ebook

New Zealand Medical Indemnity Insurance
Inihua Rata O Aotearoa

# RMO 101:

## The Handbook for New Doctors

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# Contents



In the following chapters, we'll cover some of the most common challenges you'll face and how to overcome them quickly, confidently and effectively.

# Introduction

## Welcome to RMO 101: your guide to surviving and thriving in your first years as a resident doctor.

Success over your next few years is all about being proactive, educating yourself on the common pitfalls that RMOs encounter and discovering the effective techniques that will help you to overcome them.

Often, this kind of experience can take years to build. But we're giving you a shortcut in this handbook.

In the following chapters, we'll cover some of the most common challenges you'll face and how to overcome them quickly, confidently and effectively.

We'll help you deal with medical records, navigate cultural differences in medicine, avoid common prescription errors, and how to set and maintain doctor-patient relationships without compromising on your level of care.

Let's get started.

# General advice


Make your life as a resident doctor easier. Follow these five simple Cs when you take your first steps onto the ward floor.

## 1) Confidence

Confidence in yourself is essential if you want to instil confidence in your patients. While you might still be training towards vocational registration, don't let that stop you from being confident in your decisions.

Build this confidence by not shying away from opportunities to practise your skills, especially with the guidance or supervision of a more senior doctor.

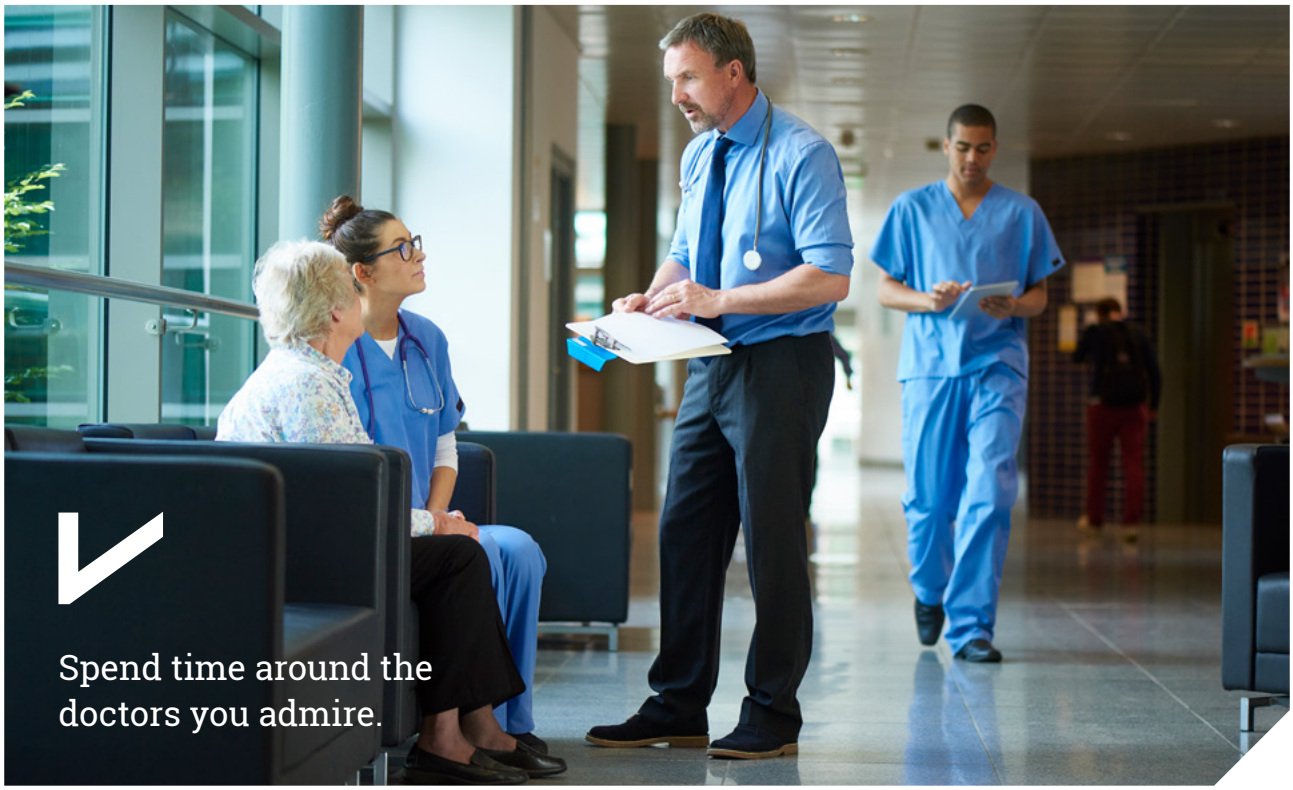
However, one addendum to consider: being confident isn't about knowing everything, it's also about being able to admit when you aren't sure about something—even to a patient.

