THE COLLEGE OF FAMILY PHYSICIANS OF CANADA

LE COLLÈGE DES MÉDECINS DE FAMILLE DU CANADA

Certification Examination in Family Medicine

Overview of Simulated Office Oral (SOO) Structure and Marking

Updated June 2023

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

Introduction

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

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

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

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

The following Appendices will be of interest to all examiners:

Appendix 1: Standardized Instructions to Candidates

Appendix :2 Ten CFPC Preparation Pointers for Examiners

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

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

RATIONALE FOR SIMULATED OFFICE ORAL EXAMINATION #

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

1. a child with atypical behaviours.

2. polyarthritis secondary to ulcerative colitis

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. **ROBERT MARTIN**, age 38, who is new to your practice.

CASE DESCRIPTION

Introduction

You are Mr. **ROBERT MARTIN**, age 38, an accountant who recently moved to this city with your wife and two children. You are here today because recently your elder son, **MARC MARTIN**, age 10 years, has been exhibiting bizarre behaviour. In addition, you have had a recent flare-up of ulcerative colitis, with associated joint pain.

History of the problems

SON'S BEHAVIOUR

Marc has always been in good health and has done well in school. He has had no developmental problems. Before your move to this city two months ago, he had close friends at his old school. In the past two weeks, however, you and your wife, **RACHEL MARTIN**, have been worried about his behaviour. He will suddenly clap his hands and shout loudly. The outbursts last only a few seconds. Marc seems embarrassed when the outbursts occur.

The first time this happened, you were at home on a Saturday morning, and he and his brother, **WILLIAM MARTIN**, age seven years, were quietly watching some cartoons on television. Marc's sudden outburst startled you all. William started to laugh because he thought Marc had made a joke. Marc, on the other hand, seemed confused. You told him to be quiet, and he replied that he did not know why he did it. "It just happened," he said.

An identical outburst occurred the next day, during a church service. Marc suddenly clapped his hands repeatedly and shouted "Ow!" You and Rachel reprimanded him, but something about the outburst worried both of you. In particular, you and Rachel also were concerned because Marc was obviously embarrassed by the occurrence. When you arrived home and questioned him, he told you again that "it just happened," and he was in tears.

The situation came to a head last week. Marc's Grade 5 teacher called Rachel to tell her that Marc had disrupted the class twice that day by clapping and shouting. The teacher wanted to know if he had any psychiatric or behaviour problems of which she should be aware. Your wife told her that this was an entirely new behaviour, and that you were also worried about it. The teacher suggested that you all try to ignore it for the time being, in case it was due to the stress of arriving in a new school.

You and Rachel went along with the suggestion last week, but the episodes became more frequent. They outbursts occurred two to three times each evening, and a few times during the day at school. Marc was clearly bothered by them and told you he could not make them stop. He also told you that the kids at school were making fun of him. You and your wife gave him general advice about how to deal with teasing and bullying; but at that point you and Rachel decided that he needed medical attention. Nevertheless, you are still trying to follow the teacher's advice by not "making a big thing out of it." You therefore made today's appointment for yourself so you could discuss Marc's behaviour with a physician before bringing Marc in. Rachel is not able to get away from work today.

Marc is a rambunctious boy. At one point you wondered if he was “a bit ADD,” but he has never shouted or acted out like this before. You and Rachel do not think that he has been exceptionally stressed about the new school. He misses his old friends, but he was not dreading going to a new school. You do not think that he has been bullied, although you are worried that these outbursts will keep him from integrating and making friends. His sleep and appetite have been normal. He has not cried out or clapped his hands during the night.

The outbursts typically last less than a minute. Marc does not seem confused or “lost” afterward. He is not incontinent during the episodes. He does not complain of headaches, and he seems to run, play, and act normally between outbursts.

His immunizations are up to date. Up until now he has received medical care from your former family physician (FP), Dr. SIMON, who assisted in the delivery of both your children and cared for all four members of your family.

POLYARTHRITIS SECONDARY TO ULCERATIVE COLITIS

During the past three months, you have been experiencing morning stiffness in your lower back when you get out of bed. This stiffness is somewhat painful, but the pain is not disabling, and there is no radiation of the pain. It seems to be only in the lower back.

You can “work the pain out” by walking around, but it seems odd to you that you feel this way. You have never been bothered by back pain, and you can’t remember straining your back. You are only 38 and don’t think this should be happening.

