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for hygienists, dental therapists and oral health therapists

Dental Protection

Teamwise

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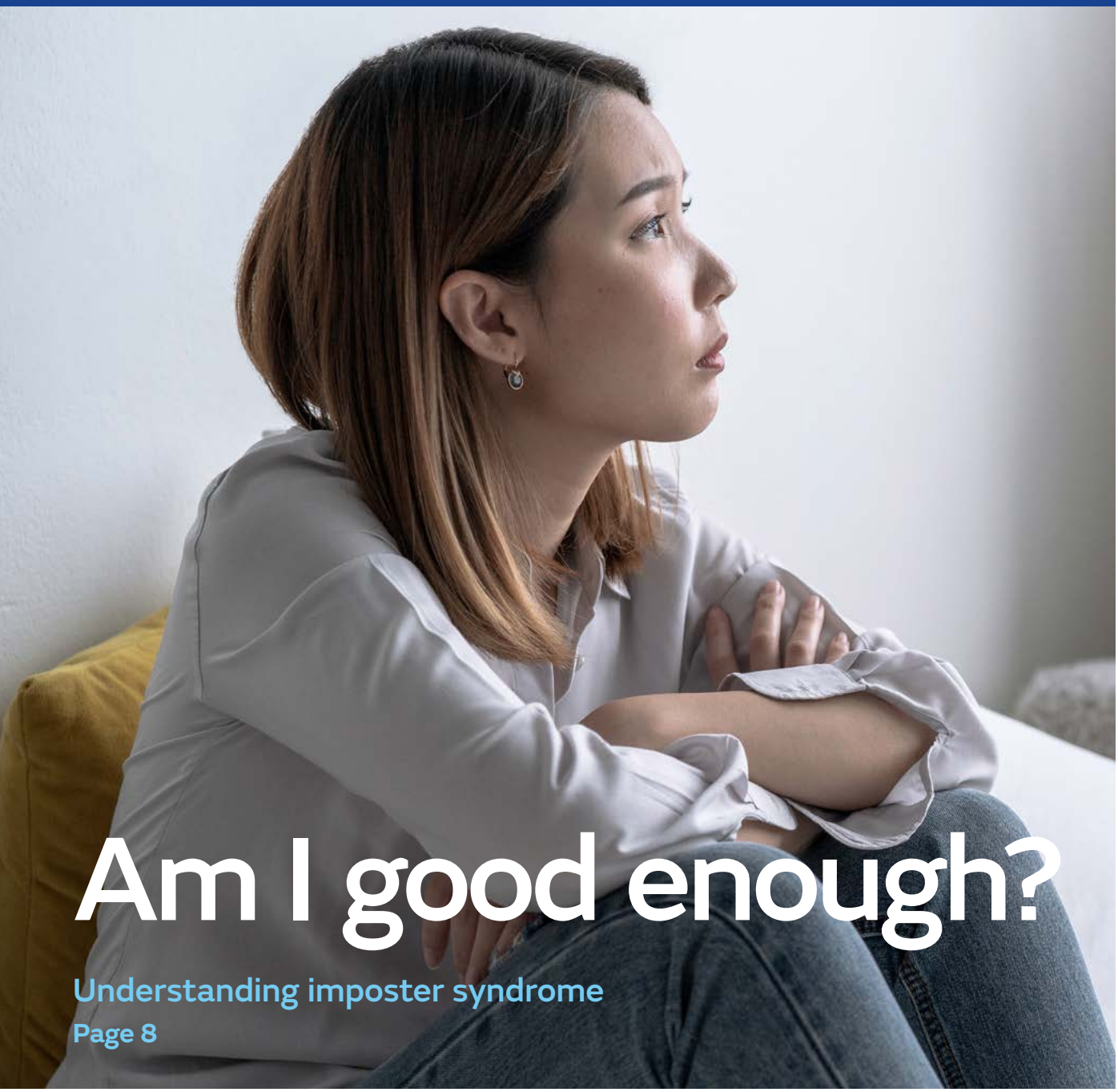

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Welcome

It is my great privilege and pleasure to welcome you to the latest edition of *Teamwise*. As you will be aware, this publication is written specifically for oral health therapists, dental therapists and dental hygienists, crafted to include the key and current issues impacting on your group of practitioners, reflected in the cases and complaints you as a group have received.

This issue of *Teamwise* is particularly meaningful for me as, after years of working with you and for you, and years of involvement in *Teamwise*, I am writing the editorial for the first time. This change has come as a consequence of my promotion to Dental Team Leader. Saddle up partners, there's a new sheriff in town!

A change in role brings with it reflection, as it should, and I wanted to share with you some of mine in the belief that this may resonate with many of you. I have in my life been and continue to be many things. I am a woman, a wife, a daughter, a mother, a friend, and a lover. I am a clinician, a doctor, a counsellor, a keeper of secrets, and a wiper of tears (of patients and, through my role with Dental Protection, practitioners too). I am a student, a teacher, a sharer of wisdom, a breaker of news both good and bad. A migrant, a citizen, a vegetarian, a swimmer, a reader, a lover of music , and I have a strong dislike of camping as I am allergic to mosquitos, but somewhat ironically, only Australian ones... These are all parts of me, and not the whole of me, and now I am a Team Leader and a manager for the company whose values I have believed in since I first joined as a student in 1993 too. I am raising this, because you too are many if not all of these things, and more besides.

The Oxford English Dictionary defines 'self-concept' as "an idea of the self-constructed from the beliefs one holds about oneself and the responses of others". It goes on to say "a self-concept is largely a reflection of the reactions of others towards the individual". How many times as a young practitioner did a patient visibly jolt when they met you, and then asked if you had done this procedure before/were competent, rocking your confidence and self-belief? How many times have you been asked if you have the knowledge, the strength, the skills, and the wisdom to perform a procedure?

And how many times has this dented your self-concept, and made you wonder if you are good enough? Imposter syndrome is rife amongst professionals, and the often well-meaning but ill-informed observations of others can feed this deep-rooted unease that many of us hold about ourselves and our skills.

