

2016/17

Dental
Protection



the youngdentist.com

INSIDE...

EXTRACTIONS AND ORAL SURGERY

Dr Janet Scott suggests
some strategies to keep you
out of trouble

INCREASING PATIENT SATISFACTION

Dr Rochelle Yong Gee
describes a patient-centred
approach to dentistry

PROFESSIONALISM IN DENTISTRY

Dr Akhil Chandra explores
dentistry as a business and
the dangers of social media



**SOMETIMES AN
ANSWER WILL BE**
neither right
nor wrong



MORE ADVICE

For Young Dentists

FREE
GRADUATE
MEMBERSHIP

For new graduates, membership is FREE*. Giving you access to expert guidance during the important early stages of your career.

MORE FOR MEMBERS



Colleague-to-colleague expertise, world-class education, events and resources



24/7 expert guidance in an emergency from dedicated teams of specialist dentolegal advisers



Essential advice once you've graduated, plus our tailored Young Dentist Conference



Access to professional indemnity insurance, including \$40 million in the aggregate**

JOIN TODAY or find out more at
dentalprotection.org.au
1800 444 542

* Free graduate membership applies if you join before 31 December of your final year of study

** with the maximum limit of indemnity for any one claim under the policy not exceeding \$20 million



4

Communication

Dealing with Dr. Google and Professor Facebook according to Dr Rick Iskandar

9

Extractions and Oral Surgery

Dr Janet Scott suggests some strategies to keep you out of trouble

14

Professionalism in Dentistry

Dr Akhil Chandra explores dentistry as a business and the dangers of social media

In the Australian Bush

Dr Mike Rutherford discusses some of the access problems that exist for patients seeking dental treatment in the remote parts of Australia

Increasing Patient Satisfaction

Dr Rochelle Yong Gee describes a patient-centred approach to dentistry

18

Protection Throughout Your Career

Meet DPL Australia's Dentolegal Advisers and Cases Consultants who have the experience to support you if you experience a problem in your own career

Out Loud

Dr Louise Hanrahan shares her thoughts on how best to communicate with patients; particularly those living in remote settings

Contact us

Dental Protection Limited

DPL Australia Pty Ltd
Po Box 1013, Milton BC, QLD 4064

Email

membership@dpla.com.au

Telephone +61 (07) 3831 6800

Facsimile +61 (07) 3831 7255

info@dentalprotection.org
dentalprotection.org

Production Team

Editors

Dr David Croser BDS, LDS, MFGDP(UK)
David.croser@dentalprotection.org

Kara Stokes

Kara.stokes@dentalprotection.org

Design

Lucy Wilson

Printer

Panther Print (Brisbane)

DPL Australia Pty Ltd ('DPLA') ABN 24 092 695 933, CAR No. 326134 is a Corporate Authorised Representative of MDA National Insurance Pty Ltd ('MDANI') ABN 56 058 271 417, AFS Licence No. 238073.

Dental Protection Limited ('DPL') is registered in England (No. 2374160) and along with DPLA is part of the Medical Protection Society Limited ('MPS') group of companies. MPS is registered in England (No. 36142). Both DPL and MPS have their registered office at 33 Cavendish Square, London W1G 0PS. DPL serves and supports the dental members of MPS. The benefits of MPS membership are discretionary, as set out in MPS's Memorandum and Articles of Association

'DPL member' in Australia means a non-indemnity dental member of MPS. DPL members have access to the Dental Indemnity Policy underwritten by MDANI. By agreement with MDANI, DPLA provides point-of-contact member services, case management and colleague-to-colleague support to DPL members. None of DPL, DPLA and MPS are insurance companies. Dental Protection® is a registered trademark of MPS.

Cover and contents photos © MPS/Paul Cliff 2015.

COMMUNICATION

“You can’t win an argument. You can’t because if you lose it, you lose it; and if you win it, you lose it.”

“A man convinced against his will is of the same opinion still”

How to Win Friends and Influence People, Dale Carnegie.



key Mrs Smith, thank you for being so patient through that clean, we’re going to give those pearly whites a polish, some fluoride and we’ll set you free”

“No fluoride please, I’m not too keen on poison in my body”

...I’m sure you’ve heard it all before...

As clinicians, our duty is to provide services and information to the best of our ability with the intention of improving the oral and systemic health of our patients. Dentists should NOT make clinical decisions on their patient’s behalf or without their consent, unless spending time with the DPL advisers is what you would like to be doing in your spare time (even though they are charming folk). Being well informed and keeping up-to-date with reliable information on “hot” (and often wildly misinformed) topics is imperative for providing honest answers, in a diplomatic manner, to patients in the chair.

One of the best pieces of advice I received from my clinical supervisors at university was to be well read in more subjects than just clinical dentistry. In *How to Win Friends and Influence People*, Dale Carnegie presents a fascinating point of view:

“You can’t win an argument. You can’t because if you lose it, you lose it; and if you win it, you lose it.”

And

“A man convinced against his will is of the same opinion still.”

I highly recommend this book to all newly graduated dentists as it gave me fantastic insights into human resource management, conflict resolution and how to win people over to your way of thinking.

Being argumentative or standoffish with a patient who has trusted you with their oral health and is willing to allow you to put your hands in their mouth is insulting at the least, and should be avoided.

In his book, *The Patient Will See You Now*, (which I also highly recommend) Eric Topol, a prominent American Cardiologist and genetics researcher, speaks of the democratisation of medicine and the departure from the traditional Hippocratic, paternalistic model of “Doctor say - Patient do”. Patients of the 21st century have the right to engage in two-way conversation with their dentist without the fear of being berated or scolded.

Instead of locking horns with a patient who you believe has an attitude or opinion detrimental to their health and wellbeing, communicate on their level using their mediums of communication. An effective method of counselling patients who may bring up a Facebook article linking vaccinations to autism may be to direct them to an infographic debunking these myths from your practice’s Facebook page. Should a patient raise concerns over an article they found on ‘fluoridealert.com’, a myriad of interviews and publications by Dr Michael Foley on the safety and efficacy of fluoride may be a suitable rebuttal and so on. In the same way that waiting room leaflets on the dangers of gum disease and smoking have educated generations of patients, Facebook articles and Google Scholar results seem to be the way of the future. The added mobility of a Facebook post or a webpage adds convenience for time-poor patients. Find a resource that works for you and for your patients’ demographic.

The position of leading national and international health organisations (ADA, WHO, AMA etc.) on many of these topics are easy to find and may be worth referring to if a patient has concerns.

It took me some time to compile my ‘go-to’ articles, but I have found that patients appreciate not being treated like children who have presented a preposterous idea. As an added benefit, a substantial amount of chair time may be saved as the discussion is usually broken up over multiple visits with the most scientifically justifiable opinion on the matter presented in these resources. Whether or not a patient takes this information on board is inextricably linked to the suitability of the article for the target audience.



Biography

Dr Rick Iskandar

Dr Rick Iskandar is a 2014 dental graduate from The University of Queensland. He is currently working as an associate dentist in North Sydney. When he's not in the surgery, Rick spends his time weight training, playing guitar, trawling through Instagram (not always at the same time) and has a keen interest in technology.

