



Teamwise

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Welcome

As part of an international company, we at Dental Protection regularly correspond with our colleagues overseas, particularly in the UK. This has made all of the Australian advisory team acutely aware of how lucky Australians in general, and dental practice in particular, have been over the last year or so, when compared with the experience of our colleagues overseas.

This is not to diminish in any way the hardships that many of our colleagues locally have and still do endure, both from a mental health and a financial perspective. It is hard to compare levels of hardship, particularly as each of us individually have been impacted in our own unique way, and all personal hardship hurts.

Having said that, the dental profession – along with most other health professions in Australia – seems to be returning to a semblance of new normality. Patients are returning for routine treatment rather than just relief of pain, and we are back to being able to provide all treatments under pretty much standard cross-infection protocols with only slight variances. While restrictions and localised lockdowns will continue to occur, we are becoming familiar with the process. It feels a bit like spring with new growth returning, and the promise of a relatively familiar landscape. Like meerkats, we are popping our heads up and looking around for meetings with colleagues, face-to-face CPD and, better still, holidays in our own piece of paradise.

Vaccines are being rolled out and, though it may seem slow, the reality is that most of us do not need the urgency that most other countries are still experiencing. Still, it will be nice when it is done.

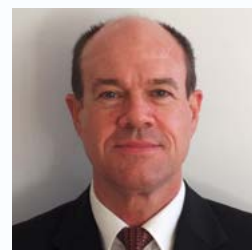
Late last year the Dental Protection dentolegal consultants and case managers sensed an air of intolerance that pervaded many of the complaints that our members reported to us. Patients seemed to be complaining about things that they would have shrugged off

in normal times, and dental practitioners seemed to be pulling hard on the reins with their patients. You know that feeling you get when it is close to Christmas and you need a break – well it was that, only more so, and compounded by the fact that most of us were not going to get the break we needed. We had all had enough.

Fortunately we seem to be getting through this period of general intolerance as well – not there yet but we seem to be heading in the right direction. I have been heartened by the general and genuine increased acknowledgment of mental health issues and the need for everyone to look after themselves. Even before we look after our patients, as a profession we must look after ourselves – if we are impaired, we cannot provide the service our patients deserve.

So I hope you find this edition of *Teamwise* interesting and perhaps uplifting, and that you share with me a feeling of optimism for our futures.

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Advertising your services: new guidelines take effect

Revised guidelines on advertising a regulated health service came into effect on 14 December 2020, along with updates for the advertising compliance and enforcement strategy for the National Scheme. **Anita Kemp**, Case Manager at Dental Protection, looks at what these mean for you

The revised guidelines on advertising have been restructured to allow practitioners easier access to information, and offer new flowcharts, case examples and content relating to testimonials, protected titles, and acceptability of the evidence required to substantiate health claims in advertising.

This article summarises the key changes and identifies what you may need to do next.

What is acceptable evidence?

AHPRA recognises the distinction between acceptable evidence for claims made in advertising and the evidence used for clinical decisions.

The consultation with a patient provides an opportunity for practitioners to obtain consent and discuss the evidence for different treatment options. Individuals are able to consider options, the benefits and risks of each option, and also ask questions, and therefore make an informed decision about their care. Advertising does not support informed decision making as the claims made are generic, and practitioners are not available to clarify whether each specific treatment is appropriate for an individual. Nor does the individual have the opportunity to ask questions, which may be critical to their understanding.

Advertisers of regulated health services must be able to substantiate claims made in advertising by means of 'acceptable evidence'. Acceptable evidence mostly includes:

- empirical data from formal research, or
- systematic studies in the form of peer-reviewed publications.

Testimonials and reviews – what you need to know

Testimonials can be construed as misleading and are therefore prohibited

as a form of advertising, as is any recommendation or positive statement relating to the clinical aspects of treatment.

Clinical aspects include:

- Symptoms – specific symptom or reason for seeking treatment
- Diagnosis or treatment – specific diagnosis or treatment provided by the practitioner
- Outcome – specific outcome, or skills or experience of the practitioner (either directly or via comparison).

Broadly, practitioners are not responsible for positive or negative reviews on third party websites as they have no control over this content. Nevertheless, practitioners should be wary if they choose to engage with reviews as this may be considered advertising.

Practitioners are, however, expected to monitor platforms that they have control of (eg social media and practice websites) and comply with the prohibition of the use of testimonials in advertising, to ensure full compliance with the guidance.

Protected titles – registration, competence and qualifications

To avoid misleading advertising, practitioners should consider how they present their title, qualifications and areas of expertise.

