HOW TO SURVIVE AS A NEW CONSULTANT

AUSTRALIAN EDITION
Dear Colleagues

Becoming a consultant is an exciting milestone that brings its own set of challenges.

Our College, The Royal Australasian College of Physicians is committed to providing you with on-going support and connecting you with a multitude of networks and external agencies, many of whom are mentioned in this guide. I encourage you to make use of these networks, to use this guide, ask questions and seek advice.

It is also vitally important to keep work and life in balance; and to look after your own health. Growth and experience come with time. Challenge yourself, but recognise your limitations. Celebrate your accomplishments and acknowledge all those who played a part.

Many of us have been where you are now: beginning a new phase in your medical career. We are here to support and applaud you throughout this journey of life-long learning.

On behalf of our College congratulations on your Fellowship and welcome.

Laureate Professor Nicholas Talley

RACP President
READY TO LAUNCH

These days people learn to skydive by parachuting down with an instructor several times before they jump on their own. On that first solo jump, they are well prepared to make a safe landing — but that doesn't take away the excitement or the fear of their independent launch into space.

Becoming a consultant physician is a bit like that — you have the sensation of being on your own in a whole new way. In reality, the key to success is recognising our own limitations and continuing to seek assistance in order to develop greater understanding and clarity. In your role as a consultant you will need to foster the same behaviours and attitudes among senior trainees.

The purpose of this guide is to assist new consultants with the planning and skill development needed to ease the transition from registrar to consultant.

The guide can be used as a practical resource when preparing for appraisals or audits (sections 6 & 9), planning your workload and meetings (sections 8 & 14), and managing complaints and reports (sections 10 & 13). It also has sections on your continuing professional development (section 7) and starting up in private practice (section 15). In addition, it offers reminders on more general but vitally important topics such as relationships (sections 1-3 & 5), conducting a ward round (section 4) and communication (sections 11 & 12). Though any or all of these may be your personal strong points, you may find yourself feeling challenged during times of stress or when under the strain of competing demands, working with many unfamiliar people and processes. At those times your family, this guide, a mentor and the advice of trusted colleagues can help restore your perspective; be sure to make good use of all these resources.
HOW TO SURVIVE AS A NEW CONSULTANT: AN OVERVIEW

Make the most of available support

Being a new consultant can be stressful. It is a steep learning curve but it is important to remember that support is available. It is not a failing to seek advice or get a second opinion when needed – in fact it is perfectly sensible and commendable.

Useful support networks can include:

- Other new consultants: peer support is both an important concept and a very practical process that everyone can benefit from. Consider joining or establishing a peer review group (see section 14 for guidance).
- Senior colleagues: many can offer pearls of wisdom and useful second opinions.
- The Quality Manager and Quality Team: this team is a valuable source of assistance with complaints, patient safety and adverse events. They can also support any improvement initiatives and help organise notes, and have access to information required for audits.
- The Australian Salaried Medical Officers’ Federation (ASMOF): for industrial and contractual matters.
- The hospital’s Chief Medical Officer (CMO) and the departmental Clinical Directors: these individuals have a wealth of experience available to you.

Learn to rely on your staff

There are many ways to support and assess the clinical expertise of your junior staff so you can become confident in their abilities to make critical decisions. For example:
• Make yourself available and accessible: encourage your staff to contact you with questions and to feel welcome to seek your advice.

• Build team morale and minimise hierarchy within your team: model collaborative problem solving and discourage blame-seeking behaviours.

• Promote an environment of communication and learning: be open to opportunities that foster professional collegiality and transparency such as informal coffee meetings.

Consider your own wellbeing

An important aspect of becoming a new consultant is learning to minimise and manage stress. Developing particular habits and behaviours can help achieve these aims. For instance:

• looking at your professional and personal life in a holistic way

• prioritising your ‘non-negotiables’ and ring-fencing time to honour both professional, personal, and family commitments.

There can be pressures and temptations to focus almost entirely on your career as you take on this new role. A critical element of ongoing success and wellbeing is ensuring you take the time to maintain your relationships with family and other loved ones.

Your own health, physical and mental, must also be a priority. Staying well and being productive is something you can plan for and commit to in advance. If you haven’t already, find your own general practitioner. Your local Doctors Health Advisory Service (DHAS) will be able to help you find one who understand the needs of doctors. You can find out how to contact your local DHAS on the RACP Support and Advice for Physicians web page.

Taking time to anticipate and avert issues is key to avoiding undue stress. Here are some practical tips:

• Address conflicts before they escalate. Whether it involves a staff member, a patient, or a family, discussing a conflict in a timely and constructive (honest, friendly and respectful) manner usually diffuses stress and sets the stage for outcomes that suit everyone.
• Learn to say no to invitations and requests which are beyond your capacity in terms of time or skill level, or which lie outside your interests. Ensure you fully understand the ramifications of taking on additional roles or projects.

• Have contingency plans you can easily activate when regular routines are upset. At times you may need to resort to child care arrangements at short notice or, conversely, you may have to call on substitute staff when urgent family issues call you away from work. Pre-planning for either eventuality is vital for meeting professional and personal commitments with minimum stress.

• Plan the year ahead to set the stage for a healthy team. Schedule the time and activities necessary to keep yourself and your team professionally, physically and mentally fit. Consider annual leave, conferences and other educational and professional development activities. Encourage your team to keep family and personal wellbeing a high priority.

