Page 2: About your submission

Q1

First name

Finn

Q2

Last name

Gilroy

Q4 **New Zealand**

Are you primarily based in New Zealand or overseas?

Q5

Company/organisation name

University of Otago / Unison Dental Specialists

Q6 **Registered oral health practitioner**

In what capacity are you making this submission?

Page 3: About your submission

Q7 **Dental specialist**

What is your profession?

Q8

Please enter your Dental Council Person ID, if applicable

13046

Page 4: Proposed registration pathways

Q9

Do you believe the proposed changes will help reduce barriers to registration for suitably trained overseas practitioners?

Somewhat

Q10

Please tell us why:

No. These proposals assume that barriers to entry are the primary problem facing the dental academic workforce. My experience suggests the real problems lie elsewhere, and that lowering entry standards will worsen rather than improve outcomes.

The current crisis at the University of Otago Faculty of Dentistry is acute. We have experienced a significant departure of experienced academics and a substantial reduction in the number of new academics entering the workforce. Financial constraints are forcing remaining staff to reduce their academic commitments. I am myself a recent example, having reduced from full-time academic work to 0.7 FTE to maintain financial viability through private practice. We are increasingly employing academics with registration in specialist scopes but not general practice who struggle to teach effectively in undergraduate general programmes. Teaching standards have noticeably declined even since I began my academic career four years ago, and our students are working with increasingly inconsistent educational quality.

The Teaching and Research pathway does not address any of these underlying problems. It will not make academic positions more financially viable, will not reduce the workload on remaining staff, will not improve career progression opportunities, and will not address the remuneration gap between academics and those in private practice. What it will do is add more practitioners who cannot meet full registration standards to teach clinical content to students who are already receiving inconsistent instruction.

The Competent Authority registration and Comparable Health System pathways are more defensible as they maintain standards whilst recognising practice experience in jurisdictions with equivalent systems. However, the Teaching and Research pathway represents a fundamental lowering of standards that prioritises immigration policy over educational quality.

Students entering dental practice will work in New Zealand for thirty to forty years. They will treat New Zealand patients, including my own family, my colleagues' families, and eventually myself. Their education must not be compromised by well-intentioned but misguided attempts to fill academic vacancies with whoever is available.

Page 5: Introduction of the proposed 'Competent authority - registration' pathway

Q11

Do you support the introduction of the 'Competent authority - registration' pathway?Click to learn more about the proposed pathway

Partially support

Q12

Please tell us why:

Yes, with reservations. This pathway recognises that practitioners who have been successfully practising in jurisdictions with equivalent regulatory systems and standards may not hold qualifications from those jurisdictions but have nonetheless demonstrated competence through supervised practice there.

The six-month oversight programme, with monthly reporting, provides reasonable assurance of a smooth transition to New Zealand practice. The requirement for thirty-three months of practice in a competent authority for general practitioners and oral health practitioners, or twenty-four months for specialists, demonstrates currency of practice.

My primary concern is ensuring that the oversight practitioner has genuine capacity to assess practice quality and is not merely a formality. The Council should ensure that oversight practitioners receive clear guidance on their responsibilities and that monthly reports meaningfully assess the practitioner's competence rather than becoming pro forma documentation.

The proposed Dental Practice in New Zealand module is a valuable addition that should support practitioners' transition to our regulatory and practice environment.

Page 6: Introduction of the proposed 'Comparable health system' pathway

Q13

Do you support the introduction of the 'Comparable health system' pathway for dentists?Click to learn more about the proposed pathway

Partially support

Q14

Please tell us why:

Yes, with significant reservations. The evidence base for identifying comparable health systems appears sound, building on the Medical Council of New Zealand's established methodology. The requirement for thirty-three months of practice in a similar health system provides reasonable assurance of competence.

However, I have three concerns. First, the twelve-month supervision requirement with direct onsite supervision is substantially more intensive than the six-month oversight programme for Competent Authority registration. This suggests that the Council recognises a higher risk, which is appropriate, but raises the question of whether the pathway should exist at all if the risk is this significant.

Second, the financial and practical burden of twelve months of direct supervision may make this pathway unworkable in practice. Finding suitable supervisors willing to commit to twelve months of direct, on-site supervision will be extremely difficult, particularly in smaller practices or rural areas where overseas-trained practitioners are most needed.

