

# MDC

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# BULLETIN

## NEW NORMS



## IN DENTAL PRACTICE

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# PRESIDENT'S *Message*



Good wishes to all who celebrated Deepavali and Christmas, and greetings to all dental practitioners.

I am sure the COVID-19 Pandemic and the Conditional Movement Control Order (CMCO) has significantly affected the practice of dentistry in Malaysia in many ways, especially economically. New norms would have also changed the way dentistry is practised in 2020 and in the years to come, until a vaccine becomes widely available.

I would like to take this opportunity to remind dental practitioners that we are still at war. Malaysia is currently experiencing the third wave of the pandemic and everyone has a social obligation to their families, their neighbours, their co-workers, to frontline hospital staff and society at large, to follow the Standard Operating Procedures (SOP) to prevent the spread of this disease. This is especially important now, when interdistrict and interstate travel, except to the Enhanced Conditional Movement Order (EMCO) areas, is allowed.

We cannot afford to let our guard down, we as healthcare professionals have to lead by example. Strictly practise social distancing, wear a mask if you have to go out, avoid crowded or enclosed spaces, take all needed precautions when treating your patients and play your part in curbing the spread of COVID-19. Continue to spread this message to your family, friends and patients.

**Together we can win this COVID-19 war.**

**(TAN SRI DATO' SERI DR. NOOR HISHAM BIN ABDULLAH)**

# From the EDITOR'S DESK



The MDC Editorial Board would like to place on record our congratulations to the Director-General of Health, Malaysia and President of the Malaysian Dental Council, Tan Sri Dr Noor Hisham Abdullah who was conferred the title “Tan Sri” by the Yang di-Pertuan Agong, Al-Sultan Abdullah Ri’ayatuddin Al-Mustafa Billah Shah. May this conferment spur him and his dedicated team to continue to put Malaysia at the forefront in the provision of healthcare services and in their relentless effort to control the transmission of the Coronavirus in Malaysia. We would also like to congratulate Dr. Noormi binti Othman on her appointment as Principal Director of Oral Health, Ministry of Health, Malaysia. In this capacity, she assumed the position of Registrar of the Malaysian Dental Council (MDC). She has previously served as Secretary to the MDC and is therefore very familiar with its workings. She

took office during this challenging period of the COVID-19 Pandemic, which has had a tremendous impact on dental practice. We feature an interview with her in this issue, to get a glimpse of her early life, which has moulded her principles in life and her journey in the dental services.

The year is fast coming to a close. Yet throughout most of the year, our activities have been restricted, due the COVID-19 pandemic. However, life will continue with the need for added precautions being put in place. The new normal is here to stay. It has somewhat shaped the public perception of dental treatment as a possible route of transmission of the Coronavirus, and the way in which we practice dentistry. Every sector of the dental profession has been affected by the pandemic, especially the private sector. This issue of the bulletin features the impact of the Coronavirus on the various dental sectors and the adaptation to the new norm in dental practice. Additionally, the role of the dental profession in the fight against this pandemic is also highlighted through the involvement of our colleagues in the armed forces.

We also feature a disciplinary proceeding, as a reminder to all members about the competency expected of a dental surgeon in the discharge of his duty to his patient. In the event that the standard of care expected is not fulfilled, the dental surgeon will be liable for his actions.

**Stay safe.**

**Dato’ Prof. Dr. Ishak Abdul Razak**

## Getting to know

# DR. NOORMI BINTI OTHMAN

*“Success is not how high you climb, but how you make a positive difference in the world.”- Roy T. Benett*

This is the philosophy by which Dr. Hjh. Noormi binti Othman models her life. “I believe in positivity and surrounding myself with people who uplift me,” she says with a warm smile. She attributes optimism, tenacity and a penchant for hard work as the bed rock of her success.

Born on 21 December 1964, in Alor Setar, Kedah to a petition writer and a home-maker, Dr. Noormi was the youngest of nine children. “I had a modest upbringing,” she says, as she fondly recalls her formative years. “Although my siblings completed school, they didn’t receive a tertiary education and so my mother hoped that I would be the doctor in the family.”

She reveals that her mother played an integral part in those early years, overseeing her homework and meticulously guiding her. “She would compare my grades to the grades of relatives and neighbours, much to my chagrin!” she joked.

It was in secondary school, that Dr. Noormi felt an appreciation for her mother’s dedication towards her. “She gave me the confidence to believe in myself, which in turn gave me the drive I needed to work hard,” she remarks. When asked to describe the qualities that embody a mentor, Dr. Noormi attributes her late mother as the most significant and positive influence in her life, and credits her mother’s unconditional support and encouragement as the reasons for her achievements. “My mother taught me to be steadfast



and to never give up,” she says with affection, “it was not solely through her words but also by her example and by the way she lived her life.”

After secondary school, Dr. Noormi enrolled in Asasi Sains, at the University of Malaya and it was here, in her third semester, that she found her calling. “When I first observed denture and crown fabrication in the dental lab, I was immediately drawn.” Her eyes light up as she recalls her decision to pursue dentistry as a career, “I have always had a passion for art,” she reveals, “to me, dentistry is an amalgamation of art and science and so I knew it was the perfect fit for me”. This pivotal decision would be the start for what was to become an illustrious career, that spanned three decades of public service and that would culminate in her becoming the Principal Director of Oral Health in Malaysia.

After being awarded a Bachelor of Dental Surgery from the University of Malaya in 1988, Dr. Noormi promptly entered the workforce on 1 January 1989, serving at Klinik Pergigian Besar Kuah in Langkawi, Kedah. She then worked at Klinik Pergigian Besar Manong in Kuala Kangsar, Perak, Klinik Pergigian Ampang and Klinik Pergigian Kampung Pandan Dalam in Selangor between 1989 and 2002. “It was a unique experience,” she reminisces, “There were just three of us in our clinic, a dental nurse, a dental assistant and myself.”

Disillusioned with the mundanities of a routine, Dr. Noormi was eager for a change of pace and made the decision to participate in Quality Assurance and Innovation. “After working for over a decade in primary dental facilities, I had a longing for something more,” she reveals. It was through her involvement in Quality Assurance, that she developed an interest in decision and policy making. “I was curious about the inner- workings of the Ministry and I felt that perhaps I could contribute in some way,” she says. She applied for a position at the Oral Health Division, Ministry of Health (at that time the office was located at PWTC, Kuala Lumpur) and was accepted.

“I am truly appreciative of my superiors, they were

patient, gracious and they gave me the opportunity to prove myself – for that I am grateful,” she says.

