

STARTING WORK IN A NEW PRACTICE



CONTINUUM SERIES – AUSTRALIA

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OVERVIEW

DPL's Continuum series of Advice Booklets forms part of our commitment to assist and support members every step of the way from student to graduate, from the early years of professional life on to safely negotiating the many challenges that can arise at critical moments throughout a professional career, and helping them through to a happy and worry-free retirement (and beyond). In particular we aim to make members aware of the dento-legal pitfalls associated with all these critical moments, so that they are more able to cope with them at a personal level and to manage them safely and successfully in a professional sense

1.0 INTRODUCTION – DIFFERENT SCENARIOS

There are many situations in a professional career where we might move into a new and sometimes unfamiliar environment. In any walk of life people move home, change jobs, and sometimes have a huge amount of change all at once when they perhaps relocate to another part of the country – or even, to a different country altogether.

Starting work in a new practice is something that happens to the overwhelming majority of dental practitioners at some stage or another during their professional career. For some it happens many times during the course of their career, while for others it happens only a few times. In some cases it happens just once or twice – either because they quickly find the practice where they want to remain, or because they decide that their future career lies elsewhere.

In some respects it probably does get easier the more often it happens, but in other respects the challenges tend to be similar. One of the practical difficulties is that, for most practitioners, the first time it happens tends to be quite early in their career when they have little or no previous experience to fall back on, and little time to prepare for what lies ahead.

Your experience when starting work in a new practice, tends to be very different when taking over from a previous practitioner (when you might inherit a ‘list’ of patients, all of whom had been treated by the same practitioner), when compared to the situation where most of the patients you see are new patients to the practice.

Similarly, there is a big difference between starting work in a new practice that you own and operate yourself and doing so in a practice which is owned by somebody else. For most people, the first experience of having that first day in a new practice tends to be in somebody else’s practice and that means that you might feel yourself to have less control over events.

One of the purposes of this advice booklet is to help you to feel (and to be) more able to influence and control events, by gaining a better understanding of them and how they can affect you. It may not be immediately obvious that DPL has a particular interest in this process, because starting work in a new practice can be a particularly risky time from a dentolegal perspective.

As you gain experience it becomes a lot easier to manage at least some of those risks, so the first occasion when you start working in a new practice is a time when you need to be well prepared. This advice booklet is designed to assist you in that preparation, and starts from the moment when you have already chosen the practice where you are going to work, and are getting ready to start.

2.0 STRENGTHS AND WEAKNESSES, OPPORTUNITIES AND THREATS

Starting work in a new practice is an opportunity to gain new experiences, meet new patients, work with new professional colleagues, try different things and hopefully learn and develop in some way. This is just as true whether you have only recently graduated, or whether you have moved to what might be the last place you intend to work before retirement at the end of a long career. This might also affect the way in which you view your new place of work.

CONTRACTS

The time to put an agreement in place is before you start working in a new practice, when goodwill on all sides is hopefully plentiful. This is important whether you are working as self-employed or employed in somebody else's practice, or working as an owner in some kind of expense-sharing arrangement or partnership. Each of these options carries different advantages and drawbacks, challenges and risks and they are beyond the scope of this advice booklet. For some aspects of any or all of these variations on professional working arrangements, it is sensible to take your own legal advice.

AVOID ASSUMPTIONS

In starting work in a new practice, you may also have moved to a new area and if so, it is unwise to make assumptions until you have learned a little more about the locality and the people who live and work there. You may encounter communities which are quite different from those that you might have worked in previously – in terms of language, culture, diet and other considerations. Their dental needs may be different from anything you have seen before, and this may translate into a demand which is greater, reduced or simply different. This in turn may be affected by local socio-economic conditions, whether the practice is located in a business district or a residential area, the average age of the local population, and so on.

Very often the practice staff are the people best able to fill in these information 'gaps' for you – don't be afraid to ask them.

Another form of assumption is that of assuming that things are done in your new working environment in much the same way as in other places where you have worked. This is very rarely the case and it is safer to work on the principle that things will not be the same, unless confirmed otherwise.

GOOD NEWS

When you arrive in a new practice, you have the opportunity to make a fresh start with a new group of patients and new work colleagues. There are no problems with any past treatment and no worries in respect of any patients who are dissatisfied with something that you have done or not done. Quite possibly, problems that you might have experienced in your previous place of work are no longer in evidence either.

BAD NEWS

You are, on the other hand, in somewhat unknown territory. Everything is new and unfamiliar and that in itself can be disorientating and perhaps stressful. As we will see in later sections, there are many risks concealed within this lack of familiarity and they need to be recognised, understood and carefully managed.

