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 thyroid mass

2. a conflict with his wife because of parenting issues.

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. **VICTOR MCALLISTER**, age 42, who is new to your practice.

CASE DESCRIPTION

Introduction

You are Mr. **VICTOR MCALLISTER**, age 42, a salesman for a large and prosperous insurance company. Over the past several weeks you have noticed a non-painful swelling in the middle of your throat, just left of your Adam's apple. You are visiting the clinic today because your wife, **JOAN MCALLISTER**, insisted that you see a doctor about the lump.

You also have some concerns about how Joan is overindulging your nine-year-old son, **DARREN MCALLISTER**. You want some advice on how to stop this behaviour.

Your own family physician (FP), **Dr. JOHN SMITH**, is working out of the country with a relief agency for a year. He has been your FP for 10 years.

History of the problems

THYROID MASS

You first noticed the neck swelling about two months ago, when you went to purchase some new dress shirts. While trying on the shirts, your finger rubbed against a small, firm lump. It feels like a large frozen pea just to the left of your Adam's apple. It moves when you swallow, but you can't roll it around with your finger (i.e., it is fixed to the thyroid). It doesn't hurt when you touch it. You have had no pain, redness, itching, or burning with this lump. It does not affect your breathing. The lump is no larger than it was when you discovered it, although you are aware of and paying attention to it. You find yourself rubbing your fingers over it several times a day.

You haven't gained weight or noticed any skin changes or changes in energy level. You have never had radiation to your neck. You have not had night sweats, a change in voice, or difficulty swallowing or breathing.

You are actually more concerned about the lump in your neck than you have let on to Joan. You wonder if it might be cancer. However, you have been avoiding the subject actively, and haven't made an appointment to see anyone about the lump because you are secretly scared to know what it is. Your wife made this appointment for you.

You have no family history of thyroid cancer.

CONFLICT OVER PARENTING

Darren is your only child. You suspect that Joan has never really gotten over the loss of two other babies, but the issue doesn't come up in conversation and this is only a suspicion. She is exceptionally devoted to Darren and fusses over him continually. For example, she drives him to and from school (which is only three blocks away), prepares special meals for him whenever he says his stomach hurts, and lets him come home from school early if he complains of pain. She encourages his artistic pursuits and has bought him an entire closet full of LEGOs.

You have strongly encouraged Darren to play sports: hockey in the winter and soccer in the summer. Darren is an average but somewhat uninterested hockey player. You feel he could be quite good if he would only apply himself. You started as Darren's hockey coach six weeks ago, and although you haven't made a connection between the two events, Darren's tummy pain started to worsen and occur more frequently at about the same time.

Darren is generally healthy, but over the past year he has complained frequently of "tummy aches". At first you and Joan felt that he was trying to get out of doing schoolwork, but he often complains on the weekend and has missed going to hockey practice. Twice in the past six weeks he has awoken with belly pain before an important game.

Darren often asks to be excused from hockey practice because he has a "tummy ache". As the coach of the team, you strongly feel that Darren should not retire to the bleachers or go home when he feels a bit unwell, but rather "play through" the discomfort. This is how you dealt with any aches or pains during sports, and it generally worked. Your wife, however, disagrees. Whenever Darren snivels that he doesn't feel well, she immediately panders to him and rushes him home to lie on the couch with a hot water bottle.

Joan rarely disagrees with you and has always deferred to you, leaving most of the household decision-making to you—at least until recently. Now she seems not to be following your instructions about handling Darren's tummy pain, and she has openly defied you by taking him off the ice during hockey games—in front of the other fathers!

Just last weekend, Joan ordered a crying Darren home before hockey practice had even started. You are concerned that she is "making the boy into a sissy". This disagreement over parenting styles has led to quarrels between the two of you over the past couple of months. You don't really fight with Joan (i.e., neither of you yells or screams), but you certainly tell her that she is behaving inappropriately and that you want her to stop.

Darren's pain subsides after a loose bowel movement. The movements do not contain blood or mucus. Darren was prone to constipation as a baby and young child. He is a picky eater but drinks several large glasses of milk a day. He refuses both fruits and vegetables. He is growing well and not losing weight.

Medical history

You are generally healthy.
Other than treatment for the occasional sports injury (you played a lot of competitive sports in high school and university), you did not require any medical therapy until about five and a half years ago, when you had a vasectomy.
The last time you visited a doctor was for an episode of pneumonia five years ago. You had antibiotics and the infection resolved quickly with no lasting effects.
You have never been hospitalised.

