RDM-p and the Trainee Experiencing Difficulty

The RDM-p model is a *diagnostic* framework to help *guide you* whenever you have a trainee in difficulty. It was developed in 2006 by Tim Norfolk, an independent occupational psychologist working for the National Clinical Assessment Service (NCAS)[*1]. Tim developed this model through his experience with doctors and dentists in difficulty. We are sure you will find this comprehensive guide helpful. We've also quoted snippets from the original published paper which is referenced at the end [2].

[*1] *NCAS is an organisation that promotes patient safety by providing confidential advice and support to the NHS in situations where the performance of doctors and dentists is giving cause for concern.*

Why should you read this document?

- Do you have a trainee currently in difficulty or have had one in the past?
- Didn't really know what to do?
- Did you feel your approach was based on themes based on what others said without really involving the trainee?
- Did you try a different framework and felt it didn't help you?
- Do you want to read about a model developed by someone who deals with trainees in difficulty on a regular basis? (I'm referring to Tim here, not myself)

Well, here's a framework that might just help you. When we have a trainee that is experiencing difficulty or causing difficulty most of us just tend to delve in, make some superficial guesses at the causal factors (often based on themes collated from others) and then spend the rest of our energies trying to fix them: a method which is fundamentally flawed.

So, why look at this model?

There are a number of models out there proposing how you should 'deal' with a trainee in difficulty – like CLMDA[3] for instance. So what's so great about RDM-p?

1. RDM-p makes a specific point of separating performance from the causal/influential factors and in doing so, makes you really tease out distinct and meaningful performance areas of concern.
2. Other models consider a smaller range of causal factors: RDM-p is more comprehensive: it's more methodical and has a deeper structure to it. As a result it gets you to consider not only *causal* factors for underperformance but *influential* factors too.
3. Most other models get you to look at the causal factors as separate entities but in real life, underperformance is a result of several causal factors interacting with each other – the reason why we believe other models are deeply flawed.
4. RDM-p starts off with evidence about the trainee – the remarks from the trainee and others around him/her *based on observed events*. In this way, you're interpretation of

that evidence is more likely to point you towards the difficulty rather than a stab in the dark approach by just going through a template of common areas of difficulty (which is what most of the other models do).

The theoretical basis of the RDM-p model

When you have a trainee with performance concerns, those concerns usually stem from pieces of evidence. Those pieces of evidence might be

- Something **you** have directly observed or noticed – for example, a trainee who doesn't follow up on learning tasks you have set him/her.
- Something **others** have said - reception staff complaining how small the trainee makes them feel, a patient complaining about his/her attitude, your practice manager telling you how they always seem to be half an hour late for work.

For the RDM-p model to work, it's important you collect as much of these *specific* bits of 'evidence' as you can. But what most of us then seem to do at this point is to make a quick judgement in terms of figuring out a cause and then trying to fix the problem. The RDM-p model, however, stops you doing this: it makes you truly define the nature of the performance problem first using a structured approach. In the RDM-p model, these *specific* bits of evidence of concerns can almost always be mapped to <u>one or more</u> of the following *performance* domains.

In their paper, Norfolk et al[2] say:

> *In essence, general practice involves a subtle interaction between three core activities: relationship, diagnostics and management. They could perhaps be visualised as three interlocking 'cogs in the wheel', for which professionalism then provides the essential oil. Within the dynamic interaction between these three areas lies every component of the job, though most attention centres on relationship and diagnostics.*

So, rather than coming to a quick rash judgement about a trainee, RDM-p gets you to map what has been observed and/or said to these four areas (i.e. generalising away from the specific evidence) thus allowing you to identify performance themes and thus the true nature of the performance difficulty.

Once you've teased out the nature of the performance difficulty into these four areas, the model then gets you to explore their *causal* and *influential* factors; again in a structured way (using something called the SKAPE framework - **S**kills, **K**nowledge, **A**ttitudes, **P**ersonal qualities and **E**xternal factors).

To summarise: in this model, three broad activities define the work of a GP (relationship, diagnostics and management) all underpinned by professionalism. Each of these demands a particular knowledge and corresponding skill set (which will be explored in the RDM-p model using the SKAPE framework).

The theoretical basis behind the SKAPE framework

The RDM-p model helps you *first* define whether the trainee has a performance problem with

1. relationships
2. diagnostics (analytical and decision making skills)
3. organising/managing their work, others or themselves
4. professionalism – as in attitude, honesty, integrity or trust.

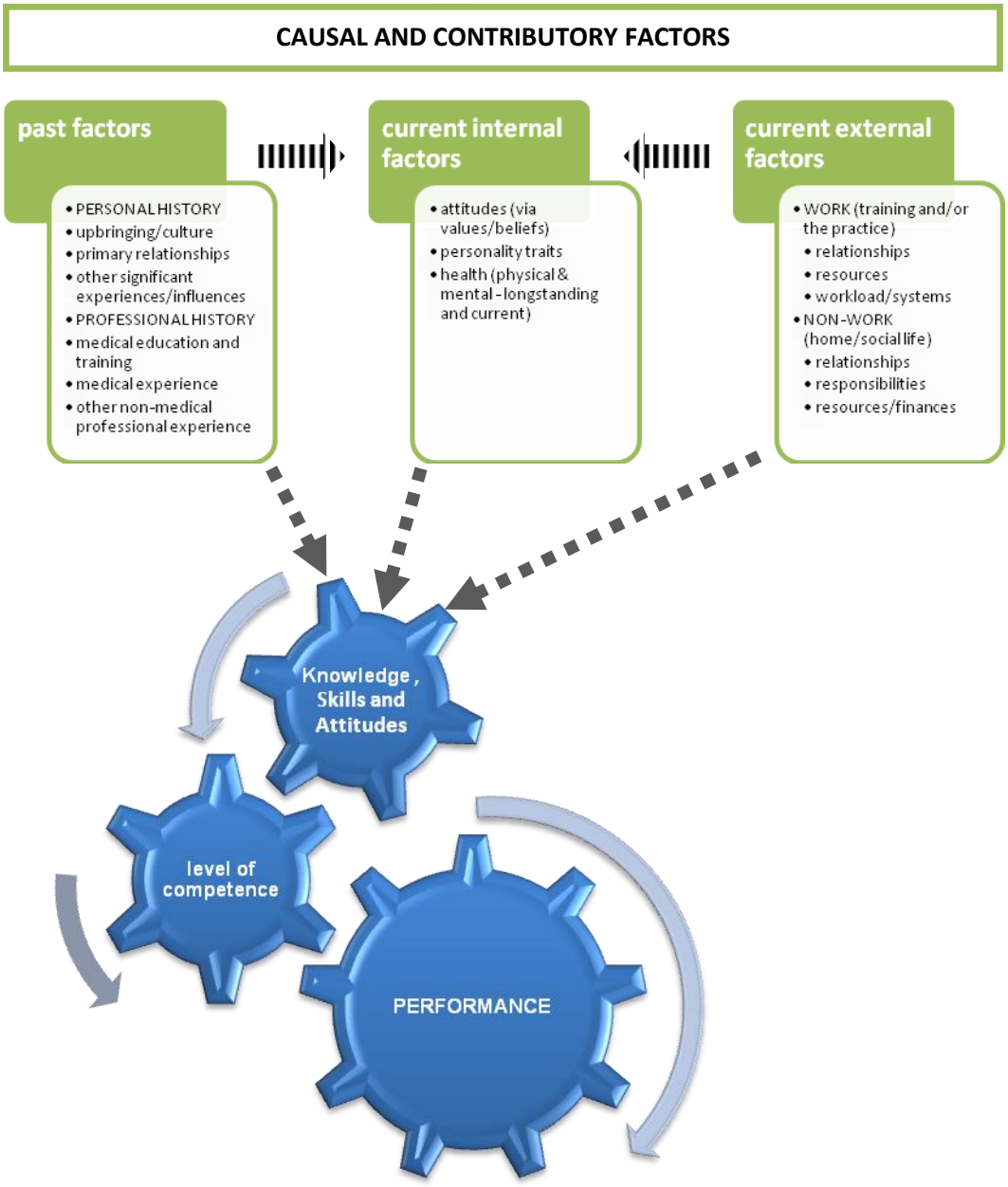
Now that we've defined the nature of the difficulty, we have to figure out what might be *causing* and *influencing* (or maintaining) it. The SKAPE framework will help you with this:

SKAPE defines a set of causal and influential factors which can underlie any of the performance domains – Relationships, Diagnostics, Management and performance.

