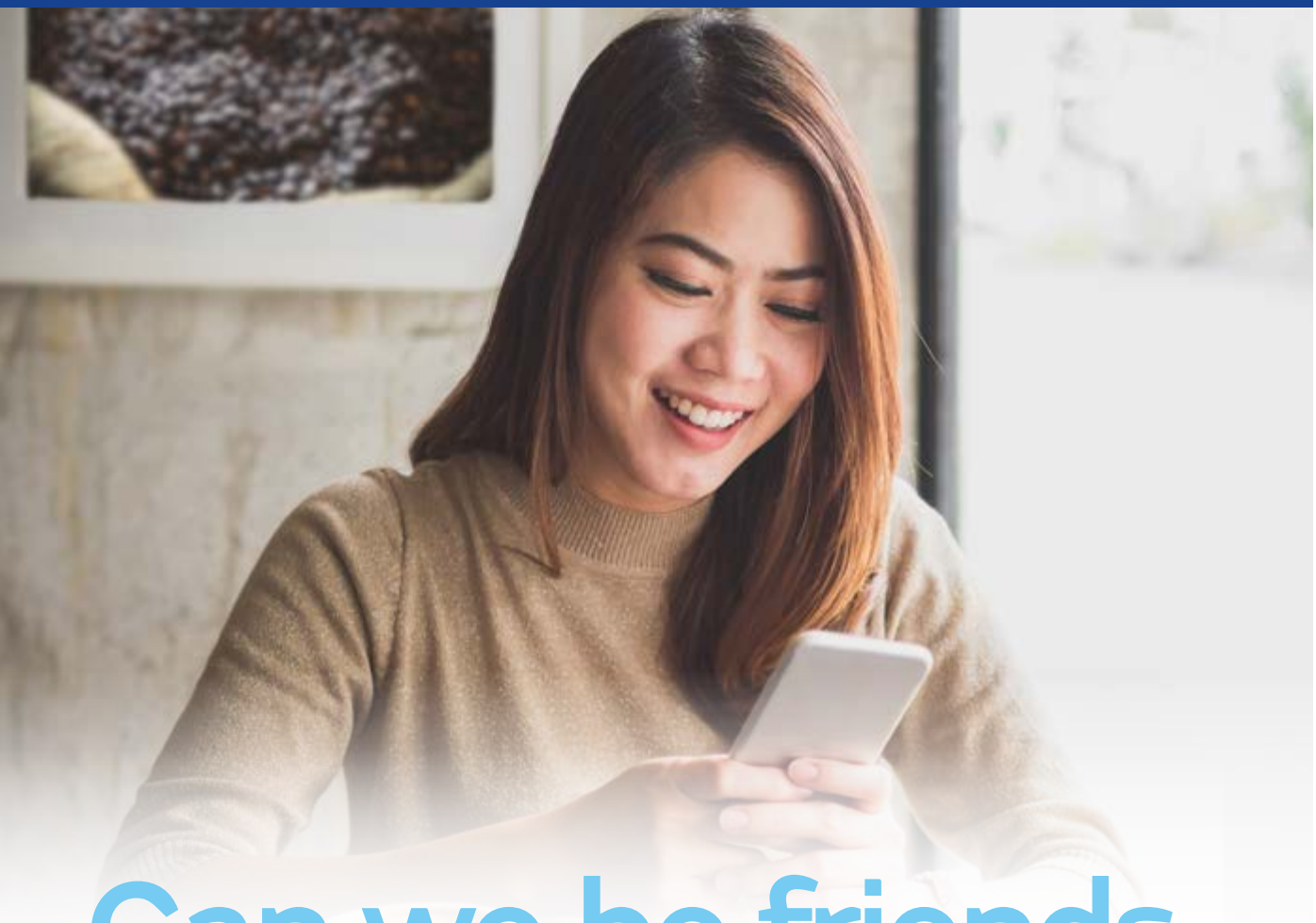
Australia

Risk management from Dental Protection
for hygienists, dental therapists and oral health therapists

Dental Protection

Teamwise

Issue 24 | **June 2022**



Can we be friends with our patients?

How to be sure where the boundaries lie

Page 6

Ten simple steps to manage risk

Be proactive – be prepared

Close contact

Is it ever OK to provide informal treatment to colleagues?

Difficult conversations: bariatrics

Our case study shows how to handle this sensitive issue

Dental Protection

Subscribe and listen to our podcasts

The Dental Protection Australia podcast series shines a light on the big dentolegal issues affecting dental practitioners across Australia today.

Packed with helpful advice and guidance from our Dental Protection advisory team, each podcast helps you avoid common dentolegal pitfalls and provide high-quality dental care. Our experts explain how you can mitigate risk to keep yourself, your team and your patients safe, and provide them the best dental care possible.

Risk Bites
Bite sized advice to reduce your risk

RiskBites is our series of short 'bite-sized' podcasts discussing dentolegal risks and issues affecting dental practitioners across Australia.

Case Matters
There are many sides to every story

There are many sides to a story. Our CaseMatters series takes a deeper dive into real life case studies and discusses the learnings behind them.

Risk Matters
When managing risk matters most

Our latest series RiskMatters is all about managing risk when it matters the most. Throughout the series we will be taking your feedback and queries and putting them to leading industry experts to answer.

Subscribe and listen today
dentalprotection.org/australia/podcast

DPL Australia Pty Ltd ("DPLA") is registered in Australia with ABN 24 092 695 933. Dental Protection Limited ("DPL") is registered in England (No. 2374160) and along with DPLA is part of the Medical Protection Society Limited ("MPS") group of companies. MPS is registered in England (No. 00036142). Both DPL and MPS have their registered office at Level 19, The Shard, 32 London Bridge Street, London, SE1 9SG. DPL serves and supports the dental members of MPS. All the benefits of MPS membership are discretionary, as set out in MPS's Memorandum and Articles of Association. "Dental Protection member" in Australia means a non-indemnity dental member of MPS. Dental Protection members may hold membership independently or in conjunction with membership of the Australian Dental Association (W.A. Branch) Inc. ("ADAWA"). Dental Protection members who hold membership independently need to apply for, and where applicable maintain, an individual Dental Indemnity Policy underwritten by MDA National Insurance Pty Ltd ("MDANI"), ABN 56 058 271 417, AFS Licence No. 238073. MDANI is a wholly-owned subsidiary of MDA National Limited, ABN 67 055 801 771. DPLA is a Corporate Authorised Representative of MDANI with CAR No. 326134. For such Dental Protection members, by agreement with MDANI, DPLA provides point-of-contact member services, case management and colleague-to-colleague support. Dental Protection members who are also ADAWA members need to apply for, and where applicable maintain, an individual Dental Indemnity Policy underwritten by MDANI, which is available in accordance with the provisions of ADAWA membership. None of ADAWA, DPL, DPLA and MPS are insurance companies. Dental Protection® is a registered trademark of MPS. Before making a decision to buy or hold any products issued by MDANI, please consider your personal circumstances and the Important Information, Policy Wording and any supplementary documentation available by contacting the DPL membership team on 1800 444 542 or via email.