A wise man called Dr Kevin Lewis once told me that we are all three people – the person we know ourselves to be, the person we want to be, and the person that other people think we are. He went on to tell me that the further apart those three people are, the greater the discomfiture the individual will feel about themselves. Regretfully, many of you will have experienced this discomfiture when a patient complains and we find to our horror that the opinion some others hold about us is far from the truth of who we are. Our patients cannot know all of the layers of us, and how complaints deeply wound us – there is a reason we talk about the "second victim" when considering complaints and adverse outcomes in care.

I truly hope the content of this publication is both helpful and meaningful to you, and that not only does it help you to identify areas of risk, but also encourages reflection into your own self-concept, and if perhaps there is anything you are holding on to that is no longer serving you (yes imposter syndrome I am talking about you).

Please remember my door is always open, and I look forward to seeing you all at upcoming events.

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It's a numbers game

The only thing that is constant is change. In the practice of dentistry, the way in which we work also constantly evolves, with a recent change in 2022 on provider number availability for oral health therapists, dental therapists and dental hygienists. But what are the issues that having a provider number can bring?

As many will be aware, as of 1 July 2022, dental therapists, dental hygienists, and oral health therapists are now able to apply for and use their own provider number for billing, for those services that accept them. This is an exciting change for the division, though to coin another well-known phrase, with great power comes great responsibility, and this does bring with it some associated risks.

When we dissect this, essentially you can characterise any dentolegal risk as: Risks to you, risks to your patients, risks to your practice, risks to your reputation and risks to your registration. Thankfully, not all of these risks apply here, as this division of practitioners holding provider numbers does not cause patient risk. In this situation, the risks are more for practitioners, and potentially their reputation.

As you are likely aware, a provider number is a site-specific claiming mechanism that enables a practitioner to access third party payments on behalf of a patient, for treatment the practitioners has provided, such as a private health fund or Medicare. This is a convenient service to offer patients, though it does carry risk should the claim entered be deemed inappropriate by the third party who paid the benefit.

Many may initially think that what this means is that the services have not been provided for the item numbers claimed. Whilst fraudulent claiming like this can and does occur, it's not as often as some may think, and there are a number of other scenarios in which a claim may be considered inappropriate. The vast majority of practitioners that Dental Protection see who have to return funds to health funds and Medicare have not wilfully committed fraud.

Instead, they fall into two categories. Firstly, those who don't have records that are sufficient to support the claim, which is something that is the responsibility of the practitioner and managed by them. The second group are those who may have sufficient records, but the claim put through does not match the treatment recorded.

Let us start with the first group. In the most basic of scenarios, a claim can be deemed inappropriate if the clinical records do not meet the third party's administrative requirement, such as not adequately reflecting the treatment provided.

A basic example of this may include:

A patient attends and you submit the code 114 for a preventative appointment on a 6-year-old which the records state "scale and polish". The Dental Board has a standard on adequate clinical records, and third-party payment providers do also. Consequently, there may be an expectation that there would be reference to clinical findings such as the presence and location of calculus, any conversation regarding oral hygiene, or the means by which it was removed. In the absence of this information, it may be that the third-party provider deems that the administrative requirements for claiming have not been met and the claim rejected.

Additionally, using the same example, the presence of calculus on a 6-year-old may be considered uncommon and consequently that it should spark some kind of comment in the records. However, in the absence of any comment, it may leave the practitioner open to the suggestion of upcoding. For those of you unfamiliar with this term, upcoding is the practice of utilising a code such as 114 rather than 111 to claim a higher benefit. Regretfully, some practitioners do upcode, and round their item number up to maximise their fee and benefit. We see this in a 111 to a 114, a 311 to a 324 and in one surface filling being rounded up to more surfaces, to get an increased benefit. Some people may say that they do this to maximise the patient's return, or cost the patient less, but the hard fact remains that the patient needs those funds to pay YOU, so if you want to help them out financially, there are ways other than tinkering with their health fund rebate and potentially committing fraud to do this.

A code would be deemed inappropriate in either of these cases if there was not rationale or justification for the treatment within the clinical records.

Essentially, it comes down to the records, as the appropriateness of the claim is verified through their content. There needs to be records supporting what the practitioner found, what treatment was provided, how and why. And these records need to be in line with the Dental Board guidance, which is available on their website. If there are not valid clinical records, to the required standard, supporting the claim, then the claim would be deemed inappropriate, regardless of whether the treatment was provided.

In the event that there are not adequate records to support the claim, the third party such as Medicare can withdraw the benefit paid. This is generally identified retrospectively through auditing processes. In the event that a health fund or Medicare, whomever the third-party payment mechanism is, require the owner of the provider number to pay back funds, they are required to pay 100% of the benefit received, regardless of whether the treatment was provided and regardless of how much the practitioner actually received from the payment.

This information can be found across a number of documents including the HICAPS agreement, the health fund terms and conditions and also in Medicare documentation such as the CDBS guidance. Which is why being familiar with all the terms and conditions is imperative.

Closely associated with the issue of upcoding, Dental Protection also sees instances flagged in auditing processes where patients are charged a mandated battery of codes when they are at reception. Or alternatively the codes being changed by directive at a business level to maximise how much the patient is charged.

In our second group, those who do have sufficient records, but the claim put through does not match the treatment recorded. A simple example can be related to the use of a battery of codes.

This can relate to the codes a patient is charged at their first appointment. An example of this may be for a new patient offer, where the patient's first consultation and associated special tests are free. There may be a direction to the reception staff to run through set codes regardless of the actual treatment provided such as four x-ray codes and a 221 on every new patient. There is no issue with this, if the treatment has been legitimately provided **and** was required. However understandably, not every patient needs or has four x- rays and needs or has a six-point pocket chart at their first appointment.

So a practitioner could be legitimately providing care and putting in appropriate codes, and someone else could be changing them without the practitioner's knowledge. Private health funds and government departments have very clever software designed to identify patterns of this nature, which can potentially then trigger further investigation or auditing. Should an audit eventuate, and the records not reflect the item codes claimed, the practitioner would be required to pay the money back for the inappropriate codes, even though they did not put them on the system. Whilst this type of issue may seem far-fetched, this does happen and at Dental Protection we see it reasonably regularly. Understandably, the practitioners involved are often shocked and left reeling when they realise, and very frightened. Dental Protection can help the practitioners work with the health fund or Medicare to get the best outcome, but the bottom line is – it is the practitioner's provider number, and they are responsible for the repayment of inappropriate codes, even if they are not complicit and their clinical records appropriately reflect the treatment provided.

