Dear Council members and clinical advisory group,

Thank you for the opportunity to comment on this proposed standard. I acknowledge the work that has gone into preparing this document. A risk-based approach using current evidence is welcomed. In general, I support these guidelines but I have a couple of points to add to the discussion.

Risk assessment for those aged below 12 years

The standard has taken a blanket approach that children ineligible for the vaccine are by default medium risk. I don't believe this to be the case. Those living in households with vaccinated adults will be lower risk than those children coming from households that are unvaccinated or adults who have remained unvaccinated. Indeed, page 9 of the document seems to make that inference (see my next point).

I propose that for those under 12 the screening questions asks for the vaccination status of the parent or guardian as a proxy.

Exemption for multi-chair clinics

This seems to be a pragmatic attempt to allow certain health services to continue working. I agree with the approach of balancing the risk of providing treatment against the harm done if clinics are unable to provide timely treatment. However, hospital, community and private paediatric clinics that see high volumes of patients aged under twelve in single chair clinics will struggle to provide care for their patients under those conditions. If the risk of treating those aged under twelve is truly the same as that of treating adults assessed as moderate, this approach is unsafe. Conversely, if those aged under twelve are being classed a moderate risk purely on the basis of being unable to be vaccinated then dental care is being restricted unnecessarily. The wording on page nine of the document[1] seems to support the latter hypothesis.

I propose that those aged under 12, whose caregivers are vaccinated are treated as low risk, irrespective of the number of chairs in the clinic.

Screening questions

The third screening question relates to varying symptoms including cough. As a hospital dentist, many of my patients have chronic conditions, including some with long-term respiratory symptoms. As this is a standard rather than a guideline there is little room for practitioner discretion to discount 'normal' symptoms with the current wording of the questions.

I propose that the third screening question is rephrased to differentiate between existing, normal symptoms and new symptoms that have manifested in the previous 14 days.

Stand-down periods

I am confused by the stand-down periods. There does seem to be increasing evidence that the role of AGPs is not as important as previously thought and that coughing and sneezing are more important. Surely then, the amount of virus that can be shed during an appointment would be dependent on the length of time the patient is in the room without a mask, yet the table detailing how long the stand-down period should be focusses purely on mitigating the risk of aerosol from AGPs. I have no proposal to make, but this is clearly an area that needs more research.

Thank you again for the opportunity to provide comment.

Ngā mihi,

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[1] 'Multi chair clinics treating moderate risk patients over the age of 12, must meet the room and stand down requirements as defined in Figure 3.'