Contents

Editor – Gareth Gillespie

Editorial consultants – Anita Kemp, Kara Stokes, Kristin Trafford-Wiezel, Dr Annalene Weston

Design – Allison Forbes

Print – Professional Print Services

Cover image © Nattakorn Maneerat/iStock/Getty Images

Pictures in this publication should not be relied upon as accurate representations of clinical situations

Greetings from the lake

As you no doubt saw on the news in March, Southeast Queensland and Northern NSW were both subject to record breaking floods. Just as we had reopened the Dental Protection office after COVID-19, it was closed again due to floodwaters.

My home, an apartment, was thankfully untouched, but the garages and grounds were flooded to a depth of three metres – and our river views were much improved to the point we actually lived on an island for a number of days. We had six days without power and were unable to leave the apartment block except on (wet) foot. No power, no internet.

Calamities such as this brings out the best and worst in people – you often see those you know quite well in a very different light when the chips are down. Some owners in our building moved out immediately when the roads were passable, others hid in their apartments and did not come out. Most, however, chipped in and worked tirelessly to clear the flooded garages and grounds of a stinking six-inch layer of mud. We all have differing abilities to cope and deal with disaster so I try not to judge those that went missing – but gee do I appreciate those that stayed and helped.

Triumph over adversity

On a moment's notice our team of Dental Protection advisers was two members down, as another team member dashed to Sydney to help family as the rains moved south.

A hole appeared in the coverage we provide to assist members of Dental Protection, and just as quickly the hole disappeared, as other dentolegal advisers and case managers picked up the slack without hesitation or question. Some staff seemed to be starting the working day before sunrise, and others in the team were sending responses to Dental Protection members long past dinnertime. Membership services, a smaller team, were also down two staff but the service remained the same. No-one hid behind their closed door. Not surprising to me, as we are all professionals and love the role we play in assisting you, our colleagues; but this also came on the back of the last two years of COVID-19 response. COVID-19 brought for us a sustained increase in the assistance required by our members.

It had become almost routine to see advisers and case managers in Zoom meetings talking to kids wandering into frame, as they juggled work and home schooling. Sometimes work hours were whenever it would fit in. Dogs and domesticity became the backdrop to working online. Undoubtedly many of our colleagues in practice have had a far tougher time over the last two years than we have for many reasons, and I do not wish to belittle this in the slightest. We have not had the financial strains, the constant battles with compliance and non-compliance, and the endless explanations to patients about what we can do and can't do, and why.

The message I am trying to convey is that I am proud of our team of professionals and their expertise, commitment and work ethic. I can assure you that no matter what the circumstances, they are here to deliver a world class service to you, our colleagues, in providing advice with complaints and claims, and management of your membership. Our door will always be open.

Dr Mike Rutherford BDSc FICD FPFA
Dental Team Leader Australia
mike.rutherford@dpla.com.au

Ten simple steps to manage our risk

While the word 'notification' commands instant anxiety, practitioners can take positive steps to ensure they are well placed to deal with any that arise. ***Daniel Spencer***, Senior Associate in the Health Law team at Panetta McGrath, and ***Dr Annalene Weston***, Dentolegal Consultant at Dental Protection, set out ten simple steps

While the receipt of a notification is not within your control, what you do in caring for your patients – from an initial consult through to discharge – certainly is. And while it is the quality of the care that is critically important, the documentation of such care is equally so.

We believe that there are also a number of 'controllables' for practitioners in seeking to mitigate any adverse finding by the Dental Board, should a notification or complaint about you arise. We recommend that you take these ten simple steps to safeguard your risk, as while they may seem onerous at the time, your future self will thank you for going the extra distance.

Maintain complete, accurate and contemporaneous clinical records.
This is a challenge with the busyness of everyday practice. It is critical for you to record the process of taking informed consent, so the conversation of consent including the actual risks discussed (rather than simply stating 'risks and warnings given'), making a note of any documentation you have provided the patient. Templates can assist in this regard, provided they are thorough, personalised and up to date.

Communicate clearly with patients and colleagues. This cannot be overstated.
Try to document all conversations with patients, and with colleagues if about a patient's care. It is also good practice to follow up important conversations with a patient by email, particularly where there is the potential for dispute or confusion about what was said or agreed.

Be open and honest and apologise if something goes wrong.
It is important that our patients know what has happened, and what we are going to do about it. It is also important that they understand what is going to happen next and that they do not feel abandoned by us when they have suffered harm. This is very much a conversation that Dental Protection are here to help guide you through.

Don't self-prescribe and don't prescribe for your friends and family.
While you may not have a prescriber number, this still holds true with practitioners often sidestepping seeing their GP to organise medicaments for themselves and their families informally through the practice. Remember, we can only issue medications related to the practice of dentistry, and any medications we seek for ourselves or our famiilies must contain a relevant clinical entry. The best way to avoid confusion is to seek all medicaments through formal routes, such your your GP.

Seek the advice of colleagues or mentors when unsure.
This may help you clarify your decision-making and assists in developing a collegiate profession. It also assists in better outcomes for our patients.

Respect professional boundaries – yours, your patients and your staff.
Be aware of professional boundaries with patients and colleagues. Seek to terminate a therapeutic relationship at the first sign of a relationship evolving into something personal.

Use a chaperone where appropriate.
Chaperones are there to protect you as well as the patient. Their presence can be critical when defending allegations of sexual misconduct. It can also be the difference in being out of practice for 12 months or more.

Inform yourself of Health Fund and Medicare requirements.
Before you begin to use your provider number you must ensure you are aware of requirements regarding the billing of items, remembering each third-party payer may have different rules and regulations. Regularly review Health Fund and Medicare updates and engage in open discussion with colleagues about what they mean. Don't assume your billing is fine 'because everyone else is doing it'. This defence won't fly in an audit.

Use social media with caution.
Be very careful when using social media (even on your personal pages), when authoring papers or when appearing in interviews. Health practitioners are obliged to ensure their views are consistent with public health messaging. This is particularly relevant in current times. Views expressed that may be consistent with evidence-based material may not necessarily be consistent with public health messaging.

Talk about it.
As well as maintaining good mental health, asking for help whether through formal channels (such as your GP) or informally, by talking through complaints or clinical concerns with colleagues, friends and family can prevent a situation escalating out of control. It can not only help you, but it can also help others as it acts to reassure that mistakes can and will happen to everyone. We can even learn from the mistakes of others, which is a valuable gift to share with a colleague.

© vlastas/iStock/GettyImages

Should we be friends with our patients on social media?

The concept of social networking can get tricky for dental practitioners, so how do we maintain professionalism in a world where such platforms are now considered mainstream communication tools? ***Anita Kemp***, Case Manager at Dental Protection, looks at the facts

These days, many dental practices rely on social media platforms to attract and maintain their patient base. The challenge with social media is that it is egalitarian in its concept, giving the illusion that it is permissible for us to be connected; yet how do we maintain the essential boundaries between ourselves and our patients without causing offence?

Definitions keep us safe

According to the Oxford Dictionary, the definition of social media is: "Websites and applications that enable users to create and share content or to participate in social networking."