Look at the diagram below: just concentrate on the blue cogwheels for now and read the following bulleted list in reference to it.

- The knowledge or skills base a trainee has determines their current level of competence. If a trainee's knowledge and/or skills are pretty poor, then they're unlikely to have a high level of competence.
- It's that level of competence that directly determines performance (=R, D, M and p). You cannot perform well if you don't have the competence to do so in the first place!

- When a trainee underperforms, we have a tendency to re-focus on knowledge and skills in order to strengthen these en route to raising aspects of competence and hence improve performance. There's nothing wrong with that – if a trainee lacks knowledge, we need to strengthen it. But the problem is that we tend only to do that and nothing more – and that is only PART of the story.

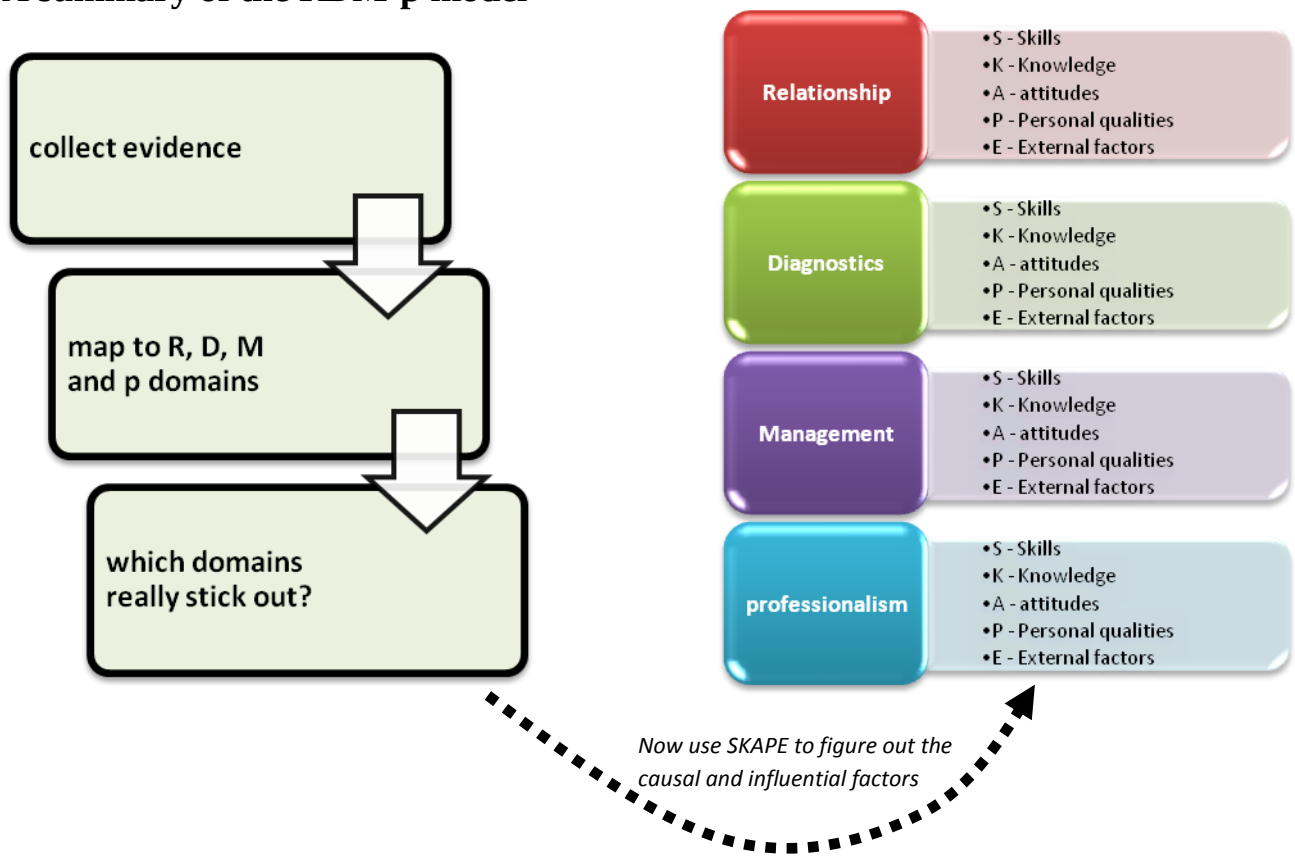


- The other part of the story is illustrated by the green boxes in the diagram above. These influence the knowledge and skills cogwheel and this means we need to consider these too if we want to adopt a truly comprehensive approach.

Dr. Ramesh Mehay (Programme Director, Bradford VTS), March 2010

- And that's the basis for the RDM-p model – to help a trainee experiencing difficulty, once we've defined the performance concerns, we need to explore not only the knowledge and skill set in relation to that performance domain but also any:
    1. **Internal factors** that are acting *within* the trainee – like their attitude, personality, and health.
    2. **External factors** that are interacting *with* the trainee – like work, home or social life related problems.
    3. **Past factors** which may be trickling through in the background – such as the trainee's upbringing, culture, experience from previous jobs (which may be non-medical) and so on.

A summary of the RDM-p model



The SKAPE framework helps you figure out some of the causal and influential factors with more preciseness. As a result, you and your trainee will be in a better position to generate 'remedies' that are more likely to resolve the performance concern.

Dr. Ramesh Mehay (Programme Director, Bradford VTS), March 2010

A little note on ‘personal qualities’ and ‘external factors’

Personal qualities are things that belong to the trainee that maybe contributing to the problem(s). We don’t just mean personality traits; it also includes things like the way they have been brought up and their culture. Be careful when using personality questionnaires to assess personality traits; they just measure general tendencies and they are difficult to apply when the social circumstances of an individual have changed or become unstable. In this context, they become difficult to use as a reference point.

External or rogue factors are unusual factors contributing to the problem: for example, a single mum trying to cope with two little ones and yet trying to stay on top of being a full time GP trainee.

Dr. Ramesh Mehay (Programme Director, Bradford VTS), March 2010

But what does each of the RDM-p domains actually mean?

Relationship

This examines whether there are any issues in the relationship between the trainee and others (others being the patient, colleagues, staff, practice, hospital, colleagues and so on).

Signs & Symptoms of a **relationship** domain performance concern:

- Communication and consulting skills – like a lack of empathy, not adapting language and style to the circumstance nor picking up and responding to verbal and nonverbal, poor negotiating skills and so on.
- Working with colleagues and in teams – not working in a team could be due to communication skills as listed above but in addition might also say something about leadership skills (encouraging or persuading people/patients to respond willingly or positively to one's decisions or suggestions).

