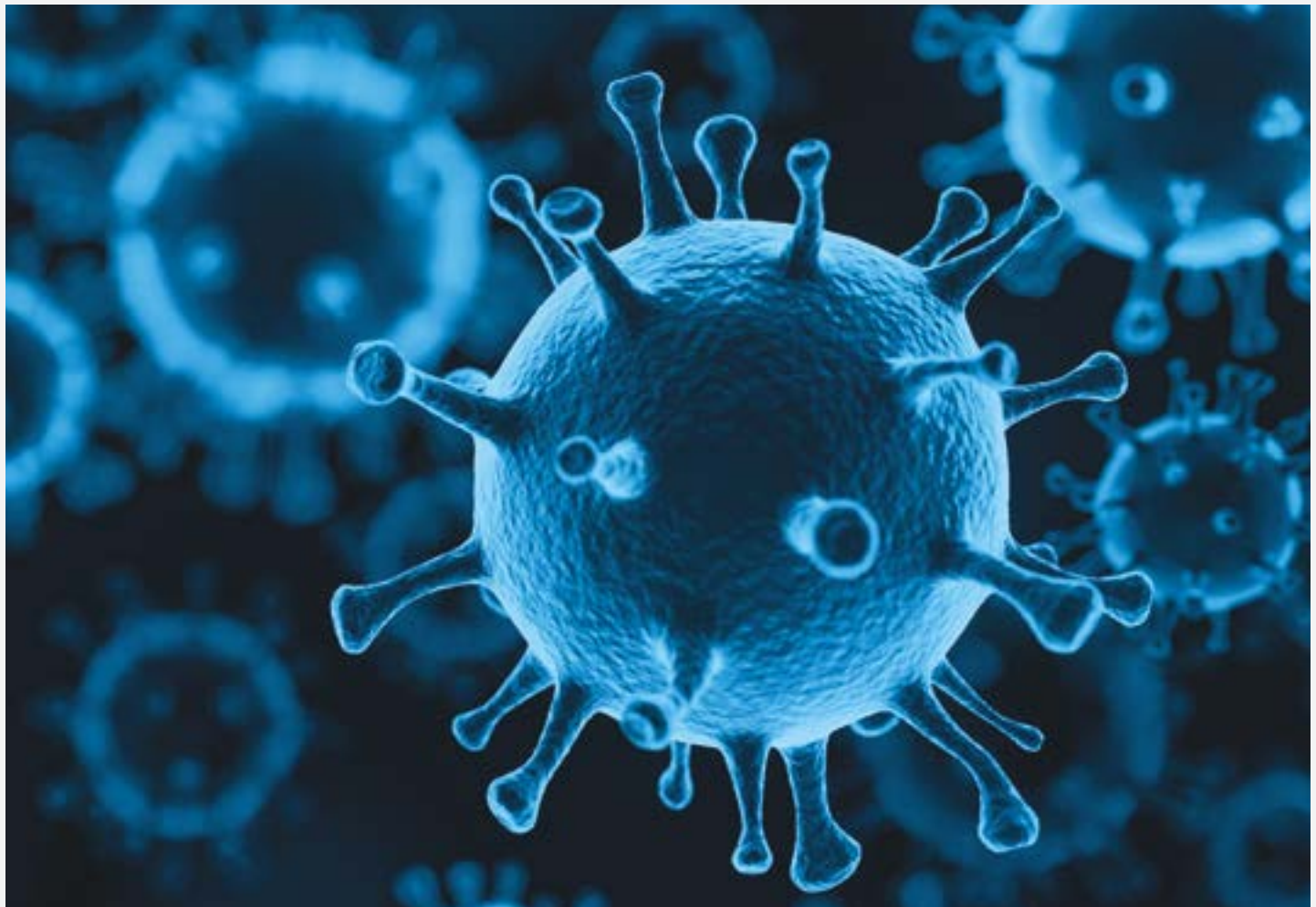




Riskwise

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Australia



COVID-19: the global experience

We look at the pandemic's past, present and future and its impact on dentistry

The road to hell is paved with good intentions

We support a member when AHPRA alleges a breach of restrictions

A review of case law – what can we learn?

A look at two Dental Board cases escalated due to their severity

Caring for the carer: the importance of wellbeing

2020 has been a challenging year – here's why self-care is more important than ever

Editorial

Dr Mike Rutherford

Senior Dentolegal Consultant



“May you live in interesting times.” An English expression incorrectly attributed to a Chinese curse.

It sounds like a fairly benign curse until you get to experience “interesting times” first hand. Not interesting in the way that our grandparents or great grandparents experienced for much of their lives with wartime, depression and no antibiotics; or interesting in the context of those of you who may have come to Australia to escape war, tyranny or famine; but interesting enough nevertheless.

Like many interesting times in history, people are affected in differing proportions for no previously discernible reasons. Many dental practitioners have had their working lives turned upside down, some with little hope of improvement in the foreseeable future; while others have had bumps in the road with an expectation of relative normality on the horizon. Our home lives, and our commitment to children and parents, shape our thoughts and ability to cope as well. Uncertainty about the future as well as the present plays with our sense of normality and our wellbeing. Uncertainty is the big unknown.

In the end everything tends to become normal. I saw a meme yesterday – “The Tiger King part of lockdown seems like a lifetime ago” – and it does, and who out there is still baking their own bread? We have all become the new norm and the uncertainty is part of it.

Soon enough someone will coin a word or phrase to signify this sense of uncertainty in COVID-19 times; and then someone else will coin a phrase to describe how every company, every publication and every institution tells you that they know you are going through tough times and they care. Maybe they do. One positive we are seeing in this uncertainty is that corporations and leaders do feel obliged to recognise people’s anguish. Instead of a gung-ho “we will fight them on the beaches” approach, we are seeing a gentler and more thoughtful recognition that many people will be harmed by these times, beyond the economics and job uncertainty.