Let's take a closer look at social networking. I like the definition by Investopedia, which states that:

'Social networking is the use of Internet-based social media sites to stay connected with friends, family, colleagues, customers, or clients. Social networking can have a social purpose, a business purpose, or both, through sites like Facebook, Twitter, LinkedIn, and Instagram.'

These definitions help us to set the scene by beginning to tease out concepts such as what is social vs professional, allowing us to explore the social relationship vs the therapeutic relationship. When we exchange the word 'professional' for 'therapeutic' the boundaries of our practice become clearly defined, which we will explore later.

Blurred lines

Often patients feel it is appropriate to contact their health practitioners about their health issues through social media, whether via a post on their practice page or direct messaging. Consequently, research indicates that health professionals and dental practitioners are experiencing an increase in friend requests from their patients, to connect not only professionally but personally as well.

In fact, for many patients sending their dental practitioner a friend request seems like a reasonable and acceptable thing to do. Yet, in most cases, it would be fair to assume that patients may not appreciate or comprehend the professional ramifications of extending a friend request, or for that matter the personal and professional boundary breaches that could occur. The challenge for practitioners is to balance these privacy and boundary requirements, by knowing where and when to draw the line between their professional profile and their personal profile.

Boundary breaches

According to the DBA *Code of Conduct*, health professionals are "expected to display a standard of behaviour that warrants trust and respect of the community" and "this includes observing and practising the principles of ethical conduct".

Broadly, professional boundaries are defined as limits or borders that exist to protect that space between professional power and client vulnerability "enabling practitioner and patient to engage safely and effectively in a therapeutic relationship".

Due to the power imbalance inherent in the practitioner-patient relationship, the preservation of professional boundaries is key to preventing abuse of this relationship, promoting good care for the patient or client, and protecting both parties.

The value of the therapeutic relationship

The overarching purpose and nature of any relationship between a dental practitioner and their patients is one that is therapeutic. Which begs the question, does accepting a friend request add to the therapeutic relationship? The therapeutic lens enables distance from egalitarian norms that pervade social media and allows for preservation of the patient-practitioner relationship. A response to personal online requests can be as simple as saying: "As a clinician I cannot accept personal requests as it affects the therapeutic relationship." This allows the practitioner to maintain their professional boundaries, while also acknowledging that the patient's wellbeing and care is at the centre of practice.

© Tero Vesalainen/iStock/Getty Images

Case scenario

Let's think about a possible scenario, which could potentially breach these boundaries.

You accept a friend request from a patient, who has a high caries rate, and you notice that they are constantly posting photos of themselves consuming high sugar content and acidic drinks. When asked previously in conversations around diet, they denied these behaviours, stating they preferred to drink water.

Would it be appropriate to bring these posts up with them during their next appointment; would this be viewed by the patient as confrontational? And on the flipside, as their dental practitioner is it appropriate to ignore these posts and not instigate a conversation around diet and caries?

What if they didn't intend for you to see the images? Would bringing it up affect your therapeutic relationship? Would this be considered crossing professional boundaries?

Professional integrity and reputation

Accepting friend requests can be an avenue into your colleagues' and friends' personal worlds where they feel safe posting their personal views and content. If content shared on your profile is not to the patient's liking or conflicts with their values, they are likely to shift their perspective and view you as professional in power, not as a 'friend', and hold you to a higher accountability. In effect accepting from a patient what presents as a benign invitation becomes a privacy issue for your friends and colleagues.

The very real fact that posted information is seen, liked and shared by others, beyond the original intended recipients, could have unintended consequences and potential ethical repercussions for your friends and colleagues, not just you. Likewise, if your friends and colleagues are unaware that you are online friends with your patients, and by consequence provide access (although limited) to comments made on your profile by them, could you inadvertently be breaching their privacy?

Although we often share personal information with our patients around common interests, shared experiences and funny stories, the purpose is intentional with the design to build rapport; these conversations are often shared with some degree of discretion and in a clinical setting. Excessive disclosure through unfiltered access is unlikely to be of benefit to the therapeutic relationship and consequently could lead to boundary breaches.

Furthermore, dental professionals, like most people, share information on their personal social media accounts that includes personal information, photos, links to websites, likes and at times off the cuff comments shared between friends, family and colleagues. Whilst made under the premise of personal interaction, any comment made by a practitioner that expresses their personal beliefs that patients may find contrary to their own vulnerabilities or personal sensitivities (eg politics, religion, immunisation) could inadvertently breach the code of conduct.

Navigating your way out of the friend request

If you do find yourself in a position of receiving a friend or other social media request, you might on one hand feel flattered, while on the other hand feel uncomfortable, concerned that not accepting their request might prove awkward.

However, as health professionals we are not held to the same standard as our patients. As a profession we are afforded special privileges that are not extended to our patients or society in general, and in return we are expected to uphold these high ethical standards, which includes maintaining professional boundaries, preserving the therapeutic relationship, and placing our patients' wellbeing and care above any concerns, beliefs or feeling of our own.

With this in mind, it would be prudent to interact with patients over social media in a professional capacity, through a professional page.

Practical tips to preserve the therapeutic relationship

As mentioned earlier, patients may not fully understand the professional ramifications of extending a friend request.

Consider separating professional, practice and personal profiles on social media platforms, and adjust your privacy settings. Change your name to a pseudonym, making it challenging for patients to access your personal page.

Speak to your patient – explain that as a health professional you are governed by codes, guidelines and standards that set out the expectations regarding our professional behaviours and boundaries regarding personal relationships with patients, which state it is "usually inappropriate to form personal relationships with patients".

You could send a polite message explaining that the practice has a professional policy not to accept patient friend requests or establish online friendships with patients – this sets the tone and expectation for the patient.

Conclusion

Because all forms of social media have become so entwined with our social fabric, managing social media on both a personal and professional level has become increasingly important. Similarly, it is imperative that we attempt to construct and maintain professional boundaries with various forms of social media as well as our interactions with our patients across these platforms.

In a situation where a practitioner's professional behaviour or conduct was to come under review because of boundary breaches relating to interactions over social media, please know that it is irrelevant if the breach was inadvertently remiss, altruistic or well meaning. It is still a boundary breach and effectively a breach of the DBA Code of Conduct, which often carries with it far-reaching consequences for the practitioner.

So, if in any doubt, err on the side of caution – choose to maintain the 'therapeutic relationship' and not the 'friendship'.

Close contact?

It can be convenient for practitioners and staff alike to access dental care at their place of employment. Though treating colleagues can carry a certain amount of risk. Dental Protection Case Manager *Kristin Trafford-Wiezel* looks at one such example

Mr A was an oral health therapist in a large group practice, where he predominantly utilised his adult scope within the team providing examinations, restorative and preventative maintenance. The practice was very busy and a spare appointment was hard to come by.

On one particular day, a new dental assistant in the team, Miss K, had the opportunity to see Mr A for her long overdue hygiene appointment in her lunchbreak, due to an opening in the schedule. Mr A ensured that Miss K filled in a full medical history, discussed her dental history and enquired if she had any specific concerns. Miss K indicated it had been some time since her last full check and clean, as over the years in the dental industry, over a number of practices, it had been that her general examinations and hygiene maintenance were performed on an ad-hoc basis, based around patient scheduling and cancellations.