Diagnostics

This is where the *process* of *making a decision* is problematic. It doesn't only refer to making a diagnosis: it could be difficulties in making a decision for patients, colleagues, the practice, the hospital or oneself! For example, a trainee may have a problem in the diagnostics domain if he or she delays seeking medical treatment or advice when their own performance or health is down (the problem in this case is in making a decision for oneself).

Signs & Symptoms of a **diagnostic** domain performance concern:

- Data gathering and interpretation in search of optimal decision making (whether for patients, colleagues, other staff or oneself)
- Analytical skills – once data has been gathered, they're finding it difficult to prioritise it in terms of relevance or significance or they may be finding it difficult to offer alternative options, suggestions or explanations.
- Decision making skills – you know it's this one if the trainee has a difficulty in reaching that pivotal point (imagine the peak of a triangle) where a decision has to be made; where they are unable to draw together prioritised information in such a way that is clear, rational and defensible. For example, many of you might think something like procrastination is a management problem when in fact it is a diagnostic one because procrastination is difficult in DECIDING (or PRIORITISING) whether and when to do something (although you have the time). Other examples include: not knowing when to treat, to refer, to wait and see etc.
- Examination and technical skills – not conducting examinations and tests (including medical instruments) in an appropriate manner; for example, someone who blindly orders all tests under the sun.

In their paper, Norfolk et al[2] say the following about relationship and diagnostics:

> *One of these activities is clearly internal (diagnostics), the other is external (relationship); together they determine the quality of much of our interaction with others at any given moment. For example, dealing effectively with a seemingly anxious or frustrated practice partner requires the same analytical skills, and similar communication skills, to dealing with a seemingly anxious or frustrated patient. We may have very different roles in the two conversations, which may demand adjustments in style and emphasis, but the basic skills are the same.*

Management

We're all used to the term management in medicine: for example, the (clinical) management of COPD usually makes us think of the stepwise approach to managing COPD involving long acting B2 agonists, steroids and so on. However, its meaning in the RDM-p model is different to this conventional medical way. In RDM-p it is used in a more general sense: the wider handling of one's professional responsibilities to not only patients but to colleagues AND oneself. It's about the administrative and organisational side of things and not the clinical protocol.

Signs & Symptoms of a **management** domain performance concern:

- Managing particular events – for example if a trainee finds it difficult to structure the consultation, manage their referral letters or pace a meeting.
- Managing comprehensive/ongoing events – like not maintaining adequate records after home visits, not keeping on top of one's other roles within the practice, not keeping up with information management and technology and so on
- Managing relationships – not being able to provide continuity of care or being unable to monitor or improve one's interaction with colleagues.
- Managing oneself – being unable to monitor and maintain one's own performance, learning and development, not being able to manage one's work-life balance (mental health), and not keeping on top of one's physical health or well being (e.g. no longer playing squash because they're too busy, failing regular scheduled health appointments etc.)

If a trainee is unhappy with their work-life balance, that's a management problem because they are essentially unable to organise themselves. If a trainee's health deteriorates as a result but they're not seeking help, that inability to track one's own performance/health also points to a management issue.

Let's say a trainee has difficulty in the clinical management of patients. Would that be a management issue or a diagnostics one? What do you think?

Answer: actually it could be either. If it is 'systems' related issue (e.g. organising a referral) the difficulty is management. If it is a decision making problem such as prioritising a hierarchical set of treatments, the problem relates to diagnostics (a problem in *deciding* which order to put things in). Remember, diagnostics is about a problem in making that *final decision*. Management is more about *processes* and *structure*. I hope this illustrates the need to gather more information rather than jumping to conclusions and categorising evidence too hastily.

In their Norfolk et al[2], they say:

> *'Management', in this sense, describes an ongoing process, for example providing clear structure within the consultation, pacing a surgery, organising one's time to balance visits alongside surgery and paperwork, monitoring one's own performance levels and health and so on.*
>
> *The use of the term 'management' in this way to suggest an ongoing responsibility for applying diagnostic and relationship skills (as also implied by the term 'manager'), can be and is widely understood and applied.*
>
> *Management here is the ongoing process across all stages of the consultation, where the doctor aims to structure or organise events so that a patient, however complex the presentation, can be dealt with efficiently and effectively within a given timeframe. The same would apply to managing one's thinking and decision-making through the course of a practice meeting, or managing one's work load on a specific day - thus, many individual diagnostic assessments being made at various points, and the process needing to be managed through efficient planning, organisation, structure and pace.*

Professionalism

Professionalism includes things like honesty, integrity and trust. It's also about altruism (an unselfish concern for the welfare of others; selflessness). In more concrete terms, this translates to **(a)** having respect for people, **(b)** maintaining an ethical approach to practice AND **(c)** having respect for your contractual responsibilities. Your contractual responsibilities essentially boil down to: relationships, diagnostics and management. Therefore, a respect of for contractual responsibilities inevitably implies a respect for relationships, for due process in gathering and analysing information (diagnostics) and for ongoing responsibilities (management).

If one cannot answer the question *'Am I doing what I should be doing'* in the affirmative, then there is a problem in the professionalism domain. Let's say you're doing a Friday afternoon surgery and you're running a little late. Professionalism is where you continue to do what is necessary for patients despite feeling pressurised, rushed and flustered: in essence, showing a

respect for the process. A problem in the professionalism domain usually boils down to an attitudinal problem that may stem from the person's core values and/or personal code of ethics.

Signs & Symptoms of a **professionalism** concern:

- Respect for others – not showing respect for patients, colleagues, staff and others; for instance by being judgemental or not treating them equally.
- Respect for their own position – not acting within one's professional roles/boundaries, not appreciating the effect of one's behaviour/actions on others, not minimising risk (e.g. where one's own health might compromise someone else's safety).
- Respect for protocol – this isn't just about failing to following clinical guidelines or local initiatives/policies but also about not adhering to established professional codes of practice. Not doing referral letters in a timely way is clearly a management issue but also shows a lack of respect to its importance (that lack of respect for process/protocol = professionalism issue).

Norfolk et al[2] say:

What then determines much of the quality of the application of these skills is the 'professionalism' that underpins them - defined here, in line with the profession's typical emphasis, as commitment to and respect for, best practice.

... 'a personal and professional obligation to strive for excellence, humanism, accountability and altruism'.

... 'the professionalism is not defined by the behaviour, but the effort or commitment made in search of best practice in each given situation or context'.

We are speaking therefore professionalism as a purposeful attitude, a positive and deliberate way of viewing or approaching one's work that will maximise the possibility of performing competently or better, whether in relationship with this or when working along. Based essentially on this notion of respect for best practice, the quality of an individual GP's professionalism therefore depends on the value they attach to the various aspects of their job.

Put simply, if the professional value attached to any individual activity is insufficient, then the energy levels and attention to detail required to ensure that activity can be performed effectively will also be weakened, and the quality of performance will very often suffer.