Advertising that uses the words (or variations of) 'specialises in', 'speciality' or 'specialised' implies the practitioner holds specialist registration. Alternative descriptions should be used. Wording such as 'substantial experience in' or 'working primarily in' are less likely to be misleading and therefore can be considered.

Advertising compliance for the National Scheme

The updated advertising compliance and enforcement strategy for the National Scheme sets out a proactive approach to advertising compliance, while encompassing a risk-based approach that determines the severity of a breach and the appropriate penalty should this occur.

Other updates include:

- Recognition that false and misleading claims about public health emergencies such as COVID-19 may be identified as high risk (critical or major)
- Additional education and engagement activities to support advertising compliance
- An indication of AHPRA's focus on testimonial compliance and enforcement action, specifically those that present greater risk.

Perhaps most noteworthy was the addition of section (f), which has overarching implications for all registered health practitioners:

"Declaration about advertising obligation and audit addition. At annual renewal of registration practitioners will be asked to declare that their advertising meets National Law advertising requirements. Future audits will be conducted to check practitioner advertising compliance against this declaration."

Reviewing your own approach

Now is the perfect time to review your current advertising compliance alongside the new requirements and guidelines.

For further resources, information and guidance regarding practitioner obligations and compliance requirements, visit AHPRA's advertising hub.

CPD – getting it right

As practitioners, there are a number of obligations expected of us as part of our registration. One of these is ensuring our skills and knowledge remain current by participating in relevant CPD. **Kristin Trafford-Wiezel**, Case Manager at Dental Protection, reviews the facts and the pitfalls when selecting CPD

The parameters for selecting appropriate CPD appear relatively straightforward – no less than 60 hours over a three-year cycle, with at least 80% of those hours being deemed scientific.¹

The Dental Board also gives quite a comprehensive guide on how to choose appropriate CPD activities and advises that you should choose activities that demonstrate the following characteristics:

- Open disclosure about monetary or special interests the course provider may have with any company whose products are discussed in the course
- The scientific basis of the activity is not distorted by commercial considerations. For example, be aware of embedded advertising and direct commercial links
- Features learning objectives, independent learning activities and outcomes
- Articles from peer-reviewed journals or written by a suitably qualified and experienced individual
- Addresses contemporary clinical and professional issues, reflects accepted dental practice or is based on critical appraisal of scientific literature
- The content of CPD activities must be evidence-based

Where relevant, select CPD activities where you can enquire, discuss and raise queries to ensure that you have understood the information.

If the CPD activity includes an assessment or feedback activity, this should be designed to go beyond the simple recall of facts and seek to demonstrate learning with an emphasis on integration and use of knowledge in professional practice. It should also provide an opportunity to give feedback to the CPD provider on the quality of the CPD activity.²

This information is then further clarified within other key documents, such as our overarching *Code of Conduct* and recently updated *Guidelines for Scope of Practice*. It is important to note that the *Scope of Practice* document clearly states that the benefits of doing CPD are to:

- maintain and improve your skills and experience, and
- broaden your scope of practice within your division.

We note that CPD will not let you move from one division to another. Dental hygienists, dental prosthetists, dental therapists and oral health therapists cannot become dentists simply by completing CPD courses.³

One function of AHPRA can be to conduct routine audits on whether practitioners have complied with their CPD requirements. Alternatively, concerns regarding a practitioner's CPD can be uncovered during the course of investigating a complaint, whereby during these investigations it is common for AHPRA to request a copy of a practitioner's CPD logbook.

Alarming, a significant number of practitioners do not have an appropriate and up-to-date log of their CPD, ultimately stumbling at the first hurdle. Once compiled, it can also quickly become apparent that the education completed does not satisfy AHPRA as being appropriate in either amount, or content. The Dental Board does not have set limits on the number of hours you can spend on particular types of CPD activities, but there is an expectation that a practitioner engages in a range of activities in line with the objectives of CPD and the practitioner's own learning needs.⁴

Should a practitioner be found to be in breach of the *Standard for Continuing Professional Development* it is important to note:

- The Board can impose a condition or conditions on your registration or can refuse an application for registration or renewal of registration, if you do not meet a requirement in an approved registration standard for the profession (sections 82, 83 and 112 of the National Law)



- A failure to undertake the CPD required by this standard is not an offence but may be behaviour for which health, conduct or performance action may be taken by the Board (section 128 of the National Law)
- Registration standards, codes or guidelines may be used in disciplinary proceedings against you as evidence of what constitutes appropriate practice or conduct for dental practitioners (section 41 of the National Law).⁵

So what can we do to help ensure that the precious time and money we invest in the CPD we undertake is well utilised, and the CPD we undertake is appropriate and relevant to us as practitioners? As discussed, it is important to be familiar with the relevant guidelines and standards and our obligations as per our registration. Additionally, the Dental Board has helpfully launched a reflective practice tool, to assist in self auditing and planning professional development.⁶ Dental Protection strongly encourages all practitioners to download and utilise this valuable resource for the planning and selection of their CPD activities.