After completing the medical and dental history with Miss K, Mr A undertook a clinical assessment and enquired when the last set of bitewing radiographs had been taken, to assess bone levels and interproximal decay. Miss K indicated that they had not been done for some time, as there had not been the time during her short 'squeeze-in' appointments, though she reassured Mr A that she was not experiencing any issues or concerns. Mr A discussed that considering the length of time since her last radiographic assessment, it would be appropriate to update these, to ensure that anything could be caught early, to which Miss K agreed, and a set of bitewings was obtained.

Sadly, both Mr A and Miss K were in for quite a shock when the images were processed. Unfortunately, though Miss K had not been experiencing any symptoms, a serious issue was uncovered. After reviewing and reporting on the images, Mr A referred these images onto the principal dentist for their opinion and advice, as the


© Harbucks/iStock/Getty Images

issue identified fell beyond his scope of practice. The radiographs indicated that a longstanding impacted lower wisdom tooth had unfortunately caused significant resorption of the distal root of tooth 47, which was also exhibiting distal coronal caries, not visible in the mouth.

Consequently, though Miss K had experienced no issues or pain to date, the team was left breaking the bad news to Miss K on the findings and undertaking the difficult conversation on what the options were regarding these teeth. Regretfully, Miss K was advised that it was likely that she would lose both the affected teeth, though a referral was arranged to a specialist endodontist for further assessment. Miss K was understandably very distressed about this turn of events, advising she was feeling it particularly keenly as she was so dentally conscious, and was mortified that she was now in the position of losing two teeth, when she was herself in the dental industry.

Understandably, though Mr A had comprehensively assessed and referred appropriately, this was cold comfort now, seeing his patient in this position. Mr A could not shake the feeling that though Miss K was a 'regular attender', the way in which she had accessed and been provided dental care over the years had had serious implications for her dental health.

Learning points

- Do you think that Miss K had been cared for well in the past? Or do you think that her plight was a regretful outcome of 'squeeze-in' appointments? Can you see the risk to her and the previous treating practitioners who failed to properly examine and diagnose Miss K?
- It is imperative that practitioners are aware of our obligations to our patients, irrespective of close personal relationships. In short, all patients are just that: our patients, regardless of any other relationships we may have with them, such as friendships or work relationships.
- A helpful resource to better understand this is the Dental Board's *Code of Conduct*, section 3.14 – Understanding boundaries, which considers the issues and states:

  "Good practice includes recognising the potential conflicts, risks and complexities of providing care to those in a close relationship, for example close friends, work colleagues and family members and that this can be inappropriate because of the lack of objectivity, possible discontinuity of care and risks to the practitioner or patient.

  - "When a practitioner chooses to provide care to those in a close relationship, good practice requires that:
    - adequate records are kept
    - confidentiality is maintained
    - adequate assessment occurs
    - appropriate consent is obtained to the circumstances which is acknowledged by both the practitioner and patient or client
    - the personal relationship does not in any way impair clinical judgement, and
    - at all times an option to discontinue care is maintained (also see Section 8.2 – Professional boundaries)."[1]
- Of note, no records had been kept for Miss K previously, and I think we would all agree that her previous assessment had been inadequate. Although not relevant in this case, we do also see many cases where a close personal relationship impairs and impacts on clinical judgement.
- In short, remember – treat ALL patients as 'patients' and next time a colleague asks you for a quick clean up, ensure they are appropriately assessed, following the steps above.

REFERENCES

1. *dentalboard.gov.au/Codes-Guidelines/Policies-Codes-Guidelines/Code-of-conduct.aspx*

© FreshSplash/Getty Images

A question of boundaries

Dr M had been treating Mrs K and her family for many years; they were both of a similar age and their children attended the same schools and shared similar sporting interests. They often enjoyed conversations about parenting during the family's dental appointments, and they often crossed paths as their daughters played in the same soccer team. Recently Mrs K had extended a friend request to Dr M over social media.

Though Dr M felt a little uncomfortable about becoming friends with Mrs K in a personal capacity and over social media, he accepted her request and reasoned that he had always found Mrs K to be very pleasant. Similarly, he was worried it could prove awkward if he didn't accept her request, given that he ran into Mrs K most weekends at their daughters' soccer matches, and they were often tagged in the team photos.

While at the soccer club one evening, Mrs K sought Dr M out while he was waiting to order dinner with friends. She mentioned that she had noticed one of her teeth had become sensitive, and thought it was likely one of the last fillings Dr M had placed. She wondered if the tooth had cracked or indeed broken, and subsequently opened her mouth and pointed to the tooth. She then advised she had taken a photo of the tooth and would send it through to his social media account for him to take a look at.

Dr M, feeling quite uncomfortable and confronted by Mrs K's out of the blue request for advice in a social setting, tried to make light of the subject. He encouraged Mrs K to make an appointment with him on Monday. Mrs K seemed offended by his response; however, Dr M was unsure of how to explain that 'now' was neither the time nor place to complete a consult or offer any meaningful advice. Moreover, he was unable to see or identify with any certainty which tooth she was pointing to. Dr M was also aware that people were looking on and listening to their conversation, and he wanted to avoid any difficult or embarrassing conversations for them both.

The next day, Dr M received additional pictures of the tooth worrying Mrs K. The images accompanied a comment about Dr M

fobbing Mrs K off at the club, which she found to be rude and disrespectful when considering she had been a long-standing patient. He was also surprised by this demeanour change as they had always been on good terms, and she referred numerous friends and family to him over the years.

This was not the type of conversation Dr M wanted to pursue over social media, and he was unsure about how he should respond. After considering his options Dr M decided not to respond at all. He felt it would be more appropriate to have his administrative staff reach out to Mrs K on Monday and offer her an appointment at the practice to review her troublesome tooth.

Mrs K noted Dr M's silence and also noticed that Dr M had been active on his social media and found it offensive and rude that he had not replied to her messages; after all, she had a genuine tooth problem and he was ignoring her.

That Monday, a call was made to Mrs K, offering her a review appointment with Dr M. However, Mrs K advised that she had gone elsewhere and signed the paperwork for hers and her family records to be transferred to her new dentist as soon as possible. She advised that she would no longer attend the practice and considered Dr M to be a dismissive, rude and uncaring dentist.

Dr M was completely taken by surprise by Mrs K's response and her decision to transfer her and her family's care to another dental practitioner. He had spent a lot of time over the weekend considering the best way to handle this matter. He had not answered her messages over his personal social media account because his intention was to preserve their therapeutic relationship by maintaining his professional boundaries. His intention had always been to assist Mrs K, and he had believed that this was best achieved in a professional capacity, and via correspondence through his dental practice.

Where did it go wrong?

Regrettably, when Dr M accepted Mrs K's friend request her view of Dr M changed, as the lines between health practitioner and friend became blurred. Mrs K believed that as a friend, she was now afforded access to Dr M outside their professional relationship and consequently viewed their relationship as a friendship, opposed to the professional and therapeutic relationship they had successfully maintained over the years.

