Professional support and expert advice for new dental practitioners

Dental Protection

Young Dental Practitioner

Issue 3 – 2021

From university to the workplace

How to make the big move into the real world of dentistry

Page 10-11

In this issue...

Dental Protection

Stay switched on with our dental podcasts

Shining a light on the big dentolegal issues affecting practitioners today

Membership means access to great podcasts from our Dental Protection advisory team. Learn about common dentolegal pitfalls and increase your CPD hours, with lots of episodes ready for you to stream right now.

To subscribe to the series, search for the Dental Protection podcast, available through many of your favourite podcast providers.

Or stream it online at

dentalprotection.org/australia/podcast

Welcome

It is our pleasure to introduce the 2021/2022 edition of the *Young Dental Practitioner* magazine.

The transition from university to full time practice can be a trying time and the articles in this publication are here to help you navigate through this challenging period. The focus of this edition is on bias as it's one of the key challenges that practitioners will face in their career, especially when first starting out. We trust that the experiences and advice shared by our authors will help you look at things from a different perspective and feel more confident in setting boundaries and expressing your concerns.

We hope that you cherish your first few years in practice as it is a new and exciting time in your life, but please know if you feel overwhelmed or are struggling to cope, we are only a phone call away. We have other resources to support you including the Young Practitioner Survival Guide section of our website, our *Young Dental Practitioner* webinar series, the e-learning platform PRISM and our monthly e-newsletter *Riskwise* Connect. We also have a new wellbeing hub that we encourage our members to visit. For those looking to boost their CPD hours we have risk management workshops that are included as a benefit of membership, so do take advantage of the many resources and CPD available to you.

Wishing you a rewarding and successful career.

Kara Stokes,
Business Development Executive

and the Dental Protection team

Cover: © FatCamera/Getty Images

20121615136

Contents

Editorial and production

Dr Annalene Weston
Editor-in-Chief

Gareth Gillespie
Editor

Kara Stokes
Business Development Executive

Production

Allison Forbes, Designer
Professional Print Services, Print

Contributors

Dr Louise Eggleton
Dr Kiran Keshwara
Dr Saba Khan
Dr Amanda Phoon Nguyen

Contacts

You can contact Dental Protection for assistance:

Membership services:
Tel 1800 444 542

Dentolegal advice:
Tel 1800 444 542

dentalprotection.org.au

Follow us:
facebook.com/dpl.australia

Introducing your dentolegal team

As a member of Dental Protection, you have access to the expertise of our team of Dentolegal Consultants and Case Managers. In this article, you can meet the people behind the job titles

Dr Annalene Weston
Dentolegal Consultant
BDS MHL FACD FPFA FICD

Dr Annalene Weston completed her undergraduate dental degree and vocational training in the UK and worked in NHS and private dentistry before immigrating to Australia. She has worked across three Australian states, in both private and public dentistry, and gained her Masters in Health Law at the University of Sydney's Faculty of Law in 2008.

Annalene was awarded a Fellowship to the American College of Dentistry in 2016 and a Fellowship to the Pierre Fauchard Academy in 2019 in recognition of her strong work in ethics and collegiate support. She became a Fellow of the International College of Dentistry in 2020. Annalene works part-time in a suburban dental practice.

Interesting fact: Annalene loves words; writing them, reading them, listening to them and speaking them. Consequently, many of you will know her from the Dental Protection webinar and podcast series, and publications. When she is not at work, she is reading, or searching out interesting books for her collection. She does this while being mother to two rambunctious boys and surrounded by oodles of poodles.

Dr Mike Rutherford
Senior Dentolegal Consultant
BDSc BA FICD FPFA

Mike Rutherford graduated from the University of Queensland and has more than 40 years' dental experience in private practice, hospital clinics, the defence forces and supervising undergraduate dental students. He spent 19 years as a member of the ADAQ Patient Liaison Panel before joining the Dental Protection team in 2012. Mike was until recently a partner in a Brisbane suburban dental practice since the late 1980s, looking after three generations of patients.

Interesting fact: Mike has a BA in Social History and International Diplomacy and will happily discuss the Vietnam moratorium movement and Cold War politics for hours. He is also a mad dog cyclist.

Dr Simon Parsons
Dentolegal Consultant
BDS (Hons), MBA (Executive)

Dr Simon Parsons is a graduate of the University of Sydney and has over 30 years' experience working primarily in private dental practice. Simon has tutored dental undergraduates and dental assistants and continues to enjoy teaching and mentoring oral health professionals. He completed an MBA at the Australian Graduate School of Management in 2001.

Balancing his interest in clinical treatment and practice management, he managed large multidisciplinary dental practices for over a decade and now works in a Sydney CBD group practice when not at Dental Protection. He also provides technical and educational support for a large multinational dental laboratory.

Interesting fact: Simon is an identical twin and is still approached on occasion by total strangers who seem to know him, when in fact it is a case of mistaken identity. Simon is an avid cook and has been known to roast his own coffee beans prior to tinkering as a wannabe barista at home and trying to perfect a microfoam for his latte.

Dr Ralph Neller AM
Dentolegal Consultant
BDSc BBus FICD FADI FPFA

Dr Ralph Neller has over 35 years' dental practice experience and held senior clinical and management positions in the public sector Oral Health Services in Queensland. He was a long-serving member of the Dental Board of Queensland and was chairman of the Board for five years. He recently held the position of President of the Australian Dental Council, which is the accrediting authority for all tertiary level courses leading to qualifications registered with the Dental Board of Australia and assesses overseas trained dental practitioners prior to registration in Australia.

Ralph was recognised in the honours list and appointed as a Member of the Order of Australia in 2015.

Interesting fact: When Ralph is not working for Dental Protection you can find him on his farm, tending his cattle or wrangling his grandchildren, often simultaneously, as all children love tractors.

Dr Colm Harney
Dentolegal Consultant
BA BDentSc

Dr Colm Harney graduated from Trinity College Dublin and worked as a GDP in the private and public sectors in Ireland and Australia. He then worked for eight years in private practice in London before returning to Australia in 2007 where he works in suburban private practice in Perth. Colm has also worked as a tutor and clinical supervisor in the UWA Dental School. He has completed post-graduate studies in dispute resolution and worked in healthcare dispute resolution as an accredited mediator. In addition to his role as a dentolegal consultant, Colm continues to work part-time in the same practice he has been in since 2007.

Interesting fact: Colm is a third dan black belt in Aikijujutsu, a traditional Japanese martial art. He maintains that the best way to forget the troubles of the day and focus your thoughts is when an opponent is throwing a punch at your face or swinging a very sharp sword in your general direction.