Upon completion of her Masters, Dr. Noormi excelled in several leadership posts, first serving as the Malaysian Dental Council Secretary from 1 April 2011 to 31 August 2016 and then as the Deputy Director of Health (Dental) in the Federal Territories of Kuala Lumpur and Putrajaya and in Selangor before Upon completion of her Masters, Dr. Noormi excelled in several leadership posts, first serving as the Malaysian Dental Council Secretary from 1 April 2011 to 31 August 2016 and then as the Deputy Director of Health (Dental) in the Federal Territories of Kuala Lumpur and Putrajaya and in Selangor before returning to the Ministry of Health Headquarters. Here, after first serving as the Director of the Division of Policy and Planning, she was appointed as the Principal Director of Oral Health on 2nd April of this year.

“When I accepted this post, I inherited the difficulties associated with the pandemic” she expresses. In the ten months since COVID-19 manifested in Malaysia, our nation has been grappling with a relentless and indiscriminating infectious disease that has cast an atmosphere of fear and anguish



over all sectors. Though this year has been fraught with uncertainty and hardship, Dr. Noormi wants us to stay united in our efforts. “Working together as a team to accomplish a singular goal is often difficult, but I want to instil in all my colleagues a sense of unity and commonality, as I believe that we can conquer any challenge before us, if we work in unition,” she insists.

When asked about the effect of the COVID-19 pandemic on the practice of dentistry, Dr Noormi was confident that it could be overcome. She acknowledges that although the task at hand might seem herculean, she feels that we must put in the effort and work unceasingly towards a common goal.



“Dental professionals are at the front line and are at risk of exposure to SARS CoV-2,” Dr. Noormi states. She understands the immense risk dental practitioners face because certain procedures generate aerosols and exposure to droplets from infected patients can perpetuate transmission. Dr. Noormi strongly urges that aerosol generating procedures (AGP) in dental practice be undertaken with strict adherence to standards of practice, that include, wearing full compliant Personal Protective Equipment (PPE) and ensuring physical distancing, with additional precautionary measures such as the use of high vacuum suction, high efficiency particulate air (HEPA) filtration and extraction hoods.

To better equip dental facilities during the COVID-19 pandemic, the Engineering Service Department was consulted in the development of methods to effectively reduce the transmission of the virus, during inpatient procedures. It was suggested that extra-oral portable suction units be used to reduce aerosol exposure and that ultraviolet germicidal irradiation (UVGI) air filters be used to clean procedural rooms and detoxify clinic surfaces. Dr. Noormi also recommends that each dental chair unit be separated in a room or with partitions on all sides. Additionally, she advises that practitioners ensure procedural rooms have a ventilation system that has the concept of ‘one-way airflow’ and to isolate the air handling unit (AHU) in dental surgeries from other areas or in the facility. Dr. Noormi was careful to add that standard operating procedures (SOP) may change, subject to the latest available evidence-based research and information about the virus. She implores all dental practitioners to abide by the latest Oral Health Programme, Ministry of Health’s guidelines that serve as a guide for the delivery of oral health services after the Movement Control Order (MCO).



“Crises tend to bring about a change in all aspects of service delivery,” Dr. Noormi maintains, and that, as a healthcare workforce, we must embrace these changes, as they contribute to innovations in the field.

“The Ministry of Health has adapted by using ‘Skype for Business’ for virtual meetings,” she

says. “The Oral Health programme is working in collaboration with various divisions in the Ministry of Health and MAMPU to undertake Proof of Concept of Virtual Dental Clinic (VDC) and Online Appointment System (OAS),” she adds. In the future, practitioners may utilize the OAS to make and re-schedule appointments to prevent congestion in dental clinics, thereby curbing the spread of COVID-19. “The OAS provides a convenient option for both dentists and patients,” she notes.

She states that the objectives of the Virtual Dental Clinic (VDC) are, to provide effective personalised dental care advice, guidance for post-operative oral health instructions and oral health prevention modules which include Mouth Self-Examination (MSE) and training in tooth brushing and flossing techniques. She hopes that this will empower Malaysians to have a more active role in their own oral health.

When discussing the limitations brought on by the pandemic, Dr. Noormi anticipates difficulties in achieving adequate Continuing Professional Development (CPD) points. “The Oral Health Professional and Development Section continue to provide training by iCPD on-line, self-learning, group study or distance learning,” she reveals, “Dental practitioners in service are encouraged to register with EPSA (e-Pembelajaran Sektor Awam) which provides online courses”.

Although, the reverberations of COVID-19 can be felt throughout the profession, Dr. Noormi admits that it has had a devastating impact on the private sector. “Private practice contributes to the economic growth of the country.” She reports that as at 31 October 2020, there were a total of 2, 638 active private dental clinics in which, 279 applications to change or shorten operating hours and 395 applications to close clinics during the MCO. “It is disheartening, but we will re-strategize to adjust to this new normal.” She is confident that

there is a way forward and she is determined to find effective solutions with the inclusion of all stakeholders, for the benefit of the profession as a whole.

Dr. Noormi emphasises the importance of a true collaborative effort between the Oral Health Programme and the other sectors in the Ministry of Health. She stresses the significance of dental and medical healthcare professionals working together as a team. “It is our responsibility to empower our communities to take ownership of their health,” she continues.

When referencing her aspirations as the Principal Director, Dr. Noormi wants to foster a change in our approach. It is her conviction that the focus should be on preventative rather than curative treatment. “We need to start young and we must work to help both the paediatric and geriatric populations in our country,” she says, her tone determined. Referencing some national data, Dr Noormi noted that it is crucial to remember that the oral disease burden, particularly caries and periodontal disease, remains high among Malaysians. Based on data retrieved from the National Oral Health Surveys, 71.3% of preschoolers and 84.8% adults have caries (National Oral Health Survey for Pre-School Children or NOHPS, 2015; National Oral Health Survey for Adult or NOHSA, 2010).



The majority of adults in Malaysia (93.9%) have periodontal disease and 99.6% of 12-year-old school children have gingivitis (NOHSA, 2010; National Oral Health Survey for School Children or NOHSS, 2017).

This in turn, reflects the high burden on the oral healthcare system. More than half (63.6%) of preschoolers require restorations, 27.8% require space maintainers (NOHPS, 2015). The majority (99.6%) of 12-year-old schoolchildren require periodontal care and almost a third (32.9%) require treatment for caries (NOHSS, 2017).

