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Foreword

We commend the Supporting Physicians’ Professionalism and Performance (SPPP) Guide to you.

Fellows of The Royal Australasian College of Physicians (the College), including all physicians, paediatricians and trainees of all disciplines, need to continue to deliver high-quality healthcare to their patients, and in order to do this require appropriate support and opportunities for Continuing Professional Development (CPD).

The College recognises the need for, and acknowledges the importance of, the provision of resources to our Fellows to enhance their clinical practice. This is particularly important in the professional qualities area as one of the key domains of CPD. The focus of CPD has, until now, been on medical expertise. The SPPP Guide provides a framework to guide and support professionalism for Fellows and trainees, thus allowing them to demonstrate medical professionalism as part of the delivery of high-quality care. The SPPP framework will assist Fellows and trainees to meet the standards expected by the College and the community in order to maintain the trust of the community.

The College recognises the need for Fellows and trainees to be able to demonstrate these standards of professionalism as part of ongoing CPD and the need for “demonstrable professionalism” to be driven by Fellows and trainees. The SPPP Guide provides practical and pragmatic guidance on expected standards of professional behaviour. This is tangible evidence that the College is striving to meet its responsibility for enhancing the day-to-day activities of physicians.

The SPPP Guide has been designed to meet the needs of all Fellows and trainees within the Divisions, Faculties, Chapters and Specialties of the College and highlights the philosophical foundation that unites us all.

This structured approach to professional development is based on the Surgical Competence and Performance Guide recently developed by the Royal Australasian College of Surgeons (RACS). We are grateful to the RACS for their outstanding support of our work. The College continues to collaborate closely with the RACS on a range of issues related to professionalism and performance.

We recommend that the framework outlined in the SPPP Guide be integrated into the professional development process throughout each physician’s career. We wholeheartedly endorse this initiative and hope it assists you in your ongoing learning, development and reflection.

John Kolbe
President

Leslie E Bolitho
President Elect
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Funding and support for the Supporting Physicians’ Professionalism and Performance (SPPP) Project was provided by the Medical Indemnity Industry Association of Australia (MIIAA) and its members, Avant and MDA National. These organisations were pleased to have the opportunity to be involved in the project and the development of the SPPP Guide.
Introduction

The Royal Australasian College of Physicians (the College), is committed to ensuring the highest standards of practice for its Fellows. Historically, the College has provided outstanding training to future Fellows and has supported Fellows to remain current through a robust approach to Continuing Professional Development.

However, the medical landscape is changing and the College recognises that Fellows have an increasing need for transparency and accountability. We are required to demonstrate high standards of performance to our patients, colleagues, organisations with whom we work and to wider society in general.

The Supporting Physicians’ Professionalism and Performance (SPPP) Guide provides a framework which identifies high standards of performance that we as Fellows aim to achieve and exceed. In doing so, it assists us to understand our practice and direct our own professional development.

The SPPP Guide will also assist in our understanding of clinical practice, demonstrating our professionalism to patients, colleagues and organisations. It can be used to encourage engagement at organisational and system levels. The SPPP Guide will support us in our day-to-day work across the range of roles we undertake, including clinical practice, management, research, teaching, policy and advocacy.

The SPPP Guide has been developed by Fellows for Fellows. It has been overseen by a Steering Committee (Appendix 1) and an Executive Group comprising the Clinical Leads, Project Consultant and SPPP project staff.

Funding for this project was provided by the Medical Indemnity Industry Association of Australia. The College is very grateful for this support.

Sarah Dalton FRACP  
Co-chair, SPPP Executive

Grant Phelps FRACP  
Co-chair, SPPP Executive
A Changing Medical Environment

More is being asked of doctors. The inevitable move towards collaborative and patient-centred models of care demands a new way of thinking about clinical practice and our roles as medical professionals. Well-publicised failures of professional self-regulation have led to society questioning the validity of this approach.

Governments throughout the world have increased their expectations of the medical profession. In Australia, undertaking Continuing Professional Development (CPD) is now a mandatory requirement of registration. In New Zealand, moves are being made towards Practice Review as a core component of CPD. In the United States (US) and the United Kingdom (UK), increased community expectations are playing out in a requirement for recertification. Professional bodies are required to provide a ‘guarantee’ of a Fellow's professional standing as an essential precursor to re-licensing or re-registration.

The College acknowledges this significant change in the regulatory environment and recognises that recertification may become a formalised requirement for Fellows in Australia and New Zealand. Recertification involves a professional organisation such as a College ‘certifying’ that its Fellows are indeed competent and performing at the level required of a member of that organisation. In the US, recertification takes the form of a knowledge-based assessment similar to the RACP written examination. Other environments, such as the UK, are taking a more global view of performance assessment, believing that actual practice is more important than what might be demonstrated in an examination. It is likely that Australia and New Zealand will follow the UK model where demonstrating appropriate performance is the cornerstone of the recertification process.

It can be assumed that Medical Colleges will have a role in the move towards a process of recertification in Australia and New Zealand. This represents a significant challenge for the RACP and its Fellows. It is therefore important that we are prepared and able to demonstrate clearly and consistently that our performance is at the expected level.
Competence and Performance

The SPPP framework makes an important distinction between competence and performance:

**Competence** is the ability to do what we have been trained to do.

The competence of a physician is developed during training under the supervision of the College. Competence encompasses what we have learned and what we are able to do. This involves acquiring and maintaining clinical, technical and non-technical knowledge, skills and attitudes.

**Performance** is what we actually do in day-to-day practice.

Performance depends on the level of competence; however it is also influenced by individual and system-related factors. Figure 1 illustrates the relationship between competence and performance and shows how physician performance in practice is affected by system-related and individual influences.

