28 November, 2021

Mark Rodgers
Acting Chief Executive
Dental Council of New Zealand

Dear Mr Rodgers

Please accept my submission for consideration relating to: **Supplementary risk management principles for oral health during the COVID-19 pandemic**

I am Dr Andrea Shepperson, Lead Dentist, PCBU and Independent Contractor working in a Lumino practice in the Auckland CBD. I make this submission as a PCBU, Independent Contractor and Director of Shepperson Dental Ltd, not as a spokesperson for the Lumino Group. I lead a team of 2 dentists and 3 OHT's, with a total staff of 12 in total.

In principle, I support the draft document *Supplementary risk management principles for oral health during the COVID-19 pandemic.* However there are aspects that raise clinical concerns and political questions.

The risk management principles raise key questions in my opinion, that will be foremost in dentist's minds:

1. Should all members of the public have access to AGP, without a risk assessment and how does that risk consider aspects of the HSWA?
2. What is the risk of transmission and subsequent infection to a Dental Healthcare Professional (DHP) from a patient who may be infectious (known or unknown) with COVID-19, including minimum viral load?
3. What are the quantifiable evidence-based measures that distinguish between the risk of transmission from a vaccinated patient and unvaccinated patient? One assumes the government hasn't introduced vaccine mandates and Covid passes if there is no difference?

The reference articles were useful to inform some of these questions and it was reassuring to read the article by Estrich, C.G. et al. (2020) which found that the weighted prevalence of COVID-19 amongst dentists was 0.9%. Among the tested respiratory samples, 3.7% had positive results. This is a low risk, but it isn't no risk.

A subsequent article by Araujo et al (**COVID-2019 among dentists in the United States: A 6-month longitudinal report of accumulative prevalence and incidence. J Am Dent Assoc. 2021 Jun;152(6):425-433**) show that prevalence and incidence rates among dentists continue to be very low in comparison with the population as a whole and with other HCPs.

The Council has acknowledged that oral health services has specific challenges, due to the closeness of oral health care, duration of interaction, and inability for patients to wear a mask during care.

I support the view that oral health practitioners should not refuse to treat those who are unvaccinated. The Council has stated:

<u>Please note: testing or vaccination are not requirements that patients need to meet to access oral health care.</u>

However I do believe that practitioners should be entitled to make a practice-based risk assessment within that context, that considers the HSWA, regional community transmission rates, nature of the treatment and individual clinician and team co-morbidities. That would mean the right to ask patients undertaking AGP who are unvaccinated to have a negative test. It would also allow the right to refuse treatment and arrange referral for patients who are abusive or unwilling to comply with a practice-based risk assessment.

To give an example, our office is in a commercial building on the second floor with lift access, which is also home to Rako Science, IGENZ DNA laboratories and 2 other dental practices. Our practice-based risk assessment determined that 75% of our staff live with vulnerable family members – children under 12, elderly parents with co-morbidities or spouses with co-morbidities. Staff members have faced episodes of depression and anxiety throughout the lockdown period and the return to work.

The team was anxious returning to work at the commencement of Level 3. We elected to request vaccination status from our patients as part of our triage mechanism and risk assessment. Unvaccinated patients who were undertaking AGP are requested to provide a negative test 48 hours prior to their appointment.

Our rationale was:

1. As a PCBU's with obligations to practice safely, we needed to weigh the transmission risk to team members and their families in a city with active community transmission. We deemed the risk of transmission to be higher in the unvaccinated than the vaccinated, in the same way we assume the government has applied the requirement for a vaccine pass to access services in the new framework and has mandated mask wearing and vaccination based on risk of exposure.

   While the Council has reviewed the risk of AGP and decided that the risk is not as high as they thought in L4 and L3, I have not seen evidence to support the minimal viral load that can cause Covid-19. The Council have indicated emerging evidence and a more generally held view among scientists, indicating that the risk attached to dental APGs has been disproportionately high. I consider 'emerging' and 'generally held views' insufficient evidence in the context of other measures and requirements to mitigate risk with contaminated aerosol, such as the implementation of fallow time.

2. Our risk assessment involved not just the transmission risk with Covid19 but also the mental health risk. Under my obligations as a PCBU this is also a consideration.

3. Our contracting dentists could not afford further mental duress and income loss from stand down periods should we have to manage team-based transmission from a patient. We currently do twice weekly surveillance testing to pick up early transmission from either the workplace or community to mitigate the risk of extended business closure.

4. We shared lift access and common areas with pandemic critical healthcare businesses, and did not wish to be the source of transmission for our business neighbours.

