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

---

[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 dying father for whom she feels some responsibility

2 nausea of pregnancy.

The patient's feelings, ideas, and expectations, as well as an acceptable approach to management, are detailed in the case description and the marking scheme.

The candidate will view the following statement:

THE PATIENT

You are about to meet Ms. **SUNRISE BARRISTER**, age 32, who is new to your practice.

CASE DESCRIPTION

Introduction

You are Ms. **SUNRISE BARRISTER** (née **MARCONI**), age 32, and seven weeks pregnant with your third child. You are visiting this family physician (FP) to discuss your severe nausea.

In addition, your estranged father has been hospitalized for several weeks with advanced lung cancer. He wishes to stay with you for the last few months of his life, but you feel this is impossible. You would like this FP's opinion and guidance.

You have visited walk-in clinics previously for medications, but you recognize that having an FP to take care of you and your kids would be a good idea.

History of the problems

FATHER'S TERMINAL ILLNESS

Your father, **TONY MARCONI**, age 68, was admitted to the local hospital three weeks ago after falling down the stairs at the boarding house where he lived. Initially he was believed to have broken his hip, but a series of X-rays and other investigations revealed stage IV non-small-cell lung cancer. The cancer has spread to several of his bones, including his right hip, ribs, and spine. He has several nodules in his lungs and multiple metastases in his liver. A brain scan is pending.

You hadn't seen your dad in some time and were surprised to learn from the hospital social worker two weeks ago that he had been admitted. Even more surprising was that he'd listed you as his next of kin. The social worker asked you to come in to review the situation with the doctors and her. You agreed reluctantly.

At the hospital you were assailed with conflicting emotions of pity and mild revulsion. The lively man you remembered was nothing like the frail, pitiful one lying in bed in a hospital gown. He had lost a tremendous amount of weight. His hair was long and unkempt. He had a scraggly beard, sunken eyes, and poor dentition. When he tried to hug you, his arms felt like sticks. You felt every rib when you hugged him back.

A doctor met with you in your dad's room. She stated that he had advanced cancer, which was incurable. She said he had refused chemotherapy but was interested in a short course of radiotherapy to his hip and ribs to reduce his severe pain. She told you that he needed very powerful injectable painkillers and that his dose was being adjusted upward to try to make him comfortable.

No one mentioned anything about future discharge.

You left the hospital upset, sad, and a bit conflicted. You visited your dad a couple of additional times before the social worker called you again for a family meeting.

This meeting was three days ago. You arranged for a woman from your church to watch your babies and went to the hospital. At this meeting, there were three doctors (the radiation oncologist, the internist, and a student doctor), the social worker, the head nurse for the floor, your father, and you.

The doctors reported that your father's pain was under good control with high doses of morphine. They were planning to switch him to oral long-acting tablets so he could leave the hospital with a simpler medication regimen. In addition to the painkiller, he had several other drugs. You don't remember them all but do recall that medication for nausea and constipation was included.

The doctors told you that your father had completed the radiotherapy and that they were hoping he would leave the hospital in a day or so. Then they dropped the bombshell on you. The social worker explained that your father was not willing to move in with his previous wife, **TIFFANY** (who didn't want him, anyway), or with his last girlfriend, **LU CHO** (whom you never met). Of all his children, you were the only one with whom he would consider living.

When you asked why he couldn't return to his boarding house, the social worker said that occupational and physiotherapy assessments indicated he was incapable of climbing stairs (his room was on the third floor), getting in and out of the bathroom without assistance, or cooking his own meals. They recommended that he be placed in the care of an institution or a family member.

At this point your father spoke and poured on the guilt. You were the only one he trusted. Didn't he make you his next of kin? You were the only one who had a stable home and could look after him. He didn't want to "go to a home where they dump you in a bed and let you die". He wanted to be out of the hospital. He was not allowed to smoke in the hospital and was dying for a cigarette. If he went to a private home (like yours) instead of a health care facility, he could go outside for a cigarette whenever he needed one. He also wanted to be close to his grandchildren before he dies. You were flabbergasted.

The social worker said you didn't have to agree right away, and to take a day or two to decide. However, you had the very strong impression that everyone wanted you to take your father home with you and you felt much pressured to do this.

You don't think you can do this. It would be a huge disruption to your life, and very difficult for your husband and children. You have a small apartment. The boys would have to sleep in your room. No one smokes in your home; how would your dad get himself down the hall, into the elevator, and out to the front entrance for a smoke several times a day while you were at work?