Surgical history

You had your tonsils out when you were six years old.

Medications

Occasionally you take ibuprophen for knee pain after running.

Pertinent laboratory results

None.

Allergies

None.

Immunizations

Up to date.

Lifestyle issues

- Tobacco: You smoked in university, "just at parties", but quit because smoking might have interfered with your ability to play sports if you had become addicted.
- Alcohol: You drink alcohol daily, usually one or two glasses of wine with dinner if you are with clients or a couple of beers if you are home with the family. You have never had a problem with alcohol.
- Caffeine: You drink four cups of coffee a day.
- Cannabis: You tried marijuana several times in university but didn't really like it.
- Recreational and/or other substances:
- Diet: Normal North American diet
- Exercise and recreation habits: You travel frequently for work, although you do not have to leave the country. In fact, you haven't travelled outside your native province for several years. You even spend your vacations at your parents' cottage in this province

Family history

Both your parents are living. Your father, **TREVOR MCALLISTER**, age 70, is healthy and active. Your mother, **BETSY MCALLISTER**, age 68, is very overweight and has been diagnosed with "thyroid problems", hypertension, and "a touch of diabetes".

You are the eldest of four siblings. Your three younger sisters are **VANESSA DEAN**, age 40; **ISABEL MASSEY**, age 38; and **JENNIFER FORREST**, age 35. They are generally healthy, although Isabel is significantly overweight and has recently been diagnosed with diabetes.

Vanessa has a son with Down syndrome.

No one has had cancer in your immediate family of origin, but your maternal grandmother died of colon cancer when you were a young child.

Personal history

- Family of Origin

You were raised in a pretty happy family. The only issue of concern you can remember from your childhood is your mother's battle with her weight. Your parents got along, and as the eldest child and the only boy, you had a fair amount of attention. You were an average student, but you excelled on the playing field and won a small athletic scholarship to university.

When you were small, you had bowel complaints similar to your son's. You specifically remember being doubled up with abdominal pain on the school bus, worried that you would have an attack of diarrhea before you got to school. Your parents were of the "old school" when it came to discipline and sickness; you never got "time off" for your bowel problems and were expected to "shush about it." Eventually your bowel problems settled into a predictable pattern of bloating and constipation, and you have figured out how to live with them by exercising and eating lots of fibre.

- Marriage/Partnerships

You met Joan through one of your teammates at a hockey game. She was the younger sister of a casual friend, and you were attracted to her gentle quietness immediately. You dated for nearly two years before becoming engaged, and waited another 18 months before marrying, because Joan wanted "everything perfect"— and, at first, everything was perfect.

You did well in your job, Joan found temporary employment until she became pregnant with Darren, and after Darren was born, life settled down. However, Darren suffered from colic starting at age four weeks, shattering the idyllic peace. Then Joan found herself pregnant again when Darren was eight months old. Neither you nor Joan was particularly happy about this. Darren continued to be fussy, you both were tired and cranky, and you had some difficulties on the job. You were a bit relieved when Joan miscarried at four months because you had really worried about how you would cope with another child at that time. Joan, on the other hand, took the loss exceptionally hard.

Less than a year later, Joan became pregnant again. This time the pregnancy was a planned event. However, at five months of gestation she went into labour and delivered at home alone. The baby was born dead.

Joan required hospitalisation for several weeks after this event, primarily for depression. Her psychiatrist strongly advised that she not chance becoming pregnant again.

You were comfortable with that decision, and quickly arranged a vasectomy. You didn't discuss this with Joan because you felt that she was too "fragile", and that you were helping the situation. Joan was having side effects from the birth control pill, and you thought that "as the coach of the family team", you would shoulder the responsibility yourself. You haven't regretted that decision at all; Joan has never discussed it.

Currently Joan is an administrative assistant for a law firm. She works part time in order to be home with Darren after school. She is healthy. Apart from care during her three pregnancies and the bout of depression, she hasn't had any medical interventions.

- Children

Darren is a great kid: active, funny, and bright. He tends to cling to your wife and seems to prefer her company to that of the other boys at school. He has never been very interested in the rough-and-tumble games of the other neighbourhood boys; he would rather spend hours reading, playing with his LEGOs, and helping your wife in the kitchen.

Education and work history

You completed a general BA at the local university. You had a partial athletic scholarship for the first two years, but you never made it to the semi-professional level.