About a month and a half ago, you had a swollen and painful left wrist. You assumed this was due to unpacking boxes after your recent move, but you could not really remember straining your wrist. You had to turn the unpacking over to your wife, because your wrist really was quite painful. The pain lasted about a week and gradually went away after you took some ibuprofen.

Three weeks ago, you had a swollen and painful right knee for five days. There was no trauma, and you could not figure out why the knee was so painful and swollen. It was not red, and you don’t think it was hot. You took some ibuprofen again and that seemed to help the problem resolve. The ibuprofen also seemed to help your back a bit. You have no joint swelling today.

You have no history of arthritis in your family. You have never had similar symptoms in the past. You have had no recent infections or illnesses. You have taken no antibiotics for any reason in the recent past. You have not travelled to any foreign destination recently.

In the past you have received follow-up management for ulcerative colitis. Your colitis has been “quiet” for the past three years, but you were told to expect recurrences at any time.

Your stools have been mostly normal for the past three years. You have a bowel movement about once a day, with no pain or bleeding. On a few occasions you have had more frequent stools for a few days at a time. When this occurs, the bowel movements may occur two to three times a day and be associated with some rectal pain and the passing of mucus. So far, these episodes have lasted for less than a week, and have not been associated with the passing of blood. Your ulcerative colitis “acted up” like this two weeks ago, but your bowel movements have been normal for the past week. You have not noticed a relationship between your bowel symptoms and stress.

Your gastroenterologist also suggested that you have a sigmoidoscopy every five to 10 years, and your last exam was about three years ago.

Medical history

You were very healthy all your life until your first episode of colitis at age 30. It began with the gradual onset of frequent mucus-like stools and some pain with defecation. After about three weeks, you went to see your FP. Dr. Simon conducted a number of tests, including stool cultures and blood tests, and then referred you to a local gastroenterologist who performed a colonoscopy. The results of the exam and the biopsy confirmed what the gastroenterologist described as "mild" ulcerative colitis. The physicians were pleased that the pain was not severe and that there was very little blood in the stool. At that time, you told yourself you would hate to know what the "severe" pain was like! They also informed you that the disease was limited to the rectum at that time.

The gastroenterologist reported to Dr. Simon that your disease could be managed with mesalamine (Asacol) at a dose of 800 mg three times a day for six weeks. The dosage was dropped to twice a day after your symptoms resolved. You continued with this dosage for several months, but then discussed with your physician the possibility of discontinuing it. You experienced mild nausea with the drug and, although you were willing to continue taking it if necessary, you would rather take it only as needed. You discussed the pros and cons of maintenance therapy, and you opted to stop the medication. Since that time, you have had only one flare-up of the colitis. This was about three years ago, and you required another few months of mesalamine. You do have occasional mild exacerbations with a few days of mucus- like stools and more frequent bowel movements, but you do not worry about it unless it goes on for more than a week or if there is blood in your stool. You understand that you would have to restart your medication if this happened.

At the time of your initial episode, the gastroenterologist also explained that you were at increased risk of bowel cancer and other complications. This is why he recommended that you have a sigmoidoscopy every five years or so. Your last one was three years ago. You don't really remember much else about that conversation. After the gastroenterologist mentioned cancer, you "missed the rest." You don't recall any discussion of arthritis related to the disease, but he may have mentioned it. You are not one to look up diseases on the Internet.

Dr. Simon has all your records and has offered to transfer them as soon as you find a physician in your new city. You and Rachel really wish that you could continue seeing Dr. Simon. You had a good relationship with him, and you can only hope that your relationship with the new FP will be as good.

Surgical history: None.

Medications

You take no medications regularly.

You take no supplements.

You recently took some ibuprofen purchased without prescription for joint pain.

In the past, you have taken mesalamine for treatment and suppression of ulcerative colitis.

Pertinent laboratory results

None are available.

You do not know what blood tests were performed at the time of your ulcerative colitis diagnosis.

Allergies

None known.

Immunizations

Up to date.

Lifestyle issues

- Tobacco: You have never smoked.
- Alcohol: You have three to four alcoholic beverages a week. Usually, your alcohol intake consists of a glass of wine with Rachel in the evening or with a client at a business lunch.
- Caffeine: You drink four cups of coffee a day.
- Cannabis: None
- Recreational and/or other substances: You do not use any illicit drugs.
- Diet: You have a "regular" North American diet, which is generally well-balanced. Rachel is concerned about your general health, and tries to encourage you to eat well.
- Exercise and recreation habits: You haven't settled into a routine in this new town yet; in your former town, you went to the gym three times a week. You and Rachel play tennis in the summer. You enjoy cycling.