Another Summary:

Norfolk et al[2] summarise by saying:

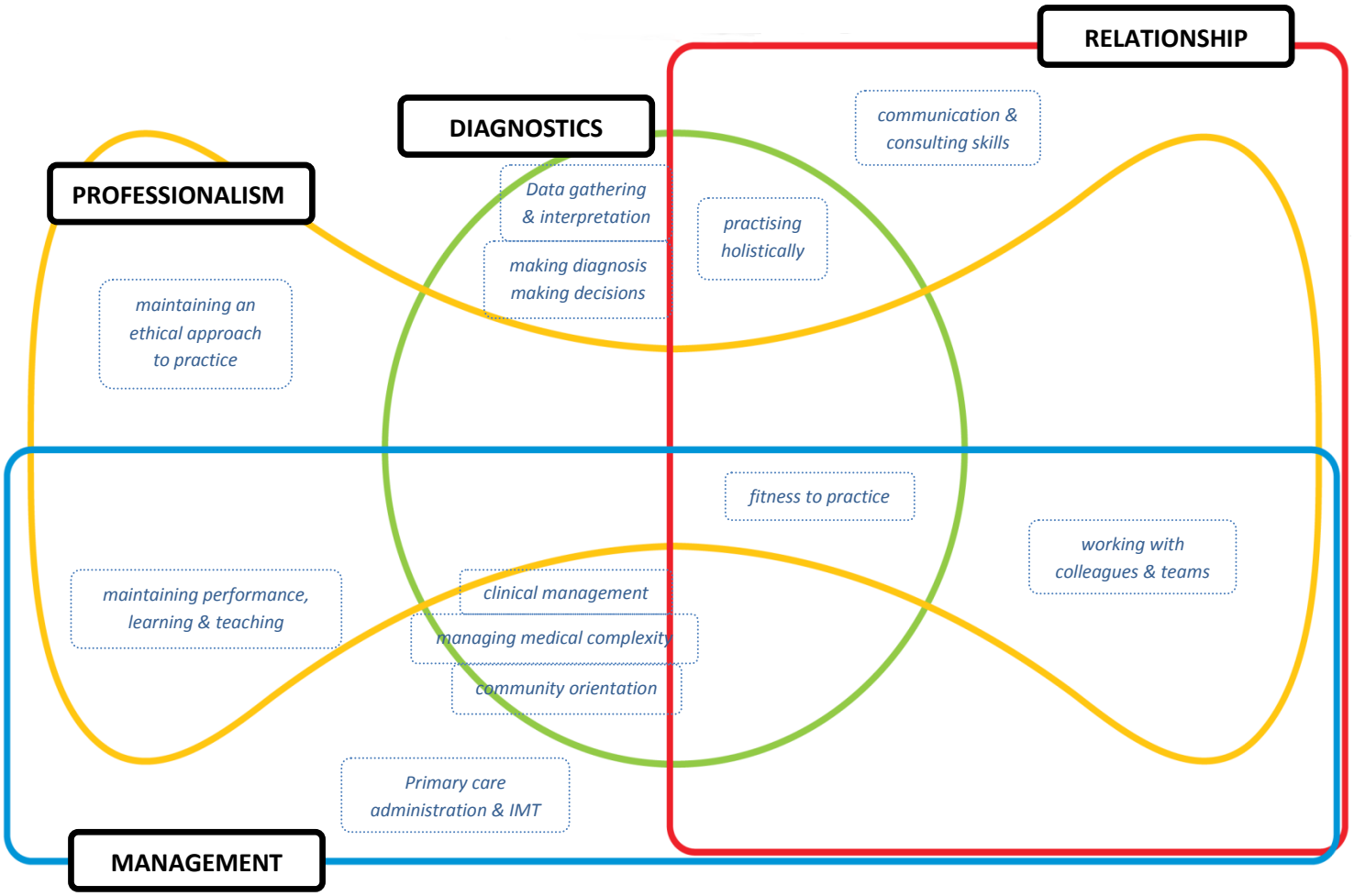
> *The four components of RDM-p together map the essence of any service profession:*
>
> 1. ***relate** to someone,*
> 2. ***diagnose** their needs,*
> 3. ***manage** the process and*
> 4. *at all times ensure you **act professionally**.*
>
> *The difference between general practice and many other services is that to be a 'competent' GP, all four elements need to be demonstrated at high levels.*

Dr. Ramesh Mehay (Programme Director, Bradford VTS), March 2010

How nMRCGP fits in with RDM-p

The nMRCGP defines12 competency domains all trainees must achieve before they can get their certification of competed training (CCT). The diagram below illustrates where each of these lie in relation to the RDM-p framework. First of all: please don't let this diagram scare you. It's a special kind of Venn diagram called an Edwards' diagram and is as easy to understand once you become a little more familiar with it. There are natural overlaps between all RDM-p performance areas. Venn diagrams are good for visually representing *3 or less intersecting data sets* BUT RDM-p has 4 (R, D, M and p). It's impossible to create a Venn diagram of four intersecting circles where each possible overlap of R, D, M and p are catered for. Don't believe me? Have a go... remember, for 4 data sets there are 15 possible permutations.

The Edwards' diagram below is a natural and intuitive way of displaying all the overlaps and it's quite visually pleasing too. Edwards figured this out after looking at a tennis ball (the yellow pattern and green circle should've given you a hint). It's basically an enhanced version of a Venn diagram. Venn himself pulled his hair out in trying to get four neat circles to do the same thing. The purpose of this diagram is to give you an 'at a glance' map view of where things lie and their relationship to one another (thus helping you interpret the data).



Dr. Ramesh Mehay (Programme Director, Bradford VTS), March 2010

So, why are we showing you this diagram?

1. First and foremost: because we want you to get used to it. We will be referring to it again later on.
2. Secondly because we want you to see how the 12 competency domains of nMRCGP relate to each other and the RDM-p domains.
3. Finally: because it's sometimes useful to revisit this diagram - for instance, a colleague might say to you *'I thought I should let you know that after several surgery debriefs, I've got some concerns about Alan's clinical management of patients'.* Your first thoughts might be that Alan's knowledge is pretty poor and that you need to work on that. But look at the diagram above and see where 'clinical management' lies. This should make you realise that Alan's problem could also be
    a) a diagnostics issue - he finds it difficult to come to a decision or does not gathering enough data to do so, or
    b) a management problem - he's got a lot of pressure at home and is finding it difficult to MANAGE his life and thus fit in time for personal reading and learning.

We also hope you've noticed that:

- **Relationship** and **Diagnostics** is what happens at the coal face in general practice
- **Management** helps to make that coal face happen

Are you still with us? If not, now would be a good time for a cup of tea and a slice of cake…then we'll come back to putting RDM-p into practice.

Dr. Ramesh Mehay (Programme Director, Bradford VTS), March 2010

RDM-p in practice: *instructions*

1. Collect evidence from a number of different people (including the trainee) like:
    - **Verbal statements:**
      A receptionist might say *'he's always late for his surgeries and even does his home visits very late... patient's ring up wondering where he is'*.
      Another doctor might say *'patients come out asking whether he's always grumpy like that'*.
    - **Written statements:** a patient complaint for instance or more formally via multi source feedback (encourage the trainee to do this if not already done).
    - **Things you have noticed**: this may be knowledge, skills or attitudes. Record the specifics of the event that gave cause for concern.
    - **Things the trainee has acknowledged themself** that they have a difficulty with.

    Don't do anything with this evidence just yet – simply collect it. Write each piece of evidence on a separate line.

2. Examine each piece of evidence (or statement) and figure out which of the four RDM-p domains it *possibly* relates to. Remember: it might be more than one of the four areas (which is usually the case).

    Mark the statement with one or more of the letters R, D, M or p. Put a '+' sign next to it if it is a positive indicator of that domain (i.e. positive feedback) and a '-' if a negative one (i.e. a criticism). Put a domain in brackets if you think the evidence is possibly a *weak* (positive or negative) indicator of it.