In addition, could you look after a dying man? Wouldn't that be too horrible for your kids? What would people at your church think of your father with his potty mouth and rough manners? You've worked extremely hard to change your life and rise above your childhood situation. Your dad is an embarrassment.

Even worse is the temptation you would face with your father's drugs in your home. You used drugs for many years, and while you quit when you became a born-again Christian several years ago, you still crave drugs on rare occasions. You also don't want any drugs where your kids might get into them.

On the other hand, don't you have a Christian duty to help your father? Doesn't the Bible teach that you must extend help where you can? How can you turn your back when you yourself are a living example of how others' charity can help? What would have happened if those who helped you had the same attitude you have now?

You haven't discussed this situation with Logan, other than to give him the bare facts. You want to talk this over, to get his opinion and advice before you make a decision. However, he won't be home for another week. He has very limited access to a phone from the work site and this contract he's working

on is too lucrative to pass up by coming home early. He did say he is conflicted, too: having your father in your small apartment would be a huge imposition, but he also wonders about his Christian duty.

You haven't slept well for the past couple of nights. The meeting at the hospital keeps running through your head. You are more irritable with the kids, although this could also have something to do with your nausea.

You hope the doctor will give you some advice. Secretly, you hope he or she will say you cannot take your father home, and then you'd have an excuse.

NAUSEA RELATED TO PREGNANCY

You have woken up with nausea for five days in a row. You had to run to the bathroom to vomit. For the past two days the nausea has persisted for several hours, although you haven't had any further vomiting. Smells worsen the nausea. You can't face your usual morning cup of coffee or even the smell of coffee brewing, and this made you suspect you might be pregnant. You had the same reaction to coffee with your last pregnancy.

Yesterday you bought a home pregnancy test at the pharmacy, and the result was positive. You were quite surprised as you were taking birth control pills (BCPs) and didn't think you'd missed any. Although you haven't had a period in nearly two months, you didn't think much of this because your periods have been very light while you've been taking the BCP. You've been using it since your second son was born.

You have been pregnant three times previously. When you were 18 you became pregnant and had a termination. You feel no guilt over this decision; at the time you were addicted to drugs and certainly weren't capable of being a mother.

You have two children, **ADAM**, age three years, and **AJ**, age 15 months. Both pregnancies were uncomplicated without any serious problems, although with the second one you had significant nausea throughout the third trimester. It wasn't so bad that you needed medications. You worry that the nausea with this pregnancy might be much worse; if it's this bad now, what will it be like four months from now?

You gained about 11 kg (25 lb.) with each pregnancy. An obstetrician delivered both boys vaginally without complications. The obstetrician can't see you for several weeks.

While you were initially surprised and a bit taken aback by this pregnancy, now that the shock has worn off and you've had a chance to think about it, you are quite pleased. Maybe you'll have a girl.

You haven't told your husband, **LOGAN BARRISTER**, yet. He is out of town working on a special contract and is returning next week. You are sure he will be fine with the pregnancy. The timing might not be the best, but he loves kids and you had talked about having one or two more, somewhere down the road. You want to see the expression on his face when he hears the good news.

You have not seen anyone for the pregnancy yet. You have no signs or symptoms of thyroid disease.

Medical history

Despite your troubled early life of prostitution and drug use, you've remained quite healthy. You were treated for some sexually transmitted diseases in you late teens and early 20s. You think you had crabs (pubic lice) and Chlamydia infection.

You are sure you never had hepatitis C, human immunodeficiency virus, or herpes infection.

Surgical history

You've never had surgery.

Medications

Because of your past drug addiction, you are extremely careful about taking any medications. You do take a vitamin every day. You have stopped taking your BCP. You bought some prenatal vitamins yesterday.

Before having your children, you used injectable birth control (Depo-Provera).

Pertinent laboratory results

You had a positive home pregnancy test result yesterday.

Allergies

You have an allergy to hamsters.

Immunizations

Up to date.

Lifestyle issues

- Tobacco: You do not smoke now but did from your early teens until you quit using drugs. Quitting smoking was really hard, but you managed to do it.
- Alcohol: You do not drink alcohol now, and neither does Logan.
- Caffeine: You drink four cups of coffee a day.
- Cannabis: None currently
- Recreational and/or other substances: You do not use any recreational drugs now, and neither does Logan. In your teens and early 20s you used illegal drugs regularly.

- Diet:
- Exercise and recreation habits:

Family history

Your father recently was diagnosed with stage IV non-small-cell lung cancer.

Your mother died of cancer when you were six years old. You have no memory of her.

