Professional support and expert advice for new dental practitioners

Dental Protection

Young Dental Practitioner

Issue 4 – 2022

Finding your first job

Top tips on starting out in dentistry

Page 4

This issue...

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Welcome

We are pleased to bring you the 2022 edition of the *Young Dental Practitioner* magazine.

The transition from university to full-time practice can be a challenging time and the articles in this publication aim to help you navigate through this early stage of your career.

Dental Protection's commitment to positively influence the wellbeing of our members continues and we encourage all readers to take the time to visit our wellbeing hub. This service endeavours to support members to take positive steps for their wellbeing and includes free access to counselling, a raft of resources, podcasts and webinars, as well as the eCare wellbeing app. 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 each member's needs and is delivered by experienced, qualified counsellors. As a Dental Protection member you can access telephone support 24 hours a day, seven days a week, and face-to-face counselling sessions can also be arranged. Please rest assured that the service is entirely confidential and independent of Dental Protection – any member's contact with ICAS remains private.

It is important to take extra care to look after yourself during tough times, as without this first step, it is impossible to continue to care for others, whether that be friends and family, or patients. 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.

Wellbeing hub at
dentalprotection.org/australia/wellbeing

Wishing you a rewarding and successful career.

Kara Stokes,
Business Development Executive

Phone for member assistance: 1800 444 542

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Contents

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Finding your first job in dentistry

Want to stand out from the crowd during the job selection process? There is a job for you, and it's a good job and the right job, but how will you know it when you see it, and what can you do to get it?

Seeking employment can be stressful, as it can lead us to wonder whether we are really 'good enough', especially if our peers are seemingly finding employment with ease. This natural self-doubt, coupled with intermittent statistics which demonstrate a decline in the percentage of graduating clinicians finding full time employment straight from dental school understandably magnifies concern in those about to graduate.

Setting yourself apart

Be honest on your CV
Your CV and covering letter are often the first contact that you will make with a practice, and therefore this is your first opportunity to impress. It is all too tempting to inflate or exaggerate your expertise and experience, but be mindful that no one expects a new graduate to be an expert. Consider joining study clubs and associations, as they are a great source of contacts and these associations represent who you are and your interests.

Remember, an honest representation of who you are is always best. If you are only employed based on an inaccurate description of your skills – this is not the right job for you.

Get good references
You may not be a well-respected practitioner yet, but you do know many people who are. Be sensible in your choices of referee, and try to choose people you wish to emulate as they will best reflect who you are. Better still, can you seek employment with a potential mentor?

Present well
We are professionals and should present ourselves accordingly. Turning up late in scruffy clothes won't help you get that job. A smile, good eye contact and a firm handshake will go a long way to making a good first impression.

Be honest in your interview
An honest representation of yourself (without being self-depreciating) is far more impressive than an arrogant representation of your skill set. Good communicators make good dental practitioners.

Be nice to the staff!
The staff will all give their opinion of you as a prospective co-worker – whether they are asked or not. Do not ignore the front office staff in your eagerness to get to the boss.

Choosing the right practice
Commencing work at our first practice is a long anticipated and memorable experience and the nature of this experience can cast a long shadow and influence your future choices. Considerations for your first practice include; regional or metro? Public or private? Part-time or full-time? Specialty or general? But what is the right choice?

Of course it depends, both on you as a person, and your lifestyle and career priorities and goals. We can however highlight a few areas which can influence your decision-making process. Consider:

Is this the right practice for me?

- Does my future principal seem approachable – particularly if something goes wrong?
- Are there other practitioners I can bounce ideas off?
- Am I expected to make an unrealistic amount of money?
- Am I expected to perform certain treatments 'for the good of the practice'?
- Is the proposed remuneration fair?
- Do I have access to the materials and equipment that I reasonably need?
- Am I taking over an established list, or starting from scratch and which would I prefer?
- Am I ethically aligned with this practice and the practitioners within it?
- Will this practice help me develop, both professionally and personally?
- Will this practice environment or ethos put me under unnecessary pressure?
- Will I be happy here? Am I a good fit?

Am I right for the practice?
You can have the best hands of your class, the best academic marks, or both, but if you do not have the mutual respect and trust of staff and patients alike, then you are not the right practitioner for that practice.

The best first practice is an environment in which you feel able to develop your skills in the direction you choose and, at the same time, the practice is enriched by your presence. Strive for a mutually beneficial working relationship wherever possible, as life (and dentistry) is hard enough without being in difficult working circumstances. Let your practising environment be one in which you feel comfortable, and the rest will follow.

Coping with stress as a dental professional

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Dental practitioners are facing increasing risks of stress related illness. Dentolegal Consultant ***Dr Annalene Weston*** looks at how to recognise the signs and manage your stress levels

Causes of stress

In order to better manage our stress and protect our health, we first need to consider the contributing factors which compound to make dental practitioners so very prone to its effects.

