THE COLLEGE OF FAMILY PHYSICIANS OF CANADA

LE COLLÈGE DES MÉDECINS DE FAMILLE DU CANADA

Certification Examination in Family Medicine

Overview of Simulated Office Oral (SOO) Structure and Marking

Updated June 2023

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

Introduction

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

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

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

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

The following Appendices will be of interest to all examiners:

Appendix 1: Standardized Instructions to Candidates

Appendix :2 Ten CFPC Preparation Pointers for Examiners

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

RATIONALE FOR SIMULATED OFFICE ORAL EXAMINATION #

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

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

1. a need for post-myocardial infarction medical management.

2. depression following a cardiac event

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. **BILL EVANS**, age 56, who is new to your practice.

CASE DESCRIPTION

Introduction

You are Mr. **BILL EVANS**, age 56, who took early retirement last year and experienced a myocardial infarction (MI) three months ago. Since the MI you have become increasingly depressed, and one month ago you stopped taking all medication.

Your wife, **RUBY**, encouraged you to visit a family physician (FP) for post-MI monitoring. She made today's appointment with the candidate because her own FP is not accepting new patients.

History of the problems

POST-MYOCARDIAL INFARCTION MANAGEMENT

Your heart attack began with some squeezing pain in your chest in the mid- afternoon. You were walking home from the supermarket and carrying some bags of groceries that were not especially heavy. The aching decreased if you stopped walking, but it continued for a good hour, off and on, and it was increasing when you got home. The pain moved up to your jaw and down your left arm. You were sweaty and you felt as if something was very wrong. The symptoms seemed to be those of a heart attack, and so you took a taxi to the emergency department (ED). In retrospect, you know you should have called an ambulance, but you were not sure about the symptoms and did not want to over-dramatize the situation.

Once you were in the ED, a nurse quickly put you on a stretcher and started attaching tubes to you. You were given medicine that made the chest pain go away, although it was replaced by a splitting headache. At one point the doctor told you that you were having a heart attack, and that you would be moved to the operating room to have a balloon put in your heart. Ruby had been called by this time, and she was with you when the doctor explained things to you. You were grateful that she was there because you were having trouble understanding everything that was happening.

Within minutes you were in the operating theatre, where the surgeon inserted a "stent." (If the candidate asks, you do not know what kind of stent. Nor do you know what vessel or vessels were involved.)

Later you were told that you had a blocked artery in your heart, and that you had arrived at the hospital "just in time." While you were in the coronary care unit, the doctor explained that your heart muscle had been damaged during the attack. He said that it seemed to be recovering well and that you had no "heart failure."

You stayed in the hospital about five days. You experienced no more chest pain during your stay, but you were sometimes a bit light-headed when you stood up. Before you left you had to walk on a treadmill while you were attached to wires; you were told the result was good. You were sent home with some medicine and told to follow up in one month with the cardiologist at the hospital. At that appointment, the cardiologist assured you that you were healing fine and that everything was okay.

You have experienced no chest pain since your discharge from hospital. You are not short of breath on exertion, but you have not really been exercising. You have no swelling of your feet. You do not need

extra pillows at night. You do not wake up with shortness of breath. You have not had any form of cardiac rehabilitation. The hospital staff might have suggested it, but you never made an appointment to go. You stopped taking all your medication one month ago, without telling Ruby.

The cardiologist said that he wanted to see you again in six months, and that an FP should also monitor your condition. You had not seen an FP in at least five years. You discovered that your former FP had retired, and so you let making an appointment slide until Ruby made one for today**.**

DEPRESSION

Before your MI you were always an "upbeat" guy who was optimistic and full of life. You enjoyed your family life and your hobbies, and you were looking forward to your early retirement from the insurance company where you had worked your entire adult life. You had been careful with your investments and had put enough savings aside to experience "freedom 55" retirement. You intended to spend summers golfing and working around the yard, and winters curling and visiting Florida for a few weeks. You liked your job, but you had no regrets about retirement. The time had come to relax and enjoy life.

Unfortunately, things did not work out as planned. First, soon after you retired your private investments did very badly in the economic downturn. You estimate that you lost about half of your personal investments for retirement. You still had a generous company pension, but your Registered Retirement Savings Plan funds had decreased considerably. You wondered if you should ask to be rehired at your former company, but it was downsizing because of the dismal economy. You would just have to make ends meet, relying much more on your wife's income than you had expected. The trips to Florida look less likely.

The next setback was the heart attack. You had always been in good health and had taken it for granted. The hospital stay and subsequent recovery shook you up badly. You had never taken medication in the past, and now you were faced with daily pills. You were told not to exercise excessively during the recovery period, and so you stopped curling. You assumed that golf would be out of the question. Your wife and children began to treat you like an invalid. The past three months have been hellish.