• Cultivate and maintain good relationships with colleagues and others. Relaxing and socialising with family, friends and peers can build resilience, restore distorted perspectives, relieve stress and help with problem solving.
Managing the clinical transition in your last rotation as a registrar

- Spend some nights being on-call as the consultant, with back-up.

- Involve yourself in the handling and resolution of any complaints that the team receives.

- Take the lead in difficult meetings involving patients and their families.

- Carry out an intern appraisal, along with the consultant, and obtain feedback on how you deliver positive feedback and how you discuss the areas for improvement.

- After seeing patients, think about how you would manage them in your role as a consultant. Analyse and discuss this with your colleagues and also explore the motivation behind different decisions made by consultants.

- Act as a resource person for junior staff in your team or service.

- Lead some post-acute rounds, with the consultant observing. Request feedback afterwards.

- Request to be observed then appraised after delivering bad news and counselling patients.

- Identify a senior colleague who would be willing to mentor you through the transition into your consultant role.

- Talk with your family about the changes ahead for all of you, sharing mutual expectations and commitments.
The contract and the job description

Considering a role within an organisation

The strengths and weaknesses of various departments are often reflected in pressures on new consultants to take on additional duties and responsibilities. Reviewing a potential role with this in mind can be good strategic practice. Avoid falling into the ‘doing one more thing’ mentality that can quickly add hours to an already full workload and, once on the job, stay aware of your expected versus actual hours.

Before signing your contract

While everyone values different aspects of a role or workplace according to their own priorities, many have found the following to be important in setting up a good professional experience. Before signing the contract is the best time to negotiate for what matters to you, such as:

- Sufficient non-clinical time for administration: 20% is strongly recommended.
- Dedicated office space: be aware this can be very scarce, especially in public hospitals.
- Mobile phone arrangements that suit you and a pager as back-up: weigh up the inherent trade-offs in using your own versus a work mobile phone (e.g. network choice, paperwork requirements, keeping home and work separate, and any entitlements for use while overseas).
- Clinics for follow-ups and for diverting acute cases: ensure there will be appropriate nursing support to organise and run them.
- Freedom to create your own clinic template so you can decide the timing and placement of new versus follow-up patients during clinic hours.
- Leave cover and call frequency: whether leave cover is provided separately or within teams significantly impacts the actual rostered call frequency.
- Student teaching: if your department is attached to a medical school, discuss any teaching expectations, whether they are remunerated and how they are organised.

If your role teams you up with another consultant, consider seniority, compatibility, conference aspirations, and ease of negotiating issues (e.g. arranging cover).
Advocating on your own behalf for appropriate remuneration can be somewhat daunting, whether or not you have done so before. You should objectively consider your skills and background, and perhaps also get advice from others in identifying your strengths. When considering your contract you might also consider:

- Getting advice from colleagues in the same area/department as you and discussing clauses they may have in their contracts.
- Getting input from ASMOF.
- Getting recognition of any additional academic qualifications you have.
- Discussing the skills you have and how they can benefit the hospital.
- Whether you would like to do any private practice and where this might fit into your role.

**Orientation and induction**

This will be arranged for you by the hospital.

Over the years, consultants and Fellows have found it very useful to:

- Meet the clinic nurse and relevant clinic administrators.
- Meet with the clinical nurse manager and other nurses working on the wards.
- Become familiar with:
  - the hospital’s clinical and administrative policies relevant to the role.
  - the current set of guidelines for trainees.
  - the hospital’s computer systems – including results, scanned medical records and electronic patient notes. Find out whether (and how) you can get remote access.
  - the hospital’s dictation systems.
- Investigate what specialties are available and where to send internal and external referrals.
• Visit the laboratory and radiology departments.

Also, make a point of meeting with your manager and, ideally, the Chief Operating Officer or equivalent in your organisation.

**Supervision**

In your role as a consultant, you will be involved in supervising junior staff. It is now your opportunity to be the supervisor that you always wish you had!

Before beginning, it is important to understand what the Australian Medical Council (AMC) and the College expects of consultants supervising trainees. It can also be helpful to talk with colleagues about how they handle the processes involved. Some consultants choose to undertake training in how best to provide supervision and feedback.

Training, supervision and mentoring can all be counted towards your annual requirements for continuing professional development (CPD).

RACP runs a [Supervisor Professional Development Program](#) which includes face-to-face workshops, coaching, and online learning and resources. It is worth familiarising yourself with the [RACP supervisor roles and responsibilities](#) and the [AMC standards for supervisors](#).

**Mentoring**

As a consultant, a good mentor relationship is an important aspect of your role. It is highly recommended you seek a mentor you can trust and with whom you would feel confident discussing issues such as complaints, conflicts and giving difficult feedback.

As a mentee you should be an active participant in the relationship, taking ownership and ensuring that the outcomes meet your personal and professional needs. For more information on making the most of your mentor, please read ‘[Making the most of mentors](#)’.

In addition to your mentor, it can also be very beneficial to build a professional relationship that offers you a sounding board for cases and other discussions. Usually the ideal person for such a role is a senior consultant outside your team who is both open to debating alternative opinions and able to explain clearly why they would make a particular decision in certain situations.
**Appraisal – 12 months**

Appraisal is an important part of your development and of the service in which you work. You should expect that you will meet annually with the clinical Head of Department/Clinical Director and your Manager to discuss the year that has been and your aims for the year ahead.