Isolation – While group practices and hospital settings have decreased the isolation of dental practice, this is still a recognised contributory factor to stress. Especially for those practitioners who have experienced an adverse outcome or received a complaint.

Many of us are lucky to work in supportive practices, or have a supportive network outside of our practice, but not all of us have this luxury. When stress attacks, and the walls start closing in, those who cannot reach out to their support network will suffer greatly. We need to find ways to talk it out and manage our stressors in a healthier and more effective way.

Confinement – We don't get out much. Some of us don't even have windows in our treatment rooms. Understandably this can flow on to a diminished sense of wellbeing and happiness. This lack of ability to move around can impact on our wellness in other ways, as we can become unfit and sedentary, further increasing our risk for ill health.

Patient factors – Patient stress and anxiety is born from their fear of us, the treatment we are going to perform, and the news we are going to break to them about their dental health and needs. It is often compounded by the fact that patients are commonly attending under duress, making a 'distress purchase' due to pain or another problem. It is only natural that they will let this stress out on the person they feel most appropriate – that person is probably you.

Through no ill intent or malice, patients can devalue our treatment, our service, and even our self-worth when they choose to shop around for a better price, or trust the advice of Google over the clinical advice we are giving.

Internal stress – We strive to provide our best work, at all times, and can become frustrated with ourselves if things don't go to plan. This constant drive for perfection can only lead to bitter disappointment as there are many factors outside of our control that can negatively impact on the appearance, success and longevity of the work we do.

External stress – There are many factors impinging on our lives which will load more stress on to us. Money is certainly at the crux of much practitioner stress as we struggle to support ourselves and our loved ones whilst simultaneously paying off hefty HECS and other debts. We are often at the stage of our most rapid career development, while at the same time building a family of our own which no doubt comes with financial and emotional burdens. The burdens do not outweigh the joys of family life, but financial and familial issues have been responsible for many

sleepless nights for generations of dental practitioners. Moreover, those who choose to open their own practice will feel these stresses to a greater extent.

Other people's 'bottom line' may also begin to impact your practising life, if the business owner finds you to be 'underperforming' and begins to apply insidious pressure on you to 'produce just a little more'. We are not working in a factory. Simply put, you cannot make people need more treatment.

Running late – This could easily have sat under any of the headings above but such a significant stressor deserves a heading of its own. We run late because things go wrong. We run late because patients are late. We run late because emergencies are squeezed in to enable patient care. We run late because it is more convenient for our patients to have that done now so they don't have to come back. And, we run late because we are chasing a dollar, for ourselves and for the business owner. We do not run late because we want to, or because we enjoy it, and no matter how you look at it, running late causes us stress.

A knock-on effect of running late can mean missing lunch, or being late for personal commitments, or simply not getting home in time to put the kids to bed. It sucks and it hurts us. And finally, we do not do our best treatment when we are under this much pressure.

Personality traits – Every strength can be a weakness. The very personality traits which make us truly great dental practitioners, our attention to detail and critical eye, our conscientiousness and our caring nature, can turn around and bite us where it hurts. These traits predispose us as a profession to reach out for a crutch to get us through the disappointments of our daily life. Regretfully, these crutches can take the form of drugs and alcohol, and dependency on any form of medication, whether prescribed or self-administered is a recipe for disaster.

Facebook fibbing – The societal tendency to hide our flaws and failures and promote only our strengths is played out daily in a narcissistic fashion in the public arena of social media. Not only does this skew one's view of what is good and what is right, but it can cause many practitioners to reflect on their own work with shame for not being 'good enough'. Read the posts with interest, take the key learning points and do not dwell. Comparison is the killer of all joy. You are on your own journey, embrace this and do not worry about the journey of others – each comes with successes and failures, joys and fears; and remember, truly great practitioners share their failures as well as their successes with others to help them grow.

Solutions for managing stress

Networking for a better 'everything' – There can be no doubt that dental practitioners who have networks of support are 'better' in so many ways. Mentors and study groups help us to talk through the challenges of practice and exchange ideas about treatment modalities. Collective treatment planning and timely constructive feedback will enable us to grow confidently as practitioners, through every stage of our career, and naturally this flows on to providing much better treatments to patients.

Networking outside of the surgery will also reap rewards. Having a solid group of people you can trust to talk through your failures with is incredibly empowering, as a problem shared is truly a problem halved. Closing the surgery door and engaging in some hobbies and relaxation will make a more balanced you, and give you groups of friends who don't want to talk about teeth. Get moving for health and wellbeing. Get some fresh air. Your emotional and physical health will thank you for it.

Don't sweat the small stuff – Regretfully, the very nature of dental practice means that things can and will go wrong. It's OK.

A calm approach in the face of adversity will lead to a better outcome for both you and the patient. And once the crisis is over, talk about it. There is no shame in struggling with an extraction, or a root canal treatment, or any dental procedure. Talking about what went wrong will help you to recognise the warning signs in the future and avoid adverse outcomes of a similar nature.