Unfortunately, Dental Protection sees these situations reasonably frequently, being at the coal face of the difficulties experienced by our members, though happily this is not something that is happening in most or even many practices and organisations Australia wide. In fact, most practitioners come unstuck connected to the first scenario, where their records are insufficient to support their claim.

As with all situations, there are protocols and practices that practitioners can put in place to reduce the risk of these issues affecting them. Firstly, Dental Protection would encourage all practitioners to review their claiming, especially when commencing employment at a new practice. This review may need to take place daily at the start, tapering off slightly over time if everything is in order. This review can be set up either informally or formally and can be undertaken by checking the HICAPS/claiming receipts processed by reception. Alternatively, some claiming can be reviewed directly with online, such as through PRODA for some government claiming schemes.

Additionally, as touched on earlier, the maintaining of clinical records to an appropriate standard is imperative in both the appropriate clinical care of our patients, as well as an administrative requirement to participate in third party claiming. The Dental Board has an easily accessible hub relating to dental records with the relevant information including links to the Code of Conduct outlining their expectations, a self-reflective tool to help practitioners comply with their obligations under the Code of Conduct and FAQs[1] to support these documents, and Dental Protection would encourage you to refresh yourself with these obligations if you have not done so recently. Additionally, Dental Protection has many resources to assist you in this area and these complement the resources provided by the Dental Board.

REFERENCE

1. dentalboard.gov.au/Codes-Guidelines/Dental-records.aspx

Impostor syndrome – am I good enough?

Impostor syndrome can be described as a pervasive feeling of self-doubt, insecurity or fraudulence – one that can stubbornly persist, despite much evidence to the contrary. ***Dr Colm Harney***, Dentolegal Consultant at Dental Protection, explores the concept

Acclaimed author Neil Gaiman recounts being invited to a gathering some years ago of the great and good somewhere in the US – artists, scientists, writers, and discoverers of things.

He was standing at the back of the hall thinking at any moment they would realise he didn't qualify to be there, when he started talking to a very polite elderly gentleman about several things, amongst others their shared first name.

And then the gentleman pointed to the hall of people and said words to the effect of: "I just look at all these people and think, what the heck am I doing here? They've made amazing things. I just went where I was sent." And Mr Gaiman replied: "Yes, but you were the first man on the moon. I think that counts for something."

And at that moment he realised if Neil Armstrong felt like an impostor, maybe everyone did. That feeling is close to my own heart having experienced it, on and off, many times in my own life and the practice of dentistry.

What is Impostor Syndrome?

Impostor Syndrome is that internal monologue that plays inside our heads and whispers to us that, any time now, I'm going to get that tap on the shoulder and be told "I see you ... I know you're a fraud ... you've been found out!"

And while it's reassuring to know that even Neil Armstrong experiences Impostor Syndrome, what do we know about its prevalence? The literature says that it doesn't discriminate on the basis of gender, race, age, or occupation. It is not some kind of abnormality and, important to note, not necessarily tied to depression, anxiety or measurable low self-esteem.

In dentistry there are a number of areas where Impostor Syndrome can play a role, for better or for worse.

First off, to state an objective truth, as dental professionals we have, to most outsiders, significant evidence of competence to do the job. It is mutually understood between patient and practitioner that there was a high threshold to entry and then a significant amount of study and testing to be done to get the golden ticket – the certificate on the wall.

We have a job, which means somebody has seen fit to hire us or we've gathered enough resources to start our own business. We wear a uniform, have elaborate equipment, use technical language and are reasonably well remunerated – by most metrics of success in modern society we are high flyers.

Yet at the same time once we graduate, if it hasn't been made clear at dental school, it dawns quickly that the qualification is really only the beginning. The practice of dentistry, in whatever field you work in, is a lifelong journey of learning on the job, continuing education, mentorship, and discovering the limits of your capabilities, only to repeat and keep learning and growing.

Certainly, I was never told this when I graduated, and the early days of practice were a significant struggle for me – the certificate on the wall telling me I'm a bona fide, fully qualified dentist – the diagnostic dilemma or the tricky procedure slowly going wrong telling me otherwise.

Impostor Syndrome in dentistry

We are proceduralists, working in confined dark spaces to very fine tolerances – anecdotally I believe that dental professionals, as a general rule, have a tendency to perfectionism.

Combine these and you have fertile ground for the flourishing of Impostor Syndrome, especially in the early days of practice.

However, once the penny drops, and we realise the qualification is only the start of the journey and not the final destination, then it becomes easier to put things in perspective – we are destined to always be on a learning journey.

Indeed, over 25 years after receiving the golden ticket I still learn something every day of practice – whether it be a subtle tweaking of a procedure, how to better use a new material, or some way I communicated more effectively to a patient that I can use again in future.

And the question of perfect – to be blunt, perfect doesn't exist – not in dentistry and not in any other aspect of life. Perfect is like unicorns and the tooth fairy – a fiction.

Another aspect of the modern world that can feed Impostor Syndrome is social media and the known impact it can have on self-esteem. If "comparison is the thief of joy", then social media has the potential to be the echo chamber that distills all our insecurities and holds them up like a mirror to our face.

The beautifully curated Instagram cases, on the 'perfect' patient, with the cusp carving and fissure staining are easy to compare with our real-world scenario of struggling to achieve a tight contact and grinding down all our barely adequate anatomy to match a worn dentition. How could I not be an impostor? Wouldn't my patient be better served by seeing someone as good as the Instagram practitioner?

Again, some perspective is needed. I've read and listened to some of the prominent social media posters say that it has taken years and years of education and training, along with trial and error, to get to the point of being able to post these 'perfect' cases. It takes a single-minded dedication, is something I really admire and can be gratifying to aspire to when I am well prepared, working on an optimal patient with my best assistant and no time pressures. Yet for me, most of the time, I am comfortable running my own race and at the same time appreciating what can be done and taking a few tips here and there.