*Individual-related influences may include personality, health and family issues or simply having a bad day.*

*System-related influences include those that arise from a hospital, service or practice and may relate to matters such as workload, staffing, funding, competing demands for time, and resources.*

**Figure 1**

There are many examples that illustrate the difference between competence and performance. For instance, in order for a physician to deliver best practice, they must not only be competent as a medical expert, but also perform as a participant or leader of a multidisciplinary team.
Demonstrable Professionalism

Transparent approaches to understanding doctors’ competence (what they are able to do) and performance (what they actually do) are increasingly reflected in public policy settings. For instance, approaches to both credentialling and open disclosure are based on a need for us as doctors to demonstrate our professionalism consistently and in a readily identifiable fashion.

Many jurisdictions are now following the lead of industry and adopting performance development and support processes as a core component of their strategy to engage with medical staff. This is occurring in both public and private settings and forms a central component of national organisation-level accreditation standards in Australia and New Zealand. These processes require Fellows to demonstrate that they are performing appropriately within their scope of practice and within a broader organisational context. All hospitals, including day hospitals, will be required to provide these processes in order to obtain and maintain accreditation. In the future, this may also have the potential to emanate to other settings, including private practice.

Consequently, there is increasing societal expectation and a developing regulatory requirement for all doctors. The medical profession will move from a position of autonomy (“trust me, I’m a doctor”), to one where doctors must be able to demonstrate clearly and consistently to their colleagues, their patients and to themselves, that they are practising in an appropriate and professional manner. This can be called “demonstrable professionalism” and is an essential personal responsibility at a time when the profession is under increasing scrutiny.
SPPP Framework

The College recognised a unique opportunity to actively support Fellows in demonstrating their professionalism with the development of the Professional Qualities Curriculum (PQC), designed to help Fellows and trainees understand their practice, using several domains that together made up a professional “whole” (RACP, 2009).

The Supporting Physician’s Professionalism and Performance (SPPP) Guide presents a framework that has adapted the PQC domains to describe a range of behaviours against which Fellows and trainees can measure their own performance. In doing so, Fellows will be able to develop a strong sense of their individual strengths and weaknesses and identify opportunities for personal learning and thus improvement. A crucial aspect of SPPP will be the provision of enhanced resources to address these learning needs. In addition, utilising the framework within the SPPP Guide will be considered a CPD activity when applied to generating a learning plan – the evidence being a completed Professional Development Plan (PDP) in the MyCPD program of choice.

The framework within the SPPP Guide recognises that medical expertise and excellence in physician practice must be underpinned by performance across all the following domains, including an ability to demonstrate safe, high-quality practice:

- Quality & Safety
- Cultural Competency
- Communication
- Collaboration & Teamwork
- Leadership & Management
- Decision making
- Health Advocacy
- The Broader Context of Health
- Teaching, Learning & Research
- Ethics

The SPPP framework and, in particular, the Quality and Safety domain need to be informed and influenced by the College at large. It is anticipated that individual elements of the Fellowship (including Divisions, Faculties, Chapters and Specialty Societies), will begin to populate the Quality and Safety domain with a range of measures or activities which clinical experts in that specialty area might be expected to meet.

The domain of Quality and Safety is absolutely fundamental to physician practice. While the generic domains of the PQC are readily applicable to any practising doctor, the Quality and Safety domain is what defines physician practice. Fellows have a depth of knowledge and unique technical skills that comprise a specific area of expertise relevant to their branch of physician practice. The broad domains of the PQC and the SPPP framework are regarded by the College as being core elements of physician practice, regardless of specialty.
**Behavioural Markers**

The performance of physicians in practice may be described and assessed through the use of behavioural markers.

Behavioural markers are short descriptions of good and poor behaviour that have been used to structure training in and evaluation of both technical and non-technical skills in anaesthesia, surgery, civil aviation, and the nuclear power industry in order to improve safety and efficiency. Behavioural markers are indicators of observable and/or assessable behaviours in the working environment.

The School of Psychology at the University of Aberdeen has identified behavioural markers across all these industries and disciplines. They developed the Anaesthetists’ Non-Technical Skills (ANTS) program in association with the Australian and New Zealand College of Anaesthetists (Fletcher *et al*, 2003) and the Non-Technical Skills for Surgeons (NOTSS) program with the Royal College of Surgeons, Edinburgh. The NOTSS program focuses specifically on the non-technical skills of surgeons in the operating room (Flin *et al*, 2006).

This program underpinned the development of the Royal Australasian College of Surgeons (RACS) *Surgical Competence and Performance Guide* (RACS, 2008) and has now been adapted for the SPPP Guide.

Many of the markers in the SPPP Guide have been drawn from the NOTSS program and from the RACS *Surgical Competence and Performance Guide*. The outstanding support of the RACS has been pivotal to the development of the RACP SPPP Guide.

Markers of good behaviour can provide guidance to physicians so they can confidently perform as good role models for trainees and other physicians. Markers of poor behaviour can provide a basis for professional support for, and targeted learning by, a physician so that patient safety and acceptable standards of care are not compromised.

Each of the domains outlined within the framework of the SPPP Guide are divided into three ‘patterns of behaviour’. These, in turn, are illustrated by a set of ‘good’ and ‘poor’ behavioural markers. It should be noted that the good and poor behavioural markers represent the extremes of physician performance. There is a wide spectrum of normal and appropriate physician behaviour between these extremes – the ‘shades of grey’ of physician practice.
Patterns of behaviour and behavioural markers are identified for each of the SPPP domains in the pages that follow.

The behavioural markers outlined within the SPPP Guide have been developed following significant consultation of the Fellowship throughout much of 2010 and 2011. The SPPP project has been widely publicised through a range of College communications, and has had extensive discussion at the the RACP Congress in 2010 and 2011. In addition, more than 40 separate groups within the College have been invited to contribute. It must be acknowledged however, that it has not been possible to capture every view and the SPPP Guide is therefore a document open to further input and development.
Using the SPPP Guide

The College believes that the SPPP Guide should be used as a self-assessment tool to encourage self-reflection and to assist each of us to identify areas requiring targeted learning. In addition, many Fellows may wish to use the SPPP Guide to support their working relationship with their employer or organisation (e.g. hospitals and private practice) through credentialling and other workplace processes.