In addition to not knowing your way around (this is less of a problem in a small practice), where things are kept, how things work, who does what etc, one may be naturally cautious about appearing too inquisitive or even 'pushy' as soon as you walk into a practice. It may be sensible to ask the practice owner who is the best person to talk to about issues such as this.

Changing the place where you work sometimes happens at the same time as changing the place where you live. While this combination adds to the pressure and slows down the process of adapting to what is possibly a variety of different changes, all of them happening at once, for most of us we are at least still doing the same job – and that is likely to be a lot less stressful than changing your job entirely.

EXPECTATIONS AND PROMISES

Everyone who starts out in a new job has hopes and expectations about how it will turn out. Sometimes these are based upon the wording of a job advertisement or statements made at an interview – they may be firm promises and undertakings, or you may simply have been reading between the lines and making a few hopeful assumptions of your own. Rarely does anything turn out exactly as we had hoped and expected, and reality generally consists of fair bit of what we had been led to expect, mixed in with a combination of a few pleasant surprises and sometimes a few disappointments too.

You don't win many friends by continually focusing on the small niggles, no matter how frustrating they are. Of course it is important to dig your heels in on the really important stuff – like patient safety and anything that impedes the quality of patient care that you can provide. Much depends, of course, on how you raise these concerns and on the relationship you have with the people who own, operate and/or manage the practice – that is, the people who are in a position to put these things right. There is all the more reason to cement these relationships at the earliest possible stage, so that you can fall back upon them if and when the need arises.

This will be discussed at greater length in the sections that follow.

3.0 YOUR NEW WORK COLLEAGUES

Meeting someone at a job interview or having known someone socially beforehand is very different to working together in the same practice. Much depends also upon what kind of relationship you want and need with these colleagues, whether you prefer to keep work separate from your home and social life, and what stage you are at in your professional career.

When arriving in any new place of work, one is quickly conscious of the established relationships between the various other members of the team. Some teams are very welcoming and inclusive, and readily absorb and assimilate new arrivals, but other teams can be more difficult to break into and feel a part of. If you are replacing an outgoing dentist it is inevitable that comparisons will be drawn and it doesn't usually take long before some of these are shared with you.

There is no magic formula to settling into a new team, not least because all teams and the personalities within them are different. But as the new arrival you do need to make an effort and take your share of the responsibility for building these important relationships.

Take an interest in getting to know your new work colleagues, how long they have worked at the practice and any particular roles and responsibilities they have within the practice.

DENTISTS

- What special skills/training and qualifications/areas of expertise do the other dentists have? Is this an opportunity to learn from them?
- Where and when did they graduate? Where else have they worked?
- Do they have any special interests in particular types of dentistry? What is the 'mix' of the patients they treat and the work they tend to do most of?
- Is there any kind of work that they prefer not to do, and/or that they would routinely refer? Do they refer externally or within the practice?

DENTAL NURSES

- Which dental nurse(s) would you be working with? How experienced are they and how long have they worked at the practice? If they are still in training, it is important to check where this training is being obtained and when they are expected to qualify.
- This is often one of the relationships that can have the biggest impact upon your working life at a new practice, so it is worth investing some time and effort into it. Make this a two-way relationship, with plenty of communication, shared understanding and patience on both sides.
- The dental nurse can play a big part in ensuring the safety of your patients – not just in obvious ways like decontamination and infection control, or the way in which they exchange instruments with you, but also in more subtle ways like reminding you about patients who need to be managed differently because of their medical history or current medication, or even (if they were already working at the practice when you arrived) because they know many of the patients and any special challenges that they might present.
- Don't forget that if you decide to make any changes and use dental materials with which you are more comfortable, and different techniques with which you are most familiar (rather than the ones previously used, or perhaps used elsewhere in the practice), this could be a real help to you, but it could also be a giant step into the unknown for your dental nurse. Ensure that they get enough time and training in the use of these new materials / techniques, rather than being left to assume that the materials need to be mixed or used in much the same way – this may not be the case. Wherever possible, have a private 'rehearsal' with no patient present, to avoid potential problems.
- A close and collaborative relationship with a trained and motivated dental nurse can not only enhance the quality of the care you provide, and the experience and satisfaction of the patients concerned, but can also help to keep you safer. One area of great opportunity in this respect relates to record keeping (see references for further information on this).