Nothing seems to be going right. Since you got home you have not felt like doing anything. Showering and shaving are a chore, and some days you don't bother to get out of your pyjamas. You eat if Ruby gives you food, but you often skip lunch when you are home alone. You also don't want to bother with the medications you received in the hospital, and you aren't sure they would do anything for you, anyway. You stopped taking them all a month ago, because you just felt you couldn't be bothered. Your wife does not know that you aren't taking the pills. In fact, in the back of your mind you wonder if there is any point in prolonging your life. Your future looks bleak. On a few occasions you have wished that you had died from the heart attack. If a candidate asks directly about your mood, you admit to being "down." If he or she asks whether you feel depressed, you reply, "Maybe. I am certainly not myself."

Your sleep has been poor since the heart attack. You have trouble falling asleep, and you often wake up early for no particular reason and then can't get to sleep again. You are probably sleeping an average of about five hours a night. The days seem so long. Friends have called to see how you are doing, but you have put them off. Conversation is difficult because you really don't feel like talking.

You and Ruby have not had sexual relations since before your heart attack. At first you were too sick and too frightened; now you have no interest. She has noticed that your mood is down. She has little

patience with your moodiness and your lack of energy, and she has told you to "stop feeling sorry for yourself." You feel that your inability to do anything or get involved in anything is frustrating her, and her impatience plays into your sense of worthlessness. She is right, of course: you are worthless. You feel yourself shutting down. Perhaps she would be better off without you now that you are an invalid.

Your daughter, **MAGGIE**, has been calling you more often—almost daily in the past few weeks. She seems worried about you and how you are coping. You haven't been able to speak much about the way you feel. When she asks how you are, you say, "I guess I am feeling my age. I'm really tired." Maggie is planning to visit in a couple of weeks. This is one reason that you agreed to see an FP. You don't want Ruby telling your daughter that you have "given up."

You have no active suicidal plans or intentions. If the candidate asks, you reply that you might be better off dead, but that you have no intention of killing yourself. You have no firearms in the house.

Medical history

You would describe yourself as very healthy before your heart attack. You had experienced no symptoms of heart disease.

Your last physical examination was "at least" five years ago. You believe you had blood tests; the doctor never called about them, and so you assume the results were fine.

You have had no operations other than the recent angiography.

Surgical history: Angioplasty with stent – 3 months ago

Medications: You were taking no medications before your MI, and you are taking none currently (see "Acting Instructions").

Pertinent laboratory results: None

Allergies: None

Immunizations: You used to get free flu shots at work. You have had no other immunizations since childhood.

Lifestyle issues

- Tobacco: You smoke half a pack of cigarettes a day. You stopped smoking after the heart attack but restarted a month ago. You are not really interested in stopping again at this time. If candidates suggest it, you listen politely. If they explore your intentions to stop, they will find that you are in the precontemplative stage.
- Alcohol: You have never been a heavy drinker. You have about one to three drinks a week. You drink wine on social occasions, or a beer after a golf game.
- Caffeine: You drink two cups of coffee a day. You drink no cola.
- Cannabis: None
- Recreational and/or other substances: You take no illicit drugs.

- Diet: Eat what Ruby cooks
- Exercise and recreation habits: You used to enjoy golfing in the summer and curling in the winter. You have done nothing since the heart attack.

Family history

Your mother is 80 and lives in a retirement home in your community. She is in good health.

Your father died suddenly at age 50 while he was at work. He was a middle manager for a local utility company. You were 21 at the time, and you don't remember the details. The doctor said that he had suffered a sudden heart attack. He was a heavy smoker, but you do not know the details of his medical history. He did not visit doctors.

You have a paternal aunt who is in good health. Your father had no other siblings.

You have a younger sister and a younger brother. Both left the province after they married. You speak to them by phone occasionally. As far as you know, they are healthy.

You are aware of no family history of depression, suicide, or mental illness.

Personal history

- Family of Origin: You grew up in this town. You have had a fairly average life with few surprises.

- Marriage/Partnerships: You met Ruby, age 54, at the local community college when you were in your early 20s. You have been happily married for 31 years. Ruby continues to work in a middle-management position at a local manufacturing company. She likes work and fears that she would go crazy if she were stuck at home "with nothing to do." Your joint retirement plans included winter vacations, but she has no desire to hang around the house with you. This is not a source of conflict. You have known for years that you have different views of retirement, and you have planned accordingly.

- Children: Your son, **ROBERT**, is 30 and married to **SUE**. They have one child, LUKE, who is eight months old. You and Ruby were thrilled when this first grandchild was born. They live in this town and used to visit frequently. In the past couple of months, they seem to come by less often—perhaps because you are no fun to be around. Ruby cannot comprehend why you don't seem enthusiastic about seeing your grandson. Your daughter, Maggie, is 28 and lives in another province. She is not dating anyone and seems to be happy with her job and her life.