Dr Kiran Keshwara
Dentolegal Consultant
BDS (Hons)

Kiran graduated from Barts and The London School of Medicine and Dentistry in the UK. After completion of his vocational training, Kiran bought a dental practice in England, which he managed for five years before selling it and moving to Australia. Kiran also spent five years with a specialist dental negligence law firm in the UK as a dentolegal consultant, advising solicitors on matters relating to litigation.

Since moving to Australia, he has worked for corporate dental groups in Queensland and the ACT as the lead dentist, supporting and mentoring clinicians. As well as being a dentolegal consultant for Dental Protection, Kiran works part-time in private practice.

Interesting fact: During his undergraduate study, Kiran worked as security at Lord's Cricket Ground, The Oval cricket ground, and Chelsea Football Club, where he got to meet many of his childhood sporting heroes. Despite their multiple failures in the past 20 years, Kiran is a passionate Arsenal fan and continues to live in hope...

Mrs Anita Kemp
Case Manager
BAppHSC (Oral Health)

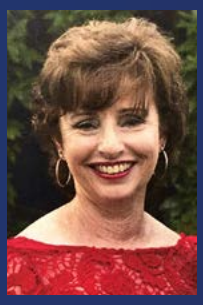
Anita has worked within the dental industry for over 20 years. Anita's vast experience includes working in private practice in administrative, hygiene, dental therapy and dental assistant roles. More recently, Anita worked as a clinical support and compliance lead for a major health fund across Queensland before joining the Dental Protection team in December 2020 as a case manager.

Interesting fact: In a previous life prior to children, numerous injuries and arthritic bones, Anita was an avid touch football and rugby union player in New Zealand and Australia. Much to the disappointment of her Kiwi relatives, both of her daughters have shunned the game they play in heaven and are staunch AFL converts and players.

Mrs Kristin Trafford-Wiezel
Case Manager
BAppHSc (Oral Health)

Kristin has a considerable background in the dental industry in both therapy and hygiene practice as well as previous dental assisting. Kristin has worked in private and government practice in Queensland and Western Australia in clinical, leadership and administrative roles. Kristin continues to work part-time in private practice alongside her role as case manager with Dental Protection.

Interesting fact: Over the years Kristin has amassed quite a collection of antique and ceramic toothpaste containers and dental instruments, which her family finds somewhat disturbing. Her strange collecting habits are not an issue however for the most important member of the household, Hugo, the insanely spoilt French bulldog.



Ms Jenny Stein
Case Management Assistant

Before joining the Dental Protection team, Jenny previously worked as a legal secretary, had a successful small business of her own, and was a practice manager of a large medical centre for 15 years. She also worked for QFES rolling out the new radios for all emergency services. Jenny works full time as a case management assistant and many of our members will recognise her friendly voice as she is often the first point of contact when members call the team for assistance.

Interesting fact: A trainer/strapper for 24 years, Jenny is currently the head sports trainer of a rugby league club which has grown from one senior team to six in the last seven years. She has also worked with many players who are now playing in the NRL. She loves to travel and has two sons who are both married to Registered Nurses and is waiting patiently for grandchildren.

© travnikovstudio/iStock/GettyImages

Rose coloured glasses, or coloured judgement?

Bias is pervasive and as such infuses all of the interactions we have. As dental practitioners, we try our very best to treat all patients as they would wish to be treated. But what about their bias towards us? And bias between clinicians? ***Dr Louise Eggleton*** and ***Dr Annalene Weston***, Dentolegal Consultants at Dental Protection, share their own experiences of bias in the workplace

Louise

My ethnicity is a mix of Malaysian Chinese and White British. While I have encountered issues regarding my ethnicity in other areas of my life, I have not experienced race-related bias working as a dentist.

Annalene

My ethnicity is also a mix, of Eastern European and White South African. I did not experience racial issues when I worked in the UK, but regretfully this did become an issue when I started work in Australia. A memorable racial interaction was a complaint I received while working for DHSV in Wangaratta for 'not speaking English properly'. The irony was not lost on me!

Both of us have experienced comments and negativity with regards to being young (when we still were!) and for being female. Both of these factors were used to query our abilities and our appropriateness to provide care, by patients and by colleagues.

Louise

I worked in an emergency access clinic for a number of years, extracting a lot of teeth. I encountered many male patients suggesting I would not be able to extract their tooth as I would not be strong enough. I was very direct in telling them I was the treating clinician and the extraction of a tooth was not related to strength, rather it was the experience and use of appropriate techniques. I would not wish to move forwards with treatment if a patient did not have complete trust in my clinical abilities; however, I made it clear I was the senior dentist for the emergency service and any patient was free to seek care elsewhere. All the patients elected to receive treatment and thankfully all teeth were extracted successfully.

I have experienced a patient grab and kiss me after I had extracted his tooth. At the time, I remember the patient being so pleased to be out of pain, with the tooth having now been extracted following a previous failed attempt at a different clinic, this was perhaps an impulsive action on the part of the patient.

While I do not believe this gesture was meant in a sexual way, it was certainly not pleasant to be seized and embraced by a patient with an open socket full of blood and saliva in his mouth. I very much doubt this would have happened if I was a male dentist!

With the nature of our profession – no matter if you are a dental assistant, therapist, hygienist or a dentist – there is obviously a necessary aspect of our jobs to infringe upon our patient's personal space in an appropriate manner when providing dental care. As a female working in this environment this becomes perhaps even more challenging when you are working during pregnancy, especially when reaching the latter stages. It can be difficult to manoeuvre yourself in a comfortable position, with your stomach being much closer to a patient than usual. While of course this is entirely natural, I have experienced many patients reaching out to stroke my pregnant stomach. In providing emergency care, often I had never met any of these patients before and so for me, this was overstepping the boundaries.

Other uncomfortable experiences include a patient who was under the influence of drugs exposing himself to me in clinic. The patient was clearly less inhibited but was not acting in an aggressive or threatening manner. During the time, I did not think his actions were meant in a sexual way. He may well have repeated the same actions to a male dentist. My experience was perhaps not necessarily related to the differences in how male and female clinicians are treated but it certainly does make you consider your working environment and safety as a female dentist, carrying out treatment in very close proximity to individuals you have often never met before.

The feeling of safety is essential if you are expected to carry out your job properly. I feel very lucky that the clinic I was working at did have security protocols. Emergency call buttons were available within every surgery, with an open-door policy when treating patients. If a security alarm was triggered, all available staff immediately went to investigate every situation. I worked with a great team who shared a huge amount of trust and camaraderie, which is so important. I realise, sadly, that other clinicians do not always experience this.