RECEPTION, ADMINISTRATIVE STAFF AND PRACTICE MANAGER(S)

- These team members can make or break your working day so develop a shared understanding of what kind of a working day you like to have, and why. Time scheduling problems and running late as a result, is known to be directly linked to patient satisfaction, and the risk of complaints and litigation, as well as operator stress and the errors and oversights that can result from working under pressure.
- The communication skills (including telephone skills) of the people at the front desk and on the phone can have a huge impact on your own risks because they can either exacerbate or inflame situations, or help to make them more easily resolved even in situations where things haven't gone to plan.
- The way in which fees, debts and other financial matters are handled, can have a significant impact upon the level of patient satisfaction. If badly handled it can provoke complaints about care and treatment in which you have been involved, that might not otherwise have surfaced at all.
- Similarly, the way in which broken appointments, or patients who arrive late, are handled, can have far-reaching consequences. Taking too relaxed and tolerant an approach does little to discourage these sometimes frustrating, costly and destructive behaviours on the part of patients. But taking too hard a line without due regard to individual circumstances can risk a backlash that could manifest itself in other ways.
- If you do any work which is funded directly or indirectly from government sources, or through insurance schemes, health funds, insurance plans or other such 'third party' arrangements, it is crucial that any staff who might be assisting you in making any associated claims for payment, fully understand how these systems work, what can and cannot be claimed under various circumstances and any rules, terms and conditions that apply. You may be held wholly or partly responsible for any inappropriate claims that are made in your name, even if you delegated this to other team members – so it is up to you to satisfy yourself in this regard.

DENTAL PRACTITIONERS

- You may or may not be working alongside other professional colleagues, but should you be doing so, it goes without saying that it is equally important to get to know them, and build an effective and respectful working relationship with them.
- Setting the parameters for each of these relationships is a matter of sensitive judgement – to what extent should you 'start out as you mean to continue' and to what extent should you avoid 'rocking the boat' and fit in with how anyone else in the practice is using and working with these professional colleagues? In some cases this may be the first time that you have worked so closely alongside this kind of dental practitioner, in which case it makes sense to take things slowly and spend time forming an understanding of how things are done and why, and how well they work for all the parties concerned.
- If you are relatively inexperienced, there are other questions that you may wish to ask yourself. Which of these colleagues could you most readily turn to for assistance if you needed some advice, or if you ran into problems when treating a patient? Here you would be thinking about how approachable and supportive they would be – or how judgmental? – How experienced they were (and in what areas) and how much of the working week they were physically present at the practice.
- The sooner you are able to get to know your new work colleagues, the easier your working day is likely to be.

4.0 YOUR NEW PATIENTS

It may or may not have occurred to you that when you start work in a new practice, your 'day list' of patients will consist of a succession of total strangers. To make matters worse, 'Day two' and 'Week two' will be pretty much the same. Gradually, more of the patients that you see each day will be people you have met before – but this takes time.

Risks of complaints and litigation initiated by patients and family members are strongly influenced by:

- whether or not they like you
- whether or not they think you like them
- whether or not they think you care (enough) about them and/or are (sufficiently) interested in them
- whether or not they trust you and believe that you have their best interests at heart
- how important /special/valued you make them feel.

It has long been recognised that there are particular risks associated with treating patients who we know little or nothing about. It is also well documented that one of our best sources of protection when things go wrong is the ability to draw upon any historic, positive relationship we have built up with a patient. When we start work in a new practice there is no such credit balance on the scoreboard.

There are many reasons why we should be trying to find out as much as possible about our patients before embarking upon any treatment and wherever possible, deferring major or irreversible treatment until we have had time to build up a relationship and mutual understanding with the patient. While this may not always be possible, we should at least always try to make the most productive use of the time at our disposal.

Our lives consist of an endless succession of encounters with people who enter and leave our daily existence on some level or another. Some of these encounters are brief and relatively meaningless while others are enduring and profound. We may remember with fondness and in great detail someone who we haven't seen for decades, but forget someone with whom we interacted only yesterday.

We all know from our personal lives outside dentistry that it takes time to develop a relationship with someone, to understand what makes them tick, their idiosyncrasies and values, qualities and vulnerabilities. Yet we jump into the back of a taxi, knowing little or nothing about the person behind the wheel, and quite literally place our life in their hands. Much of healthcare is founded upon that same kind of blind trust and confidence, mitigated only by the knowledge that someone, somewhere has vouched for the fact that the healthcare professional is trained and competent in the relevant branch of healthcare. To that extent at least, the patient is in a better position than we are ; just as the taxi driver has no idea who is jumping into the back of the cab, we start out knowing much less about the patient than the patient knows about us.