With the expansion of Basic Periodontal Examinations (BPE) to our school dental teams, Dr. Noormi believes we will be better able to handle the situation and she hopes to encourage oral health awareness among school children, whilst instilling a sense of responsibility in them. “We need to start young and inculcate good habits,” she says, “my mission is ‘Zero Cavities among toddlers!’” she adds emphatically.

**By**

**Dr. Jade D’Silva**

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**Klinik Pergigian Bandar Botanik**

**Klang, Selangor**

Dr. Noormi is hopeful for the future and encourages the new generation of dentists to believe in their abilities, have a sense of purpose and a love for their career. She advises young professionals to master their clinical acumen and to set clear goals. “Practise and develop your skills before pursuing your further studies,” she suggests, “do not rush into making decisions, remember that hard work pays off.”

She is a firm believer in the importance of being constructive rather than destructive. “Surround yourself with people who inspire you and who bring out the best in you” she asserts.

Dr. Noormi hopes that through her example she inspires a culture of tenacity and perseverance. Her wish is that we see the positive in every situation, believe in our limitless potential and live a life of purpose.

She challenges us to look beyond the horizon and find that beacon of light.

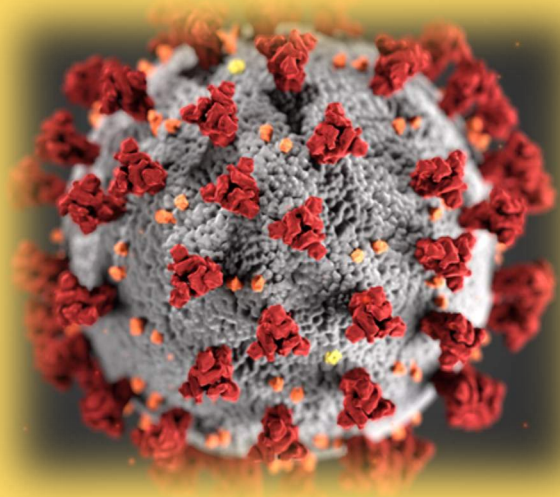
# Oral Health Programme's RESPONSE TO THE COVID-19 PANDEMIC

**C**COVID-19 is an emerging infectious disease caused by a new virus known as the Systemic Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-CoV-2) or the COVID-19 virus. It was first discovered in the province of Wuhan in late December 2019 and the first positive case of COVID-19 in Malaysia was detected on 25 January 2020. On 11 March 2020, the World Health Organization (WHO) declared the spread of COVID-19 a global pandemic. This disease has significantly affected the practise of dentistry worldwide. At this point of time, there is still a lack of scientific evidence for therapy and no vaccine to cure or prevent COVID-19 is available.

The mode of human transmission of the COVID-19 virus is mainly through direct contact with positive COVID-19 individuals, via droplets of saliva when coughing and sneezing. Transmission is also possible between asymptomatic individuals and non-confirmed positive COVID-19 patients as 80% of those infected will only have mild to moderate symptoms. In addition to this, during the incubation period, which can last between 2 to 14 days, the person is infectious.

Although, there is minimal scientific evidence to support airborne transmission of COVID-19, WHO has recommended that strict measures be taken when carrying out aerosol generating procedures (AGPs). Most routine dental treatment involves

AGPs, which produce micro droplets ( $< 5\mu\text{m}$ ) of aerosol mixed with contagious saliva and blood. This includes the use of ultrasonic scalers, air water syringes and high-speed handpieces. Furthermore, the close-contact position between the patient and dentist makes infection more likely.



In view of the risk involved during dental procedures, and in-line with the government effort to curb the infection rate of COVID-19 in the country, the Oral Health Programme (OHP), Ministry of Health decided to treat only emergency cases and temporarily postpone all routine dental care involving AGPs. All community outreach oral healthcare programmes were also postponed, and this includes the School Dental Service programme. The *Garis Panduan Pengendalian Isu-isu Berhubung Penularan Jangkitan Wabak COVID-19 di Perkhidmatan Kesihatan Pergigian* pertaining to handling the COVID-19 pandemic and services delivery in all Ministry of Health dental facilities was first issued on 18 March 2020. Since then the

guideline has been revised and updated three times. During this period screening counters were setup at health / dental facility entry points to ensure all patients are stringently screened for COVID-19 signs and symptoms. Patients were also required to fill up the Health Declaration form. Dental facilities now advise patients to book their appointment slots via phone calls or on-line, instead of the usual walk-in method. Patients' appointments were staggered to reduce the time spent in the dental clinic, with adherence to the Standard Operating Procedure (SOP) of physical distancing. Adult patients are advised to come alone, while children and the elderly can be accompanied by only one adult. Strict adherence to the use of Personal Protective Equipment (PPE), maintenance of hand hygiene and adherence to universal precautions in cross infection control among oral healthcare personnel in their daily clinical routine were also monitored. Regular disinfection of common areas and the dental surgery were also carried out to reduce the risk of transmission.

In response to the government announcement of the Conditional Movement Control Order (CMCO), the OHP on 18 May 2020, issued another guideline – *Garis Panduan Perkhidmatan Kesihatan Pergigian Pasca Perintah Kawalan Pergerakan Pandemik COVID-19 No. 1/2020*. This guideline served as a supplementary to the previous guideline. In this latest guideline, patients' and healthcare workers' safety were still the top priority during oral healthcare delivery. Routine dental care involving AGPs was offered to patients, who were free of COVID-19 signs and symptoms, in a few selected dental clinics, which met the minimum requirements for delivery of AGPs. The minimum requirements include a dedicated dental unit for AGPs, located in an isolated and well-ventilated room/space, equipped with high volume suction, usage of rubber dam whenever deemed needed,

pre-procedural mouthwash rinses and sufficient personal protective equipment (PPE).

The guideline was then further updated as the pandemic situation nationwide improved and came under control. Subsequently the *Garis Panduan Perkhidmatan Kesihatan Pergigian Pasca Perintah Kawalan Pergerakan Pandemik COVID-19 No. 2/2020* was issued on 18 August 2020. In the latest version of the guideline, the oral healthcare service delivery seemed to be more "relaxed", as routine dental treatment, involving AGPs, can now be offered in more dental clinics. The COVID-19 screening procedure for patients was still maintained, while the MySejahtera application for online check-in has replaced the manual Health Declaration form. Outreach programmes are slowly re-opening and the School Dental Service has started as schools begin to reopen gradually.