Annalene

I too had patients touch my pregnant stomach without permission. It was a strange experience as on the one hand, I am grateful they felt comfortable with me and saw me as a person, but on the other, I do agree that this is a boundary transgression. I was surprised by how uncomfortable it made me feel.

I suspect that every young practitioner has their ability to provide care questioned. I certainly have had my strength and ability to extract teeth questioned, by both patients and colleagues. It can be very challenging when you are a recent graduate to be questioned in this way, as your confidence can already be shaky. As Louise said, I used to back myself, and I would encourage every practitioner to do so.

The threat of sexual harassment and assault is a creepy reality for many practitioners. I have had patients ask me on a date and bring me gifts. A dear friend of mine had a patient present her with tickets for a flight and a mini-break – with both his and her names on. She dealt with that firmly and handed his care over to another practitioner.

I have had more than one patient touch me inappropriately, in an attempt to sexualise our time together. It is critical to have a protocol and for this to be understood practice-wide. It is also critical to be chaperoned whenever possible, and to consider an open-door policy when providing treatment if not. Naturally, these patients are best treated by others once a boundary violation of this nature has occurred.

Bias is broader than gender

Racial bias and racial abuse remain a regrettable factor in practice, as in the balance of our lives. While the expectation that every clinician will be a 'middle-aged white male' may have shifted, there can be no doubt that racial bias, whether it is conscious or unconscious, exists for all genders of different ethnic origins. The Black Lives Matter movement has certainly demonstrated this still exists in society in general and therefore we would be ignorant to think dentistry would not be affected by it.

It is also worth mentioning that bias may be completely unconscious, with many a young clinician being expected to perform steri, or make their own bookings, when a more mature age practitioner would not be asked to do so.

Challenging the challenge of bias

We have shared our stories with the hope this will help others recognise situations where they may not have been treated fairly, and to offer support.

There are many steps we can take both at individual and organisation level to challenge bias and elicit change. The first one being to acknowledge that bias exists, and that we all can view situations and circumstances through our own filter of bias. By acknowledging this, we can then take steps to ensure that bias does not become prejudicial, both in our decision-making and also against others.

Needless to say, we should have a zero-tolerance policy to discrimination, and call it out when we see it rather than letting a silent endemic persist.

And finally, we should encourage our workplaces to develop policies that support staff and categorically set out that bias or discrimination against any person on the basis of age, gender, race, being differently abled, religion or sexual orientation cannot and will not be tolerated.

We need to speak up, both for ourselves and others, and it is important to acknowledge that if we do not have trust and support from our colleagues, our career in dentistry will be so much more stressful and challenging if we are on the receiving end of discrimination of any kind.

In her shoes

"Before you judge a man, walk a mile in his shoes", is an oft-spoken idiom, cautioning the person not to make assumptions without an understanding of the wider circumstances. In short, it is cautioning empathy rather than judgement. So when could this cautionary phrase be helpful in dental practice? ***Dr Annalene Weston***, Dentolegal Consultant at Dental Protection, explores this issue

Empathy is a helpful tool of successful communication, as understanding others' positions, or putting ourselves in their shoes so to speak, can assist us in understanding their point of view, hopes and expectations. What happens if we fail to step into a person's shoes, and see things from their point of view?

Scenario 1

Ms M was suffering with terrible morning sickness, while trying to maintain her job from home, and wrangling an energetic toddler. She was exhausted and knew her toddler was suffering too, living on a convenience diet of takeaway children's meals. However, Ms M managed to get herself and her toddler to their annual check-up, and attended Dr R.

Dr R found that the toddler had not had his teeth brushed that morning and was somewhat appalled at the state of his diet. While he had no caries yet, Dr R felt duty-bound to provide Ms M with all the relevant OHI and dietary advice, in order to avert disaster.

Naturally, Dr R's information was critical to provide but the delivery here is important, as this is a transient and circumstantial phase in Ms M's life, which Dr R would be able to establish from her oral cavity and lack of restorations. Empathy would be needed to provide this requisite information, in a way that supports, not criticises.

Regretfully, Dr R did not consider how Ms M may be feeling, and why, and delivered the information sternly, to ensure they 'made an impact'. Ms M felt ashamed and judged. She cried when he set out her failings as a parent. Humiliated, Ms M lodged a formal complaint with the practice, to try to ensure no-one else was degraded by Dr R as she had been.

Sometimes we may even step into the wrong shoes; not those of the patient at all, but someone else entirely.

Scenario 2

Mr L attended the practice to enquire about options for tooth replacement. He managed his own business, and so put 'business owner' on the new patient form. He did not disclose that his business revolved around trading in pink diamonds and was consequently very lucrative, as he did not believe this to be relevant.

Mr L booked to attend his appointment when he was on annual leave, and he was taking his leave as an opportunity to work on his hobby farm. He came across some trouble while fencing, so arrived at his appointment late and flustered, and he had not had the time to shower and change as he had planned.

Dr W, irritated by the late attendance, called Mr L through.

Now imagine you are Dr W. What options for tooth replacement are you going to offer Mr L based on his appearance? Be honest with yourself. Are you **really** going to give him all of the options in a balanced manner, or are you perhaps going to brush over some options based on what you believe he can afford?

Regretfully, Dr W did indeed judge Mr L on appearance, and fail to fully outline implants as a meaningful solution for Mr L. Mr L, initially amused by this judgement, took his business elsewhere, seeing it as Dr W's loss. However, with time, he began to resent being judged by a practitioner half his age and made a complaint to AHPRA on the grounds that he had been discriminated against based on his appearance.