Our governments and leadership generally seem to be more cognisant of individual circumstances and hardship. The Australian Dental Association, some indemnifiers and even the banks are taking measures to cater for the specific needs of individuals. There is generally a broader understanding of mental health and acceptance that this is every bit as important as respiratory health – the virus will affect many, but in varying degrees the new demands on our mental health will affect us all. Hopefully, part of this acceptance is an increased willingness for people to recognise they need help, and a willingness to talk about it and seek it out.

The team of dentolegal consultants at Dental Protection are not trained in mental health but they are certainly available to talk to you about concerns you may have with patients, compliance and dentistry issues in general, to hopefully ease some of the burden.

If more appropriate, we can also introduce you to our counselling service, which is operated by trained psychologists and counsellors. This is a confidential and complimentary benefit of membership and is available to all members. PRISM, Dental Protection’s online CPD portal, also has information and a webcast on Building Resilience and Avoiding Burnout – you can access PRISM via the Dental Protection homepage at dentalprotection.org.au

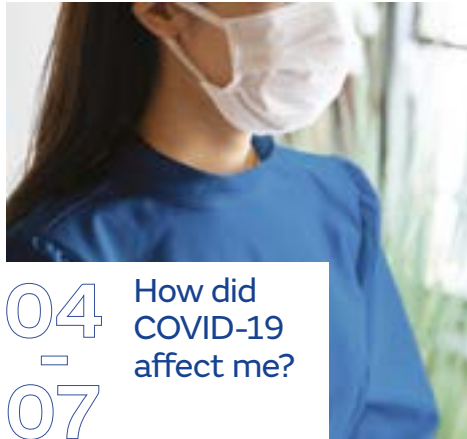
Perhaps we can borrow from NZ Prime Minister Jacinda Ardern’s call out to her people – “be strong, but be kind” – be kind to your family, your patients, your colleagues and also yourself. We don’t all have to learn another language or yoga in our downtime now, we can just simply look after ourselves and those around us.

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How did COVID-19 affect me?

The end of 2019 brought with it many challenges. While our bushfires raged, a new virus was reported further to the north – little did any of us know how these factors would lead to a PPE shortage, isolation and a major impact on patient care. And to loss in general – not just employment.

At Dental Protection, we moved from our offices to our homes, and continued to provide advisory services around the clock. We received an unprecedented number of calls through this time seeking advice and assistance, but most of all people just wanted to talk. And we listened. We listened to stories of hopelessness and helplessness, we walked with you through fear and despair. And with time came stories of hope. Some of our members are willing to share their stories with you too, so we can reflect together on these unprecedented times.

*Dr Annalene Weston, Dentolegal Consultant,
Dental Protection*

Part one - A public dentist

My experience as a public dentist would undoubtedly be very different to those working within the private sector during the COVID-19 pandemic. Throughout March, tensions were starting to build among staff

and a lot of lunchtime talk revolved around COVID-19 and what this would mean for us in life going forward. Mid-March, we received an email that students would not be in clinic until further notice, effective the next day. This shocked a lot of staff, but it was just the beginning. As the days went on, the changes started rolling in. First slowly, and then sometimes at great speed with multiple emails each day from management on new implementations. Some staff became quite stressed and uncomfortable working and chose to take leave, some to be at home with their children as they felt uncomfortable with them being at school.

We started having daily stock monitoring of our PPE, with all PPE being kept in management offices and handed out for the day, then returned and counted. We were advised to conserve PPE supplies but also assured that we had sufficient stock. We were using level 2 surgical masks. Some staff felt this wasn't enough though.

Just before level 3 restrictions came into effect, some staff felt we weren't doing enough to be protected. Many of us were keeping up to date by watching COVID-19 dentistry-related webinars and wondering how we were still running almost as per normal. We were denied anything more

than a level 2 mask, denied the use of gowns or hair nets and it felt like we were lagging behind in still creating aerosols. Management and the dental department reassured us this was sufficient and we were working safely.

Emergency only

The peak of changes coincided with level 3 restrictions in late March when we became emergency only. Thousands of patients were cancelled, and it was 'all hands on deck' to get this done. We had almost daily morning meetings to touch base with management on any new information and advice. Staff who worked at multiple clinics ceased movement and stayed at a base clinic. Some smaller clinics were closed and patients diverted to larger satellite clinics. Staff who were considered vulnerable or high risk due to medical history ceased frontline duties. These staff were placed on other duties, from updating their online learning modules and answering phones to assisting with triaging patients and archiving records. Many staff filled in resumés to prepare for redeployment to other government roles like COVID-19 tracing, but by the time this could be put into action, level 2 restrictions were coming back in and things were winding down. We were never forced to take leave and we were reassured that if we wanted to work, a job would be found for us.

Clinically, we were working very differently under level 3 restrictions: we had a set roster with minimal clinicians working each day and rotating around on a daily basis. We were given face shields to use if we wanted them and implemented hand hygiene for patients upon entering clinical areas and chlorhexidine mouthwash pre-procedurally. I remember the first day working under level 3 restrictions and seeing a patient who I anticipated would be a difficult extraction, with the root likely to break and requiring surgical retrieval. Normally, I would refer to the oral surgery unit; with level 3 restrictions in place this wasn't an option. Starting endodontic treatment wasn't an option either as the decay was subgingival and extending through most of the root of the tooth. I felt lost as to how to help this patient, sending him off with a script for antibiotics and pain relief as instructed by the oral surgery department and advising him we would contact him when we could complete the treatment. I remember feeling at the end of that first day very useless and dejected, not ever thinking that I would be reduced to using ART technique to complete a restoration that I knew was of sub-par quality and feeling like I was failing my patients.