In addition to the new norms adopted in service delivery, the OHP has also introduced the weekly monitoring of COVID-19 risk exposure among oral healthcare personnel in primary care and specialist care dental facilities during the MCO and CMCO phase. This is aimed at evaluating whether the safety of patients and healthcare personal are strictly monitored during healthcare delivery. As at 30 April 2020, there were 15,413 government dental healthcare personnel that were screened for COVID-19. Out of these only 6 cases (0.04%) were confirmed positive and 424 cases (2.75%) were categorised as persons under investigation (PUI). None of the positive and PUI cases were infected due to non-compliance with SOPs when carrying out dental procedures.

Oral healthcare personnel were also actively involved in activities as part of solidarity with other healthcare personnel. These includes deployment of personnel to help in COVID-19 screening for

high risk groups, deployment as Crisis Preparedness and Response Centres (CPRC) hotline volunteers, making of own PPE (disposable isolation gowns and face shields) and actively creating new innovative equipment to adapt to the new norms.

In conclusion the COVID-19 pandemic has affected the oral healthcare service delivery in government facilities in many ways. Oral healthcare personnel are advised to be extremely cautious, and

to adopt the new norms in their day-to-day clinical dental routine. This is to ensure that the risk of COVID-19 transmission is minimised and controlled in the dental setup. The OHP will continue to upgrade both existing and new dental facilities for preparedness in handling pandemic situations for now and in the future.

**By**

***Dr Azliza binti Dato' Zabha***

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***Oral Health Programme***

***Ministry of Health***

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# Dental Treatment

## *IN THE ERA OF COVID-19*

The COVID-19 pandemic has undoubtedly thrown the world into a state of chaos, fear and unpredictability. Healthcare systems around the world have been stretched to the limit and beyond, with many countries still grappling with just flattening the curve. Malaysia has been vigilant, and considerably lucky, and has managed to stem the rise of cases and resultant deaths, with only single digit new cases recorded and no deaths for over the past 3 weeks (at time of writing). Be that as it may, dental treatment, with its close proximity and exposure to the oral cavity, remains a risk and concern to practitioners. Many of the guidelines, issued by the authorities<sup>1-3</sup>, have been invaluable in elucidating the nitty gritty in dental management of patients from start to end, and this article is not meant to be a facsimile thereof.

I would like to tread a different path, and just focus on certain topics with regard to patient management, which, hopefully, will stimulate discussion and further fine tuning on how we approach this issue.

### 1. Lack of a Practical and Reliable Test

The obvious concern is the asymptomatic patients, as however robust your health declaration form is, it still comes down to patient honesty, which unfortunately is not tangible. Therefore a practical and reliable test will greatly clear up any doubts.

As we are well aware the gold standard test for COVID-19 is the real time reverse transcription polymerase chain reaction (RT-PCR) swab test. At the peak of the pandemic, turnaround time to obtain results stretched up to a week. The rapid test

kit antigen (RTK antigen) test to allow for a quick turnaround time of 45 minutes to 1 hour, made it a more practical test at the outset, but anecdotal evidence has shown that results may take up to half a day. Coupled with the fact that both tests require specialised lab support and the concomitant costs, widespread availability to dental practitioners is a non-starter.

An ideal test would be something akin to the dextrostix to determine blood glucose level or urine pregnancy test that provides an objective and highly specific and sensitive result respectively. This will enable practitioners to triage and risk stratify efficiently, so as to delay treatment of positive cases, while treating negative cases with peace of mind.

### 2. Aerosol Generating Procedures (AGPs) & Infection Control

Airborne transmission is a possibility in specific circumstances and settings in which procedures or treatment that generate aerosols are performed. In the dental setting, 90% of the aerosols produced are extremely small, in fact as small as 5 microns or less<sup>4</sup>. These are produced mainly during procedures which utilise ultrasonic scalers and high speed rotary instruments. However, aerosols in the dental setting have also been associated with the use of low-speed handpieces, air/water syringes, patient coughing, and intraoral radiography<sup>5</sup>.

In 1985 the Centers for Disease Control [now the Centers for Disease Control and Prevention (CDC)] introduced the concept that all blood and body fluids that might be contaminated with blood,

should be treated as infectious<sup>6</sup>. Initial infection control measures were introduced largely because of the human immunodeficiency virus (HIV) epidemic, and were expanded to Universal Precautions to include other blood borne pathogens such as the hepatitis B virus (HBV) and hepatitis C virus (HCV), and has been further expanded in recent years to include other potentially infectious agents. Today infection prevention is predicated on Standard and Transmission-based Precautions<sup>7</sup>.

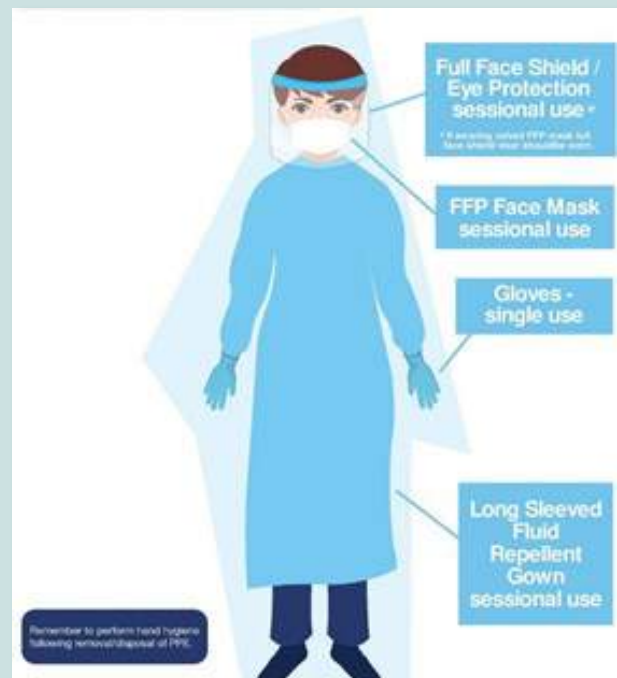
Generally, what any well-run dental facility is practising should be sufficient to control this novel virus and it should not require a radical revamp of the infection control protocol. Clinics that have been adhering to the current Infection Control Guidelines and other relevant Standard Operating Procedures (SOPs) should be able to cope and adjust, by simply procuring more PPEs or tweaking their infection control measures. Clinics that have been lax and failed to follow SOPs and guidelines, may require significant infrastructure and procedural changes in order to conform.