Pulling together all this information will assist practitioners in the selection of appropriate CPD, as well as ensuring they are aware of the reasoning and benefits, and limitations of the CPD undertaken.

REFERENCE

1. Continuing Professional Development (CPD) Resources. dentalboard.gov.au/Codes-Guidelines/CPD.aspx
2. As per reference 1
3. Know Your Scope. dentalboard.gov.au/Codes-Guidelines/Know-your-scope.aspx
4. As per reference 1
5. As per reference 1
6. Reflective Practice Tool. dentalboard.gov.au/Codes-Guidelines/Know-your-scope/Resources-to-help-you/Reflective-practice-tool.aspx

Case study

Ms D, a registered oral health therapist, had undertaken a unit on orthodontics at dental school. She had enjoyed this course and sought work at a practice that mostly provided orthodontics, including growth appliances and orthopaedic appliances. Ms D attended a clear aligner course with her colleagues, registering herself on the course as an OHT. During the course, she timidly raised her hand to advise she was an OHT and would not be able to provide the appliances to patients – she was just there to learn. The course convener told her this was untrue as she had studied orthodontics at dental school, and consequently this fell within her scope of practice. With the encouragement of those around her, Ms D began to prescribe aligners for her patients, following the diagnostic formula provided by the course.

Patient Q was unhappy with their care and reported Ms D to AHPRA. On discovery of the treatment provided, AHPRA took immediate action and suspended Ms D.

Ms D is not alone. Good, ethical practitioners across Australia have found to their horror that treatment courses they have attended and been mentored in have been found wanting when their training is examined by the regulator. This particular practitioner happens to have been affected in the field of orthodontics, but the issue is not limited to this discipline of dentistry.

We encourage all practitioners to critically appraise any CPD they are considering and apply the guidance from AHPRA to their course selection.

Sorry seems to be the hardest word



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Regretfully, things in the practice of dentistry do not always go to plan. What is expected of us when things go wrong, and is it ever wrong to apologise? **Anita Kemp**, Case Manager at Dental Protection, looks at the facts

Open disclosure requires of us honesty, openness and timeliness when divulging an adverse event or outcome to our patient. The Australian Commission on Safety and Quality in Healthcare states that an expression of regret for any harm that has resulted should be made as early as possible. Similarly, the Dental Board of Australia's *Code of Conduct* charges us with the responsibility of providing an apology and a prompt explanation of the event that has occurred, if appropriate.

When adverse events occur, and open disclosure and a subsequent apology is required, we can often feel extremely vulnerable. The progression of a procedure that did not go as planned or as expected can leave both our patients and ourselves feeling anxious, upset and at times angry. In these circumstances our inherent fight or flight responses can be activated and, in some instances, what was meant as an apology can come across as defensive and evasive in nature. During these times of distress and uncertainty, an understanding of the integral elements and the purpose of an apology can be invaluable.

Why should we apologise when something goes wrong?

Notwithstanding the requirements of our professional obligations, Leape (2012) identifies that patients expect an apology from their doctors after being harmed by an error. He continues that apologies convey a sense of respect, mutual suffering and responsibility.¹

Mutual suffering in itself is an integral element of an apology worth consideration. As practitioners we never suffer the outcome, pain or anxiety of treatment experienced by our patients. Nevertheless, as Robbennolt (2009) suggests, if we are able to demonstrate an understanding and empathy towards our patient, a reduction in anger and blame may be observed – leading to a positive increase in trust.²

Trust is an important aspect of any therapeutic relationship. When a practitioner works with honesty, openness and the ability to acknowledge an adverse event or problem, patients are more likely to trust in the practitioner's ability to either remediate the problem themselves or provide a

suitable pathway for specialist referral that will ensure the most favourable outcome for them. If trust is lost and the patient goes elsewhere, the practitioner may in fact be more vulnerable to complaints or concerns arising from the treatment provided.