Now we are back to full capacity and trying to get through our long cancellation lists. Some clinics are unable to run at full capacity due to social distancing in the waiting area limiting clinic capacity. We are still only booking one to two weeks in advance and everyone sits far apart in the lunch room, having conversations across the room.

Overall, I am extremely proud to say I work for the government as a dentist, and of the contribution I have been able to make to the community. I appreciate my government position all the more as it has offered me job security to a level I can never have imagined before. I feel quite well supported by management and it has strengthened many of my relationships with my colleagues. I feel we have all encouraged and supported one another throughout this period and it has made us an even stronger team.

Part two - A corporate dental chain #1

As the world declared the COVID-19 crisis a pandemic, the world of dentistry as we know it changed. The dental team became guarded regarding the risks associated with patient care, and we followed intently the early struggles of our medical colleagues as they clamoured to get set for the impact of thousands of patients needing intensive care.

We watched as China, Italy, South Korea, Iran, Spain, the UK and the US succumbed with hospitals struggling under the sheer numbers of patients needing care. As a result one of the things most in need became PPE. Masks of all kinds, gowns, face shields, all were in short supply. It was amazing while

researching guidelines about PPE, to see just how many queries, comments and papers we found about the reuse/sterilisation of masks – both surgical and P2/N95 masks, which are considered single use. Thankfully in Australia, I am not sure it came to this, although there were certainly many questions on this floating around the social media sites.

We did, however, feel the effects of PPE shortages, both physically and in the hip pocket. I don't think anyone was truly prepared for this. With the usual luxury of being able to source PPE readily and within a few days (or overnight if desperate), I expect that not many dental practices here in Oz had abundant supplies in their stores. PPE then became a bit like loo paper, with everyone in healthcare trying to source it and ensure sufficient supplies to last the distance. For dentists, competition with hospitals became evident. Clearly, there was a real need for hospitals treating patients confirmed with COVID-19 to have the necessary PPE. But as more and more information came out about transmission, dentists also started to look for that extra level of PPE, with P2/N95 masks being requested in the event we began to see asymptomatic patients who unknowingly had COVID-19, as the disease spread in the community.

Dealing with the PPE shortage

The battle to secure PPE was real. Normal suppliers started to run low in stock, and there were insufficient supplies being manufactured to cover the world's requirements. Many of the manufacturers in China were impacted by the pandemic itself, and many of the supplies coming into Oz were being directed to government stores in discreet locations as a priority for medical teams. We were fortunate enough to source sufficient Level 2 surgical masks to comply with standard precautions, but we had to put strict protocols in place to ensure that none were wasted. We began to count out the number required in each surgery pending the number of patients to be seen. While additional masks were provided if required, to comply with infection prevention and control protocols, the teams were all conscious that we needed to use them wisely.

P2/N95 masks were also hard to come by. We checked in with many of the regular suppliers and were able to secure small numbers at a time across the centres (one to two boxes). We tried to limit their use to AGPs but understood that if practitioners felt they needed these to feel safe, we would continue to source. We used a number of suppliers and the ADA (which did a great job securing these) to source these box by box. Thankfully Australia did extremely well in flattening the curve and we managed to get by with the few numbers we had.

I think our biggest struggle was, and continues to be, sourcing disposable gowns. These are like gold to find and just as expensive, ranging from \$8-23 per gown (normally about \$3 per gown). We have spent hours on the phone calling every supplier to source these and, again, many of the suppliers have advised that the government have secured these for hospitals. Everything is also "arriving in ten days". The number of times we heard this, only then to be told that delays have occurred and the supplies have been held in Hong Kong, or held in customs in Australia.

As a result of the shortages, the natural consequence of the supply and demand issue is the price of PPE. In a similar vein to the gowns, the P2/N95 masks were anywhere between \$2 and \$6 per mask (although we were quoted up to \$9 per mask). Surgical masks have also increased by 800%. We are no longer paying \$6 to \$10 (or thereabouts) per box of surgical masks, but \$50+ a box. Sadly we are still paying this price, despite shortages easing, as suppliers bring stocks in by air rather than sea. Perhaps, however, given recent events where shipping containers filled with masks have fallen into the sea, this is safest after all.