It is worth bearing in mind that we owe the patient precisely the same duty of care, whether we are seeing them for the first time or the hundredth time. At one extreme the danger lies in how little we know about the patient, while at the other extreme the danger is that we may think we know and understand the patient a lot better than is actually the case.

The legal onus will always be upon the clinician to exercise a reasonable degree of skill and care, and if it can be shown that the clinician failed to do so in some material respect, and as a result the patient suffered avoidable harm, then the necessary ingredients are present for a successful negligence claim against the clinician in question.

It is interesting to note that many such claims are known to arise out of the first course of treatment provided to a patient by a particular clinician, and we will shortly be considering why this might be so.

CONSENT (CAPACITY, MATERIAL RISKS)

When meeting a patient for the first time, the clinician needs to make a judgement about the patient's competence and capacity to exercise their autonomy and free will in making decisions about their dental care. This can be difficult enough when treating longstanding patients and is fraught with problems and risks when dealing with patients about whom we know very little. In any assessment of capacity there are a number of questions to ask:

- Can the person understand the information being provided?
- Can a person assimilate that information and appreciate its significance?
- Can the person weigh up alternative options in a balanced and rational fashion?
- Can the person make a decision?
- Can the person communicate that decision in a clear and unambiguous way?

Your patient may not share the same first language as you, and even if s/he does, the words, phrases and 'jargon' you use may create a further barrier to effective communication and mutual understanding.

Because of our scientific training and clinical knowledge and experience, we may find something perfectly simple to understand, while many of our patients who have never had such a background, may find it obscure and impossible to understand. On other occasions the sense is clear to your patient, but the relevance and application to his/her own personal situation is not. When we start work in a new practice, every patient is a mystery as yet unrevealed to us – and therein lies both the challenge, and the risk.

Another challenging aspect of the consent process when dealing with patients that we have only known for a short time, is that of deciding how much information we need to provide, and in what terms, in order for the patient's consent to be valid. From a dentolegal perspective, one of the most important requirements is the duty to warn each patient of possible limitations of treatment, and potential risks and complications. In doing so, we need to make another difficult assessment of what risks they might need to be made aware of.

This question was conveniently described in a landmark Australian High Court decision in 1992 (*Rogers v Whitaker* 67 ALJR 47) in which the judgment stated:

A risk is 'material' if in the circumstances of the particular case, a reasonable person in the patient's position, if warned of the risk, would be likely to attach significance to it, or if the medical practitioner is or should reasonably be aware that the particular patient, if warned of the risk, would be likely to attach significance to it.

Similarly, consent cannot be said to be adequately informed if your patient misunderstands the information, perhaps because of the words you used, or the way in which you imparted the information. At the beginning of the consent process, you as the clinician have the advantage of knowing much more than your patient does, about what the procedure involves, about its risks, benefits, limitations, about alternatives and how they compare in each of these respects and also in terms of relative costs.

On the other hand, you may also be at a similar disadvantage in knowing relatively little about your patient, and his/her life and personal circumstances. Meeting a complete stranger is never an ideal starting point for carrying out any clinical procedure, but it is inviting disaster when contemplating any procedure that carries significant risks for the patient.

You must therefore ask the patient the right questions in the right way, at the right time, and you will need to listen carefully to their responses, in order to gain an insight into any additional information that this particular, individual might require in order to decide whether or not to proceed with treatment. Any failure on your part to elicit this information, if it could be material to your patient making a decision, is more likely to be used to criticise you, than to criticise your patient for not having volunteered the information without prompting. After all, your patient may not understand why the information is even relevant, let alone important.

It will be obvious from the above that the less you know about your patient, the greater the risk that you leave yourself vulnerable to challenge in the consent process. For as long as your patient remains a relative stranger, the chances of you stumbling by chance upon the very information that has the greatest importance for them, are slender indeed. This underlines the wisdom of doing as little treatment as possible in the early stages, while trying to find out as much as possible about your patient and proactively building up a relationship based on an insight.

PAST EXPERIENCE

In section one, we discussed the important difference between seeing a new patient to the practice, on the one hand, and a patient who has attended the practice before, but has been treated by another practitioner. There are two further important differences that you need to be aware of:

- Whether that previous practitioner has since left the practice, or is still working at the practice
- How long the patient has been attending the practice.

You may find yourself having to comment upon treatment provided (or not provided) by a previous clinician and it will be self-evident that these conversations may be made more difficult according to the answers to the above questions. A separate advice booklet in this series provides guidance on how best to manage these sometimes awkward and sensitive situations.