### 3. Personal Protective Equipment (PPE) & Barrier Usage

Use of PPE and patient barrier systems should be tailored appropriately and not applied carte blanche to all patients. The main issue of course, is cost. If money is no object then this discussion is moot and all patients walking into the surgery will be accorded the same level of PPE regardless of the procedure performed. The practitioner, while fully cognizant of the infection control protocols discussed above, can use his or her clinical judgment to determine if the PPE donned is suitable for the procedure. One must balance protection to the practitioner as well as the ability to perform a safe and efficient procedure. For example, extraction of a deep distally impacted lower 8 would not be the same as a simple lower incisor extraction.

Another barrier method being viral is the various clear plastic sheeting or boxes placed around the

patient's head, with the practitioner sitting fully upright while performing procedures. While it may look good in pictures (almost all posed with models), actual practicality is still unknown. What if the patient needs to get up and rinse his mouth, or the procedure involves certain sections of the oral cavity that are not accessible in an upright position? Anecdotal evidence has been shared with the author that those intubation plastic barrier boxes produced for our anaesthesia colleagues were actually impeding their procedures and in fact more dangerous as good visualisation is impaired. So, this will remain a work in progress as we strive to find a balance between practitioner



and patient safety.

### 4. Local Community Incidence

As mentioned earlier, a proper triage and risk stratification procedure is crucial in identifying potentially infected patients. This has been detailed in various guidelines. Once again, if resources were not an issue, then one could just test all patients walking in. One way of making the screening more robust would be the availability of public health data on the local incidence of COVID-19 outbreaks within a particular community. This data is accessible from the local Public Health Unit,

Ministry of Health Malaysia. With this added layer of information the practitioner will be better able to exercise his or her judgment on whether to proceed or defer treatment.

In the present pandemic setting, circumstances would allow a practitioner to defer the elective treatment until the situation improves either locally or nationwide.

As the world is still in the midst of the pandemic, one should still be aware and alert to the possibility of transmission and not be lulled into complacency due to the low numbers released by the Crisis Preparedness and Response Centre (CPRC), Ministry of Health daily.

**By**

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This is especially true as international borders are still effectively closed at the time of writing and things may change once international travel returns to normal. The dental practitioner has to be vigilant and keep up-to-date, while constantly modifying his practice to conform to the latest evidence-based information, taking into account practicality and safety for themselves, their staff and the patient.

### **Acknowledgment**

Many thanks to Dr Leong Kei Joe, President Malaysian Dental Association and Senior Consultant in Paediatric Dental Surgery, Kota Kinabalu Women's & Children's Hospital for his invaluable point-

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# Dental Services Involvement In Combating COVID-19;

## *THE MALAYSIAN ARMED FORCES DENTAL SERVICES EXPERIENCE*

Year 2020 is a remarkable year for everyone, regardless of where they live. This year, an unprecedented global health issue, COVID-19, emerged and became a pandemic. To date, the disease has infected more than 25 million, and over 800,000 lives have been lost. In Malaysia, we are facing the third wave of the pandemic and must prepare ourselves for battle once more. The Malaysian Ministry of Health (MOH) managed to flatten the infection curve for a few months from the first month of its surge as a result of the continuous efforts of our frontliners. Amongst those who contributed to these efforts was the Dental Services of the Malaysian Armed Forces (DSMAF).

The first and second pandemic waves in the country were transmitted from abroad. A wise man once said, 'An ounce of prevention is worth more than a pound of cure'. The need to control international borders to ensure that carriers would not infect local citizens prompted the Malaysian Government to implement international air movement restrictions. Passengers reaching the gateways were screened and delivered to quarantine centres. This health-screening programme directed towards airline passengers and crew began in January 2020 and was conducted by Kuala Lumpur International Airport (KLIA) Health Division officers and staff without any assistance from other agencies for over 3 months. Thereafter, 20 dental auxiliaries from Institut Latihan Kesihatan Angkatan Tentera (INSAN) were employed to assist with the

in-house programme. The main task at this point was to ensure that all passengers abided by strict standard operating procedures, including social distancing, hand sanitising and mask wearing. Passengers with a fever, cough or flu were separated and observed by medical personnel.

The fight against COVID-19 continued with the redeployment of a group of 7 dental specialists, 4 dental officers and 12 dental auxiliaries from DSMAF to KLIA on 9 April 2020. The screening programme was expanded, and the DSMAF were called to continue assisting the MOH with swabbing, tagging and home-surveillance activities. Healthcare workers in the dental field, routinely battle invisible microorganisms in the mouth, and we are comfortable with wearing personal protective equipment (PPE) throughout the day. However, the experience fighting this virus has taught us different perspectives on virulence and the importance of proper PPE 'donning' and 'doffing' for total protection.



The National Public Health Laboratory and the officer in-charge of the pathology laboratory of Sungai Buloh Hospital trained us to collect nasopharyngeal (NPS) and oro-pharyngeal (OPS) swabs as samples. Duty rosters were circulated, and our team was closely involved in setting up testing areas. We then participated in the registration, name tagging and swabbing of asymptomatic airline passengers with known comorbidities. Due to the Movement Control Order, only a small number of flights, mostly carrying Malaysian passengers returning from overseas, arrived. Inserting swab sticks deep into someone's nose and throat was difficult at first, especially when a passenger moved his or her head, which is a common reflex. The head must be positioned upright for easy access to landmarks of the NPS and OPS. We were advised to insert the stick until it reached the necessary marker to ensure that the specimen was correctly swabbed. All collected samples were processed using reverse-transcription polymerase chain reaction (RT-PCR) assay, which required several days to produce results.

Being away from home was not a comfortable feeling. We had to leave spouses, children and babies behind to keep ourselves isolated from spreading the virus to family members. The Airport Management Centre kindly provided us with quarters nearby and food every day. We were blessed with food donations from non-governmental organisations (NGOs) and concerned citizens who treated us as Malaysian saviours. Working in a nice, comfortable building at KLIA was a warm experience.

After 2 weeks at KLIA, we were directed to the Kuala Lumpur and Putrajaya Health Department to receive new orders and tasks. Our new working places was the Kepong Health Office (KHO), which was responsible for our presence and was the authority in charge. On 20 April, 2020, the government announced that the Kuala

Lumpur Wet Wholesale Market (KLWM) was under an Enhanced Movement Control Order (EMCO).