Research by psychologist Beverly Engel (2002) suggests that the art of apology is crucial to mental and physical health. Studies have found that the recipient of an apology experiences physiological changes including a decrease in blood pressure, slower heart rate and steadier breathing. These noticeable physical effects allow space for problem solving as opposed to a heightened reaction.³

Similarly, regret, remorse and shame are feelings often felt when we inadvertently hurt another person. In the event of an adverse outcome, all these feelings have the potential to cause negative emotional and physical effects in the treating practitioner. Engel continues that when an apology is given and responsibility for actions are taken, we are able to help rid ourselves of esteem-robbing, self-reproach and guilt.

So if we should apologise – why don't we?

Innate fight or flight responses, coupled with vulnerability and fear, can all determine our reasoning and rationale; to provide, or not provide, an apology. Hubris too can also play a part, particularly when our self-image is founded in being a caring and competent practitioner. Fear of loss of patient confidence, ridicule from colleagues and regulatory investigation can undermine our self-esteem and affect our ability to make emotive decisions.

If we do apologise, what should it look like?

Most importantly in these instances, we should ask 'what does our apology look and feel like to our patients?' An apology must feel genuine, sincere and heartfelt; it must refer to the specific incident or problem and must acknowledge each patient's specific circumstance. Apologies should be delivered in the first person by the practitioner responsible in a personalised manner. Use of language is pivotal and the practitioner should aim to soften the apology by using 'sorry' rather than the formal 'I apologise'.

According to Lazare (2005) the four key components of an effective apology comprise:⁴

Acknowledgement – acknowledge what has happened

Remorse – offer empathy for the position the patient is now in

Explanation – give a clear and specific explanation of what actually happened

Reparation – anything from remediation by you or by referral or monetary compensation.

An apology should include:

- Assurance that the circumstances will be investigated and that the standards of the profession will be maintained
- An explanation of what has occurred. This should be provided to the patient's level of satisfaction and should include opportunities for the patient to relate their experience and to ask questions. The practitioner should also seek assurance from the patient that they understand and are comfortable with the content of their discussion
- The word 'sorry', which is not an admission of liability.

Furthermore, an apology needs to be personal in nature, not vague or imprecise, but clear and specific regarding the events that have occurred. The use of layman's language as opposed to quasi-legal or technical jargon should be used in both the description of the event and the likely outcome. The research broadly indicates patients want a meaningful apology along with an honest and open explanation.

When this is not forthcoming, a patient is more likely to feel aggrieved and take the matter further.

In our experience at Dental Protection, we're concerned that an apology can be viewed as an indication or admission of fault or liability. In the event that an adverse outcome or problem does occur, I implore you, don't be afraid to offer an apology: fundamentally this is what every patient in this situation wants to hear. Remember there is considerable evidence that supports the protective benefits of an apology and, when you do apologise, don't be afraid to begin with three very powerful words, 'I am sorry'.

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1. Leape L, Apology for Errors. *Frontiers of Health Service Management*, 28 (3) pp. 3-12 (2012)
2. Robbenolt JK, Apologies and Medical Error. *Clinical Orthopaedics Related Research*, Feb 467 (2) pp.376-82 (2009)
3. Engel B, The Power of the Apology. *Psychology Today*. July 2002
4. A Lazare (2005) Quoted in *Riskwise* 25, Jan 2012, p20



Wellbeing – a reminder of the support available

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

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

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

What we are doing to help

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

In consideration of the above, and Dental Protection's ongoing commitment to positively influence the wellbeing of our members, we have taken additional steps by recently launching our wellbeing hub, available at dentalprotection.org/australia/wellbeing. This service endeavours to support members to take positive steps for their wellbeing and as explained in detail below, includes free



access to counselling, a raft of resources, podcasts and webinars, as well as the wellbeing app eCare from ICAS.

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

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

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

We also have a **recorded lecture** called *Under Pressure*, which looks at the internal and external pressures of being a dental practitioner and how to recognise and manage them. Dr Annalene Weston and

Dr Samantha King explore the causes and consequences of this strain, both from the pressure cooker of the surgery and our own internal stresses.

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

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

Taking care of ourselves

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



Difficult conversations in difficult situations

Dr Annalene Weston, Dentolegal Consultant at Dental Protection, looks at the communication skills required for those challenging conversations

It is a regrettable truth that difficult conversations can and will occur, and worth considering that we don't just have difficult conversations with patients, but also with their partners, or parents and carers, and with our colleagues and staff too. The purpose of this article is to consider what makes a conversation difficult, and what steps we can take to prepare ourselves.

What does make a conversation difficult?

There are a number of factors that can influence the difficulty of a conversation. It is important to note that as with many things in life, what may be difficult for me, may not be difficult for you, and what may be difficult for me one day, may not be difficult for me on another.