In-chair interactions are still a fundamental part of our practice and can be especially beneficial for open-minded patients who seem willing to hear your suggestions. These interactions should be approached with a respectful, light-hearted attitude.

In my own practice, I have found that patients are especially receptive to information presented as a suggestion based on observations from the examination component of the appointment. 21st Century Australians receive visceral stimulation in the form of a light, LED screen, vibration or otherwise on a near constant basis. Intra-oral cameras are widely available and are an invaluable tool when communicating complicated dental concepts in such a way that our overstimulated patients can appreciate.

Case acceptance is markedly increased through understanding aetiological factors that contribute to caries and periodontal disease. This may be achieved by showing patients images of their own carious lesions and subgingival calculus deposits. As an adjunct to good clinical records, intra-oral photography can also play a big part in avoiding litigation in the event of unfavourable treatment outcomes.

There is no denying that society is changing in the 2010s. Technology is advancing at a perpetually accelerating rate, access to information (reliable or otherwise) is more freely available than ever before in human history, and all in the palm of your hand.

Sources of this information range from peer-reviewed randomised controlled trials on the Cochrane database to that weird guy you met that one time's incoherent conjecture on Game of Thrones politics – a significant proportion is bound to be false or misleading.

So how should we go about communicating with patients beset on all sides with Facebook articles purporting links between root canals and cancer or fluoride and decreased IQ? The short answer is *politely*.

BACK IN THE CHAIR...



EXTRACTIONS AND ORAL SURGERY

Dr Janet Scott suggests
some strategies to keep
you out of trouble



Often we will receive enquires about extractions and oral surgery in the DPL office, either as a consequence of something that has happened and the member is seeking reassurance, or because you have received a complaint from the patient. Looking at those enquiries that we do receive, the only factor that is common to most is the TBFTGOGGI factor. In other words, any of the enquiries could happen to any of us. Prevention is always better than cure, so let's see what we can do. The hypothetical case at the end of this article encompasses most of the enquiries we have seen in the office at Dental Protection (Australia).

With apologies to the airlines, today, you are working in a litigious environment. Subtly, every patient is different. That's why you need to read this article. To continue the analogy of flying, let's consider the treatment plan for the extraction along the lines of the pre-flight checks, the flight itself and the landing.



REFERENCES

1. "There but for the Grace of God go I."
2. WWY Tong, EA Anderson and CH Katelaris: Medicinal Mishap - Cross reactivity of penicillins and cephalosprins - Australian Prescriber, 2007:30, 25
3. Australian Dental Journal, 2005:10; Supplement 2
4. MIMS online, accessed via www.ada.org.au members log in.

1. PRE-OPERATIVE ASSESSMENT (THE PRE-FLIGHT CHECK)

Medical History – an up to date medical history is important prior to removing a tooth. Recording any changes to the history is also vital. Most practices use a paper health questionnaire and it is a good idea to run through this with the patient on a regular basis and record and initial any changes, or have the patient fill in and sign a new one. Even if you have it computerised, you should check it regularly and record your changes. I always double check with the patient about allergies – I have lost count of the number of times a patient has ticked ‘no’ and then tells me they are allergic to penicillin.

It is now generally agreed that anticoagulants do not need to be stopped prior to extractions, but if in doubt, check with the patient’s GP. Less well recognized is the chance (albeit low) of cross reactivity between penicillin allergic patients and cephalosporins. The Medications in Dentistry Supplement to the Australian Dental Journal is a good reference tool and MIMS is available through the ADA website for those who do not subscribe to the hard copy.

If the patient has had teeth removed in the past, ask whether they were difficult – if the patient tells you that the previous dentist took three hours to get the tooth out and even then it broke into lots of pieces, it might be an idea to either plan on your extraction being a long one, or refer the patient straight away.

X-Rays – opinions differ as to whether a pre-operative radiograph is necessary or not. It might be hard to justify the radiation to remove that single lower incisor with advanced periodontal disease, but in the case of an upper molar in a patient with a history of difficult extractions, I think it would be prudent. (See the case example later in this article). Ask yourself if you had a radiograph, would it affect the way you plan the treatment?

Treatment options and informed consent – you should not assume that the down at heel patient who arrives in your practice and obviously hasn’t seen a dentist for a long time is only interested in an extraction. Consider if other options are available; if there are, let the patient know and advise him/her of the costs involved and record the fact in the notes. There are lawyers out there who will argue that had their client known of other options, he/she would not have opted to have the tooth removed in the first place and therefore would not have suffered all the “additional pain and suffering”. The professional indemnity organizations have not been able to defend many cases due to the fact that the case notes have been somewhat lacking in detail, especially as to the options discussed with the patient.

Having logged the pre-flight check, we can now take off and enjoy the flight itself.

2. THE PROCEDURE (THE FLIGHT)

In the vast majority of cases, things will progress smoothly and the tooth will be out before you know it, but occasionally we hit a pocket of turbulence. You will need to ask yourself if you are prepared for it. It’s a good idea to have a sterile setup available should that root fracture off, so that you can remove it surgically, if you feel competent and confident. If not, what is your strategy?

Do you have sutures/haemostatic agents should the patient continue to bleed? Are you prepared for a medical emergency (the commonest being fainting)?

Do you need to warn the patient about every possible complication in the book? Personally, I don’t think so – the standard here would be that if a “reasonable and competent” dentist would foresee a given complication, then the patient should be warned about it. For instance, it would be a good idea to advise every patient about post-operative swelling, discomfort and bruising as these are fairly common, but a fractured root,

tuberosity or even mandible is not that common. If it looks as if any of these may be a possibility, then the patient should be warned and perhaps offered the option of referral to an oral surgeon. If there is a large restoration on the adjacent tooth, it would be advisable to warn the patient it may be dislodged during an extraction. Remember, certain people might attach more significance to a particular type of complication; for example wine makers and lingual nerves, wind or brass players and oro-antral communications.

What do you do if turbulence hits during the procedure and things don’t quite go according to plan? What NOT to do is hide the fact from the patient – explain to the patient what has happened and the likely consequences of that. For example, if an oro-antral communication is apparent after you have removed that upper molar, tell the patient what he or she should expect. Immediate surgery may not be necessary to repair this, as nature often takes its course and does the job for you. If you are confident that you can cope with the complications, then do so, or phone your oral surgeon for advice, and record the fact in the notes. If the filling in the adjacent tooth is dislodged, as a gesture of goodwill it may be nice to offer to replace it at no cost to the patient if that filling was not defective to start with.

In orthodontic extractions, confirm with the specialist if the treatment plan does not make sense or is at variance with what the patient or parents think is happening. If you are dealing with a quadrant of dubious teeth, advise the patient what you are doing – this could save them coming back later if the patient decides the pain was from a different tooth and accuses you of taking the wrong tooth out. If you do take the wrong tooth out, then tell the patient what has happened and inform us immediately.

3. POST-OPERATIVE COMPLICATIONS (THE LANDING)

Patients should ideally be given a list of written instructions on how to care for their mouths after an extraction. You can use a generic one or tailor-make one to suit your practice and your situation. There should be some phone numbers where the patient can contact you, both during and after normal working hours. Ensure that your ancillary staff know the normal post-operative course, as they are the ones most likely to be taking the phone calls after the event. If they suspect that things are not progressing as they should, you need to be informed and you should offer to see the patient.

