • No significant problem found yet. 3. James – pertinent negatives: • No change in school performance. • No bullying/sexual interference. • Development normal. 4. no red flags for headaches/neurological symptoms – e.g., seizures, somnolesence, head injury, vomiting etc.	**Description of the patient's illness experience**. You are worried that previous doctors might have missed something serious regarding your son's headaches. You are also upset that your wife hasn't been more proactive in having their son seen by doctors. You think it might be something serious as it's been affecting interactions with your son such as reading/story time, playing hockey.

		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: PTSD

Issue #2	Illness Experience
Areas to be covered include: 1. sleep disturbance: • Nightmares. • Difficulty falling asleep. • No early morning wakening. • No use of hypnotics/medication. • No excessive caffeine. 2. other associated symptoms: • Hyper vigilance. • Flashbacks. • Visual misperceptions (e.g. mistaking curtains for people at night). • Difficulty concentrating. • No depressed mood. 3. recent stressors in job: • Witnessed bloody aftermath of battle in conflict zone • Constant threat of violence and danger. • Work is extremely busy and complex. 4. has not changed ETOH intake as a result of recent stress.	**Description of the patient's illness experience.** You are worried that you might have PTSD and it is affecting your day-to-day activities. You have difficulty sleeping and nightmares. You cannot concentrate on work and are unable to finish reports.

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

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

3. Social and developmental context

Context Identification	Context Integration
Areas to be covered include: 1. Family/marriage: • Married. • Two children. • Father worked in foreign service. 2. Support system: • Mother-in-law involved. • His parents not available. • No close friends. • EAP is available. 3. Job: • Diplomat in foreign service. • Current job posting is a promotion. • Not going back will hurt his future career prospects. • Difficult to discuss his work stress due to confidentiality factors/political constraints. 4. Problems with marriage: • Wife unhappy with his job. • Wife wants to try and re-establish her career.	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: "I can understand that you would be worried about your son after having been away from home for as long as you have. The circumstances of your particular situation with regards to your job also makes it challenging to get help, particularly as you are also balancing your own career prospects against the needs of your own family."

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: Son's Headaches

Plan for Issue #1	Finding Common Ground
Areas to be covered include: 1) Suggest that son's headaches are likely to be benign, based upon history given. 2) Offer to see son for further assessment. 3) Offer to see you and wife together to discuss how to handle James' headaches as you will be going away and wife will be sole caregiver. 4) Discuss long-distance parenting strategies.	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: Sleep Disturbance/PTSD

Plan for issue #2	Finding Common Ground
Areas to be covered include: 1) Discuss how his symptoms may be related to his recent stressful experience in the conflict zone. 2) Offer counselling options to help him make sense of his symptoms in view of time constraints. 3) Discuss use of pharmacological management e.g. hypnotics, anxiolytics. 4) Discuss what follow up would be available to him should he feel his symptoms worsen whilst he is overseas.	Behaviours indicating efforts to find common ground go beyond the candidate asking "Any questions?" after a management plan is presented. Finding common ground is demonstrated by the candidate encouraging patient discussion, providing the patient with opportunities to ask questions at multiple points, encouraging the patient to express their thoughts, seeking clarification, checking for consensus, and recognizing then addressing patient hesitation or disagreement if it arises. Examiners need to determine the candidate's ability to find common ground based on behaviours they demonstrate during the interview.

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

6. Interview process and organization

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

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

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

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

Appendix 1 Standardized Instructions to Candidates

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

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

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

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

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

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

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

Appendix 2 CFPC Preparation Pointers for Examiners

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

Think of the following:

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

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

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

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

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

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

4. Occasionally a candidate will get off on a tangent or onto a completely unproductive line of questioning. During this exam you must walk the fine line of not giving away too much, but also of not leading the candidate down a completely inappropriate path of inquiry. Time is limited. If a candidate begins a completely unproductive line of questioning, answer "No" (or find another appropriate way). This should help prevent the candidate from wasting several valuable minutes

on tangents not in the script.

5. Do not overact.

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

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

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

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

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

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

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

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

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

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

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

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

Prepared by: K. J. Lawrence, L. Graves, S. MacDonald, D. Dalton, R. Tatham, G. Blais, A. Torsein, and V. Robichaud for the Committee on Examinations in Family Medicine, College of Family Physicians of Canada, February 26, 2010.