Ram's 8-point Consultation Model

for face-to-face, video and telephone consultations

DESKTOP VERSION - KEEP THIS ONE YOUR DESK – for those familiar with this model

In a 12-min consultation: watch for minute 6. When that arrives, tell yourself that you have ONE minute to close Data Gathering. Then move on to Clinical Management (CM) at 7 minutes. Otherwise you will run out of time. Mental Health issues require longer – perhaps move onto CM at 8 mins stage.

8 point mnemonic: O-HPE DIM-F

DO NOT FORGET YOUR INTER-PERSONAL SKILLS (IPS)

SMILE ☺	QUICK NOTES
A. INITIATION (OSA)	
1. Opening, Screening, Agenda-setting* **OSA**	• Opening statement • Screening • Set the Agenda
B. DATA GATHERING (HPI)	
2. Clinical History & Story* **H**	• **Natural narrative story** (golden minute) • **Clinical History** • **Red flags** • **Lifestyle factors** - alcohol, drugs, smoking • **Follow curiosity, Explore vague areas**
3. PSO & ICE **PI**	• PSO first = Psycho-Social-Occupational • ICE after = Ideas, Concerns, Expectations (often I and E is enough) *Sometimes PSO & ICE more appropriate to do BEFORE detailed history taking. Other times more appropriate NOT to do it so early. Listen to story, you decide.*
C. CLINICAL EXAMINATION (wrap up between minutes 6-7 of the consultation)	
4. Examination **E**	If F2F • physically examine If telephone • Would a **brief visual look** help? • Remember, you can do some Ex over phone e.g. does patient sound SOB, in severe pain? • Other Ex too complex to do over phone. If video • **Cast eye** over • **MSK examinations** - ask them to mirror you • *(make sure patient in a private place)*
D. EXPLANATION & PLANNING (DIM) (should start at minute 7 of the consultation)	
5. Working Diagnosis & Differentials **D**	• **Verbalise working diagnosis** +/- **other possibilities** • **Integrate ICE and PSO** where possible.
6. Investigations (= further clinical examination + tests) **I**	• If a telephone consultation - bring in for **further clinical examination**? • **Blood tests**? **X-rays**? **Scans** - CT/USS/DEXA? Other
7. Shared Management plan* **M**	Explain **rationale** for… • **Medicines** - name of drug, doses, typical side effects. • **Referrals** - why, who and when. • **Other** - leaflets, internet resources, other people • **Use patient's ICE & PSO** where relevant.
E. CLOSURE (F&S)	
8. Follow Up & Safety-Netting **F&S**	Safety Net (Ram's EDF) • What you **Expect** to happen • Explain what would be a **Deviation** from Norm • **Follow Up** - when, who, how

*red asterisk areas indicated areas more difficult in a telephone consultation compare to face-to-face.

Any improvements? Let me know. Dr Ramesh Mehay, rameshmehay@googlemail.com, www.bradfordvts.co.uk, original Oct 2020, v4 July 2023.
Many thanks to Dr Lucy Clarke for some wonderful suggestions highlighting key areas of difficulty in telephone compared to f2f (red asterisk)

Ram's 8-point Consultation Model

for face-to-face, video and telephone consultations

SUMMARISED VERSION - with brief notes – for those semi familiar with this model

In a 12-min consultation: watch for minute 6. When that arrives, tell yourself that you have ONE minute to close Data Gathering. Then move on to Clinical Management (CM) at 7 minutes. Otherwise you will run out of time. Mental Health issues require longer – perhaps move onto CM at 8 mins stage.

8 point mnemonic: O-HPE DIM-F

DO NOT FORGET YOUR INTER-PERSONAL SKILLS (IPS)