I believe that you should have action plans for events such as; prolonged pain and discomfort, bleeding, swelling, infection and bruising.

Let's look at a hypothetical patient and plan the perfect procedure. The OPG belongs to a 30 year old female patient in pain who has driven down from the country to see you as you are the only dentist available today. It is 4.30pm when she arrives, fortunately clutching the OPG which you had the foresight to arrange to be taken on her way in to your surgery. She is a new patient, has a clear medical history, but is understandably very apprehensive.

Your examination shows the grossly carious 28 (the last molar) and a partially erupted 38 with a lot of soft tissue inflammation on the distal aspect. The 36 also looks a bit suspicious. Referral to an oral surgeon is not an option as they are all away at a golf afternoon.

There is no right or wrong answer to how you would plan your treatment here, but factors you should be considering are:

- Your experience in extractions, especially surgical extractions.
- Where is most of the pain coming from?
- Should you remove the 28 now and allow the 38 to settle?
- What should you do about the 36? Given that the patient has to drive for 4 hours to see you, is endodontic treatment a viable option?
- Should you place a dressing in the 28 and refer the patient to the oral surgeon?
- If you opt to remove the 28 today, should you warn about the possibility of an oro-antral communication? If you don't and it happens, what are you going to do? Would it have made any difference to the patient's decision on what to have done?

You will have probably gathered by now that I am not giving you any solutions, as there is not a right and wrong answer to any given scenario. However, leaving the patient in pain is not an option. The 28 will need to be removed at some stage, so even if an OAF is created, I doubt the patient could say that had she known it would have happened, she never would have had the tooth out. What is important is that any discussions about options that you have with the patient are recorded in the notes, and also record what the patient decides to do. If the patient decides on a treatment plan which you do not feel is in her best interests, record the fact in the notes. (Have you spotted the common theme yet?)

Finally, if a patient does complain to you about anything, resist all urges to phone the patient and give him/her a piece of your mind. The first thing to do is to sit down and count to 10

– slowly – and then call us for advice. That's part of your membership dues at work. We can advise on the most appropriate way forward. Similarly, if a "please explain" letter comes from the Dental Board, do not reply in a frank manner immediately; ask us for advice in formulating your reply.



PROFESSIONALISM IN DENTISTRY

Dentistry as a Business and the Dangers of Social Media

DEFINING PROFESSIONALISM

It is common to designate as a professional anyone who is skilful at what they do, is not an amateur in doing it, and is paid for their work.¹ Historically, professionals have 'professed' a competency based on advanced learning for which they will be morally accountable in placing this expertise in service to society. The concept of profession is deeply rooted in the notion of making a promise to society of "doing one's duty", promoting good, and following moral rules that will keep one away from harm.²

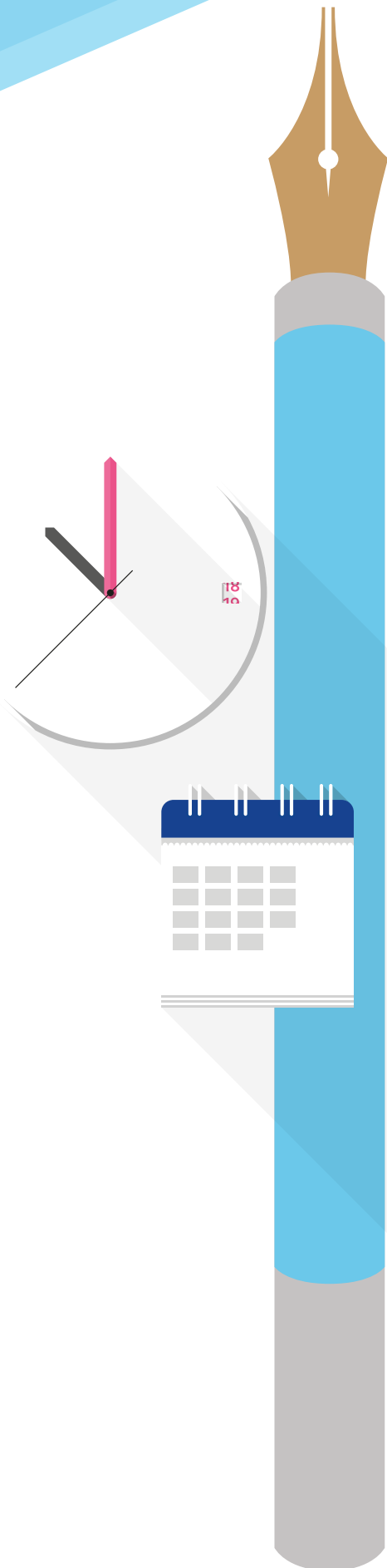
Looking specifically within the dental profession, two themes portray the contemporary notion of professionalism in the literature: altruism, the idea of putting the needs of others first, and mixed into this core theme is the notion of possessing a high level of skill, commitment to the cause, and trust from the public.

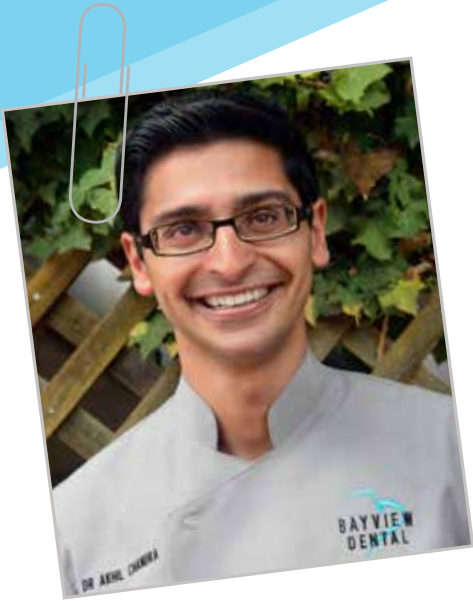
Professionalism in the dental industry lies firmly in the realm of ethics as it informs us how one ought to act, not how one must act. Within the context of dentistry, the 'must' represents a decision taken on minimum standards that dentists are expected to achieve, for the safety of their patients, their staff, and themselves. The 'ought' represents the constant attempt to achieve more than is required: to realise our potentials.³ This is a concept which gets to the heart of professionalism.

The obvious difficulty with such a nebular concept as professionalism is that there is no obligation for a professional to act in a way that is considered ideal. Crossley and Mubarik⁴ suggested that dental students were significantly more likely to be motivated by 'status and security', 'high income' and the

'nature of the occupation', when compared with doctors, whereas medical students were significantly more likely to be motivated by 'altruism' than dental students. It is also interesting to note the results of the Roy Morgan Image of Professions Survey from 1987-2015.⁵ The respondents were asked that "As I say different occupations, could you please say – from what you know or have heard - which rating best describes how you, yourself, would rate or score people in various occupations for honesty and ethical standards (Very High, High, Average, Low, Very Low)?" In 1987, both dentists and doctors were rated as having a score of 65% for ethics and honesty. In 2015, the score was 71% and 84% respectively. There should be some concern in the dental profession with these results.