The use of the SPPP Guide by individual Fellows within an organisational performance development process can both guide individual performance and assist organisations in finding the best way to support their Fellows. The use of the SPPP Guide may support, enhance and add value to performance feedback processes.

Some Fellows may choose to use the SPPP Guide within a peer-based context to help develop consistent approaches to professional practice (e.g. within a hospital department, specialty society, or a group of ‘like’ Fellows). Multi-source feedback is an example of assessment, where a range of colleagues and/or patients assess performance.

A list of resources that may assist Fellows is available for each domain in Appendix 2 (pages 40-44).

What tools are available to help Fellows understand their clinical practice?

A variety of tools are available to assist physicians to reflect on and understand their clinical practice. These include:

- Clinical audit
- Morbidity and mortality meetings
- Adverse occurrence screening/targeted case note review
- Formal peer review
- Clinical indicators
- Patient complaints and patient satisfaction surveys
- Incident reporting and analysis

Each of these has its place but none should be used in isolation. Properly implemented, they can contribute to a comprehensive approach to performance development.

More information on understanding clinical practice may be found in the following documents:

- NSW Health Department 2001—The Clinician’s toolkit for improving patient care
- Department of Health Victoria 2010—Understanding clinical practice toolkit
Where to next?

The College is determined to ensure the SPPP Guide meets your needs as Fellows. At future RACP Congresses there will be sessions based on SPPP where you will have an opportunity to tell your stories about the Guide and associated framework. There will be regular SPPP contributions to RACP News and other College communications and the SPPP Executive is interested to hear from you regarding improvements to the SPPP Guide.

Feedback and commentary regarding any or all of the following are most welcome:

- The SPPP project
- Physician competence and performance
- Domains, patterns of behaviour and behavioural markers
- Resources and supports that you have found useful
- Further developments to the SPPP Guide

The SPPP Guide will be continually reviewed, with consideration given to all feedback received.

Please visit the SPPP website at www.racp.edu.au/page/sppp. The website provides a range of resources as well as opportunities for providing feedback to the project team to inform future versions of the SPPP Guide. We would be delighted to hear from you. The SPPP Executive can be contacted at sppp@racp.edu.au.

We wish you all the best as we embark on this exciting journey together.

SPPP Executive
## Quality and Safety

### Maintaining medical expertise
Supporting safety and quality by adhering to accepted codes of conduct and standards of practice.

<table>
<thead>
<tr>
<th>Examples of good behaviours</th>
<th>Examples of poor behaviours</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Continually endeavours to develop and maintain medical expertise</td>
<td>• Fails to observe standards or protocols (e.g. disregards prescribing guidelines or infection control protocols)</td>
</tr>
<tr>
<td>• Keeps up with current literature and standards of clinical practice</td>
<td>• Rushes or cuts corners in order to complete work</td>
</tr>
<tr>
<td>• Contributes evidence and experience to the development of policies and protocols designed to protect patients and enhance patient care</td>
<td>• Acts as a poor role model for standards of professionalism and conduct in clinical and other settings</td>
</tr>
<tr>
<td>• Demonstrates required compliance with accepted standards of practice</td>
<td>• Fails to contribute to organisational learning by not notifying clinical incidents</td>
</tr>
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</table>

### Monitoring and evaluating care
Regularly reviewing and evaluating clinical practice, medical outcomes, complications, morbidity and mortality.

<table>
<thead>
<tr>
<th>Examples of good behaviours</th>
<th>Examples of poor behaviours</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Uses clinical data and patient feedback to guide and improve practice</td>
<td>• Fails to regularly attend audit, case discussion and clinical meetings or audit own results</td>
</tr>
<tr>
<td>• Compares own results with those of departmental peers, other physicians in the community and published material</td>
<td>• When outcomes are poor, inappropriately implicates others in causation</td>
</tr>
<tr>
<td>• Actively promotes best practice and evidence-based medicine principles</td>
<td>• Makes no comparisons of own work to others’ results or agreed standards</td>
</tr>
<tr>
<td>• Participates in reporting, investigation, root cause analyses and other reviews of adverse events</td>
<td>• Employs new therapy or technique without considering evidence, health assessments and organisational or other approval processes</td>
</tr>
</tbody>
</table>
Defining and working within scope of practice

Working within a defined scope of practice and demonstrating appropriate diagnostic, therapeutic and procedural skills.

**Examples of good behaviours**

- Willingly works within a scope of practice appropriate to local hospital conditions and support services
- Knows own limitations and when to ask for help, referring conditions outside their usual scope to colleagues
- Willingly and fully involves themselves in organisational credentialling and performance development processes
- Evaluates scope of practice in accordance with current qualifications and experience

**Examples of poor behaviours**

- Lacks insight into own clinical capabilities and is unwilling to call for assistance
- Fails to refer appropriately or in a timely manner
- Undertakes practices that are not in the best interests of the patient or wider community
- Takes on cases beyond skill set and competency

“We are what we repeatedly do. Excellence, then, is not an act, but a habit.” Aristotle
## Cultural Competency

### Communicating effectively with people from culturally and linguistically diverse backgrounds

Communicating with patients, family members, carers and team members in a culturally sensitive manner.

<table>
<thead>
<tr>
<th>Examples of good behaviours</th>
<th>Examples of poor behaviours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Incorporates cultural understanding into communication</td>
<td>Uses unskilled person to translate for patient when better alternatives are available</td>
</tr>
<tr>
<td>Uses interpreters appropriately and effectively</td>
<td>Fails to allocate sufficient time to allow for communication across linguistic and cultural barriers</td>
</tr>
<tr>
<td>Seeks the engagement of cultural ambassadors such as Aboriginal and Torres Strait Islander or Maori Health Workers</td>
<td>Fails to modify communication for patients from different cultural backgrounds</td>
</tr>
<tr>
<td>Provides translated written materials or other information resources</td>
<td>Makes culturally insensitive or racist remarks</td>
</tr>
</tbody>
</table>

### Responding to cultural, extended family and community needs

Demonstrating understanding of the impact of culture, ethnicity and spirituality on medical care at individual, family (including Māori Whānau and Australian indigenous kinship groups), community and population levels.