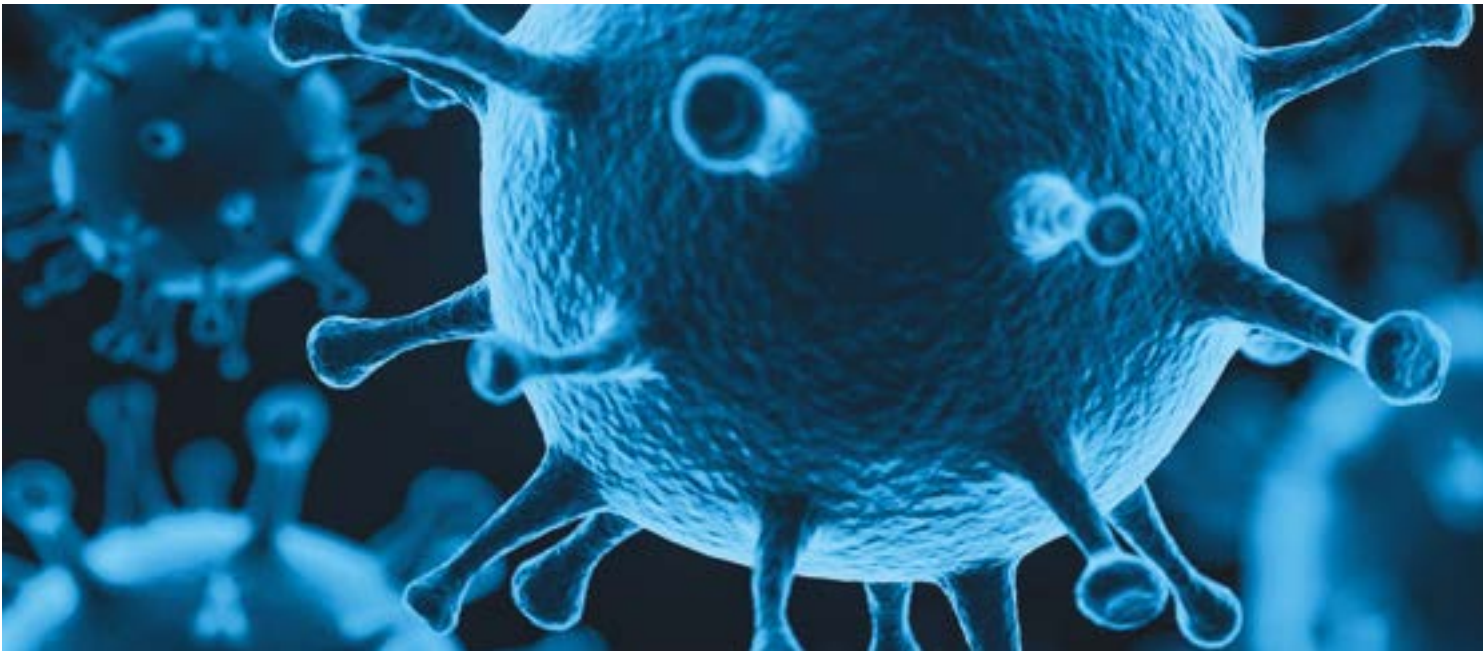
A corporate dental chain #2

As a large employer experiencing challenging times through COVID-19, the announcement of JobKeeper was welcomed. The concept that the federal government would provide a wage subsidy allowing us to keep our employees engaged and employed was pleasing. The implementation, however, hasn't been without its challenges.

Given the significant media coverage about the scheme, employees would often create their own view about the intention or application of the scheme. This was compounded by the timing of the scheme's announcement, prior to the legislation and ATO rules being confirmed.

Assessing and applying the eligibility criteria for over 1,000 employees was a time-consuming process, and it was disappointing to realise how many people did fall outside the eligibility criteria. Naturally, this was devastating to the individuals involved. We did need to rely on the support of our legal partners to assist in this process and ensure we were administering correctly. This of course attracted reasonably material additional legal expenses. Ongoing, we still spend administration time updating the reporting required by the ATO.

Regretfully, we have found that the application of JobKeeper has created some negative sentiment towards us (the employer), especially if the employee was not eligible. These were challenging messages to deliver during times when people were experiencing stressful financial hardship.



For some of our workforce, JobKeeper is more than their ordinary earnings and we have seen some increases in requests for leave without pay and casual employees being less available or declining more shifts than normal. It's difficult to attribute this solely to JobKeeper but it appears to be a key influencing factor.

Nevertheless, despite the challenges we have faced, being able to retain our workforce and provide financial support during a global pandemic has been invaluable.

For our eligible employees, they have experienced a relatively seamless experience of JobKeeper and this has been a positive for them during a difficult time.

Part three - A practice owner

I've owned my clinic for nearly 25 years, and I've seen some good times and bad. But these times, going into the pandemic, were the darkest I have had. You're the boss, so everyone turns to you to lead, and usually that's OK, but this time I had no answers. All of my associates were great, sharing information, sourcing PPE and trying to help me get some sort of sensible plan in place, while the ground kept shifting and turning. One of my associates stepped away from practice at the start of March because they had a young child at home, a decision I completely supported, as it was right for them. Although initially, it left us short.

The restrictions kept escalating, and it became clear that as our cashflow was hit, we couldn't keep paying all the staff. I called Fair Work Australia for some advice, and ultimately I had to stand my staff down. I felt like a dog. Some of them had been with me from the start. Many of them had dependents, or their partners had already lost their jobs. None of them cried, and they

all kept reassuring me and telling me how great I was. I didn't feel great. That night I closed the door, not knowing if or when we would open again, and when I drove home I thought about driving into a wall, as I felt so desperate. Looking back now, I don't know if I really meant it, or if it was an aberrant thought. I talked to my doctor about it though, and he's been great.

And out of nowhere the next day, JobKeeper was announced. I could have kissed ScoMo. I don't excel at paperwork, so I got my accountant to complete all the forms and once I knew everyone was going to be paid, and I could stop worrying about my staff, I could sit down and look at my other obligations. Rent, leases, mortgages. I got all that sorted and then had this weird thing. Free time.

I haven't really had free time before; the business flowed into all my spaces. So at first I slept a lot. And ate a lot too. And then I found my hobbies, and my wife, and my children. I hadn't lost them, I just hadn't really focused on them for so long. I think I was going through the motions. We laughed more and had better times as a family, while the practice was shut, than we had done for years.

I was glad to get back to the practice, we all were, there was a lot of relief, and not just relief my work pants still fitted. I don't know what the future holds, but I have cut back a day, because I have realised that pre-COVID me wasn't as nice a guy as post-COVID me. And I'm not going back to being him.

Part four - A private OHT

After over 20 years in the dental industry and not having been unemployed since my first part-time job at age 13, COVID-19 is responsible for me joining the masses (1.2 million jobseekers) in relying on the government for financial assistance.

However, it wasn't just COVID-19, but the fear, stress and panic associated with it, in the emotional business decisions from an employer who was already under stress from the impact of limited PPE at the beginning of the year. This resulted in standing down 19 staff and terminating myself and other colleagues during this pandemic. Unfortunately, the 'dental family' team ideals quickly crumbled into every man for himself.