    For example:

M- p-	*'receptionists have said that he's always late for his surgeries and even does his home visits very late – patients ring up wondering where he is'*
R- D+ M- p-	*'some of the doctors have said that although he's good at diagnosis and making decisions, some patients have asked them whether he's always grumpy'*

    Quick Tip:
    - Actually, I *only* mark the positive ones with a plus sign and assume everything without a '+' is a negative: looks less messy and is easier to delineate/digest the positive from the negative.
    - Don't worry for now why I've put 'p-' for the first example and 'M- p-' for the second. The worked example at the end of this chapter will make the whole mapping process a lot more clearer.

3. Step back and review your collated evidence as a whole and the RDM-p areas you have linked them to. Which of the four areas dominate? Mapping it out on an Edwards' diagram will make it easier to interpret the data as a whole.

4. Meet with your trainee. Let them digest what people have written.

5. Using the SKAPE framework (**S**kills, **K**nowledge, **A**ttitudes, **P**ersonal qualities and **E**xternal factors) explore (with the trainee) the factors causing or influencing the performance problems identified in the R, D, M and p domains.

6. Finally discuss ways of making things better. Be specific: talk about ways of dealing with each of the four domains – 'relationship issues might be dealt with via...; diagnostic issues via...; management issues via...; professionalism issues via...'. Try and get the trainee to come up with the suggestions as much as possible. More about the discussion later.

Some key points about the process

The process should parallel the principles of 'good consulting (in essence, it's a similar journey):

1. Person-centred
2. Systematic and thorough
3. Fair and respectful.

Information gathering (the diagnostic phase) maximises the possibility of an accurate differential and working 'diagnosis', which in turn maximises the possibility of shared decision making en route to a functional management plan – understood and owned *sufficiently* by the trainee to suggest (s)he will act on the plan. ***The quality of the outcome is determined by the quality of the input.***

Involve your trainee as much as possible from the start

Make sure your trainee knows in advance about the concerns. Don't engage in a discussion meeting without any prior warning. Let them see in advance the sheet where you have collated all the evidence. Give them some time space to digest and reflect on it.

Involving the trainee as much as possible from start to finish is central to the RDM-p process: just as you would involve a patient in the management of their own problems, you need to involve the trainee too.

Setting the agenda: get the trainee in the right frame of mind

Our aim is to get the trainee into a positive frame of mind that makes them want to explore and make things better. So, before setting any agenda ask the trainee about their *feelings* and explore them. Negative mind sets (a defensive trainee for example) will simply prove to be an obstacle to the rest of the process. Exploring feelings and empathising where appropriate is one way of moving on from negativity.

Another way is to provide a powerful 'hook' for the trainee – showing them what's in it for them (getting them to focus on positive outcomes and therefore a much easier and better future). Remind the trainee of the purpose of the discussion:

'Remember, I'm not here to have a go at you but instead to help you make things better. Imagine in 3 months' time how your working life might be if we managed to fix some of these things? Wouldn't that be great?'
'... but in order for me to help you as best as I can, I need you to be completely open and honest with me, is that okay?'
'Okay, shall we see how we can make life better?'

Structure the discussion in a way that encourages behaviour change
When it comes to the discussion, start by going to one particular event; something real that you can work with like a complaint such as *'he ignored my concerns'*. Be careful though with the interpretation: for example, when somebody says *'he's a poor listener'* there must be somebody this person listens to in their life. Therefore, by definition, they cannot be a poor listener; we need to figure out why it is they are like this at this moment in time; what are the causal and influential factors: that's what RDM-p is all about. The discussion has two purposes:

1. For you and the trainee to accurately build a picture *together* (data gathering).
2. To generate workable solutions are more likely to have impact.

So, get the trainee to talk about each piece of 'evidence' before trying to problem solve it:

1. How does the trainee *feel* about this particular piece of evidence?
2. Tease out specific ***s****kills* to make things better.
3. Try and figure out specific ***k****nowledge* gaps
4. Explore specific ***a****ttitudes* and ***p****ersonal qualities.*
5. Is there a *rogue element*? If so, appreciate ***e****xternal factors* (personal or professional).
6. Get the trainee to suggest ways of making things better (the 'remedies').

Periodically check to see how the trainee is feeling throughout the discussion process. It's important to stick with feelings (and not thoughts) to gauge how responsive they are to the feedback process you are engaged in: '*How are you feeling now?', 'How do you feel about that?'*

And remember to give some positive feedback too – your aim isn't to destroy your trainee; balanced feedback is essential.

Another word of caution: When someone says something about the trainee, bear in mind who is right. Sometimes the evidence might not be the truth. Consider two people A and B. Let's say A thinks B lacks insight. But A might lack insight of B. And sometimes A can be a bully (some consultants can be like this).

A couple of other points:

- It not uncommon for trainers to speak to everyone (e.g. the programme directors, other colleagues and staff) but the trainee experiencing difficulty. The trainee is often the last one to be informed and involved: a sure recipe for disaster. Involve them as early as possible. Share the agenda. Come to a joint plan… and you can't go wrong.
- I hope by now you can see that the *skills* involved in this process are not that dissimilar from consulting with patients. With patients you start by building rapport before going on to tease out the agenda or problem. You gather more and more information from them. You then pick out patterns that make you think of various diagnoses. You share this with your patient, checking out what they think, before finally collaborating together on a plan of how to proceed. If you think you're consultation skills are good, then you have all the skills to help a trainee experiencing difficulty using the RDM-p model. Don't be scared, try it out.

The trainer-trainee relationship

Many trainers and their trainees have a relationship that's not too dissimilar from that of a parent and their child (where the parent tells their child what to do rather than both working together). Do you naturally fall into parent mode by *telling* your trainee (the 'child') what is good, what is bad and what needs to change? Not sure? Well, it's likely the case if your trainee frequently rejects what you have to say *('no I didn't!', 'that's not fair!')* or goes into defensive mode by offering some sort of justification *('I only did that because blah blah blah').*

You can see how this type of relationship is unhelpful in terms of getting the trainee to adopt change. What we need to aim for is an adult – adult relationship: where both you and the trainee have equal status. This enables us to think and determine action for ourselves and when we suggest changes for ourselves, we are more likely to adopt them compared to those offered by someone else. No doubt you can relate to that.

More about the parent-adult-child

The parent-adult-child model discussed above is often referred to as transactional analysis (TA for short) and is detailed in Eric Berne's book *'Games People Play'*[4]. Another good book is *'TA Today : A New Introduction to Transactional Analysis'* by Ian Stewart[5] (although it can be heavy at times).

Transactional analysis basically says that we all possess the following three states but whichever one dominates depends on the circumstances prevailing at the time.

- Parent - this is our ingrained voice of authority, absorbed conditioning, learning and attitudes from when we were young.
- Child - this is our internal reaction and feelings to external events. It is the seeing, hearing, feeling of an emotional body of data within us. When anger or despair dominates reason, the child is in control.
- Adult – we're in this state when we think and determine action for ourselves: the rational state.

The good news is that we can control whichever state we play at any given moment *providing* we pay *conscious* awareness to it. The way other people react to us depends on which state we play. For instance, if you play the parent, the other person is likely to play the child. By consciously going into the adult mode you can encourage others (like the trainee) to respond in an adult way.

If you don't think about the mode you're playing and you simply dive straight in, the gut reaction from the trainee will be a defensive one. Our aim is to get the trainee on board so that we're

both comfortable discussing the issues and we're both signed up to trying to make things better: that can only happen if you promote an adult-adult type relationship.

How to achieve an adult-adult relationship with your trainee

1. **Establish a safe climate**
   And by that we mean an atmosphere that both you and the trainee feel comfortable in and which promotes you both being open and honest with each other. Devoting some time at the beginning to the purpose of the meeting and exploring feelings (like fears) will help achieve this. Don't rush this bit: quality time spent here will serve you well.