This is an excellent opportunity to reflect on the alignment between your job description and the work you are doing.
THE JOB

1: Relationships with colleagues

The experience of senior colleagues means many of them are invaluable as a resource for second opinions and advice. These relationships can have benefits in terms of ongoing mentoring and the growth of your own knowledge and experience.

If you’re practising in the same hospital where you did part of your training, you may now be a colleague of the consultants who were previously your ‘bosses’. This can be daunting but remember that your fellow consultants will be interested in your new and different perspective on issues that arise.

Remember respect from all staff is earned and is not an automatic right of anyone’s position.

There will be colleagues with whom you have disputes or conflicts and it is best to work through these quickly and professionally as you may have to work together over a long period. When deciding if you should hold your ground it can be helpful to consider whether the issue impacts patient care or if the result you are after is worth the negative impacts of conflict.

Most clinicians can be encouraged to see a different position even if they don’t agree with it. Sometimes it may become necessary to involve a senior clinician to help mediate disagreements.

2: Relationships with junior staff

As a new consultant you may have staff working for you who were once fellow trainees, as well as staff who only know you in your role as a consultant.

Establishing boundaries around decision making, especially with previous colleagues, will help lend clarity if disagreements occur. Ultimately responsibility lies with you.

Over time, you will become increasingly comfortable – and even enjoy – discussing and debating the choices senior registrars make, despite their course of action differing at times
from what you would have done. There is, after all, more than one way to manage most situations.

All consultants have their own style, but being approachable by all staff, including the most junior, will benefit all parties. A call directly to you when an issue is arising will give you the opportunity to intervene before the situation gets out of hand.

In Australia, most consultants are addressed by their first name and they make their mobile phone and pager numbers available to all team members; this is common practice and is rarely misused.

**How to identify and manage a struggling trainee**

Poor interactions with staff can sometimes reflect a lack of confidence and knowledge, or it can be a sign that you have a trainee in trouble. Take all staff feedback seriously.

It is important to meet regularly with your trainees to discuss the clinical expectations of the job, the important skills and competencies needed to be a good physician, what you expect from them and what they can expect from you (a useful reference is the [RACP Professional Qualities Curriculum](#)). During these meetings, identify and document any weaknesses in trainee performance and discuss what can be done to achieve a satisfactory outcome. Encourage the trainee to raise solutions of their own. You should both be as specific as possible and make these recommendations measurable.

Letting the Director of Physician Education (DPE) or the trainee’s educational supervisor know early on is beneficial as they can provide advice and support to both you and the trainee.

If the trainee is struggling in the clinical aspects of their role, you may have to become more involved. This may mean longer and more frequent ward rounds, more reviews, and more frequent meetings and discussions.

More information about helping a trainee in difficulty can be found at the [College’s Trainee Support webpage](#).

Early intervention is the most simple and effective method of dealing with a trainee in difficulty.
3: Relationship with other hospital staff

Developing and maintaining relationships with other staff throughout the hospital is important and can often be mutually beneficial.

The nursing staff spend the most time directly looking after your patients. As the senior clinician, engaging with them is crucial; no question or idea should be dismissed and all opinions should be heard. Having a senior nurse on the ward round is desirable but has become less common, so it is important to take the lead in communications with other members of the multidisciplinary team.

If actions you request are not being carried out then it is acceptable to discuss this constructively with the staff member involved. However, managing the nursing staff is the role of the clinical nurse manager for the ward. If there is a pattern of behaviour or an issue that cannot be sorted out at a lower level, this is the person to speak to. Keep all contact professional and never make comments that criticise another member of staff. Issues should be discussed in terms of the tasks, actions and consequences for patient care, not personalities.

If an issue arises between the nursing staff and your staff, always take this seriously and discuss the matter directly with the relevant staff members in a clear, open and respectful manner. It can be helpful to keep in mind that behaviours are usually born out of fear or a lack of knowledge, or may relate to circumstances outside work, miscommunication, or differences in perceptions, culture or personality. However, if a pattern of behaviour is present, you may find it useful to seek advice from your senior colleagues or the Director of Physician Education.

Clear documentation is as important as good communication in strengthening and maintaining relationships within the team; it also helps ensure each person involved understands their part in delivering the plans of care.

Participating in teaching for medical, nursing and therapy groups is a good way of building relationships and teams.

It is likely that you will not have a secretary or a personal assistant, but that one secretary will act for the whole department. This person will be able to assist you in sorting out matters relating to refunds, meetings, payroll and other hospital processes.

Dictation systems vary between different hospitals, networks and private practices. You may find that your typing will be undertaken by a medical typist in the typing team. If so, it is
important to meet the members of this team (and your nominated typist) as they are the ones you will turn to with the occasional urgent job or to repair a mistake you’ve made such as dictating under the wrong patient identifier. In other organisations, typing may be outsourced and letters reviewed online without direct contact with the person who is typing your documents. In either case, it is important that you speak clearly, keep your message succinct (colleagues don’t have time to read long letters!), and have clear communication lines to those that are helping you perform your job.

4: Conducting a ward round

During the course of your training you will have observed the different ways senior colleagues conduct a ward round and you will have developed your own approach. Post-acute general medical ward rounds may be particularly “pressured”. You may be faced with assessing a large number of patients who are frequently complex. These assessments take place within a noisy ward environment and you may encounter unexpected disruptions such as junior staff being called away, unexpected absences and bed management pressures.

