Ram's 8-point RCA Telephone & Video Consultation Model

SIMPLIFIED VERSON - KEEP THIS ONE YOUR DESK

INTER-PERSONAL SKILLS (IPS) | DATA GATHERING (DG) | CLINICAL MANAGEMENT (CM)

SMILE 😊	CALG-CAMB.	QUICK NOTES
1. OPENING (ROLA) **REMEMBER TO SMILE** — **O**	**INITIA-TING**	• Rapport • Opening • Listen • Set the Agenda
2. The Story & Clinical History — **SH**	**GATHERING INFORMATION**	• Natural story • Open questions • Explore vague areas. Follow curiosity • Natural Clinical History taking • Red flags • Lifestyle factors - alcohol, drugs, smoking
3. PSO & ICE — **PI**		PSO = Psycho-Social-Occupational + IE = Ideas, Concerns, Expectations • PSO 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 *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*
4. Preliminary Examination **WRAP UP BETWEEN 6 → 7 min** (add 1 minute for those with extended time) — **E**	**EXAM-INATION**	• Cast eye over the patient? • Would a brief look help? • Anything that you can do to HELP you with your diagnosis? • If not, bring in – step 6, but before you do, is there anything worthwhile just doing now?
5. Working Diagnosis & Differentials **START @MINUTE 7** (add 1 minute for those with extended time) — **D**	**EXPLANATION & PLANNING**	• Verbalise working diagnosis. • +/- Verbalise other possibilities • Integrate ICE and PSO where possible. • Language clear. Keep concepts simple.
6. Further Examination & Tests — **ET**		• Bring in for further clinical examination (Ex) - 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.
7. 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 Language clear. Keep concepts simple. • Use patient's ICE & PSO where relevant. • Shared plan or negotiate. • Patient understands + is happy? • Watch for cues of disgruntlement - stop and explore.
8. Follow Up & Safety-Netting — **FS**	**CLOSURE**	When will you see them next (FU) Safety Net (Ram's EDF) • Expect to happen • Deviation from Norm • FU - when, who, how Safety net against the serious stuff in a balanced way - not to worry the patient unnecessarily.

For those on 10-min consultations: the only time you have to watch for is minute 5. When that arrives, you have ONE minute to close Data Gathering and move onto Clinical Management. Those on 12-min consultations: the time you watch for is minute 6.

Any improvements? Let me know.

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Ram's 8-point RCA Telephone & Video Consultation Model

DETAILED VERSION - FOR YOU TO STUDY & LEARN

INTER-PERSONAL SKILLS (IPS)

DATA GATHERING (DG)

SMILE

1. OPENING (ROLA)

REMEMBER TO SMILE

- Rapport - start building rapport right from the beginning.
- Opening- allow patient to tell story uninterrupted if possible (c.f. Golden Minute).
- Listen is so crucial.
- Set the Agenda - 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.
- Screening - can be useful to screen for other problems the patient might want to talk about. But don't do it for the RCA exam - you will run out of time.

2. The Story & Clinical History

- Listen - and let the natural **story** unfold first via **open questions**.
- Integrate with **clinical history** taking **open questions**.
- Then move to **closed questions** around **differentials**. This will also include covering the **red flags**
- **Clarify** vague areas. Explores areas of **curiosity**
- Explore **lifestyle factors** that may be influencing the complaint - **alcohol**, **drugs**, **smoking**.

3. PSO & ICE

- PSO = Psycho-Social-Occupational & ICE = Ideas, Concerns, Expectations

Explore **Their thoughts** about..
- What is going on
- What are their concerns, fears or worries
- What are they hoping you might do

Explore the **Effect of the problem** on their
- Social life
- Working life
- 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. Preliminary Examination

START WRAPPING UP BETWEEN MINUTE 6 → 7

(add 1 minute for those with extended time)

- **Cast 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?
- 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?

CLINICAL MANAGEMENT (CM)

5. Working diagnosis & Differentials

START @MINUTE 7

(add 1 minute for those with extended time)

- **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. Further Examination & Tests

- Bring in for **further clinical examination** (Ex) - 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. Management plan

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?** Sometimes patients are not happy, and that is okay too.
- **Watch for cues of disgruntlement** - stop and explore.

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.**

Any improvements? Let me know.

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