2. **'Start LOW, and go SLOW'**
   By LOW we mean initiating the discussion with things that are not likely to evoke a strong *negative* emotional response - usually things to do with professionalism like a poor work attitude. Otherwise, your trainee will bite back! How would you feel if someone told you your core values needed changing? So find an appropriate entry point to the discussion - maybe by starting with one of the other themes instead (**R**elationships, **D**iagnostics or **M**anagemen)t. And then go SLOW: don't rush from one theme to the next. Give each issue the time it deserves. Only start tackling **p**rofessionalism when you feel you have developed enough rapport and the trainee is *positively* engaged.

3. **Build an accurate picture together**
   By collecting evidence from all sides and discussing it.

4. **Don't automatically dive in and suggest a trainee's perception is wrong.**
   For instance, if a trainee feels that all the other partners in the practice are against her don't say *'That's not true because they actually told me they likely you. Therefore let's move onto something else'* or *'I wonder if that's a perception in your mind rather than real?'* You cannot settle a false perception by rashly negating it. What you need to do is to **explore** this further and **go into specifics**:

   - *'What makes you feel that way?'*

   Discussion ensues

   - *'Okay, so at meetings you feel they don't look at you or they don't pay much respect to what you have to say and that makes you feel like you don't matter?'. 'Give me an example of the last time that happened?'*
   - *'That's interesting. Actually, some of the partners have said some really nice comments about you. Would you like to know what they are?'*

   Discussion ensues

   - *'Knowing that now, what are your thoughts and feelings?'*
   - *'So how can we move this forward?'*

5. **Encourage as much reflection and self evaluation by the trainee as possible.**

Rather than telling the trainee what you make of it all, reflect things back to the trainee as much as possible. Get them to come up with conclusions, ideas and solutions. Only butt in when you feel the trainee is struggling to come up with something. See discussion (in italics) above.

6. **Find an appropriate and specific route to change (collaboratively)**
   Using the SKAPE framework, get the trainee to come up with specific suggestions. Plan together and follow the patient centred model you are familiar with:

   - *'So, how can we move this forward?'*
   - *'What changes do you think you could make to help the situation? For instance, are there any skills, knowledge or attitudinal changes that might help?'*
   - *'Okay, so your knowledge isn't as good as it could be because you're finding it difficult to make time for personal study in what seems to be a very busy home schedule. How can we free up time?'*
   - *'That's a good suggestion. Do you think your mother would be willing to help out with the kids giving you a bit more space and time?'*

   I hope you can see from this example how it's important to keep drilling down and down until you come to a suggestion that is specific and realistic rather than open and vague.

How to reduce the risk of a trainee getting into difficulty in the first place

Wouldn't it be great if all your trainees simply didn't have problems and therefore you didn't have to use something like RDM-p? Unfortunately, life's not so sweet: problems and difficulties form part and parcel of the fabric of life itself. But you can avoid the chaos and headache that often results.

Trainers: build in regular scheduled review times with your trainees - perhaps once every 2 months. The advantage of this:

- You work with issues when they arise and not the whole backlash when they have been allowed to develop.
- You work with a few issues at a time rather than a whole bag of them.
- It's easier for the trainee to accept because you're not throwing 101 negative comments at them all at once.
- Most importantly, if you identify and work on issues EARLY, the more time there is to remedy them. Identifying everything at the end leaves no room for manoeuvre.

Programme Directors (PDs): do you have a file for each trainee for any difficulties flagged up through discussions amongst yourselves, trainers, consultants and trainees? It would certainly help gather evidence *early*, notice concerns *early* and identify/work on themes *early*.

Pulling it all together: a worked example to illustrate

Alana is an ST3 trainee, has been at the practice for three months and has another nine months to go. She is experiencing problems at home and you've noticed she seems unhappy and unenthusiastic when at work (for example, not following up on learning plans from tutorials and not having CBDs/COTs prepared for a session you both previously agreed on).

Video reviews show doctor centred consultations and as a result she is getting poor patient feedback and complaints. However, she documents her consultations and deals with paperwork and referrals very well. Having discussed this with her you've also picked up on her difficulty to accept feedback whether it is positive or good. She makes you feel stressed and she feels everyone is against her.

Although she is always punctual she has taken above average sick leave in the last three months alone. In fact she doesn't even inform the senior receptionist about leave until the last minute.

Step 1 – tease out the evidence

From the information paragraphs above, spend 5 minutes teasing out and separating the bits of evidence.

You should have something like this:

- problems at home
- scenes unhappy
- unenthusiastic
- doctor centred consultations
- poor patient feedback
- patient complaints
- find it difficult to receive positive or negative feedback
- above average sick leave
- always punctual
- good documentation
- does not prepare adequately for COT, CBD, tutorials
- does not inform senior receptionist about leave till the last minute
- makes me feel stressed
- generally deals with paperwork and referrals
- feels everyone is against her

Step 2 – map the evidence to R, D, M and p

Instructions:

1. Map each item on your evidence list to the RDM-p domains they *may* be related to.
2. Put a '+' next to a positive marker and a '–' next to negative ones.
3. Use brackets to indicate *weakly* positive or negative indicators of a domain.
4. Write some areas you want to explore further in the last column.
5. Using a table like the one below will help you with this.

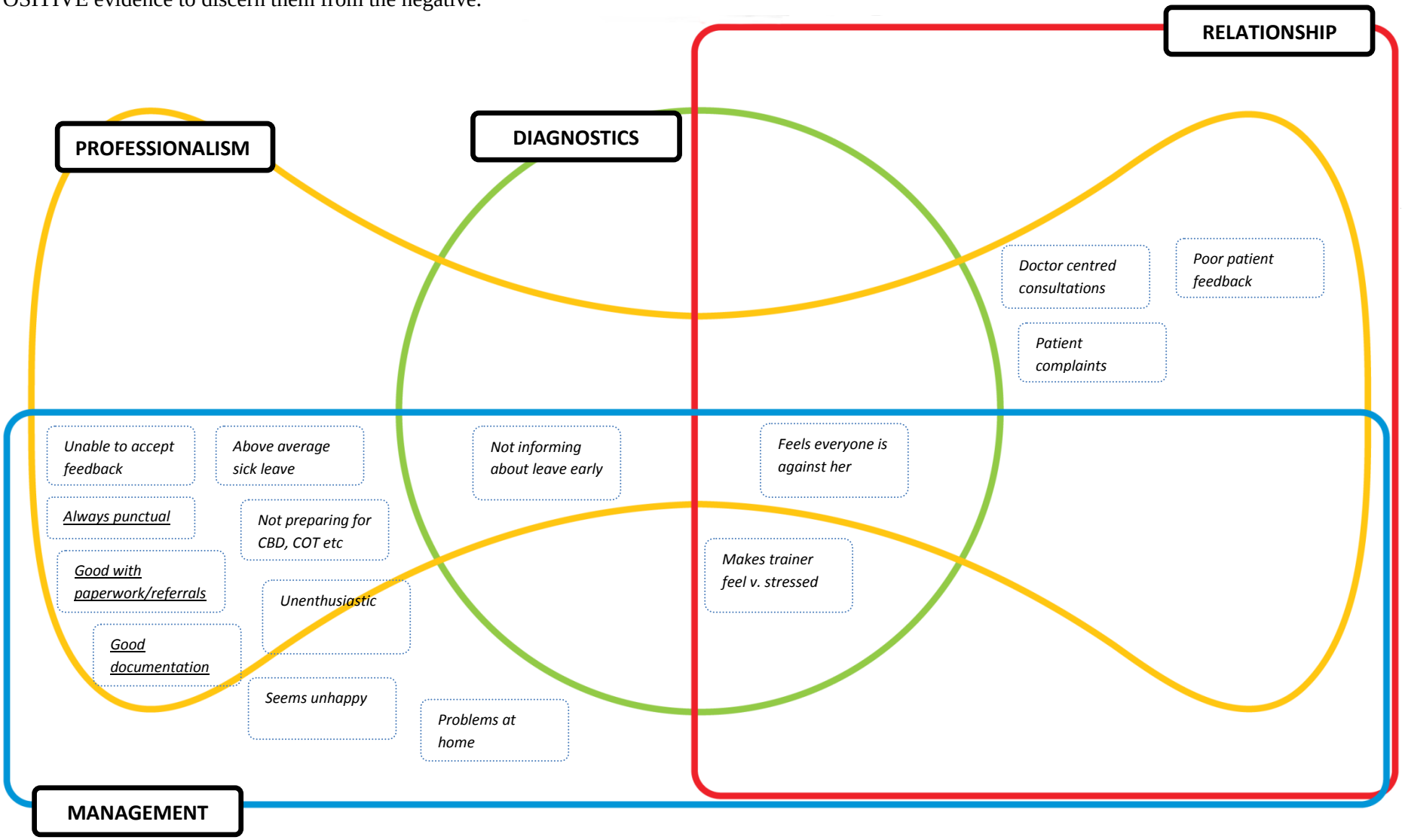
*Quick Tip: Actually, I **only** mark the positive ones with a plus sign and assume everything without a '+' is a negative: looks less messy and is easier to absorb and interpret the overall evidence at a glance. Take a look at the table below and see for yourself.*

