How to survive as a new consultant
FOREWORD

Both the Royal Australasian College of Physicians (RACP) and the Internal Medicine Society of Australia and New Zealand (IMSANZ) are committed to providing our members with ongoing support throughout their training and their careers.

Many individuals have been where you are now: beginning – or soon to begin – a new phase in your career in medicine. On behalf of the College and the Society, congratulations and welcome.

Moving into a consultant role is an exciting time. It also brings its own set of challenges. So it is important to remember support is available through a multitude of networks: the Colleges, your colleagues and external agencies (many are mentioned in this guide).

We encourage you to make use of these networks, make use of this guide, ask questions, seek advice and, most importantly, stay grounded and focused. The journey ahead is best approached with confidence and humility – as well as a sense of humour. Commit to keeping a balance in your home and work life and to looking after your own health.

Growth and experience come with time. Challenge yourself, but recognise your limitations. Make a habit of celebrating accomplishments and acknowledging all those who played a part.

Best of luck with your future endeavours.

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INTRODUCTION

Becoming a consultant physician involves many new and exciting challenges. Many senior trainees and new consultants before you have found it encouraging to remember that no one will ever magically have all the answers. 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 a culture of these same behaviours and attitudes amongst senior trainees. However, you are not on your own in this task.

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

It has been designed to be used as a practical resource when preparing for appraisals or audits (sections 6 & 8), planning your workload and meetings (sections 7 & 12), and managing complaints and reports (sections 9 & 11). 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 (section 10). 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/whānau, this guide, a mentor and the advice of trusted colleagues can help restore your perspective; be sure to make good use of all those sources.

In fact, the overriding message of this guide is: in managing others, and in managing conflict, your workload and any aspect of your new role, support is widely available; you are encouraged to seek it and use it.
Making 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 – in fact it is perfectly sensible and commendable to seek advice or get a second opinion when needed.

Useful support networks can include:

a. 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 12 for guidance).

b. Senior colleagues: many can offer pearls of wisdom and useful second opinions.

c. 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.

d. The Association of Salaried Medical Specialists (ASMS): contact the ASMS regarding industrial and contractual matters.

e. The hospital’s Chief Medical Officer (CMO) and the departmental Clinical Directors: these individuals have a wealth of experience available to you.

Learning 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. Some examples are:

a. Making yourself available and accessible: encourage your staff to contact you with questions and to feel welcome to seek your advice.

b. Building team morale and minimising hierarchy within your team: model collaborative problem solving and discourage blame-seeking behaviours.

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

Addressing conflicts and setting boundaries

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

- looking at your professional and personal life in a holistic way.
- prioritising your non-negotiables and ring-fencing time to honour both professional and personal, family/whānau commitments.

There can be pressures and temptations to focus almost wholly on your career as you take on this new role. However, a critical element to ongoing success and wellbeing is ensuring you take the time to maintain your relationships with family/whānau and other loved ones.

Your own health, physical and mental, must also be a priority. Staying well and being productive can in large be something you plan for and commit to in advance.
Taking time to anticipate and avert issues is key to avoiding undue stress. Some practical examples are:

a. Addressing conflicts before they escalate: whether it involves a staff member, a patient, or a family/whānau, 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.

b. Learning to say no to invitations and requests which are beyond your capacity in terms of time or skill level or lie outside your interests: ensure you fully understand the ramifications of taking on additional roles or projects to which you’ve been invited.

c. Having 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/whānau issues call you away from work; pre-planning for either eventuality is vital for meeting professional and personal commitments with a minimum of stress.

d. Advance planning 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 continuing professional development (CPD) activities. Encourage your team to keep family/whānau and personal wellbeing a high priority.

e. Cultivating and maintaining good relationships with colleagues and others: relaxing and socialising with family/whānau, friends and peers can build resilience, restore distorted perspectives, relieve stress and help with problem solving.
PLANNING

Managing the clinical transition in your last run 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/whānau.
• Carry out the house surgeon 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 registrars or house surgeons 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.
• Get feedback from the typists about your dictation and how this can be improved.
• Talk with your family/whānau 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.