One consideration to raise is that it will always be difficult to break bad news, even for the most skilled communicators; in the practice of dentistry, regrettably we have to break a lot of bad news to patients. That aside, it would be fair to say that the difficulty of the interaction is a direct result of the interplay between four factors.

Patient factors

It is manifestly unfair to label someone a 'difficult patient' or 'difficult person', and far better to simply acknowledge that this person is 'difficult for me'. Naturally, however, there are patient factors at play in a difficult interaction. Communication can just

be difficult, perhaps due to the patient's overarching fear of you and the environment that they find themselves in, perhaps because you are not speaking the same first language. Consider how excessive technical talk can act to hinder good communication. There can be no doubt that some cultural barriers can also exist when it comes to having a conversation with a patient, and it is always important to take the time to understand any appropriate cultural context as best you can, particularly if the culture is one you have not been exposed to before.

Some of the communication issues related to the patient themselves can be due to their personality type, and we have all experienced a situation where the patient has unrealistic expectations or fixed and rigid views regarding the nature and type of treatment we can provide, and what their outcome is going to be. This can also be based on their prior experiences with colleagues, some of which may not have been favourable. Other patients can demonstrate this as they have such a strong internal locus of control that they cannot let you advise them, or conversely, such a strong external locus of control that they refuse to make decisions, attempting to pass all of that responsibility on to you, the clinician.

System factors

It is incredibly challenging to communicate well in an unruly or disruptive environment, whereby we are suffering with constant interruptions particularly in a 'bad news breaking' situation. Lack of privacy can impact on the quality of a conversation with a patient.

Think about how hard it is to talk to someone when you are trying to reboot your system while maintaining a constant explanatory stream. Distraction, whether yours or on the part of the patient, will lead to ineffective communication – have you ever tried to talk to a patient who is glued to their phone? It is impossible.

Sadly, many practitioners have described to us circumstances where they are under the scrutiny of a third party such as their employer, who does not approve of trivialities such as talking with patients, and will clock watch and pester them if they are perceived as talking too much.

Dental team

A great team around us can make our job smooth and be such an advantage when it comes to communicating well and offering good quality care. Conversely then, a poorly functioning toxic team will leech into every interaction you have, and impact on your communication style and ability.

‘Me’ factors

We do not exist in a vacuum and try as we might to keep our private and work lives separate, the boundaries will, from time to time, lose distinction. Dealing with patients when you are dealing with personal stress is a challenge, and there can be no doubt that stressed out and burned out practitioners do not communicate as well as they do when they are on an even keel. This means that they receive more complaints, at a time in their lives when they least need it. It doesn't even need to be a big influencing factor to negatively impact our communication style. Getting caught in traffic and arriving to work late and grumpy can be a recipe for a difficult day, peppered with terse patient interactions.

Essentially, there are two types of difficult interactions – ones you knew were going to happen and ones you did not. We would call these planned and unplanned difficult interactions.

Planned difficult interactions

Planned interactions are always preferable, as you know they are going to happen. You know that a patient is on their way in with an issue after your treatment, so you can prepare yourself and your environment for that. Another good example is having to tell a colleague that you have seen one of their patients and that there are problems with the care they provided. A challenging discussion to have, so one we would plan if we can.

It can be incredibly helpful to have some idea of the words you are going to use, or, in the case of a patient, the solutions you intend to offer them. We definitely can and should choose our words wisely. There are other elements that would not necessarily be obvious at first blush. For example, choosing your venue and your audience. Consider – do you want to have a heated discussion with a patient in the waiting room, in front of all the other patients who are scheduled that day? Our experience tells us it is far better to find a private space for the conversation, away from prying eyes, and one where the patient can feel comfortable. Remember, many patients are scared of the dental surgery environment – do you have an office space where you can talk with them instead? If you do, the interaction will likely go a lot better.

The audience can be a critical component. With a patient, it's best to be chaperoned if possible, preferably by a calm and sensible staff member who is not going to be more of a distraction than a support to you. But what about a discussion with a colleague? Simply put,

take this away from all staff if you can, maybe even away from the practice, as you do not want your colleague to feel that everyone has been talking about them, or poking fun at them behind their back. That would be an awful way to make someone feel and, respectfully, is not going to help you achieve your desired outcome of setting out your concerns for your colleague in a way that they listen to and respond to meaningfully.

