Page 2: Your information

Q1

Your details

First name	**Joseph**
Surname	**Antoun**
City/town	[redacted]
Email	[redacted]

Q2 **dentist or dental specialist**

Your submission is in the capacity as

Page 3: Name of company/organisation

Q3 **Respondent skipped this question**

Name of company/organisation

Page 4: Your Person ID number

Q4

Please add your Dental Council Person ID registration number

[redacted]

Page 5: Please provide your feedback by responding to the following question

Q5

Do you support the proposed Supplementary risk management principles for oral health during the COVID-19 pandemic? If you do not support the draft, please share your concerns, reasons for your view, and proposed alternatives if you have any.

No

Q6

Please share any comments you have below:

Thank you for the opportunity to comment on this submission. Some aspects of the draft guidelines are great; however, I have two areas of concern.

First, the definition of a multi-chair practice is ambiguous (and the subsequent implication and rationale for the stand down period). For instance, in an orthodontic setting, an orthodontist may have a practice with either no wall partitions, a small glass partition, or a piece of GIB dividing walls (with possibly some minor air gaps between areas). The clinical processes may very well be identical between all three clinics where the Orthodontist, with the support of his or her auxiliaries, moves between the chairs (whether they have a wall partition or not). I am unsure how a completely open plan clinic with HEPA filters would pose less risk to the public compared to a semi-isolated or fully isolated multi-chair clinic (with possibly more sophisticated air exchange systems). In all honesty, I would have expected the stand down period to be the reverse – higher for these open plan settings with staff, parents, and children sharing one space. I feel that the need for stand-down periods should ultimately be based on objective measures such as ‘air exchange rates’ and ‘negative air pressure systems’ rather than ambiguous terms such as ‘multi-chair’ and ‘single-chair’ rooms.

Second, the current guidelines would practically mean that a large proportion of children may fall into the ‘moderate’ risk category. While the proportion of the population being vaccinated is encouragingly high, there are differences between child and adult populations that need to be considered. Classifying an asymptomatic child who is ineligible for vaccination as being the same as an adult patient who has declined vaccination is hardly fair and will result in inequities in the provision of oral health care which are outside the child or parents’ control. As an orthodontic practice, we see a large proportion of young patients under the age of 12 years who will now require significant stand down periods. Our fear is that these patients, who are currently in the middle of treatment (as well as new patients with urgent treatment needs), will have to withstand significant delays to treatment because of this non-specific and inconsistent approach which places significant constraints on our existing infra-structure.