Education and work history

You attended a local high school and community college, where you studied basic accounting. After graduation, you found a job in the payroll department at a branch of a large insurance company. Later you transferred to the investment department, where you were working when you retired.

Finances

You and Ruby have enough to live on with her salary and your retirement income.

Social supports

You have isolated yourself. You have supports, but you do not recognize them.

Your wife is your main support, but you can tell that she is frustrated with the way you are acting. She has little patience with your moodiness and your lack of energy. Her apparent impatience plays into your sense of worthlessness. In the back of your mind, you are thinking that she would be better off without you now that you are an invalid.

Your children are worried about you. Your daughter, in particular, is concerned that you are not recovering as expected from your heart attack.

You have avoided friends. You put them off if they call.

Religion

You and Ruby are “Christmas and Easter” Anglicans. You have no strong religious convictions and are not part of a faith community.

ACTING INSTRUCTIONS

You begin by saying that Ruby sent you here. Act the part of a depressed patient— not very animated, and co-operative but a bit disinterested. You do not have a lot of hope that you will get better. However, at the beginning of the interview you should not overact the part of a depressed person. Stick to your cardiac history as much as possible, so that you do not derail the candidate. The fact that you are depressed should become evident as the interview progresses.

You are feeling depressed, but if the candidate asks how you are feeling, you say that you are not having any pain right now. Only if asked specifically about your mood do you say that you are a bit "down" or "sad." If the candidate asks why you feel this way, respond with something like "I didn't think my retirement would be like this." In terms of your MI, you say that you are worried you will have another heart attack without warning.

Your think of yourself now as an invalid because of your heart attack. You see no point in taking medication because you will never be healthy again. You do not have any idea about your mood. If the candidate asks what you think is going on, you could respond with "I guess this is normal after a heart attack." If he or she tries to get you to commit to an "idea" about your depression, you respond with something vague like "I guess the heart attack has taken away my energy."

Your function has been affected by both the heart attack and the mood shift. Initially you were afraid to restart physical activity and sexual relations. Now your depression has made you uninterested in anything. You avoid friends and even family members: "My daughter is planning to visit, and I am not really sure that I even want to see her." You might also say, "It is all I can do to get dressed these days." If the candidate resorts to direct questioning about your functioning, you answer with a comment like "I really am not good for much anymore." This can be followed by a discussion about the abandoned physical activities. Do not mention sexual activity unless the candidate asks.

Introducing the fact that you are not taking your medication occurs at the 10-minute prompt, but it may well come up earlier. If the candidate asks if you are taking any medication, say, "Not at the moment." This might elicit an inquiry about why you are not taking medication. If the candidate asks what medications you were given when you left the hospital, reply with a fairly vague answer, such as the following: "They gave me a lot of pills. There was something for my cholesterol, something for my blood pressure, some Aspirin, and something called Plavix." You should then say, "I took them for a while." So, the fact that you are not taking the medication may come up at the 10-minute prompt or before. When the candidate asks you why you stopped, you answer, "There didn't seem to be any point. I didn't feel any different." You would sound a bit "flat" when you say this.

Your expectations are limited. Your wife sent you to see this FP and you really don't expect that things will improve as a result. You do expect that the FP will try to get you to take some pills again. You agree to do so if he or she tells you to— but you will actually intend to start taking them again only if the candidate explains why they will help. A good candidate will understand why you stopped taking your medications and will address the issue. In short, you need some hope. A good candidate will offer you this, even though you are not expecting it.

You do not really want to take medication for depression, if it is offered. This would indicate that you have yet another illness. If an antidepressant is offered, say that you would rather not take medication, and ask if there is any alternative. (You may do this even in the last three minutes, if the issue comes up at that time, as negotiation for treatment is included in the marking scheme.)

Cast of Characters

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

BILL EVANS:	The patient, age 56, who took early retirement one year ago and had an MI three months ago.
RUBY EVANS:	Bill's wife, age 54, who works in middle management.
ROBERT EVANS:	Bill and Ruby's son, age 30, who lives in the same town.
MAGGIE EVANS:	Bill and Ruby's daughter, age 28, who is unmarried and lives in another province.
SUE EVANS:	Robert's wife.
LUKE EVANS:	Robert and Sue's son, aged eight months.

Timeline

Today:	Appointment with the candidate.
1 month ago:	Stopped taking the medications you received in the hospital.
2 months ago:	Follow-up visit to the cardiologist.
3 months ago:	Suffered an MI.
8 months ago:	Grandson, Luke, born.
1 year ago, age 55:	Took early retirement.
5 years ago, age 51:	Last visit to your former FP.
28 years ago, age 28:	Daughter, Maggie, born.
30 years ago, age 26:	Son, Robert, born.
31 years ago, age 25:	Married Ruby.
56 years ago:	Born.