<table>
<thead>
<tr>
<th>Examples of good behaviours</th>
<th>Examples of poor behaviours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Develops one’s own cultural competency</td>
<td>Disregards cultural competency as an issue for physicians</td>
</tr>
<tr>
<td>Makes an effort to understand people’s cultural background</td>
<td>Fails to identify how one’s own cultural values can impact on physician practice</td>
</tr>
<tr>
<td>Shows sensitivity towards different patients’ backgrounds, cultural beliefs or attitudes</td>
<td>Discriminates on the basis of culture, ethnicity or religion</td>
</tr>
<tr>
<td>Identifies and takes appropriate action to address cultural bias in colleagues</td>
<td>Shows little or no interest in community engagement, education or cultural development</td>
</tr>
</tbody>
</table>
Supporting team members from different cultures and backgrounds

Providing cognitive and emotional help to team members from culturally and linguistically diverse backgrounds.

**Examples of good behaviours**

- Provides constructive feedback to both locally and overseas-trained team members
- Ensures delegation of tasks is appropriate to the skills and training of overseas-trained team members
- Establishes rapport with team members from culturally and linguistically diverse backgrounds
- Gives credit for tasks performed well, irrespective of team members’ backgrounds or cultures

**Examples of poor behaviours**

- Derides international medical graduates, trainees or colleagues
- Fails to recognise needs of co-workers from different cultural backgrounds
- Shows hostility to team members of a different cultural or linguistic background, e.g. makes sarcastic comments to nurses or medical staff
- Makes no effort to welcome or enquire about the clinical, cultural and family backgrounds of new team members

“Diversity is not about how we differ. Diversity is about embracing one another’s uniqueness.” Ola Joseph
# Communication

## Communicating effectively

Exchanging information with patients, families, kinship groups, carers, colleagues and other staff.

**Examples of good behaviours**

- Clearly explains the thinking behind the diagnostic process, findings and the management plan to all patients
- Demonstrates empathy and compassion when breaking bad news
- Encourages medical, nursing, allied health and other team members to ask questions
- Communicates management plans clearly and checks that the team understands
- Engages with the patient families and/or kinship groups and carers when appropriate

**Examples of poor behaviours**

- Is discourteous to patients or staff
- Frequently talks in technical jargon to patients and doesn’t check for adequate understanding or invite questions
- Routinely interrupts or dismisses the comments of patients, families, colleagues or staff
- Questions patients without regard for their background, environment, literacy or particular concerns about the presenting problem
- Does not engage with the patient families and/or kinship groups and carers, and disregards requests for consultation

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## Empowering patients and respecting their rights

Empowering patients and being respectful of their rights in all aspects of communication.

**Examples of good behaviours**

- Involves patients and families in their own care
- Encourages patients to ask questions and seek information about their condition and care
- Considers interpersonal relations and current emotional state of patient and their family
- Discusses the need, or otherwise, for follow-up arrangements and, where appropriate, offers emergency contact details to the patient

**Examples of poor behaviours**

- Shows insensitivity to the impact of illness, impairment or disability on communication
- Fails to consider patient wishes when planning treatment in poor prognostic situations and end-of-life care
- Engages in medical discussion with colleagues and trainees before addressing the patient
- Fails to acknowledge when errors occur or offer patient an explanation of events
Gathering and understanding information

Seeking timely and accurate information during the consultation in the wards, clinic or procedure room.

**Examples of good behaviours**

- Ensures that all relevant documentation, including notes, results and consent, is available and has been reviewed
- Reflects on and discusses significance of information
- Promptly follows up investigation results and informs patient and referring doctor
- Makes appropriate use of information resources, e.g. pharmacopoeia and other guidelines

**Examples of poor behaviours**

- Fails to review relevant information collected by team
- Disregards information from general practitioner or referring doctors
- Fails to check understanding of clinical decisions with patients and families
- Unnecessarily interrupts consultation or procedure to check information

“Think like a wise man but communicate in the language of the people.” William Butler Yeats
Collaboration and Teamwork

Documenting and exchanging information

Giving and receiving knowledge and information in a timely manner to aid establishment of a shared understanding among team members.

**Examples of good behaviours**
- Is collegial and professional in dealings with members of department or practice
- Listens to, discusses and appropriately acts upon concerns of team and staff members
- Considers other points of view in difficult situations
- Records contemporaneous and legible notes as required

**Examples of poor behaviours**
- Fails to listen to team members or other staff
- Needs help from staff member but does not make it clear what the staff member is expected to do
- Refuses to accept opinions of others
- Fails to ensure provision of timely information to patients’ referring doctor or general practitioner

Establishing a shared understanding

Ensuring that the team has all necessary and relevant clinical information, understands it and that an acceptable shared “big picture” view is held by members.

**Examples of good behaviours**
- Provides briefing, clarifies objectives and ensures that the team understands treatment and other plans
- Encourages input from all members of the team
- Actively works with the team to adjust plans in response to changing circumstances
- Debriefs relevant team members, discussing what went well and problems that occurred

**Examples of poor behaviours**
- Fails to do regular ward rounds involving interdisciplinary team members in a hospital setting
- Does not share significant information with other team members during ward rounds, meetings or other discussions
- Does not encourage or accept input from other team members
- Fails to explain the rationale for decision making to other team members
Playing an active role in clinical, interdisciplinary and other teams

Working together with other team members to carry out cognitive and physical activities in an effective, coordinated and collaborative manner.

