29 January 2026

Dental Council of New Zealand
Level 7, 22 The Terrace
Wellington 6011
By email: consultations@dcnz.org.nz

Tēnā koutou,

Re: Submission on Proposed Changes to Prescribed Qualifications for Oral Medicine Specialists

SUMMARY

We are four dual-qualified oral medicine specialists with hospital appointments in New Zealand. We oppose the proposal as currently framed (Question 5) but would support alternative pathways if specific conditions are met.

Key points:

- New Zealand currently has no accredited oral medicine training programme. The Council is setting policy for a pathway that does not yet exist.
- We propose a two-pathway model: shorter training for dual-qualified candidates, extended training for single-qualified candidates. Both routes would confer identical registration and scope.
- Four conditions for our support: (1) clear articulation of required medical competencies, with input from medical practitioners; (2) clinically immersive training; (3) assessment by evaluators qualified in those competencies; (4) ongoing outcome monitoring.
- The consultation proposes removal of the medical degree without the extended training duration that accompanied similar changes elsewhere. We ask the Council to explain this departure.
- We offer to meet with the Council to discuss clinical experience relevant to competency requirements, which cannot be detailed in a public submission due to patient privacy.

We write as four oral medicine specialists holding dual qualifications in medicine and dentistry. We each hold hospital appointments in New Zealand, with two of us also currently in private practice. Two of us have previously worked in Australia. We declare a professional interest in this consultation.

We oppose the proposal as currently framed in the consultation document (Question 5). We are not commenting on other aspects of the consultation.

We are not opposed to exploring alternative training models that could achieve equivalent outcomes without mandating a medical degree as an entry requirement. We oppose *this proposal* because it lacks the detail necessary to evaluate whether patient safety and training quality will be maintained. **We would support a revised proposal that addressed the following conditions:**

1. **Clear articulation of the medical competencies required for oral medicine practice in the New Zealand context, developed with input from medical practitioners;**
2. **Clinically immersive training in these competencies, not merely didactic;**
3. **Assessment by practitioners with the background to evaluate medical proficiency; and**
4. **Ongoing monitoring of outcomes for graduates, with commitment to review if concerns emerge.**

The Current Accreditation Context

The consultation document notes that accreditation of the University of Otago oral medicine programme ended in December 2023, and that "to date, in New Zealand no oral medicine programme has been accredited by Council that embeds the required medical components into the programme."

This context is critical. The Council is not proposing to modify an existing accredited pathway. It is proposing to change the prescribed qualifications in circumstances where:

- **No compliant domestic programme currently exists;**
- **No curriculum has been developed that embeds the "*necessary medical components*";**
- **No assessment framework has been established; *and***
- **It is unknown when, or whether, such a programme will be developed.**

The Council is therefore setting a policy framework for a training pathway that does not yet exist and may not exist in the form contemplated. If the prescribed qualifications are changed but no compliant programme emerges, New Zealand will have removed a training standard without replacing it with anything. We would encourage the Council to satisfy itself that implementation is feasible before finalising policy, rather than resolving implementation details after the decision is made.

A Two-Pathway Model

We suggest the most equitable approach would be two recognised routes to oral medicine specialist registration, each culminating in identical registration and scope:

- **A dual-qualification pathway (medical and dental degrees) with approximately three years of specialty training, reflecting the foundation already established; *and***
- **A single-qualification pathway (dental degree only) with extended training that incorporates the medical components necessary to achieve equivalent competency.**

This model has precedent elsewhere. In the United Kingdom and Ireland, practitioners holding both medical and dental degrees complete specialty training in approximately three years. Those entering with only dental qualifications undertake a longer programme, minimally five years, but practically, and often, exceeding this. Elsewhere in the Commonwealth, South Africa, which does not have a medical requirement, typically has a five year pathway to oral medicine specialisation (MSc 1 year, followed by clinical registrar training for 4-5 years).

We are aware that some in the UK have reported positive experiences with their revised framework. We note, however, that the UK change was accompanied by development of an extended training pathway for single-qualified candidates, and that this framework evolved iteratively over time with input from the specialty. The consultation document before us proposes removal of the medical degree requirement without proposing extended training. This is a material difference.

Training time is finite. If time must be devoted to acquiring medical competencies within specialty training, this affects time for oral medicine-specific competencies. There is no way to add substantial content without extending duration, unless something is removed or diluted. This logic applies regardless of jurisdiction.

Suggestions to simply align with Australia, which has never had a medical qualification in its framework, are overly simplistic. Australia's model evolved in a different context: a larger population, bigger training centres, and greater access to subspecialised care. Although oral medicine in Australia was historically considered for development as a dual-trained specialty, this never eventuated. New Zealand maintained a dual-qualification requirement because of judgments about what oral medicine practice here requires. To abandon that requirement without extending training assumes the historical judgment was wrong, or that competency requirements have changed. Neither assumption has been demonstrated.

If New Zealand intends to remove the medical requirement without extending training, we respectfully request that the Council explain how equivalent competency will be achieved in less time than comparable jurisdictions determined necessary.