Always follow up an "I don't know..." with a "...but I will find out from our hematologist/cardiologist/specialist and get back to you". Have confidence in your team as well as yourself.

## 2) Competence

Confidence is great. Competence is better. Competence will come with time and practice, but there are ways to speed up the process.

Firstly, **always consult protocols, policies and guidelines** if you aren't sure about something—and double check even if you are. For example, performing an ECG test for atypical chest pain might seem like an unnecessary drain on




resources, but in reality it ensures that potentially fatal problems aren't missed. The rules are there for a reason, and following them is an easy way to develop competence.

Secondly, remember that **competence is infectious**. Spend time around the doctors you admire; learn from the way that they work. Imitation is the sincerest form of flattery, but it's also a fast-track to developing competence of your own.

Lastly, remember that **competence isn't just about having medical knowledge**—sometimes it can be as simple as always carrying a spare pen for taking patient notes when you inevitably lose the one you had in your pocket just this morning. It can be as simple as a quick but insightful chat with a senior nurse about a patient's behaviour since you were away. It can even be simply taking some time to reflect at the end of a shift on your successes and challenges.

Anything that makes your colleague's work (and your own) easier and your patients' stays more comfortable can help you develop competence.

## 3) Culture

It's essential to work in a culture where it's encouraged to voice concerns and ask questions, regardless of who the question or concern is targeted to—whether that's a senior specialist, a nurse, or a resident doctor like yourself.

This means you get the opportunity to learn from any and all comers. Don't make the mistake of thinking that a senior nurse's advice isn't necessarily valuable—and don't be afraid to ask "stupid questions" either. The answer might save someone's life.

This culture of communication also ensures that people are willing and able to share up-to-date information about patient circumstances without feeling they are wasting someone "more senior's" time.

One last thing to note, however: there are no stupid questions, but there are good ways to ask questions. The key is specificity.

Asking a haematologist for assistance with an anaemic patient, for example, isn't particularly specific and may result in the haematologist spending more time than necessary with your patient.

Asking about the merit of a bone marrow biopsy under specific patient circumstances, on the other hand, gets to the point far more quickly and ensures the culture of communication operates on **relevant** communications.

Always come to the table with the knowledge you have, and what you think the best course of action is—and be ready to adjust that course with guidance from those more senior.

## 4) Curiosity

The sheer volume of what you need to learn as a resident doctor can be intimidating, but don't back away from it. Curiosity means not rushing through learning opportunities—now is the time to learn, so take your time. You will get faster.

Read the notes, ask questions, listen to your patients and their families—it could reveal a missed diagnosis. Make the most of your clinical rotation and attachments—each has its own unique learning opportunities.

Ultimately, curiosity will keep you hungry for learning, and satisfying that hunger will make you a better doctor.

**One last tip:** If you are feeling lost and don't know how to deal with a particular issue, "What do you normally do in these situations?" is a good question to ask another doctor to get some pointers on steps to take next.

## 5) Consistency

Consistency in a hospital is ensuring that patient care is your number one priority, regardless of what other factors may interfere with you, your team or your DHB.