You also need to choose to respond rather than react. Difficult conversations are stressful, and stress can limbically hijack us and cause us to lose higher function thinking. Loss of this occurs as the switch has been flipped on our sympathetic nervous system, and as adrenaline and cortisol start coursing through our systems, we are now in a full fight or flight reaction. While it is possible to have a meaningful conversation under these conditions, it is a lot harder than if we are cool, calm and collected. Choosing to respond, and squashing the fight or flight reaction, will invariably lead to a smoother outcome to the conversation.

Unplanned difficult interactions

If you are unaware that the interaction was about to occur, you have essentially lost control of some of the elements of this interaction. Consequently, it is critically important that you do not lose control of yourself. That limbic hijacking needs to be kept in check as far as is possible, so our fight or flight reaction can be managed. Do not underestimate the value of a few deep breaths here to help you stay calm and keep your head clear.

Bear in mind that your audience is judging you and your professionalism based on how you handle this interaction. Also bear in mind that in this day and age it is likely you are being illicitly filmed on someone's phone. While this is a breach of the legislation across most of the States and Territories, it is hard to take the video back when you have become the latest YouTube sensation, and have been turned into a meme. Not what any of us would want or hope for.

Consequences of difficult interactions

Professional

The professional consequence of a difficult interaction can be a complaint, and while many of these complaints will be low level ones made at the practice, some will be escalated to the regulator. The code of conduct is the overarching guidance framework that sets out how we are expected to behave, and the regulator takes a dim view of those who do not communicate respectfully with their patients.

Personal

Also of concern are how difficult interactions can make us feel and, simply put, when things don't go well, we feel bad. Bad about ourselves and sometimes bad about the situation or the patient. Needless to say, the consequences of these difficult interactions can be cumulative, and a snowball effect can occur, where we are so disenchanted it almost becomes impossible to have healthy interactions with patients and colleagues. This can seep into our personal life too.

In all, it is far better to try to pre-empt difficult conversations in difficult situations, and manage them, and ourselves, as best as we can.



Rose coloured glasses, or coloured judgement?

Bias is pervasive and as such infuses all of the interactions we have. As dental practitioners, we try our very best to treat all patients as they would wish to be treated. But what about their bias towards us? And bias between clinicians?

Dr Louise Eggleton and Dr Annalene Weston, Dentolegal Consultants at Dental Protection, share their own experiences of bias in the workplace

Louise

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

Annalene

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

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

Louise

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

I have experienced a patient grab and kiss me after I had extracted his tooth. At the time, I remember the patient being so pleased to be out of pain, with the tooth having now been extracted following a previous failed attempt at a different clinic, this was perhaps an impulsive action on the part of the patient. While I do not believe

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

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

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

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

Annalene

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

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

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

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

Bias is broader than gender

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

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

Challenging the challenge of bias

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

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

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

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

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

Infection control audit causes criticism

M r H was an employee dental hygienist working in a busy group practice of six dental practitioners: four dentists, one OHT and himself.

A typical day for Mr H included a full day of patients every 45-50 minutes with a lunch break, providing appointments went to plan. Mr H arrived early each morning to review his patient records prior to commencing treatment for the day, and exited the practice after treating his last patient in the evening. Essentially Mr H spent his day treating patients and authoring contemporaneous notes, while delegating the day-to-day running and, to that end, the infection control compliance requirements to the practice management and practice owner. Mr H viewed himself primarily as a clinician responsible for patient treatment, and trusted that the practice's infection control policies and procedures undertaken were in compliance with the *Dental Board of Australia (DBA) Infection Control Guidelines* and *DBA Code of Conduct*.

Unbeknown to Mr H, a complaint had been made about one of the dentists in the practice. Within certain states of Australia, a complaint can trigger an infection control audit of the practice, regardless of the reason for the initial complaint.

An infection control audit of the premises was undertaken and, regrettably, it identified a number of deficiencies. While Mr H was aware that the audit had taken place, he was unaware of the audit outcome and was not provided with any follow-up information.

To Mr H's surprise each practitioner working within the practice received notification from the regulator a week or so later, advising they were required to attend Section 150 proceedings to determine if any action should be taken, including possible suspension from practice or conditions placed on their registration. A copy of the audit was provided.

The infection control audit identified the following deficiencies:

- Lack of access to two of the four required infection control documents outlined in the *DBA Guidelines*
- No validated process for reprocessing of Nickel-Titanium (Ni-Ti) endodontic files
- Non-compliant instrument packaging and storage of critical extraction instruments
- Incomplete sterilisation log – no record of content for every sterilisation load
- No protocol in place in the event of infection control breach, such as a recall procedure and incident review and assessment.

Following the findings, practitioners were required to submit a written response regarding the audit within three days and attend a hearing shortly after.

