AUSTRALIAN
DENTAL COUNCIL

Level 6, 469 La Trobe Street
Melbourne VIC 3000 Australia
Phone: +61(0) 3 9657 1777
ABN 70 072 269 900
www.adc.org.au

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Mr Martin Fletcher
Chief Executive Officer
Australian Health Practitioner Regulation Agency (Ahpra)
GPO Box 9958
Melbourne VIC 3001

Via email: ahpra.consultation@ahpra.gov.au

Dear Martin,

Public consultation on the review of the shared Code of Conduct

I write on behalf of the Australian Dental Council (ADC) in response to the invitation to provide feedback on the draft revised shared Code of conduct (the Code).

The ADC thanks the National Boards and Ahpra for the opportunity to provide comment.

The ADC's response is structured around the consultation questions.

1. The revised shared code includes high-level principles to provide more guidance to practitioners especially when specific issues are not addressed in the content of the code. Are shorter, more concise principles that support the detail in the revised shared Code preferable or are longer, more comprehensive principles a better option? Why?

The ADC appreciates the inclusion of concise principles listed in the introduction to the Code, as well as expanded information on each principle set out in the body of the Code.

The ADC recommends retaining both approaches, noting that the concise list of principles captures the ethos of the Code and is designed to be printed, and the subsequent, detailed explanations allow for clarity of how each principle is expected to be applied in practice.

2. In the revised shared code, the term 'patient' is used to refer to a person receiving healthcare and is defined as including patients, clients, consumers, families, carers, groups and/or communities'. This is proposed in order to improve readability of the code and to support consistency for the public. Do you support the use of the term 'patient' as defined for the revised shared code or do you think another term should be used, for example 'client' or 'consumer'? Why or why not?

The ADC has adopted the term 'dental consumer (including patients)' within the recently revised *Accreditation standards for dental practitioner programs*.

This decision was made following wide-ranging consultation, where it was determined that community representatives participating in the review process preferred the use of the term *'health consumer'* to *'patient'*. This was due to the potential for *'patient'* to suggest a power imbalance between practitioners and patients and was potentially inconsistent with the focus on patient-centred care.

Conversely, the use of the term 'patient' was preferred by practitioners involved in the ADC's consultation. A finding of the practitioner viewpoint was that a 'patient' may refer to an individual receiving a health service, the term 'consumer' may be more reflective of the group of end users of health services. Therefore, the ADC supports the term health consumer.

3. The revised shared code includes amended and expanded content on Aboriginal and Torres Strait Islander health and cultural safety that uses the agreed definition of cultural safety for use within the National Registration and Accreditation Scheme. (Section 2 Aboriginal and Torres Strait Islander health and cultural safety). **Is this content on cultural safety clear? Why or why not?**

The ADC strongly endorses the inclusion of *Cultural safety for Aboriginal and Torres Strait Islander Peoples* as a principle within the Code, including the reference to the definition as determined by Aboriginal and Torres Strait Islander Peoples. It is recommended that the National Scheme's Aboriginal and Torres Strait Islander Health and Cultural Safety Strategy is provided as a link on page 32 in addition to the other external links.

It is suggested that the link to the National Safety and Quality Health Services Standards, direct readers to the website of the Australian Commission on Safety and Quality in Health Care to provide ease of access for practitioners to the Commission's other resources.

4. Sections 3.1 Respectful and culturally safe practice, 4.1 Partnership, 4.9 Professional boundaries and 5.3 Bullying and harassment include guidance about respectful professional practice and patient safety. **Does this content clearly set the expectation that practitioners must contribute to a culture of respect and safety for all? e.g. women, those with a disability, religious groups, ethnic groups etc.**

The ADC supports the inclusion of multiple principles within the Code to emphasise the Boards'/Ahpra's expectation for respectful professional practice and patient safety.

5. Statements about bullying and harassment have been included in the revised shared code (Section 5.3 Bullying and harassment). **Do these statements make the National Boards'/Ahpra's role clear? Why or why not?**

The ADC considers the information provided in section 5.3 is clear.

The ADC also appreciates the inclusion of the link to the Australian Human Rights Commission fact sheet as a useful resource for practitioners.

6. The revised shared code explains the potential risks and issues of practitioners providing care to people with whom they have a close personal relationship (Section 4.8 Personal relationships). Is this section clear? Why or why not?

The ADC considers the information provided in section 4.8 is clear.

7. Is the language and structure of the revised shared code helpful, clear and relevant? Why or why not?

The language and structure of the revised version of the Code is clear and simple to understand.

8. The aim is that the revised shared code is clear, relevant and helpful. Do you have any comments on the content of the revised shared code?

The ADC considers the content provided in the Code is clear however has made a recommendation to enhance the understanding of the relevance of the Code across all stakeholder groups. Please refer to question 9 below.

9. Do you have any other feedback about the revised shared code?

The ADC notes in the consultation paper that an example is provided of how this Code might be used by consumers. The ADC endorses the encouragement of consumers to understand the Code and the expectations of their health practitioners. The ADC recommends that the potential for consumers to use the Code should be captured in the *Purpose of the code*.

Feedback received by the ADC during the review of the Professional competencies of the newly qualified dental practitioner has also highlighted that the term 'vulnerable' should be reconsidered due to inferences of inherent incapacity and victimisation.

10. Would the proposed changes to the revised shared Code result in any adverse cost implications for practitioners, patients/clients/consumers or other stakeholders? If yes, please describe.

The ADC does not foresee any adverse cost implications for practitioners, consumers or other stakeholders resulting from the revised shared Code.

11. Would the proposed changes to the revised shared Code result in any potential negative or unintended effects? If so, please describe them.

The ADC does not foresee any potential negative or unintended effects resulting from the revised shared Code.

12. Would the proposed changes to the revised shared Code result in any potential negative or unintended effects for vulnerable members of the community? If so, please describe them.

The ADC does not foresee any potential negative or unintended effects resulting from the revised shared Code for vulnerable members of the community.

13. Would the proposed changes to the revised shared Code result in any potential negative or unintended effects for Aboriginal and Torres Strait Islander Peoples? If so, please describe them.

The ADC strongly endorses the inclusion of *Cultural safety for Aboriginal and Torres Strait Islander Peoples* in the revised shared Code. The ADC does not foresee any potential negative or unintended effects for Aboriginal and Torres Strait Islander Peoples.

The ADC thanks Ahpra for the opportunity to provide comment on the draft Code.

Yours sincerely,

Chief Executive Officer
Australian Dental Council

Cc: Ms Luisa Interligi, Executive Officer, Dental Board of Australia, Australian Health Practitioner Regulation Agency (Ahpra)