There will always be a minority who decide to ignore the ideals of professionalism to such an extent that they may harm patients, colleagues and ultimately themselves. Certain aspects of professionalism can be imparted into dental professionals. Learning new procedures and consolidating existing techniques is fundamental to continuing professional development in Australia. Changing or teaching self-sacrifice and philanthropy is much more difficult. As a result, medicine and dentistry admission boards throughout the world appear to be deriving the view that aspects of professionalism are innate and the desire to select students based on professional characteristics is becoming a driving force, rather than merely based on an individual's academic performance. Many schools require sitting an exam designed for high-level intellectual study (e.g. UMAT or GAMSAT) as well as an interview designed to allow applicants an opportunity to display some of the personal qualities considered desirable in medical and dental practitioners.





DENTISTRY AS BUSINESS

Dentistry is a profession in healthcare, however, dental practice, where the majority of dental professionals are employed, is often perceived as operating more overtly as a business than medicine.³

Currently, the increased patient demand for improved aesthetics and marketing of dental practices is pushing the dental profession further toward the business model, less helping those in need but more serving those who demand, and can pay.

It has been argued by some that the related socioeconomic phenomenon of entrepreneurship or commercialism is an enemy of professionalism. The entrepreneurial whiz is a charismatic, media-glorified figure. Large organizations employing professionals may also be toxic to professionalism in their focus on financial bottom lines to the detriment of patient interests and doctor autonomy.⁶ "Today's market triumphalism exalts economic enterprise to a position of commanding social value and highest individual virtue." Professionalism appears "simply indigestible within our increasingly competitive, unequal, and market-driven society."⁶ People such as Welie⁷ suggest that these ends are conflicting, and there cannot be a coexistence of a professional's social contract and the pursuit of business; either one aims to serve others or aims to serve oneself. The danger of commercialism lies not in the use of business-based management tools, but in the course of neglecting to embrace altruism. Many dentists today seem to be striving to create a successful profit-driven enterprise. The perception of dentistry as a business is that the private, personal good is to be maximised.

In Australia, where dentists are primarily employed in private practice, if a dentist wishes to exclusively practise altruism (and therefore not generate income) ultimately little will be achieved: a bankrupt practice cannot meet the needs of patients. The business owner should hold some responsibility for sustaining employment for his/her employees, who in turn can support families. One cannot escape the fact that if a business mentality were to be ignored totally, dentistry in Australia would be in disarray. This supports the dentist who is both a professional and a business person on the grounds that keeping the business working well is part of the social corporate responsibility to the benefit of all patients treated there.³

It appears cynical for us to believe that every business decision is self-centred in the quest for profit. Perhaps certain community incentives may be seen as a grab for attention and advertisement of the practice, indirectly increasing profits; however, giving back to the community does not always have to constitute an act of business. Allowing practitioners to propose treatment plans that prioritise the patient's best interests, prioritising good oral hygiene over cosmetic dentistry in the local community, offering charitable donations, and maintaining a high level of technical proficiency are just some of the ways private practice can continue to be profitable and selfless. Accordingly, dentistry is only a business in the sense that good business practices must exist in support of a professional practice.

DANGERS OF SOCIAL MEDIA

Traditionally, dentistry as a profession has focused on serving the oral health needs of patients. Today, increasing numbers of dentists are practicing in the marketplace of health care; competing for patients through whatever marketing avenues are possible including the prolific use of social media. Much of the literature frames social media usage as risky behaviour, exposing dental health professionals to various counts of unprofessionalism as it enables social interactions between people who may or may not be known to each other.⁸ This 'always-on/always-

on-us'⁹ relationship with technology and social media has particular implications for healthcare professionals and our construction of professionalism. As such, there have been attempts by most governing bodies to release position statements on social media etiquette.

The literature reveals four ways in which social media can undermine the social contract of the dental profession.¹⁰ Firstly, social media blurs the personal-professional divide: many dental practices have their own Facebook pages through which they post practice opening hours, updates on health topics and often, testimonials from satisfied patients.¹¹ Patients and dentists have an increasing desire to build rapport with one another, therefore many practices post on topics that are engaging yet unrelated to dentistry, such as personal milestones. Practices need to be aware of the potential impact on professionalism by this blurred boundary of public versus private.¹² It is also worthy to mention that one bad testimonial can outweigh numerous positive reports; thus, it is of utmost importance to monitor and update practice social media pages.

Secondly, social media content can colour personal and professional reputations. The advent of social media means that an array of personal information is now available online. Studies have reported that roughly half of people interviewed admitted to having embarrassing photos online and/or photos that they would not want their future employer to see.^{13,14} It is important for an individual to review privacy settings and discuss with friends and colleagues when they do not wish to have photos uploaded to social media.

Another way in which social media can have a damaging effect on professionalism is via the potential for self-expression. This becomes an issue when inappropriate comments are made, or when patients view and disagree fundamentally with the opinion expressed. Once again, reviewing privacy settings and a 'think before act' approach can be of assistance to minimise the risk of an adverse outcome.

Finally, it is important to consider patient confidentiality in a multi-media world.^{15,16,17,18} The advent of Twitter feeds, Facebook posts and Instagram posts have enabled dental professionals to post videos and photographs of themselves and patients. There are several Facebook groups designed for dental professionals to share cases and discuss treatment plans. These forums suggest that as much information as possible is shared to enhance learning and interaction i.e. study models, photographs, radiographs. The ramifications could be significant if information was shared without the patient's permission.

Dental professionals utilising social media must inform themselves about their choices and options when online so as to protect their own reputation, the profession itself and the interests of the public at large.¹⁹ This means that every dental professional should know how to review their privacy settings, pause to reflect before they post information in any context, be proactive in determining where information will be displayed, and be willing to refuse permission for inappropriate content to be posted if necessary.



CONCLUSION

Among the most important learning that occurs in dental schools is that of learning to be a professional. Knowledge, technical skill, and problem solving ability are all basic principles in teaching. Developing these skills with a commitment to integrity, compassion, altruism, continuous improvement, and excellence is fundamental to having high professional standards. The perception of dentistry as a business and contemporary use of social media are both areas of concern to the dental profession. The caring and ethical behaviour demonstrated by former dentists has earned the dental profession the trust and confidence of society. Each individual and practice must understand the nature of dental professionalism and attempt to maintain integrity when finding the correct balance between the conflicting ends of altruism and personal gain.



Biography Dr Akhil Chandra

Dr Akhil Chandra is a 2009 dental graduate with honours from The University of Western Australia. He is the owner / principal dentist at Bayview Dental in Claremont, Perth, WA and has special interests in preventive hygiene techniques, dentofacial aesthetics and dental implantology.