Prior to signing your contract

While not everyone places the same value on different aspects of a role and a workplace, many have found the following to be important in setting up a good work experience. Before signing the contract is the best time to negotiate for what matters to you, such as:

• Sufficient non-clinical time for administration: 30% is strongly recommended.
• Dedicated office space: be aware this can be very scarce, especially in public hospitals.
• Cell phone arrangements that suit you and a pager as back-up: weigh up the inherent trade-offs in using your own versus a work cell phone, e.g. network choice, paperwork requirements, keeping home and work separate, and any entitlements for use whilst 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. Objectively considering your skills and background and accessing support from others in identifying your strengths are useful. 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 ASMS.

• 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 Resident Medical Officers (RMOs)
  - the hospital’s computer systems – including results, digital radiology system and ordering – both manual and electronic

• 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 (COO).

**Supervision**

In your role as a consultant, you will be involved in supervising junior staff. Before beginning, it is important to understand what the Medical Council of New Zealand (MCNZ) and your respective College expects of consultants supervising house surgeons and trainees. It can also be helpful to talk with colleagues about how they handle the processes involved. Some consultants choose to undertake training in providing supervision and feedback.

Training, supervision and mentoring can all be counted towards your annual Continuing Professional Development (CPD).

See the References page of this document (p. 22) for the link to the MCNZ website.

**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.

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**

See Appendix A of this document (p. 17) for a template used by the Hutt Valley District Health Board (DHB).
Section 1: Relationship 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.

As a new consultant, 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 of time. When deciding if you should hold your ground it can be helpful to consider whether the issue impacts the patient’s care or if the result you are after is worth the headache of remaining staunch.

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 this situation.

Section 2: Relationship with junior staff

As a new consultant you may have staff working for you who were once colleagues, 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, however, 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.

While consultants have their own style, being approachable to 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 New Zealand, most consultants are addressed by their first name and they make their cell phone and pager numbers available to all team members; this is common practice and is rarely misused.

When you attend your first supervisors’ meeting ensure you give your registrar and house surgeon a copy of your written expectations for discussion.

Refer to the References page of this document (p. 22) for the MCNZ’s expectations of interns.

How to identify and manage a struggling registrar

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 registrar 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 document is the RACP Professional Qualities Curriculum (PQC); refer to the References (p. 22). During these meetings, identify and document the area/s where the trainee is not performing and discuss what can be done to achieve a satisfactory report. 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 registrar is struggling in the clinical aspects of their role then you may have to become more involved. This may mean longer and more frequent ward rounds, more reviews, and more frequent meetings and discussions. Early intervention is vital when a trainee is in trouble and will benefit both parties.

Section 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 the communications with other members of the multidisciplinary team.

If actions you request are not being carried out then it is acceptable to constructively discuss this 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, directly or indirectly, criticising another member of staff.

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.

Good, 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 another good way of building relationships and teams.

It is likely that you will not have a secretary or a Personal Assistant (PA) but there will be one 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.

Your typing will be undertaken by a medical typist in the typing team. 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 National Health Identifier (NHI). Keep the lines of communication open and maintain a relationship with this team; for example, ask if there are ways you can improve your dictation to make their job easier as you are not likely to have received feedback on this before.

Section 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, some points worth considering are:

• 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 avoids missing important information.
• If it is available 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 if further investigations are necessary. Encourage the junior staff to demonstrate their critical thinking and invite their opinions. This is not only necessary for their development but a safeguard for yours. 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.

• 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 area of medical practice. 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.

• 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.

Section 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 more beneficial to avoid judging their ability or value and to instead 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 utilised in another area.

The Chief Executive Officer (CEO) and Chief Operating Officer (COO) 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.
Section 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 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. It may also be an opportunity to discuss any 360° assessments you have taken part in and to promote improvements for the department.