When Dr M did not respond to her messages sent over social media, outside surgery hours and over the weekend, Mrs K – somewhat offended and annoyed – then changed her view of Dr M. She then held Dr M to the high standards expected of a health practitioner and believed he should have at the very least responded to her concerns directly.

In the absence of any response from Dr M, Mrs K then interpreted Dr M's silence as a professional decision to withhold dental treatment, assistance and care. She then proceeded to seek alternative treatment with another practitioner, thereafter requesting her records be transferred and effectively ending their therapeutic relationship.

© Daria Kulkova/iStock/Getty Images

Learning points

- It is imperative that we attempt to construct and maintain professional boundaries with various forms of social media as well as our interactions with our patients across these platforms.
- Accepting friend requests from patients can engender the belief that it is permissible and reasonable for contact over personal platforms, opposed to professional platforms. Instigating a shift from a therapeutic relationship to a friendship can prove to be a slippery slope.
- Preserving the therapeutic relationship allows the practitioner to maintain their professional boundaries, while also acknowledging that the patient's wellbeing and care is at the centre of practice.
- Maintenance of the therapeutic relationship enables protection of the space that exists between the egalitarian norms that pervades social media and the patient-practitioner relationship. This allows practitioners to sustain a definitive separation between their professional and private lives.
- When advice or behaviour and actions conflict with a patient's values and beliefs, they are likely to shift their perspective and view you as a professional in power, not as a 'friend', and hold you to a higher accountability.
- If in any doubt, err on the side of caution – choose to maintain the 'therapeutic relationship' and not the 'friendship'.

Proactive resilience – what is it, and why should I invest in it?

Dr Annalene Weston, Dentolegal Consultant at Dental Protection, looks at 'prosilience' – or proactive resilience which is how we can build our capacilty to become resilient

If we consider resilience to be the capacity or ability to recover from difficulties, proactive resilience – or 'prosilience' – is the steps we can take to develop, deepen or embed our emotional and mental capacity to recover, before this resilience is needed. Naturally, this can be on an organisation or an individual level.

COVID-19 has been a marathon, not a sprint. A seemingly endless cacophony of Herculean tasks, with no fixed end in sight. 2020 brought with it challenges that none of us foresaw. 2021 brought with it fresh challenges and issues. The impacts on our personal and professional lives are far-reaching and varied and it is unlikely that anyone of us has had an identical experience.

The divisive nature of COVID-19 and the decisions that our State and Federal Governments have made has further compounded the difficulty of the time. The early research is demonstrating that many clinicians are experiencing one or more of the following: grief, fear and anger. These feelings are magnified by the pervasive sense that clinicians are perpetually selfless, working through their own sickness and ignoring their own needs.

While in the past this unrealistic expectation on clinicians did exist, with the passage of time and an increased acknowledgement that we are human first and clinicians second, it has largely dissipated. This has come with a greater understanding that self-care is critical. After all, if we are unwell ourselves, how can we care for others?

© Sean Anthony Eddy/Getty Images

There are some simple strategies that individuals can put in place today to deepen their resilience, and some of these mirror the strategies we can use to recover from burnout. Naturally, we cannot mention burnout or prosilience without mentioning our third space, a topic on which we already have resources readily available – listen to our *RiskBites* podcast, '*Burnout – using your third space wisely*'.

Develop your rituals

The development of personal rituals is both protective against burnout and effective in developing proactive resilience. These rituals can be small or large, related to work or related to home; it doesn't matter. The studies overwhelmingly demonstrate that having personal rituals is protective for mental and emotional health.

By way of example, a simple example is a ritual for health we all have – by leaving our toothbrush, usually in view, by the bathroom sink, this reminds us to brush our teeth.

Rituals focused on creating prosilience could include the incorporation of regular exercise or movement into our day, ensuring dedicated time to do something you love, like reading or playing the guitar. Having a morning coffee. It doesn't matter what it is. The point is to have a ritual, meaningful to you, preferably that benefits your health or at least is not detrimental, as this has a stabilising effect, supporting mental and emotional health and resilience.

Reframe your thoughts

Reframing is commonly used in cognitive behaviour therapy and is achieved by shifting your perspective of the events at hand. For example, if your filling fails, rather than focusing on that, considering all of the thousands of successful fillings you have provided for your patients.

Reframing your thoughts and beliefs, in this difficult time where many people are holding divergent and divisive views, can be a very helpful strategy in protecting your emotional and mental health, and ensuring a less anxious or reactive response. If you are able to reframe your thoughts when challenged with something difficult and new, you would be able to better manage how this makes you feel.

Filtering what you are exposed to

Filtering is considering the sources of information you are exposed to and removing those that are not helpful to you. Consider the stream of information you are constantly bombarded with. It is factual? Is it helpful? Is it relevant? And this stream can be from traditional sources such as news channels, more contemporary sources such as social media, or simply from people you know. Consider the input you are receiving. When, where and how much. Do you need this? Do you want it? Would limiting or filtering some of these sources be of benefit to you?

Civility

Treating our colleagues and co-workers, and family and friends, with courteous civility and respect assists in our sense of psychological safety and our resilience, and helps develop prosilience. We have also seen and experienced incivility in these times of COVID-19, so know first-hand how unhelpful it is. Respect and courtesy should always be our focus.

Want to know more about this case?

Go to dentalprotection.org/Australia/podcast and listen to our podcast on proactive resilience.

Professional indemnity – why do we need it anyway?

© tdub303/Getty Images

Professional indemnity is a requirement of our registration, but why? And is that all it is? ***Kristin Trafford-Wiezel*** Case Manager at Dental Protection, unpacks the issue

It's a really simple question, though incredibly important – what is indemnity and why do we need it?

I know there are quite a few people out there – and being honest, I was one before I started working at Dental Protection – that took out indemnity with their free policy while at university, didn't really think very much about it again, and simply renewed that policy each year. Back in those days professional indemnity wasn't actually a requirement, though I thought it seemed like a pretty smart option to take up.

These days, having appropriate professional indemnity insurance is a requirement of our registration. This is set out in our overarching and all-encompassing Code of Conduct, Section 8.5: "Practitioners have a statutory requirement to ensure that practice is appropriately covered by professional indemnity insurance."[1] Which then directs us to the Board's professional indemnity insurance registration standard.

The Dental Board of Australia's *Registrations Standard: Professional Indemnity Insurance Arrangements 2016* is the more detailed document. In the first instance, this document defines what a professional indemnity insurance arrangement is, in that it "means arrangements that secure for the practitioner's professional practice insurance against civil liability incurred by, or loss arising from, a claim that is made as a result of a negligent act, error or omission in the conduct of the practitioner. This type of insurance is available to practitioners and organisations across a range of industries and covers the cost and expenses of defending a legal claim, as well as any damages payable. Some government organisations under policies of the owning government are self-insured for the same range of matters".