SMILE ☺	QUICK NOTES	
A. INITIATION (OSA)		
1. Opening, Screening, Agenda-setting* **OSA**	*Things you need to do…* • **Opening** statement • **Screening** • Set the **Agenda**	*Skills you use…* • **R**apport • **L**isten **REMEMBER TO SMILE**
B. DATA GATHERING (HPI)		
2. Clinical History & Story* **H**	*Things you need to do…* • **Natural narrative story (Golden Minute)** • **Clinical History** • **Red flags** • **Lifestyle factors** - alcohol, drugs, smoking	*Skills you use…* Observe the following points… • **Open questions** • Explore **vague areas**. • Follow **curiosity**
3. PSO & ICE **PI**	*Things you need to do…* • PSO = Psycho-Social-Occupational • ICE = Ideas, Concerns, Expectations (often I and E is enough) *Sometimes PSO & ICE more appropriate to do BEFORE detailed history taking. Other times more appropriate NOT to do it so early. Listen to story, you decide.*	*Skills you use…* • **PSO come naturally first, ICE after**. • **Listen** to the responses carefully. • **Clarify** vague areas. • Pick up on **cues** (verbal + NV). Follow **curiosity.** • **Verbalise** or show that you understand their perspective
C. CLINICAL EXAMINATION (wrap up between minutes 6-7 of the consultation)		
4. Examination **E**	If F2F • physically examine	If telephone • Would a **brief visual look** help? If so, at the end → switch to video to cast a quick eye. • Remember, you can do some Ex over phone e.g. does patient sound SOB, in severe pain? • Other Ex too complex to do over phone.
		If video • **Cast eye** over • **MSK examinations -** ask them to mirror you • *(make sure patient in a private place)*
D. EXPLANATION & PLANNING (DIM) (should start at minute 7 of the consultation)		
5. Working Diagnosis & Differentials **D**	*Things you need to do…* • **Verbalise working diagnosis** +/- **other possibilities** • **Integrate ICE and PSO** where possible.	*Skills you use…* • **Language clear.** • Keep **concepts simple.**
6. Investigations (further examination & tests) **I**	*Things you need to do…* • If a telephone consultation - bring in for **further clinical examination**? • **Blood tests**? • **X-rays**? • **Scans** - CT/USS/DEXA? Other	*Skills you use…* • **Verbalise** your thinking around **examination & tests** - **describe precisely** what you recommend and why. • **Language clear.** • Keep **concepts simple.**
7. Shared Management plan* **M**	*Things you need to do…* Explain **rationale** for… • **Medicines** - name of drug, doses, typical side effects. • **Referrals** - why, who and when. • **Other** - leaflets, internet resources, other people • **Use patient's ICE & PSO** where relevant.	*Skills you use…* • **Language clear.** • Keep **concepts simple.** • **Shared plan or negotiate.** • **Patient understands + is happy?** • **Watch for cues of disgruntlement** - stop and explore.
E. CLOSURE (F&S)		
8. Follow Up & Safety-Netting **F&S**	*Things you need to do…* Safety Net (Ram's EDF) • What you **Expect** to happen • Explain what would be a **Deviation** from Norm • **Follow Up** - when, who, how	*Skills you use…* • **Safety net** against the serious stuff in a **balanced way** – do not to worry the patient **unnecessarily**.

*red asterisk areas indicated areas more difficult in a telephone consultation compare to face-to-face.

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DETAILED VERSION – with detailed notes for beginners

*red asterisk areas indicated areas more difficult in a telephone consultation compare to face-to-face.

SMILE

1. Opening, Screening, Agenda-setting*

Skills you need to use…

- **R**apport - start building rapport right from the beginning. It's more difficult on the phone than face-to-face. Use the **patient's name** – it's powerful. Adjust the **tone** of your voice to one that is calm, kind and inviting.
- **L**istening is so crucial. Allow the patient to tell their story uninterrupted if possible. Think about the Golden Minute.

Things you need to do or say…

- **Opening**- Open and engage with **phrases that are warm and kind** e.g. "Are you okay to talk?", "And what is it you would like to talk about", "Okay, let's see how I can help you, but before we do would you mind telling me about…". And if you **smile** as you talk,even though the patient cannot see your smile, you phrases are more likely to come out in a kind and caring way.
- **Screening** - can be useful to screen for other problems the patient might want to talk about.
- Set the **A**genda - In a single problem consultation, may not need to do this overtly, but reassure patient you will cover their concerns and expectations. You may need to do this overtly if there are multiple problems - where you negotiate and agree on what to cover in today's consultation.

2. Clinical History & Story*

- Listen - and let the natural **story** unfold first via **open questions**.
- Take a detailed enough history by:
  - Using **open questions** to explore areas of curiosity
  - Use **open questions** to clarify vague areas and areas of uncertainty
  - Using **closed questions** based around the **differentials**. This will also include covering the **red flags.** This will help hone in on your diagnostic differentials.
- Explore **lifestyle factors** that may be influencing the complaint - **alcohol**, **drugs**, **smoking**.

Top Tips

- *As doctors, we often build our assumptions much earlier on the phone. Yet in face-to face consultations, we have all that extra information from our visual scan during the interaction. So, slowwww down! Listen carefully to what the patient is actually saying. You will be surprised at how often we really don't listen to some parts of the consultation as our internal dialogue hijacks the arena! One way to help you listen more is to actively mirror and echo words – repeat patient statements or paraphrasing them which in turn will tell the patient they have been properly heard and tell us that we have properly listened.*
- *Some doctors are good at using mild jokes in the f2f consultation to lighten the mood. Try not to use jokes in telephone consultations – they often misfire.*

3. PSO & ICE

PSO = Psycho-Social-Occupational	&	ICE = Ideas, Concerns, Expectations
Explore **Their thoughts** about..		Explore the **Effect of the problem** on their
– What is going on		– Social life
– What are their concerns, fears or worries		– Working life
– What are they hoping you might do		– Mental state