To prepare for appraisal meetings it is useful to summarise your achievements, involvements and intentions using the template found in Appendix A (p. 17).

Section 7: Taking on extra roles

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.

There are a variety of clinical committees and working groups such as:

• The Infection Prevention and Control Committee
• The Resuscitation Committee
• The Information Systems Clinical User Group
• Lab and Radiology User Groups
• The Patient Flow Group
• The Emergency Department six-hour target group.

There are also various Medical School or College committees and groups associated with your professional societies such as the Internal Medicine Society of Australia and New Zealand (IMSANZ); these may include conference organising committees.

Section 8: 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:
  a. It takes approximately six months to get a feel for the current systems and processes.
  b. Try and establish the reasons for the current processes.
  c. See if support exists for changing processes.

• Use relevant evidence such as accepted clinical guidelines to assist change:
  a. Evidence of benefit motivates clinicians.
  b. Evidence of efficiency motivates management.
  c. Improving processes can improve patient outcomes.

• Aim to work with people who will support you:
  a. Look for colleagues who are early adopters of change and engage them.
  b. 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:
  a. 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 programme. Be sure to check the CPD requirements for your chosen programme and also what the MCNZ requires you to complete. There are cases that present opportunities for both learning and improvement, for example: “proton pump
inhibitors causing severe hypomagnesaemia”, or “thiazide associated severe hyponatraemia”. Consider through audit how frequently the issue occurs at your hospital, what is the best management strategy for these patients and how often particular drugs are involved or not recognised as a cause.

You can find more information about clinical audit on the Ministry of Health website: www.health.govt.nz

Section 9: Dealing with complaints

Patients and their family/whânau are experiencing a high stress situation. It is vital to remember this 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.

When a complaint is received:

- Write to the complainant and acknowledge their complaint.
- Apologise for any distress that the patient/family/whânau may have experienced.
- Make sure all aspects of the complaint are addressed in the letter.
- Offer to meet and discuss the complaint.
- 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.
- Ensure you also repeat the apology at the face-to-face meeting.

Prior to sending out the letter, discuss your response and the complaint with the Medical Protection Society (MPS) to obtain the appropriate guidance and advice.

If the Coroner or the Health and Disability Commissioner are involved, then you should involve MPS early in the process. The CMO, 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 need be.

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 prior to your next meeting with the family/whânau. You should advise them, if appropriate, to discuss the case with their insurer also.

Section 10: Interacting with families/whânau

Most families/whânau 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/whânau 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 they need to be in hospital?
- Will they need additional support once they are discharged?

Obtain the patient’s consent to meet with the family/whânau 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/whānau:

- 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/whānau.
- 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/whānau finds that useful.
- Explain uncertainty – this is an important part of these consultations.

The Royal Australasian College of Physicians (RACP) has developed guideline commentary “Consulting with Māori and their whānau” that you may find useful. Refer to Appendix B (p. 18) for this document.

**Section 11: 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 to other medical 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.

**Section 12: Guidelines for peer review and other meetings**

*Peer review is an MCNZ requirement for CPD. When setting up a peer review group and subsequent meetings, there are particular steps to follow. These are additional to the requirements of organising and running other types of meetings.*

**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 programme 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*. Please visit the MCNZ website for further information on these CPD requirements.
- 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 25 of the Medical Council 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 prior to 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 – this must be agreed upon
- 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 prior to 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 prior to 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.
CONCLUSION

Given any new role brings its own challenges, this guide can support you as a new consultant to face and manage those issues and related stress.

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/whānau.