A hard work ethic and high personal integrity has served me well in always having multiple jobs to ensure I never needed government assistance... even being a single mother or during my university studies.

However, with my vast experience and impeccable employment history the job prospects from a strained dental industry is worrying, and I am now having to look for any position outside my professional qualifications and knowledge to get back into the workforce.

I have remained positive and proactive during the restrictions by undertaking over 40 hours of the free online CPD from generous dental companies and the associations, completed numerous home projects and the spring cleaning we all never get time to achieve. The most valuable factor was being able to slow down and cherish quality time with my son.

Nonetheless, the uncertainty of finding another position in my chosen profession is very worrying, not to mention the underlying financial stresses that accumulates as the time passes without finding employment. Consequently, I am very eager to return to any position in the workforce even if that means another industry.

Part five - A private associate

The past three months have been a thought-provoking and cathartic experience for me. The catalyst was in early March, when I had what I thought was a head cold, and the news of the pandemic was just gaining momentum. The busy group practice where I work one day per week (I am a mother working part-time) was running as normal, but they advised me that due to the impending worldwide crisis, I would need to self-isolate until I could provide them with a clearance certificate from a doctor. I would not be permitted to return unless I could declare that I was not infectious with the coronavirus. My local doctors were not amenable to providing this for me and recommended I attend a hospital testing facility, but would provide a referral; those facilities were not offering to test the public unless you were referred by your GP, or had very specific symptoms. I felt I was going around in circles. Was life meant to be this difficult?

I was mindful at that time that this meant I would experience a period of absence from my clinical role. I accepted this with good grace, while lacking any strong feelings about it initially. I'd been practising for around 25 years, always as a GP dentist to a patient base of families. I'd enjoyed it, but knew it was pretty routine work, which neither excited me nor really depressed me. I wasn't energised by it and would return home after a busy day feeling quite drained and exhausted. I'd shower, eat and then crash out. Then I would contemplate having to do it all again in a week from now.

As the weeks went by, I actually felt like a weight had been lifted off my shoulders. My mood improved and my husband commented to me that I seemed more positive about life in general. I was conscious that I was not missing work, despite being

at home as the pandemic continued and not being able to enjoy a break from work in the customary way. A holiday would have been nice, but I honestly didn't feel it was necessary. Being away from work, even as a one-day commitment, felt like a holiday already. It didn't seem important that I was not earning money. I simply felt free.

During the next month or so, I had the time to reconsider my priorities and whether my work-life balance was correct. I reflected on it during the luxury of quiet times at home, while the kids were doing their school lessons online. I realised it wasn't so much a question of imbalance, for I was only working as a dentist for nine hours a week. It was a much bigger issue – one of work itself, and whether that work still suited me (and me, it). This was despite my patients seeming to love me and having a supportive team environment in the workplace. The realisation, as it crystallised over several weeks, was that I was suffering from burnout. It was as simple as that.

I asked myself why I was persevering at something I no longer enjoyed doing, and I didn't have a good enough answer. I spoke to my husband and explored other part-time work options, ones that might allow me to use some transferable skills (such as customer service, organisational skills, analytical skills and my clinical knowledge of dentistry) in an endeavour to still be in employment. He reassured me that I wouldn't be abandoning my patients if I stepped away from dentistry, perhaps permanently. I'd served my patients well over the years, and it wasn't helpful nor healthy to feel guilty about contemplating a break from caring for them. I accepted that for what it was – permission to look after myself, and care for me, not just others.

I haven't yet succeeded in finding my next role, but I have set my mind firm to leave

practice by the end of this year. COVID-19 has not been a hardship, but rather a blessing for me. It's given me space to experience some much-needed insight. It's allowed me to finally address something that has been weighing down on me for years.

It's also given me enough clarity and conviction to set myself new goals to find true fulfilment. I don't know if what I do next will make me happier, although of course I hope it will. I do know that I could not keep going as I was and pay the emotional price for my dogged perseverance in treating my patients, one week after another.

A part of me feels for all those affected by COVID-19. It's clearly been a harrowing and heart-wrenching experience for those directly afflicted by an awful disease. I really wish they would not have had to pay such a price, as innocents in a global catastrophe.

Perhaps it has touched us all, in great or even little ways, not necessarily in our respiratory health, but in our physical, mental and spiritual wellbeing. Who really knows? What I do know is that I'm really grateful that, even in these dark times, there has been immense good, at least for me.

Caring for the carer: the importance of wellbeing

2020 has been a tough year. As with all challenging times, it can be helpful to view this as an opportunity to take stock of our lives, and see if we can take any steps to reduce our stress.

Dr Kiran Keshwara, Dentolegal Consultant at Dental Protection, explores the issue of caring for ourselves, so we can care for others

You're already running 15 minutes late, and that simple extraction that was meant to take you a maximum of ten minutes has now turned into a surgical. On top of that, the only staff member that has any idea of how to set up the surgical handpiece is busy assisting another clinician – you know it's going to be a long day...

The day ends and you have to write up your referral letters, check your emails and check that you have the lab work for the patients coming in the next day, and when you get home, along with feeding the kids (and yourself), you've signed up to another webinar...

And the next day, the cycle starts again.

Most clinicians can identify aspects of themselves in the description above and have found themselves stressed, frustrated and extremely busy. In being so busy looking after others, many forget to care for themselves.

Clinicians should take time to introspect, and try to identify if they are getting enough sleep, if they feel constantly exhausted or frustrated, and whether they are looking after themselves and, by extension, their relationships.

Self-care is important for everybody – it involves purposefully taking time to care for yourself and pay attention to your needs. It can be both preventative and therapeutic. Self-care involves setting boundaries, maintaining a work-life harmony and building the foundations for better long-term physical, mental and emotional wellbeing. If we care better for ourselves, we will be able to care better for others.