Third, there is no discussion of how the Council will ensure consistent application of supervision standards across different supervisors and practice settings. Without clear guidance and potentially some form of supervisor training or accreditation, there is a risk of highly variable oversight quality.

If Council proceeds with this pathway, I strongly recommend developing comprehensive supervisor guidance, providing supervisor training, and carefully monitoring outcomes in the first cohort to assess whether the supervision model is working effectively.

Page 7: Introduction of the proposed 'Teaching and research' pathway

Q15

Do you support the introduction of the 'Teaching and research' pathway?Click to learn more about the proposed pathway

Oppose

Q16

Please tell us why:

No. I strongly oppose this pathway for multiple reasons, including concerns about educational quality, risk management, and the likelihood that it will be used as a stepping stone to private practice rather than addressing any genuine academic workforce shortage.

Educational quality concerns
Clinical teaching requires current, evidence-based knowledge and the ability to teach within an established curriculum. Teaching in simulation clinics is not separate from clinical practice; it is where students develop the clinical judgement and decision-making patterns that will govern their future practice. Even teaching on plastic teeth requires sound clinical reasoning, current knowledge of evidence-based techniques, and understanding of the New Zealand practice context.

We currently employ internationally qualified individuals in simulation clinic roles who regularly contradict evidence-based curriculum immediately after registered faculty have provided instruction to students. These individuals fail to follow established teaching protocols, which undermines student learning through inconsistent messaging. This occurs despite these individuals not holding New Zealand registration and therefore having no formal authority over student education in New Zealand.

This pathway would formalise and exacerbate that problem by granting such individuals registration status, thereby legitimising their teaching role and making it substantially more challenging to address issues related to teaching quality. The proposed permanent supervision by a Council-approved supervisor employed by the same teaching institution does nothing to address this problem. Supervisors will not be present during teaching sessions and cannot monitor what is being taught to students in simulation clinics or tutorials.

The fundamental question the Council must address is whether anyone teaching clinical content to students should be required to hold complete registration in that scope of practice. Suppose a practitioner cannot meet the standards for full registration. In that case, they should not be teaching future practitioners clinical skills, because that is where clinical judgement and decision-making patterns are established. The fact that teaching occurs on plastic teeth rather than on patients does not diminish the importance of accurate, evidence-based, curriculum-consistent instruction.

Clinical competence degradation
As both an endodontist and educator, I understand that clinical competence requires regular practice with actual patients. A practitioner who spends three or more years teaching on plastic teeth, never treats actual patients, never manages complications or anxious patients or unexpected anatomy, and never works within New Zealand's medico-legal framework, is less clinically competent at year three than at initial registration.

This creates a perverse situation where practitioners who initially fail to meet registration standards spend several years further degrading their clinical skills due to a lack of practice, and then potentially seek complete registration and entry into private practice. This is backwards risk management. We should require demonstrated clinical competence before allowing teaching, rather than using teaching as a means to circumvent competence requirements.

The stepping stone problem
This pathway provides a clear path to complete registration for practitioners who cannot meet the standard requirements. The likely sequence is predictable. First, a practitioner who cannot meet the Competent Authority or Comparable Health System requirements due to insufficient practice hours, questionable training, or training in a non-recognised jurisdiction can use the Teaching and Research pathway to obtain New Zealand residency and establish themselves and their families here. Second, they spend two to three years in a teaching role, during which time their clinical skills deteriorate due to a lack of actual practice while they learn the system and build networks. Third, once established, they apply for complete registration via individual assessment or registration examination, potentially claiming their New Zealand teaching experience as evidence of competence or familiarity with New Zealand practice.

The result is that practitioners entering private practice who could not initially meet the usual registration standards have not maintained clinical competence through actual practice, have never been assessed treating actual patients in the New Zealand

context, and have used teaching as an immigration and establishment strategy rather than pursuing a genuine academic career.

The document itself notes the global shortage of dental academics. This raises an obvious question: why would practitioners remain in lower-paid academic roles if they can transition to private practice? There is no mechanism in this pathway to retain practitioners in teaching roles. Academic salaries are typically two-thirds to a half of what a private practitioner could earn, perhaps even more so in a busy specialist practice. There is no bond or commitment to remain in teaching, and registration can be transferred once the conditions are removed.