Let this guide be a reminder to avoid common pitfalls others have endured – such as over committing yourself or becoming isolated through neglect of family/whānau or lack of contact with colleagues – and to not 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.
GLOSSARY

ACC – Accident Compensation Corporation
ASMS – Association of Salaried Medical Specialists
CMO – Chief Medical Officer
COO – Chief Operating Officer
CPD – Continuing professional development
DHB – District Health Board
HDC – Health and Disability Commission
IMSANZ – Internal Medicine Society of Australia and New Zealand
MCNZ – Medical Council of New Zealand
MPDT – Medical Practitioners Disciplinary Tribunal
RACP – The Royal Australasian College of Physicians
RMO – Resident Medical Officer
SMO – Senior Medical Officer
## Preparing for your annual appraisal

*Template supplied by Hutt Valley DHB*

Fill this out and take to your annual appraisal to ensure all your achievements from the past 12 months are discussed.

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<tr>
<th>My clinical role:</th>
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<td>Quality Improvement Activities and Audits:</td>
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<td>Peer group activities:</td>
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<td>Committees and projects:</td>
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<td>Relationships with Colleagues:</td>
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<td>Work life balance/Family:</td>
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<td>Vocational Registration or any new Qualifications:</td>
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APPENDIX B

Consulting with Māori and their whānau
Developed by the Māori Health Committee and New Zealand CPD Committee
The Royal Australasian College of Physicians
*Version correct as of August 2012

GUIDELINE COMMENTARY ON CONSULTING WITH MĀORI AND THEIR WHĀNAU

When a Māori patient seeks medical advice he/she may ask for their whānau or support person to be present. whānau is the immediate and extended family descendent group, normally consisting of individuals from a specific Hapu or iwi, who may or may not be living in close proximity. This group approach to the consultation may provide a challenge to the health practitioner who has not previously encountered this situation. This document provides practical advice to ensure the consultation is conducted in a culturally sensitive manner.

INTRODUCTION

CULTURAL COMPETENCE IN CONTEXT

Under the Health Practitioners Competence Assurance Act 2003¹ a health practitioner practising in New Zealand must be culturally competent. The College wishes to focus on developing a culturally competent physician workforce. We believe that this will improve the health outcomes for all including Māori. The importance of culturally appropriate communication cannot be over-emphasised when delivering health services. Cultural misunderstandings between patient and physician can be a barrier to effective health care and impede the development of a meaningful therapeutic relationship².

You are encouraged to address cultural competence in your CPD programme. Clinical competence is not possible without cultural competence.

PURPOSE OF THE GUIDELINE COMMENTARY

The purpose of this guideline commentary is to provide you with assistance so you may interact confidently with Māori and their whānau in a respectful manner.

The guideline commentary will not provide you with all the answers but highlight points to be cognisant of when working within another cultural group. A list is provided of relevant resources; this list will identify opportunities for further reading.

THE Māori CONCEPT OF HEALTH (HAURORA)

A working knowledge of traditional Māori attitudes to health (hauora) is essential to understand Māori tikanga. The Māori paradigm of health differs from the classical biomedical model. As a health practitioner you are likely to base your understanding of health on scientific methodology such as evidence-based research and scientific proof. Consequently ill health is manifested in physical symptoms that require clinical interventions and treatments.

Māori view health as having four interwoven components (Te Whare Tapa Whā). The four dimensions are: Te Taha Whānau (social environment & family), Te Taha Wairua (spiritual), Te Taha Hinengaro (psychological or emotional) and Te Taha Tinana (physical). These components must be viewed holistically when considering an individual’s health status. For example, it may be entirely possible that the Māori patient views his/her physical presentation as a sequela linked to an emotional event in the past. Being familiar with these concepts may prove useful when working with Māori.

BEFORE STARTING THE CONSULTATION

Your hospital may have a Māori advisor who may provide additional guidance when interacting with Māori patients. Contact your Human Resources department. On initially meeting a referred patient you cannot assume that their cultural customs are primarily Māori even if they look Māori and have a Māori name. Māori often view the individual patient’s health issue as a whānau issue; therefore before commencing the consult it is important to check discreetly with the patient (or apparent key whānau member in the case of a child) that she/he is expecting the whānau to be present.