Also, talk to your staff. If you are struggling because of time pressures, they need to give you a bit more time. If they are not prepared to do that, then this may well not be the best practice for you.

HALT– Dental Protection review the complaints and adverse outcomes reported to us, and one thing we have identified, is that you (and the patient) are more at risk of something going wrong if you are Hungry, Angry, Late or Tired (HALT). Sometimes, time spent having a quick break will save heartache for all. Don't be scared to take a break between patients to clear your head if needed.

Patient factors – Accept that you don't see the best side of people when they come to you frightened and in pain. Accept that people say silly things, that they come to you because they DO like and trust you, and don't take the silly comments personally.

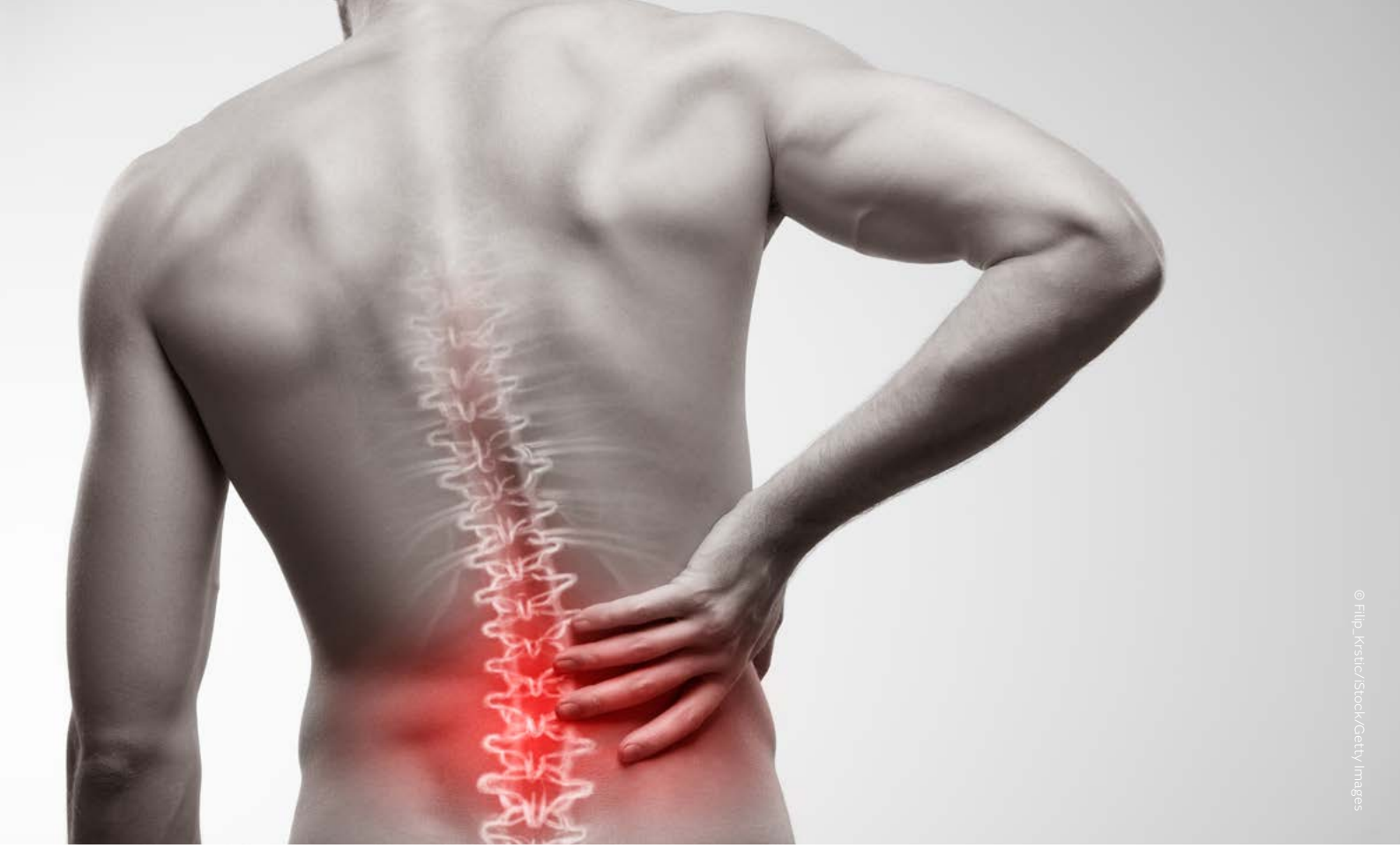
Try to work with patients, within their time and financial constraints to provide the best treatment you can. If you are unable to produce quality treatment with the constraints they place on you, then consider referring the patient to another practitioner who may be a better fit for them.