This is not an academic recruitment pathway. It is an immigration pathway disguised as academic recruitment. The permanent supervision and prohibition on independent practice will be temporary stepping stones, not career-long commitments.

Why the current approach is failing
The academic workforce crisis is real, and I am experiencing it firsthand. I am one of only three endodontists serving the South Island outside the dental school. I value teaching deeply and remain actively engaged in academic pursuits. Yet, even I could not sustain full-time academic work financially, and I have recently been reduced to 0.7 FTE.

If someone like myself, a registered specialist committed to education with a unique workforce position, cannot make full-time academic work viable, how will this pathway retain practitioners who are using teaching as an immigration strategy, cannot meet full registration standards, and have significantly higher earning potential once they obtain complete registration and leave teaching? It will not retain them. We will provide them with a pathway to establishment in New Zealand, where they will pursue private practice. However, we will return to the same crisis while having compromised the education of a cohort of students in the interim.

The problems facing the dental academic workforce include remuneration that cannot compete with private practice, a workload that continues to increase as staff numbers decrease, limited career progression opportunities compared to private practice, and an overall lack of financial viability for committed academics. This pathway addresses none of these problems.

What students need
Our students are already struggling significantly. They are entering a profession with high debt loads, increasing compliance burdens, uncertain economic futures, and competition from corporate dentistry. They deserve the best education we can provide. They require consistent, evidence-based teaching from registered practitioners who understand the New Zealand practice context, rather than an increased number of educators teaching contradictory material.

I would rather maintain high standards with fewer academics than compromise the education of students who will practise in New Zealand for three to four decades. Quality matters more than quantity in education. Smaller faculties of excellent, committed, and fully registered educators will produce better outcomes than larger faculties of inconsistent quality.

If the Council proceeds despite these concerns
Suppose the Council determines to proceed with this pathway despite the concerns raised. In that case, minimum safeguards should include time-limited registration with a maximum of three years that is non-renewable, explicit prohibition on using teaching experience as evidence for individual assessment applications, a requirement to sit complete registration examinations if seeking full registration with teaching time not counting as practice, bond requirements to repay proportionate costs if leaving teaching within five years, independent rather than same-institution oversight with Council-appointed assessors reviewing teaching quality, and requirements to maintain actual clinical practice such as one day per week in a supervised clinical setting to prevent skill degradation.
However, I remain opposed to the pathway in its entirety. If we need academics, we should recruit practitioners who meet full registration standards and address the systemic problems that prevent those practitioners from choosing or sustaining academic careers.

Page 9: Proposed removal of requirement for a medical degree for oral medicine specialist registration

Q17

Do you support removing the requirement for a medical degree for oral medicine specialist registration in New Zealand, subject to the relevant medical training and clinical experiences being embedded into the specialist training programme?Click to learn more about the proposed changes.

Support

Q18

Please tell us why:

Yes. This change appropriately aligns New Zealand with international oral medicine training whilst maintaining the requirement that essential medical components be incorporated into specialist training programmes. The requirement for a standalone medical degree has created an unnecessary barrier to registration for oral medicine specialists trained in other competent authority jurisdictions, where medical components are integrated into specialist training rather than requiring a separate prior degree.
The proposed approach of articulating the necessary medical components within the Gazette notice provides appropriate transparency and ensures Council can assess whether programmes adequately incorporate medical training. This is particularly important given that no New Zealand programme currently exists, and we are reliant on overseas-trained specialists.
My only concern is ensuring that Council maintains genuine oversight of whether programmes claiming to incorporate medical components do so to an adequate standard. The detail provided in the proposed Gazette notice about the required medical components will be essential for consistent assessment.

Page 10: Proposed removal of requirement to register in dental technology before registering in CDT

Q19

Do you support removing the requirement to register in dental technology before registering in clinical dental technology?Click to learn more about the proposed changes.

Support

Q20

Please tell us why:

Yes. This requirement is inconsistent with the Council's approach in other areas. We do not require dentists to register before registering as dental specialists, for example. Clinical dental technology is a distinct profession with its own scope of practice and competency requirements.
The competencies for clinical dental technology encompass the technical areas covered in dental technology, and entry into clinical dental technology training requires completion of an appropriate dental technology programme. Requiring separate prior registration in dental technology places an unnecessary regulatory and financial barrier in the pathway.
We already have practitioners registered only in clinical dental technology, either because they elected to remove dental technology registration after gaining clinical dental technology registration or because they registered under the Trans-Tasman Mutual Recognition Act based on Australian dental prosthetics registration. This demonstrates that the requirement is not necessary for safe practice.