- **Listen** to the responses carefully. **Clarify** vague areas. Pick up on **cues** (verbal + NV). Follow your **curiosity.**
- **Verbalise** or show that you understand their perspective: *"Oh I see", "Goodness me", "How awful", "So if I have heard you correctly, what you are saying is.."*
- **PSO first, ICE after** - it is more natural to explore the PSO first before the ICE.
- **Which first - Clinical History or PSO/ICE?** *Sometimes PSO & ICE appropriate to do before detailed history taking (i.e. shortly after opening statement). Especially if it is clear the PCO and ICE is part of the natural story telling. Other times it is more appropriate NOT TO DO IT SO EARLY (as some patients only divulge after good rapport built) - in which case, do it after Story-telling & History-taking. Listen to story, you decide.*

4. Examination

- If you are doing a telephone consultation, would it be easier and safer to **cast an eye** over the patient? Sometimes you level of worry can be set to the right level by simply glancing over the patient. Decide for yourself - would a **brief look** help? If so, switch at end to video consultation? Or from that point, convert to a video consultation?
- Anything that you can do to **HELP you with your diagnosis**? If doing examination, **must be proficient.** Don't just do it because you think it will please the RCA examiners. Do it because you feel it is **clinically indicated and it is possible to do competently over the video/phone.**
- If not, bring in – step 6, but before you do, is there anything worthwhile just doing now?

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5. Working Diagnosis & Differentials

- **Verbalise** working diagnosis: *"What I think is going on here is.."*
- May need to verbalise **other possibilities:** *"There are several things this could be"*
- **Keep language clear. Keep concepts simple.**
- **Use info from ICE and PSO** where possible. If you don't agree with the patients ICE - explain your rationale: *"I know you're worried about these headaches being a brain cancer, but I'm quite certain they're not. Let me explain why. You see, in a brain cancer you would get x,y and z, and you have not been getting those have you. But in a tension headache, you would get a, b and c - and that is exactly what you're experiencing. Does that help?"*
- Explain whether you agree with the patient's diagnosis or not - and why.
- *Sometimes you can only talk about working diagnosis after an Examination (step 5 below).*

6. Investigations (further examination & tests)

- If telephone, do you need to bring the patient in for **further clinical examination** (Ex) – only if necessary.
- **Blood tests**? **X-rays**? **Scans** - CT/USS/DEXA? **Other**
- **Verbalise** your thinking around **examination & tests** - **describe precisely** what you recommend and why.
- **Language clear.** Keep **concepts simple.**
- Don't do tests and examinations just because you can. You are being tested on your decision-making skills. Do what is appropriate to do. Do not be wasteful (especially with ordering tests). Yes, different GPs often do different things - but what they all have in common is that they can JUSTIFY why they chose various tests. They don't do them just because they can. The NHS only has limited resources.

7. Shared Management plan*

- Does a SHARED management plan ever happen on the phone effectively?
- It's so much easier for us to shut patients down and become doctor centred on the phone. And unfortunately, that is what happens most of the time.
- Read these two columns to get an idea about how to make it more shared...

Explain your **rationale** for...

- **Medicines** - name of drug, doses, typical side effects.
- **Referrals** - why, who and when.
- **Other** - leaflets, internet resources, other people

Language clear. Keep **concepts simple.**

- **Use patient's ICE & PSO** where relevant.
- Develop a **shared plan or negotiate.** Alter plan to patient desires **IF YOU FEEL** CLINICALLY REASONABLE to do so.
- **Patient understands + is happy?** Ask yourself – has the patient any idea of what I am on about? Are we on the same page? Remember, different patients have differing levels of home and outside distractions. They also have differing educational abilities. Therefore the quality of understanding will vary from patient to patient, and you need to amend and tailor what you say so that it is matched up to the level of the patient before you. Generic phrasing and scripts will not work for all patients. And therefore, to do this effectively, one must first listen and analyse the patient as they tell their story and interact with you. The first half of the consultation will tell you how to 'frame' the second half for the specific patient sat in front of you.
- **Watch for cues of disgruntlement**
- Stop and explore.
- Just even being aware that the patient might not have fully understood or is not happy is a start!
- Sometimes patients are not happy but accepting of what you say - and that's okay too. But patient's on the whole should not be leaving unhappy and angry with you. If that is a frequent occurrence – then it says more about your skills than the personality of the patient. Please reflect.

8. Follow Up & Safety-Netting

Follow-Up: when will you want to see the patient again. Don't say 2-3 weeks' time; which is it? 2 or 3? Decide.
Safety Net (Ram's EDF)

- Explain what you **Expect** to happen?
- Explain what would indicate a **Deviation** from Norm
- Provide details about **Follow-Up** - when to contact for more advice, who to contact, how to contact them.

Safety net against the serious stuff - but in a **balanced way** - do not worry the patient unnecessarily just because you want to cover your back medico-legally. But do not falsely reassure either. **As a general 'light' rule, the level of worry you genuinely feel inside of you is the level of worry to portray.**

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