REFERENCES

- Nash, D. A. On ethics in the profession of dentistry and dental education. *Eur J Dent Educ* 2007; 11: 64–74. –
- May, WF. Code and Covenant or philanthropy and contract. In: Reiser SJ, Dyck AJ, Curran WJ, eds. *Ethics in Medicine*. Cambridge: M.I.T. Press, 1977.
- Trathen A, Gallagher JE. Dental professionalism: definitions and debate. *Br Dent J* 2009; 206: 249–253
- Crossley ML, Mubarik A. A comparative investigation of dental and medical student's motivation towards career choice. *Br Dent J* 2002; 193: 471–473.
- Roy Morgan Image of Professions Survey 2015 - Nurses still easily most highly regarded – followed by Doctors, Pharmacists & School Teachers. April 28 2015, Finding No. 6188, Topic: Special Poll Public Opinion Press Release, Country: Australia.
- Sullivan WM. *Work and integrity: the crisis and promise of professionalism in America*. 2nd ed. San Francisco: Jossey-Bass, 2005.
- Welie J V. Is dentistry a profession? Part 3. Future Challenges. *J Can Dent Assoc* 2004; 70: 675–678.
- Chandler D, Munday C. *Oxford dictionary of media and communications*. Oxford: Oxford University Press, 2011.
- Turkle S. Always-on/always-on-you: the tethered self. In Katz J E (ed) *Handbook of mobile communications studies*. pp 121–137. Cambridge, MA: MIT Press, 2008.
- Neville, P, Waylen, A. Social media and dentistry: some reflections on e-professionalism. *Br Dent J* 218.8 (2015): 475–478.
- Eckler P, Worsowicz G, Wesley Rayburn J. Social media and health care: an overview. *PM R* 2010; 2: 1046–1050.
- Turkle S. The tethered self: technology reinvents intimacy and solitude. *Contin High Educ Rev* 2011; 75: 28–31.
- Garner, J, O'Sullivan H. Facebook and the professional behaviour of undergraduate medical students. *Clin Teach* 2010; 7: 112–115.
- Hall M, Hanna L A, Huey G. Use and views on social networking sites of pharmacy students in the United Kingdom. *Am J Pharm Educ* 2013; 77: 9.
- Lagu T, Kaufman E J, Asch B. Contents of weblogs written by health professionals. *J Gen Intern Med* 2008; 23: 1642–1646.
- Chretien K C, Azar J, Kind T. Physicians on twitter. *JAMA* 2011; 305: 566–568.
- Thompson C A, Black E, Duff W P. Protected health information on social networking sites: ethical and legal considerations. *J Med Internet Research* 2011; 13: e8.
- Thompson C. Facebook-cautionary tales for nurses. *Nurs NZ* 2010; 16: 26.
- Livingstone S. Maximising opportunities and minimising risks for children online: from evidence to policy. *Intermedia* 2009; 37: 50–53.

IN THE AUSTRALIAN BUSH

Dr Mike Rutherford, a Dentolegal Adviser based in Dental Protection's Brisbane office, met up with Dr Andrew Lee to discuss some of the access problems that exist for patients seeking dental treatment in the remote parts of Australia

Australian historian Geoffrey Blainey coined the term "tyranny of distance" to describe Australia's remoteness from Great Britain, and its effect on the European settlement of Australia. The same term applies equally well to describe the dilemma of delivering health services to rural and remote Australian communities spread over vast distances in small settlements often with limited infrastructures. Oral health services have the additional difficulty of needing cumbersome and expensive equipment for all but basic treatments.

Australians are one of the healthiest populations in the world yet within this success story there are marked inequalities in care – the marginalised, special needs groups including the elderly, Indigenous Australians, the poor and rural and remote populations; they all share a smaller slice of the healthcare "cake". This discrepancy in access to health services must be viewed as a failure of the equality that Australians are so proud of.

Overcoming the difficulties posed by distance and isolation, rural oral health services are provided by both government and private services. A combination of rural public health centres, mobile vans, private practices, and innovations such as urban private practitioners providing "fly in-fly out" services accessing existing but under-utilised government clinics, all contribute to an unevenly distributed service for rural communities. These communities then have to make their own commitment to access treatment – a two hundred kilometre drive would not be considered unreasonable to seek dental care – a whole day and travel costs set aside for one dental visit.

Remote areas however can have additional layers of complexity. Services are provided by predominantly government-employed practitioners and some voluntary schemes - often lacking dental infrastructure, services must be provided by practitioners bringing their own equipment typically by truck or caravan, and in some instances by light

aircraft or The Royal Flying Doctor Service. These services are generally delivered by extraordinarily dedicated people. Dental Protection member and Senior Lecturer in Special Needs Dentistry at James Cook University, Dr Andrew Lee was one such practitioner.

Dr Lee describes the skill sets required of any dental practitioner contemplating this difficult but immensely satisfying work:

- **The ability to work without access to advice or help**
- **More sophisticated than average surgical skills**
- **An ability to repair and maintain dental equipment**
- **A desire to drive a truck and trailer long distances on dirt roads**
- **A willingness to work and live in predominantly hot, dusty conditions**
- **A tolerance of insects and rodents**
- **The skills to maintain necessary hygiene standards for delivery of treatment**

Dr Lee describes success under these conditions as being as basic as leaving a patient pain free and free of infection. It is a far cry from urban concepts of dental success, but stripped back, this is the fundamental objective of health care.

In remote areas, these basic requirements are what our profession is about - and it is a service most valued by the recipients. Dr Lee also describes the personal feeling of success in being able to provide these essential services, and the precious moments of living in a landscape unknown to most Australians and in the company of the tough and self-reliant people who inhabit these communities.

Over the years many schemes have been implemented to improve the dental health of non-urban Australians. Federal President of the Australian Dental Association, Dr Rick Olive has recently advocated for expansion of the "fly in-fly out" model into public sector dental services.

Some Dental Schools have departments dedicated to rural and remote dentistry which organise placements for dental

students in non-urban environments preferably for extended periods. In the process students encounter the challenges and the satisfaction of working in remote settings.

Preferential entry to Dental Schools for rural students, amnesty for payback of university fees for rural or remote service on graduation, expansion of duties and employment of more Oral Health Therapists, as well as differing models of service delivery have all been proposed to improve access to dental services. Some of these ideas have yet to be implemented, and others have already improved the dental services provided to smaller communities.

Ultimately though, as with most not commercially viable health services, success will depend on the goodwill and commitment of the dental practitioners who are prepared to provide this service.



Biography

Dr Mike Rutherford BDS Sc BA

Mike is a Dentolegal Adviser based in our Brisbane office. He brings with him more than 30 years' dental experience in private practice, hospital clinics, the defence forces and supervising undergraduate dental students

This article previously appeared in The Annual Review 2016 published by Dental Protection



Dr Andrew Lee



@Dr Andrew Lee

INCREASING PATIENT SATISFACTION

Dr Rochelle Yong Gee describes a patient-centred approach to dentistry

Communication and interpersonal skills are core proficiencies essential to any qualified dentist as they allow for effective patient management as well as the competency to work with fellow staff members. These soft skills, although not a substantial focus during dental school, are, arguably, some of the most important for dentists to attain. The overall advantages of good communication skills include increased patient satisfaction and patient outcomes, development of patient rapport, trust and higher levels of treatment acceptance.

THE PATIENT'S DENTAL EXPERIENCE

Due to the very nature of dentistry, standard communication may be physically restricted and when combined with a patient's feeling of vulnerability and anxiety, can create a significant barrier to developing rapport with a patient (DiMatteo and Hays 1980, Jones and Huggins 2014).

Poor communication has been shown to have a strong positive association with higher levels of patient anxiety, thus affecting the patient's inclination to return for future treatment (Lahti et al. 1995).

