AUSTRALIAN DENTAL COUNCIL

Dental Council
Te Kaunihera Tiaki Niho

ManuAroha Walker Submission to ADC Draft Accreditation Standards Consultation

Respondent details	
Name:	ManuAroha Walker
Organisation:	Kaitiaki Niho
Role/capacity:	Dentist
Location:	Rural/regional

Response to consultation questions	
Do you consider that the draft Standards are at the threshold level to deliver competent graduates who are safe to practise? (Yes, Somewhat, No, Unsure)	Somewhat
Additional comments:	The draft Standards are broadly suitable as a minimum ("threshold") framework for producing graduates who are safe to practise. They clearly prioritise public protection and take an appropriately outcomes-focused approach, rather than prescribing fixed hours or narrow curriculum inputs. However, I have rated this as "somewhat" because several parts could be interpreted differently across providers. In particular, the Standards would be stronger if they more clearly signalled that clinical education must prepare students for safe practice across a sufficient range of settings, patient groups, and levels of clinical complexity. Without clearer wording, there is a risk that programs could demonstrate "sufficiency" through a narrower set of clinical experiences than is appropriate for safe independent practice
Do you agree with the specific proposals as incorporated in the draft Standards? (Yes, Somewhat, No, Unsure)	Yes
Additional comments:	To improve consistency and strengthen public protection, I recommend considering the addition of criteria in three areas:

	Safe learning environments (professional behaviour and protection from harm) A clear requirement for programs to have effective systems to prevent and respond to bullying, harassment, discrimination, and racism in university and placement settings, including safe reporting pathways and timely remediation. Digital health and data governance An explicit requirement that students are trained and assessed in safe use of digital systems and technologies relevant to oral health practice, including privacy, security awareness, and ethical responsibilities. Assurance of clinical breadth without prescribing hours A requirement that programs show how they ensure students experience an adequate case-mix and sufficient clinical complexity (including high-need groups) and how competence is verified across these contexts.
Are there any additional Standards or Criteria that should be added? (Yes, No, Unsure)	Yes
Additional comments:	With respect, I suggest there is an opportunity to add a small number of targeted criteria that would strengthen consistency of interpretation across providers, while still preserving an outcomes-based, non-prescriptive approach. I offer the following options for consideration (as criteria and/or strengthened guidance), with a particular focus on cultural competency and patient safety. Explicit cultural competency and cultural safety capability, taught and assessed longitudinally A criterion could require programs to demonstrate that cultural competency (knowledge, skills, behaviours for effective care with diverse communities) and cultural safety (critical self-reflection, attention to power and bias, and accountability to patients/communities) are embedded across the curriculum and assessed in authentic contexts. This would reduce variability where cultural capability is treated as a stand-alone

module rather than a core clinical competency.

Assurance of culturally safe and respectful learning environments

A criterion could explicitly require prevention and response systems for racism, bullying, harassment, and discrimination affecting students, staff, and patients—covering reporting pathways, protections from retaliation, timely investigation, remediation, and ongoing monitoring. This recognises that the learning environment is a patient safety issue as well as a workforce sustainability issue.

Digital health competence and safe use of emerging technologies

A criterion could require programs to ensure graduates demonstrate competence in digital documentation, information governance and privacy, and safe professional use of technology (including decision-support and AI-enabled tools) in ways that protect patients and uphold professional standards.

Clearer assurance of breadth and equity-relevant clinical experience (without prescribing hours)

A criterion could require providers to evidence how they assure sufficient breadth of supervised clinical experience across case-mix and complexity, diverse patient groups (including high-need populations), and an appropriate range of service contexts where feasible. This would support transferability of competence beyond a single setting and reduce unintended narrowing.

Graduate capability in quality improvement and patient safety systems

A criterion could require graduates to demonstrate practical capability in quality and safety activities (e.g., incident recognition and reporting, improvement methods, infection prevention and control as applied practice), aligned with contemporary clinical governance expectations.