Recognise dependency – The path to dependency is short and easily followed, but the road to recovery takes a lifetime. Be honest with yourself about what you drink and consume. There is no place for drugs of dependency for those who choose to become a dental practitioner, and use of both legal drugs and illicit drugs can lead to the loss of your registration. Alcohol may be legal, but it too is open to abuse. Please reach out if this section has in any way made you feel uncomfortable because it is relevant to your life, right now.

Bringing it all together

The key to health is multifaceted and complex, but we can start on the right path by caring for ourselves, mentally, physically and emotionally, by stepping away from the surgery to develop some perspective. It's important to be kind to ourselves when things don't go to plan, and reach out to our support network for support.

Eating right, exercising, finding some fresh air and work-life balance all feed into this, but we can start by being kinder, to ourselves and others to set the tone for a less stressful life.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Avoiding injury in dentistry

Ian Homan of Chiropractors of Ascot 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 from your first day, 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 life.

The greatest amount of postural stress associated with dentistry is found in the upper thoracic and cervical spine. I will take you through some tips to help avoid and alleviate these common issues.

Practitioner positioning

If possible sit at the head of the chair to avoid repetitive (rotational) movements, which over time will create asymmetry in your musculature and create poor muscle patterns. These may lead to chronic upper cervical issues.

Patient positioning

Try to have your chair high at a workable height and position. Having the patient too high will cause a shortening in the upper shoulder musculature (ie upper trapezius), which again over a career will create chronic hypertrophy of the muscles involved. I would recommend trying to have your shoulders relaxed and elbows at 90 degrees, allowing for some variation to this as you will have to move around the patient.

Try to have the patient as close to you and your midline as possible, thus reducing the load placed upon your upper thoracic and cervical spine, while also allowing you to work from a stronger, more stable position.

Take regular short breaks

If you only have 20 seconds to spare between patients use it wisely. As your work positioning is in a position of extension, combat this by looking at the ceiling for 20 seconds minimum between patients. This gives your suboccipital muscles a break. Start this from your first appointment of the day as it's generally too late if you start doing the exercise after you feel tightness. Your head is heavy and you are putting it in a position of stress so give it some love.

Look after yourself

Often this gets overlooked. If you're not physically capable of doing the job then it's going to show in your work, or worse still it will stop you working. Go to the gym, yoga, pilates or whatever it is you enjoy doing, and make time for it within your weekly schedule. Try to focus on exercises that work your posterior chain (extensor muscles). Humans are flexion dominant and your positioning as a practitioner further adds to this flexor domination, so when you're exercising give some thought to working on your extensor strength – these are the muscles that will be under the most stress at work.

Eat

If possible have small nutritious snacks throughout the day (eg a handful of almonds, trail mix or a banana). This will keep your body fuelled and prevent fatigue and exhaustion on your muscles!

Losing control – how far can autonomy take us?


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Patient autonomy is a pillar of the consent process, but does it ever become problematic? ***The Dental Protection Advisory Team*** consider this in the context of a recent case

The generation of patients imbued with the mantra of 'doctor knows best' are still present in contemporary practice. However, the social movements cultivated and grown by the 'flower power' generations of the 60s and 70s were a catalyst for widespread global social change. Following this, the tension between paternalism and autonomy finally gave way, and by the mid-80s patient rights were the winner. This means that we predominantly treat autonomous patients. Patients who are empowered to question us, who can choose and refuse our care, and even review us, and not always kindly.

Case study

Miss S was unhappy with her smile. She attended a specialist orthodontist for an assessment and was advised surgery would be essential for her to achieve an ideal outcome. However, she could consider a two-year course of fixed orthodontics if she was willing to accept a compromised camouflaged outcome. Unhappy with both these options, Miss S sought an appointment with Dr Z, a GDP who advertised aligner treatments. She expressed that she understood that she needed complex care, but reassured Dr Z that she was not looking for 'perfect'; she was just looking for 'better'. And, as her wedding was rapidly approaching, couldn't he consider providing her with something quick and easy to help?

Despite his reservations, Dr Z agreed to take records and assess what, if anything, he could do. Dr Z proceeded as far as a ClinCheck, and at that stage his reservations outweighed his desire to please. He called Miss S and advised her that he couldn't proceed, as he could not achieve an acceptable outcome for her. Miss S bombarded Dr Z with impassioned pleas, by email and by text. Surely he would help! She understood the risks and limitations – wasn't it her money, her mouth and therefore her choice?

Dr Z agreed to one more consultation to show her the ClinCheck and outline his concerns. Miss S reviewed the proposed treatment and proclaimed it to be everything she wanted. She paid the full fee in advance on leaving the surgery and scheduled all her appointments. Surely, Dr Z couldn't say no now, could he?

Difficult as it may have been to decline to treat Miss S, Dr Z very quickly began to wish he had stood his ground. While the treatment progressed as anticipated from the ClinCheck, the outcome did not meet Miss S's expectations. She became difficult to manage and rude to the staff. Dr Z was pleased to reach retention so this nightmare could be over. Regretfully, although perhaps not unexpectedly, Miss S was unaccepting of her outcome, demanding a refund.

