Mark Rogers
Acting CEO
DCNZ

Dear Mark

Thanks for the opportunity to provide some feedback. I would comment that the recent "incoming" from DCNZ , and answers to my questions of the staff have been excellent.

Introduction:

Here are a couple of quotes that might be applicable to the proposed Supplementary Risk Management Principles (SRMP).

1) This is really directed at those practitioners that might be resistant to "something new…again".

2) The following could be directed at those who are opposed to the changes, but have not offered alternatives.

"Complaining about a problem without posing a solution is called whining."

~ Teddy Roosevelt

3) Finally, below could be the most important one. It is about principles versus methods.
The quote is paraphrased and modernised for gender neutrality.

"As to methods there may be a million and then some, but principles are few. The person who grasps principles can successfully select their own methods. The person who tries methods, ignoring principles, is sure to have trouble."

Ralph Waldo Emerson:

Comments

1. There is a list of references provided in attachment 2. However there are not always clear links between the guidelines / rules and the evidence based literature. Usually there are superscript numbers for statements that apply to the specific reference. That way there is a transparent pathway for a principle to "why". This would be an excellent way to present the information.

1a For example, I may wish to know why a surgical mask needs to be provided to a patient when they are already wearing one on arrival. Would this act as a disincentive for them to wear their own mask into the building? Is moving the responsibility from the patient to the provider proven to be more effective than the status quo? One reason may be that patients wear all manner of masks and this method would standardise this. It would be good to have an explanation of the principles and the evidence though. Furthermore there could be more specifics about mask protocol (e.g. only removing the mask just before having the procedure and having replacing it during down time and at the end of the procedure).

1b Where would the relevant reference (s) be found indicating that the current protocol regarding short-sleeved gowns is significantly worse than a new one, requiring a landfill mountain of a new and unknown entity, being disposable aprons, to be used? This change is one of methodology without reference to principle or real clarity about effectiveness and utility. I am struggling with the aprons, as you can see. In addition, the supply chain for disposable aprons is scant. Including the principles, the reasons and a link to an actual reference for such a change would be greatly appreciated and could do much to enhance the uptake if we really understood the "why". Given the volume of changes in this document, and the possible absence of evidence (I mean evidence ..not just a paper), then perhaps the gown protocol change and even the provision-of—surgical-masks-to-patients changes could be saved for another day, when more evidence comes to light?

2. Aerosol. For the last 18 months my staff and I have been lead to believe that aerosol is bad and a certain amount of paranoia has arisen amongst the staff as a result. We have done no aerosol since May 2020 however we are talking orthodontics where this is possible. The proposal is a pretty big change of lightening up on aerosol, but with 200 covid cases a day, and so once again the principles could be clarified, with more direct references, like in a scientific paper, rather than just a list that may not inspire transparency. I need to be convinced and so do my staff.

3. Vaccination status. Last month I received an excellent explanation about vaccination and it really helped us to get on with our work and just assume that a) some patients may not be vaccinated and that vaccination is not a silver bullet and the vaccinated can still be at risk to us and others…so just assume all are unvaccinated. I acknowledge the update on this matter provided to me by Andrea Knight on 26-10-21 is now out of date regarding methods, however the principles seem to still be valid regarding vaccination status.

So this is where I wish to question the reversal of two risk categories in level 3, back again to three risk categories. It would be great to see the evidence provided in terms of the actual scientific papers regarding how accurately we can differentiate between "Low and Medium". I am going to have a wild guess and state that some will be treated as "medium" when they are low, and less appealingly, the other way

around. The suggestion would be universal precautions using the "good for one-session" N95 mask, treating everyone as unvaccinated (medium). Moving forward it might be easier (for us) just to assume "medium" and perhaps this might be a comment that could be added as an option, ie it is OK to go OTT.

So really all of the above is indicating a request (with the little time that remains) to improve the packaging (principles, reasons, direct evidence from the literature), rather than stating principles in the heading, only to revert to mostly methods. I hope you all (that is DCNZ exec and staff) don't mind this comment as it is an incredibly big task with not much time reflect and I do acknowledge a shot-gun approach in an attempt to leave us alone for a while. My feeling is that small tweaks every now and then are OK, especially when there is great communication and evidence to support them (See Stephen Hawking above). The idea of creating a "final" document rather than a "living" document that responds to change might not be realistic. Greater clarity (evidence) may result in improved adherence and acceptance among the, shall we say, restless practitioner. To finally answer the big question, I support the changes "IN PRINCIPLE" however strongly suggest REALLY communicating principles and clear links to the evidence, and flag another edit in the near future, rather than a false expectation of no further changes for a while.

Finally is one of monitoring. Dentists are not immune to cutting corners, particularly if no-one is checking. It's the human condition. Are resources likely to go into auditing? If so, perhaps this could be communicated to practitioners, to reward those who are adopting the principles faithfully and perhaps to "encourage the reluctant".

With kind regards

Peter

Peter J. Barwick
BDS (Otago) MSD, Cert Ortho (U. Washington)
ORTHODONTIST