When meeting a new patient to the practice for the first time, a sensible strategy is to ask them why they have decided to change their dental practice. You probably don't need (or want) to know the identity of that previous practice, but it is invaluable to know if that practitioner or a member of that practice's staff, did something (or failed to do something) that was sufficient for this patient to leave them and look elsewhere. If nothing else, you can take steps to ensure that you don't make the same mistake.

For some patients the change of practitioner has been enforced by another clinician retiring or leaving a practice, or moving to a different area, and the patient may have been very happy with the previous clinician and perhaps even nervous about seeing you for the first time. In these situations it is also worth asking the patient what they particularly liked about their previous practitioner – this can be a useful pointer as to the patient's preferences and can help to speed up the development of your own rapport with the patient.

PATIENT EXPECTATIONS

Time invested at the outset in establishing the extent of the patient's expectations is almost always likely to be rewarded. Many complaints and claims result from treatment failing to meet the patient's expectations, and in many of these cases the problem can be traced back not to any deficiencies in the treatment itself, but to a failure to manage those expectations and keep them within the realms of the possible and achievable.

A revealing exercise is often to ask the patient (using 'open' questions that cannot be answered with a simple 'yes' or 'no') what they are hoping and expecting the treatment to achieve for them. This then creates a natural opportunity to correct any unrealistic expectations before starting treatment.

THE NATURE OF RAPPORT

Rapport (from a common French and Latin root meaning a close relationship or connection, especially of a harmonious or sympathetic nature) has been shown in many studies to be an essential prerequisite of a successful patient-clinician relationship in healthcare. The intimate physical relationship involved in healthcare raises the stakes in that patients feel safer and more comfortable and confident when they are satisfied that the person treating them is interested in them at a human level ('engagement'), and has their best interests at heart.

We can speed up the establishment of rapport with our patients by making it a conscious, deliberate process and central to this is a technique known as active listening. This is discussed in more detail in a separate advice booklet in this series, which discusses communication skills.

Many studies have demonstrated a close correlation between the ability of healthcare professionals to communicate effectively, and the likelihood of them facing complaints or of being sued.

Prominent amongst these studies is the work of Dr Gerald Hickson, who highlighted differences in the attitudes and behaviour of doctors (in his original research, obstetricians) in the US who had never been sued, and those who had been sued frequently. The most significant differentiating feature between these groups was not the actual treatment provided, but the way in which it was delivered. The perceived characteristics of doctors who were most likely to be sued were:

- An unwillingness to listen
- An appearance of not having sufficient time for their patients, or of being rushed
- An impression of detachment, disinterest or lack of respect for the patient
- Perceived lack of care and concern
- No 'small talk'
- Any sense of arrogance on the part of the clinician.

This perception on the part of a patient, that a clinician is rushed and/or not listening, can arise for a variety of reasons. Interrupting patients when they are trying to tell their story is the surest way to give them the impression that you haven't got time for them, are trying to rush their consultations and are not really interested in what they have to say.

Critical factors include:

- How long you let patients speak without interrupting them (especially at the start of a consultation)
- How often you interrupt them
- The way in which you interrupt them
- If you look as if you are about to interrupt them or are waiting for an opportunity to do so.

Rhoades, McFarland and Finch, and other researchers, have highlighted a disturbing tendency for clinicians to interrupt patients surprisingly early in the patient's attempt to tell their story – the first interruption typically occurring after as little as 12 seconds and often within 8 seconds in a study which spanned both medical GP practice and hospital interns. 25% of the interruptions were of the most damaging kind – talking 'over' the patient. In other words, the clinician started talking before the patient has finished talking. Male clinicians were found to be more likely to interrupt than female clinicians, but female patients were more likely to be interrupted than male patients, irrespective of the sex of the clinician.

Wendy Levinson and Debra Roter's study in the US reviewed 1,200 audiotapes of consultations by 120 clinicians in Colorado and Oregon – 10 consultations each, roughly half family practitioners and half general and orthopaedic surgeons. A clinician's tone of voice and the extent, to which they allow patients to speak without interruptions, has a huge impact on the likelihood of being sued. When you meet a patient for the first time – as you will regularly be doing when you start working in a new practice – they need to be given time to get to know you, just as you need time to get to know them. The more you seem to rushing this process, the greater the risks become.

Another useful insight comes from the work of **Robert Bunting** and others, who found that many complaints are triggered not just by the actual event(s) that tipped the patient over the edge into complaining (the 'precipitating factors') – like an adverse clinical outcome of some kind - but also because other things had already happened (the 'predisposing factors') to create doubts and concerns. These precipitating factors included poor communication, a perceived lack of interest, rudeness or a lack of respect – in short, 'people' stuff.