Self-care strategies

There are many things that you can do to practise self-care. It is best to identify what works for you and by making slow and intentional positive changes towards self-care, you can function better and find more enjoyment inside and outside work. While it is natural to want to help and serve others, it is important to put your oxygen mask on first.

Breaks – take regular breaks throughout the day to help you reset and recharge. Make use of your lunch break and use this time to eat healthily and perhaps go for a walk outdoors.

Holidays – many clinicians do not take time off for a number of reasons. For example, they may be self-employed and

so no work means no income, or they are worried that their backlog of patients will increase and there is no-one else there to help them. It may even be the spectre of Imposter Syndrome prevents them from being away from the clinic for the fear that their perceived shortcomings will be exposed to their colleagues through their absence. It is important to give yourself some time away from work as it will allow you to come back recharged and reinvigorated and, ultimately, in a better position to help your patients. While the borders remain closed, don't underestimate the power of a 'staycation' to simply relax and take a break.

Realistic expectations with a good work-life harmony – trying to fit in an extra patient at the end of the day or before lunch can make your day feel much more rushed and stressful. You should identify how long you need for appointments and try not to over-commit yourself. Many clinicians have taken to working part-time and found that this helps significantly with maintaining a healthy work-life balance.

Strong relationships – for most people, their families and friends are important to them. I find spending time with friends and family



members and talking about things outside dentistry is a great way for me to relax, laugh and reduce stress. Everyone needs support from their inner circle, be it family, friends or close colleagues and we should spend time nurturing these relationships. On the other hand, if you find that a relationship is toxic or draining, it would be a good idea to reduce contact with them.

Exercise – this doesn't necessarily mean going to the gym and spending hours on the treadmill or lifting weights. You could play a sport, such as soccer or basketball, or join a dance class. Walking the dog counts too! Exercise can be a great way to relieve stress, practise mindfulness and focus on your enjoyment.

Eating well – eating can be a social activity and trying out a new recipe can help you be more aware of your surroundings and yourself. It is important to take time to eat well and actually enjoy and taste your food, instead of swallowing and gulping in a rush.

Sleep – lack of sleep can cause irritability and tiredness throughout the day. This is a dangerous combination for you and your patients and can lead to increased risk of an

adverse outcome. Setting up a regular sleep routine helps get the mind and body ready for sleep. Practising good sleep hygiene by putting down the phone, avoiding caffeine and intense or stressful TV shows can aid a restful sleep.

Self-compassion – it is common to find that increased awareness of or exposure to negativity surrounding us will lead to us focusing more on the negative aspects of ourselves. We are the most critical of ourselves and always think that we can do better and, while this can be useful, focusing solely on the negatives can have an overall detrimental effect on you and your emotional and mental wellbeing. A good way to manage negative thoughts can be to identify it as a negative thought and consider how these thoughts are impacting you.

Enjoying yourself – simply doing things for no other reason apart from the fact that it brings you joy – this could be anything from playing an instrument, singing, dancing, going for a drive or watching your favourite sports team.

Don't be afraid – don't be afraid to identify negative thoughts, frustrations and stress.

It's OK to talk to your colleagues, GP or other people about this. Look after yourself and make changes for a better you.

Incorporating the above tips all in one go can be overwhelming and can lead to further frustration. Start introducing some of the tips, or others that you think may work for you, and focus on caring for yourself first.

Dental Protection has extensive resources on wellbeing and taking care of yourself. These are all available at dentalprotection.org.au and include:

- Podcast – *Using your third space wisely*
- Webinar – *Under pressure*
- Webinar – *Human error*
- Workshop – *Building resilience and avoiding burnout*

There are other external resources widely available, such as the *Self Care for Dentists* booklet produced by the New Zealand Dental Association,¹ which can help you on the path to introspection and self-care.

References

1. <https://dcnz.org.nz/assets/Uploads/Publications/Self-care-for-dentists-booklet-NZDA-2013.pdf>

A review of case law – what can we learn?

The implications of case law developments can be far-reaching. Here we look at two recent cases and what can be learned from their outcomes



Very few Dental Board matters enter the public arena where they can be viewed by all, as most matters are resolved privately and at low level. Some, however, are escalated into the tribunal and judicial systems due to their severity, and from these there are lessons to learn. Two very different cases, viewed from two different perspectives follow:

Case one: Kirby v Dental Council of NSW [2020] NSWCA 91

When going above and beyond does more harm than good

Reviewed by Mr Anthony Yeung and Mr Mark Doepel, panel lawyers at Sparke Helmore Lawfirm

If a patient or practitioner has concerns about your conduct, one option available to them is to make a complaint. In different states around Australia, there are different complaints handling bodies. In New South Wales, complaints against dental practitioners are handled by a general body called the Health Care Complaints Commission (HCCC) and a specialist body known as the Dental Council of NSW (Council). Whenever a complaint is made, both bodies work together to determine if

the complaint gives rise to a risk to public health and safety.

On 6 August 2015, Dr Green, a dental practitioner, made a complaint to the HCCC when one of his patients disclosed that they had received treatment in the form of Cansema (a banned alternative cancer treatment) for basal cell carcinoma on the nose by Dr Kirby, another dental practitioner.

In his complaint, Dr Green noted that Dr Kirby's treatment was outside the scope of practice of a dental practitioner, and that treatment itself carried considerable risk of metastases – both of which could give rise to a risk to the health and safety of the patient (and thus the public at large).

Upon receiving the complaint, the HCCC sought a response from Dr Kirby. He denied the allegations and asserted that he never treated the patient. However, the HCCC and the Dental Council was concerned by the matter, and so the Dental Council arranged an inspection of the practice that audited Dr Kirby's records and infection control procedures.