This announcement was the reason for our presence, but our work environment had completely changed. Instead of staying in cool air-conditioned rooms, we braved the hot weather. Instead of dealing with locals coming back from their flights, we dealt with foreigners who worked and stayed in the KLWM compound. We wore PPE for nearly 5 hours a day under these circumstances. We had no choice if we were to take care of ourselves in this highly viral environment. The objective at this time was to screen all households within the vicinity, with an estimated 15,000 residents, within 5 days. Residents with positive swab results and their close contacts had to be identified, isolated and referred to the appropriate hospitals and quarantine centres. We were not alone in battling this virus. Several teams were involved and took their positions in the war field. We worked with personnel from the MOH, dental private practitioners and NGOs, including the Medical Relief Society (MERCY) Malaysia and The Islamic Medical Association of Malaysian's Response and Relief Team (IMARET).

Sekolah Kebangsaan Sri Murni, Kepong, was the first venue we reached after leaving KLIA. Officers and staff from KHO led the whole team in organising the day-long programme, liaised with the Cheras Health Office for logistic back up and carried out multiple communications with other security agencies. We collected unforgettable memories over the course of our collaboration with KHO in setting up tents, arranging sterile and non-sterile areas and spotting 'donning' and 'doffing' areas around the school.



The announcement of EMCO by the government activated all health and security agencies to team up and execute the health-screening programme. The *Angkatan Pertahanan Awam* Malaysia (APM) installed the tents, and the Malaysian Armed Forces (ATM) Infantry division maintained and guarded the EMCO borders. Moreover, the Royal Malaysian Police (PDRM) personnel put on PPE and called every resident in every house within the compound and asked them to submit themselves to a swab test. When the residents reached the swabbing areas, they were registered, swabbed and tagged and then advised to comply with home surveillance before leave the area.

The bizarre behaviour of some individuals and the unforgettable memories we collected throughout the days made us happy and sometimes sad; in fact, we carry these memories to this day. One unusually windy, rainy day forced all of us to promptly cease all swabbing-related procedures even though the queues were still long. We

encountered a pregnant mother, a mother carrying a baby and old folks with no choice but to return home and comeback for swabbing the next day. Not all planned daily programs were carried out uneventfully. Based on experience, we had to develop back-up plans for rainy days and address other challenges, such as uncooperative residents and healthcare workers who passed-out. In some instances, we expected to obtain 1,000 swabs for the day but collected only 500 to 600 samples. Thus, we had to extend our swab days until the targeted number of samples was achieved.

We also helped the MOH Health Inspectorates in 'mopping', an important step after targeted residents are swabbed and tagged, to ensure that they follow all quarantine instructions and that no one misses out on their swab test. The procedure of visiting homes one after another was tedious and uncomfortable because we were required to wear complete PPE, walk around the shop houses and climb tight, dark staircases with fogged-up face shields and sweat running down our faces and backs. 'This is the last straw', I would always think to myself, but I carried on, nevertheless. We noted that some houses were occupied by over 20 workers and their families seeking shelter in inconvenient, messy and suffocating dwellings. Some of individuals failed to wear their wristband consistently, and some were without tags; thus, these individuals had to proceed to the swabbing areas for sample collection and the related procedures. We learned about the difficulties associated with being a Health Inspector. These personnel are the first to enter the homes of residents with high COVID-19 potential and the last to leave the area after decontaminating it.

We moved again from KLWM to Chow Kit and Kampung Baru for another cycle of mass sampling. Our movement order was essential to stop the virus, because the number of targeted resi-

dents that had tested positive for COVID-19 had exponentially increased in these localities. Chow Kit was declared under EMCO on 5 May, 2020. On one hand, we were glad to be close to our family members as this new area was fairly near where we lived; on the other hand, we knew that our tasks would become extremely difficult.



We now worked at the centre of Chow Kit under unforgivingly hot weather and an atmosphere filled with air pollution from cars and buildings. We were briefed by the officer-in-charge at Titivangsa Health Office (THO), where nearly 200 healthcare officers and staff were present, together with PDRM, APM and ATM Infantry personnel. Fully respect and commend the top management of the MOH, ATM and the National Disaster Management Agency (NADMA) for their ability to organise such collaborative programmes, in order to stop the virus from spreading in Kuala Lumpur, which is such a large city. Our new job scope and expectations were no different from those in previous venues. As usual, we worked for several hours each day despite the Ramadhan season being upon us. Unlike at previous venues, I was given the opportunity to familiarise myself with the new method of Active Case Detection (ACD), a mobilised process in which census is taken amongst targeted residents at a specific EMCO place. The job here was to conduct house-to-house visits, identify the number of members living in the house, register the head of the family's name and urge them to come in for

swab tests at designated locations. Being in a 'walking sauna', having a fogged-up face shield whilst walking to a house, constantly speaking loudly because of the PPE barrier and finding ways to reach all of the houses on our list was a challenge.



The compounds comprised not only single or double-storey houses but also three to four-storey buildings occupied by workers and labourers, all of whom must be seen and reached for ACD.

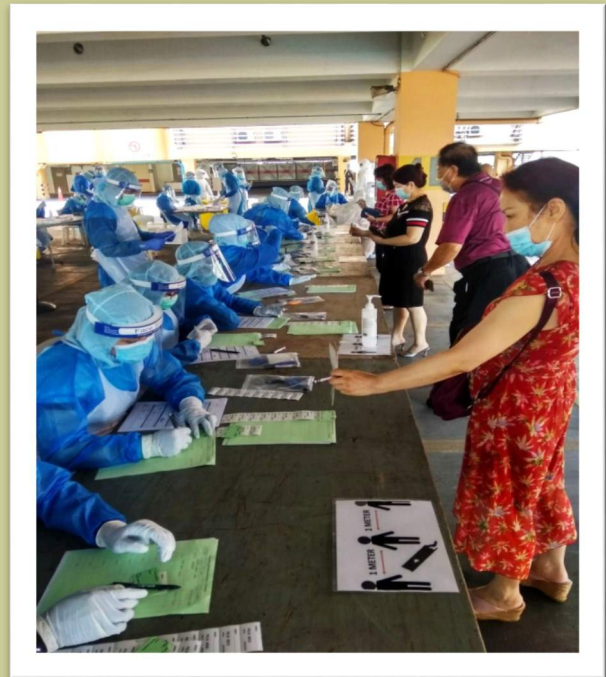
This sweaty and tiring process truly challenged our endurance and patience. Along the way, we were exposed to the virus and followed by local news reporters; however, we always maintained our professionalism and credibility as healthcare providers. When I had nearly completed my tour, I reached the swabbing area and could identify my comrades performing traffic control; I then assisted the registration team. I barely recognised my own colleagues because everybody was required to put on Tyvex and face masks. Some of us felt faint, became drowsy and doffed their PPE much earlier than expected because of early dehydration. At this point, we were challenged beyond our expectations. As team members, we had to support our colleagues and ensure that the given tasks were correctly performed. All data collected from over 3,000 targeted residents, was achieved in 3 days, and was delivered to the THO for further notification to higher authorities.