Scenarios such as these occur so commonly in practice that they are addressed in the first section of the *Code of Conduct*, our roadmap document for professional practice:

2.2 Good care

Maintaining a high level of professional competence and conduct is essential for good care. Good practice involves:

- recognising and working within the limits of a practitioner's competence and scope of practice, which may change over time
- ensuring that practitioners maintain adequate knowledge and skills to provide safe and effective care
- when moving into a new area of practice, ensuring that a practitioner has undertaken sufficient training and/or qualifications to achieve competency in that area
- practising patient/client-centred care, including encouraging patients or clients to take interest in, and responsibility for the management of their health and supporting them in this
- maintaining adequate records
- considering the balance of benefit and harm in all clinical management decisions
- communicating effectively with patients or clients
- providing treatment options based on the best available information and not influenced by financial gain or incentives
- taking steps to alleviate the symptoms and distress of patients or clients, whether or not a cure is possible
- supporting the right of the patient or client to seek a second opinion
- consulting and taking advice from colleagues when appropriate
- making responsible and effective use of the resources available to practitioners
- ensuring that the personal views of a practitioner do not affect the care of a patient or client adversely
- practising in accordance with the current and accepted evidence base of the health profession, including clinical outcomes
- evaluating practice and the decisions and actions in providing good care, and
- facilitating the quality use of therapeutic products based on the best available evidence and the patient or client's needs.[1]

Consider for a moment: did Dr R communicate effectively and practise patient-centred care? Did Dr W practise in accordance with the current and accepted evidence base, and provide treatment options based on the best available information? Or did Dr R fall foul of judging a patient, without truly knowing the facts of the matter or stepping into their shoes. And honestly, would you have perhaps done the same?

Regretfully, many practitioners fall into the traps of pre-judgement and bias; please know that it doesn't help us as clinicians, and it most certainly doesn't help our patients.

We need to be mindful that bias is pervasive, and often based on our experiences. Bias affects us all. As a working mother, I can recognise a 'Ms M' at 40 paces, because I have walked in her shoes, but it would be unreasonable to suggest that we have to have experienced every life experience a patient faces to truly understand them. Rather, perhaps we ought to take a moment to get to know our patients and talk with them about their expectations, hopes and values relating to their dental care, so we can provide them with the requisite information and treatment options appropriately and with respect.

We were able to assist both practitioners in their responses, and both had good outcomes, but this didn't make them feel good; both expressed that they knew they had let themselves and their patients down through being biased.

Learning points

- Accept bias is real, and affects us all
- Try to get to know your patients before making decisions about them, or for them
- Engage empathy, not judgement, as you never truly know what another person is going through, if you don't walk in their shoes.

References

1. Dental Board of Australia, *Code of Conduct*

From university to the workplace

Dr Saba Khan provides guidance on managing the clinical transition from university to the workplace into the real world of clinical care

You will achieve multiple milestones as you approach the completion of your studies. Academically, these include consolidating the skills and knowledge that you have acquired over the years and being able to work towards independently applying it clinically.

Professionally, one of the biggest milestones that you achieve will be securing your first job as a dental practitioner. The initial thought about commencing clinical work in a professional environment can be daunting at first. We have all experienced this thought at one stage or another, whether it be on our first day of university or the first day of clinic as a student. This can be attributed to our fear of the unknown. While transitioning from university to the professional environment, it is important for you to have confidence in the knowledge that you have gained at university, and you should be able to trust your ability to implement it in a way that achieves the best outcome for your patient.

Getting the most out of clinical placements

The clinical placements at university gradually allow us to utilise and further develop our interpersonal and clinical skills under the supervision of our clinical demonstrators. Our clinical demonstrators provide a safety net for us. They are there for us when we need them for guidance about our clinical approach or even when we require them to bail us out when we are stuck. They offer a plethora of clinical knowledge from their experiences, and we have the luxury of receiving constant feedback from them to improve.

During your first few days at work, you may initially be taken aback by the lack of constant supervision. The patients that you see may require complex treatment planning involving a multidisciplinary approach or they may want a second opinion. It is therefore important to ensure that the workplace you choose has some form of support system or mentorship available for case discussions. Establishing a good relationship with your mentor and having regular discussions about your strengths and weaknesses is imperative. From a personal development perspective you should not hesitate to ask for guidance from your mentor or other colleagues, as they will be able to provide you with the support you need to ease into the working environment and improve the quality of work you complete.

Developing your interpersonal skills is crucial. At university, we tend to be concentrated on perfecting our clinical skills and easily neglect focusing on our communication with our patients or staff members around us. From a personal point of view, patients value your ability to communicate well with them more than your level of clinical expertise. At the end of the day, your empathic approach and ability to explain the diagnosis or procedures in layman's terms to your patient plays a key role in their acceptance of any treatment you offer and their continuity of care.

You should be able to confidently discuss the risks and benefits of any given treatment option along with the costs involved. The latter may take some practice to develop as we do not get a lot of exposure to discussing finances with the patients at university. Any form of communication with your patient should also be documented well as it plays a key role in appropriately attaining informed consent prior to providing any services for which you will be accountable. Building rapport with your staff members is also of utmost importance. Ultimately, taking the teamwork approach will assist you with achieving the goals set out for the day and ensure patient satisfaction.

Compared to the student clinic, you will see more patients back-to-back in one day to provide a range of dental services. This can initially be overwhelming; therefore, time management is another vital area to work on. Organise your appointment book in a way that allows you to provide treatment in a timely manner, while ensuring that the final quality of your work is not compromised. As you settle in and develop a routine, you will naturally see improvements in your time management and overall productivity levels.

As a new graduate, you are bound to find yourself in new challenging situations which you must be able to navigate around and manage, often within a limited timeframe. These situations can range from managing a clinical procedure gone wrong to dealing with patients with unrealistic expectations or those who may express any form of bias. Communication plays a key role in managing those situations.

My own experiences

Personally, most of the interactions that I have had with patients during my time at the student clinic were pleasant. Those patients showed no hesitation when they were asked to be treated by a student with limited clinical experience. I was quite surprised by my first interaction with a patient who expressed bias against inexperienced clinicians. I had a limited amount of time to manage this as the patient presented in pain and had dental anxiety, which was stemming from past bad experiences, specifically with young clinicians.

The approach I took to work around the patient's generalisation that older dentists were better at providing dental care came down to good communication. I acknowledged the patient's concerns and informed them that I will not be completing any procedure without their consent. The option of being treated by a more experienced dentist was also presented if they did not trust my ability. I also had a thorough discussion about the rationale behind my diagnosis along with my treatment plan. With a lot of initial hesitation, the patient consented to proceed with the treatment for pain relief. I followed up with the patient a few days later to get an update on how they were going – the patient was grateful for the treatment provided, as the main cause of their dental concern was not properly identified in the past. The outcome of this scenario was gratifying because it contributed to changing the patient's judgement about trusting the capabilities of a young clinician.

The initial clinical transition from university to the new workplace is a stepping stone towards building your career. It is important to be aware of your scope of practice and focus on building your confidence in the basic clinical and interpersonal skills first. Participate in professional development programmes to further complement this. Some plans may not go according to your wishes; however, treat these as a learning opportunity to figure out what works best for you. Lastly, build a supportive network and ensure that you maintain a good work-life balance.