The whānau may designate one person as the key spokesperson to speak on behalf of the patient/whānau.

THE CONSULTATION: THE INITIAL CONTACT

Whatever uncertainties exist over the cultural identity of the patient she/he must always be greeted warmly with every attempt made to correctly pronounce their name. For Māori stating their surname is very important as first names in isolation provide no guidance as to the individual’s links to the Whenua and whānau. If you are unsure of the pronunciation seek clarification.

A handshake will be acceptable to men and women. A Hongi is the traditional greeting with Māori and may be omitted at the first contact as it may be unclear as to the whānau’s engagement with Taha Māori. Again kissing of a Māori woman on one cheek can be deferred unless confidence exists about the patient’s Māoritanga.

A handshake or a Hongi or kiss should be made to each accompanying support person, if they are introduced as part of the patient’s whānau.

The presence of a significant number of support people with the patient certainly increases the chances of a Polynesian ethos in the family, although this situation is not exclusive to Polynesian peoples.

SETTING THE SCENE FOR THE CONSULTATION

You welcome the patient and any supporting whānau into the consulting room.

The size of the available consulting room may require the swift provision of extra chairs to accommodate the whānau. In keeping with Māori protocol you should try to have a definitive gap between you (and any residents, students or colleagues present) and the visiting family. This protocol is in keeping with the seating arrangements on entering a Marae, where there is delineation between the manuhiri (visitors) and those who normally occupy this place (the tangata whenua), i.e. you as the health professional.

When everyone is seated then you should ask the simple but profound question “Where are you from?” The question “Where are you from?” is equivalent almost to “Who are you?” The patient’s response should provide a reasonably clear picture if this family is comfortable with Taha Māori.

If you are not sure of the patient’s or whānau’s level of understanding of Te Reo then it is advisable not to begin the conversation in Te Reo as it may embarrass the patient/whānau whose knowledge is limited.

As with personal names, one skill that is necessary to facilitate a respectful relationship with Māori is the correct pronunciation of Māori place names. Special attention should be given to the towns and cities where you are practising and where your patients reside.

The question about the familial or historical links (whakapapa) and origins of the whānau should provide an opportunity for you to establish rapport with the whānau.

THE CONSULTATION

Once these exchanges have occurred then you move to clarify the purpose of the consultation. In this conversation the patient should be asked whether his/her symptoms have any particular significance to the whānau and whether any other events have occurred recently in the patient’s life that makes him/her wonder about a link to a specific event.

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3 See Mason Durie’s “Whaiora” provides the relevant detail.
During the consultation whānau members may add comments and, if they do not, then you may ask them if they have any significant information to add to the consultation.

When it comes to the physical examination of the patient you should explain briefly what you propose to do and why, and establish with the patient if this is acceptable. Māori, like many cultures, have some sensitivities around examination of the head (Tapu), breast and genitalia, and therefore specific permission must be sought before touching these areas.

After the history and examination have been completed the patient and whānau will have an expectation that some conclusions and a proposed plan of action have emerged.

If the matter seems potentially very serious there should be an opportunity to signal your own concerns, and key whānau and support people should be informed at the earliest appropriate time. In more routine situations a management plan relevant to the diagnosis should be proposed for the whānau’s response. An opportunity could be given then to ask whether the whānau have any special or traditional treatments they were considering.

CLOSING THE CONSULTATION
At the conclusion of the consultation you thank the patient and whānau for their presence, cooperation and helpful comments. You should provide a clear plan of further follow-up arrangements. This plan should involve the whānau as in many cases they will be involved in delivering care or following the treatment plan with the patient. Involving the whānau may also increase compliance with the treatment plan.

If the family have clearly identified themselves as Māori, during the course of the consult, then it would be appropriate to Hongi or kiss whānau members as they leave and wish them well. A brief farewell exchange in Te Reo may help cement communications.

It should be clarified in the wrap-up discussions as to whether the patient would like some written or visual material sent to them to reinforce your comments. Lastly the patient and whānau should know how they might be able to contact you should some questions subsequently arise.