Page 11: Proposed changes to the New Zealand registration examination requirements

Q21

Do you support the proposed changes to the New Zealand registration examination requirements?Click to learn more about the proposed changes.

Support

Q22

Please tell us why:

Yes. The clarification that USA registration examinations for applicants without prescribed qualifications must include a psychomotor clinical skills assessment is appropriate, given that some USA examinations have transitioned to theory-only formats. Registration examinations should assess actual clinical skills, rather than merely theoretical knowledge.
The reopening of dental hygiene, dental therapy, and oral health therapy examinations to candidates holding dental qualifications is reasonable. Whilst I understand Council's previous concerns about poor pass rates for dentists sitting these examinations, ultimately, the examination outcome assures competence. Candidates can make their own informed decisions about whether to invest in the examination process.
Extending oral health therapy examination eligibility to those holding combined dental therapy and hygiene qualifications provides consistency across the pathways.

Page 12: Proposed administrative changes to the prescribed qualifications

Q23

Do you have feedback on the proposed administrative changes to prescribed qualifications for any of the scopes of practice, as reflected in the draft Gazette notices?

Oral and maxillofacial surgery

Q24

Please tell us your feedback. When discussing multiple scopes, please indicate clearly which scope of practice you are referring to in your comment.

The administrative changes provide clear and consistent clarity. The amended footnote for the FRACDS(OMS) qualification appropriately clarifies that the prescribed qualification relates to the programme accredited and gazetted by the Council in March 2012, rather than the Fellowship the College may award based on its own criteria.
The general updates to terminology for consistency across scopes of practice and the removal of outdated entry pathways are sensible housekeeping measures that improve clarity.

Page 13: Proposed fees for the new registration pathways

Q25

Do you find the proposed fees for the new registration pathways reasonable?Proposed fee notice

Yes

Q26

Please tell us why or why not?

The proposed fees appear reasonable in terms of cost recovery for the oversight and supervision requirements built into each pathway. The Competent Authority registration fee of one thousand eight hundred and eighty-eight dollars for six months of oversight monitoring, the Comparable Health System fee of two thousand one hundred and seventy-nine dollars for twelve months of supervision monitoring, and the Teaching and Research fee of one thousand seven hundred and forty-three dollars for the first six months of supervision reports, all appear proportionate to the Council resources required.
However, I note that the actual cost of the Comparable Health System pathway, in particular, will be substantially higher when considering the supervisor's time commitment for twelve months of direct, on-site supervision. This cost falls on the supervisor and practice rather than being reflected in Council's fee, but it is a real cost that may make the pathway unworkable in practice.
The annual monitoring fee of ninety-seven dollars for Teaching and Research registrants with permanent supervision conditions is reasonable for the ongoing review of annual reports.

Page 14: Thank you for your time

Q27

Is there any additional feedback you would like to share on the consultation?

I understand the pressures facing Council in managing workforce shortages across the dental professions. I am experiencing those pressures directly as an academic, watching our faculty shrink and our teaching quality decline, whilst simultaneously working in private practice in a severely underserved specialist area.
However, the solution to workforce shortages cannot be to lower standards for entry to practice or, in the case of the Teaching and Research pathway, to create immigration pathways disguised as workforce solutions. The Competent Authority registration and Comparable Health System pathways represent reasonable risk-based approaches to recognising overseas practice experience whilst maintaining appropriate safeguards. I support those pathways with the reservations noted above.
The Teaching and Research pathway is fundamentally different. It does not maintain standards; it explicitly lowers them. It will not address the academic workforce crisis because it does not address any of the underlying causes of that crisis. It will compromise educational quality at a time when our students are already struggling. It will likely be used as a stepping stone to private practice rather than creating committed academic educators.
I urge Council to reject the Teaching and Research pathway and instead focus on addressing the systemic problems that prevent qualified, registered practitioners from choosing or sustaining academic careers. Better to struggle with high standards than succeed at lowering them.
The future of dentistry in New Zealand depends on the quality of education we provide to current students. That education must not be compromised.