The new DCNZ standards indicate a similar categorisation, deeming a vaccinated patient or a patient with a negative test within 72 hours of treatment, as low risk. **I wholeheartedly support this risk assessment** and the proposal for a hierarchy of controls in managing the risk of COVID-19 transmission within our **specific practice setting** to enable care to be provided safely, in a safe environment. **I agree with the proposal** to apply discretion to raise or lower patient risk depending on the results of patient testing, screening, level of community transmission or other relevant risk factors. A negative test within 72 hours has

been added to the low risk category when the Council have indicated that testing or vaccination are not requirements that patients need to meet to access oral health care. It has added confusion for dentists and offers mixed messaging. Either we are testing our unvaccinated patients or not.

In addition, I draw DCNZ's attention to the Ministry of Health Position Statement on routine pre-consultation testing of unvaccinated individuals in healthcare settings, 25 November 2021 Version 2.0 (https://www.health.govt.nz/our-work/diseases-and-conditions/covid-19-novel-coronavirus/covid-19-information-health-professionals/covid-19-advice-all-health-professionals#position)
which states:

"Vaccination status is one of many risk factors for infection and transmission. Unvaccinated patients who contract COVID-19 pose a high risk to themselves and to others. However, there is no evidence that the routine application of an approach incorporating pre consultation testing is justified."

I am uncomfortable with the Ministry's assessment and advice that access to essential services, including healthcare services, will not be restricted based on vaccination status. I believe the statement reflects a medical setting where a consultation is a more common interaction in a GP setting, and a patient continues to wear a mask throughout a consultation. We would like the right to retain the ability to screen patients prior to **AGP treatment**, which we believe presents a ***different risk*** in the dental setting to a **consultation,** despite the Council's assurances.

I also ask the Council the question: Is resourcing and testing capacity driving a political decision to take this view, rather than an ethical or safety stance? Recent media reports signalled that doctors are advising test results are taking 5 days to be delivered due to stress within testing capacity. Our team has had delays of up to 3 days for nasopharyngeal results to be returned. We can get Rako saliva PCR test results on the same day, within 6 hours.

We would like DCNZ to establish the difference in our ability to classify a patient as low risk, by virtue of testing or vaccination, much more clearly in order to mitigate the risk to our teams and have the Ministry of Health provide that distinction in their publicly available guidelines to avoid patient confrontation, abuse and practitioner and staff stress.

To date we have not encountered resistance to our vaccination status requests, and 96% of our patients are vaccinated. Those who are not, are happy to get a test. However some dentists have faced abuse, threats and intimidation. It is essential that the DCNZ balances ambivalent messaging with firmer guidance and consideration of those working daily at the coal face of dentistry.

I therefore **support the view** that the introduction of vaccine certificates/passes has provided some validity to the concept that unvaccinated individuals should be managed differently to individuals who are vaccinated, because of their public health risk. Vaccination status is one of many risk factors for infection and transmission.

I support the Supplementary documents position that the new standard provides for the delivery of care to both vaccinated and unvaccinated patients with risk mitigations. I would ask that testing of unvaccinated patients be a permitted requirement for AGP, as part of that risk mitigation.

I did note a contradiction in the draft. Currently we see both vaccinated and unvaccinated patients for consultations without fallow time and schedule patients back-to-back with standard infection control protocols for surgery turnover. In the Supplementary document

we note that unvaccinated patients, without a negative test, require fallow time irrespective of the procedure which will include a consultation.

I find this confusing and different to L3 protocols and would ask for greater clarity and justification. The draft proposal also seems to highlight a level of risk that isn't then applied to our ability to ask for a negative test prior to AGP in unvaccinated or 'moderate risk' patients. The two conflicting concepts seem out of synch with DCNZ's statements that the risk attached to dental APGs has been disproportionately high and therefore over-rated. If the transmission risk from AGP is not the issue previously thought, why do we have fallow time at all? Clearly, based on the new draft guidelines for fallow time, aerosol still poses a significant risk.

I have attached links to 2 recent articles which address the issue of viral shedding from the oral cavity. Key messages are:

1. Viral shedding often peaks earlier in saliva versus the nasal compartment
2. Viral shedding from the oral cavity may contribute to the high prevalence of pre-symptomatic SARS-CoV-2 transmission
3. Significant degree of compartmentalization between these adjacent but distinct tissue site (oral cavity versus nasal cavity)
4. The durations of both infectious virus shedding and symptoms were significantly reduced in vaccinated individuals compared with unvaccinated individuals. We also observed that breakthrough infections are associated with strong tissue compartmentalization and are only detectable in saliva in some cases.

Links to the articles in Pre-Print are:
https://pubmed.ncbi.nlm.nih.gov/34282424/
https://pubmed.ncbi.nlm.nih.gov/34494028/

These articles highlight the ongoing and unknown risk of AGP to DHP's in my view, particularly from an asymptomatic patient being seen in early stages of the infection.