In isolation, neither predisposing factors nor precipitating factors are generally sufficient to make a patient complain – it is the combination of the two that motivates the patient to take things further. Good communication creates a better and stronger relationship between patient and clinician. Other dental team members can enhance (or detract from) this relationship, or help to compensate for less-than-ideal communication skills on the part of the clinician.

5.0 YOUR NEW WORKING ENVIRONMENT

Many aspects of your new working environment can be important in terms of how easy it is to settle in, and work safely to your maximum potential.

THE PHYSICAL ENVIRONMENT

The layout of a treatment area makes a big difference to how easy or how difficult it is to work effectively – for every clinician, but especially for clinicians who are left handed as most surgeries are designed for right-handed operators. You never really know how things will work out until you start work but sitting in the surgery and familiarising yourself with the physical layout is a sensible preliminary step, before you see your first patient. Think also about:

- Its accessibility. How easy is it for children, the elderly, or the physically impaired to reach from the reception / waiting area?
- The lighting, heating and ventilation – which may be an important factor at different times of day, or different times of the year.
- The design of the cabinetry and work surfaces.
- The flooring and cabling. Is there sufficient free floor space to administer CPR in the event of a medical emergency? Does any cabling or ducting create an obstruction or hazard?

EQUIPMENT, FIXTURES AND FITTINGS, INSTRUMENTS

Even ‘state of the art’ dental surgeries take a bit of getting used to. Any clinician will know how much more difficult even the simplest and most routine of procedures can become, when having to carry them out in an unfamiliar environment.

Dentistry is very reliant upon equipment and instruments, and because the range of designs is almost endless, a number of questions arise. Simple questions like where x-rays and other forms of image can be taken, whether they are created digitally or need to be processed chemically, and what other special pieces of equipment are available (where are they stored and are they shared between two or more surgeries?). What emergency drugs and equipment are available and where are they physically stored?

And then more practical questions like the design of the dental chair and operator stools, the type of dental instrumentation unit, where it is situated and how reliable it is. Leading on from this, how and where instruments are re-processed and stored.

Some clinicians will have particular needs which require specific instrumentation and equipment, but most clinicians have their individual preferences, whatever the mix of the treatment they provide.

DENTAL MATERIALS

The quality of the treatment you provide is likely to suffer if you are suddenly confronted with having to use a lot of materials that you have never used before. Mixing requirements, handling characteristics, setting time and other key features can all be very different, and this can take some getting used to. See also comments at section 3.0 – Dental nurses.

But on the plus side, you may discover that you much prefer these new materials to those that you had been using previously.

INFORMATION TECHNOLOGY

Practices tend to be computerised to varying degrees and for different purposes, and there is of course a wide variation in the design and functionality of different IT systems anyway. It is important to familiarise yourself with the system(s) in use in your new practice, especially if this is the primary means of creating, and the central archive for your clinical records. If entries made on your behalf need an identifier of some kind (eg, a Password or PIN number), think carefully about who would have access to this and what it would be used for, because you could well be held responsible for – and accountable for – these entries even if they are made without your knowledge.

Each design of computer software has its own strengths and weaknesses in dentolegal terms. Crucial elements for your own protection include:

- A robust audit trail so that third parties (such as Dental Councils/Boards and courts of law) can be satisfied as to the integrity and authenticity of the records.
- The automatic dating of entries so when changes/amendments/additions are made, it is clear when they were made (and ideally, by whom) rather than allowing entries to be deleted or modified retrospectively while appearing to be contemporaneous (ie, made at the time they purport to have been).
- Adequate protections and controls regarding over-writing, ie, balancing the need to have current, up to date information readily accessible, without losing the ability to see the equivalent historic information, ie, the situation as it existed at previous moments in time.
- The integration of all records relating to an individual patient – ideally a single point of storage of all personal details, information regarding past appointments attended/cancelled/missed and treatment recommended and provided, images of all kinds (x-rays, photographs), correspondence with the patient, professional colleagues and others, financial details and so on.

Dental Protection has published a variety of articles and risk management modules on these and related subjects (see references at the end of this advice booklet).

Find out whether or not you need to register with an Information (Data Protection/Privacy) regulator as an originator and processor of personal data. This varies from one country to another and the regulations also change from time to time.