Dr Z had barely had time to consider how he felt about this request when a letter from AHPRA arrived. The notification was accompanied by an expert report from an orthodontist setting out why the aligner treatment wouldn't work in the presence of a gross-skeletal discrepancy, and a complaint from Miss S, alleging to have been unaware of this fact and accusing Dr Z of "misleading her for profit", soon arrived.

Dr Z is not alone in his plight. Patients attend daily demanding specific treatments, researched on Google with a preconceived endpoint and price point. The critical point remains, however, that just because someone wants a specific treatment, it doesn't mean that you have to provide it to them, particularly if – like Dr Z – you are uncomfortable because you do not believe the treatment will be successful, or in the patient's best interests. Fortunately for Dr Z, his records accurately reflected the conversations that had been had, and critically those indicating Miss S's understanding and acceptance of the treatment and its limitations. AHPRA dismissed the matter.

Learning points

- Patient autonomy is one of the four underpinning principles of medical ethics and a vital component of patient consent.
- This does not, however, mean that the patient is in the driver's seat – dictating the nature and type of their treatment, and controlling all decisions.
- It is important that practitioners are not bullied or coerced into providing treatment they do not wish to – regardless of whether they are uncomfortable because they are out of scope, because they do not believe it to be in the patient's best interests or for any other reason.
- The documentation of conversations we have with our patients in their clinical notes is a vital component – both of patient care and, when required, practitioner defence.

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

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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'), while 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.

Inform yourself of Health Fund and Medicare requirements

Be 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.

Don't self-prescribe and don't prescribe for your friends and family

Various guidelines stipulate that this should be avoided wherever possible. If you have to do so, be prepared to justify your decision, make a clear record of what you have done, and advise the patient's GP in writing, including your clinical reasoning where appropriate. Remember, you are limited to prescribe medications related to the practice of dentistry only.

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 due to suspension.

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.

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

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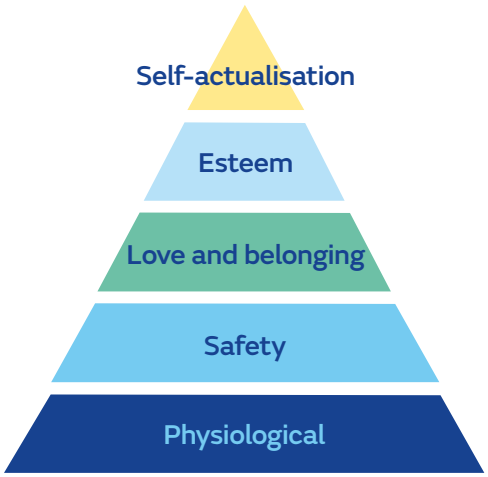
In difficult times, we all look for ways to better manage ourselves and our staff. Considering the psychosocial safety climate of our practice is one helpful strategy that may in the past have been overlooked. ***The Dental Protection Advisory Team*** provide an overview

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.

From rags to riches and back again

Dr Laura Hunter, Dental Protection's Young Dental Practitioner Representative, looks at some unexpected financial situations you can find yourself in as you transition from dental school to working life are here to help

Embarking on the dental school journey is no mean feat and living on a student budget becomes second nature. All the while racking up significant debt and loans over the 5+ years from costs associated with this particular career path. By the end of my time at dental school I liked to joke with my professors whenever another expense cropped up, "Just add it to the tab". That's what eight years of university loans will do to you.

It comes as no surprise when we hold on to the beacon of hope, the light at the end of the tunnel, that upon graduating we will finally have a disposable income. That we can start to climb out of the hole that is student budgeting and start to enjoy ourselves. A common question among my classmates was: "What will you spend your first paycheque on?" We explored the lavish ideas of buying the expensive couch, nice dress or even meal out that we had always wanted but could never justify while studying. So, it came as quite a surprise to me that four months after graduating, I sit here with $30 in my account. Arguably worse off financially than when I was a student. Not through a lack of discipline or financial folly, but instead due to a lack of awareness of how costly and slow transitioning from student to work can be, despite your best efforts.

Everything costs – but just how much really?

As we all know, nothing in life is free. And in the case of dentistry nothing is cheap, let alone free. I thought it would be prudent to lay out some of the expenses you can expect when first starting as a practitioner, as well as laying out factors that you may not be aware of (or at least I was not) that require consideration when creating your 'New Grad Budget'.

As medical professionals we are all required to be registered with AHPRA, a yearly subscription of around $1,200 which I've been told hurts every time you pay, but alas is part of being in the business. This is an expense I like to think most graduates are aware of and like myself, add it to the tab.

However, that is merely the beginning.

Then comes the rest of the licensing. Firstly, a radiation licence required for each state. In my case, Victoria. Out goes $200. CBCT? That'll be extra, out goes another $200. Plus the training course, another $200. You need an updated CPR certificate? Another $200.

