Tēnā koutou,

Thank you for the opportunity to comment on the Draft Sedation Practice Standard 2026. I acknowledge the Dental Council of New Zealand's statutory responsibility to protect the public and the considerable work that has gone into reviewing and modernising this standard, including alignment with contemporary international guidance.

I am responding in my personal capacity as a general dentist in active practice. I am also a member of the New Zealand Society for Sedation in Dentistry (NZSSD) and broadly support the substance of the NZSSD and NZDA submissions. Rather than restating their detailed technical analysis, I offer additional perspective on proportionality, internal consistency, and system-level impacts as they present in day-to-day clinical practice.

Sedation carries inherent risk and requires robust safeguards. That premise is not in dispute. However, regulation is most effective when it is proportionate to demonstrable risk and grounded in the realities of clinical delivery. Several elements of the draft, while well intentioned, appear likely to increase complexity, staffing requirements, and cumulative compliance burden without clear articulation of the specific risk profile or trend these changes are intended to address, or evidence that they will materially improve patient safety.

Pharmacology and internal consistency

The exclusion of IV sedation from the definition of minimal sedation has practical consequences. By definition, this categorisation increases staffing and monitoring requirements for IV sedation regardless of clinical context. Risk, however, is driven primarily by pharmacology, patient factors, and intended depth of sedation rather than route of administration alone. Where route-based categorisation increases compliance cost without demonstrable safety gain, access to care is likely to be affected.

Competence as a graduated, experience-based construct

The draft appropriately emphasises training and professional development. However, formal training and PDP activity are necessary but insufficient proxies for competence. Sedation competence is sustained through repetition, familiarity with protocols, and reflective review of outcomes. A practitioner providing sedation regularly within a defined, audited scope may be more clinically prepared than one who meets credentialing requirements but practises infrequently. A framework that privileges episodic certification over demonstrated experience risks becoming procedural rather than protective.

Cumulative compliance and unintended burden

The proposed introduction of additional logbook and recertification requirements adds to an already substantial compliance framework mandated by DCNZ. While audit and reflection are sound quality-improvement tools, cumulative administrative burden consumes clinical time and resources. Privacy considerations relating to identifiable case logging are not fully addressed, and in the context of regulatory enquiries the volume and complexity of document provision can be considerable. Each additional requirement should therefore be justified by clear and demonstrable safety benefit.

Access, equity, and risk redistribution

Sedation delivery occurs across primary care, specialist, and hospital environments. When regulatory requirements constrain primary-care sedation, demand is displaced rather than eliminated, redistributing risk rather than reducing it. I am increasingly seeing children and financially vulnerable families unable to access specialist sedation for otherwise straightforward procedures. Delayed treatment, untreated disease, and avoidance of care due to cost are themselves adverse outcomes that should be considered within a comprehensive patient safety framework.

By way of illustration, patients are presenting with specialist quotations in the vicinity of $5,000 for relatively simple extractions under IV sedation. I appreciate that hospital facility and overhead costs contribute materially to these figures rather than professional fees alone. Nevertheless, the practical effect is reduced affordability and access. Regulatory settings should avoid inadvertently accelerating this displacement unless clear safety gains are demonstrated. Higher-acuity environments introduce different system and rescue dependencies; standards that do not account for this interaction may unintentionally increase overall system risk.

Conclusion

I support a strong and contemporary sedation safety framework. However, effective regulation must balance public protection with proportionality, access, and system impact. In my view, the final standard should:

- Align staffing and monitoring requirements with pharmacological risk;
- Recognise competence as graduated and experience-based;
- Avoid unnecessary cumulative compliance burden; and
- Consider access, equity, and whole-system consequences alongside procedural risk.

Patient safety is best served by proportionate, evidence-aligned regulation grounded in real-world clinical delivery. Clarity regarding the evidence base and risk profile informing these proposals would assist practitioners to understand the problem being addressed and support proportionate, evidence-aligned implementation of the standard.

Ngā mihi/kind regards,

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Dentist