OTHER WORKING SYSTEMS AND PROCESSES AND PRACTICE POLICIES

Every practice develops a tapestry of different systems and processes, some of which work better than others. Appointment systems and patient recall systems, stock control systems, equipment maintenance and servicing systems, internal communication (phone) systems, and then a host of other daily, weekly or monthly 'routines' that are followed. You may discover systems that make no logical sense to you at all, and sometimes the other team members have no idea as to why things are done that way either – other than the fact that things have always been done that way. Find out what is expected of you in terms of using and adhering to these systems and policies and don't be afraid to ask if something doesn't make sense.

DECONTAMINATION AND INFECTION CONTROL

Spend a little time getting to know the practice's infection control policy/protocols and where (and by whom) contaminated instruments are reprocessed. Show your concern for the safety and welfare of your dental nurse by checking that he/she is up to date with their personal immunisation protection, has a good understanding of the safe management of sharps and clinical waste, and has a good understanding of infection control principles generally. Let your dental nurse and the other members of the practice team see that you take a responsible and professional approach to these matters, and set the kind of standard that you would like others to follow.

MEDICAL EMERGENCIES

As a new member of the practice team, seek an early opportunity to go through a medical emergency and resuscitation drill with that team so that you are aware of your own role and can satisfy yourself as to the training and skills of others. Find out where emergency drugs and related equipment are kept, and satisfy yourself that any drugs are up to date and a means of delivering them is readily to hand.

Do not simply assume that these important matters are the responsibility of others and have been taken care of.

6.0 YOUR NEW PRACTICE AND YOUR WORK-LIFE BALANCE

FINANCIAL CONSIDERATIONS

Your income can be affected in a variety of different ways, which will be largely influenced by the way in which you are paid. The more dependent your income is upon your personal productivity, the more vulnerable you are to issues such as patient flow and unfilled 'gaps' in your appointment schedule. This may be more of a problem when your arrival represents an additional clinician in a practice (or when starting a new practice or branch practice) than when replacing an outgoing practitioner with a full patient list. The mix of patients you see, and the amount and nature of the treatment they require, may also be very significant.

Even when your time is fully and productively occupied, there may be a delay between the time when you carry out the work, and when you receive payment for it.

Never allow your clinical decisions to be adversely influenced by personal financial considerations.

STRESS

Starting work in a new practice environment can affect people in many different ways ranging from anxiety and fear of the unknown, to exhilaration. There are likely to be frustrations and irritations along the way, and these need to be seen in proper perspective and managed appropriately and proportionately. It is important to appreciate that any situation that stimulates a reaction from you – whether good or bad – is stressful.

The human stress response has a number of predictable components, some being more obvious than others. The primal reaction to threat or stress has been described as a 'fight or flight' response. When we perceive such a threat, this triggers a response which has three components:

- A physiological component – changes occur in our bodily systems over which we have little or no control
- An emotional component – we feel tense and anxious
- A behavioural component – stress impacts upon our performance both intellectually and physically (see overleaf).

The evolutionary increase in human intelligence has enabled men and women to perceive stress in ever more varied and numerous situations; some people have a diminished capacity for adaptation and feel threatened by situations that for others would be trivial and innocuous, particularly in circumstances involving change of an established routine or when meeting a situation for the first time. This perception of threat is an elective decision – in most cases you can decide to treat a given situation as stressful, or not.

But less obviously, any demand for change is a demand for adaptation and by definition can activate our stress response. It is no surprise, therefore, that the upheaval of starting work in a new practice can be stressful, and this in turn can affect our mood, our behaviour and our performance even to the extent of the quality of the care and treatment we provide. And we may not even realise that all this is happening.

MANAGING CHANGE

Individuals vary enormously in their reaction to change, but the emotional component of any individual's response will tend to include features of the four main types of response – Fear, Joy, Anger and Sadness. You may be able to recognise these feelings in yourself, or you might recognise having seen them in others during times of change. The important point to understand is that these emotions are not mutually exclusive and during the process of adjusting to and dealing with change, the same individual may well go through phases where different emotions predominate.

The four main types of response, and some examples of the feelings associated with them, are as follows:

FEAR	JOY	ANGER	SADNESS
Anxiety	Excitement	Temper	Hurt
Worry	Happiness	Frustration	Pain
Tension	Energy	Irritability	Unhappiness
Dread	Positivity	Agitation	Tears
Apprehension	Elation	Obstructiveness	Depression
Uneasiness	Contentment	Bloody-mindedness	Sense of loss
Panic	Goodwill	Negativity	Vulnerability
Sleeplessness	Euphoria	Ill-will	Negativity
Introversion	Talkativeness	Destructiveness	Moodiness
Silence	Hyperactivity	Rudeness	Silence
Absenteeism	Good Humour	Over-reaction	Apathy

It will be seen that some manifestations of different emotions are the same, or similar. And don't forget that your arrival into a practice for the first time represents a change for others as well as for you. You may do things differently, or appear to be questioning or even criticising the status quo – some of the existing members of the practice might take this personally.