Dr Saba Khan is a 2020 dental graduate from La Trobe University and Dental Protection's *Young Dental Practitioner* Representative for 2021. Saba has started off her dental career working in public practice in a regional town of South Australia. She enjoys all aspects of general dentistry and has special interests in preventative and restorative dentistry.

Wellbeing – a reminder of the support available

Kara Stokes, Business Development Executive at Dental Protection, provides a timely reminder that you are not alone – we are here to help

Relentless Australian bushfires followed by the outbreak of a global pandemic not only made 2020 a very challenging year, but we can still feel the effects that have carried on into 2021. COVID-19 has shaken us all and affected the way we live our lives and interact with one another. It felt like there was no time to catch our breath, and no end in sight.

Our dentolegal consultants were inundated with calls from distressed members who were unable to cope with the uncertainty they were faced with. We want to remind you that the team at Dental Protection is always here to support our members through difficult times, and we were able to offer financial relief to members last year when working hours were impacted and many practitioners' roles were in a state of limbo. Although work has returned to normal for many, some of our members will find that their mental health has been less quick to recover.

What we are doing to help

Dental Protection is more focused than ever on the health and wellbeing of our members. In a survey that we ran in 2019 called *Breaking the Burnout Cycle*, 42% of respondents said they had considered leaving the profession for reasons of personal wellbeing. That was before COVID-19 hit! We understand that dentistry can be a struggle and takes its toll on practitioners even on a good day, let alone when dealing with the aftermath of a pandemic.

In consideration of the above, and Dental Protection's ongoing commitment to positively influence the wellbeing of our members, we have taken additional steps by recently launching our wellbeing hub, available at **dentalprotection.org/australia/wellbeing**. This service endeavours to support members to take positive steps for their wellbeing and as explained in detail below, includes free access to counselling, a raft of resources, podcasts and webinars, as well as the wellbeing app eCare from ICAS.

Dental Protection members have access to counselling for work-related issues or stress that they feel could impact their practice, such as burnout, anxiety and conflict. Our counselling service is provided by our trusted partners ICAS, who offer a personalised and professional service tailored specifically to the member's requirements and delivered by experienced, qualified counsellors. Members can access telephone support 24 hours a day, seven days a week, and face-to-face counselling sessions can be arranged if necessary. Please rest assured that the service is entirely confidential and independent of Dental Protection – any member's contact with ICAS will remain private.

We also have a not-to-be-missed podcast on sleep disorders. In it, Dr Pallavi Bradshaw, Medicolegal Lead of Risk Prevention at Dental Protection, talks to Dr David O'Regan, Consultant Psychiatrist and Sleep Specialist at the Sleep Disorders Centre at Guy's and St Thomas' Hospital. Exploring the potential impact of the COVID-19 crisis on sleep and


© tomwang/Stock Photo/123RF

wellbeing, this podcast offers practical tips and techniques to help improve sleep during a time of worry and uncertainty.

We have a recorded webinar that is accessible through our online e-learning platform, Prism, called *Building Resilience and Avoiding Burnout*. The webinar looks at how increasing demands placed upon the modern clinician means measurable burnout is significantly growing among the profession. Dr Suzy Jordache and Dr David Monaghan will walk you through these demands to help inform and empower practitioners to manage this threat to themselves as well as patient safety.

We also have a recorded lecture called Under Pressure, which looks at the internal and external pressures of being a dental practitioner and how to recognise and manage them. Dr Annalene Weston and Dr Samantha King explore the causes and consequences of this strain, both from the pressure cooker of the surgery and our own internal stresses.

If you're one of many practitioners who suffer back pain, there is also a helpful article written by Ian Homan, where he provides his top tips for staying healthy and avoiding back pain in your practice. While the health of your back may not be your primary focus, there are some things you need to consider to make sure that your back (pain) doesn't become all you can think about later in your career. The greatest amount of postural stress associated with dental practice is found in the upper thoracic and cervical spine. Ian's article will take you through some tips to help avoid and alleviate these common issues.

The eCare app offers members a fun and interactive way to monitor, measure and promote balanced healthy living and enables you to keep on top of your wellbeing with recipes, articles and advice. It also allows members to take positive steps in self-improvement with five-day challenges, wellness assessments, personal health reports and interactive quizzes, and the team strongly encourages members to download and access this fabulous new resource.

Taking care of ourselves

Looking to the future, we are yet to discover the fallout and long-term implications from such unprecedented times. How will things evolve, and what will our new normal look like? We know that these times of uncertainty can lead to added stress and that all of us have been impacted in some way. It is important that we take extra care to look after ourselves during these tough times, as without this first step, it is impossible to continue to care for others, whether that be our friends and family, or patients.

Oral cancers: what not to miss

Dr Amanda Phoon Nguyen, Oral Medicine Specialist, looks at the unique position of dental practitioners in spotting the signs of oral cancer

When clinicians talk about oral cancer, they often mean oral cavity squamous cell carcinoma. However, the term 'oral cancer' really refers to a heterogenous group of conditions encompassing the main subsites of the external lip, oral cavity and oropharynx.

It is important to consider and think of these as distinct entities, as they have differing presentations, aetiologies and risk factors and treatment options. A very large portion of oral malignancies are oral squamous cell carcinoma (OSCC), of epithelial origin. This is the eighth most common cancer worldwide. Early detection and prompt management is key to improving prognosis.

Despite technological advances over the past, the five-year survival rate of OSCC remains poor and is approximately 50% for all anatomical sites and stages. Cases that present with regional lymph node infiltration (Stages III and IV) are reported to have a five-year survival rate of 9-41%, compared to the 66-85% survival associated with cases without lymph node involvement (Stages I and II). The poor prognosis of oral cancer can largely be attributed to its frequent diagnosis at an advanced stage. Therefore, early detection is key.

OSCC is more common in the older population, and more common in females. It appears to be rising in the younger (<40 years) population. OSCC may be preceded by lesions termed oral potentially malignant disorders (OPMDs). The most common OPMDs are leukoplakia, erythroplakia, oral submucous fibrosis, actinic chelitis and oral lichen planus. The aetiology of oral cancer is multifactorial. Human papillomavirus (HPV) infection, most commonly HPV16 and 18, is implicated in oropharyngeal SCC. Alcohol and smoking are considered major risk factors, with a synergistic effect when used together. Other risk factors for OSCC include areca nut or betel quid chewing, other smokeless tobacco use, marijuana and qat use, use of alcohol containing mouthwash, a poor diet and genetic predisposition.

Evaluation of the head and neck area is a fundamental part of a comprehensive patient examination. Dentists play a critical role; there are few health professionals better placed to detect signs of more sinister pathology in the oral cavity and head and neck region.