What Medical Training Enables in Our Practice

Oral medicine is distinguished from other dental specialties by its focus on conditions where the mouth serves as a window to systemic health. The clinical presentations we manage, from autoimmune mucosal conditions to oral complications of immunosuppression, frequently require assessment and management that extends beyond the oral cavity. This is why medical competencies are integral to the specialty, not ancillary to it.

It has been suggested that even a medically qualified oral medicine specialist functions primarily through collaboration rather than independent clinical reasoning. This does not reflect our experience.

Collaboration is central to oral medicine, but we participate as colleagues contributing to diagnostic reasoning, not simply as referrers requesting assessment by others. When we consult with dermatologists, rheumatologists, neurologists, or physicians, we propose hypotheses, interpret findings, and contribute to management decisions. This differs qualitatively from referring because one lacks the competency to form a clinical view.

In daily practice, medical training enables us to:

- Identify when an oral presentation signals underlying systemic pathology, or indicates significant deterioration in a known condition;
- Request and interpret laboratory and imaging studies in the context of the whole patient;
- Prescribe and monitor systemic medications, including immunosuppressive agents;
- Evaluate patients with significant medical comorbidity in their broader clinical picture; and
- Recognise when a patient is acutely unwell and initiate appropriate urgent assessment.

These competencies matter particularly for at-risk populations: those with autoimmune conditions requiring immunosuppression, patients receiving emerging immunotherapy agents with mucosal toxicities, those with cognitive impairments who cannot easily articulate symptoms, and individuals with complicated medical histories who struggle when care is split across multiple providers. If the Council accepts these competencies are necessary for oral medicine practice, any training pathway must explicitly develop them.

Our Clinical Experience

We regularly encounter cases where medical competencies directly inform clinical reasoning and patient outcomes. Each of us has examples where medical training enabled recognition of serious systemic disease, presenting both with and without oral features, and where this recognition led to expedited, appropriate, and coordinated care.

We cannot describe these cases in a public submission due to patient privacy. We offer to meet with the Council or relevant advisors to discuss our clinical experience in a confidential setting, and would encourage such engagement prior to the Council reaching its conclusion.

Articulation of Required Competencies

The consultation document refers to "*necessary medical components*" being incorporated into training but leaves their content undefined. We raise a specific concern: has the

determination of what is "*necessary*" been informed by practitioners with medical registration and clinical experience in relevant domains?

Decisions about what medical competencies are necessary for a scope of practice that encompasses medical assessment and management should involve those with medical training. If the analysis has been conducted solely by those without medical qualifications, we question whether it can adequately identify the competencies required.

Before removing the medical degree requirement, we would anticipate the Council to articulate what medical knowledge and skills are required, at what level, how they correspond to the intended scope of practice, and how proficiency will be developed and tested. We would also expect transparency about who contributed to this analysis. Defining competencies with appropriate expert input should precede, not follow, a decision to change prescribed qualifications.

Clinically Immersive Training

Medical competencies cannot be developed through didactic teaching alone. They require sustained clinical immersion: direct patient contact, graded and supervised responsibility for clinical decisions, and exposure to the breadth and unpredictability of medical presentations.

The ability to recognise that a patient is seriously unwell is not primarily knowledge-based. It is developed through repeated exposure, pattern recognition, and calibration of judgment through feedback. Any revised pathway should include substantial, structured clinical placements in medical settings with active participation, not observation alone.

The UK facilitates this through multidisciplinary clinics enabled by population and practitioner numbers. Whether equivalent clinical exposure is feasible within New Zealand's health system, in smaller training centres, and particularly given the absence of an accredited programme, remains an open question that should be resolved before policy is finalised.

Assessment of Medical Competencies

If medical competencies are required for oral medicine practice, evaluating whether trainees have attained them requires examiners with relevant expertise. A supervisor or examiner without medical training is not well placed to judge whether a trainee can recognise systemic disease, interpret investigations, or manage a deteriorating patient.

We seek clarification regarding whether medical practitioners will be involved in examining or certifying trainees, and whether external validation will be sought from medical colleges or regulators. The means by which competency is tested is the mechanism through which training standards are assured. If the assessment process

cannot reliably evaluate medical proficiency, the standard cannot be maintained regardless of curriculum content.

Monitoring and Review

Any significant change to training requirements carries inherent uncertainty. We consider it essential that the Council establish mechanisms to track outcomes for graduates of any revised pathway and revisit arrangements if concerns emerge.

Workforce pressures may create reluctance to revisit arrangements once implemented. We encourage the Council to commit in advance to longitudinal tracking of safety outcomes and articulate circumstances under which it would reconsider its decision. Such commitment would provide assurance that the change is being implemented with appropriate ongoing scrutiny.

Conclusions

We support accessible training pathways for oral medicine, provided they unambiguously achieve the competencies required for safe practice. We have proposed a two-pathway model consistent with international precedent and identified four conditions we consider essential. These are not obstacles to change; they are the mechanisms by which change can be implemented responsibly.

We respectfully request the Council address these matters before finalising its decision, to ensure any change is made on a sound evidentiary basis, with appropriate consultation, and with proper regard to the standard of care patients are entitled to expect.

Nāku noa, nā

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