Commercial pressures and resource constraints do not override expected standards of care. It's a bitter pill to swallow, but ultimately these are challenges that every doctor will have to learn to deal with. Regardless of what is going on outside of those walls, your patients need to feel safe, secure and cared for—consistently.

One quick tip for ensuring consistent levels of care for your patients: communication. This might as well be the sixth C on this list, but it's particularly important for consistency.

Keep communication open with both the patient and their family. Sometimes, all that's needed is reassurance that an ongoing complaint is being resolved, or is running its expected course.

Five minutes of time spent explaining something can save your patient hours of stress later down the line and ensure a **consistent level of care** both inside and outside of the hospital.

> Keep communication open with both the patient and their family.

# Medical records

Getting to grips with medical records and their maintenance is one of the key skills that every doctor should learn in their first years.

Medical records give you the information you need to treat patients with a high level of care, ensure you only spend time on necessary examinations and procedures, and even protect you against medical complaints.

In a word, they're important. Here's what you need to know to begin mastering medical record creation, maintenance and transfer.

## What should be in medical records?

Generally speaking, the information included in a medical record will be **all relevant information related to the patient's care**.

This includes:

- Relevant clinical findings
- Clinical decisions made
- Information given to the patient
- Any drugs or other treatments prescribed.

Within this information there will be distinctions between acute or emergency care, long-term patient care and management. For example, a chronic condition would be noted as separate from an emergency issue, and any illnesses/injuries that appear together would be listed as co-morbidities.

These medical records will also include negative findings (e.g. no sign of heightened cholesterol), making it easier to exclude a diagnosis or preclude an additional examination.

There will also generally be communication information, such as "safety net" advice dictating when the patient has been asked to return to the hospital, as well as any referrals to secondary care (and communication between primary and secondary).

**A rule of thumb** is that records should be comprehensive enough to explain the rationale of underlying clinical management decisions.

## When should they be changed?

These records should be updated at each consultation, at the time they are relevant or provided **as soon as possible afterwards**.

This ensures the information remains accurate and nothing is forgotten during a busy hospital day.

## Who should see medical records?

Medical record confidentiality is a significant issue in the mind of both doctors and patients.

Generally speaking, remember these key facts:

- Only relevant staff members need to see medical records, not everyone who works at the hospital.
- Patients are normally allowed to view their medical records, as the information provided belongs to the patient. However, there are times when this allowance is overridden by other factors. If in doubt, refer to your senior's direction or speak with a medicolegal advisor.
- If in doubt, don't share medical records and consult with your supervisor.

## How to transfer medical records

If your patient leaves your care, you may need to transfer their medical records.

As an RMO, you likely won't need to deal with this particular aspect directly, but it is still valuable to know the process.

Firstly, should medical records be requested, they don't always need to be dealt with immediately. However, they should be handled within 20 days or as soon as reasonably practicable, and there are times when they may be required urgently—in which case they should be dealt with immediately.

These records can be transferred physically or, as is more common nowadays, electronically. Regardless of the method used, there must be a way of tracking when they are sent and the receipt of delivery. This might involve using registered mail if sending physically, to ensure the records can be traced should they go missing.

Lastly, hospitals keep medical records for at least 10 years, from the date of the patient's last treatment at the facility.

However, there are additional factors that affect the exact retention time, including DHB protocol and the type of record. If in doubt, refer to a senior doctor or speak to a medicolegal advisor.

Once transferred, your care facility will generally retain a copy of these records as well.

## More information

For more detailed information about making and keeping medical records, you should read this guide from the Privacy Commissioner.

It has all the nitty-gritty on what information can be used in medical records, how they should be transferred, and many other details that doctors should keep in mind in their work. ›

# Cultural differences


While the wide variety of cultures present in New Zealand makes us richer as a nation, some cultural beliefs and practices can present challenges to doctors.