Family history

Your parents are in their early 60s and have no health problems of which you are aware. One paternal grandmother is still alive and well. Your other grandparents died "of old age." You are not aware of any

history of cancer, bowel disease, or rheumatic diseases, other than older relatives' aches and pains. There is no history of psychiatric illnesses, degenerative neurological diseases, or seizure disorders in the family.

Personal history

- Family of Origin

You grew up in a happy home with one older brother and one younger sister. Your father was employed as an office manager, and your mother stayed at home to care for the children.

Your brother joined the military in his early 20s and is still with the armed forces. He is married with two children who are a bit older than yours. The cousins do not see each other often, as your brother's family travels a great deal with the military.

Your younger sister works as a real estate agent. She is an unmarried lesbian. She enjoys caring for her cats.

- Marriage/Partnerships

You met Rachel when both of you were attending university. You were studying management, while she was studying social work. You attended the same church at the time. Rachel sang in the choir. After dating for a couple of years, you decided to marry. You had graduated and had just started working as a junior accountant at that time. Both of you were 26.

- Children

You have two children. Marc, age 10 and William, age 7.

Education and work history

You graduated with good grades in high school (and in CEGEP, if the exam is taking place in Québec). Then you went to university and graduated with a management degree. Subsequently, you passed exams to practise as a chartered accountant. You began working for a large bank. Your transfer to this town is a result of a promotion within the bank.

Finances

You are quite comfortable financially. You have a good salary with the bank and good insurance. Your plan would cover any additional health-related expenses. (You mention this if the candidate asks if you could afford private treatments or therapy.)

Rachel has found a job with the local social service department, which involves residential planning for the elderly with loss of autonomy. This is the type of work she had in your former community. She started her job this week and is excited about it.

Social supports

The move to this new town has left you without your usual supports. You have yet to make friends here. You have been attending church on Sunday, but do not yet know members of the community.

Your family and Rachel's live in your old community. Both of you are close to your parents, and you have been in contact with them about Marc and his strange behaviour. Both sets of grandparents are worried, although your parents were willing to accept the explanation that this might be a temporary behaviour problem due to stress.

Rachel was an only child, and her parents dote on their grandchildren. It was very difficult for them when you left your former community. Now that Marc might have a problem, they are almost frantic. They have been calling every day to find out "if it has happened again." They were very relieved when you said you were going to consult a doctor. At this point, they are more "anxiety-enhancing" than supportive. On the other hand, you know that all the extended family on both sides would help in any way possible if one of your children became sick or disabled.

Religion

You and your family are churchgoers. (Choose any denomination or faith community.) You consider yourself to be a man of faith, and you and Rachel believe that raising your children within the church (or synagogue or mosque) is important. You were embarrassed by Marc's outburst during the sermon, especially as you and your wife and sons are new members of the congregation. You miss the support of your faith community in your former town.

ACTING INSTRUCTIONS

You are in business attire, as if you have come directly from your job at the bank. You are nervous about meeting the new physician. You had a very good relationship with Dr. Simon, and you hope that you can have the same trust in this new physician.
When you discuss Marc, you are clearly worried and want to be reassured. You are hoping so hard that nothing is wrong, that you are almost apologetic about taking up the FP's time. You might make statements such as the following:

1. "I am sure it is nothing, but it worries us."

2. "The teacher told us that we shouldn't draw attention to it, but we are worried anyway."
3. "My wife is quite upset about it, even though we hope it is going to go away as the teacher told us."
4. "Should we be worried?"

If the candidate reassures you **inappropriately** (i.e., if he or she thinks Marc has a simple behaviour problem due to stress or acting out), express your concern a bit more forcefully. You might make comments such as the following:

1. "He is always such a good kid; we don't understand where this behaviour is coming from."
2. "It just doesn't seem normal."

3. "I have not seen other kids acting like this."

Your **FEELING** is worry. The candidate probably will not need to ask the question about your feelings, as you likely have already said you are worried. If he or she does ask, you could say, "Well, I guess we are worried. Do you think we should be?"