Image 1:
A thorough intraoral examination is key to not missing potentially suspicious pathology. Image shows: lip vermilion and vermilion border, upper and lower labial mucosa, bilateral buccal mucosa and sulci, gingiva, hard palate, dorsal, ventral and lateral tongue, posterior lateral tongue, floor of mouth, soft palate and oropharynx and floor of mouth palpation.

High risk sites for OSCC include the lateral tongue and floor of mouth. Early presentation of oral cancer is usually asymptomatic. It can appear as an ulcerative, flat, raised or exophytic, red and/or white lesion. The oral cavity can also be the site of cancer metastasis from other parts of the body, most commonly of breast, kidney and lung. Metastasis may present similarly to primary cancers, or mimic inflammatory or reactive lesions.

Some red flags include:

Signs and symptoms for oral cancers and OPMD

- Non-healing ulcerated lesion
- Induration
- Flat/slightly raised white, red, mixed white-red lesion
- Exophytic, proliferative, papillomatous lesions
- Mobile teeth
- Pain or numbness in the mouth/face
- Inability to wear dentures
- Fixed, firm, mass
- Solitary pigmented lesion
- Non-healing extraction site
- Mixed radiolucent/radiopaque lesions
- Non-healing sore on the lips.

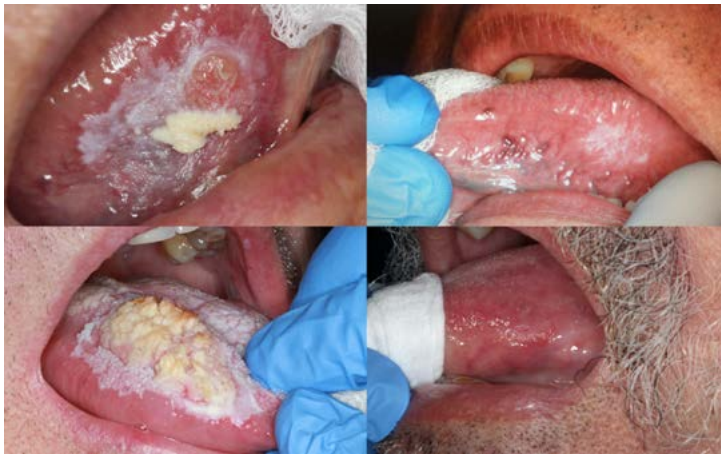


Image 1

Image 2:
These images all demonstrate cases of oral squamous cell carcinoma (tongue). The presentation may range from the subtle to the obvious, but it is imperative that even subtle pathology is not dismissed.

Incorporating these systematic processes into your comprehensive examination can decrease the likelihood of OSCC being missed, and give any patient who does present with an issue a better chance at a good outcome.

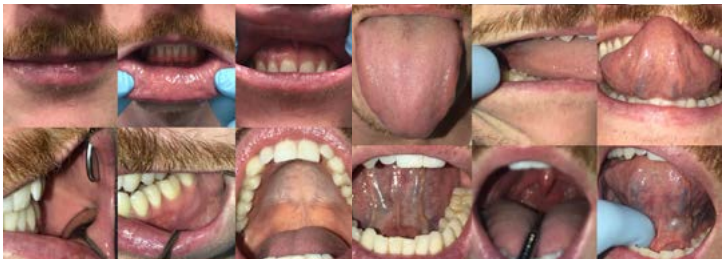


Image 2

Extraoral examination:

Site	Observations	Tips
Visual inspection of the patient in the waiting room and as they enter the dental operatory	▪ Height and weight ▪ Personal hygiene ▪ Posture and gait ▪ Speech, mood and cognitive ability.	
Skin, nails, hair	▪ Evaluate any other visible areas of skin, including the hands. ▪ Pathology of note may include pigmented or ulcerated skin lesions, gross asymmetry, hair loss and nail changes.	Close attention should be paid to sun-exposed areas such as the nose, ears and lips.
Eyes	Observe general features and note any asymmetry.	
Temporomandibular joints and muscles of mastication	Detailed examination of the TMJs is out of the scope of this summary, however, evaluation should include if there is limitation in mouth opening, the end-feel, if there is swelling, joint sounds, and deviations or deflections with jaw movement. The normal range for maximum opening is variable (approximately 40–60 mm) and may be obtained by using equipment such as a ruler.	▪ The muscles of mastication should be palpated with adequate pressure (1kg). ▪ If examination elicits pain, further investigation should be undertaken.
Neck	▪ Neck muscles, such as the sternocleidomastoids, posterior cervical muscles and strap muscles of the neck may be similarly palpated and evaluated for range of motion. ▪ Mobility of the trachea can reveal if there is possible encroachment of neck neoplasms. The trachea can be palpated and moved laterally from midline to appreciate symmetric movement. Grating from the movement of the cartilaginous rings is normal. ▪ The thyroid should be palpated for any nodules, asymmetry or swelling. When the patient swallows, the thyroid gland should move with the trachea.	▪ Practitioners should feel comfortable performing this part of the extra-oral examination by explaining to the patient the procedure and asking for permission to proceed. ▪ By pushing on thyroid gently in a lateral direction, you can palpate the lobes of the thyroid gland. The left and right should be palpated in turn. ▪ Dysphagia should not be ignored.
Lymph nodes	▪ Recall of the lymphatic drainage systems of the head and neck is important. An anatomy textbook or other online resources are useful to refresh knowledge in this area. ▪ Lymph nodes should be assessed for enlargement, firmness and fixation to palpation. Tenderness to palpation is non-specific but should be reviewed.	▪ Looking for the outline of the sternocleidomastoid muscles, and asking the patient to lift and turn their head away from the side being examined is often helpful identify the landmark and palpate the triangles of the neck which border this. ▪ The lymph nodes should be palpated with adequate pressure (1kg). ▪ For the submandibular nodes, it may be helpful to gently pull the soft tissues laterally across the inferior border of the mandible and palpate the nodes against the border of the mandible.

How can you meet the new standards for clinical records?

In late 2020, new guidelines on record-keeping came into force. ***Dr Kiran Keshwara***, Dentolegal Consultant at Dental Protection, looks at what has changed and the new resources available

On 1 October 2020, the Dental Board of Australia (the Board) retired the four-page Guidelines on dental records, as it felt that the *Code of conduct* contained adequate guidance to dental practitioners about record keeping. In addition to the guidance in the *Code of conduct*, the Board has developed a factsheet and a self-reflective tool to help clinicians understand and comply with their obligations.