Equity-oriented monitoring of outcomes within clinical training services

Where programs deliver clinical care, an additional criterion could strengthen

	expectations that services monitor access, experience, and outcomes across key population groups and use this information for continuous improvement—supporting both quality and fairness of care.
Are there any Standards or Criteria that should be deleted or reworded? (Yes, No, Unsure)	Yes
Additional comments related to your response, and clearly reference the specific criteria you are referring to for refinement.	1) Reword criterion 3.4 to restore explicit breadth expectation. Current: "The complexity, quantity, duration and variety of clinical education is sufficient to produce a graduate competent to practise." Recommendation: reintroduce wording equivalent to "across a range of settings and patient populations" (or similar). Rationale: the consultation paper argues for diverse placements and notes simulation is not a substitute for patient care; removing "range of settings" risks unintended narrowing in how providers evidence sufficiency. 2) Tighten Australia Domain 6 drafting so "cultural safety" remains the outcome. The standard statement includes "culturally responsive safe care" phrasing. Recommendation: explicitly frame the outcome as culturally safe care, with cultural responsiveness as the means (consistent with the consultation rationale). 3) Editorial consistency check (risk of confusion). In the tracked section, Domain 3 is labelled "Public safety" even though public safety is Domain 1 in the same document set; this appears to be a drafting error that should be corrected for clarity.
Do you have any other questions or comments on the Standards?	The intention to remain outcomes-focused (rather than prescribing hours or curricula) is sound. However, an outcomes approach only functions well when the accompanying guidance is sufficiently clear to ensure consistent interpretation across providers, particularly where there are material differences in resources, placement availability, and local population needs. In Aotearoa New Zealand, this clarity is especially

important where programs are training for practice with whānau, iwi, and diverse communities across rural and urban contexts.

I encourage guidance that more explicitly distinguishes what can reasonably be achieved through simulation and what must be achieved through supervised patient care. In doing so, it would be valuable to articulate the "why" in patient safety terms: relational practice, clinical judgement under uncertainty, managing complexity, and communication with patients and whānau cannot be fully replicated in simulated environments.

The strengthening of assessment quality and responsiveness to emerging risks is welcome. To support consistent threshold decisions, guidance should clearly state expectations for assessor calibration, moderation, and inter-rater reliability—particularly for high-stakes clinical decisions—so that competence judgements are defensible, equitable, and comparable across cohorts and sites.

In the context of tikanga and whānau-centred care, it would be helpful if guidance clarified how cultural capability is assessed as a core clinical competency (not an adjunct). This includes observable behaviours such as whakawhanaungatanga, respectful engagement with whānau involvement in decision-making, safe communication practices, and reflective practice that demonstrates awareness of power, bias, and structural barriers to care.

Relatedly, it may be useful for guidance to signal that cultural competency includes the capacity to practise appropriately within Māori contexts—where relevant—such as understanding basic tikanga in clinical environments (e.g., respectful handling of taonga, appropriate communication and consent processes, and sensitivity to tapu/noa considerations). The intent is not to impose uniform cultural protocols, but to ensure graduates have foundational capability and humility to practise safely and respectfully across settings.

Where programs rely on external placements, guidance could more explicitly encourage authentic partnership with iwi and Māori health

providers in placement design, supervision expectations, and feedback loops. In practice, this means treating iwi and Māori providers not simply as "placement sites," but as partners whose expertise should shape learning objectives, supervision models, and assessment of cultural and relational competence.

It would also be useful for guidance to address ethical partnership and reciprocity with iwi and Māori providers. This could include expectations around appropriate resourcing (e.g., time, supervision load, and remuneration where appropriate), acknowledgement of mātauranga contributions, and mechanisms to ensure placement relationships are mutually beneficial and not extractive.

Consideration could be given to guidance on Māori data governance and accountability where student-led clinical services generate patient data used for teaching, assessment, and quality improvement. Programs should be encouraged to demonstrate respectful stewardship, transparency, and appropriate engagement where data relate to Māori communities—particularly if used for research, publications, or service reporting.

As digital health and AI become increasingly embedded in education and practice, guidance should explicitly address integrity safeguards and ethical use, including how programs verify authenticity of student work and ensure students can demonstrate independent clinical reasoning. This should be framed as both an academic integrity issue and a patient safety issue.

Finally, for New Zealand stakeholders, if a key domain is deferred pending legislative or regulatory change, it would be helpful for the relevant council to signal—at least at a principles level—how interim accreditation decisions will maintain alignment with evolving expectations around cultural safety and equity. Even a short transitional statement would provide assurance to providers, learners, and communities that the standards framework remains responsive during the interim period.