RDM-p category	The Evidence	Our reasoning/things we want to explore
M	Problems at home	*Problems at home usually imply a difficulty in **managing** one's life.*
M	Seems unhappy	*Being unhappy usually means being unable to **manage** one's life and health. Maybe they're unable to 'track' their own performance or health issues; an inability to 'track' is a management problem.* *A poor work-life balance almost always leads to unhappiness.*
(M) p	Unenthusiastic	*Someone who appears unenthusiastic about their work which involves dealing with people is clearly unfair to others. It could also mean the doctor has a poor attitude in terms of their approach to work. Both of these are a **professionalism** issue.* *But it could also be a **management** issue – maybe there's so much else going on in their life (at home for instance) that they're stressed. When you're stressed, you're unlikely to show enthusiasm.*
R p	Doctor centred consultations	*A doctor centred consultation says something about the **doctor-patient relationship** and possibly about the attitude of the doctor. Attitude problems always relate to **professionalism**.*
R p	Poor patient feedback and complaints	*Poor patient feedback obviously signals a **relationship** problem with patients.* *It may also indicate that the attitude of the doctor needs to change **(professionalism).***
M p	Find it difficult to receive feedback whether positive or negative	*If a person finds it difficult to accept feedback that's given with good intention, they need to change their thinking and attitudes towards it **(professionalism).** **Management** has been selected because it may be that they don't know what to do with that feedback or maybe that they're finding it difficult to manage other*

		aspects of their life that they feel they don't have 'space' for further feedback.
M p	Above average sick leave	*A doctor who is taking above average sick leave is usually an indication that they're finding it difficult to **manage** other overwhelming aspects of their life.* *If you think a doctor takes sick leave in a 'willy nilly' sort of way, that indicates a lack of consideration for patients and colleagues **(professionalism).***
M+ p+	Always punctual	*A punctual doctor is someone who obviously **manages** their time well.* *It also shows a respect of other people's time in terms of not keeping them waiting **(professionalism).***
M+ p+	Good documentation	*This doctor is **managing** her record keeping very well and respects its importance **(professionalism).***
M p	Does not prepare adequately for COT, CBD, tutorials	*A doctor may not be preparing for tutorials because they are not **managing** their time well at home (being overwhelmed by other things). It might also indicate an underlying attitude problem in reference to their own learning and its importance **(professionalism).***
M D p	Does not inform senior receptionist about leave until the last minute	*Not informing senior reception staff about sick leave until the last minute clearly indicates problems with **managing** time, making a **decision** in a timely way, and the lack of appreciation for others to know early **(professionalism).***
D M R	Makes me feel very stressed	*This is an interesting one: you've got to figure out who's got the problem – is it you (e.g. personalities) or is it genuinely them?* *If the trainee is not aware of how stressed she makes other people feel then this is a **diagnostic** problem. Clearly making someone else feel stressed is a **relationship** problem.* *However, if a trainee could **manage** the overwhelming aspects and problems in their home/working lives, perhaps they wouldn't yield such stress.*
M+ (p+)	Generally deals with paperwork and referrals	*Dealing with paperwork effectively and efficiently means good **management** skills and also respect to its importance **(professionalism).***
D M R p	Feels everyone is against her	*This one fits all four categories. This trainee feels everyone is against her and this judgement (or conclusion) might be wrong **(diagnostic problem).** Clearly it says something about the **relationship** between the trainee and others. If the trainee feels everyone is against her, it is likely her approach (attitude) to going into work is also affected **(professionalism).** People who are finding it difficult to **manage** overwhelming stressful problems at home may then become irritable and sensitive to the extent they feel everyone is against them.*

Step 3 – create an Edwards' diagnostic map

Don't be scared of the map below: it's quite simple really once you get used to it. The Edwards' diagram below (which is a bit like a Venn diagram) is a natural and intuitive way to visualise 4 sets of data and thus ideal for RDM-p (Venn diagrams are only good for 3 or less data sets). It gives you an 'at a glance' map view of where to focus the discussion. Map the elements from the table above to the diagram below (blank version at the end of this document). The brackets you used earlier to indicate weak positive or negative indicators will help you place them more precisely. Underline POSITIVE evidence to discern them from the negative.



Dr. Ramesh Mehay (Programme Director, Bradford VTS), March 2010

Step 4 – explore personal qualities and external (rogue) factors

Write down any personal qualities or external (or rogue) factors you need to bear in mind. Let's say in this case all we know at this stage is that Alana has two young children. You will probably be able to add more (especially to the external factors column) during the discussion with the trainee as more personal stuff is shared with you (but for that to happen, you have to create a climate of openness, honesty, trust and respect).

Personal Qualities/Traits?	External Factors?
	Has two young children.

Step 5 – which RDM-p domains are causing concern?

Back to the Edwards' diagram - look at each domain in turn:

1. First the red 'relationship' box,
2. Then the green 'diagnostics' circle
3. Then the blue 'management' box and
4. Finally the yellow 'professionalism' tennis ball shape.
5. Where do most of the negative pieces of evidence lie?

In this particular example:

- Most of the items live in the blue (management) and yellow (professionalism) areas.
- This tells us to focus our discussion *primarily* on management and professionalism.
- There are less items in the other two remaining boxes (red= relationships and green = diagnostics).
- At some point in our discussion, we may want to briefly dip into these two areas just to make sure we're not overlooking anything else that might prove important.

Step 6 – explore the domains further using the SKAPE framework (i.e. to tease out causal/influential factors)

Using the SKAPE framework, explore the performance concern domains with a view to identifying causal and influential factors: **S**kills, **K**nowledge, **A**ttitudes, **P**ersonal qualities and **E**xternal factors. By teasing these *specifics* out, you'll be in a better position to discuss solutions that might make a *positive* difference.