Examples of good behaviours

- Introduces self to new or unfamiliar members of the team
- Works effectively and cooperatively with colleagues in other areas to ensure that patient care is seamless
- Advises all relevant staff of admissions and other planned activities in a timely manner
- Informs team members of important changes in management

Examples of poor behaviours

- Proceeds with team-based activities without ensuring that relevant nursing and allied health staff are present or have been consulted
- Fosters disharmony or conflict in the team
- Fails to engage with members of the broader healthcare team, including general practitioners and community providers
- Fails to communicate changes in availability to people who need to know in a timely manner

“Learn from the pros, observe them, seek them out as mentors and partners.” Colin Powell
Leadership and Management

Planning ahead
Predicting what may happen in the near future as a result of possible actions, interventions or non-intervention.

Examples of good behaviours
- Prioritises workload and arrives in a timely fashion for clinics and other scheduled commitments
- Plans patient management, taking into account patient needs, availability of resources and other services
- Shows evidence of having a contingency plan in response to changes in patient condition and response to therapy
- Carefully considers the relative merits of intervention and non-intervention on patient and broader health outcomes

Examples of poor behaviours
- Fails to provide an appropriate clinical handover to colleagues
- Does not help team prepare for predictable or likely events
- Fails to issue clear instructions to staff
- Is difficult to contact when on call and admonishes staff for continued attempts to make contact

Leading that inspires others
Retaining a calm demeanour when under pressure and emphasising to the team that he/she is under control in a high-pressure situation. Adopting a directive manner if appropriate without undermining the role of other team members.

Examples of good behaviours
- Remains calm under pressure, working methodically towards effective resolution of difficult situations
- Resolves team conflicts quickly and appropriately
- Acts as a role model to others in all aspects of physician and health professional practice
- Consistently acts with integrity and fairness

Examples of poor behaviours
- Displays inability to make decisions under pressure
- Fails to provide appropriate feedback to staff
- Blames subordinates for errors and does not take personal responsibility
- Loses temper repeatedly or inappropriately, has tantrums or is abusive to others
Recognising and respecting other leaders

Recognising and respecting the roles and authority of other leaders and responding effectively and appropriately to their direction.

**Examples of good behaviours**

- Constructively contributes to health service or private practice strategic planning and management processes
- Recognises the benefits of shared leadership models where all members can assert their individual leadership qualities
- Fosters effective working relationships with other leaders and managers
- Supports other medical colleagues who have chosen to take on leadership and management positions

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**Examples of poor behaviours**

- Fails to recognise and respect the roles of other health professionals, managers and leaders
- Undermines or sabotages the work of other leaders or managers
- Fosters dissent among team members
- Refuses to recognise the mission, goals and strategic direction of a healthcare organisation or practice

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“Leaders don’t create followers, they create more leaders.” Tom Peters
Decision making

Considering options
Generating alternative possibilities or courses of action to solve a problem. Assessing the hazards and weighing up the threats and benefits of potential options.

Examples of good behaviours
- Recognises and articulates problems to be addressed
- Initiates balanced discussion of options, pros and cons with relevant team members
- Carefully considers contraindications, potential interactions and complications of therapeutic options
- Respects the patient’s right to self-determination

Examples of poor behaviours
- Does not consider or discuss options
- Does not solicit views of other team members
- Fails to adequately document discussions around options and the basis of decision making
- Fails to seek second opinion, where appropriate, on behalf of patients or other physicians

Discussing and communicating options
Discussing options with patients and communicating decisions clearly and effectively.

Examples of good behaviours
- Reaches a decision in an appropriate timeframe and clearly communicates it
- Makes provision for and communicates other options and plans
- Informs patient, family and relevant staff about the expected clinical course of the patient
- Is decisive and has clear goals and plans of management

Examples of poor behaviours
- Fails to inform team or patient of treatment plan
- Is aggressive or unresponsive if plan questioned
- Selects approaches and therapies incongruent with patient wishes
- Is indecisive or unable to make and communicate decisions in a timely fashion
Implementing and reviewing decisions

Undertaking the chosen course of action and continually reviewing its suitability in light of changes in the patient’s condition. Showing flexibility and changing plans if required to cope with changing circumstances to ensure that goals are met.

Examples of good behaviours

• Implements decisions within an appropriate timeframe
• Reconsiders plan in light of changes in patient condition or when problems occur
• Calls for assistance if required
• Routinely follows up investigation results and outcomes of therapy and acts accordingly

Examples of poor behaviours

• Frequently fails to implement decisions
• Makes the same error repeatedly
• Continues with initial plan in face of predictably poor outcome or when there is evidence of a better alternative
• Fails to reflect on decision making and outcomes

“No problem can withstand the assault of sustained thinking.” Voltaire
Health Advocacy

Compassion and respect for patient rights

Providing optimum care while respecting patients’ rights, choice, dignity, privacy and confidentiality.

**Examples of good behaviours**

- Encourages patients to seek different views or opinions and to exercise informed choice
- Treats patients courteously and compassionately, engaging them in decision making and respecting their choices
- Exhibits concern and respect for patients’ privacy
- Is willing to spend further time with distressed patients to listen to their concerns

**Examples of poor behaviours**

- Gives the impression of being ‘heartless’ or lacking in empathy or concern for the patient
- Lacks a patient-centred approach and does not listen closely to patient needs
- Spends insufficient time with a patient to build an appropriate therapeutic relationship, particularly in an emotionally charged situation
- Delegates the process of informed consent to inexperienced or inappropriate staff/doctors

Meeting patient, carer and family needs

Engaging patients and, where appropriate, families or carers in planning and decision making in order to meet their needs and expectations in the best possible way.