The standard also sets out the Dental Board's requirements for professional indemnity arrangements. This includes the information relating to:

- Who the standard applies to – which is all registered dental practitioners except those with student or non-practising registration.
- What you must do – including what your professional indemnity insurance must cover.
- The amount of cover – ensuring that you take out adequate and appropriate insurance or professional indemnity cover.
- Any exemptions. This issue is summed up very succinctly in that there are no exemptions to the standard.
- What this means for you. When you apply for registration, when you renew your registration, during your period of registration, providing evidence of your professional indemnity and also, an area that many may not consider – when you cease practice.

Lastly, it also sets out: "What happens if I don't meet the standard?" The National Law establishes the possible consequences of practising without appropriate professional indemnity insurance. There is also a page on the AHPRA website

containing information about the standard, including additional resources such as a Fact Sheet and Common FAQs.

We agree to abide by all these guidelines and standards every year, as we work through the paperwork and acknowledgment statements and renew our registration with the Dental Board. So please do ensure you are familiar with this information and your obligations.

What else is there to professional indemnity?

If you have ever been to any of Dental Protection's previous continuing professional education offerings, you will likely be familiar with some information about Dental Protection. Dental Protection is in fact the world's leading protection organisation for dentists and dental care professionals.

As a not-for-profit mutual organisation, we protect and support the professional interests of more than 68,000 members around the world. Membership with Dental Protection provides access to expert advice and support, and depending on the type of membership required, may also be connected with the right to request indemnity for complaints or claims arising from your professional practice.

Beyond just support for clinical negligence, membership can also protect you in many ways you might not expect, with the right to request advice and legal assistance for matters such as complaints to the regulator, criminal investigations, coroner's inquests or disciplinary proceedings. More than this though – and this is connected directly with Dental Protection's core philosophy – is to support you in the safe practice of dentistry, by helping to avert problems in the first place. Which is part of why we are here now, going through this article.

As outlined in the professional indemnity insurance arrangements standard, your professional indemnity is there to support you in claims of clinical negligence. This may be the first thing you think of when you consider why you need professional indemnity: people are terrified of being sued. So, in the event that you see that dreaded letter from a solicitor, your policy can respond to assist you where appropriate, such as engaging a solicitor on your behalf to assist in your defence.

But what other things can your policy assist you with? Your professional indemnifier can assist in responding to other matters such as tribunals, investigations regarding claiming of fees, criminal investigations and notifications to the regulator regarding you or your practice. And this is in fact where we spend a substantial amount of our time assisting members, as we assist in protecting both your reputation and professional registration.

The receipt of these types of official documentation can be a distressing and upsetting experience for us as healthcare providers, and not something that anyone wants to go through, which is why Dental Protection focuses on safe practice and averting problems in the first place. And this is where the additional (and what we see as huge) benefit of your indemnity insurance with Dental Protection is – that we provide advice and collegiate support to our members.

A lot of the above issues may have actually started as a patient complaint – to you, the front reception, your dental assistant – and then worked its way on from there. With this in mind, you can see how helpful it can be to have access to colleagues with experience in this area, and be able to talk through the issues relating to practice and complaints, and assist you in resolving issues at a low level – so the little stuff doesn't become the big stuff. Importantly and reassuringly, the advisory team that are available to you are all dentally trained, so they understand the issues you are facing in practice and what this means.

What else can your indemnity assist with?

As part of that support in safe practice, Dental Protection provides risk management through professional education.

We provide large amounts of free CPD to members through our online education resource PRISM – this has about 60 hours of free CPD and is constantly updated. This is obviously valuable for registration requirements, as well as in the event of conditions placed by the board, which can often require necessary education in soft skills such as record keeping, consent or communication.

This education also extends to our webinar series, lecture series, workshops and a number of print publications such as *Riskwise* and *Teamwise*. We also have the Dental Protection podcast series, including *RiskBites*, *CaseMatters* and *RiskMatters*, assisting practitioners in the provision of safe dental care.

Part of the focus of providing safe care is also our focus on self-care. This area has come to the forefront recently with practitioners battling through difficult times, and the impact this can have on us personally and professionally. We have developed a wellbeing hub on our website, which supports members through free access to counselling and a raft of resources, podcasts and webinars, as well as our wellbeing app eCare from ICAS.

Burnout is a real issue within the dental industry and can affect not only our personal relationships, but also those with our colleagues and staff, and our ability to respond in times of stress such as patient complaints.

So overall, professional indemnity insurance arrangements are in place initially as a requirement of our registration; to assist you, the healthcare provider and also patients in times where things may have not gone to plan and a patient may have been harmed. Or in matters of your defence.

But in reality, it can encompass so much more. By providing that contact and support, to assist you in times of stress and confusion, and responding to patient complaints, it can help resolve these matters at an early stage. And it goes those extra steps further with the provision of risk management advice and education, and self-care.

REFERENCES

1. dentalboard.gov.au/Codes-Guidelines/Policies-Codes-Guidelines/Code-of-conduct.aspx

Want to know more about this case?
Listen to the full *RiskBites* podcast
'Professional indemnity – Why you need it any way'
at **dentalprotection.org/Australia/podcast**

What is a psychosocial safety climate, and why do I need one?

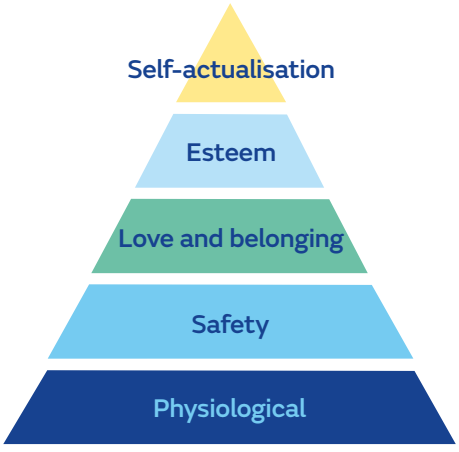
In difficult times, we all look for ways to better manage ourselves and our staff. Considering the psychosocial safety climate of our practice is one helpful strategy that may in the past have been overlooked. ***Dr Annalene Weston***, Dentolegal Consultant at Dental Protection, provides an overview

When considering a new or unfamiliar concept, it is always helpful to start with a definition: 'Psychosocial safety is the belief that you will not be punished or humiliated for speaking up with ideas, questions, concerns and mistakes.'

When contextualised as a workplace climate or culture, it is easy to understand that psychosocial safety could be an important workplace value. How important it is, or why it is important, is however easily overlooked in favour of seemingly 'bigger-ticket' items.

Why is it important?

Maslow's *Hierarchy of Needs* is a well-recognised concept that essentially highlights that basic human needs must first be met, if people are to achieve all that they are capable of.



Pyramid tier of Maslow's *Hierarchy of Needs*. Adapted from freepik.com.

If we do not feel safe in our workplace, for fear of ridicule or humiliation, or simply we feel we will not be heard, how can we feel safe at work? Naturally this feeling of discomfort would be compounded if we did not work in an environment with a no-blame culture, and mistakes are not forgiven but rather blame is apportioned between parties, appropriately or otherwise. Why would you ever speak up or voice a differing view if this was the reality of your workplace?