Developing your own ward round routine is important. Your assessments will need to be time-efficient yet thorough enough to develop a reasoned and appropriate investigation and management plan. Information may be presented to you in “reverse order” (e.g. laboratory data and then clinical data) with the potential to lead you down the wrong path.

Whatever approach you take to assimilate the information, here are some points worth considering:

- Find a relatively quiet place on the ward where you have access to laboratory, radiological and clinical information so you can do a “paper round”. The “paper round” needs to be done without interruption as this helps avoid missing important information. If you can, take time to review the original referral letter from the general practitioner and the ambulance officer’s or Emergency Department’s reports.

- Ask the junior staff to present the clinical findings, integrating the laboratory and radiological findings, to confirm their diagnosis. This may identify whether further investigations are necessary. Encourage junior staff to demonstrate their critical thinking and invite their opinions. Avoid micro-managing junior staff: this can impede their development and yours. The article by Trowbridge [Twelve tips for teaching](#).
avoidance of diagnostic errors’ may give you some useful techniques to use with your junior staff.

- You may wish to make a few pertinent notes in the clinical record under a heading such as “paper round” or “pre-ward round”. You may elect to review manageable groups of patients before you embark on the ward round proper, returning to this “quiet place” to review another group before continuing the ward round.

- Another suggested approach is to start with the sick/unstable patients, potential discharges, and new patients and then deal with the remainder. This helps prioritise severity of patient illness and bed allocation. This means more walking on rounds, but hopefully better patient care and flow through the hospital.

- On the ward round, after introducing yourself and the team to the patient and relatives, take time to ask the patient an open-ended question such as “What has brought you to hospital?” After acknowledging the humour in the answer “an ambulance”, try to focus the patient on exactly what they understand as to why they have been admitted. Ensure junior medical staff and the patient’s relatives don’t interject while reassuring both groups that they can have their say in a moment. Don’t accept the assertion that the patient is a poor historian or confused until you reveal this for yourself. If necessary, do a focused physical examination (a skill you will have honed for your Part 1 Clinical Examination).

- Explain to the patient and/or relatives what you think the problem is and how it will be managed. This may mean explaining that at this stage you don’t know but will plan further investigation. In some circumstances explain that in your opinion the aim of treatment will be to keep the patient comfortable and for no further investigation to be undertaken as the patient is terminally ill.

- Your junior staff may have completed an “NFR” (Not For Resuscitation) or a “DNAR” (Do Not Attempt Resuscitation) form if the clinical assessment indicated this would be appropriate or if these were the patient’s previously expressed wishes. This can be a sensitive and challenging area of medical practice. NFR should be discussed with the patient whenever appropriate/possible, and all discussions with colleagues and relatives should be patient-centred. It is appropriate to explain that, from a medical standpoint, resuscitation in the event of cardiac arrest or further deterioration is felt not to be appropriate but short of this all care will be given. Explain that should the situation dramatically change, then the
continuing appropriateness of the NFR decision will be reviewed. Given this situation, it is good practice for medical staff to invite the relative(s) to express a view but care must be given to ensure that the relative is not left feeling that they are making the NFR decision. For more information on the legal and ethical issues related to DNAR orders please refer to page 4 of the Australian Resuscitation Council’s Guidelines.

- Another important consideration on the ward round is the discharge plan. Letting the patient and their relatives know the day you are thinking the discharge might take place allows you to outline any follow-up care which may be required, and with whom, and ensures the patient is fully informed and able to progress through the discharge process quickly.

- Ensure that a member of the team is documenting all relevant findings and discussions as the ward round progresses and that enough information is provided in the medical record to give a reliable picture of the thinking and rationale behind management decisions. The notes should not be so detailed as to impede the ward round but, if reviewed months later, should be easily understood and convey what has gone on. Such documentation is the best protection for both you and the medical team.

5: Relationship with managers

While consultants and managers will approach problems from different backgrounds and perspectives, both views are equally valuable; it is worth taking the time to understand the other’s perspective.

Recognising that managers work under different pressures, it is better to avoid judging their ability or value and instead to work alongside them and plan the direction of the department together.

Managers are receptive to improvements in care – particularly if they come with benefits such as shorter stays or fewer admissions.

When organising clinical audits within the department, ensure that some of these focus on utilisation, demonstrating how savings or waste reduction achieved in one area might be used in another area.
The Chief Executive Officer and Chief Operating Officer can influence decisions and processes that reach across departments and throughout the whole organisation. Your observations as a clinician working on the floor may provide them with useful insights and evidence to support improvements.

The Quality Manager and team are able to assist in a variety of areas and also have a wealth of knowledge and expertise on processes around clinical audits, patient safety issues, adverse events and other areas that ultimately make the hospital a better and safer place for patients.

6: Appraisal

Appraisal is an important part of your development and of the service in which you work. You should expect that you will meet annually with the clinical head of your department and your manager to discuss the year that has been and your aims for the year ahead.

This is an excellent opportunity to reflect on the alignment between your job description and the work you are doing. It may also be an opportunity to discuss any 360-degree assessments you have taken part in and to promote improvements for the department.

There is no standard process for the conduct of performance appraisals and the priority given to them varies significantly. The first step is to make sure you know what is required, and when it is required. In some cases appraisal processes and credentialing processes are linked and this can be an important opportunity to review and adjust your defined ‘scope of practice’. There will often be forms to complete and a list of specific items that you will need to provide to your head of department prior to the appraisal meeting.