LINKS TO THE PROFESSIONAL QUALITIES CURRICULUM
The Professional Qualities Curriculum outlines the key competencies for Trainees and Fellows of The Royal Australasian College of Physicians.

Domain 1: Communication places particular emphasis on communicating with the patient’s family and carers.

Domain 4: Cultural Competency notes that the Fellow or Trainees should demonstrate the ability to communicate effectively with people from culturally diverse backgrounds. In order to deliver culturally appropriate health care one needs to have an understanding of one’s own cultural perspective and an awareness of their patient’s cultural context.

5 The Royal Australasian College of Physicians, 2008, Professional Qualities Curriculum www.racp.edu.au
RESOURCES
The Royal New Zealand College of General Practitioners 2007. Cultural Competence, Wellington, New Zealand
Tai Walker 2006. Whānau is Whānau. The Families Commission, Wellington, New Zealand

TERMINOLOGY
Hongi – a greeting by pressing of nose to nose
Hapu – subtribe
Tapu – sacred. Tapu is concentrated in the head, therefore touching of the head or any object coming in contact with the head is deemed Tapu and should be avoided
Taha Māori – Māori things
Te Reo – Māori language
Tikanga – the customs and traditions that have been handed down through the passages of time
Waka – founding canoe
Whānau – family
Whenua – of the land. (Tangata Whenua means people of the land)

The authors of this guideline commentary are Dr Leo Buchanan FRACP, Chair of the Māori Health Committee, Dr Hamish McCay FRACP, CPD Director, New Zealand CPD Committee, and Rosemary Matthews MA, Senior Executive Officer, The Royal Australasian College of Physicians.
REFERENCES

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

2. The Medical Council of New Zealand. Education and Supervision for Interns
   (Expectations of Interns, pgs 13-26)

3. The Medical Council of New Zealand. Supporting doctors’ health

4. The Medical Council of New Zealand. Recertification and continuing professional development

5. The Royal Australasian College of Physicians. Supporting Physicians Professionalism and Performance (SPPP)
   Link: http://www.racp.edu.au/page/sppp

6. The Royal Australasian College of Physicians. Professional Qualities Curriculum
   Link: http://www.racp.edu.au/images/dmlImage/SourceImage/professional_brochure_icon.jpg

7. The Medical Protection Society (MPS)
   Website: http://www.medicalprotection.org/newzealand/

8. Internal Medicine Society of Australia and New Zealand (IMSANZ)
   Website: http://www.imsanz.org.au/

9. The Royal Australasian College of Physicians (RACP)
   Website: http://www.racp.org.nz/
About the Internal Medicine Society of Australia and New Zealand (IMSANZ):

The IMSANZ represents over 580 Consultant Physicians and trainees in Internal Medicine (also known as General Medicine or General and Acute Care Medicine) within Australia and New Zealand. The Society provides a mechanism for developing the academic and professional profile of general medicine and seeks to advocate for, and sponsor the educational training, research and workforce requirements of general internal medicine. IMSANZ is a separate and freestanding body but is closely aligned with and works in harmony with the Royal Australasian College of Physicians (RACP). This is especially relevant for our trainees in General Medicine who are the most rapidly growing group within the RACP.

www.imsanz.org.au

About the Royal Australasian College Of Physicians (RACP):

The RACP trains, educates and advocates on behalf of more than 13,500 physicians – often referred to as medical specialists – and 5,000 trainees, across Australia and New Zealand. The College represents more than 32 medical specialties including paediatrics and child health, cardiology, respiratory medicine, neurology, oncology and public health medicine, occupational and environmental medicine, palliative medicine, sexual health medicine, rehabilitation medicine, geriatric medicine, general medicine, and addiction medicine. Beyond the drive for medical excellence, the RACP is committed to developing health and social policies which bring vital improvements to the wellbeing of patients.

www.racp.edu.au