The way you discuss health, or even who you talk to about health, can upset a patient, making it difficult to establish trust. People want to feel safe in your care, and it's difficult to feel that if you are (even accidentally) breaching their cultural norms and expectations.

There are ways to work with them and come to a culturally-sensitive, mutual understanding. This quick guide will help you get started.

## Working within cultural boundaries

As mentioned, there are an enormous number of different ethnicities, religions and other cultural groups present in New Zealand. Almost 40 per cent of Auckland's population, for example, is made up of people born overseas. That makes it more diverse than Sydney, Los Angeles, and even New York, which is often heralded as the "melting pot" of the world.

With this in mind, the prospect of learning each and every single cultural norm of each and every ethnic group may seem like an impossible task. Are you expected to know all of them?

Thankfully, the answer is a resounding no—but doctors are expected to be aware of their own beliefs, cultures and ideas, and how that affects their work and how they interact with patients.

Doctors must be willing to be introspective, as well as learn how the patient views their illness and how to deal with it within culturally acceptable parameters. Asking questions like "What do you think is wrong?" and "How have you been treating this illness?" is an excellent start to a medical-cultural conversation that is respectful and productive.

## Common cultural faux pas to avoid

While it would be difficult to learn every intricacy of every culture present in New Zealand, there are a few regularly-recurring challenges that doctors should be ready for.

### Physical touch

Among traditional groups, particularly those of the Islamic faith, there can be strict rules around gender interaction. A woman, for example, is often not allowed to be touched for any reason by any man who isn't a member of her family.

### Decision-making

You may also notice that major decisions in some groups—including those around healthcare—are made not by the patient, but rather by the males of the family. While in New Zealand we aim for egalitarianism in these circumstances, not adhering to this decision (or trying to bypass it) can cause more consternation than good.

### Modesty

Modesty tends to be another recurring issue, for example, where traditional garb may be required for everyday dress and must not be removed. This can cause obvious issues during examinations. This is often a gender-related issue, so be ready with a nurse, doctor or other healthcare practitioner of the appropriate gender to assist in these cases.

### Taboo foods

While most issues can be dealt with by having a frank discussion with the patient, there is one arena that doctors must be proactive with information: diet.

Many medicines and/or treatments are made with animal products (including insulin) that are prohibited by various cultural groups. The easiest way to avoid issues caused by prescribing such medicines is to simply inform all of your patients if there are animal-based products in the treatment.

### Eye contact

Even something small like maintaining or avoiding eye contact can mean different things in different cultural groups. In New Zealand, avoiding eye contact might seem like the person is being suspicious or dishonest. In other cultures, it can be a sign of respect.

If in doubt about cultural norms and expectations, there is no harm in simply asking your patient or their family about previous experiences, taboos and what they expect from you as a doctor.

While you may not agree with all cultural practices, it is integral to your responsibility of care that you ensure your patient feels comfortable in your practise—regardless of what cultural beliefs they may have, and how much they may differ from yours.

### Summary

Over time, you'll become more familiar with the variety of cultural behaviours and beliefs among your patients, and be better ready to work with them to ensure they have an excellent healthcare experience.

Remember, if in doubt, just ask. ›

# Prescription pitfalls


Prescribing malpractice pitfalls are easier to fall into than you might think—wrong dose levels or mistaken drug names are just the beginning.

Arm yourself with the knowledge you need to provide the best care for your patients by avoiding the seven most common issues listed below.

## 1) The prescription

The "big five" of a prescription are the most important and also the source of some of the worst mistakes.

These include:

- Patient—check full name, address, date of birth and NHI
- Drug
- Dose level
- Route
- Timing (frequency and duration).

If giving out a prescription, double-check that each of these five are accurate and coherent. These are also the five factors that should be top-of-mind during prescription reviews (including the three-month checks for long-term illnesses).

A mistake in any of these could result in adverse drug reactions.

Monitor plasma concentrations or biomarkers to ensure the patient is following the parameters of the prescription, and that the prescription is resulting in the expected outcome(s).

