A/PROFESSOR AJITH D. POLONOWITA

Date: 16/12/2025

Marie MacKay
Chief Executive of the Dental Council of New Zealand
Level 7
22 The Terrace
Wellington 6011
Email: marie.mckay@dcnz.org.nz

Dear Marie,

Re: Consultation on Proposed Changes to the Prescribed Qualifications for Oral Medicine

Thank you for the opportunity to provide feedback. We are writing as:

1. Head of Discipline in Oral Medicine, Faculty of Dentistry, Otago University
2. A/Prof of Oral Medicine, Faculty of Dentistry, Otago University

Based on our combined extensive clinical and academic experience in Oral Medicine, in both Australia and New Zealand and working in University, Hospital and Private sectors we make the following observations:

1. **Historic rationale for the medical degree requirement is outdated.**
   Oral Medicine was combined with a lateral entry 3-year Medical Degree in the 2000's as it was convenient and the cost of a second undergraduate degree was significantly lower. As the specialty has matured in Australasia, it has become clear that this model no longer reflects contemporary best practice. Internationally, immersion in targeted medical rotations rather than a second full undergraduate medical degree is the preferred and more relevant approach. Crucially, the essential medical, dental, and research competencies required for safe and effective Oral Medicine practice are obtained through the DClinDent program. In real-world practice, even medically qualified Oral Medicine specialists collaborate with dermatology, gynaecology, neurology, and gastroenterology colleagues rather than independently managing systemic manifestations. Scientific research training at DClinDent level is also fundamental to maintaining evidence-based practice and contributing to the scholarly advancement of the specialty.

2. **Current barrier to training has had direct impact on New Zealand's access to Oral Medicine services.**
   Barriers to training directly reduce workforce capacity, leaving New Zealand patients especially those with chronic orofacial pain, complex mucosal disease, and conditions requiring surveillance for oral cancer development and at risk of morbidity and early mortality relating to delayed diagnosis.

3. **A second undergraduate degree imposes a significant and inequitable financial burden.**

Many prospective Oral Medicine trainees in New Zealand have identified the cost of the three-year lateral-entry medical degree as prohibitive. This creates inequity compared with international training pathways that do not require this additional expense or time commitment.

4. **Removing the medical degree requirement would enhance equity.**
   This removal of the current requirement for a medical degree would make Oral Medicine training more accessible to all New Zealanders, including Māori and Pasifika communities, for whom current financial and structural barriers are disproportionately impactful.

5. **Alignment with the current Australian model is appropriate and evidence based.**
   Australia has over 50 AHPRA registered Oral Medicine specialists, with training and ongoing professional standards overseen by the Oral Medicine Academy of Australasia (OMAA). All past and present specialists in Australia and New Zealand have demonstrated exemplary professional performance without a required medical degree, demonstrating that the current model in Australia, which incorporates the relevant medical experience pertinent to the practices of Oral Medicine, is robust, safe, and fit for purpose. Of note, this current model is considered international standard and accepted by almost all jurisdictions.

6. **Trans-Tasman collaboration is essential.**
   Given the small size of the specialty, audit, peer review, and professional interaction between Australian and New Zealand specialists are crucial for maintaining standards. The current divergent training model has created unnecessary barriers and weaken professional integration.

7. **University-based DClinDent programs remain the international gold standard.**
   In Australia, all Oral Medicine training occurs at the postgraduate level [Australian Qualifications Framework (AQF) 9–10] with strong clinical and research components. Attempts in other countries to adopt alternative models have resulted in ambiguity, inequitable dual-tier specialist systems, and ultimately poorer outcomes for patients.

8. **Trans-Tasman Mutual Recognition must be considered.**
   This legislative framework extends beyond dentistry and medicine. Without alignment between Australian and New Zealand Oral Medicine training requirements, New Zealand is placed at a clear disadvantage.

Based on the above considerations and our collective experience, we strongly recommend that the medical degree requirement be removed from the criteria for Oral Medicine registration in New Zealand. Furthermore, creating a two-tier training and registration system would introduce unnecessary complexity and long-term challenges for the specialty, further disadvantaging both specialists and patients.

We also urge the Dental Council of New Zealand to ensure that any changes to Oral Medicine training are not driven by reactionary views or by individuals without substantial career experience in Oral Medicine across New Zealand and Australia. Apart from the barrier with regards to the requirement for a medical degree for registration, the existing training model has

been effective and fit for purpose and hence it should not be altered without clear evidence of benefit.
Decisions made at this juncture carry significant implications for the future of the specialty in New Zealand and will have a significant impact on the provision of clinical services.

Accordingly, the proposed prescribed qualifications for Oral Medicine must be examined with careful consideration and due diligence

Thank you for your consideration. We would be pleased to provide any additional clarification or information if required.

Sincerely,

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