Your **IDEA** is that Marc could just be demonstrating a behaviour pattern because of the new school, but that this behaviour could also indicate a serious disorder. If pressed, you say something like "I hope it is nothing and that it will go away—but do kids who have mental problems start acting like this?" This comment will convey the fact that you and Rachel really have no idea what to expect. Could this be early mental illness? Epilepsy? A brain tumour?
The story clearly indicates that there has been no impact on **FUNCTION** at this point, and it would be an odd question for a candidate to ask. Your response might be "What do you mean?"
Your **EXPECTATION** is that the physician might give you some idea of what is going on. You expect that he or she will want to see Marc very soon if there is any possibility that he could have anything more serious than a transient behaviour problem due to stress. If the candidate says that he or she has to see Marc before suggesting what might be wrong, ask, "Well, what kind of things could cause this?"

You believe that your own physical problem is minor in comparison. You should begin by discussing the joint swelling and pain in an almost offhand way. The prompt should lead you to make some brief, apologetic comments about your joint pain.
Stress the fact that you have had actual joint swelling. The candidate should discover the ulcerative colitis history, either by questioning you about possible causes of joint inflammation or by asking general questions about your past medical history. You might respond with the following types of comments:

1. "Yes, I do have ulcerative colitis, but it rarely causes me problems. I had a bit of a flare-up two weeks ago, but it is back to normal."

2. "I know that I will have to make an appointment with you about that some time. The family doctor who was treating us in our hometown told me that I should make an appointment with someone here to follow up on that."

Your **FEELING** is mostly annoyance that this is happening when so many other things are going on in your life.

Your **IDEA** is that you seem to have some early kind of arthritis. You might say, "I don't know. Do you think this could be arthritis? I am only 38! But it is odd the way the wrist and the knee swelled up for no reason." You do not know of any connection between ulcerative colitis and joint involvement.

There has been no major effect on your **FUNCTION**, except that you have had to leave some of the unpacking to your wife. You were limping quite a bit when your knee was swollen, but you still got around. The back pain means you take a bit longer to get going in the morning, but you do keep going.

Your **EXPECTATION** is that the FP will probably "want to do some X-rays or something." You would be pleased if investigations were started soon, although in your current state of mind you would not prioritize these.

Both these problems are potentially complex, with many possible differential diagnoses. The successful candidate will not necessarily diagnose the problem but will recognize the potentially serious possibilities and will suggest reasonable diagnostic investigations. You should leave the office appropriately concerned about Marc and your own joint problems, but with the feeling that the problems "will be sorted out."

Cast of Characters

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

ROBERT MARTIN:	The patient, age 38, an accountant with joint swelling and ulcerative colitis.
RACHEL MARTIN:	Robert's wife, age 38, a social worker whom he married 12 years ago.
MARC MARTIN:	Robert and Rachel's son, age 10 years, who is exhibiting uncontrollable, stereotypical behaviours.
WILLIAM MARTIN:	Robert and Rachel's son, age seven years.
Dr. SIMON:	Robert's former FP.

Timeline

Today:	Appointment with the candidate.
2 weeks ago:	Marc's first outburst.
3 weeks ago:	Right knee became swollen and painful.
6 weeks ago:	Left wrist became swollen and painful.
2 months ago:	Moved to this community.
3 months ago:	Stiffness in lower back began.
3 years ago:	Last flare-up of ulcerative colitis/last sigmoidoscopy.
7 years ago:	William born.
8 years ago:	Diagnosis of ulcerative colitis.
10 years ago:	Marc born.
12 years ago:	Married Rachel at age 26.
38 years ago:	Born.

Examiner Interview Flow Sheet - Prompts

Initial statement	**"Thank you for seeing me, Doctor. We just moved to this town, and my son, Marc, is behaving strangely."**
10 minutes remaining* Optional, use only if you feel it's needed	If the candidate has not brought up the issue of the joint pains, the following prompt is to be used: **"It has been one thing after another since we moved. I started having pain in my joints."**
7 minutes remaining* Optional, use only if you feel it's needed	If the candidate seems to have forgotten about your son's behaviour, the following prompt is to be used**: "I hope we can do something for Marc."** (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: Son's Behaviour

Issue #1	Illness Experience
Areas to be covered include: 1. history: • Sudden onset. • Occurring more frequently. • Happened at school and church. • Child cannot control or explain the behaviour. 2. psychological factors: • No history of disruptive behaviour in the past. • Did not seem stressed (e.g., was sleeping well). • No history of integration problems in school. • Children at school now making fun of him. 3. neurological factors: • No confusion /cognitive changes following the outbursts. • No weakness before or after. • No incontinence. • No headache. • No history of repetitive behaviour (tic) 4. no family history of psychiatric and / or neurological disease.	**Description of the patient's illness experience**. Although you hope this is due to stress, you are worried it could be something more serious. You hope the FP will be able to tell you what is wrong.