Let me just pay for that police check again – $150. Double that if you're an international practitioner. Working with children check? You guessed it, another $100.

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You can sense a pattern here. Pretty quickly you're out almost two and a half thousand dollars, and you haven't earned a penny. But you've added it to the tab and are ready to begin working right?

Well. Not quite.

Graduates have often moved interstate or internationally to attend dental school and while a few still remain at home or return home to live with family, many will move rurally or to another city for that dream job. It probably doesn't need to be said but moving isn't cheap. Having moved eight times in eight years I thought I was as savvy as it gets. But even then, combining movers, truck rentals, new furniture, rent for the month in advance plus the bond for the flash new flat (because we are young professionals now, leaving behind those grubby student flats once and for all) you find yourself, once again, down another two and a half thousand dollars.

But now you are locked and loaded, registration is paid, house sorted, absolutely raring to dive into some exam and cleans headfirst.

This brings me to my next topic, the job.

That first paycheque

We are extremely fortunate to have a career in which job security and income levels will hopefully not be a significant source of stress and anxiety if we manage our time and finances responsibly.

So how have I found myself in this position you may ask?

I, like many graduates, accepted a job towards the end of final year, forecasted my living costs and debt repayments and looked on at my future with somewhat of a smile, knowing that I would be okay. Taking the month off after graduating over Christmas to get some well-deserved post-exams RnR, spending time with the family and getting ready to start the new chapter of your career is pretty typical, and something I would encourage. Therefore, the majority of grads will begin their dental journeys in January.

It is not uncommon for practices to start new grads off with a few weeks to a month of observation and training at a significantly reduced wage, regardless of your status as commission or salary. All the while you are waiting for the provider number that allows you to start practising – average wait time 28 business days. So now you are a large portion through February and the paycheques are barely covering living costs.

You open your books and despite what everyone says it always takes time to fill up days even for the busiest of practices. Weeks can be 'gappy' and patients will FTA, it's just life, so even the first few weeks of 'dentist pay' can be less than the desired 40 hours.

But the real kicker is whether pay comes fortnightly or monthly. Count yourself among the lucky if it is fortnightly, otherwise you can see yourself working for a month with nothing to show for it. Suddenly it's April and you're wondering where a third of the year has gone.

However, things do start to improve quickly after this point. I found there were very few outgoings requiring such large sums of money once work and life routine was established and that is when the savings can start to accrue substantially. This is where my journey has taken me thus far and reflecting on these past few months I will leave you, the reader, with these four points.

Things I wish I had known

- Lower your expectations – it takes a lot longer to get 'there' than you think. And that's okay, good things take time.
- Ensure you are living well within your means – stick with the frugal student budget mindset until you are a few paycheques down to help build your base savings.
- Do not wait for your AHPRA and Provider number to come in the mail. Always get on the phone and see where your application is on the waitlist.
- Always have an emergency savings fund – never ever compromise on having at least six months of basic living costs in an account you never touch. You never know when you'll need it.

Would you like Endone on the side?

By ***Dr H***
(name withheld due to confidentiality)

As a fresh graduate, I started working in the public system in a small country town with another graduate and a mentor/ senior dentist who would come by a few times a month to extract wisdom teeth

The group practice consisted of GPs, allied health and oral health along with other community services. A patient came in with a partially erupted 38 which needed a surgical extraction and an appointment was scheduled with the senior dentist.

The day before the extraction the senior dentist stated he was unable to attend on that date and time and, despite efforts to contact this patient to reschedule his appointment, he was unreachable. The day of the extraction came and naturally the patient attended. The practitioner who originally saw the patient was running late and, as I was free, I offered to see him to apologise and explain the situation. The patient complained of severe pain resulting in limited opening and there was reddening and swelling of the operculum surrounding the visible portion of the 38.

I recommended a chlorhexidine mouth rinse and provided a monojet syringe for irrigation under the operculum. I also scripted paracetamol 500mg and codeine 30mg. As per usual with my scripts, I cross hatched the blank space at the bottom.

The next day I spoke to the pharmacy as they said there was more than one painkiller on the script; "You shouldn't have put two S8s on the same script!" they said. I was confused about this and clarified that I only scripted paracetamol and codeine; I asked what else was on the script. The pharmacist said 'Endone' (oxycodone) and that he provided it to the patient in conjunction with the paracetamol and codeine.

It later become apparent that the pharmacist had suspected the script had been tampered with or falsified in the first instance and had called through to discuss this with me. Regretfully, they had contacted another department within the centre and for reasons unknown, this call was not transferred to me. Disheartened, the pharmacist had proceeded to issue the prescription in its entirety.

I was very upset and felt professionally violated, and immediately called Dental Protection's dentolegal advisory service.

I was advised to telephone the police, prepare a signed written statement of my version of the events and cancel the rest of my patients for the afternoon as I was too upset to continue.