**Examples of good behaviours**

- Plans investigations and treatment, firstly taking into account the needs of the patient and carers
- Truthfully discusses prognosis and possible effects of recommended treatments on quality of life and dignity of patient
- Follows up referred patients and seeks reports on progress
- Allows sufficient time for the patient to express concerns or misgivings regarding the course of treatment

**Examples of poor behaviours**

- Consistently runs late and keeps patients and staff waiting
- Inappropriately delegates tasks to junior staff in order to avoid dealing with difficult problems
- Undertakes an inadequate or incomplete assessment in the context of a patient’s physical or cognitive disability
- Fails to keep track of referred or transferred patients
Supporting and promoting change and improvement in the clinical work environment

Understanding factors that may adversely affect the working environment and driving change to improve the quality and continuity of patient care.

**Examples of good behaviours**

- Contributes to governmental, regulatory policy making and other submissions and reports that impact on patient outcomes or the physician’s working environment
- Actively encourages and promotes benchmarking of like services to improve quality of care
- Promotes and seeks systematic processes for meaningful consumer feedback from patients and families
- Demonstrates the full scope of evidence-based practice as part of routine service delivery

**Examples of poor behaviours**

- Is resistant to change and systems improvement initiatives without an adequate evidence base to support their attitudes
- Refuses to engage in meaningful clinical audits
- Resists working in partnership with health management to ensure efficient and effective operation of health services
- Refuses to acknowledge a role other than that of providing clinical services

“Of all the forms of inequality, injustice in health care is the most shocking and inhumane.”

Martin Luther King Jnr
The Broader Context of Health

Considering the broader context of health

Effecting change and improvement in the health of the community and determinants of health locally and more broadly across Australia and New Zealand.

### Examples of good behaviours
- Develops strategies to ensure equity of access to healthcare services
- Recognises wider health needs of community in the context of constrained resources
- Demonstrates an understanding of the necessary steps required to effect change in the determinants of health in a community
- Appropriately supports notifiable conditions

### Examples of poor behaviours
- Disregards the community impact of decisions
- Lacks awareness of health priorities for the local community and more broadly for Australia and New Zealand
- Is unable to identify and articulate the determinants of health in a community
- Fails to work with others to effect sustainable change at local, community or population level

Promoting health and preventing illness

Using clinical and other patient encounters to promote healthy lifestyles, quality of life, illness prevention and participation in relevant screening programs.

### Examples of good behaviours
- Even in busy clinics or emergency settings, steps back and considers the wider issues that may contribute to presentations
- Actively promotes preventative interventions to individual patients and community
- Advocates for the health of the community as a whole to be considered in policy-making decisions
- Promotes appropriate advanced care planning by patients to prevent futile care

### Examples of poor behaviours
- Exhibits a poor understanding of the role of physicians in community health
- Acts as a poor role model regarding individual health risk factors
- Fails to promote appropriate screening or prevention programs
- Ignores wider quality of life impacts on patients when providing care that may be deemed unnecessary or futile
Taking into account the costs and benefits of medical care

Demonstrating an awareness of the costs and benefits of diagnostic and therapeutic interventions and using this to inform decision making.

**Examples of good behaviours**

- Advocates for patients requiring novel or costly treatments when supported by evidence or health technology assessments
- Advises patients and families and educates junior colleagues about the cost-benefits of medical intervention
- Examines evidence such as systematic reviews to assess value for money, potential harm or side effects of interventions
- Demonstrates awareness of the cost implications of prescribing and pharmaceutical benefits

**Examples of poor behaviours**

- Takes no account of the cost implications of new therapies at individual and community levels
- Exhibits a poor understanding of health funding and the costs of specific treatments
- Fails to consider ‘out of pocket’ expenses, travel cost and time implications of ambulatory drug treatment, tests and other interventions
- Takes no account of the clinical and financial consequences of inappropriate investigations

“While the health system has a vitally important role, broader actions to reduce social risk through improving wealth, education, employment and housing also have a major influence on the status of a society’s health and wellbeing.”
Australian National Health and Hospitals Reform Commission 2009
Teaching, Learning and Research

Showing commitment to lifelong learning

Engaging in a lifelong commitment to reflective learning both through their own learning and by passing on their knowledge to others.

**Examples of good behaviours**

- Participates regularly in conferences, courses, simulation exercises and other evaluations of assessment, decision-making and technical skills when appropriate
- Encourages questioning by colleagues, trainees and junior medical officers
- Engages with staff and encourages their learning, development and career planning
- Demonstrates understanding of the recent literature and its impact on medical practice

**Examples of poor behaviours**

- Shows errors in understanding of literature or doesn’t acknowledge recent literature
- Fails to keep up to date with current literature
- Avoids involvement in teaching, grand rounds and supervision/mentoring
- Demonstrates no interest in the training and development of junior staff

Actively participating in research and evidence-based practice

Contributing to the development of new knowledge through research and applying that knowledge in day-to-day clinical settings.

**Examples of good behaviours**

- Strives to improve medical practice through participation in clinical research and development
- Ensures that prior to commencement all research projects are reviewed and approved by an appropriately constituted research ethics committee
- Uses evidence-based medicine approach to present findings in a critical and analytical manner
- Always looks for better solutions to improve care and opportunities for innovation

**Examples of poor behaviours**

- Deliberately ignores the evidence base regarding emerging therapies and techniques
- Fails to work within guidelines for the study or implementation of new treatments and techniques
- Fails to inform patient when a treatment or intervention is innovative, new, experimental or lacking an evidence base
- Does not contribute to research through the provision of data, involvement in trials or the encouragement or support of others
Teaching, supervision and assessment
Facilitating education of their students, patients, trainees, colleagues, other health professionals and the community.

Examples of good behaviours
- Provides a level of supervision appropriate to individual junior staff members
- Regularly uses clinical encounters as an opportunity for teaching others
- Provides regular constructive feedback without personalising the issues
- Seeks feedback from students and junior doctors regarding teaching style and abilities and provides feedback to others

Examples of poor behaviours
- Demonstrates arrogance, rudeness or disinterest in the training of junior staff
- Regularly fails to attend scheduled tutorials and other teaching sessions
- Fails to delegate appropriately to junior staff
- Is openly critical of junior staff and belittles them if unable to answer questions

“Tell me and I’ll forget; show me and I may remember; involve me and I will understand.” Chinese Proverb
# Ethics

## Observing ethics and probity

Maintaining standards of ethics, probity and confidentiality and respecting the rights of patients, families and carers.

