Not just for SOOs....
SOO Prep Guide and review of the Patient Centred Clinical Method (PCCM)

1. All Simulated Office Orals are based on actual cases from family physicians’ experiences in the office setting. The best way to approach a SOO is the same way you would approach a patient clinically. This should be like any day in the office and therefore practicing the PCCM every day when seeing patients will integrate this approach into your usual care. That makes going into the exam much easier. This is not an exam format – this is a tried and true method of clinical practice that research supports as effective for you and your patients. Refer to the PCCM text to review the evidence.

2. There are often two problems in each 15 min SOO but the nature of the problems are such that they can be dealt with in the 15 min and they often test different skills in the PCCM so there is usually only one “medical expert” problem. Don’t “fish” for the second problem. With good interviewing skills and use of the PCCM the SOO is designed for it to come out.

3. The physician/examiner will always provide the following in a SOO –
   i. An opening statement
   ii. Built in “prompts” that are used as needed. The purpose of the SOO is not to hide the problems from you and therefore the patient/examiner have statements they will use that are built into the SOO to put you on track to deal with each of the issues. So pay attention to “cues” as they come up.
      - A prompt can put you onto the second issue raised in the SOO
      - A prompt can bring you back to the initial presenting problem if it has not been covered
      - These prompts are timed to be given at specific intervals in the case such as when there are 7 min and 10 min remaining in the SOO thus ensuring you have time to explore them
      - Prompts are not done when you have already covered the material

4. At the 12 min mark into a SOO, the examiner/patient will state clearly that you have three minutes left. They will often raise 3 fingers so that during a stressful exam you are being given both a visual and a verbal indication of the time remaining. At this point, the examiner is not likely to volunteer any further information but they will certainly give answers to direct questions. The reason for this is so you won’t be thrown off with new information and will use the final 3 minutes for a brief summary and most importantly in family medicine, have the time to find agreement on a plan and arrange follow up.

5. When a SOO is marked officially, the examiner will not give you marks for aspects of the SOO that were not covered – so if they don’t hear the issues in the dialogue with you, you won’t receive marks for it. This emphasizes the point that you have to verbalize what you think is going on. Don’t just think about and act on a diagnosis without engaging with the patient. In the practice of “thinking out loud” you are helping the patient see where you are coming from and ensuring there is an opportunity to come to shared decision making (common ground)
about the nature of the problem, the goals for treatment/follow up and the roles of who is
going to do what (you or another provider and/or the patient) such as tests, return for a physical
exam, follow up appointment etc.

6. In general, when doing a SOO, you should be specific about tests that are appropriate to the
SOO. Don’t just say “x-ray” or “blood” tests are needed- be specific about what you would
order. You also need to ask for the patient’s input into these decisions. “Is this okay with you?”

7. Do not cut the patient off too early in their story. You do have to learn more about them using
the medical model – history of past health, medication history, social history including habit
data such as smoking and alcohol/drug use – but don’t jump to this too early in the encounter.
Once you get the presenting complaint and some of the details, use a “transition statement”
stating that to proceed effectively in their care, you need to ask some general questions. Ask if
this is okay with the patient before proceeding.

8. This is not an OSCE and so there is an expectation this interview will not be an interrogation
covering a “checklist”. Using open ended questions is essential initially and then over time you
can get specifics with more close ended questions. Active listening through the use of a brief
summary is good in a SOO and can buy you time if you are drawing a blank on where to go next.
You can do notes if that helps too.

9. “Tell me more” is also a useful technique in a SOO.

10. Be empathetic. It is the basis of effectively creating a relationship in the encounter so ALWAYS
remember to express an empathetic comment when told something that demonstrates the
difficult, challenging or sad aspects of the patients’ story.

11. To elicit the patient’s illness experience, do not tack FIFE questions onto a typical medical
history. You have to weave these questions into your history in a comfortable and appropriate
way that is conversational. Sometimes the answers to FIFE questions come out naturally when
open ended questions are asked. You do not have to repeat the questions – if you know their
expectations of the visit or the impact on work, etc. – you don’t have to ask again.

12. Exploring context can be done while doing a family history or adding an employment history to
the social history. You can ask who is at home or who they have for support and this usually
provides an easy entry into this aspect of the PCCM and is an important part of the SOO.
SOO Flowsheet

Identify Problem 1 (usually medical)

Explore Illness Experience
1. Ideas about what's wrong
2. Feelings/Fears about problem
3. Impact on daily function
4. Expectations of doctor

Past Medical History
Family History
Social/Development History
(family context, relationships, work, finances, supports, life cycle, culture)

Friends
Family
Love
Money

Identify Problem 2 emerges (usually psychosocial; can also be physical)

Explore Illness Experience
1. Ideas about what's wrong
2. Feelings/Fears about problem
3. Impact on daily function
4. Expectations of doctor

Integration Statement
(pull the entire story together, relating the problems and experience of illness to the person's life situation.)

Management of Problems 1 and 2
-explaining the diagnosis
-exploring management options
-further visits/tests
-community resources

Finding Common Ground
-encouraging discussions, feedback, check for understanding and agreement, ask for questions.
The Patient-Centered Clinical Method
The four interactive components of the patient-centered process

1. Exploring Health, Disease, and the Illness Experience
   ➢ Unique perceptions and experience of health (meaning and aspirations)
   ➢ History, physical, lab
   ➢ Dimensions of the illness experience (feelings, ideas, effects on function and expectations).

2. Understanding the Whole Person:
   ➢ The person (e.g., life history, personal and developmental issues)
   ➢ The proximal context (e.g., family, employment, social support)
   ➢ The distal context (e.g., culture, community, ecosystem).

3. Finding Common Ground:
   ➢ Problems and priorities
   ➢ Goals of treatment and/or management
   ➢ Roles of patient and doctor.

4. Enhancing the Patient-Clinician Relationship:
   ➢ Compassion and empathy
   ➢ Power
   ➢ Healing and hope
   ➢ Self-awareness and practical wisdom
   ➢ Transference and countertransference.
PATIENT-CENTERED CLINICAL METHOD

1. Exploring Health, Disease and the Illness Experience
   - Cues & Prompts

2. Understanding the Whole Person
   - Health
   - Disease
   - Illness

3. Finding Common Ground
   - Problems
   - Goals
   - Roles
   - Mutual Decisions

4. Enhancing the patient-clinician relationship

Weaving back and forth

Unique perception and experience of health

The broken part:
- Signs & symptoms
- Abnormal tests

A category

Unique and personal illness experience:
- Feelings
- Ideas
- Function
- Expectation

Personal understanding

To find common ground, the clinician must take into consideration all aspects of the patient-centered clinical method: knowing the patient’s health, disease, and illness experience; appreciating the person and his or her life context; and constantly building on the patient-clinician relationship.
References