My dental assistant had gone to the pharmacy to obtain a photocopy of the script for our review. On looking at the script the patient had crossed out two words and slipped in 'Endone' in excellently forged handwriting. Despite the paracetamol and codeine both having dosages (500mg and 30mg) written next to them, the word 'Endone' had no dosage written next to it.

The police soon arrived and looked at the script, and then took the patient in for questioning. Despite initially warning that prosecution of the patient would be difficult because a copy of the original script was not available, the police were eventually able to obtain a full confession from the patient.

The principal GP of the practice has since taught me a better way of writing scripts in absence of a triplicate and recommended I number all items in future, and write in words at the bottom 'total number of items: ONE'. I now do this religiously for all my scripts. The police also encouraged me to take digital photos of all future scripts for any future prosecution of fraud cases. I also found a **Medicare fraud tip-off line** for script fraud and I gave them the patient's full details as well as a pledge to give evidence if Medicare proceeded with an investigation.

That's not the end of the story. Two weeks later, the patient left the practice a voicemail, annoyed that we had not contacted him to reschedule his surgical extraction! We do have a duty of care to refer him appropriately but he is no longer welcome at our practice. To paraphrase the police: barring the patient from your practice will teach him far more of a lesson than our court system ever could!

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The dentolegal consultant's perspective

Dr Mike Rutherford, Senior Dentolegal Consultant, Dental Protection

This example highlights an extremely difficult and upsetting time for any dental practitioner, regardless of their postgraduate experience. It is challenging enough to deal with the usual patient dilemmas day-to-day, let alone having to manage the often distressing interactions with third parties such as the police, or a regulator.

Our young graduate did the correct thing by contacting a colleague immediately for support; always contact a dentolegal consultant if you have any issues or concerns regarding patient management as we are here to offer support and advice and most importantly help you through this difficult time until the matter is resolved.

In every clinical situation or patient interaction, you need to ensure that you have documented the events accurately and thoroughly and, in a situation such as this which escalated rapidly, you may wish to consider ceasing working until the situation stabilises. Trying to continue to work when you are acutely distressed may have disastrous consequences.

Situations that place us at most risk are:

- Emergency situations
- When we are anxious or fearful
- When we have difficult interactions
- Where we are under time pressure
- When we are hungry, angry, late or tired (HALT)

It can be a difficult call to cancel pre-booked patients, but always remember that the most important person in the room is the patient in the chair, and, if through circumstances outside your control you are unable to offer that person your full attention, you are best to defer until such a time that you can care for them in the manner they deserve.

These case studies are based on real events and provided here as guidance. They do not constitute legal advice but are published to help members better understand how they might deal with certain situations. This is just one of the many benefits Dental Protection members enjoy as part of their subscription.

Learning from cases:
a difficult conversation in bariatrics

Many adults are currently overweight or obese. Naturally, this has some impacts on how we can physically practise dentistry, and there are also some additional considerations regarding the treatment of bariatric patients that may not be obvious at first blush

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 already 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 which 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.

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Case study

Dr 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. Dr 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 examination, as the chair reclined an audible crack was heard, accompanied by the chair lurching downwards, as plastic casing of the chair fractured under the patient. Though unharmed, Mrs J was distressed by the events, despite Dr L's assurances.

Dr L was sympathetic about the event and felt he ought to have broached this difficult subject to avoid the upset in the first instance. It led to the pressing issue however, that as Mr J, the larger of the couple, was scheduled in for implant surgery the next week. Though Dr L would likely be able to get his chair repaired in time, his greater concern was whether the chair would break during this procedure, and the harm that could be caused to Mr J during surgery if it did.

Dr 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 clinicians who have been accused of discrimination when they have declined to treat an overweight patient.

Equally, some of our 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, Dr L had a long-standing relationship with Mr J and was able to talk through his concerns respectfully. Critically, Dr 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 Dr 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 for patient safety, and as bariatric patients are becoming increasing common, 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 does not form the view that the dental team is being obstructive or discriminatory.