Overcoming Impostor Syndrome

So how do we push past Impostor Syndrome and grow as practitioners? We need to continue making progress, at a bare minimum keep up to date and not remain stagnant or fall behind in standards required to remain compliant with our regulator.

It is important to say that there is no one solution as everyone's circumstances will be different, while also having influences from individual past experiences, upbringing and culture.

While some practitioners we see, especially in the early days, may be too bold in launching into ventures and cases that they shouldn't, for the practitioner prone to Impostor Syndrome there will be an inherent bias towards holding back, biding their time until they feel they are good enough.

The only suggestion I can posit is to consider, like Neil Armstrong, that most of us feel slightly out of our depth, especially when it comes to important work and breaking new ground.

We need an optimal amount of caution – enough to keep progressing yet not so much as to slip drastically beyond our scope or skillset and risk harming our patients. This tension and balancing are a good thing.

To feel like an impostor means that you care, are conscientious and will give your best effort with all resources available to you at the time – this can only be a virtue and a measure of the type of practitioner I would like to see if I were a patient.

Code of Conduct – what does it mean for you?

As practitioners, we are all aware that there are significant expectations placed upon us as part of our registration, including the current Code of Conduct, which came into effect on 29 June 2022. ***Kristin Trafford-Wiezel***, Case Manager at Dental Protection, looks at how it influences us as professionals, when providing healthcare to our patients

The Code of Conduct is a shared document that applies to registered health practitioners in 12 professions. The Code sets out the National Board's expectations of professional behaviour and conduct for practitioners registered in these professions and was developed by these 12 National Boards under section 39 of the *National Law*, with the primary purpose to protect the public by assisting and supporting practitioners to deliver effective regulated health services within an ethical framework.

More simplistically, the Code of Conduct is a principle-based document that gives important guidance to practitioners, about what the National Board's expectations are of their professional conduct, in numerous areas, supporting you in your practice, with good patient care at the very core.

As a profession we have some fundamental values and qualities that embody who we are, and these values underpin our Code of Conduct – such as:

- A belief that good practice is centred on patients
- That we endeavour to treat each patient as the individual that they are, being culturally aware and respectful of individual differences, whether that be gender, sexuality, age, or beliefs
- That we have effective communication, which is imperative in our treatment of patients
- That we are ethical and trustworthy people, and that we have a responsibility to protect and promote the health of individuals, as well as the community.

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Another quality that practitioners are expected to have, which is fundamental to our personal growth, is the ability to look inside themselves and reflect on their knowledge and their skills. To evaluate whether we are practising safely and keeping up to date and conversely, the ability to recognise and work within our limits, and be committed to the safety and quality of the healthcare that we provide.

Fundamentally, we can consider the Code of Conduct assists and supports us in striving to be the type of person and professional we can be proud to be.

The Code of Conduct is a principle based document, structured around 11 principles. As many of these principles are expansive in their context, the boards have also helpfully developed some additional resources to assist us in implementing them into our practice. Though we will briefly step through the principles, please do take the time to familiarise yourself with this document in more detail.

The Principles

Putting patients first – practitioners should practise safely, effectively and in partnership with patients and colleagues, using patient centred approaches, and informed by the best available evidence to achieve the best possible patient outcomes.

This section focuses on providing good care, which is our primary concern in clinical practice. This principle steps through what providing good care includes, as well as what good practice includes, as they are actually slightly different. So, when the Code talks about good care, it touches on areas about how we care for our patients, the assessment, the management plan, including co-ordinating with others, ensuring the continuity of their care. It includes recognising the rights of patients and involving others with shared responsibility for their care. Good practice, however, focuses more on the nitty gritty in terms of how you practice; your training, records, communication, alleviating symptoms and distress of patients, and the treatment you provide and the products you use being evidence based.

Aboriginal and Torres Strait Islander health and cultural safety – the practitioner should consider the specific needs of Aboriginal and Torre Strait Islander peoples and their health and cultural safety, including the need to foster open, honest and culturally safe professional relationships.

I mentioned previously one of the values of professionalism is about recognising patients as the unique individuals that they are. This principle focuses on ensuring culturally safe and respectful practice, to support the rights and dignity of Aboriginal and Torres Strait Islander people and colleagues.

Respectful and culturally safe practice for all – respectful culturally safe practice requires practitioners to have knowledge of how their own cultures, values, attitudes, assumptions and beliefs influence their interactions with people and families, the community and colleagues. Practitioners should communicate with all patients in a respectful way and meet their privacy and confidentiality obligations, including when communicating online.

This principle of cultural awareness, which carries all the way through to end-of-life care, then expands further to encompass the importance of effective communication as well as our confidentiality and privacy expectations, directing us to additional complementary guidance on areas such as social media.

Working with patients – focuses on the importance of basing relationships on respect, trust and how effective communication enables practitioners to work in partnership with patients. Our obligations are to maintain effective and professional relationships with patients and provide explanations to enable patients to understand and participate in their care.

This is certainly the cornerstone of what we do as healthcare providers, working in partnership with our patients, and touches on important areas of consideration such as patients with additional needs, such as children, and dealing with relatives and carers.

It also discusses areas such as adverse events, open disclosure and complaints, informed consent, professional boundaries, and ending professional relationships, whether that be with patients or practices. These are areas that we touch on regularly here at Dental Protection and have many additional resources, such as those contained on our online e-learning platform.

Working with other practitioners – this principle is something that is important to consider, in that by having good relationships with our colleagues and other practitioners, this can positively affect patient care.

This principle focuses on respect for colleagues and other practitioners, teamwork, delegation, collaboration and referrals, enhancing patient care. Additionally, this principle also clearly sets out the **absolute** lack of tolerance for discrimination, bullying, and harassment in healthcare in Australia.

Working within the healthcare system – this principle touches on practitioners' responsibilities to contribute to the effectiveness and efficiency of the healthcare system, using resources wisely, as well as health advocacy, and public health.

Minimising risk to patients – the Code expects that we put patient safety, including cultural safety, first. Practitioners should minimise the risk by maintaining their professional capabilities through ongoing professional development and self-reflection, and understanding and applying the principles of clinical governance, risk minimisation and management in practice.