Somewhat alarmingly, if considered through to its natural end point, placing a barrier based in fear in front of a clinician or member of support staff will prohibit them from speaking up if there is a problem, or admitting an error they may have made. Errors in healthcare cost lives. And one thing we can all be sure of is that humans make mistakes, and we are all only human.

How do I make my psychosocial climate safe?

There are a number of strategies that you could consider implementing to improve the psychosocial safety of your workplace. Not only would this meet the basic psychosocial needs of your team and enable them to be the best version of themselves at work, but also it would serve to increase the likelihood that your colleagues and staff will bring their issues and concerns to you. Some simple strategies to implement tomorrow are described below.

As a leader or manager, you could consider encouraging a 'no-blame' culture, where mistakes and errors are seen as opportunities to learn rather than blame or label those who admit to their mistakes. A no-blame culture increases the likelihood of error being reported and decreases the likelihood these errors will be repeated, therefore improving patient safety and outcomes.

Another helpful strategy is to 'ask' rather than 'tell', and really listen to people's responses. We are not all going to share the same views, and this will be more apparent than ever in divisive times such as COVID-19. Don't make assumptions about how or why your staff or colleagues feel the way they do. Be curious, not furious, if their beliefs differ from your own. You may even learn something. And importantly, the act of listening without judgement will encourage that person to voice their concerns or opinions in the future, empowering a happier and safer practice.

Embrace a culture of mutual respect and civility, where differing viewpoints can be courteously discussed. Increased civility in the workplace serves to develop psychosocial safety and reduce the likelihood of bullying.

Finally, consider sharing your failures as opportunities to learn, not judge. Many are delighted to spruik their prowess, and engender the image that they are infallible, but the reality is that we learn more from our mistakes than we ever will from our successes. If we are open about our failures, and the lessons learned, not only do we entrench a culture where failure and error can be discussed without fear, but it also serves to give learning for all. Perhaps then, they will not need to repeat our mistakes.

A difficult conversation in bariatrics

Many adults are currently overweight or obese. Naturally, this has some impact on how we can physically practise dentistry, and there are also some additional considerations. ***Dr Annalene Weston***, Dentolegal Consultant at Dental Protection, discusses a recent case

The dental setting is already a stressful environment for many, and a conversation about a patient's weight may be the last thing they want when they attend for a check-up.

Some patients may not consider themselves to be overweight or obese. Likewise, some bariatric patients may have experienced societal discrimination against them in the past regarding their weight.

But why do we need to discuss it in the first place? It all comes down to safety – specifically the safe weight that a standard dental chair can carry, which varies chair to chair.

There are many businesses that rely on seating to provide their services to members of the public. The airline industry is one where the issues associated with obesity have previously been the subject of discussion, with some airlines requiring passengers of a certain size to purchase two seats side-by-side for their flight. This usually produces a response from the passenger concerned who may feel they have been discriminated against, while the airline will often consider the request to be one of common sense and fairness to other passengers.

Dental chairs need to be mechanically sound; however, they also have a maximum loading weight that should be observed. Most medical equipment, such as operating tables and hospital beds, are constructed to cope with a maximum load of up to 140kg. Equipment liability insurance may be invalidated beyond specified safe limits, so you might want to check the loading limit for your own dental equipment, to ensure you safely treat your patients.

Case study

Mrs L had been treating Mr and Mrs J for many years. Both husband and wife were tall and had been incredibly active in their youth. The passage of time, however, had led to injury and a general slowing down, and ultimately some weight gain. Mrs L had never considered whether Mr and Mrs J were over the safe weight of the chair – which was 135kg – and certainly didn't think to ask.

During Mrs J's six-monthly periodontal review and cleaning, as the chair reclined an audible crack was heard, accompanied by the chair lurching downwards, as the plastic casing on the chair fractured under the patient. Though unharmed, Mrs J was distressed by the events, despite Mrs L's assurances.

Mrs L was sympathetic about the event and felt she ought to have broached this difficult subject to avoid the upset in the first instance. However, it led to a more pressing issue, as Mr J, the larger of the couple, was scheduled for an extended periodontal debridement appointment the next week. Though Mrs L would likely be able to get her chair repaired in time, her greater concern was whether the chair would break during this procedure, and the harm that could be caused to Mr J if it did.

Mrs L had no option but to contact Mr J and advise him on why he would require a referral, and so contacted Dental Protection for some advice on how to best proceed.

Our advice

Declining to treat a patient who exceeds the weight limit for the equipment in the surgery needs to be handled sensitively. Dental Protection is aware of dental practitioners who have been accused of discrimination when they have declined to treat an overweight patient.

Equally, some of our global members have been sued by patients who were injured as a result of the sudden collapse or breakage of a dental chair, so it is a risk that needs to be addressed.

Fortunately, Mrs L had a long-standing relationship with Mr J and was able to talk through her concerns respectfully. Critically, Mrs L did not let on that the weight limit of the chair had come to light during the treatment of Mrs J, as naturally this would have been a breach of her privacy. Mr J was understanding of Mrs L's concerns, and somewhat reluctantly accepted the offer of a referral to a colleague who was better equipped to treat him safely.

What to do

Our primary consideration as a dental practitioner always needs to be patient safety, and as bariatric patients are becoming increasing commonplace, it would be prudent for a practitioner to know where the closest centre with a bariatric dental chair is to enable appropriate referral. This requires a sensitive discussion with the patient so that they appreciate the reasons for such a referral and do not form the view that the dental team is being obstructive or discriminatory.

Another option to consider is better equipping ourselves to treat bariatric patients in our own clinic, as dental chairs with a weight limit of 198kg are now available.

Case study

A case of periodontal disease

© zlikovec/iStock/Getty Images

Mrs D had been attending Dr L's practice for many years, seeing Dr L as her treating practitioner. Dr L expanded her practice to employ some OHTs and hygienists to undertake appropriate examinations and treatment within their respective scopes of practice, while she performed high value treatments.

Mrs D had been handed over to Ms W, a registered hygienist, by Dr L some years previously, although Dr L always popped into Mrs D's examination appointments – initially to run a second pair of eyes over her dentition, but in later years purely as a social visit. The issue here arose largely because neither Ms W nor Mrs D fully understood that a handover had occurred, both believing that Dr L was assessing Mrs D, and, that Dr L retained final responsibility for Mrs D's care.

Dr L took some extended annual leave, and in her absence Mrs D sought advice from a local dentist, Dr V, regarding her bleeding gums and bad breath. Examination revealed multiple teeth with 7 to 9mm pockets, many of which were bleeding and some of which were suppurative. Dr V took an OPG which painted a dim picture, with over 50% bone loss on most of the teeth, and some teeth having 70% clinical attachment loss. Dr V broke the bad news to Mrs D and referred her to a specialist periodontist for assessment and treatment.

A specialist treatment plan was developed, with a guarded prognosis for some teeth, and ultimately 47, 46 and 45 were lost as they did not respond to the treatment. Mrs D contacted the practice seeking answers and, in Dr L's absence, her letter was passed to her treating hygienist, Ms W, for response.