On 1 December 2015, a report of the inspection indeed revealed the use of

Cansema as well as unsatisfactory infection control practices. The Dental Council held a hearing on 18 December 2015 (which Dr Kirby chose not to attend). The Council determined that the risks arising from improper use of Cansema and non-compliant infection control practices were serious, and they suspended his registration.

Shortly after, Dr Kirby sought a review of his suspension, which prompted the Council to impose conditions on his registration in the alternative. Dr Kirby, unsatisfied with those conditions, then brought several appeals before different courts and tribunals, ultimately ending up in the NSW Court of Appeal. That appeal was recently rejected, thus confirming the suspension was appropriate.

Learning points

This case serves as a timely reminder for dental practitioners to ensure that they always practise within their scope of training, that they ensure infection control procedures are strictly followed, and that complaints should not be ignored but rather raised with Dental Protection so that we can provide you with appropriate assistance.



Case two: Dental Board of Australia v Trijo [2020] VCAT 558

Dentist suspended after treating women with intellectual disabilities

Reviewed by Dr Annalene Weston,
Dentolegal Consultant at Dental Protection

Some patients are unable to make decisions about their own clinical care and require a substitute decision-maker. Dr Trijo examined and treated five such patients with intellectual disabilities who resided in a Supported Residential Service. These five patients were unable to communicate and required a “responsible person” to make decisions about their medical and dental treatment. The allegations made were that Dr Trijo failed to obtain informed consent, she provided substandard treatment and care, she failed to provide adequate follow up, she adopted inappropriate billing practices and that she failed to maintain adequate clinical records.

When these allegations are unpacked and the cases examined, they reveal non-diagnostic or no x-rays at all, and missed caries and periodontal disease. They also reveal some questionable treatment decisions and a lack of follow up care.

This was further compounded by poor records that do not document everything said and done, making it hard for Dr Trijo to evidence both the discussions and the treatment.

Another issue faced by Dr Trijo was that each patient was billed exactly the same amount, regardless of how much or how little treatment they received, and that this amount corresponded with the maximum amount the Trustee could authorise. Coincidences of this nature are always held up for scrutiny.

This case is further soured by the vulnerable nature of the patients impacted, and the lack of consent from the patients or the appropriate substitute decision makers. This is a core legal and ethical principle, adopted from the United Nations *Convention on the Rights of Persons with Disabilities*:

States Parties recognise that persons with disabilities have the right to the enjoyment of the highest attainable standard of health without discrimination on the basis of disability ... In particular, States Parties shall: ... Require health professionals to provide care of the same quality to persons

*with disability as to others, including on the basis of free and informed consent by, inter alia, raising awareness of the human rights, dignity, autonomy and needs of persons with disabilities through training and the promulgation of ethical standards for public and private health care.*¹

Dr Trijo broadly admitted to the allegations and was found guilty of professional misconduct. She received a reprimand, had conditions placed on her registration that required her to undergo further education in the area of informed consent, and was suspended for three months.

Learning points

The case serves as a reminder regarding the importance of ensuring that valid consent is in place before proceeding with treatment, particularly in patients who lack the capacity to give their own consent. Further, the dental records in this matter were criticised by the tribunal and served to undermine rather than support Dr Trijo's treatment and decision-making.

References

1. Article 25 of the United Nations Convention on the Rights of Persons with Disabilities, New York 13 December 2006

Data breaches: avoiding the screen of death

The digital age has heightened the risks around the safe storage and protection of sensitive data – and dentistry is no different. Dr Simon Parsons, Dentolegal Consultant at Dental Protection, explores the key issues and provides helpful guidance

Calls to Dental Protection for advice regarding practice data corruption or loss are occurring with increased frequency. These have varied in severity. Some have indicated that despite the best efforts of IT experts, all clinical records, including treatment notes, chartings, digital radiographs, scanned referrals and financial records were irretrievable from the server. Regretfully, there have been some circumstances where appropriate backup has not been undertaken, compounding this loss.

Naturally, the members involved have been incredibly distressed as they no longer know who was attending the practice next and what treatment was still planned for any of their patients. Future complaints are possible in the absence of records to defend their care, and many practitioners are unaware of the legal and ethical implications of the data loss and their responsibilities in this area.

Let's review some commonly asked questions from members.

What are my responsibilities around the loss of data?

Our online article "Health privacy and how to report data breaches"¹ has previously discussed the issues relating to any need to report a data loss or breach to regulatory authorities.

The data breach must be assessed on whether the breach is notifiable and needs to be reported to the office of the Australian Information Commissioner (OAIC). This is a critical step – not only are we professionals and should act accordingly, but also the fines for failing to report a notifiable breach are significant.

Whether notifiable to the OAIC or not, it is important to inform all affected patients of the event and your strategy to address data recovery or rebuilding. This can be extremely difficult if there is a total loss of the database. It is wise to ensure this communication indicates whether the patient's data was breached or merely lost; the latter does not pose the same level of risk to affected patients in terms of their privacy and the risk of identity theft.

What recovery strategies are helpful?

It can be helpful to source as much information as possible from affiliated third parties to try to rebuild treatment histories. This can mean contacting health funds, dental laboratories, government agencies (such as Veteran's Affairs, Medicare) and the specialist referral base to see if copies of some of the records can be obtained. There can be limitations on what information such bodies are prepared to provide.

When received, this needs to be manually entered into a new database.

Within the practice, a robust manual system will be needed to create the new dental records. This will include systems to document clinical notes, infection control tracking, new medical histories and patient contact details for every patient and a temporary appointment book. Additionally, future radiographic and study model records would be created in most instances, at no charge.

What must I look for to ensure a robust IT system?