What does the factsheet explain?

The factsheet sets out the expectations of clinicians and directs them to the relevant documentation.

A practitioner is expected to:

- Practise in accordance with the Board's regulatory standards, codes and guidelines, including:
  - The *Code of conduct*, which contains information on confidentiality, privacy and informed consent
  - Ongoing CPD courses on record keeping
  - Ensuring appropriate professional indemnity insurance is in place.
- Comply with:
  - The relevant state and territory legislative requirements on health records
  - Relevant privacy requirement – this includes the Privacy Act 1988, which details the use, disclosure and release of a patient's personal information and details.
- Understand:
  - What constitutes a health record
  - Your responsibilities when making a health record
  - What should be recorded in the health record.

What is the *Code of conduct*?

This is the main document containing the standards that all practitioners are held to and was developed in 2014. Along with Section 2 (Providing good care) and Section 3 (Working with patients or clients), Section 8.4 of the *Code of conduct* specifically details expectations of clinicians concerning dental records. It states:

Good practice involves:

a. keeping accurate, up-to-date, factual, objective and legible records that report relevant details of clinical history, clinical findings, investigations, information given to patients or clients, medication and other management in a form that can be understood by other health practitioners

b. ensuring that records are held securely and are not subject to unauthorised access, regardless of whether they are held electronically and/or in hard copy

c. ensuring that records show respect for patients or clients and do not include demeaning or derogatory remarks

d. ensuring that records are sufficient to facilitate continuity of care

e. making records at the time of events or as soon as possible afterwards

f. recognising the right of patients or clients to access information contained in their health records and facilitating that access, and

g. promptly facilitating the transfer of health information when requested by patients or clients.

Self-reflective tool – a must for practitioners

This is the newest document made available to practitioners and should definitely be reviewed. The self-reflective tool is a series of questions and statements that encourages clinicians to think about the different aspects of the records created, which will further help clinicians identify any gaps in their knowledge, skills and systems. This information can then be used to improve the record keeping process, encourage discussion amongst clinicians and highlight areas where further record keeping CPD is required.

It is important to remember that the self-reflective tool is not a comprehensive list of the detail that should be included in patient records. It should be used as a starting point to reflect on and consider the records, and for understanding the type of information that should be included.

The self-reflective tool encourages clinicians to complete random audits of the records created to check and remind them of important aspects of the dental records including:

- Ensuring that records are accurate and up to date
- Evidence that patients were fully informed of their options and these options were explored in detail, including costs and personal circumstances
- Diagnostic data (eg dental charting, temporomandibular joint examination findings, pulp sensibility tests and periodontal probing)
- Diagnoses
- Medication prescribed, including information on dose, quantity and instructions provided
- Continuity of care.

The Code of conduct, which is the main documentation for all dental practitioners, and the new factsheet and self-reflective tool, make it very clear that the Board expects clinicians to create records that are detailed and accurate, which can be used to facilitate ongoing patient care. The Board also highlights the need to be aware of the relevant legislation for the state that clinicians work in, and to undertake ongoing CPD and audits of their clinical records.

Further resources

RiskBites – Dental Protection's podcast series, *How to document risks and warnings in your dental records.*

Recorded webinar – *What does the new standard on record keeping mean for me?*

Case study

Critical content – the risks of auto templates

Auto-templates are often used by dental practitioners to increase the efficiency of their dental records. However, they can lead to inaccuracies.

Mrs C attended Dr D with a tooth ache in her 37. She reported that the pain was continuous, keeping her awake at night, and unresponsive to pain medications. Dr D assessed the tooth and found it to be unrestored and caries free, but with a distal pocket of 8mm and grade 1 mobility. The periapical radiograph was unremarkable, and Dr D offered Mrs C several options including debridement of the pocket only and referral to a specialist for an assessment; on the day, Mrs C opted to try the debridement. However, she failed to attend the scheduled review appointment, leading Dr D to believe that all was not well.

Regretfully, Mrs C attended approximately two weeks after the review was planned with exquisite pain associated with tooth 37. Dr D retook all of the diagnostic tests, and a distal crack was identified. Dr D again offered referral, and also extirpation of the tooth as an option. Mrs C preferred an extraction as, simply put, she had had enough.

The extraction did not go well. Dr D luxated the already mobile tooth, getting some reasonable movement, but on the application of the forceps the tooth decoronated. Dr D spent a fruitless 40 minutes attempting to remove the remaining roots piecemeal, until eventually admitting defeat. Mrs C, tired and overwhelmed, preferred to not proceed with a surgical approach on that day, and refused a referral. She wanted to go home.

Dr D did not enter notes immediately, intending to come back later in the day, as he was now running very late. At the end of what had been an arduous day, it slipped his mind, which meant that the auto-template note only was entered as follows:

311: 2 x 2% lignospan. Simple exo. Luxators and forceps. HAEM. POIG.

Not only did this not reflect the truth of the extraction, but also critical discussions with Mrs C were missing.

Listed, in no particular order of importance, the records missing are:

- The reason for attendance
- The patient's symptoms
- The special tests undertaken
- The diagnosis
- The treatment options given, including the risks and warnings of each
- The mode of administration of the local anaesthetic
- The fact the tooth fractured when the forceps were applied
- The fact that the roots were chipping and extracted piecemeal
- The fact the roots were retained, and that Mrs C was advised of this
- The fact Mrs C declined a surgical approach
- The offer of a referral both before the commencement of the extraction, and after the retained roots could not be removed.

Mrs C suffered with pain after the extraction and went to see another dentist. They took a PA and uncovered the retained roots, a fact that Mrs C had either forgotten in the distress of the appointment, or perhaps never truly understood at the time. This discovery, and the new dentist's reaction to Mrs C's apparent ignorance to the facts, prompted her to complain to the regulator.

On this occasion, the regulator chose to meet with Dr D to talk through their concerns. They were clear with him that the failed extraction in itself was not the reason they were considering disciplinary action, but rather the seeming inaccuracy of his records. In the absence of accurate notes reflecting what actually happened, Dr D could not defend himself against Mrs C's allegations that he had not assessed her properly, and that he had not told her of the retained roots, nor offered to refer her to a specialist colleague for management.

Pleasingly, the regulator accepted that Dr D had undertaken appropriate pre and postoperative steps, and that his management of Mrs C was appropriate – he just couldn't prove it. They counselled him regarding accurate record keeping in the future.