Ms W was of the view that she had acted appropriately through her examination and cleaning of Mrs D's teeth, and that any failure to refer lay with Dr L alone, as Dr L was responsible for Mrs D's care, not Ms W. Dr L was not told of the complaint, and feedback was provided to the patient that there was no error on the part of the practice, and it was just 'one of those things'. Mrs D was devastated but resolved to do no more. Dr V, however, was deeply troubled by what he had seen, and how it had been handled. He reviewed the guidelines on mandatory notifications and believed that this matter required he make a mandatory notification about both Dr L and Ms W, which he promptly did.

AHPRA assessed the matter by reviewing all documentation from Drs V and L and Ms W, from the specialist periodontists and an independent expert. They made the following findings:

Dr L was issued with a caution on the grounds that she had or may have fallen below the standard reasonably expected of a professional of an equivalent level of training.

Ms W was directed to attend a performance interview to assess her theoretical understanding of, but not limited to, periodontal treatment, diagnosis, treatment planning and referral. This could have a potentially serious outcome for her registration, if she was found to be lacking at this performance interview.

The difference in outcome arose because AHPRA formed the view that the care of Mrs D, in the form of regular examinations, was handed over by Dr L to Ms W, and by definition from the regulatory guidance, this meant that all responsibility for this aspect of her care was held by Ms W. If, however, Ms W had identified an issue that fell outside her scope of practice, then it would have been appropriate for her to hand back over to Dr L or refer to another colleague as appropriate.

Dental Protection assisted Ms W in preparing for the performance interview and attended with her. Pleasingly, Ms W had a good outcome, only receiving a caution.

Dental Protection supported Dr L and Ms W in contacting Mrs D to apologise and assist with her future treatment costs, as neither practitioner felt it appropriate to ignore what had happened.

Learning points

- In a handover/delegation/referral it is important to have clarity about who is managing which aspects of the patient care, for all involved parties.
- Ms W's view that Dr L retained responsibility for Mrs D was flawed.
- Periodontal disease is a commonly overlooked condition, and it does not serve anyone well to monitor the progression of this condition without notifying the patient and without considering an appropriate referral.

Want to know more about this case?
Listen to the full *CaseMatters* podcast *'How could you ignore this?'* at dentalprotection.org/Australia/podcast

Case study

When your number is up

The announcement that dental hygienists, dental therapists and oral health therapists would be able to apply for a provider number and claim directly for services provided under the Child Dental Benefits Schedule (CDBS), with a planned commencement date of 1 July 2022[1], feels long overdue. We can all see the benefit of this change, but what are the risks? ***Dr Annalene Weston***, Dentolegal Consultant at Dental Protection, finds out

© BrianAJackson/iStock/Getty Images

Provider numbers are in essence a site-specific fee claiming mechanism. Something so simple should not be contentious, and yet we see an alarming number of cases relating to the inappropriate use of a provider number. We wanted to highlight some of the risks relating to holding a provider number, in the hope that we can help you protect yourselves from the same issues.

Dr W was a recent graduate and looking for a permanent practice role. He had given a lot of consideration about the type of practice he wanted to work in and was seeking a group practice with plenty of other practitioners, as he was concerned about professional isolation. Dr W was keen to be surrounded by likeminded colleagues to enable him to develop and grow. The practice did not have a principal dentist, but rather a 'flat hierarchy' of practitioners and a non-dentist practice owner.

On assessment, Dr W formed the view that the contract seemed fair, and the practice seemed reasonably well equipped. The other dentists were all welcoming and said that they had a good flow of patients, particularly new patient examinations, so made a good income.

He took the job. For the first few weeks, he kept a tight eye on his billings and, indeed, he had a steady flow of patients and a good income. With the passage of time, Dr W became more relaxed at the practice, as he was happy there and had formed good relationships with both colleagues and patients alike.

He was surprised to receive a letter from the Health Fund, stating that he was an outlier and requesting validation for the number of codes charged per patient, and the number of five-surface fillings. The five-surface filling comment came as a surprise to Dr W who could not recall having placed many five-surface fillings. The practice owner reassured Dr W that they would manage this on his behalf, stating it was likely that the front office staff had entered the codes on the wrong provider number – a common administrative mistake, and that they would look into this and respond. Dr W did not seek advice from Dental Protection as he believed the matter to be 'routine' and in hand.

The second Health Fund letter followed quickly, with similar allegations to the first. Dr W again contacted the practice owner to alert them to the issue and seek some assistance. However, this time the practice owner did not respond in a helpful way, and Dr W felt quite threatened by their reaction. At this point, Dr W contacted Dental Protection, who advised him to look a little deeper and see what the patients' invoices cited. To Dr W's horror, the HICAPS transactions did not reflect his clinical notes, with two-surface fillings being invoiced as five-surface fillings, patients being charged for teeth adjustments that Dr W had not undertaken and, most alarming, a recent crown not being visible in the invoice stream, having been replaced with an invoice for eight five-surface fillings instead.

When Dr W challenged the front office staff, they were nonplussed, calling him naïve and advising him that the only way to treat patients fairly was to maximise their Health Fund rebates. They confirmed that they were working under the direction of the practice owner, and that their 'fair billing' policy attracted many patients.

Dr W was alarmed by these statements, and even more so when he realised that because the billings had gone through on his provider number, he was solely responsible for the repayment of all monies inappropriately claimed back to the Health Fund. These billings were in the tens of thousands of dollars.

Dental Protection assisted Dr W in responding to the Health Fund and Dr W subsequently moved on from the practice.

Learning points

- This case is sadly not unique, with many practitioners finding codes are put through on their provider number or altered without their knowledge.
- As the 'owner' of the provider number you are solely responsible for the codes billed. This means that regardless of the percentage you may have been paid for any treatment, if the money is clawed back by the third party who made the payment, 100% is clawed back from you, and you alone.
- You are responsible for the accuracy and validity of all codes put through under your provider number. Make sure you regularly check your HICAPS receipts to ensure that the coding is correct. As the coding will be CDBS only at this stage, you can also check through PRODA.
- Take the time to close off your provider number when you leave a practice to ensure that no inappropriate billing is put through on your provider number after you have left.
- Provider numbers can be suspended or withdrawn if there is a continued pattern of inappropriate billing.

REFERENCES

1. adohta.net.au/resources/Documents/Media%20Releases/211105%20Provider%20Number%20media%20release%20.pdf

Want to know more on this issue?
Go to **dentalprotection.org/Australia/podcast** and listen to our *RiskMatters* podcast *'Why are item numbers so important?'* with Dr Annalene Weston and Dr David Hallett, CEO of ADAWA.

Dental Protection

Here to protect you and your professional reputation

Learn how to manage your risk and improve patient safety

As a benefit of membership, you receive access to risk prevention tools and techniques including

- Online learning
- Lectures and seminars
- Workshops

Join today or find out more
dentalprotection.org/au

Find us on dentalprotectionaustralia

Contacts

You can contact Dental Protection for assistance

dentalprotection.org/au

Membership Services: Telephone 1800 444 542
Dentolegal advice: Telephone 1800 444 542

2108062348: 05/22