To prepare for appraisal meetings it is useful to summarise your achievements, involvements and intentions. Having a file that you add to throughout the year is more efficient than trying to gather it all together just prior to the meeting. Links to more information about appraisal can be found in the Resources section of this document.

7: Continuing professional development

An effective physician is a lifelong learner. Continuing professional development (CPD) is the key to successful practice. It is also a requirement for registration. The Medical Board of Australia requires all physicians and paediatricians to meet the CPD standards set by the RACP, so be sure to check what these requirements are.
The RACP's MyCPD program is intended to support the planning, conduct and reporting of professional development that is aligned to your scope of practice and stage of career. Planning your learning strategy at the outset is essential.

You may want to consider the following questions:

- What do you need to learn in order to survive as a new consultant?
- What are your priorities?
- What resources are available that will help you?
- How much learning do you need to do in general areas and how much in your areas of special interest? Don't forget the need for CPD in the professional qualities domains.
- What time are you planning to set aside for learning? How will these sessions impact on your other commitments? One key to time management it is that if you don't allocate time, it won't happen. You need to draw up your schedule so there is time for self-directed learning.
- If you practice in a department, what educational meetings will you allow in your schedule? (If you are going to go to grand rounds you cannot schedule clinic at that time!)
- If you will be working in private practice or in a small centre, you might have to search to find available activities that you can either visit or join by teleconference. Formal teaching is not the only way you can learn, even if your practice is remote or isolated. Make the most of online learning or webinars.
- Are there any projects you want to take on that will help provide structure to your learning? You might introduce a quality control project and/or other research innovations. For example, the use of a screening tool to measure patient-reported or other outcomes can standardise data collection and provide good evidence to drive practice improvement. This is a high quality form of CPD which is recognised as such by the College.
- How are you going to tell if you are providing a good service? Are you going to include any performance measures in your practice? These could be process measures like the standard of your documentation, or the percentage of patients
treated according to guidelines, or patient outcomes. The data you collect systematically now will determine what questions you can answer later.

- How are you going to organise and document your learning? There are various software tools that can help, such as online bibliographies that allow you to keep track of papers that you have read and annotate items of interest. You can organise electronic diaries to permit retrieval of CPD activities for documentation in your annual return.

CPD participation is monitored by the College through MyCPD. Documenting your CPD is easiest if you do it as you go along. Each year the College undertakes a random audit to meet the requirement of the regulators who also conduct their own random audits. It is a good idea to record your CPD in such a way that you will have no difficulty in demonstrating that what you have entered is correct if you are ever audited. Here are some suggestions for how you can make recording CPD less of a chore.

**Take notes**

One of the easiest ways to create source material is to take notes. Notes can document CPD activities that would otherwise be invisible, such as teaching on the wards. The most straightforward method is to dedicate a notebook that you bring to conferences, journal clubs, meetings, rounds, and other activities. Note-taking doesn’t need to be extensive, but it will be most helpful if you focus on what you learned and how to apply these insights in your practice.

You can also employ a note-taking app, such as Evernote, on your mobile phone or tablet computer.

**Keep a journal diary**

Proof of a journal subscription does little to demonstrate engagement or learning for CPD. Some Fellows find it helpful to keep a journal diary to reflect on their reading, and often do so as part of a larger note-taking strategy.

You can annotate papers you have read (electronically or otherwise) as evidence of your involvement with the material as well as a way of consolidating your understanding.
Use social media

Most conferences now create a specific Twitter hashtag for the event (see #RACPcongress, for example). Tech-savvy Fellows can use the hashtag to tweet their comments on sessions and panels during the day, potentially initiating discussion with other Fellows. You can also use tweets to yourself as a way of keeping contemporaneous notes.

Update your calendar

The simple habit of annotating your calendar (whether online or in your pocket diary) can provide you with a daily record of CPD activities and the time you allocated to them. Blocking out time for CPD, particularly activities outside your routine or comfort zone, also makes you more likely to complete it. Many calendar software programs allow you to assign categories to activities. Create a tag for CPD and at year’s end you can view and print everything you’ve classified in a complete list.

Time activities

For CPD that defies any of the documentation strategies above, consider just keeping track of your hours. Beyond a stopwatch, there are a range of apps and time-management programs available: Toggl, for example, is a free cross platform timer that lets you enter with a few clicks what you are doing, when you start, and when you stop. It then generates automatic reports.

Upload files to MyCPD

MyCPD has the capacity for you to upload documents, providing you with a ready collection of source materials in case of an audit by the RACP or AHPRA. If you are recording a lecture or a paper in MyCPD, consider uploading it at the same time.

The systems you set up now to promote learning effectively and efficiently and to document your learning achievements will pay large dividends over a lifetime of professional learning, and contribute to creating a fulfilling and sustainable professional life.

8: Taking on extra roles

Consultants are invited to take on many related administrative roles, including positions on departmental and hospital committees, medical school or College committees, and groups
associated with professional societies such as the Internal Medicine Society of Australia and New Zealand (IMSANZ); these may include conference organising committees.

It is wise to postpone joining committees until you have settled into your role as a consultant. After you have given yourself six months, consider first what you can bring to the department before making any decisions to commit yourself elsewhere – whether within the hospital or externally.

9: Service development and audit

There are some successful methods and principles which can be helpful when attempting to make changes within your department or hospital.