<table>
<thead>
<tr>
<th>Examples of good behaviours</th>
<th>Examples of poor behaviours</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Provides an ethical role model for other staff</td>
<td>• Makes questionable claims for medical benefits, insurance, third party, accident or workers compensation payments</td>
</tr>
<tr>
<td>• Respects the dignity and privacy of patients at all times, including confidentiality of health records</td>
<td>• Exhibits bullying, harassing or sexist attitudes towards trainees, other staff or patients</td>
</tr>
<tr>
<td>• Carefully explains examinations or treatments to the patient and seeks informed consent before carrying them out</td>
<td>• Breaches confidentiality by discussing patient details in public areas or through social networks</td>
</tr>
<tr>
<td>• Maintains appropriate personal and sexual boundaries with patients at all times</td>
<td>• Engages with pharmaceutical companies and other sponsorship without adequate recognition of influence</td>
</tr>
</tbody>
</table>

## Maintaining health and wellbeing

Maintaining personal health and wellbeing and considering the health and safety needs of colleagues, staff and team members

<table>
<thead>
<tr>
<th>Examples of good behaviours</th>
<th>Examples of poor behaviours</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Has a personal general practitioner and attends appropriately</td>
<td>• Uses alcohol indiscriminately, e.g. when on duty or on call</td>
</tr>
<tr>
<td>• Has regular rest and holidays and does not allow annual leave to accumulate unreasonably</td>
<td>• Abuses prescription medications or uses illegal drugs</td>
</tr>
<tr>
<td>• Enquires after the welfare of colleagues and junior staff and offers support as appropriate</td>
<td>• Regularly exhibits moodiness or dispirited behaviour in the workplace</td>
</tr>
<tr>
<td>• Enjoys leisure activities and interests outside medicine</td>
<td>• ‘Battles on’ even when unwell or overtired without recognising the impact on clinical performance</td>
</tr>
</tbody>
</table>
Having awareness and insight

Reflecting on an individual’s medical practice and having insight into its implications for patients, colleagues, trainees and the community.

**Examples of good behaviours**

- Modifies clinical practice in response to illness, impairment or limitation of cognitive function, decision-making abilities or manual dexterity
- Responds positively to questioning, suggestion and objective criticism
- Seeks out, identifies and explores errors and uses this as a basis for improvement
- Recognises poor outcomes and the need to reflect and improve

**Examples of poor behaviours**

- Stubborn, refuses help when it is clearly required
- Blames registrars or others for poor outcomes
- Allows personal moral considerations within the context of ethical decision making
- Berates or humiliates subordinates

“Only one rule in medical ethics need concern you—that action on your part which best conserves the interests of your patient.”

Martin H. Fischer
Support for Physicians

The College encourages all physicians to recognise and discuss the challenges facing them and to ensure that self-care is part of managing professional life.

Self-care

Self-care involves taking care of your physical, mental and emotional health. It also involves eating, sleeping and living well. To ensure you enjoy your work and leisure, priorities and boundaries need to be set.

Physicians are at risk from stress, burnout and a range of illnesses. You have a responsibility to be alert to your symptoms and to seek appropriate professional care as patients.

Consult Your General Practitioner

Physicians are encouraged to regularly visit a general practitioner they trust to manage their healthcare. Encourage your colleagues to do the same. By allowing another doctor to objectively manage your health, you will be free to do what you do best—concentrate on the health of your patients.

Support Networks and Physician Colleagues

Maintaining an effective support network is recognised by many specialties in many countries as being the single most important means by which medical practitioners can maintain balance and health in their lives. Support networks can include medical department heads and peers, colleagues, structured support networks and personal support from family and friends.

Many physicians find it invaluable to select one or two ‘physician friends’ who are available to help and support in stressful times. This arrangement is best made proactively before specific incidents or trouble occurs.

Strengthening Your Skills

There are a number of professional development opportunities available that promote and strengthen skills for managing the challenges and pressures of medical practice. These include courses and tools on time and practice management skills, coping with stress and burnout, conflict resolution and self-care strategies for the healthy doctor.
**Need more help?**

**Doctors’ Health Advisory Services**

Doctors’ health advisory services provide independent, confidential support and medical advice to doctors.

**ACT:** Colleague of First Contact (24hr)
Helpline: +61 407 265 414

**NSW:** Doctors’ Health Advisory Service (24hr)
Helpline: + 61 2 9437 6552
Website: www.dhas.org.au

**NT:** Doctors’ Health Advisory Service (24hr)
Helpline: + 61 2 9437 6552

**SA:** Doctors’ Health Advisory Service (24hr)
Helpline: +61 8 8273 4111

**QLD:** Doctors’ Health Advisory Service (24hr)
Helpline: +61 7 3833 4352

**TAS:** AMA Peer Support Service (8am – 11pm)
Helpline: +61 1300 853 338

**VIC:** Victorian Doctors Health Program (24hr)
Telephone: +61 3 9495 6011

**WA:** Colleague of First Contact (24hr)
Helpline: +61 8 9321 3098

**NZ:** Doctors’ Health Advisory Service (24hr)
Helpline: +64 4 471 2654

**Australian Medical Association (AMA) Telephone Assistance**

Victoria Peer Support Service: +61 1300 853 338

**Rural Support**

**Australia:** The Bush Crisis Line and Support Services: +61 1800 805 391 (24hr)
A confidential telephone support and debriefing service.