Currently you work for a large insurance company that is nationally known and quite prosperous. You sell insurance to small independent companies, and really enjoy your work. You have worked for this company for 11 years. Before that you worked for a competitor.

Finances

You have no financial worries. You live in a duplex in a great neighbourhood, and paid off your mortgage last year because you live in a smaller, less costly home.

Social supports

Your main support is Joan. You consider that you have a close and stable relationship with her.

You are particularly close to Vanessa, because you are only 17 months apart in age and she is also “very into” sports. You played tennis with her for many years while you were growing up. She lives in the same city as you and you meet once a week for a tennis match. She is married and has three children. Her youngest, a boy, was born with Down syndrome three years ago.

You get along well with your co-workers. You have several male friends with whom you play hockey in the winter.

Religion

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

ACTING INSTRUCTIONS

You are wearing a high-necked shirt or a turtleneck. You frequently finger the collar or rub your Adam's apple.

You are pleasant and cordial, straight to the point and factual. You often use sports metaphors in your speech ("team player", "drop the ball", "winning is everything", etc.). You frequently say things such as "Don't you agree?" and "You understand, don't ya, Doc?" because you want the candidate on your side.

You show some mild disdain for Darren's lack of interest in sports and preference for quiet games. You refer to these quiet pastimes as "sissy" and worry that your wife will somehow make Darren cling to her more as time goes by.

You have little concern for Joan's feelings, not because you don't care for her, but because they don't fit in with your idea of what is correct. You have little insight into how your pushing sports, ignoring Darren's belly pain, and getting the vasectomy without your wife's knowledge may have affected your family. You express surprise if the candidate raises these issues and isn't wholly supportive.

You should be forthcoming about Darren's history: his symptoms and the fact that he is otherwise very healthy and growing well. You should specifically say that you force Darren to play hockey even though he complains of pain.

Cast of Characters

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

VICTOR MCALLISTER:	The patient, age 42, an insurance salesman who has a mass in his neck.
JOAN MCALLISTER:	Victor's wife, age 43, who works part time as an administrative assistant.
DARREN MCALLISTER:	Victor and Joan's son, age nine, who suffers from abdominal pain.
TREVOR MCALLISTER:	Victor's father, age 70, who is healthy and active.
BETSY MCALLISTER:	Victor's mother, age 68, who is very overweight and has thyroid problems, hypertension, and mild diabetes.
VANESSA DEAN:	Victor's sister, age 40, who has a son, age three, with Down syndrome.
ISABEL MASSEY:	Victor's sister, age 38, who is significantly overweight and diabetic.
JENNIFER FORREST:	Victor's sister, age 35.
DR. JOHN SMITH:	Victor's FP for the past 10 years, who is currently working with a relief agency for a year.

Timeline

Today:	Appointment with the candidate.
6 weeks ago:	Began coaching Darren's hockey team and his abdominal pain began to worsen and to occur more frequently.
2 months ago:	Discovered the neck lump.
1 year ago:	Start of Darren's abdominal pain.

Today:	Appointment with the candidate.
6 weeks ago:	Began coaching Darren's hockey team and his abdominal pain began to worsen and to occur more frequently.
2 months ago:	Discovered the neck lump.
1 year ago:	Start of Darren's abdominal pain.

Examiner Interview Flow Sheet - Prompts

Initial statement	**"My wife is worried about this lump in my neck."**
10 minutes remaining* Optional, use only if you feel it's needed	If the candidate has not brought up the issue of the parenting disagreement, the following prompt is to be used: **"I need your opinion about my son."**
7 minutes remaining* Optional, use only if you feel it's needed	If the candidate seems to have forgotten about the thyroid nodule, the following prompt is to be used: **"What do you think this lump is?"** (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: Thyroid Nodule

Issue #1	Illness Experience
Areas to be covered include: 1. history of the current problem: • Patient found it two months ago. • Not changing in size. • Non-painful. • The size of a pea. 2. ruling out a thyroid problem: • No weight change. • No change in energy. • No skin changes. • No bowel changes. • No temperature intolerance. 3. ruling out malignancy: • No night sweats. • No voice changes. • No other lumps. • Non-smoker. • No difficulty swallowing. 4. no history of neck radiation.	**Description of the patient's illness experience**. You are worried about the lump and concerned that it might be cancerous. There hasn't been any impact at work. You are irritated that your wife is pressuring you to have the mass checked out. You are expecting that the doctor will arrange for the lump to be tested and removed.