You are unaware of the health histories for your sisters, **STARLIGHT**, age 38, and **LUNA**, age 37. You also do not know the health histories for your younger twin half-brothers and half-sister.

Personal history

- **Family of Origin**

You are the third of eight children and the youngest child of your father's first marriage. However, you never really distinguished between full and half siblings. To her credit, neither did your stepmother, Tiffany, whom your father married soon after your mother died. Tiffany was barely out of her teens when they married. She had been a frequent household visitor before your mother's death because she lived on the same street and often babysat you and your sisters.

Tiffany and your dad had twin boys and a girl in the first two years of their marriage, and the household was chaotic and noisy. Tiffany did her best but often seemed overwhelmed. Your dad wasn't around much; he was holding down two jobs, as a mechanic and a road crew member, to make ends meet.

Tiffany often seemed at odds with Starlight and Luna. As they entered their teens, the fighting with Tiffany worsened. When Starlight was 14 and Luna was 13, they ran away from home. You were eight. The police came to your home and your dad yelled that he wanted "those girls out of my house". Starlight and Luna went to live with your mother's sister, and they have not been in contact with you or your father since.

Things remained chaotic after your two older sisters moved out. There was a bit more money because there were fewer mouths to feed, but your dad wasn't around anymore than he had been. Tiffany and your dad yelled a lot, but you don't think there was any physical violence.

You weren't close to any of your siblings as you grew up. You always felt a bit apart.

- **Marriage/Partnerships**

You met **JOEY** when you were 13 and he was 18. His father and yours worked together at the garage. He asked you out on a date, and you began a relationship that lasted for several years. You became sexually active within a month of dating. You didn't really enjoy the sex, which was uncomfortable and rushed, but you did like feeling grown up and the centre of someone's attention.

Joey introduced you to alcohol and then to mild drugs like marijuana and Ecstasy. By the time you were 15 you were using harder drugs, and Joey's attitude began to change. He demanded that you pay for drugs; if you couldn't, he insisted that you have sex with the dealer, as payment.

Around this time, your father and Tiffany separated. Tiffany, the twins, and your half-sister moved in with Tiffany's mom. Your father took up with another woman; you can't remember her name as you never met her. You had to leave home, and Joey let you move in with him and two of his buddies. You didn't realize until later that you would have to sleep with them to pay your share of the rent.

For the next year you stayed off the street, but barely. You left school at 16. You had missed a lot because you were high, so it wasn't worth going anymore. You worked at odd jobs, but the money wasn't great, and you needed more and more for drugs.

You didn't argue when Joey suggested you work the streets. At that point you didn't care about yourself. Besides, where would you go and who, except Joey, would look after you?

You worked as a prostitute for nearly seven years. Much of the time you were so high, you didn't know what you were doing. Your drug use increased. You lost track of days at a time.

Then, one day when you were 23, you woke up on the floor of a cheap hotel with a Gideon Bible clutched in your hands. It was as if a huge light bulb clicked on over your head. You knew you were going to die if you didn't turn your life around.

You couldn't do this on your own. Before you could change your mind, you called the Christian crisis line number written on the inside cover of the Bible and spoke with a counsellor, who got you into rehabilitation that week.

Of course, your life didn't change overnight. You had several setbacks and had to start over, but you've been clean and sober since your 25th birthday.

Logan is a quiet man, whom you met at church. You have been married for five years. He is aware of your past and feels that God brought you to him for a new chance at life. He has forgiven whatever you've done previously.

- **Children**

You have two children. Alex, age 3 and AJ, aged 15 months.

Education and work history

You were a poor student. You didn't have much interest in classes and didn't seem to have any talents. No one really noticed you were in the class; that's the way it was at home, too. However, you never failed a grade, and you were never diagnosed with a learning disability. Although you left school at 16, recently you earned your GED.

You work as a receptionist at a tanning salon.

Finances

Finances are tight. Logan has a good job as a heavy-equipment operator, and benefits (health care, dental coverage) come with his employment. The two of you are saving for a down payment on a duplex, which will have more room and a yard for the kids, in a new neighbourhood. Every extra penny you earn goes toward that. A third child is going to strain the budget, but you can manage.

You hope you don't miss work because of the nausea.

Logan is working on a 10-day contract up north. The contract pays really well, and if the bosses are happy with him, there is the possibility of further jobs.

Social supports

Your best support is Logan. You also have several friends at church. Most do not know of your past, but you think they would be supportive even if they did.