Let's say from our discussion that Alana tells us she is experiencing relationship problems with her partner and has a busy home schedule with two young children (and that she *feels* like a single mum). This fits in nicely with what the Edwards' diagram says – perhaps her difficulty to manage her home situation means she is finding it difficult to manage her work situation and as a

result of all the stresses, she's unhappy, irritable, with an undesirable attitude (professionalism). This tells us that the root of the problem is at home and that is where the focus of discussion and problem solving should lie.

Step 7 – Formulate a functional management plan

How might a particular issue be addressed? The key thing here is that by having a clear and accurate enough classifying system (R, D, M and p), one can develop plans to target specific performance areas either alone or in combination. In RDM-p language this would mount to something like: 'relationship issues might be dealt with via...; diagnostic issues via...; management issues via...; professionalism issues via...'.

We hope that this worked example gives you a clearer understanding of R, D, M and p in practise. We also hope you can see how the RDM-p classification system not only helps with *diagnosing* what the problem is, but its *assessment* and the frame within which *planning* is then shaped. Now you're truly in a position to try it out. Seriously, give it a go: even with a problem outside of the trainer-trainee context.

A final word from original published paper[2]:

> *The model brings a unifying clarity and commonsense meaning to what have previously been seen as rather disparate list of competences or definitions. In particular, significant insights have been reached by a number of individuals who have explored their own performance through the model. Many trainers introduced to the model have also felt that it has given them an accessible language and structure for helping guide and support their trainees.*

References:

1. The National Clinical Assessment Service (NCAS) www.ncas.npsa.nhs.uk
2. In Quality in Primary Care. 2009;17(1):37-47. A unifying theory of clinical practice: Relationship, Diagnostics, Management and professionalism (RDM-p).Norfolk T, Siriwardena AN.
3. Dealing with Difficult Doctors, Jennifer King, BMJ Career Focus 2002;325:43 (10 August)
4. Games People Play: The Psychology of Human Relationships (Paperback) by Eric Berne, 2010 (Penguin)
5. TA Today : A New Introduction to Transactional Analysis (Paperback) by Ian Stewart and Vann Joines, 1987 (Lifespace publishing)

Blank RDM-p Templates

Instructions:

- Map each item on your evidence list to RDM-p domains they *may* be related to.
- Put a "+" next to a positive marker and a "–" next to negative ones.
- Use brackets to indicate *weakly* positive or negative indicators of a domain.
- Write some areas you want to explore (in the discussion) in the last column.

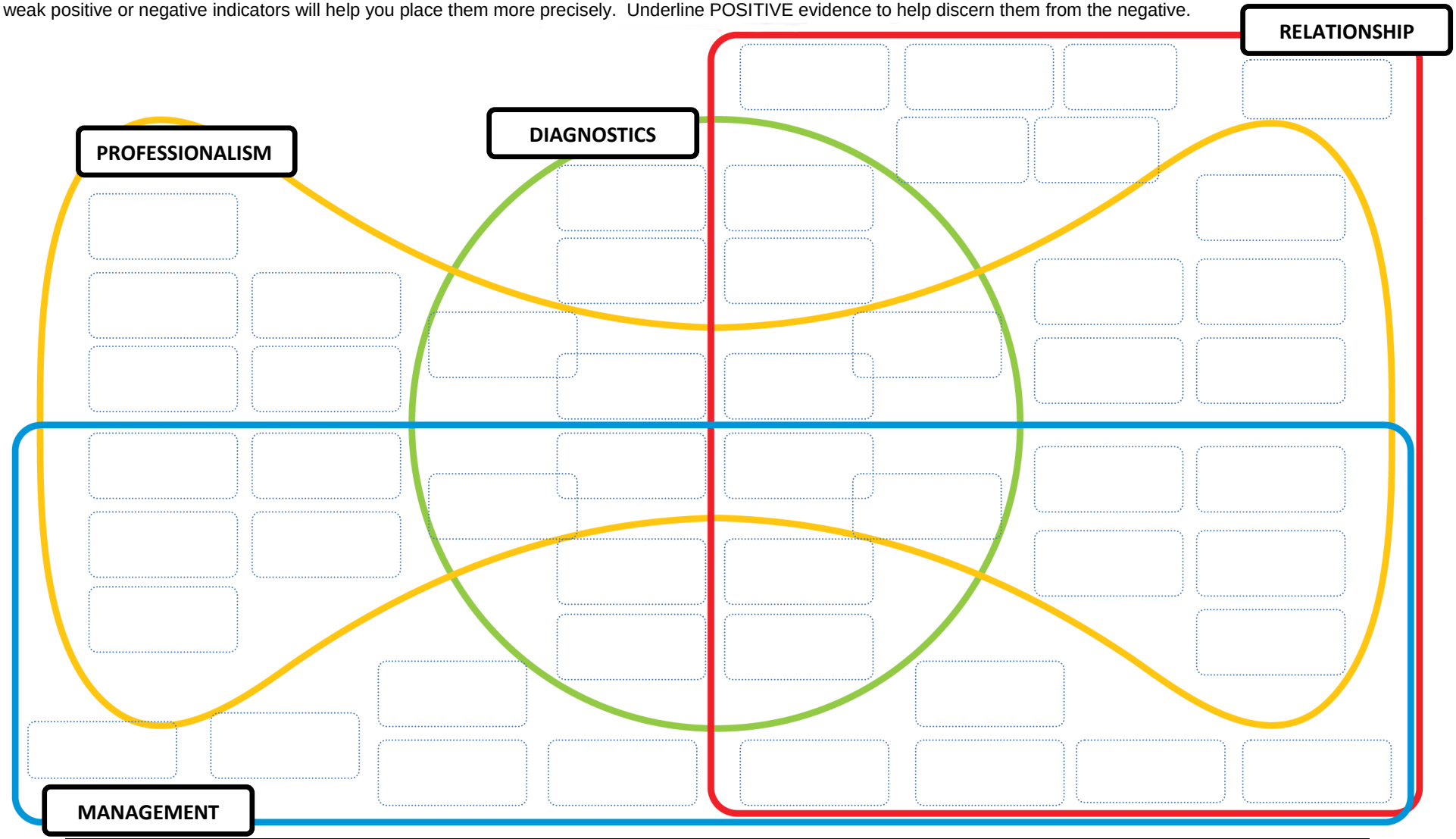
Quick Tip: Actually, I *only* mark the positive ones with a plus sign and assume everything without a + is a negative: looks less messy and is easier to absorb/interpret the overall evidence at a glance.

RDM-p category	**The Evidence (= comments or observed behaviour)**	**Your reasoning/areas you want to explore**
Example *M- D- p-* *M+ p+*	*Example* *Does not inform senior receptionist about leave until the last minute* *Good documentation*	*Example* *Not informing senior reception staff about sick leave until the last minute may indicate problems with **managing time, making a decision** in a timely way, and the **lack of appreciation** for others to know early (professionalism)* *This Doctor is **managing** her record keeping very well and understands its importance (this is **professionalism**).*

Now map this 'evidence' to the R, D, M and p domains in the Edward's diagram below.

Edward's Diagnostic Map for RDM-p

Map the elements from the evidence table above to the diagram below (type in the blue boxes - click and drag to rearrange them). The brackets you used earlier to indicate weak positive or negative indicators will help you place them more precisely. Underline POSITIVE evidence to help discern them from the negative.



Personal Qualities/Traits?	External Factors?

Dr. Ramesh Mehay (Programme Director, Bradford VTS), March 2010

1. **Look at each domain shape in turn: which R, D, M and p themes seem to dominate?**
2. **Now explore these using the SKAPE with the trainee.**

Dr. Ramesh Mehay (Programme Director, Bradford VTS), March 2010

Space for your notes...