Examiner Interview Flow Sheet - Prompts

Initial statement	"**My wife made this appointment for me to see you. She thought I should check my heart**."
10 minutes remaining* Optional, use only if you feel it's needed	If the candidate has not brought up the issue of the depression, the following prompt is to be used: "**To be perfectly honest, they gave me some medication in the hospital, but I stopped taking it**."
7 minutes remaining* Optional, use only if you feel it's needed	If the candidate seems to have forgotten about the post-MI management, the following prompt is to be used: "**Do you think I will have another heart attack soon?**" (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: Post-MI Management

Issue #1	Illness Experience
Areas to be covered include: 1. history: • Three months ago. • Had rapid angiography with stent placement. • Five days in hospital. • Was told there was some damage. • Was told there was no heart failure. 2. risk factors: • Father's sudden death at age 50. • He restarted smoking. • No history of diabetes. • Asymptomatic before his MI. 3. post-hospital course: • Was prescribed medications for cholesterol and blood pressure, acetylsalicylic acid, and clopidogrel (Plavix). • Saw the cardiologist two months ago. • Negative stress test before discharge. • No recurrence of chest pain. 4. no cardiac rehabilitation.	**Description of the patient's illness experience**. You are worried that you will have another heart attack. You see yourself as an invalid. Moving from being healthy to being sick, you have stopped exercising and have stopped sexual activity. You don't expect anything from the doctor's visit and are only at the doctor's office because "My wife made me come."

		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: Depression

Issue #2	Illness Experience
Areas to be covered include: 1. diagnostic features: • No previous depression. • Sleep disturbance. • Loss of interest in activities. • Loss of appetite. • Loss of libido. 2. suicidal risks: • No psychotic features. • Has wished he had died. • No suicidal plan. • No firearms in the house. 3. other relevant factors: • Quantity of alcohol—one to three drinks a week. • No substance abuse. • No family history of psychiatric illness. 4. trying to rule out medical causes of depression (e.g., thyroid disease, malignancy).	**Description of the patient's illness experience.** You are feeling depressed and hopeless, and think it is normal to feel this way after a heart attack and that you won't ever feel normal again. You cannot be bothered to take care of yourself. As such, you don't have any expectations from this visit.

		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. retirement issues: • Planned early retirement. • Does not miss working. • Hoped to continue to be active after retirement. • Unable to be rehired. 2. financial concerns: • Lost part of his retirement investment income. • Wife is still working. • Wife does not want to retire. • Unable to travel. 3. social support: • Wife is becoming impatient with him. • Has isolated himself from friends. • Son comes by less often. • Daughter will be visiting soon.	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: "Mr. Evans, I can see how everything is turned upside down for you. You were hoping for a happy and healthy retirement, and now you have unexpected financial worries and health concerns. Many people would feel a bit depressed in this situation, but I want you to understand that we can work together to help you to feel normal again."

Superior Level	Covers points 1, 2, and 3.	Demonstrates initial synthesis of contextual factors, and an understanding of their impact on the illness experience. Empathically reflects observations and insights back to the patient.
Certificate Level	Covers points 1 and 2.	Demonstrates recognition of the impact of the contextual factors on the illness experience.
Non-Certificate Level	Does **not** cover points 1 and 2.	Demonstrates minimal interest in the impact of the contextual factors on the illness experience or often cuts the patient off.

4. Management: Post-MI Management

Plan for Issue #1	Finding Common Ground
Areas to be covered include: 1) Explain the need to restart medication. 2) Explore the patient's willingness to stop smoking. (He is in the precontemplative stage.) 3) Obtain hospital records or the cardiology report. 4) Suggest cardiac rehabilitation.	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: Depression

Plan for issue #2	Finding Common Ground
Areas to be covered include: 1) Identify the problem as depression. 2) Explain that this is a common occurrence after a cardiac event/major illness. 3) Suggest that medication may be helpful with the depression and/or suggest psychotherapy or counselling. 4) Outline a plan in case the patient becomes suicidal.	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.

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Certificate Level	Covers points 1, 2, and 3.	Involves the patient in the development of a plan. Demonstrates flexibility.
Non-Certificate Level	Does **not** cover points 1, 2, and 3.	Does **not** involve the patient in the development of a plan.

6. Interview process and organization

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

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

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

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

Appendix 1 Standardized Instructions to Candidates

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

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

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

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

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

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

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

Appendix 2 CFPC Preparation Pointers for Examiners

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

Think of the following:

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

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

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

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

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

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

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

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

5. Do not overact.

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

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

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

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

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

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

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

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

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

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

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

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

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