With most practices relying on practice management software and hardware, it is critical that secure offsite backup is in place. This backup should be automated to reduce human dependency and be located sufficiently remote from the practice to make catastrophic loss of all data sources unlikely. If backing up to the cloud rather than a physical drive, ensure all connections are securely encrypted and that the backup provider can demonstrate compliance with Australian Privacy Principles.^{2,3}

As many cloud services do not physically exist within our state, territory or country borders, there is an obligation to ensure that data being transferred is managed in accordance with these regulations.



It is prudent to regularly check the content of backups for the integrity of the data within. Backup drives must be securely stored, encrypted and password protected to minimise the risk of their loss or theft. They should *not* be plugged into a terminal behind a reception desk that might be regularly unmanned throughout the day while staff are assisting in clinical procedures.

Corrupt software can arise in many IT platforms and it is wise to have in place arrangements to keep critical software up to date. Vendors regularly supply patches to fix security and stability issues. A failure to access these updates may leave practice systems vulnerable.

Most practices will have an interface between their software and the internet and it is essential that firewalls, antivirus/malware protection and password protected access is in place for these systems. These should all be updated regularly.

Practices may also wish to appoint a privacy officer role to a member of staff, so that a trusted individual can oversee compliance with privacy and IT security and report any vulnerabilities or breaches to practice owners.

What if I am already doing all this? Is there anything else I should do?

At Dental Protection we recommend you plan for critical eventualities. It is likely that at some point in time your IT systems will go down and often patients will be in treatment at the time. Having a recovery plan in place can be invaluable in these situations and should outline the contact details of hardware and software vendors, backup details/locations, VPNs, ISP arrangements and contingencies (such as how to connect to cloud-based appointment books via secure mobile should the NBN be out of service). Having preprinted dental record templates (odontograms, headings for key consultation/examination findings, common item codes and their prices and so on) can simplify and facilitate the management of patients while systems are being restored.

Finally, it can be helpful to print the next day's daysheet well before the close of business each day, and use it to ensure labwork has arrived, appointments have been confirmed, and antibiotic cover reminders have been given. These are of particular use if you arrive the next day at a practice only to see a blank screen remain when you turn your computer on!

Who said you don't need paper anymore?

Further resources

You can listen to the Dental Protection *RiskBites* podcast *Practical data protection*, available at dentalprotection.org.au

Dental Protection's booklet *The Privacy Act* is also available at www.dentalprotection.org/australia/publications-resources/publications

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1. dentalprotection.org/australia/publications-resources/dentolegal-articles/articles/health-privacy-and-how-to-report-data-breaches
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Case study

The road to hell is paved with good intentions

By *Dr Annalene Weston, Dentolegal Consultant, Dental Protection*

The restrictions placed on the practice of dentistry as a consequence of COVID-19¹ meant that we were unable to provide patients with their usual care. The higher the level of restriction, the more limited the treatments we could provide were, and there can be no doubt that this created many issues for patients and practitioners alike. However, we would hope that these restrictions did address the key objectives of:

- Proportionate, pre-planned response to the possible escalation of COVID-19 based on the evolving community context
- Staged restriction of dental services to reduce transmission risks for COVID-19
- Avoidance of likely burden on medical primary care and emergency services should access to urgent dental care cease.

Many practices offered some services during level 3 restrictions to assist their patient base with urgent care. Dr T worked in one of these practices and attended to a new patient who presented with pain from periodontal disease and a broken tooth. A discussion ensued about the restrictions, and what could and could not be done. Consequently, a temporary filling using the

ART technique was placed. The patient pleaded for more to be done, and ultimately Dr T picked up the ultrasonic scaler to attend to the periodontal concerns, truly believing this to be in the patient's best interests.

Prior to commencing the treatment the patient advised they only had limited funds, and Dr T agreed to carry out all the treatment for those funds only, discounting the fee by 50%, as an act of kindness.

After the patient left, Dr T felt uneasy about breaching the restrictions, but comforted himself that he had helped a patient at their time of need; after all, he had provided a huge discount so had not profited from the treatment. Unbeknown to Dr T, the patient was stood at reception, refusing to pay on the grounds that Dr T was unethical, as he had worked in breach of the restrictions. Somewhat stunned by these allegations, the receptionist waived the debt; the patient left and promptly reported the practitioner to AHPRA for breaching the guidance.

Dr T received a notice from AHPRA regarding this breach, and also a desktop infection control audit. Had Dr T failed to demonstrate adequate knowledge and performance of infection control procedures at the practice, he would have faced immediate suspension.

Dental Protection talked through the matter with Dr T and assisted him both with the desktop review and also his communications with AHPRA. On our advice, Dr T immediately acknowledged to AHPRA that he had shown a significant lapse of judgement in breaching the guidance, and immediately undertook some CPD in ethics. The desktop infection control audit revealed some minor discrepancies of which AHPRA was advised, with immediate steps taken to remedy them. The practice undertook some infection control CPD collectively and Dr T waited for the judgement to come, hoping that this was not the end of his career.

Pleasingly, AHPRA took a very proportionate approach to this matter. Dr T was cautioned for his lapse in judgement, and acknowledgment was made of the effort that he and his practice had put in to ensuring that the requisite standards were met.

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1. [ada.org.au/Campaign/COVID-19/Managing-COVID-19/Practice-Resources/Dental-restriction-Levels/ADA-dental-restriction-levels-in-COVID-19-Publishe.aspx](https://www.ada.org.au/Campaign/COVID-19/Managing-COVID-19/Practice-Resources/Dental-restriction-Levels/ADA-dental-restriction-levels-in-COVID-19-Publishe.aspx)



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Contacts

You can contact Dental Protection for assistance

Membership services

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Dentolegal advice

Telephone 1800 444 542

dentalprotection.org.au

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