Mr H sought advice from Dental Protection, and immediately reviewed his recent CPD log, realising it had been two and a half years since his last infection control update. While there is no specific guidance regarding the frequency of infection control CPD, it is expected an update or refresher course be completed every

two years. Additionally, Mr H reviewed the four required documents outlined in the *DBA Infection Control Guidelines* alongside the *DBA Code of Conduct*, and realised that while the emphasis placed on his clinical treatment was important, so were his responsibilities and duty of care as a health practitioner.

While Mr H viewed his primary role as a clinician, the regulator looked further, measuring the practice's ability to preserve public health and safety in the context of risk minimisation and prevention of infectious disease. In effect Mr H was being held accountable for the deficiencies identified in the audit, and while Mr H, as a dental hygienist, did not complete critical treatment procedures or have direct oversight into processes undertaken in the sterilisation room, the regulator held that the accountability sat with every practitioner in the practice due to the duty of care that governs a practitioner's role. In effect, risk sits with all registered practitioners, irrespective of their division of practice or who holds operational accountability.

During Mr H's practitioner registration renewal he had declared that he was aware of the DBA guidelines on infection control, and by admission indicated he was compliant with these guidelines in his practice. Upon review, Mr H recognised that the *DBA Infection Control Guidelines* were very clear: their application in daily practice is a requirement for all dental practitioners (dentists, dental prosthetists, dental hygienists, dental therapists, dental specialists and oral health therapists). Furthermore, all practitioners are expected to act in accordance with the requirements set in all four documents referred to in Section 1, "Documentation", of the *DBA Infection Control Guidelines*.

During Mr H's hearing he was able to demonstrate his understanding and compliance with *DBA Guidelines on Infection Control* and their application in practice. The practice staff as a collective were able to discuss and action the changes required to rectify the deficiencies identified in the audit, and Mr H was able to speak to these changes in his hearing with the regulator. Mr H was able to prove that he was not a threat to public safety and this was reflected in his knowledge and understanding of the *DBA Infection Control Guidelines*, *DBA Code of Conduct* and his recent completion of CPD. This was further supported by the action taken to address the regulator's concerns. Pleasingly in Mr H's case, no further action was taken, and Mr H determined the experience had reaffirmed his duty of care and responsibilities as a registered dental practitioner. Mr H was able to see this stressful event as a learning opportunity that would inform and guide his future practice.

Learning points

- Practitioners have a duty to ensure the care of their patients is their first concern and to practise safely and effectively.
- Practitioners must ensure the premises in which they practise are in compliance with the Dental Board of Australia infection control guidelines.
- Practitioners cannot delegate their responsibilities or duty of care and must ensure their practice is safe, appropriate and to the standard expected.

Critical content: the risks of auto-templates

Mrs C attended Mr A, an OHT, for an assessment of her periodontal health. Examination revealed generalised pocketing between 3.5 and 5.5mm, with no great pockets. Mrs C had generalised sub gingival calculus deposits, particularly interdentally, and significant bleeding on probing around her lower premolar teeth.

Mr A advised Mrs C of his findings and explained the nature of periodontal disease. He advised she would require debridement over multiple appointments and offered her LA to make the treatment more comfortable.

Mrs C agreed to this, but also requested that Mr A “clean her teeth” on that day, as she had a wedding coming up, and was conscious of her staining and bad breath. Mr A agreed, and undertook a general debridement, not focusing on the sub gingival deposits, but ensuring that the teeth ‘looked good’. Mr A requested the reception team issue Mrs C with an appointment and an estimate. She declined both at the front office.

Regretfully, Mr A did not have time to complete his records at the time, intending to come back later in the day, as he was now running very late. At the end of what had been an arduous day, regretfully it slipped his mind, which meant that the auto-template note was entered as follows:

114: Ultrasonic and hand. Propphy.

This meant that Mr A's assessment was not documented and that critical discussions with Mrs C were missing.

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

- The reason for attendance
- The patient's symptoms
- The special tests undertaken
- Mr A's conversations regarding Mrs C's periodontal health
- The CPITN or probing depths
- The diagnosis
- The treatment plan, including the possible need for LA.

Mrs C went to see another practice around a week later, to enquire about in-office whitening as she wanted her teeth to be as white as possible before the wedding. They undertook a

comprehensive examination and advised Mrs C of the presence of sub gingival calculus deposits. Mrs C had either forgotten that she needed to come back to have the scaling completed, or perhaps never truly understood at the time. The discovery that her “teeth hadn't been cleaned properly” and the new practitioner's reaction to the fact that Mrs C's had ‘just had a clean’ and yet still had so much left to do, prompted her to complain to the regulator.