		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: Parenting Conflict

Issue #2	Illness Experience
Areas to be covered include: 1. wife's parenting: • Special meals for Darren. • Drives Darren to and from school. • Allows Darren to come home from school early. • Encourages Darren's non-athletic pursuits. 2. patient's parenting: • Forces Darren to play hockey when he is in pain. • Strongly encourages Darren to play sports. • Coaches Darren's hockey team. 3. Darren: • Abdominal cramps. • No other identified medical conditions. • No constitutional symptoms • (no weight loss, bleeding, mucus, etc.). • Pain worsened six weeks ago. 4. conflict: • The patient and his wife are arguing. • The wife is asserting herself. • The wife took Darren home from hockey.	**Description of the patient's illness experience.** You are annoyed and frustrated because you feel that Darren's abdominal pain is not serious, and you think he should be involved with more appropriate male activities. You and your wife have begun to disagree openly and you are hoping the doctor will agree that there's nothing to worry about in regard to Darren's abdominal pain.

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

		to see the patient as a unique person with an illness, more than just a textbook disease process to be appropriately managed.
Superior Level	Covers points 1, 2, 3, and 4.	Actively explores the illness experience to arrive at an **in-depth** understanding of it. This is achieved through the purposeful use of verbal and non-verbal techniques, including both effective questioning and active listening.
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Non-Certificate Level	Does **not** cover points 1, 2, and 3.	Demonstrates minimal interest in the illness experience, focusing mainly on the disease process, and so gains **little** understanding of the illness experience. There is little acknowledgement of the patient's verbal or non-verbal cues, or the candidate often cuts the patient off.

3. Social and developmental context

Context Identification	Context Integration
Areas to be covered include: 1. immediate family: • One living child. • Parents living. • Three sisters. 2. Joan's history: • Two miscarriages. • History of depression. • Victor feels she has never gotten over the loss of two babies. 3. Victor's history: • Athletics are very important. • Parents dismissed his childhood aches and pains; he always "plays through" his pain. • Sees a father's role as being "captain of the family team". • Had a vasectomy without his wife's knowledge. 4. social factors: • Insurance salesman. • Financially secure. • Plays hockey regularly.	Context integration measures the candidate's ability to: • Integrate issues pertaining to the patient's family, social structure, and personal development with the illness experience. • Reflect observations and insights back to the patient in a clear and empathic way. This step is crucial to the next phase of finding common ground with the patient to achieve an effective management plan. The following is an example of a statement a superior level candidate may make: "You have concerns that this neck lump is something rather serious, and you worry that your wife's overprotection of Darren is subversive to your role in the family. You worry that your role as the father is being undermined, and you feel helpless to reinstate it."

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: Thyroid Nodule

Plan for Issue #1	Finding Common Ground
Areas to be covered include: 1) Review various possible causes. 2) Arrange for a physical examination. 3) Reassure the patient that appropriate investigations will be arranged, based upon the examination. 4) Discuss "red flags" (e.g., increase in size, pain, change in voice, etc.) that require investigation.	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: Parenting Conflict

Plan for issue #2	Finding Common Ground
Areas to be covered include: 1. Offer to see and examine the son. 2. Offer to see the wife with the patient to discuss the son. 3. Explore the possibility of marital conflict underlying the parenting disagreement.	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, and 3.	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 and 2	Involves the patient in the development of a plan. Demonstrates flexibility.
Non-Certificate Level	Does **not** cover points 1 and 2.	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 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	**Cultural and Age Appropriateness** Adapts communication to the individual patient for reasons such as culture, age, and disability. Sample behaviours • Adapts their communication style to the patient's disability (e.g., writes for patients with hearing challenges) • Speaks at a volume appropriate for the patient's hearing • Identifies and adapts their manner to the patient according to the patient's culture • Chooses appropriate medical terminology for each patient (e.g., "pee" rather than "void" for children)
Non-Verbal Skills Expressive • Is conscious of the impact of body language on communication and adjusts it appropriately Sample behaviours • Ensures eye contact is appropriate for the patient's culture and comfort	**Language Skills** Verbal • Has skills that are adequate for the patient to understand what is being said • Converses at a level appropriate for the patient's age and educational level

• Is focused on the conversation • Adjusts demeanour to ensure it is appropriate to the patient's context • 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")	• Uses an appropriate tone for the situation, to ensure good communication and patient comfort Sample behaviours • 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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