## 2) Unintended omissions

Sometimes prescriptions are inaccurate not because of what is there, but what is **not** there.

Unintended omissions such as failing to put an end-date for a repeated course of treatment, or an inadequate evaluation of potential harm for that particular patient—especially when dealing with drugs that may cause dependency—can cause problems for future prescriptions (and the doctors prescribing them).

Repeat prescriptions should always include the number of repeats on the prescription itself, and every prescription should have a dispensing frequency. If it doesn't, it's open to abuse or misuse by the patient.

## 3) Inaccurate taking of medication history

Writing a prescription relies on knowing previous and current medical issues and associated treatments, as well as patient behaviour in regards to adherence to the treatment. This information can be found by checking the patient's medical records (assuming they have been well-kept).

If in doubt, consulting TestSafe or the regularly dispensing pharmacist of previous medications can be a good idea. This ensures that patients are using the prescribed treatments as they should and as frequently as they should.

## 4) Patient sharing

If you prescribe a new medicine to a patient who you share the care of with another doctor, the other doctor needs to be informed as soon as possible.

As the prescribing doctor, you will be responsible for that prescription and its effects, but your colleague(s) will need to know as well to ensure they are aware to keep an eye out for adverse reactions or drug interactions.

## 5) Polypharmacy

While every prescription needs your full attention, any prescription that features drugs that can interact with previous or current treatments requires special care.

This is particularly common when the primary medicine has side effects that are then treated with additional medication.

Communication with previous healthcare providers is valuable here as it may allow you to expand on existing medical records if required. Ideally, you will be able to create a list of previously prescribed medications (and current) and be able to link them to individual disease states.

Any prescription you make should fill gaps in the patient's healthcare landscape, rather than treating illnesses that are already being treated. Adding unnecessary alternative treatments merely increases the chance for adverse side effects or interactions.

Writing a prescription relies on knowing previous and current medical issues and associated treatments.

## 6) Over-complicated prescriptions

Prescribing is one thing; adherence is another. About 50 per cent of patients do not take their prescribed drug correctly, either doing so irregularly or not at all. This is often due to symptoms disappearing, side effects, feeling like the drug isn't working or getting frustrated with the dosage schedule.

This last reason is one that you can easily resolve at the prescription level. Avoid more complicated treatments when a more simple one will do. Aim for:

- As few drugs as possible (preferably one),
- As few potential side effects as possible,
- As simple a dosage form and schedule as possible, and,
- As short a duration as possible.

## 7) Error reporting

One of the biggest pitfalls of prescription errors is failing to report them.

The Medication Error Reporting Programme (MERP) collects reports of errors to supplement, contribute to and improve the safe use of medicines.

Operated by the New Zealand Pharmacovigilance Centre, MERP is an online, national, voluntary, no-blame reporting system designed to help identify hazards and risks in prescribing that will allow doctors to learn from these issues and avoid them in the future, including:

- Product labelling
- Compounding
- Distribution
- Dispensing
- Administration
- Monitoring.

MERP operates alongside the Centre for Adverse Reactions Monitoring (CARM).

# Doctor-patient relationships


Doctors are people too, but the social relationships that other professions build over the course of their careers may not be suitable for doctors and their patients.

Here, we outline what is expected and what is appropriate (and inappropriate) for a doctor and their patients.

## Social media

It can seem impossible for some to imagine a world without Facebook, Instagram, Snapchat, Twitter or many of the other social networks available today.

However, these platforms also present a danger to a young doctor's professionalism. They are a prime example of how easy it is to blur the boundaries between the personal and the professional.

As soon as a friend request or follow is accepted, a patient no longer sees a doctor as an authoritative, well-intentioned, ultimately neutral party that is there for their health only. They get to see their doctor worse-for-wear at a social gathering, or arguing with their friends or colleagues, or otherwise being less than the professional they need to be in order to provide the best care.

As important as it is for doctors to be empathetic, there's a lot of value in keeping distance as well—including on social media. It could be the difference between a patient trusting your opinion as a doctor, and rejecting your advice because they see you as a "friend".