The main points to be aware of are:

- Don’t try to change things too soon:
  - it takes approximately six months to get a feel for the current systems and processes
  - try and establish the reasons for the current processes
  - see if support exists for changing processes.

- Use relevant evidence such as accepted clinical guidelines to assist change:
  - evidence of benefit motivates clinicians
  - evidence of efficiency motivates management
  - improving processes can improve patient outcomes.

- Aim to work with people who will support you:
  - look for colleagues who are early adopters of change and engage them
  - most of those who are hesitant to change will come around in their own time if the benefits are shown to have positive outcomes for patients or make processes simpler and easier.

- Evaluate the effects of the changes you have introduced honestly and openly: don’t push on if your proposal turns out to be unsuccessful.
Clinical audit and practice review are important parts of your role as a professional; they should be regularly recorded along with other professional development activities in your CPD program.

10: Interacting with families

Most families who have a relative in the hospital want to be kept informed and up to date about decisions and treatment plans. They may find this difficult if they are working during the day and can only visit after hours. Not keeping the family informed can lead to miscommunications, frustrations and possibly complaints.

The main areas of concern for families are:

- Has the problem been diagnosed?
- How is the problem being treated?
- What tests are being done?
- How long will the patient need to be in hospital?
- Will the patient need additional support once discharged?

Obtain the patient’s consent to meet with the family to discuss the patient’s case. Advise the patient that you will discuss with them what was said during the meeting with their family.

When you meet with the family:

- Arrange meetings in a private room and only when you have sufficient time to spend with them.
- Arrange a fixed time separate from ward rounds.
- Have the attendees identify one person to act as the conduit of information; this is particularly important for extended families.
- Document the meeting carefully as this may assist you later.
- Understand that the family may be frustrated and emotional during the meeting and may take this out on you.
• Use language that the family understands and answer all questions honestly; offer to provide further information if the family finds that useful.

• Explain uncertainty – this is an important part of these consultations.

11: Cultural competence

In your role you will be coming into contact with people from culturally and linguistically diverse backgrounds, whose family and community needs may differ from your own. As a consultant you are in a position of influence as to how healthcare is delivered in your workplace. As well as continuing the process of gaining cultural competence you should lead by example, looking to influence and even challenge colleagues’ behaviour.

For some useful resources regarding cultural competence please refer to the Resources section of this document.

12: Dealing with complaints

Patients and their families are experiencing a high stress situation. It is vital to remember that if you get a complaint from them it is not personal, even though it may feel that way. Most complaints can be settled with a simple face-to-face discussion.

Getting a complaint does not make you a bad doctor – everyone gets them at some stage. What you learn from the experience of dealing with a complaint will result in important process improvements and this is clearly a positive outcome.

Keeping compliments and cards received from patients and reviewing them periodically can provide you with reassurance and reaffirmation.

Different institutions have different policies about dealing with complaints. Familiarise yourself with your institution’s policy and speak to your Hospital Patient Liaison Officer (or equivalent) as soon as you receive a complaint. It is sensible to review your notes thoroughly before taking any action to remedy the complaint.

Generally, when a complaint is received:

• Write to the complainant and acknowledge the complaint. Before writing, discuss your response and the complaint with your medical defence organisation to obtain the appropriate guidance and advice.
• Apologise for any distress that the patient/family may have experienced (apologising is not an admission of guilt or negligence).

• Make sure all aspects of the complaint are addressed in the letter.

• Offer to meet and discuss the complaint.

When meeting, ensure you also repeat the apology. You do not have to accept the complainant’s recollection of the events. Refer to the notes and discuss any differences. It is important not to become defensive or take an adversarial position as this will not help to reach a resolution.

If the Coroner or your state/territory Workers Compensation Authority is involved, then you should involve your medical defence organisation early in the process. The Chief Medical Officer, Clinical Director and/or Quality team can all provide assistance and constructive advice based on previous experience in dealing with complaints. The Quality team can also provide a contact point for the family if needed.

It is useful to discuss the complaint and the case with a trusted senior colleague to gain their perspective. If a junior staff member is involved in the complaint it is best for you to deal with the patient and/or family and then discuss the outcomes separately with the staff member in an honest and non-threatening environment. In this meeting, cover what was written in the original letter and later what occurred in the face-to-face meeting. They should review the notes and offer their perspective on the events before your next meeting with the family. You should advise them, if appropriate, to discuss the case with their insurer also.

13: Writing reports for the Coroner and other agencies

It may be necessary in your role as a consultant to provide reports to the Coroner or other agencies.

Support is available to you through your organisation or insurer and it is encouraged that you take advantage of this, especially if this is a new situation.

Before any report is submitted, have the Quality team check the format. Also request your insurer to review the content as well as questions being asked of you by the Coroner.

If you are required to attend an inquest you will be informed by the Coroner’s office via the Quality team. When going through this process:
• State the facts as documented in the notes.

• Don’t interpret the notes unless specifically asked to by the Coroner.

• Keep focused on the questions asked and do not address any side-issues.

• If simply asked for a summary of events, give a chronological description of the events as documented.

• If you state something that is not documented in the notes, this will carry less weight. It is still acceptable to do this, but ensure you can provide evidence to support your response.

• Answer all questions at the inquest as honestly and succinctly as possible.

• You may be reporting on an event that occurred several years ago and it is acceptable to say that you don’t know the answer or can’t recall a certain event. Don’t try to guess or attempt to provide an answer in these circumstances.