This principle recognises that minimising risks to patients can be twofold. Firstly, in terms of the systems and protocols that we have in place to reduce errors and improve patient safety. Secondly, with individual practitioner performance. This is related to ensuring your education is up to date with current contemporary practice by meeting CPD requirements. Additionally, it can even be more basic than that: what about looking after ourselves? Dental Protection has many great resources on burnout. In those resources we often touch on the concept of HALT – Hungry, Angry, Late, Tired. How can we be expected to care for others if we don't first care for ourselves?

Professional behaviour – this principle touches on the expectation that practitioners display a standard of professional behaviour that warrants the trust and respect of the community. This includes practising ethically and honestly.

This principle covers many significant areas and outlines expectations on areas such as reporting obligations, records, giving evidence and conflict of interest and financial dealings.

It also touches on a number of areas that have significant additional separate guidance from the Dental Board, such as professional indemnity insurance arrangements and advertising.

Maintaining practitioner health and wellbeing – the Code recognises how important it is for practitioners to maintain their health and wellbeing, and a work-life balance. It is recognised that good practice **does** include looking after your own health – whether that be your physical health, or your mental health, as all these things impact significantly on our ability to treat our patients and provide quality care. This section also discusses our obligation to look out for our colleagues and take action when necessary.

Teaching, supervising and assessing – the Code outlines the importance of supporting teaching supervising and mentoring of other practitioners and students, in order to develop the health workforce.

Ethical research – practitioners should recognise the vital role of ethical and evidence-based research to inform quality healthcare and policy development. Things change and evolve constantly, and the code recognises that to improve the health of the population as a whole, there needs to be a focus on research for the future and discusses how this can be conducted ethically.

As you can see, this document is extensive and all-encompassing of everything we do as professionals. Consequently, the Dental Board has helpfully developed a Code of Conduct hub on their website: **dentalboard.gov.au/Codes-Guidelines/Policies-Codes-Guidelines/Code-of-conduct.aspx** This hub contains additional resources that can assist us in implementing or living this code in our practice.

The resources include additional FAQs on common questions about the Code of Conduct, especially in areas that may not have traditionally been covered on contemporary matters, such as vaccination and COVID-19. Further to this, the Board has developed a series of case studies, to help us in our understanding of how to apply the code to our practice, and day to day lives.

Additionally, just as we utilise the Code of Conduct to understand the expectations around how we treat patients, and the bar by which we measure ourselves, conversely the Code is also there as a resource for patients, so that they too can understand what it is that they can expect from practitioners, their rights and how they can expect to be treated.

Consequently, patients have easy access to a full copy of the Code of Conduct, in English, as well as in several translations, including Arabic, Chinese, Italian, Greek, and Vietnamese.

As well as access to all the information in the Code on what to expect when accessing care from a health professional, the Board has also developed a number of case studies for patients in a number of key areas, so that they too have examples of situations where the code may impact on their healthcare or interactions with health professionals.

The Code of Conduct. Who are we, as professionals and healthcare providers? This document guides us though the comprehensive expectations placed on us. If you have not done so already, please log on and review this valuable document, as well as the supporting resources. Additionally, you can find complementary relevant and helpful content on the Dental Protection e-learning platform, to assist – as we all strive to embody what it means to be a healthcare professional.

It's not always about the treatment

Anita Kemp, Case Manager at Dental Protection, looks at the consequences of failing to recognise what could trigger a patient before they have even met the practitioner

It can be extremely rewarding and enjoyable to work in a practice where there are a number of practitioners and support staff. However, this can also mean that there will be times when our patients will be treated and cared for by our colleagues and conversely there will be times when we will have to care for our colleagues' patients.

When preparing to meet patients for the first time we are often able to rely on their clinical records to ensure the continuity of their care, and if the records permit, an insight into who these patients are can be gleaned. At the very least we can utilise their records to establish an initial rapport by inquiring about their most recent appointment and asking how they have been in the interim.

Unfortunately, this same opportunity is rarely reciprocated for patients, and it can come as a surprise when they attend their appointment and are told they are seeing someone else or someone new. I'm sure many of us can recall a time when we have happily strolled out to the reception area, introduced ourselves to the patient and invited them into the treatment room, only to be met by the patient's obvious shock or, even worse, contempt. After an awkward moment we realise that our patient attended their appointment expecting to see their regular dentist, hygienist or OHT and as such, that horrible feeling of dread and anticipation that we have already started out on the back foot, is difficult to ignore.

Case study

Mr T had landed his ideal role in a long-standing busy dental practice. The practice was expanding, and they had decided to create a new role within the team for an oral health therapist. Both existing dentists had worked independently for many years and welcomed the prospect of another set of hands to assist with their patients' treatment and care.

Mr T's appointment book was quickly filled by the administrative team, which equated to a much-needed reduction in the appointment wait lists for Dr G and Dr P, so it really felt like a win-win for everyone.

Mr T had been working in the practice for a number of months and all seemed to be going well. His schedule for this particular day concluded with a family visit for Maddie, 8 years old, and Tom, 10 years old, and they were accompanied by Billie, Maddie and Tom's mother.

When Mr T happily greeted the family and introduced himself as the "new oral heath therapist", he sensed immediately that something didn't seem quite right with Billie. Though comparatively the children seemed excited to meet Mr T and headed straight down to the treatment room, with Billie trailing behind.

During Maddie's appointment, Mr T advised Billie that Maddie needed a small restoration, in fact her first ever filling.

Once again, he noticed Billie seemed hesitant and when she asked if Mr T was sure about the filling because Dr J had only examined Maddie's teeth six months earlier and said they were perfect, there was part of him that was not surprised. Although Mr T sensed Billie's reservations towards him, he genuinely wanted to build rapport between them so he spent extra time going over the x-rays and the intraoral images, hoping to bridge this gap and establish the initial stages of mutual trust.