		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: Polyarthritis / Ulcerative Colitis

Issue #2	Illness Experience
Areas to be covered include: 1. history of joint involvement: • Began with lower-back pain. • Morning stiffness in back. • Knee and wrist affected on separate occasions. • Swelling and pain. • Not temporally related to ulcerative colitis flare-ups in his case. 2. history of ulcerative colitis: • Diagnosed eight years ago. • Described as "mild form of ulcerative colitis." • Treated with mesalamine. • Last severe flare-up three years ago (needing medication). 3. management to date/ current symptoms: • Was told he should have sigmoidoscopy every five years. • Opted not to have maintenance therapy. • Aware of increased cancer risk. • Had one week of frequent stools with mucus two weeks ago. 4. no other extra-intestinal manifestations of ulcerative colitis (e.g., uveitis, erythema nodosum, hemolytic anemia).	**Description of the patient's illness experience.** You are annoyed by the inconvenience that is being caused: you have minor difficulties unpacking, you were limping, and you are slow to start moving in the morning. You wonder if it is arthritis, and you expect that the doctor will want to do some tests to get to the root of the issue.

		Determining the patient's illness experience is **not** a checklist assessment where a candidate asks about the patient's feelings, ideas, functioning, and expectations and should two or three of these four be asked aloud, a pass is then awarded. A certificate level illness experience performance is where the candidate gathers the patient's illness experience conversationally and integrates the knowledge gained in a way

		that communicates to the patient that this candidate is working to see the patient as a unique person with an illness, more than just a textbook disease process to be appropriately managed.
Superior Level	Covers points 1, 2, 3, and 4.	Actively explores the illness experience to arrive at an **in-depth** understanding of it. This is achieved through the purposeful use of verbal and non-verbal techniques, including both effective questioning and active listening.
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. life-cycle issues: • Married with two children. • New employment. • Moved to this new city. • Wife also working. 2. social/personal supports: • Support through religious belief. • Not yet integrated into the religious community. • Emotionally close to parents and in- laws, but now separated • by distance. 3. The family would have access to private therapy/treatments if these were needed.	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: "Everything does seem to be happening at once, doesn't it? We know that stress can make some things worse. Moving and starting a new job is stressful. Children often act out when they are stressed, and ulcerative colitis can get worse. But I think you realize that we would be wrong to blame all of this on stress. It would seem that these illnesses are adding to your stress rather than resulting from it, wouldn't you agree? We need to figure out what is going on. It is especially hard on you and your wife since you are missing the support of your family and your usual doctor."

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: Son's Behaviour

Plan for Issue #1	Finding Common Ground
Areas to be covered include: 1) Recognize that this is not a normal behaviour. 2) Discuss differential diagnostic possibilities, which might include Tourette's syndrome, atypical epileptic behaviour, or compulsions. 3) Outline possible investigations (e.g., electroencephalography, neurological referral). 4) Consider supportive services for the child to help him cope with the problem at school (e.g. school resources to help with bullying).	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: Polyarthritis / Ulcerative Colitis

Plan for issue #2	Finding Common Ground
Areas to be covered include: 1) Make the possible connection with ulcerative colitis. 2) Arrange to obtain old records. 3) Discuss appropriate investigations (such as inflammatory markers in blood tests, radiographs of the lower back). 4) Arrange referral for specialised arthritis treatment.	Behaviours indicating efforts to find common ground go beyond the candidate asking "Any questions?" after a management plan is presented. Finding common ground is demonstrated by the candidate encouraging patient discussion, providing the patient with opportunities to ask questions at multiple points, encouraging the patient to express their thoughts, seeking clarification, checking for consensus, and recognizing then addressing patient hesitation or disagreement if it arises. Examiners need to determine the candidate's ability to find common ground based on behaviours they demonstrate during the interview.

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

6. Interview process and organization

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

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

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

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

Appendix 1 Standardized Instructions to Candidates

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

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

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

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

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

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

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

Appendix 2 CFPC Preparation Pointers for Examiners

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

Think of the following:

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

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

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

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

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

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

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

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

5. Do not overact.

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

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

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

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

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

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

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

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

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

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

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

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

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