**Lifeline**

**Australia:** Telephone: +61 13 11 14

**Medical Board of Australia**

Working in partnership with AHPRA to protect the public and guide the profession
+61 3 8708 9001
Other Services

Alcoholics Anonymous

**Australia:**
Telephone: +61 2 9599 8866
Website: [www.aa.org.au](http://www.aa.org.au)

**New Zealand:**
Telephone: +64 800 229 675
Website: [www.alcoholics-anonymous.org.nz](http://www.alcoholics-anonymous.org.nz)

Alcohol and Drug Information Service

**Australia:**
Telephone: 1800 422 599 (24hrs)

Alcohol Drug Helpline

**New Zealand:**
Telephone: +64 800 787 797
Website: [www.adanz.org.nz](http://www.adanz.org.nz)

Narcotics Anonymous

**Australia:**
Telephone: +61 1300 652 820
Website: [www.naoz.org.au](http://www.naoz.org.au)

**New Zealand:**
Website: [www.nanz.org](http://www.nanz.org)

Australian Hearing

Telephone: + 61 2 9412 6800
Website: [www.hearing.com.au](http://www.hearing.com.au)

Hearing Association New Zealand

Telephone: +64 800 233 445
Website: [www.hearing.org.nz](http://www.hearing.org.nz)

Vision Australia

Telephone: +61 1300 84 74 66
Website: [www.visionaustralia.org.au](http://www.visionaustralia.org.au)

Physicians are also encouraged to seek counsel from within their community (e.g. local community and denominational services).
References


## Appendix 1

### SPPP Steering Committee

<table>
<thead>
<tr>
<th>Name</th>
<th>Position and Location</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Professor John Kolbe</strong></td>
<td>President, RACP, Auckland, New Zealand (Chair SPPP Steering Committee until July 2011)</td>
</tr>
<tr>
<td><strong>Professor Richard Doherty</strong></td>
<td>Dean, RACP, Melbourne, Victoria (Chair SPPP Steering Committee from July 2011)</td>
</tr>
<tr>
<td><strong>Dr Grant Phelps</strong>*</td>
<td>Gastroenterologist, Health Care Consultant, Ballarat, Victoria (Co-Chair, SPPP Executive)</td>
</tr>
<tr>
<td><strong>Dr Sarah Dalton</strong>*</td>
<td>Paediatric Emergency Physician, The Children’s Hospital at Westmead, New South Wales (Co-Chair, SPPP Executive)</td>
</tr>
<tr>
<td><strong>A/Professor Caroline Brand</strong></td>
<td>Rheumatologist, Melbourne, Victoria Melbourne Epicentre, University of Melbourne and Melbourne Health Associate Director, Centre for Research Excellence in Patient Safety, Monash University</td>
</tr>
<tr>
<td><strong>Dr Jonathon Burdon</strong>*</td>
<td>Respiratory Physician, Melbourne, Victoria (MIIAA Representative)</td>
</tr>
<tr>
<td><strong>A/Professor Peter Gow</strong>*</td>
<td>Rheumatologist, Auckland, New Zealand</td>
</tr>
<tr>
<td><strong>Dr Gavin Frost</strong>*</td>
<td>Public Health Physician, Fremantle, Western Australia</td>
</tr>
<tr>
<td><strong>Dr Nada Hamad</strong></td>
<td>Trainee Representative, Sydney, New South Wales</td>
</tr>
<tr>
<td><strong>Clinical A/Professor Peter Kendall</strong></td>
<td>Clinical Associate Professor Fremantle Hospital, Western Australia</td>
</tr>
<tr>
<td><strong>Dr Alasdair MacDonald</strong>*</td>
<td>General Medicine, Launceston General Hospital</td>
</tr>
<tr>
<td><strong>Professor Geoff McColl</strong></td>
<td>Rheumatologist, Melbourne, Victoria Director, Medical Education Unit, University of Melbourne</td>
</tr>
<tr>
<td><strong>Dr Nigel Millar</strong>*</td>
<td>Chief Medical Officer, Canterbury District Health Board, Christchurch, New Zealand</td>
</tr>
<tr>
<td><strong>Dr Pam Montgomery</strong></td>
<td>Director, Division of Fellowship and Standards, Royal Australasian College of Surgeons</td>
</tr>
<tr>
<td><strong>Professor George Rubin</strong></td>
<td>Public Health Physician, Sydney, New South Wales</td>
</tr>
<tr>
<td><strong>A/Professor Ian Scott</strong>*</td>
<td>Director of Internal Medicine and Clinical Epidemiology, Princess Alexandra Hospital, Brisbane</td>
</tr>
<tr>
<td><strong>A/Professor Rohan Vora</strong></td>
<td>Director of Supportive and Palliative Care Service, Gold Coast, Queensland</td>
</tr>
<tr>
<td><strong>Dr Gregory Williams</strong>*</td>
<td>Paediatrician, Starship Children’s Hospital, Auckland, New Zealand</td>
</tr>
</tbody>
</table>
In attendance:

Dr Ian Graham       Project Consultant
Lauren Dalton       Project Manager (Part-time),
                     RACP, Sydney Office
Bianca Heggelund    Project Manager (Full-time until July 2011)
                     RACP, Sydney Office
Keith Johnstone     Manager, Fellows Learning Support
                     RACP, Sydney Office
Rose Matthews       Senior Executive Officer, New Zealand
                     RACP, New Zealand Office
Fiona Simpson       Senior Executive Officer, Continuing Professional
                     Development, RACP, Sydney Office
Karen Steadman      Senior Policy Officer, RACP, Sydney Office
                     (August 2009 – July 2010)

* SPPP Executive
Appendix 2

Resources

Quality and Safety


Cultural Competency


**Communication**


**Collaboration and Teamwork**


**Leadership and Management**

Decision making


Health Advocacy


Broader Context of Health


Teaching and Learning


Ethics


Royal College of Physicians (2005). Ethics in Practice: Background and recommendations for enhanced support. Available online: http://bookshop.rcplondon.ac.uk/contents/pub82-e6d08817-6875-4f28-aea3-6917b3f7af64.pdf [accessed 19 September 2011]
Other


Please send your feedback to:
sppp@racp.edu.au
The Royal Australasian College of Physicians

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 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.

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