14: Guidelines for peer review and other meetings

A peer review group can provide a supportive forum for professional development and clinical consultation.

Planning or setting up a peer review group

• A group of between 7 and 12 participants works well and the range allows for individuals being away.

• Decide on the focus of the group (e.g. general physicians or any physicians). Confirm the members of the meeting and what expertise or specialty they each bring to the meeting.

• Identify who will coordinate the meetings, where you will meet and who will act as the contact person.

• Establish a regular meeting cycle (monthly works well) and a time limit.

• Identify the appropriate category in your CPD program for recording these meetings on your annual return, for example, in the RACP MyCPD program,
peer review meetings and clinical audits can be entered under Category 5: Practice Review and Appraisal.

- Outline the meeting rules (see below).
- The group should evaluate its progress and rules at least annually.
- Have the participants sign a confidentiality agreement that covers both the information acquired and the discussion held. It should also cover:
  - whether or not a person can act as a reviewer for a case that has been discussed at a peer group they have attended
  - what will be done if an issue of competence comes up with respect to a colleague (see point 2.1.d of the AMA Code of Ethics).

The ground rules for any meeting – including peer review group meetings

The ground rules for any meeting should be circulated to the participants before the first meeting. These ground rules may include:

- the rules of membership
- responsibilities of the Chair and the participants (see below)
- what constitutes a quorum
- the confidentiality of the information to be discussed (this should be explicitly noted)
- the requirement for attendees to identify any perceived and real conflicts of interest; these should be declared before the first meeting
- the commitment to:
  - keep meetings constructive
  - maintain a supportive environment and encourage all participants to contribute at each meeting
  - confirm the time and date for the next meeting before participants disperse.
Role of the Chair

- Ensure the meeting starts and finishes on time.
- Ensure the agenda is circulated before the meeting along with relevant background information and the previous minutes.
- Encourage attendees to participate and identify who will keep minutes.
- Allow participants to express their view without interruption as long as it is succinct, and politely intervene if the participant goes beyond this.
- Outline any limit to the number of issues that a single attendee can bring to this meeting.

Any disagreements or rule changes will be resolved through the Chair by either stopping discussions that may be inappropriate or putting contentious issues to the group after hearing from each side.

Role of the participants

- Arrive on time.
- Participate in a constructive manner.
- Be concise and stay on topic.
- Be sure to have reviewed the minutes from the previous meeting and feedback as necessary on actions taken.
- Do not hold private background discussions during the meeting.

15: Setting up in private practice

You may be considering whether to set up in private practice. While you may be able to seek advice from your consultant colleagues, some may be reluctant to share their experiences with someone who may, in essence, be seen as a competitor.

AMA NSW and AMA Victoria both publish guides to starting up and running a private practice, which can be bought by members or non-members (for an increased fee). The AMA Victoria guide is updated periodically and you can pay to subscribe to updates.
Some of the issues you should consider when deciding whether to set up in private practice include:

**Am I professionally ready?**

- Do I have the professional experience, competence and skills required to work in private practice?
- Do I have access to individual or peer supervision?
- Do I have sufficient professional indemnity insurance?
- Am I familiar with and understand the relevant:
  - laws?
  - code of ethics?
  - ethical guidelines?
- Can I manage the requirements of my own case load independently?

**Am I personally ready?**

- Do I want to own and run my own business?
- Do I have the time to devote to establishing and running a private practice?
- Am I physically and mentally able to meet the demands of a private practice?
- Am I willing to undertake risk?
- Do I want to practice as a sole practitioner? Do I want a team around me?
- What will I gain from working in my own private practice?
- What will I lose/miss from not working in public health/other sectors/models of practice?

**Am I business ready?**

- Do I understand the basic business and regulatory requirements of running a small business?
• Can I calculate and evaluate the costs of running a business?

• How can I calculate/project my income?
FOR THE FUTURE

While everyone has their own style of practice it is useful to have a toolkit to help you establish your own solutions. Much of the advice in these pages is specific to particular processes, the nuts and bolts of life as a consultant. Yet senior consultants would probably agree the most important suggestions are around relationships, communication and managing stressful situations. When there seems to be a shortage of hours in the day or inevitable issues arise, it is invaluable to have colleagues and team members you can count on as well as the support and goodwill of your family.

Let this guide be a reminder to avoid common pitfalls others have endured – such as overcommitting yourself or becoming isolated through neglect of family or lack of contact with colleagues – and not to lose sight of why you chose your particular specialty in the first place.

Keeping these suggestions top of mind can benefit your career and help ensure your job satisfaction in the early days and throughout the years ahead.
RESOURCES

How to survive as a new consultant: an overview

Consider your own wellbeing
RACP support and advice for physicians (includes links to Doctors Health Advisory Services (DHAS)
http://www.racp.edu.au/page/physiciansupport

Planning

Supervision
RACP supervisors’ roles and responsibilities
http://www.racp.edu.au/index.cfm?objectid=08B49A77-F874-7BFB-0F1266E49F6069DD

RACP Supervisor Professional Development Program
http://www.racp.edu.au/index.cfm?objectid=B92BAD82-E85D-0B0F-313883E3DFB2DDC4

AMC Standards for Specialist Medical Training (section 8.1 refers to supervisors)

Mentoring
Making the most of mentors: a guide for mentees (Academic Medicine. 2009;84(1):140-144)

AMSA’s guide to finding a mentor (relevant beyond student years)
The Job

2. Relationships with junior staff
RACP Trainee Support Page
http://www.racp.edu.au/page/educational-and-professional-development/trainee-support

RACP Professional Qualities Curriculum

4. Conducting a ward round
Twelve tips for teaching avoidance of diagnostic error

Australian Resuscitation Council’s Guideline 10.5 – Legal and Ethical Issues Related to Resuscitation

6. Appraisal
Your employer will most likely provide a guide that will help you prepare for an appraisal meeting. The link below is to the guide provided in the Partnering for Performance process used in Victoria. Not all of this information will apply to all appraisal processes.