After they said their goodbyes, Mr T returned to the surgery and checked his book, and felt reassured in his efforts when he saw that Billie had scheduled Maddie's next appointment with him. When Maddie returned for her treatment, Mr T explained the restorative procedure and assured Maddie that she could let him know if she needed a break. He then commenced treatment and was very surprised when Maddie became fidgety and unwilling to co-operate, despite his best efforts. He attended to Maddie's needs by stopping and providing rest breaks, and confirmed that both Maddie and Billie were happy to proceed prior to resuming any treatment. With much effort, patience and kindness he was able to complete the restoration and congratulated Maddie on her bravery and persistence and, also, Billie for being a great support.

He thanked Maddie and Billie for attending their appointment and continued on with his day. The next day Mr T was informed that Billie was unhappy with Maddie's appointment and Mr T's care.

Billie had sent an email setting out her discontent:

We arrived expecting to See Dr J, as we have done so for the last six years and were told we were seeing a "Mr T", the 'new' oral health therapist.

No-one had explained to me that we would be seeing someone else or even asked if we were OK with this. Because we weren't! Also, my appointment was made six months ago so there was ample time to let us know.

Prior to our appointment we had never met Mr T or even heard of him and what's more I had to go home and Google what an oral health therapist was. All of this ***after*** *he had already examined Maddie and Tom and* ***after*** *I had made an appointment for Maddie's filling. I am extremely angry and disappointed that I wasn't even given any choice in the matter. I mean no offense to Mr T (I suppose) but surely this is something that I should have a say in.*

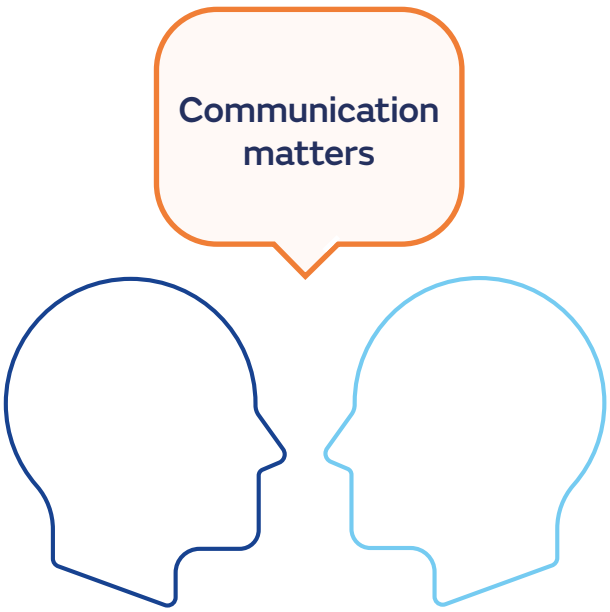
Maddie's appointment was awful, she seemed really uncomfortable, and they had to keep stopping and coaxing her on. I get that he was doing his best, but this never happened with Dr J, albeit that she hasn't had a filling before.

When I went out to settle the account, I expected that the fee would be reduced given Mr T isn't a dentist and I was surprised when Jane explained that the fee was the same irrespective of which practitioner provided the treatment.

Had I known this to be the case, I would have waited to see Dr J, and what's more I should be able to choose who we see. If there are changes to our appointments, then I should be notified of this at the very least and given the opportunity to decide whether we attend.

Mr T read over Billie's email and realised that most of her concerns were not directly related to Mr T's treatment or his care of Maddie and Tom, but a result of poor communication and Billie feeling that they had been abandoned by Dr J, then shuffled onto Mr T without her consent. Billie and her family had a longstanding relationship with Dr J and the practice, and this lack of communication and 'care' had left her feeling very upset.

Interestingly, in this case there wasn't an actual tipping point, where something happened that changed the course of treatment or affected an existing relationship. In this situation, there were obstacles already in play, even before Mr T walked out to meet and introduce himself to Maddie, Tom and Billie. Every time something was said or was different to their usual visits with Dr J, this solidified Billie's contempt for not being included in the decision to transfer their care to Mr T. This decision had been made without her knowledge or her consent and Mr T was unfairly compared and scrutinised as a result. Unfortunately, Billie no longer felt like she was an equal partner in her care but more like a number and considered this a personal affront after years of being a loyal patient.



Why communication matters

This case highlights the importance of good communication and consent across the entirety of our patients' care. Had the practice and Dr J let Billie know that she would be seeing Mr T, and explained his role in the practice, things might have been different. Though Billie may not have been happy that her appointment had been moved to Mr T she would not have been surprised and, most importantly (and in Billie's mind), she would be given an opportunity to consider her options and decide whether this new modality of care suited her and her family.

When considering this case, we might apply the old adage "what we tell our patients prior, is an explanation and what we tell them after, is an excuse". Patients don't like excuses, nor do they want to be cared for by a practitioner or practice who applies a paternalistic filter over their care. In fact, Billie and Mr T's case is a good reminder that the conversation of consent is not only confined to our discussion about treatment but a necessary consideration in all aspects of our therapeutic relationship, from the very beginning to the end.

Case study

Role reversal

Have you ever noticed that the patients you go the extra mile for are often the quickest to complain? Have you ever wondered why? ***Dr Annalene Weston***, Senior Dentolegal Consultant at Dental Protection, searches for answers

Ms S was an irregular attender with chronic periodontal disease. She could not afford to see the specialist periodontist, and instead attended Mr B, for three-monthly scales, or rather she was treatment planned to. Mr B had suggested this recall pattern a compromise, to try to help Ms S keep her teeth, until such a time that specialist care was an option for her. Unfortunately, as Ms S was a single parent and a working mother of twins, the complexities of her day-to-day life often interfered with her attendance. This meant that when she did attend, her periodontal condition was far from stable.