Despite the difficulty we experienced in breathing whilst wearing 'space' suits, we were committed to accomplish the job without any errors. As we carried out contact tracing and taking swabs, we learned how to use the COVID-19 Antibody Rapid Test for residents in Kepong and Chow Kit during EMCO. This kit is not a diagnostic tool but an indicator that could detect the presence of viral antibodies in the blood. Blood is drawn via a finger prick and then transferred into the sample well of a test cassette with a strip; the appearance of a single bar reflects a negative result, whilst the presence of double bars indicates a positive result. A case with a positive result was directed for the NPS or OPS for confirmation of our findings by RT-PCR.

After three horrible days in Chow Kit and Kampung Baru, we were delighted to be given a once-in-a-lifetime chance to enter Istana Negara (National Palace). I was happy to explore the breezy and calm environment surrounding the Palace. We joined forces with the KHO and swabbed nearly 300 staff working in the Palace. Although our tasks here ended, the pandemic did not allow us to stop working or rest; in fact, we did not have time even to visit our families.



The MOH detected a new cluster at the Pudu and Pudu Plaza areas. We spent our days performing swab tests on nearly 1,300 residents in this semi-EMCO area; fortunately, all operations proceeded smoothly and uneventfully. This narrative reflects our journey as frontliners. After concluding our tasks in the semi-EMCO at Pudu and Pudu Plaza, the number of daily cases found to be COVID-19 positive significantly decreased; indeed, we had successfully flattened the curve.



This journey has helped mould our character in preparation for our future tasks as bold, strong and resilient frontliners. This task is not a single-man job; rather, it is one that requires strong teamwork. We, the DSMAF, are proud and honoured to be given the opportunity to serve the people.



***By***

***Lt. Col. Dr. Muhammad Hidayat bin Muhamad Daud***

***Restorative Dentistry Specialist***

***Pusat Pergigian Angkatan Tentera KEMENTAH***

# IMPACT OF COVID-19 ON PRIVATE DENTAL PRACTICE

**D**ecember 2019, the outbreak of a new virus infection known as COVID-19 began in Wuhan, the People's Republic of China.

What happened next was unimaginable - citizens of countries around the world were forced to change the way they live and work, almost overnight.

## Chronology of Events

### January 2020

*The World Health Organization (WHO) declared the outbreak a Public Health Emergency of International Concern on 30 January 2020.*

### February 2020

*The first local Malaysian COVID-19 case was identified. However, reported cases remained low.*

### March 2020

*11 March 2020: WHO declared the COVID-19 outbreak a pandemic.<sup>i</sup>*

*In Malaysia, localised clusters began to emerge leading to a significant spike in cases.*

*16 March 2020: To break the chain of infection, a Movement Control Order (MCO) was announced by the Prime Minister of Malaysia.*

### April 2020

*Malaysia recorded the highest number of confirmed COVID-19 cases in Southeast Asia, breaching 2,000 cases from less than 30 cases in March 2020. The MCO was extended thrice.*

### May 2020

*4 May 2020 : Conditional MCO (Phase 5) was imposed*

*10 June 2020 : Recovery MCO (Phase 7) enforced*

*31 August 2020 : Recovery MCO (Phase 8) extended to 31 December 2020<sup>ii</sup>*

## Private Dental Practice (PDP)

Posing serious implications to peoples' health, COVID-19 has significantly impacted the economy in general. Even the Malaysian private health sector has not been spared.

## PDP in Numbers

The Malaysian Dental Council (MDC) Annual Report 2019 confirmed a registry of 10,801 dentists of whom 34.3% (3,714) are in private practice.<sup>iii</sup>

In the current PDP scenario, the uncertainties of a prolonged MCO will have far reaching economic, mental and social-cultural ramifications for all.

It is estimated that the private healthcare sector suffered nearly 70% losses.<sup>iv</sup> Some PDP reported 90% deficit as patients wrongly believed that they could get infected with Covid-19 at private clinics.

Anecdotal reports indicate that the not-so-well established younger dentists (an estimated 300 PDP clinics) are hit hard whilst most established senior PDPs have coped quite well with near normal patient flows.

### The MCO Period

Considered an 'essential service', the healthcare sector including PDP could operate throughout the MCO period with some clinics opting to limit dental work to only emergency cases.

The rationale was to provide dental support to the Malaysian healthcare system and not overload public facilities during the MCO with dental emergencies.

It was an uphill battle for PDPs to optimise patient care whilst managing personnel safety, adhering to the strict standard operating procedures and safety protocols with an acute shortage of materials and supplies e.g. thermometers for temperature checks, face masks and Personal Protection Equipment (PPE).

### The 'New' Normal

As we adjust, uncertainties will continue to arise until a vaccine is found. What are the realities of COVID-19 in PDP?

PDP should expect patients to continue to be cautious and avoid health facilities. However, as they say, there is opportunity in every crisis.

PDPs can take this time to take stock, focus on the health aspects of the private delivery of dentistry and how to remain relevant and viable.

## A. Patient Management

On 3 August 2020, an interim guidance<sup>v</sup> issued by WHO stated:

*"WHO advises that routine non-essential oral health care be delayed until there has been sufficient reduction in COVID-19 transmission rates from community transmission to cluster cases."*

The silver lining to this scenario for Malaysia is the prompt and effective response mounted by the Majlis Keselamatan Negara (MKN) and Ministry of Health (MOH). Quick action and strict protocols successfully confined transmission to cluster cases.

Pursuant to MKN guidelines and compliance with MOH's standard operating procedures, PDPs can proceed and carry on with routine dental treatment.<sup>vi</sup>

This is of course subject to additional protocols such as:

- advanced dental bookings
- registration via the MySejahtera app or maintaining manual recording
- temperature screening on entry
- social distancing within the waiting room
- improved ventilation
- regular sanitisation of surfaces like doorknobs, table surfaces and formites.

During treatment, the routine wearing of PPE like medical facemasks, face shields, gloves, surgical gowns and sterilisation and disinfection of instruments and equipment has been the norm for PDPs for years, as per the already-stringent cross-infection protocols by the MDC.

Whilst such measures do not guarantee non-transmission, it will allow PDPs to resume practice with ease of mind; keeping PDP staff safe from possibly infected or asymptomatic patients and vice versa.