7. Continuing professional development
RACP MyCPD Program

Making CPD Easy: useful tips for streamlining the process (pages 16-17)
http://www.racp.edu.au/index.cfm?objectid=000FD8E2-0D27-08C0-D4323C99E9732150
RACP Supporting Physicians Professionalism and Performance (SPPP)
http://www.racp.edu.au/page/sppp

The Australian Health Practitioner Regulation Agency (AHPRA)'s standards and guidelines for Continuing Professional Development (CPD)

Evernote
https://evernote.com/

Toggl
https://www.toggl.com/

12. Cultural competence

RACP SPPP: Cultural Competence
http://sppp-guide.racp.edu.au/#sppp-cultural-0

RACP SPPP: Cultural Competence resources
http://sppp-guide.racp.edu.au/#sppp-appendix2-0

Indigenous Health & Cultural Competency online course – provided by the Australasian College of Emergency Medicine

Cultural Competence – Online Intercultural Learning Course (funded by RHCE)

Online Aboriginal Cultural Orientation package – created by the Western Australian Centre for Rural Health

Queensland Health’s Five Cross Cultural Capabilities for Clinical Staff

14. Guidelines for peer review and other meetings

The Australian Medical Association’s Code of Ethics
15. Setting up in private practice

The Australian Medical Association NSW’s guide to private practice

The Australian Medical Association Victoria’s guide to private practice

Australian Psychological Society, Setting up a private practice: Issues to consider, March 2014

Other new consultant guides

RACP NZ and IMSANZ. How to survive as a new consultant
http://www.racp.edu.au/download.cfm?downloadfile=09C0FCAD-0DAE-0AB1-1E206981105DCCA6&typename=dmFile&fieldname=filename

Royal College of Physicians (London) 2011. A Tricky Time: How to survive as a new consultant – some useful advice
http://www.rcplondon.ac.uk/sites/default/files/a-tricky-time-june-09.pdf
ACKNOWLEDGEMENTS

This guide is based upon “How to Survive as a New Consultant”, published by RACP (NZ) and IMSANZ.

The original guide’s principal author was Dr Stephen Dee, supported by the Wellington Young Physicians Peer Group and the Specialist Advisory Committee in General and Acute Care Medicine (NZ).

Acknowledgements from the original publication

Helen Sinclair – Quality Manager, Hutt Valley DHB
The New Zealand Adult Medicine Committees, The Royal Australasian College of Physicians
The New Zealand Paediatric and Child Health Committees, The Royal Australasian College of Physicians
The New Zealand Trainees’ Committee, The Royal Australasian College of Physicians
The Overseas Trained Physician Assessment Committee (NZ), The Royal Australasian College of Physicians
Māori Health Committee, The Royal Australasian College of Physicians
Rosemary Matthews, Senior Executive Officer, The Royal Australasian College of Physicians
Simone Evans, Communications and Membership Services Officer, The Royal Australasian College of Physicians

Acknowledgements for this publication

RACP Trainees’ Committee, especially Dr Evan Jolliffe
RACP Continuing Professional Development Committee, especially Professor Matthew Links, Dr Carole Khaw, Professor Christian Lueck, Dr Hamish McCay
RACP AFRM Continuing Professional Development Subcommittee, especially A/Professor Ruth Marshall
## GLOSSARY

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>AHPRA</td>
<td>Australian Health Practitioner Regulation Agency</td>
</tr>
<tr>
<td>AMA</td>
<td>Australian Medical Association</td>
</tr>
<tr>
<td>AMC</td>
<td>Australian Medical Council</td>
</tr>
<tr>
<td>ASMOF</td>
<td>Australian Salaried Medical Officers’ Federation</td>
</tr>
<tr>
<td>CMO</td>
<td>Chief Medical Officer</td>
</tr>
<tr>
<td>COO</td>
<td>Chief Operating Officer</td>
</tr>
<tr>
<td>CPD</td>
<td>Continuing Professional Development</td>
</tr>
<tr>
<td>DHAS</td>
<td>Doctors’ Health Advisory Service</td>
</tr>
<tr>
<td>DPE</td>
<td>Director of Physician Education</td>
</tr>
<tr>
<td>IMSANZ</td>
<td>Internal Medicine Society of Australia and New Zealand</td>
</tr>
<tr>
<td>PQC</td>
<td>Professional Qualities Curriculum</td>
</tr>
<tr>
<td>RACP</td>
<td>Royal Australasian College of Physicians</td>
</tr>
<tr>
<td>RMO</td>
<td>Resident Medical Officer</td>
</tr>
<tr>
<td>SMO</td>
<td>Senior Medical Officer</td>
</tr>
<tr>
<td>SPPP</td>
<td>Supporting Physicians' Professionalism and Performance</td>
</tr>
</tbody>
</table>