Empathy in healthcare is perceived as an essential component of communication whilst creating trust as well as engaging with patients is considered to be a prerequisite for any therapeutic relationship with a patient (DiMatteo and Hays 1980, Kim et al. 2004, Yarascavitch et al. 2009, Garg and Guez 2012, Neumann et al. 2012). This is particularly relevant in a dental setting where patients are expected to place a significant amount of trust in their professional's knowledge and skills to provide care that is in their best interest (Nash 2010). This level of trust can only be founded by adequate communication skills and sound perceived technical competency (Sbaraini et al. 2012).

COMMUNICATION IN THE DENTAL SETTING

Another aspect of communication to consider is the interaction between dental professionals and their fellow staff members. Open, clear and amicable communication between colleagues is essential for creating positive interaction and developing trust between team members and can instil a patient's confidence in their dentist along with the wider dental team (Miller C. et al. 2001). Moreover, clear expression of expectations to an assistant is vital to prevent misunderstandings and ensure quality of care is offered to the patient at all times.

The contribution of the dental assistant should not be forgotten as their role is not only to support the dentist but also support in patient management and enable a positive patient experience (Groody, 2013). Ensuring the working environment involves communicative and empathetic individuals can facilitate patient comfort, allow for higher levels of treatment acceptance and ultimately, patient-centred treatment (Levinson, 2011).

A CHANGING DENTAL CLIMATE

Following the significant escalation in the number of dentists working in Australia, the dental climate has become increasingly competitive, causing the general public to increase their level of expectation over the quality of their treatment, service provision and costs (Australian Dental Association 2012).

Conceivably, as a result of this, the ever-changing dental environment is becoming more impersonal and less patient-centred (Sachdeo et al. 2012). This is particularly the case in Australia, where 80% of qualified dentists work privately and dental practices are commonly viewed as a combination of health care and business.

Additionally, the dental profession is exposed to an increasing number of lawsuits and patient complaints (Suchman et al. 1997, Sachdeo et al. 2012, HQCC 2013) and interestingly, this was identified to be less associated with the quality of

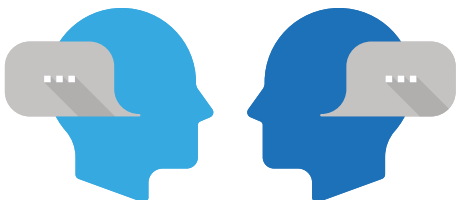


dental treatment offered and provokes questions regarding why patients are dissatisfied (Nora 1986). According to the Health Quality and Complaints Commission annual report, lack of communication and comprehensive provision of information was the second highest reason (15%) for complaints against dentists (HQCC 2013). Sources have indicated that patient satisfaction is highly related to communication skills, including a failure to explain a problem or diagnosis, treatment and confidentiality of medical records (Dewi et al. 2011).

SHIFTING THE FOCUS

The increasing competitive nature of dentistry has resulted in the reality that clinical competency alone is not sufficient to succeed within the dental market; instead, the modern dental practice is required to provide an exceptional overall patient experience.

Possibly due to a patient's difficulty to accurately assess their dentist's competency levels, it was indicated by Sbaraini et al. (2012) that their level of satisfaction is less to do with technical competence of the dentist and more to do with their attitude and communication skills (Sbaraini et al. 2012). Loyalty to a dental practice no longer depends on the practitioner's ability to offer an adequate service to the patient; communication and how comfortable the patient feels throughout the appointment has a discernible effect on the patient's dental experience (Jones and Huggins 2014).





It has been suggested that a positive patient-practitioner relationship along with empathy and communication skills are important for patient satisfaction and enhanced patient outcomes (DiMatteo and Hays 1980, Kim et al. 2004, Yarascavitch et al. 2009). This drives us to consider that a patient-centred psychosocial approach where a dentist is capable of displaying key competencies of active listening, empathy and self-awareness may be necessary to facilitate patient satisfaction (Wener et al. 2011).

Ultimately, the importance of communication is not only to provide patient-centred care but to also attain high levels of patient satisfaction, trust and loyalty. Despite this, a strong focus on academic results is widely prevalent for all Australian dental school admissions. Furthermore, the dental school experience is mostly governed by ensuring clinical and technical competence with limited training on developing soft skills. Upon general examination of Australian dental school curriculums, many embed teachings on 'communication skills' with a very broad introduction to dentistry or placing this class at the beginning of the course with minimal ongoing assessment.

In the future, the dental school curriculum may consider enhancing further the significance of communication skills. Further training in empathetic communication and emotional intelligence has the potential to ensure all practising dental professionals, both new graduates and experienced dentists, are equipped to ensure high levels of patient understanding, satisfaction and care.

IN CONCLUSION

The ability to express concern for a patient and communicating clearly can facilitate a stronger empathetic understanding and ultimately provide patients with a better clinical outcome, a greater likelihood to return for completion of treatment or further recall visits and higher levels of patient satisfaction. Consequently, improved compliance with treatments, clinical outcomes and effectiveness of care can be seen as some of the many benefits of improved empathetic communication in both academic and clinical dental environments.



Biography Dr Rochelle Yong Gee

Dr Rochelle Yong Gee is a 2014 dental graduate from Griffith University and a former member of DPL Australia's Young Dentist Committee. Having had previous public experience in the rural town of Roma, Rochelle is currently working privately in Brisbane. With a dentist as a father and psychologist as a mother, she has developed a special interest in integrating the two fields, exploring the importance of communication and empathy as vital aspects of dental practice.