PPE

I note in the Araujo article cited earlier that:

The level of adherence to enhanced infection control procedures in response to the COVID-19 pandemic continues to be high among US dentists. The low rates of cumulative prevalence (2.6%) and monthly incidence ranging from 0.2% through 1.1% reflect the high level of self-care among dentists. Oral health care is being delivered safely because dentists are showing adherence to a strict protocol for enhanced infection control, which should help protect their patients, their dental team members, and themselves.

Currently our protocols require N95 masks for AGP. The new draft indicates this is not required for low risk patients for any procedure, including AGP. We are also aware of supply chain issues, the cost of obtaining PPE and Ministry demands and requisitioning of PPE in the nationwide pandemic response.

I raise these concerns and ask DCNZ directly if this change to the requirement for N95 masks for AGP in low risk patients is driven by supply chain challenges and public health requisitioning of PPE, rather than safety?

We note that the United States Department of Labor OSHA guidelines for recommended PPE in dentistry recommend both surgical face masks and N95 respirators for aerosol-generating procedures, but indicate an N95 offers more protection to workers (Fig. 1). (https://www.osha.gov/coronavirus/control-prevention/dentistry)

Recommended PPE ensembles for dentistry

Care of patients in areas where community transmission of COVID-19 has subsided in the local area		Care of patients in areas where community transmission of COVID-19 continues in the local area		Care of patients with suspected or confirmed COVID-19, regardless of community transmission of COVID-19 in the local area	
Dental procedures not involving aerosol-generating procedures	*Dental procedures that may or are known to generate aerosols*	*Dental procedures not involving aerosol-generating procedures*	*Dental procedures that may or are known to generate aerosols*	*Dental procedures not involving aerosol-generating procedures*	*Dental procedures that may or are known to generate aerosols*
▪ Work clothing, such as scrubs, lab coat, and/or smock, or a gown ▪ Gloves ▪ Eye protection (e.g., goggles, face shield) ▪ Face mask (e.g., surgical mask,)	▪ Gloves ▪ Gown ▪ Eye protection (e.g., goggles, face shield) ▪ At a minimum, face mask (e.g., surgical mask,) with face shield ▪ NIOSH-certified, disposable N95 filtering facepiece respirator (or better) offers more protection to workers who may encounter asymptomatic or pre-symptomatic patients who can spread COVID-19 or other aerosolizable pathogens†	▪ Work clothing, such as scrubs, lab coat, and/or smock, or a gown ▪ Gloves ▪ Eye protection (e.g., goggles, face shield) ▪ At a minimum, face mask (e.g., surgical mask,)with face shield ▪ NIOSH-certified, disposable N95 filtering facepiece respirator (or better) offers more protection to workers who may encounter asymptomatic or pre-symptomatic patients who can spread COVID-19 or other aerosolizable pathogens†	▪ Gloves ▪ Gown ▪ Eye protection (e.g., goggles, face shield) ▪ NIOSH-certified, disposable N95 filtering facepiece respirator or better†	▪ Gloves ▪ Gown ▪ Eye protection (e.g., goggles, face shield) ▪ NIOSH-certified, disposable N95 filtering facepiece respirator or better†	▪ Gloves ▪ Gown ▪ Eye protection (e.g., goggles, face shield) ▪ NIOSH-certified, disposable N95 filtering facepiece respirator or better†

Figure.1

The Araujo study also commented:

The risk of getting SARS-CoV-2 infection decreases substantially with appropriate PPE use.

An important distinction between dentists and other HCPs is that many medical procedures that do not involve intubation for anesthesia can be performed while a patient is wearing a mask. However, dental procedures universally require patients to be seen unmasked. This highlights the importance of continued use of enhanced PPE, in particular N95 masks, and the need for continued availability and prioritization of such protections for dental HCPs. We observed a minor shift in the use of PPE during the 6-month period of our study, most likely owing to access to the equipment, clinical judgment, schedule planning, and other resources that dentists implemented since practice reopening. Expanded use of N95 masks may be limited by supply shortages and the number of hours each HCP may be exposed to potentially infected patients.

The draft document indicates “at minimum, medical/surgical mask Level IIr” is appropriate for AGP for low risk patients. I have concerns that paves the way for employers of contractors to avoid expenditure and limit access and supply to more costly N95 protection under the guise of DCNZ guidelines. We would prefer wording similar to the OSHA table which states that N95’s would offer more protection to workers who would encounter asymptomatic or pre-symptomatic patients. This is particularly important for our hygienists and Oral Health Therapists will feel particularly vulnerable in the proposed hierarchy of risk. They work with AGP at every session, without an assistant or rubber dam.

Thank you for the opportunity to make a submission.

Kind regards

Dr Andrea Shepperson