Recognising these emotions helps you to identify how individual staff members are dealing with your arrival, or changes that are taking place because of it. Having this 'emotional intelligence' is important during times of change.

No matter what your feelings about life in your new practice environment:

- Give yourself time and space to adjust. Don't overload yourself. Think about your dietary/drinking/smoking/exercise habits and give your body the best chance you can to cope with the change.
- Take active steps to reduce your stress levels (relaxation techniques etc). Exercise is particularly valuable here as it dissipates the biochemical component of the stress response.
- Don't be afraid (or too proud) to seek help and support. Think about who you can turn to and make them aware of any problems that you are facing (a problem shared is a problem halved, as the saying goes). Feeling alone and isolated at times of change makes us less able to cope – recognise when you need an extra level of help and think about who could provide it.
- Regain control to whatever extent you can. Develop positive attitudes, beginning with your own self-esteem. Accentuate the positive and eliminate the negative aspects of yourself and/or your situation.
- Prepare an action plan – what am I going to do about the situation in practical terms? Set yourself priorities and targets, and a realistic and achievable time scale for them.

WORKING HOURS

In a new practice you may find that you will be expected to work different hours from those that you are used to working – perhaps including evenings and weekends. It is important to get this expectation clear from the outset – to what extent are you required to fit in with the core hours of the practice, and to what extent can you depart from this? There is a legitimate point of view that a practice is either open or it isn't, but a practice owner may not be happy to pay staff to work longer hours, or to have somebody working with nobody available to answer the phone, etc.

On the other side of this same coin sits your own requirements – do you need someone on the front desk as well as your dental nurse? Are you expecting the support of another practitioner when working different hours to the rest of the practice?

Some practices work longer days for part of the week, but close the whole practice at other times. Sometimes this is for the purposes of staff training or practice meetings that everybody is required to attend. This may or may not suit your own needs or preferences and these are all issues that require discussion. Similarly, what are the arrangements for emergencies and out-of-hours cover? Are you expected to participate in the provision of this cover, perhaps on a rota basis? If so, how often and how much notice (and choice) would you get?

ADMINISTRATION

Many clinicians view administration as an unwelcome and unproductive chore, and much prefer actually treating patients. The more tedious you find these tasks, the less likely it becomes that you will devote sufficient time and attention to them and you may endlessly procrastinate when faced with them, the result being that important things get forgotten.

Many find that the pressures of a working day are such that there is not enough time to complete all the associated administration during normal working hours, and they tend to do this at the beginning or end of the day, or in the evenings and at weekends. Others try to do it in snatched moments between patients and at what should be a lunchtime rest break.

You need to find a formula that works for you and allows you to complete the necessary tasks to an appropriate standard without overflowing too much into your personal life and breaks during the working day.

Finding yourself in a practice where you have very little administrative support can be a source of frustration and potential vulnerability because key tasks and important details may be overlooked. But there are also dangers in having so much support available that you start leaving it to others to do things that you could and should be taking responsibility for yourself. This is abdication, not delegation and you need to be clear in your mind about what the consequences might be for you personally if administrative errors are made by others. Some such errors carry much greater consequences than others and you should at least make a conscious decision about what you will delegate and what you would prefer to do yourself.

7.0 SUMMARY AND REFERENCES

Starting work in a new dental practice can be an exciting time, but also a challenging one. In this Advice Booklet we have sought to highlight the many ways in which it can introduce additional risks into your professional life, and also to suggest ways to keep these risks to a minimum.

Whether you are working in a practice environment for the first time, or simply moving from one practice to another, there are pitfalls for the unwary and the greatest danger of all is complacency. The early days, weeks and months of starting work in a new practice are a time of heightened risk, and this is an important concept to engage with when starting out.

More detail on other resources available to supplement the contents of this advice booklet is available from dentalprotection.org.

Amongst the other downloads available from the website are:

- Risk Management Module No Clinical records
- Risk Management Module No Computerised records
- Articles from back-issues of Annual Review
- Articles from back-issues of Riskwise/Teamwise
- Managing Risk series – interactive programme on clinical records (via e-learning platform).
- On the Record – Interactive CD programme on record keeping including security issues, electronic records. A 20% discount available to DPL members Available from smile-on.com/dploffer (a preview is available from this site).

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