You are involved in weekly church activities, which you enjoy. After a lifetime of not belonging anywhere, you have a strong sense of community and fellowship. You do not want to jeopardize this in any way.

You have little contact with Tiffany. You know where she lives and that she has remarried and has two more children with her new husband. You met her in the hospital; she is not willing to participate in your father's care.

You don't know where Starlight and Luna are. They may be in another province.

You don't think the twins, or your younger half-sister would be willing to help with your father. The boys are in the United States somewhere and you don't know how to contact them. Your half-sister lives in this city, but in the past she has made very clear her wish to have nothing to do with you. You think she is a single mother of two little kids and that she might be afraid of your past.

Religion

You are a born-again Christian whose religion is extremely important to you. Your faith and the church community saved you from certain death. You try to live as the Bible tells you to.

Your church does not have an affiliated nursing home where your dad could be admitted. You think that members of the congregation would be willing to help you look after him, but likely they couldn't help 24 hours a day.

ACTING INSTRUCTIONS

You are plainly dressed in jeans and a T-shirt. Both are clean but inexpensive. You wear only a wedding ring, as you don't have money for jewellery.

You speak plainly. You are not stupid, but big words and medical phrases confuse you. You do not use profanity.

You are open and speak clearly about your past, giving details succinctly.
You do not feel much guilt about your troubled past; in many ways, it seems to have happened to someone else. You are a new person - a better person.

You don't express overt anger toward any members of your family of origin. They did the best they could. You are somewhat annoyed that Tiffany won't help your dad, but you forgive her.

You **FEEL** conflicted about your father.

You are surprised but pleased about your unexpected pregnancy.

Your **IDEA** is that you have a Christian duty to care for your father, but that there are also good reasons not to have him in your home. You really don't want to take him home and are looking for permission to not take him home. You feel pressured from the hospital.

You believe you are more nauseated with this pregnancy than with the last one, and you are worried about missing work.

Your **FUNCTION** has been affected by your difficulty sleeping as a result of your worry about your father's living arrangements. You also are more irritable than usual.

So far, your nausea of pregnancy has affected your tolerance for coffee, but you have been able to work.

You **EXPECT** that the doctor will provide some direction on what to do about your dad.

You also hope that he or she will give you advice and possibly medications for the nausea so that you don't miss work.

Cast of Characters

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

SUNRISE (MARCONI) BARRISTER:	The 32-year-old patient, who is pregnant, suffering from nausea, and trying to decide whether to let her terminally ill, estranged father live with her.
LOGAN BARRISTER:	Sunrise's husband.
ALEX BARRISTER:	Sunrise and Logan's son, age 3.
AJ BARRISTER:	Sunrise and Logan's son, age 15 months.
TONY MARCONI:	Sunrise's father, age 68.
SUNLIGHT MARCONI:	Sunrise's sister, age 38.
LUNA MARCONI:	Sunrise's sister, age 67.
TIFFANY:	Sunrise's former stepmother, age 48.
LU CHO:	Tony's most recent girlfriend.
JOEY:	Sunrise's former boyfriend and pimp, age 37.

Timeline

Today:	Appointment with the candidate.
1 day ago:	Discovered you are pregnant.
3 days ago:	Hospital social worker asked you to take your father home.
2 weeks ago:	Found out your father was in the hospital.
3 weeks ago:	Father admitted to the hospital.
15 months ago, age 31:	AJ born.
3 years ago, age 29:	Alex born.
5 years ago, age 27:	Married Logan.
9 years ago, age 23:	Entered rehab and quit using drugs.
16 years ago, age 16:	Quit school; began working as a prostitute and continued abusing drugs.
17 years ago, age 15:	Father and Tiffany split up; moved in with Joey and his friends.
19 years ago, age 13:	Met Joey; started using drugs.
32 years ago:	Born.

Examiner Interview Flow Sheet - Prompts

Initial statement	**"The hospital told me I have to take my dad home."**
10 minutes remaining* Optional, use only if you feel it's needed	If the candidate has not brought up the issue of the nausea, the following prompt is to be used: **"On top of everything else, I'm really nauseated."**
7 minutes remaining* Optional, use only if you feel it's needed	If the candidate seems to have forgotten about the issue with her father, the following prompt is to be used: **"What can I do about my dad?"** (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: Caring For Dying Parent

Issue #1	Illness Experience
Areas to be covered include: 1. father diagnosed with cancer: • Fell three weeks ago. • Lung cancer with several mets. • Had radiotherapy. • No more treatment possible. 2. place of palliation: • Father wants to go to her house. • Ex-wife will not care for him. • Ex-girlfriend refuses to care for him. • No other family available or willing. 3. contributing factors to conflict: • Never had to look after sick/dying person before. • Opioids in the house. • No relationship with father. • Father is a smoker. 4. husband is as conflicted as she is over this issue.	**Description of the patient's illness experience**. You are feeling conflicted and overwhelmed. When you were at your worst, the church cared for you and you feel that same responsibility to do the same for others. However, you feel like there are many good reasons why you shouldn't bring your father to live with you. Thinking of these decisions has interrupted your sleep and you keep on thinking about the meeting over and over. You expects that the doctor will give you advice and information.