REFERENCES

1. Australian Dental Association (2012). Review of Australian Dental Workforce Supply to 2020
2. Charles Sturt University, n.d. Bachelor of Dental Science. [Online] Available at: <http://www.csu.edu.au/courses/dental-science>. [Accessed 9 August 2015].
3. Dewi, F. D., G. Sudjana and Y. M. Oesman (2011). "Patient satisfaction analysis on service quality of dental health care based on empathy and responsiveness." *Dental Research Journal* 8(4): 172-177.
4. DiMatteo, M. R. and R. Hays (1980). "The significance of patients' perceptions of physician conduct: a study of patient satisfaction in a family practice center." *J Community Health* 6(1): 18-34.
5. Garg, A. and G. Guez (2012). "Studies Highlight Loss of Empathy Among Dental Students During Training." *Dental Implantology Update* 23(4): 30-32.
6. Griffith University, n.d. Communications for Oral Health. [Online]. Available at: https://courseprofile.secure.griffith.edu.au/student_section_loader.php?section=1&profileid=81029. [Accessed 9 August 2015].
7. Groody, T. (2013, May). The Hidden Attributes of the Dental Assistant. *Inside Dental Assisting*, 9(3)
8. Evans and A. Blinkhorn (2012). "Experiences of dental care: what do patients value?" *BMC Health Services Research* 12: 177.
9. HQCC (2013) "Annual Health Check 2012: A snapshot of our work in resolving healthcare complaints and monitoring the quality of health services in Queensland."
10. James Cook University, n.d. [Online]. Available at: <http://www.jcu.edu.au/smd/dentistry/index.htm>. [Accessed 9 August 2015].
11. Jones, L. M. and T. J. Huggins (2014). "Empathy in the dentist-patient relationship: review and application." *New Zealand Dental Journal* 110(3): 98-104.
12. Kim, S. S., S. Kaplowitz and M. V. Johnston (2004). "The effects of physician empathy on patient satisfaction and compliance." *Evaluation & the Health Professions* 27(3): 237-251.
13. Lahti, S., H. Tuutti, H. Hausen and R. Kääriäinen (1995). "Comparison of ideal and actual behavior of patients and dentists during dental treatment." *Community Dentistry & Oral Epidemiology* 23(6): 374-378.
14. Latrobe University, n.d. Oral Health. [Online]. Available at: <http://www.latrobe.edu.au/courses/oral-health>. [Accessed 9 August 2015].
15. Levinson, W. (2011). Patient-centred communication: a sophisticated procedure. *BMJ Qual Saf*, 20(10).
16. Miller C, Freeman M, Ross N. *Interprofessional Practice in Health Care and Social Care: Challenging the Shared Learning Agenda*. London: Arnold; 2001.
17. Nash, D. A. (2010). Ethics, Empathy, and the Education of Dentists. 74: 567-578.
18. Neumann, M., C. Scheffer, D. Tauschel, G. Lutz, M. Wirtz and F. Edelhäuser (2012). "Physician empathy: definition, outcome-relevance and its measurement in patient care and medical education." *GMS Zeitschrift Für Medizinische Ausbildung* 29(1): Doc11-Doc11.
19. Nora, R. L. (1986). "Dental malpractice: its causes and cures." *Quintessence International* 17(2): 121-126.
20. Sachdeo, A., S. Konfino, R. U. Icyda, M. D. Finkelman, H. Gulati, P. Arsenaull, J. B. Hanley, Sachdeo, S. Konfino, R. U. Icyda, M. D. Finkelman, H. Gulati, P. Arsenaull and J. B. Hanley (2012). "An analysis of patient grievances in a dental school clinical environment." *Journal of Dental Education* 76(10): 1317-1322.4
21. Sbaraini, A., S. M. Carter, R. W. Evans, A. Blinkhorn, A. Sbaraini, S. M. Carter, R. W.
22. Snyder, A. Lazare and M. Lipkin, Jr. (2003). "Effect of communications training on medical student performance." *JAMA* 290(9): 1157-1165.
23. Suchman, A. L., K. Markakis, H. B. Beckman and R. Frankel (1997). "A model of empathic communication in the medical interview." *JAMA* 277(8): 678-682.
24. The University of Adelaide, n.d. Course Outlines. [Online] Available at: <http://www.adelaide.edu.au/course-outlines/ug/dent/>. [Accessed 9 August 2015].
25. The University of Melbourne, n.d. Doctor of Dental Surgery. [Online]. Available at: <http://www.dent.unimelb.edu.au/study/courses/doctor-of-dental-surgery/entry-requirements#nav>. [Accessed 9 August 2015].
26. The University of Queensland, n.d. About the School. [Online]. Available at: <http://www.dentistry.uq.edu.au/about-the-school>. [Accessed 9 August 2015].
27. The University of Western Australia, n.d. Doctor of Dental Medicine. [Online]. Available at: <http://www.dentistry.uwa.edu.au/courses/dmd>. [Accessed 9 August 2015].
28. University of Sydney, n.d. Study Dentistry. [Online] Available at: <http://sydney.edu.au/dentistry/study/dentistry/index.php>. [Accessed 9 August 2015].
29. Wener, M. E., D. J. Schonwetter, N. Mazurat, M. E. Wener, D. J. Schonwetter and N.
30. Yarascavitch, C., G. Regehr, B. Hodges and D. A. Haas (2009). "Changes in Dental Student Empathy During Training." *Journal of Dental Education* 73(4): 509-517.
31. Yedidia, M. J., C. C. Gillespie, E. Kachur, M. D. Schwartz, J. Ockene, A. E. Chepaitis, C. W.

PROTECTION THROUGHOUT YOUR CAREER

Meet DPL Australia's Dentolegal Advisers and Cases Consultants who have the experience to support you if you experience a problem in your own career

DR GEORGE LAZARIDIS

graduated from Otago in 1978 and worked briefly in general practice in Wellington, New Zealand. He then went on to establish a preventive-based general practice in London for over 27 years and more recently a private practice in Melbourne with a particular interest in endodontics. He has supervised undergraduates at the Melbourne Dental School and also has involvement with teaching ADC candidates. George is based in DPL's Melbourne Office.



DR RALPH NELLER

is a Past President of the Australian Dental Council having retired from this position at the end of 2012. Having served in various positions with Queensland Health for over 30 years, Ralph has wide experience of the hospital service and the Government sector, and is a past President of the Queensland Public Sector Dentists' Association. Ralph is also a past Chairman of the Dental Board of Queensland, and of the Dental Technicians and Prosthetists Board so he brings a wealth of knowledge, understanding and experience to his work for the benefit of DPL members.



DR MIKE RUTHERFORD

brings enormous experience to the DPL Australia team having worked in private practice, hospital clinics, the defence forces and as a supervisor in the undergraduate teaching of dental students. He also spent 19 years as a member of the ADAQ Patient Liaison (fee inquiry and treatment complaint) Panel. He has a special interest in oral surgery, and also preventive dentistry and the oral health of children. In 1995 he achieved a BA in Social History and International relations.



DR ANNALENE WESTON

has previously worked both in general dental practice and in Government Health Service positions, in both Victoria and New South Wales before moving to Queensland where she has been based in recent years. She was awarded a Masters Degree in Health Law from Sydney University. Until recently Annalene was practising in Central Queensland and serving on the local HCC; however, she is now based in Brisbane and, in addition to her role with DPLA, Annalene works part-time in a suburban dental practice.



JOAN JAMES

graduated with a Bachelor of Science in Dental Hygiene in 1975 from the University of Nebraska and more recently completed a Graduate Certificate in Dentistry from the University of Adelaide. Joan worked in a specialist private dental practice in Australia for over 20 years and was on the academic staff at the University of Queensland, teaching into the Bachelor of Oral Health Program. Joan has also served on both the State and National DHAA Executive and has been with DPL since 2016.



DENTAL STUDENTS AND YOUNG DENTIST REPRESENTATIVE

KARA STOKES

graduated from the University of Queensland with double degrees in Business Management and Commerce, having majored in Marketing. She joined the DPL team in 2012 and is based in our Brisbane office, although her role takes her to every dental school in Australia as well as working with our recent graduates and young dentists. Kara is involved with our student and young dentist website, Facebook page and other resources. She is also responsible for organising the Australian YDC.



FRIENDLY, ACCESSIBLE MEMBERSHIP SERVICES

KEN PARKER OPERATIONS MANAGER DPL AUSTRALIA.

Ken joined the DPL team in 2000, initially managing our membership services before becoming Operations Manager two years later. Ken's earlier career was in banking and finance; he spent ten years with ANZ and 20 years with Metway (now Suncorp). Having served as a Justice of the Peace and as a prominent and longstanding Rotarian and experienced management consultant, Ken provides an outstanding, friendly and professional service for DPL members across Australia, and leads our membership services team



MICHAEL PEARS MEMBERSHIP MANAGER DPL AUSTRALIA.

After 10 years in banking first at Metway and then with the Bank of Queensland, Michael spent 10 years as a Corporate Account Manager for Travelex. Since 2007 he has worked in the Energy industry. Michael's proven strengths are his friendliness and approachability, coupled with his focus on customer care, quality of service and building relationships – a perfect fit with his role as DPL's Membership Manager, working alongside Ken Parker in our Brisbane office.