At the same time, this will support the Government's endeavours to minimise clusters and curtail infections in the country.

A separate, problematic issue which is worth considering is Aerosol Producing Procedures (APP). Such procedures, when performed on patients are more likely to generate higher concentration of infectious respiratory aerosols than coughing, sneezing, talking, or breathing.

APPs potentially, may put healthcare personnel and others at an increased risk of infection. However, a disciplined approach will mitigate its risks to a large extent. This includes:

- a. Compulsory wearing of PPE
- b. Better ventilation
- c. Oral rinsing before treatment
- d. High-vacuum suction
- e. Introduction of disinfectants like hydrogen peroxide, povidone iodine, hypochlorous acid into the clean water systems of the dental chairs and equipment.

Such steps help to minimise spread of embedded contaminants such as infective bacteria and viruses in aerosols that are produced.

PDPs may also consider investing in HEPA filters and COVID-19 sanitizer machines which disinfects the ambient air and fixtures continuously throughout the day.

## **B. Staff Management**

Everyone has a role to play in this continuous battle to ensure containment of the pandemic. PDP staff have no leeway for negligence and must adapt to the issues discussed earlier. Any divergence from standard operating procedures must be addressed immediately.

Management must also ensure that relevant information is delivered effectively. Periodic tracking of staff movement is also important to help minimise risk between employees.

PDPs may also consider sponsoring health screenings for all employees in the interest of patient safety.

## **C. Financial Management**

Economists have forecasted that even after ex-

iting the MCO, things will not return to normal for at least two years.

Increasing layoffs and salary cuts are expected with shopping malls and small businesses (which thrive on daily incomes) fighting closure and industries like medical tourism and travel grappling to get back on track.<sup>vii</sup>

Domestic violence, family squabbles, stress/mental problems and risk-infection perception issues will certainly translate to decreased quality and quantity of patients in the short/medium term.

**Fact: there will be less disposable income to spend on dental treatment.**

PDPs must be ready to face this period where patient attendance is reduced whilst still having to pay salaries, rental, loans, and personal expenses.

At the same time, PDPs will also have to manage increasing expenditure from accommodating stringent standard operating procedures and requirement pursuant to the pandemic.

With the Government's loan moratorium ending soon, impacted PDPs may want to be pro-active in managing this possible risk.

From approaching banks for a further extension of the moratorium or restructuring of finances to negotiating with suppliers to ensure there are adequate dental equipment and supplies to keep the practice viable.

## **The Way Forward**

The risk of transmission in dental practice is real. To combat this, the National Health Programmes for Communicable and Non-Communicable Diseases (for reduction of co-morbidities) has been revitalised and strengthened by the MOH.

In the same vein, all health professionals, including PDP have to be more diligent in adapting to infection control procedures.

PDPs must also educate their patients in giving

accurate information whilst not causing fear among them.<sup>viii</sup>

Patients need to understand their role and the PDP's role in curbing infection to avoid panic and prevent a 2<sup>nd</sup> wave.

To conclude, it is envisaged that PDPs will find it challenging in the next two years or at least until a vaccine is found.<sup>ix</sup>

More than ever, PDPs must be ready to innovate, re-evaluate how we practice, implement new and better clinic management and infection control procedures.

**By**

**Dr. Wong Foot Meow BDS (Mal), FDSRCPS (Glasg), AM (Mal), FICD, NSR.**

For others, it may be a good time to go back to dental management basics – balancing income and expenditure to pull through this difficult period without sacrificing the quality of Malaysian PDP's dental care.

At this juncture, knowledge-sharing and understanding of the transmission of the virus is key to the betterment of our future health and financial status.

Together, we can and will overcome the pandemic to find our equilibrium in the 'new normal' of practice.

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<sup>ii</sup> Flanders Trade-Corona Virus-The Situation in Malaysia, July 2020

<sup>iii</sup> MDC Annual Report 2019

<sup>iv</sup> MP Durgahyeni, 'Pandemic Hits Malaysian Private Health Sector Hard', CodeBlue, 29 April 2020

<sup>v</sup> WHO Interim Guidance, Considerations for the provision of essential oral health services in the context of COVID-19, 3 August 2020

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# DISCIPLINARY *Proceedings*

## Facts Of The Complaint

A complaint was received from Miss N against Dr X, a private dental practitioner, regarding unsatisfactory orthodontic treatment. Miss N claimed that the orthodontic treatment provided by Dr X was not done properly. She claimed that most of the brackets were placed incorrectly and Dr X did not give her a proper explanation for the reasons the brackets were placed incorrectly. Miss N later went to two orthodontists for consultation and it was confirmed that the orthodontic brackets were incorrectly placed.

## Findings Of The Preliminary Investigation Committee (PIC)

Based on the oral evidence of the complainant and witnesses and supporting documents available, the PIC found that:

*Dr X failed to provide a high standard of care that was expected when treating and managing the complainant during the period of treatment.*

## Charge Against The Respondent

Dr X failed to provide a high standard of care that is expected when treating and managing the complainant during the period of treatment. In that respect he failed in his responsibility to meet the needs of the patient by not offering all possible treatment with, if necessary, the assistance of professional colleagues.

In relation to facts alleged, Dr X may be found guilty of infamous conduct in a professional respect under section 32 (2)(b) of the Dental Act 1971, which is punishable under Section 33 of the Act.

## Dr X's Explanation

- a. Dr X explained that Miss N went to see him initially for extraction of her first premolar in preparation for orthodontic treatment with an orthodontist. Miss N later returned requesting orthodontic treatment by him.
- b. Fixed appliances were inserted and after 10 days, the patient requested a change of arch wires. Two weeks later, Miss N requested a change of the molar rings because they were uncomfortable. Dr X informed her that pain was to be expected when the fixed appliances were activated.
- c. Miss N was last seen for orthodontic treatment by Dr X 4 weeks later. The arch wires had been removed by the patient.
- d. Dr X explained that he had more than 20 years of experience in performing orthodontic treatment, including fixed appliances. He further explained that he has experience treating cases like Miss N's, but had never received any complaints.

## Recommendation Of PIC

The PIC, after deliberation, is of the opinion that the competency of Dr X is doubtful and this was corroborated by the opinion and evidence provided by a specialist. The PIC unanimously agreed that he was not competent to handle this case and recommends that the Council holds an inquiry.

## Verdict Of The Council

The Council found the practitioner guilty of the charge and the practitioner was reprimanded under Section 33(1)(c).

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## 132th Malaysian Dental Council Meeting



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