On this occasion, the regulator chose to meet with Mr A to talk through their concerns. They were clear with him that the reason they were considering disciplinary action, was the seeming inaccuracy of his records. In the absence of accurate notes reflecting what actually happened, Mr A could not defend himself against Mrs C's allegations that he had not assessed her properly, that he had failed to advise her she needed to return to complete the debridement, and that he had discussed her periodontal condition with her at all. His records gave the appearance he had not assessed her or spoken with her, and that he had provided her with inappropriate care.

Pleasingly, the regulator accepted that Mr A had undertaken an appropriate assessment and that he had been denied the opportunity to complete the treatment he had planned – he just couldn't prove it with his notes on the day. They counselled him regarding accurate record-keeping in the future and scheduled a record-keeping audit three months later to ensure that he was meeting the required standard, every time.

Learning points

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

Why communication counts



Master P was a patient at a general dental clinic, though his family were somewhat irregular attenders, and had not been in for their regular maintenance for some time. Unfortunately, Master P lost a filling one weekend and his father subsequently booked an emergency appointment at the clinic to have this addressed.

When Master P arrived at his appointment, Ms L conducted a thorough clinical assessment to assist in formulating a plan on how to address the lost filling and broken tooth. Ms L's examination revealed a significantly broken down deciduous tooth that had lost the previously placed restoration, as well as additional tooth structure. The resultant cavity was subgingival in areas, as well as close to the nerve. In light of the significant breakdown of the tooth, Ms L recommended the two options of either extraction, or a restoration that would allow the tooth to stay in place. This would maintain the space until such a time as the area could be assessed for the long-term options available for Master P.

Ms L explained the findings and options available to Master P and his father. Master P indicated that he would prefer not to have an extraction and alternatively they elected to place a temporary restoration, to maintain the tooth for as long as possible. This treatment was completed without incident and Master P departed his appointment in good spirits.

Unfortunately, subsequent to this appointment, Master P began to experience issues with food packing and on inspection of his mouth his mother noted that the

tooth that had been restored was not the same shape or height as the surrounding teeth. Mrs P was understandably troubled by this in light of the issues Master P was now experiencing, and clearly having not had the information regarding the limitations of treatment for this tooth relayed, proceeded to email a complaint to the practice regarding her concerns on the appropriateness of the treatment Master P had been provided.

The practice received Mrs P's complaint and forwarded this on to Ms L for her to review and respond. Ms L was somewhat surprised by the receipt of this complaint considering the discussions that had taken place and, feeling somewhat hurt in what she perceived as a slight on her clinical skills, responded to Mrs P's complaint with a somewhat brusque email with equal parts "I told your husband this already" and "if only you all came regularly this may not have happened".

As you may likely anticipate, this response did not achieve the resultant de-escalation that Ms L had anticipated, with further upset emails arriving from Mrs P. Consequently, Ms L decided it may be an opportune time to get some advice on how best to proceed and called Dental Protection to discuss their concerns.

Dental Protection assisted Ms L with a further response to Mrs P. In this email, Ms L took the time to explain the situation and the options available in a non-defensive way and in terms that Mrs P understood. Ms L also took the time to convey her genuine concern for the patient and the situation they now found themselves in,

and offered a heartfelt apology, as well as a suggested resolution. In this case an offer of a refund for the temporary restoration was made to enable Mrs P to have Master P's treatment addressed with another practitioner, should they wish to do so.

Ms L was genuinely surprised by Mrs P's response to this letter, which acknowledged the time Ms L had taken to respond a second time, which Mrs P was not anticipating, and politely declined the offered refund. Mrs P advised that what had meant the most to her was that Ms L had not just "fobbed off" her concerns and had taken the time to explain the situation in an open and honest way. Mrs P continued to attend the practice, along with her husband and Master P for their dental care.

Learning points

- Communication matters – not only the content of our communication but also the tone. Though at times difficult, communication with our patients should be genuine, sincere and heartfelt. This lends itself to a more open and meaningful experience that is more inclined to address the heart of the matter and prevent unnecessary escalation.
- Dental Protection can offer advice and support on effective communication with our patients. Please do take the time to access helpful resources on our online learning platform, Prism.

Dental
Protection



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for you

Rain, hail
or shine.

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dentalprotection.org.au

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Contacts

You can contact Dental Protection
for assistance dentalprotection.org.au

Membership Services

Telephone 1800 444 542

Dentolegal advice

Telephone 1800 444 542

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