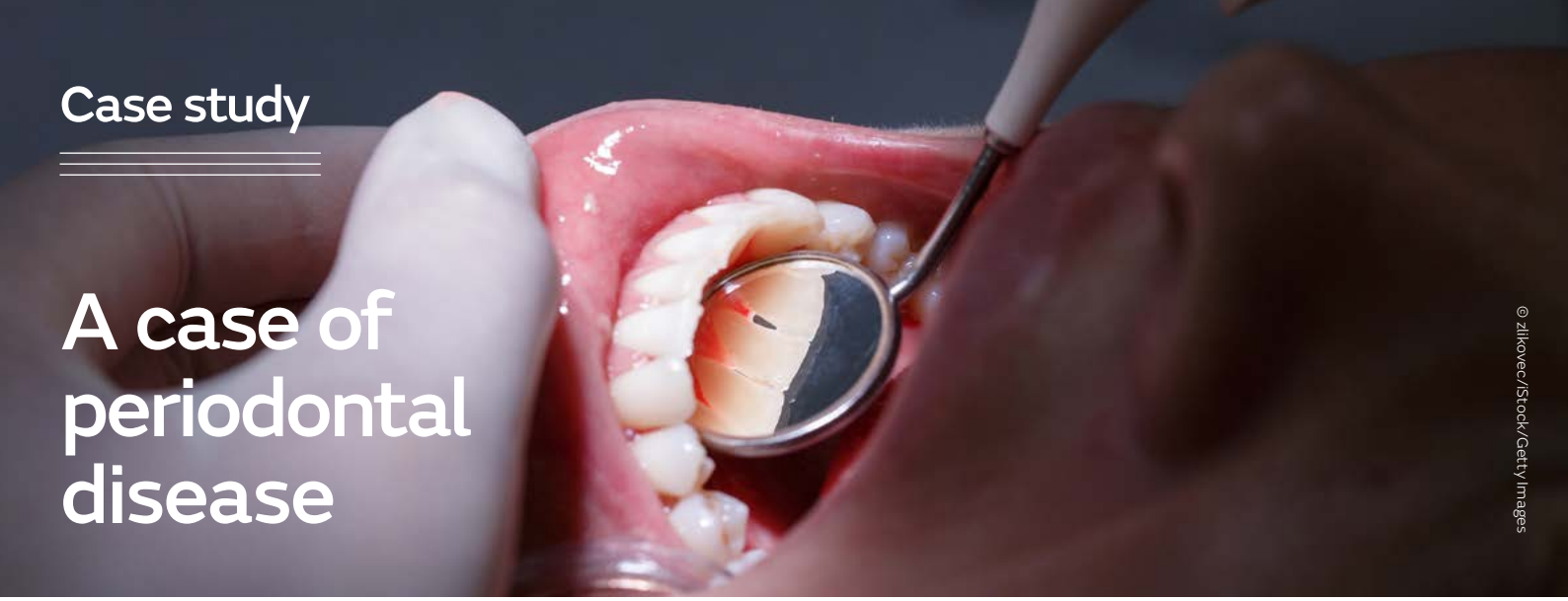
Another option to consider is better equipping ourselves to treat bariatric patients in our own clinic as dental chairs with a weight limit of 198kg are now available.

Learning points

- Be sure to check the operating limit of you own chair
- Determine the weight of your patient
- Highlight the safety issue respectfully
- Where necessary make a referral to a practice or clinic more suitably equipped.

Case study

A case of periodontal disease



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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

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Are you incompetent?

The Dental Protection Advisory Team walks you through a case where this very question was asked of a practitioner

Mr R was an irregular attender, with a heavily restored dentition that included an incomplete root filling in tooth 36. Dr L had raised this as an issue that required addressing and reiterated this to Mr R at every appointment. Mr R was reluctant to undergo treatment as the tooth was asymptomatic.

However, as Dr L had anticipated, the tooth became symptomatic. These symptoms quickly became unbearable and unresponsive to pain relief. Mr R attended Dr L in the pre-lunch emergency spot, hypoglycemic as he could not eat, exhausted as he could not sleep and in tremendous pain.

Dr L talked through the risks and warnings, including that the tooth would likely fracture during the extraction and may require a surgical approach. She offered Mr R a specialist referral; however, understandably, Mr R wanted the tooth extracted there and then.

As anticipated, despite sufficient anaesthesia, the extraction was uncomfortable and challenging. Regretfully, the tooth fractured on application of cowhorns, leaving the distal root in situ. Dr L was unable to remove this retained root by luxation and recommended a surgical approach. Overwhelmed, Mr R declined a surgical procedure on that day, and they agreed to talk the following day to arrange for the remainder of the tooth to be extracted by an oral and maxillofacial surgeon. Critically, Dr L did not charge for the extraction and offered to take Mr R home, as he was feeling so unwell. Desperate to leave, he declined. He missed the calls made to him the following day.

Mr R then had a challenging few days of pain and vomiting. He had taken a considerable number of painkillers, well above the recommended dose, but did not consider this to be the likely cause of his sensitive stomach. He was very focused not on Dr L's repeated recommendations to get tooth 36 assessed and treated, nor the risks and warnings she had outlined before attempting the extraction, but rather her perceived inability to 'get the job done'.

Mr R sent an unpleasant letter of complaint to Dr L, asking whether "she was incompetent" and this was swiftly followed by a letter to the regulator setting out his perceived failings on her part including her incompetence, charging for treatment not provided and her complete lack of care for his wellbeing.

Dental Protection assisted Dr L with her formal response to the complaint. Pleasingly, the matter was dismissed, as there was no evidence that Dr L had acted incompetently. Dr L was also able to evidence she had not charged Mr R and that all appropriate steps had been taken to care for him.

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

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