Learning points

- While they can increase our efficiency, auto-templated records must be modified for each patient to accurately reflect the unique circumstances of their treatment
- Inaccurate or inadequate records do not enable continuity of patient care, as the next practitioner is not party to what really happened on the day
- Inaccurate records impact on our ability to defend ourselves against allegations
- Inaccurate records reflect poorly on our professionalism as we are breaching the standard required by our regulator
- You can check how your records stack up using this self-reflective tool: **dentalboard.gov.au/Codes-Guidelines/Dental-records.aspx**

Case study

Forget me not

© AaronAmat/iStock/Getty Images

Incorrect extractions are commonplace. The following two cases exemplify how this may arise, and highlight some steps than can be taken to reduce this risk.

Dr M was a recent graduate who had been working as a dentist for around 12 weeks. He was the only practitioner in on Easter Saturday and was leaving that night for a holiday. Mr D attended as a walk-in emergency with constant pain, keeping him awake at night. The clinic was ending, and the practice closing, but Dr M did not feel that he could turn Mr D away. Mr D pointed to tooth 27 as the cause of his pain, and Dr M could see a large filling in this tooth. Dr M took a PA, which captured 17 16 15, but not the apices of these teeth. The x-ray revealed a large composite filling, proximal to the pulp in tooth 17. 17 was mildly TTP and responded non-vital to cold spray.

On discussion of his options, Mr D agreed to an emergency extirpation of 17 on that day, for relief of pain, and for his treatment to be continued after Dr M returned from annual leave. The procedure was uneventful.

Dr M returned from annual leave to find a letter from the regulator, as Mr D had complained that Dr M had treated the incorrect tooth. Mr D claimed that the pain had not abated after his treatment, and that he had attended another dentist who had identified a cavity on tooth 15 as the cause of the pain. Extirpation of this tooth immediately resolved the pain. He now believed that he needed an additional root filling due to a misdiagnosis.

A PA was included in the bundles of documents with the complaint, and this showed 17 16 15 14 and their apices. There was a clear clinical cavity in the 15 which extended to the pulpal complex and 15 had a visible peri apical area. Dr M quickly opened his clinical notes to compare the x-rays and look at his examination and findings on that day. To his horror he found that he had coned off the x-ray, and, worst of all, in his haste to leave the practice for his holiday, he had not made any clinical records. Dr M entered records about the appointment from his recollection, appropriately dated when he made them, not the date of the treatment. He contacted Dental Protection.

Ultimately, the regulator requested a meeting with Dr M to consider the issues. He was able to explain what he had seen on that day; however, as the records had not been written contemporaneously, it was impossible for him to truly prove what he said.

However, the regulator was impressed by Dr M's honesty about why he failed to make records and his integrity in making them without attempting to falsify when they had been created. Dr M had also attended some targeted record keeping CPD, and improved his processes regarding the creation of records, which he was able to evidence. He had also enrolled in a radiography course.

The regulator counselled Dr M on the positioning of his x-ray and encouraged him to look at the whole side of the mouth, not just 'one tooth' as the cavity on 15 was clearly apparent. The regulator accepted that Dr M was not lying about the findings of the testing of 17, and formed the view that booth teeth were non-vital, although 15 was the likely cause of Mr D's pain on the day he presented.

Dr M received a stern telling off, but no other action was taken.

Learning points

- **Ensure you create accurate records as soon as possible after seeing a patient, and preferably before you see the next one**
- **Additions to dental records can be made, providing they are appropriately date stamped**
- **Look beyond one tooth when examining an emergency patient**
- **Honesty is always the best policy.**

Missing the mark – an incorrect extraction

Dr L, a recent graduate, worked in a public health clinic. The clinic was busy, and often demand outstripped resource. Most days Dr L had the support of additional, more experienced practitioners, but on Fridays, Dr L was the sole practitioner. Fridays could be famine or feast, with some days patchy and others in overdrive. This particular Friday was the latter, with more patients scheduled than Dr L could reasonably see.

Mr W attended with pain in quadrant 2, which he reported to be a constant ache that was causing sleep disturbance. Examination revealed gross caries in 27, 26, 25 and 24. 27 was badly broken down and unrestorable. 26 and 25 were TTP with caries extending into the pulp. 26 and 25 tested negative to EPT, however 24 was not TTP and responded to the EFT within normal limits; consequently, 24 was judged likely to be restorable.

Dr L advised Mr W of his findings, and Mr W was pleased that 24 could be saved, as he had a shortened dental arch on the upper right hand side, so he felt he could still function if the 24 remained. It was agreed that Dr L would extract 25, 26 and 27 that day, and Mr W would return for the filling on 24.

The 26 decoronated during extraction, so Dr L decided to remove the premolar unit, and to give more space to access the 26 and 27. Regretfully, the loss of landmark of the 26 crown, in a situation where Dr L was already flustered, running late with several patients in the waiting room, and rattled by the unanticipated difficulty of extraction of 26, led to Dr L placing the forceps on 24, which he successfully delivered. Distressed when he realised his mistake, Dr L quickly removed the 25, 26 and 27 as planned and then sat Mr W up to break the bad news to him.

Understandably, Mr W was devastated, as this now led to him having only the 23 and anteriors on that side to function.

Dr L apologised and, while awaiting haemostasis, stepped out to call his mentor. His mentor suggested that it would be appropriate to replace the tooth, and perhaps Mr W would value an upper partial cobolt chrome to restore his occlusion. Naturally, this could be provided by the clinic at no cost. Dr L proposed this solution to Mr W who was grateful the offer had been made and, ultimately, after a period of healing, the cobolt chrome was inserted.

Learning points

- **Mistakes often arise when we are flustered or distracted**
- **A mentor or senior clinician can be a helpful guide when things do not go to plan.**

The dentolegal view

By *Dr Annalene Weston*, Dentolegal Consultant, Dental Protection

This unfortunate incident, although considered by many to be unavoidable, occurs all too often. Some helpful strategies to avoid extracting the incorrect tooth include marking the tooth with an appropriate pencil or pen, and getting the patient to check in the mirror once the mark is made, to make sure that the patient agrees it is the correct tooth. Another helpful strategy called 'pointing and calling' has been adapted from the railway industry to healthcare. Watch this video for more information.

Scan me

Critically, do seek advice if a tooth is incorrectly extracted. Dr L was lucky to have a supportive mentor who was able to find an acceptable clinical solution in a timely fashion. Many incorrect extractions do not resolve so promptly and amicably. Please do contact Dental Protection, should you find yourself having incorrectly extracted a tooth.

Dental Protection

For protection and support

—

That's out of this world

Find out more
dentalprotection.org.au