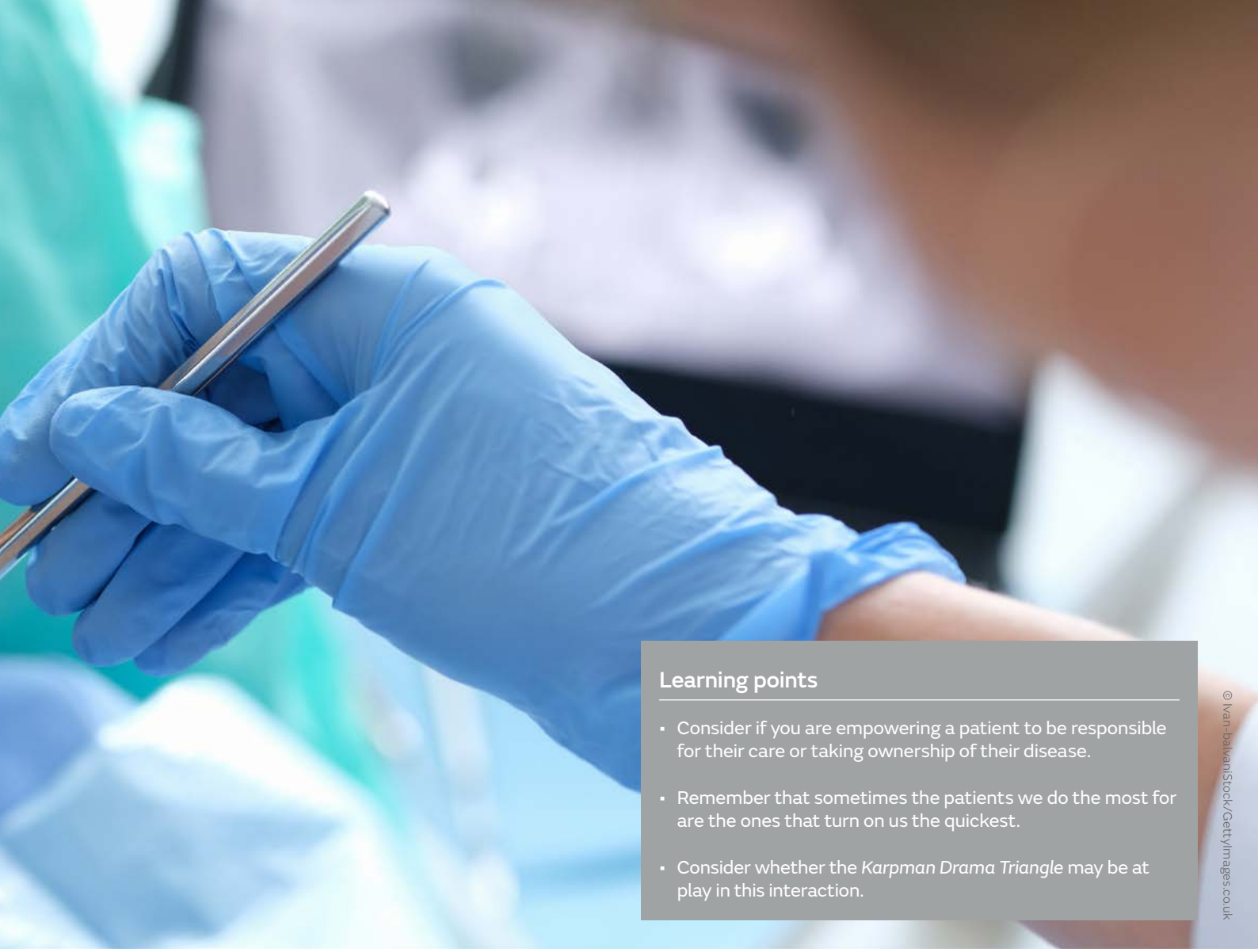
Rather than highlight this to Ms S, and emphasise the issues her irregular attendance was causing, Mr B trod around the issue gently, as he was loathe to add to her mental load. Further, Ms S was almost always late, so Mr B started scheduling her before his lunch break or at the end of his working day, so he could run over and give her the time she needed. He would work unassisted, so his DA could manage the twins to enable Ms S to complete her treatment without distraction. Many times he worked through lunch altogether to see her, and he always discounted her fee as, simply put, he felt deeply sorry for her.

Ms S would only be treated by Mr B, and he made sure he gave her the best care he could. In his heart, he knew that she needed more, but he also knew that it would be many years before she would be in the position to get the treatment she needed, and he wanted to help.

I know that every person reading this knows what happened next.

Ms S felt one of her teeth was loose and walked into a practice close to her work, where examinations were offered at Health Fund rebate only during her lunch break. They were able to squeeze her straight in with the new grad dentist, who quickly diagnosed her with 50% bone loss on most of her teeth, and 70% on the tooth in question. Ms S was stunned – why had Mr B never told her things were so bad? Why had he never referred her to the specialist? Fueled by some well-meaning but unhelpful commentary from the treating dentist who, in keeping with their limited experience, took their obligations to outline the likelihood of tooth loss very seriously indeed, without considering the consequences to all.

Ms S proceeded to make a vitriolic complaint against Mr B, both at the practice demanding compensation and to the regulator, questioning whether Mr B was even safe to practice. This diatribe continued on social media and through online reviews, and Mr B could only wonder why this person, who he had treated with such care, and really gone the extra mile for, turned on him. After all, the treatment had been provided with her consent, and with her full



Learning points

- Consider if you are empowering a patient to be responsible for their care or taking ownership of their disease.
- Remember that sometimes the patients we do the most for are the ones that turn on us the quickest.
- Consider whether the *Karpman Drama Triangle* may be at play in this interaction.

knowledge of the limitations and the compromised nature of care. Why was she doing this to him?

Pleasingly the regulatory matter was relatively easy to resolve, as Mr B's records, particularly relating the conversations he had had with Ms S, were strong. The regulator did however question the appropriateness of not reaffirming the issues with Ms S at every visit, as they formed the view that by failing to do so, Mr B was not only in breach of his duty of care, but also essentially complicit in her decline, essentially making this a case of supervised neglect. He received a caution.