OUT LOUD

Dr Louise Hanrahan shares her thoughts on how best to communicate with patients; particularly those living in remote settings

CONVERSATION WITH PATIENTS

I have a list of small-talk topics to fill in time and help build rapport throughout appointments. They range from the weather (currently in Mudgee, it's cold. Lately, we've had snow around), to where I am from (Townsville, North Queensland – so in Mudgee, I'm really cold). I continue where I am from to where I have been – mostly because I haven't lived in Townsville since finishing high school. I'll explain that "uni" was in Cairns for four years, but final year was in Alice Springs and Launceston.

It was a huge leap from Cairns to Alice and Launceston – a complete change in scenery and patient needs. Suddenly it was clear that graduation was nearing rapidly and very soon I would be completely responsible for my patients. I was worried that my clinical skills weren't good enough, and if I could convince my patients to take me seriously as a student and almost-clinician.

IN THE CLINIC

During year three, I attended my first clinic and began to see how patients can so quickly trust and distrust a clinician. It all breaks down to a few seconds, and even hours of rapport building can be dashed over a minute detail. Being at a university that focuses on rural and remote health care, I was very lucky to be mentored and taught that there is a difference between talking at people and talking to people. I also learnt the obstacles faced by clinicians and patients in areas who struggle to access health care professionals, for many reasons beyond logistics and location.

Five whole months of placement at one site was unheard of for most of my friends studying at other dental schools. But it was absolutely essential for a number of reasons: I could manage a large treatment plan to completion, which meant complex cases could be followed through giving the patient the chance to stay with a single clinician; I was able to spend two weeks total in remote Indigenous communities in Central Australia; I could go out of the clinic and treat patients in the corrections

center and manage a patient's care under general anaesthesia at Alice Springs hospital. It was an excellent place to be thrown in the deep end, with two supportive mentors and supervisors, Drs. Meg and Bruce Simmons, and the staff working out of Flynn Drive Dental Clinic.

LOCAL LANGUAGE

I initially thought that my time in Alice would be where I learnt how to extract teeth and manage acute pain. I wasn't wrong about that; but I also learnt a great deal about communicating with patients. I began to speak an entirely new language in Alice – from "rusty" (cariou) teeth, to taking out "slack" (mobile) teeth, and taking care of a patient's "paining". I learnt the importance of waiting and listening, allowing patients time for contemplation when being asked questions. I found by encouraging family members to come in during appointments, I could have another aid in translation or a familiar face to help reduce anxiety.

REMOVING BARRIERS

Creating rapport with the Indigenous individual in Alice Springs was so important. It required understanding the barriers our patients faced – limitations in opportunities to improve oral health literacy, and accessibility to services were common issues patients dealt with every day. Each appointment was an opportunity to impart knowledge and the way in which it was delivered – a key part of that was delivering a positive broad message, rather than speaking as we often find ourselves in Western culture. By explaining how everyone can keep their teeth and gums healthy, we were avoiding patients from feeling individually targeted and shamed by what they were or were not doing.

A relationship with the community, both within town and out in the remote communities, was more difficult to build. Central Australia is an area with countless allied health programs, some of which incorporate oral health screening as part of general health checks. Introducing ourselves to the community clinic nurses out bush, and walking around

the community during quiet times on bush trips were excellent ways to begin breaking barriers and encourage patients to visit us in the fixed or mobile dental clinics.

COLLABORATION

In Alice Springs, we had a good relationship with the Congress Aboriginal Medical Service, who would refer patients requiring dental care. It was saddening to hear from some patients referred from Congress that they had not previously had positive dental treatment. After spending time discussing the "Find Out" survey, developed by Bruce for the Alice Springs clinic, patients would explain they had felt rushed during appointments and as though they were a problem. In some cases, their main concern wasn't what the dentist considered the most pressing problem. This led to patients distrusting the dentist, and avoiding treatment, until they only attended for removal of pain.

It was rewarding to hear patients thank us for our care, not just for fixing their pain. After a few weeks, we would be doing our grocery shopping or walking home in the afternoon and have patients recognize us on the street and happily wave hello or come up for a chat. We began getting more siblings, aunts and cousins coming in for treatment, and parents bringing in young children for check ups.

TWO EXPERIENCES OUT BUSH

Going out bush was a unique experience – one I think I won't have anywhere else. My two trips were completely different – Yuendumu, in March, saw us delivering care to patients in what is considered the largest community in Central Australia with roughly 1000 people. We travelled on mostly unsealed roads for 293km for a week's stay to treat patients. Chronic health conditions included renal failure, obesity, type two diabetes, and rheumatic heart disease. Dentally, this meant a lot of periodontal disease management and antibiotic prophylaxis before treatment.

My second trip in May to Canteen Creek, was a short flight to the community, as it is located almost 600km from Alice

Springs. The mobile clinic was set up and waiting for us, and our patient care was focused on very different health conditions. In the sixty person community, we dealt with caries, assessments, and managing patients with rheumatic heart disease.

This huge change in needs compared to Yuendumu could be explained by what the local store sold – no junk food, no soft drinks; instead there was a small selection of fruits, vegetables, meat and canned goods. We saw most of the community in four days, and took our time visiting the school to encourage the children to come in to see us. It was great to see their fascination in what dentists do every day, and would enthusiastically ask if they could be our assistant and brought in their family and friends to help check their teeth.

ALICE SPRINGS DISCOVERY

This article is not long enough to talk about my time in Alice Springs – I could spend hours talking about it with people who have worked in similar environments, and even longer talking to people who haven't, and who should go out to remote areas. There is always a need for clinicians, and it's a brilliant place to learn and improve your skills in practicing dentistry and communication with patients. It's clear after working with Meg and Bruce that their dedication to patient care and communication has paid off. Many patients would ask after Bruce and Meg while we were out bush, and clinicians across the country who had also spent time in Alice would always recount their time in Central Australia fondly.

I was expecting my placement there to be extremely difficult at times, with feelings of isolation and complete fear that my patients would sense my nervousness and request to be seen by someone else. I was surprised by how quickly I found my feet, and how much I enjoyed my time there in general. Every now and then, I reflect on my time in Alice and realize how lucky I was to be there, and how I miss it every now and then.

My time with Meg and Bruce in Alice has helped me to define the kind of clinician I want to be – making patients feel as comfortable as I can – ensuring good communication pathways. I've encouraged dental assistants and dentists to become involved in RAHC placements out in Central Australia, even in the short time since I have been there. In time, I hope I can go back out to Alice on at least a locum basis, to continue delivering care in an amazing part of the country.





Contacts

You can contact Dental Protection via the website dentalprotection.org.au or by using the contacts below

For membership enquires

DPL Australia Pty Ltd
Po Box 1013, Milton BC, QLD 4064

Email
membership@dpla.com.au

Telephone
+61 (07) 3831 6800

Facsimile
+61 (07) 3831 7255

Freecall
1800 444 542

Kara Stokes, Marketing Coordinator
kara.stokes@dpla.com.au

Ken Parker, Operations Manager
ken.parker@dpla.com.au

Michael Pears, Membership Manager
michael.pears@dpla.com.au