26 January 2026

Dental Council of New Zealand
By email: consultations@dcnz.org.nz

Submission: Proposed Changes to Prescribed Qualifications for Oral Medicine Specialists

Dear Members of the Dental Council,

We thank the Council for the opportunity to submit on this consultation. We write jointly as two dental graduates who have subsequently undertaken medical training and who intend to pursue careers in oral medicine. We therefore are writing on the specific parts of the proposal looking towards changes in oral medicine training (Question 5), but not the other aspects of the consultation document on registration of overseas practitioners.

We declare that we have a personal interest in the training pathway for oral medicine, as the outcome of this consultation may affect our future training options and career trajectory. We offer this submission to contribute a perspective that we believe may not otherwise be represented in this consultation: that of prospective trainees.

We support the development of training pathways that maintain high standards while improving accessibility. However, we have concerns about the framing of this consultation and wish to offer observations that we hope will assist the Council in its deliberations.

1. Reconsidering Which Training Component Presents the Greater Barrier

The consultation document characterises the medical degree as a barrier to oral medicine training. From a trainee's perspective, this warrants closer examination.

The DClinDent programme at the University of Otago is a three-year full-time residential programme. Domestic tuition fees are approximately $35,000–40,000 per year, totalling $105,000–120,000. The programme's intensive clinical and research requirements effectively preclude paid employment during training. Trainees must also meet living expenses in Dunedin for three years, adding approximately $60,000–75,000 to the total cost.

By comparison, the MBChB (medical degree) for graduate entry is three to four years, with domestic tuition fees of approximately $18,000–19,000 per year—totalling $55,000–75,000. Students in their sixth year (trainee interns) also receive a stipend. Additionally, we have found that most dental graduates who find themselves in lateral entry medical training are able to support themselves with ongoing employment in dentistry. Critically, upon graduation, medical graduates enter paid employment as house officers, while continuing to develop clinical experience relevant to oral medicine practice.

We raise this to note that where training costs and associated barriers have become an important argument, that the characterisation of the medical degree as the primary financial barrier may not reflect the lived experience of trainees. If equity is a concern, then the barriers presented by full-time doctoral study without income may warrant equal attention.

2. Supporting Multiple Pathways Without Creating New Barriers

We understand the Council's interest in developing training options that do not require a medical degree. We do not oppose this in principle, provided that any new pathway demonstrably prepares graduates for the full scope of oral medicine practice.

However, we would be concerned if the development of a single-qualification pathway inadvertently devalued or discouraged the dual-qualification pathway that we are already embarked on. Trainees may wish to pursue medical training for other reasons: educational, clinical, or career reasons. They should not find that their choice is treated as redundant or that it disadvantages them relative to colleagues who train(ed) differently.

We would support an approach that offers genuine choice (i.e. the greatest reduction of barriers and increase of equity): multiple pathways leading to the same scope of practice, with each pathway required to demonstrate that it prepares graduates for that scope.

3. Observations on Medical Training

We offer the following observations about our medical training, not to suggest it is the only valid pathway, but to contribute to the Council's understanding of what it provides:

- Systematic exposure to pathophysiology across body systems, which has shaped how we recognise oral manifestations of systemic disease and vice versa.
- Longitudinal responsibility for acutely unwell patients, developing clinical judgment about deterioration, risk stratification, and escalation.
- Integration into multidisciplinary teams, learning not only clinical content but how to communicate across disciplinary boundaries as a peer.
- Competence in ordering and interpreting investigations, understanding pharmacology at a systems level, and participating in shared decision-making with medical colleagues.
- A global understanding of the mechanics and intricacies of the New Zealand public health system which may not reasonably be obtained by practitioners entering the pathway from a private practice or university-based perspective; this is essential when considering the majority of oral medicine work is carried out in public-based systems.

If a single-qualification pathway is developed, we would respectfully ask how these competencies will be acquired and assessed.

4. New Zealand Context

New Zealand's small population and healthcare system present unique challenges. With limited case volumes, oral medicine trainees may have less exposure to rare conditions than their counterparts in larger centres or jurisdictions. A broad foundation in medical reasoning as found in the MBChB qualification and post-graduate training may help compensate for this by equipping graduates to recognise and manage unfamiliar presentations.

Additionally, New Zealand’s healthcare system operates with a degree of clinical integration that differs from that seen in larger and more established systems. Specialists are often required to work across a broader range of clinical contexts, with oral medicine specialists commonly spanning both specialist and generalist roles. Training frameworks should align with this integrated model of practice.

5. International Recognition and Workforce Sustainability

We note that internationally, jurisdictions have addressed the question of training pathways in different ways. The United Kingdom, for example, offers two routes to oral medicine specialty recognition: one for dual-qualified practitioners (with medicine), and an extended pathway (minimum five years) for those with dental qualifications alone. This reflects a recognition that different entry points may require different training durations to achieve equivalent competency for practice.

We raise this not as prescriptive, but to observe that the training pathway chosen will have implications for how New Zealand graduates are recognised elsewhere around the globe. Trainees making career decisions benefit from clarity about the international standing of their qualifications.

6. Engagement with Prospective Trainees

We note that neither of us has been directly engaged by the Council to understand our perspectives on these proposed changes. We appreciate that written consultation is open to all, but we respectfully observe that prospective trainees have direct insight into the practical implications of pathway design including the financial, logistical, and career considerations that influence specialty choice.

We would welcome the opportunity for the Council to engage directly with prospective trainees before finalising this decision. Such engagement would strengthen the foundation for the Council's decision and ensure that the perspectives of those who will constitute the future oral medicine workforce (i.e. the one you are trying to grow) are appropriately considered.

Conclusion

We support the Council's efforts to develop sustainable training pathways for oral medicine in New Zealand. We do not oppose the development of pathways that do not require a medical degree, provided these pathways demonstrably prepare graduates for the scope of practice they will be expected to perform in the New Zealand setting.

We would ask that the Council:

- Consider the breadth of training qualifications and assess the financial ramifications of all of these on trainee access and equity;
- Ensure that trainees who wish to pursue dual qualification are not disadvantaged by the development of alternative pathways;
- Articulate clearly the medical competencies required for oral medicine practice and how any new pathway will ensure these are acquired and assessed;
- Engage directly with prospective trainees to inform its decision.

We remain committed to pursuing careers in oral medicine and to contributing to the oral health of Aotearoa New Zealand. We thank the Council for considering this submission and remain available to provide further input if that would be of assistance.

Yours sincerely,

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