The damage to Mr B, however, went further than that. Not only had he to contend with the stressful regulatory matter, but the online hounding by Ms S and repeated demands for compensation as well. In time and with Dental Protection's help each of these issues was resolved, but the toll on Mr B was great, making him wonder why he ever tried to help Ms S in the first place, and to regret not refusing to treat her and writing a referral **only.**

Mr B is not alone. It has rightly been said that the road to hell is paved with good intentions, and we have all been in situations where we have given the patient our all, and more besides, only to be attacked. One possible explanation for this is described by the Karpman Drama Triangle.[1]

This cycle is a social model of human interaction and was proposed by Dr Stephen Karpman, an Assistant Clinical Professor of Psychiatry. The Drama Triangle essentially casts three roles to be filled – those of the persecutor, the rescuer and the victim. In a situation such as this, Ms S was the victim, a victim of disease and of circumstance. Cue Mr B in his role as the rescuer, wanting to help and wanting to heal. The role of rescuer comes naturally to many healthcare providers, particularly those who entered the profession with the primary driver to help others. So naturally in fact, that we may not even realise what has happened, or how we have been drawn in. I feel that we have likely all met people who feel very comfortable in the victim role too. In many situations, this rescuer-victim relationship is fine, right up until the point where it isn't, as in this case, when Ms S flipped the narrative and moved from rescuer to persecutor, it cast Mr B as the unwitting and unwilling victim.

Fascinating as the concept of the Karpman Drama Triangle is, is it inevitable? Or can we avoid it? Pleasingly we can, but first we need to recognise when we are dealing with a 'victim' and taking up the cudgels to be their 'rescuer'. Rather than plunge headfirst into rescue mode, we can sidestep the drama triangle and its inevitable consequences by empowering the patient to manage their own disease, and to find their own solutions. Had Mr B done that, rather than seeking to protect Ms S from bad news, she would more likely than not have found a way to get the treatment she needed, or at the very least valued more highly all that he was doing for her. Remember, knowledge is power, and knowledge empowers our patients to make the best choices for them. If we truly wish to work in our patients' best interests, this can be the only way.

REFERENCES

1. karpmandramatriangle.com

Case study

The template trap

What is the tipping point in record-keeping between a useful time-saving modality and a harmful shortcut? ***Dr Annalene Weston***, Senior Dentolegal Consultant at Dental Protection, considers the 'template trap' through the lens of a recent regulatory matter

Ms M owned a practice in an area of high dentistry population, employing two dentists and working within the practice herself. Despite the large local population, Ms M had issues attracting and retaining staff, and in a post-COVID-19 landscape, Ms M found herself constantly crippled by agency fees for DAs. Ms M offered discounted treatments to certain vulnerable groups within the community, and with the passage of time attracted more and more of these patients.

Ms M did not have the heart to increase her fees, and therefore found that some days it was best for one practitioner to work unassisted, utilising the small suction and relying on reception to perform steri so she could reduce her overheads to a manageable level. The dentists were unwilling to work unassisted, and so Ms M often took this role herself.

Naturally then, Ms M had to generate some efficiencies within her practice, to enable her to safely work unassisted. One step she undertook was the development of a comprehensive record pro-forma, with all of the details for each procedure already entered in their entirety. The intent was to amend the document, removing what had not been done or discussed from the record, to ensure accuracy. By and large Ms M achieved this, although it did make the record somewhat difficult to follow.

On one such unassisted day, Ms B attended the practice drunk and belligerent with her child Lizzie who was six years old. While Ms M recognised Ms B was intoxicated, Lizzie had lost a filling from a deciduous anterior tooth and was distressed. Ms M assessed that it would be a quick fix without the need for LA, so decided to proceed. Consent was obtained from Ms B (although we should all pause for a moment to consider whether we can truly obtain consent from an intoxicated patient...) and the procedure to repair the front tooth was uneventful. Upon Lizzie checking the filling in the patient mirror, Ms B leant over to see the final result and became enraged as Ms M had closed Lizzie's diastema. Ms B threw the patient mirror at Ms M and pushed the tray of instruments onto the floor, shouting accusations of negligence and assault. So loud and alarming was this interaction that a local business owner in adjacent premises called the police.

The police arrived and escorted Ms B off the premises, as she had been refusing to leave, leaving a shocked and bewildered Ms M to continue with her day, now running very late.

Two weeks later, a letter from the regulator arrived, advising Ms M that Ms B had made an allegation of assault and treating Lizzie without consent against her, and requesting a copy of Ms M's records. Ms M dutifully provided this, with a covering submission to explain what had occurred. Two short weeks after that, Ms M was summoned to attend the regulator as the regulator had concerns regarding Ms M's professional conduct. At this point Ms M contacted Dental Protection.

Simply put, comprehensive as Ms M's records were, as they contained everything, they were in fact completely inaccurate, reflecting a number of things that did not occur, including the provision of risks and warnings for several treatment modalities

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not provided to Lizzie or discussed with Ms B. For example, the records reflected Lizzie had been given LA, a written treatment plan, and that the treatment had been provided under rubber dam. The list of inconsistencies was high, and from the context of the complaint, and the explanation Ms M had given, the regulator knew it.

The formal meeting with the regulator was frustrating for all involved parties as the practitioner felt (understandably) incredibly wronged to be there. They felt that an abusive and reckless parent's point of view was being held over their own, and that this was profoundly unfair. The delegates of the regulator maintained their line of questioning regarding the veracity of the records, frustrated by Ms M's seeming lack of insight into the fact that her records did not reflect the procedure or events of the day at all.

It became apparent to all that Ms M had fallen into the 'template trap' as, in the heat of the moment, upset by what had transpired, Ms M had not omitted the irrelevant and unrelated sections of the records. Ms M reassured the regulator that this was a one-off event, and the regulator felt it fair to let Ms M verify this. Consequently, they attended the practice to audit Ms M's records. Pleasingly, the audit findings were favourable, and Ms M received a caution and recommendation to make her templates less 'fulsome' and more of a 'framework' to support the collection and documentation of the relevant information. In their recommendation, the regulator highlighted the ease of forgetting to amend seemingly complete records, and the issues of honesty this raised, as well as the potential impact on the patient's continuity of care.

Learning points

- Some auto templating can be helpful in capturing what occurred in an appointment efficiently and consistently.
- Putting too much in however – for example the complete notes for each procedure – is dangerous, as you may not accurately discuss **those risks** as they may not be relevant to **that patient**, and you likely don't use exactly the same materials for every patient you treat.
- Allowing the space and time for personalisation of records increases the likelihood of the record being accurate and of value in ensuring the continuity of patient care.
- With a template, less is really more.
- The regulator is ALWAYS interested in your records, regardless of the underpinning complaint.

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