		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: Nausea Due to Pregnancy

Issue #2	Illness Experience
Areas to be covered include: 1. pregnancy history: • Three prior pregnancies. • LMP (last withdrawal bleed) eight weeks ago. • She is sure of her dates. • Was taking the birth control pill when she got pregnant. 2. nausea: • Mild nausea with second pregnancy. • Already nausea is very strong. • Vomited every morning this week. • Able to eat in afternoon and evening. • Didn't use medication in previous pregnancy. 3. waiting until husband is home to tell him. 4. deals with first trimester urgencies: • Taking folic acid. • No smoking. • No drinking.	**Description of the patient's illness experience.** You are shocked but pleased that you are pregnant. You have more nausea with this pregnancy than with your previous ones. You cannot miss work. You would like advice on how to minimize the nausea. You would welcome medication for nausea so you can avoid missing work.

		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: • Married. • Limited contact with family of origin. • Two children. 2. finances: • Works as a receptionist. • Husband has benefits. • Money is tight. • Lives in small two-bedroom apartment. 3. supports: • Husband is main support. • Has made many friends within the church. • Ongoing active involvement with the church (Sunday school, fundraisers, and fellowship meetings). 4. life cycle: • Chaotic childhood (loss of mother, stepmothers, multiple siblings). • Worked as a prostitute. • "Saved" by her discovery of religion. • Previous addiction to drugs. • Husband aware of past.	Context integration measures the candidate's ability to: • Integrate issues pertaining to the patient's family, social structure, and personal development with the illness experience. • Reflect observations and insights back to the patient in a clear and empathic way. This step is crucial to the next phase of finding common ground with the patient to achieve an effective management plan. The following is an example of a statement a superior level candidate may make: "You've really moved your life forward and made many gains in becoming a better person with a future. But taking care of your father poses significant risk to those gains. You feel your duty compels you to care for him but you recognize the risk this poses. In addition, now that you are pregnant and nauseated, you have fewer reserves to cope with such a situation."

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: Caring for Dying Parent

Plan for Issue #1	Finding Common Ground
Areas to be covered include: 1) Acknowledge that this is a challenging situation. 2) Outline that patient is not legally obligated to care for father (cannot be forced to take him home). 3) Suggest further discussion with the medical team about discharge plans. 4) Offer supportive counselling (with self/palliative care team/church, etc.). 5) Indicate that there are supports available in the community should she decide to take her father home.	Behaviours indicating efforts to find common ground go beyond the candidate asking "Any questions?" after a management plan is presented. Finding common ground is demonstrated by the candidate encouraging patient discussion, providing the patient with opportunities to ask questions at multiple points, encouraging the patient to express their thoughts, seeking clarification, checking for consensus, and recognizing then addressing patient hesitation or disagreement if it arises. Examiners need to determine the candidate's ability to find common ground based on behaviours they demonstrate during the interview.

Superior Level	Covers points 1, 2, 3, and 4 OR 5.	Actively asks about the patient's ideas and wishes for management. Purposefully involves the patient in the development of a plan and seeks his or her feedback about it. Encourages the patient's full participation in decision-making.
Certificate Level	Covers points 1, 2, and 3.	Involves the patient in the development of a plan. Demonstrates flexibility.
Non-Certificate Level	Does **not** cover points 1, 2, and 3.	Does **not** involve the patient in the development of a plan. Only asks the patient "any questions" after a management plan is presented without doing more to involve the patient.

5. Management: Nausea of Pregnancy

Plan for issue #2	Finding Common Ground
Areas to be covered include: 1) Suggest that most likely this is a physiologic problem/normal nausea of pregnancy. 2) Outline non-pharmacological methods of controlling nausea. 3) Offer a prescription for medication in case patient needs it. 4) Discuss follow-up plan should symptoms worsen.	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 • Asks open- and closed-ended question appropriately

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

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.