### What do you do if a patient does follow you on social media?

If a patient 'friend requests' you on a social networking site, respond with a straight-forward but polite message informing them that you don't generally establish online friendships with patients, and the reasons why: it's inappropriate and undermines the patient-doctor relationship.

Remember to tighten up your social network privacy settings as well, while you're at it.

## Current patients

It's acceptable, even encouraged, to retain a friendly rapport with current patients. However, when this friendliness turns into being actual friends, there can be problems.

First, your role as a doctor requires you to remain objective and truthful with your patients. This is something that two-thirds of young doctors struggle to do with patients they like.

Emotional engagement is important for patients to feel like their concerns are being dealt with, but blurring that line too far can result in a doctor giving too much of themselves to a patient's recovery.

Doctors can end up spending their work time as well as their personal time worrying about the patient's recovery, and this can impact on their ability to treat other patients.

This is not acceptable, and is a particular concern for doctors who treat patients with recurring/ chronic conditions.

Doctors who live in the same area as they practise have a similar problem—rural doctors are likely to see their patients in social settings as well, for example.

### What if you are pursued by a patient?

A doctor may be dedicated to creating a distance between them and their patients, but may still be pursued by a patient themselves.

If this does occur, the key is to re-establish the professional boundary and re-iterate expectations of the professional relationship.

Keep in mind that even small things like hugging a patient, giving out personal phone numbers (even for professional reasons) or letting patients use your first name can be enough to blur the boundaries. It can be difficult to know where empathy ends and inappropriate friendliness begins.

Keep an eye out for gifts, even small ones, flirtatious notes, texts or calls that aren't related to their healthcare, or invitations to meet socially. These behaviours must be discouraged, as ignoring them can be falsely interpreted as encouragement (playing "hard to get").

If all else fails and the patient continues their pursuit, you may need to consider referring them to another doctor if possible.

## Former patients

While pursuing any kind of relationship with a current patient is inappropriate, there can appear to be something of a grey area when dealing with former patients.

One of the primary reasons that a relationship between a doctor and a patient beyond the professional one is inappropriate is because of the inherent power imbalance between a doctor and a patient. When a patient puts their trust in a doctor to cure their ailment, and in doing so shares private and sometimes sensitive personal information, they make themselves beholden to that doctor, and thus make themselves vulnerable.

Even after treatment has finished, this vulnerability in the patient can remain. Any friendship or romantic involvement between a doctor and a patient under these circumstances, then, could be seen as manipulative on the part of the doctor.

Also consider that you may treat this former patient again in the future, especially if they suffer from a chronic ailment. An existing relationship may then make it inappropriate for you to treat them, straining both your professional and personal relationship and affecting treatment outcomes.

If in doubt, don't pursue any former patient.

## Friends and family of former/ current patients

Friends and family of former or current patients are also usually off-limits, as they can create problems for the professional relationship between you and your patient too.

Imagine that you were sick, and the doctor treating you was best friends with your sibling. Would you be likely to reveal every detail about your illness to your doctor? What about if it was an embarrassing condition?

These kind of social relationships disrupt the ability of the doctor to provide treatment and can impact the quality of the care a patient receives.

## A rule of thumb

In general, **don't let your social relationship with the patient take priority over the therapeutic relationship**. Be aware of blurred lines. A relationship that is too close impairs clinical judgement. ›

# Protect yourself and your patients...

Medical indemnity insurance might be mandatory, but that doesn't mean you don't have a choice. Compare the main medical indemnity providers' offerings with our free checklist here.

Get the **FREE CHECKLIST**

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**FINANCIAL STRENGTH RATING**
New Zealand Medical indemnity Insurance has been issued a Financial Strength Rating of B+ (Good) and an Issuer's Credit Rating of bbb- (Good), with the outlook on both ratings assigned to 'Stable'. These ratings were issued by A.M. Best on 1st April 2022.