[redacted]

Below are some reflections re re-certification that I would be happy to be forwarded for submission.

1. It may be possible for a dentist to be oblivious (ie not "self-aware") of any of their shortcomings (of their competency or health "drift") and to sincerely believe that all is well. If their practice is growing, patients are happy with their care, and no complaints are received, this results in a false sense of security. This dentist will be unaware of where their competency/ies are lacking and will therefore be unlikely to focus the mooted PDA on these areas - a classic case of "you don't know what you don't know". If such a dentist pairs with another dentist who is also not self-aware then what value will their PDAs be in "ensuring" competency ? This would be a case of the "blind leading the blind" and will be a disservice to both patients *and* dentists.

2. Is there value in seeking feedback from dentists/others who have been involved (eg on behalf of DC) over recent years in competence/review/supervision matters to canvass their opinions of specific problem areas that need to be addressed ?

As DC KPI templates/standards will have been used to assess dentists' competencies, might this feedback (eg commonly observed shortcomings) be more objective and therefore assist DC formulate "preventative guidelines" ?

3. The proposed mandatory eye tests should be of value in enhancing patient care as some dentists may under-estimate the status of their own visual acuity/health (regular testing can result in the verdict of "borderline case" - to use opticians' parlance ). How will DC confirm that appropriate/remedial eye-wear adjustments (specific to dental needs) have been implemented and adopted ?

4. Could examples of evidence-based practices (a few examples below) be included in a "best practice" checklist to complement current DC guidelines ? The more specific guidelines are, the more dentists will know what is required of them.

EBD benefits of:

- risk-based caries (CAMBRA / CMS) and periodontal disease management
- Intraoral camera use.
- Protection of adjacent teeth eg fenderwedges/metal strips/other

- caries detector dye
- sectional matrix use, whenever possible for class II composites

- collimators

5. Would/could attendance/completion (within "x" years ?) of relevant/contemporary (or "core" as some jurisdictions describe them) clinical/ hands-on courses eg SMS use, adhesive C&B and administrative DPL workshops be encouraged/mandated ? What do other jurisdictions require ?

6. Would it be more effective/appropriate to include DC KPI / professional standards at the beginning of/throughout re-certification documentation rather than at the end ? This may focus attention with each of the standards' question being asked ?

I believe that as a profession we want the best for our patients. I also believe that dentists are willing and receptive to making the required changes in response to evidence-based criticism - that is delivered in a positive and supportive manner. Even if it takes time, perhaps dentists need to accept such a targeted, robust peer-review process as being a requirement of belonging to a profession ?

This re-certification review process is not an easy one and I wish DC well in devising protocols in which the status quo can be improved upon.

Kind regards
Frederik Dean